Marchman Act
User Reference Guide
2003

FLORIDA DEPARTMENT OF
CHILDREN
& FAMILIES

Produced by
State of Florida
Department of Children and Families
Substance Abuse Program

Marchman Act Handbook
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Development and Use of Marchman Act Handbook

Use of Handbook

This Handbook is intended to be used for information purposes only. The information presented herein is not legally binding and does not have any legal authority. Only Chapters 397, F.S., 65D-30, F.A.C., and federal laws/regulations have legal authority.

The creation of administrative rules to implement and clarify statute is governed by Chapter 120, F.S. Thus state law prohibits repetition of statute in administrative rules. Therefore, persons must be familiar with and routinely reference both the statutes and the corresponding rules to ensure correct implementation of the Marchman Act law.

Substantial sections of the Appendices have been taken from the Florida Drug Control Strategy, published by the Office of Drug Control in the Executive Office of the Governor.

For training purposes, that statute and the corresponding administrative rules concerning the same subjects have been displayed side-by-side; statutes are sequentially displayed in the left column of each page in numerical order. The corresponding administrative rules are sequentially displayed in the right column. However, some rules are intentionally listed out of numerical sequence to display them next to the statute to which they refer. Other rules pertaining to program standards, licensing standards, Children's Substance Abuse Services, and other sections to which no specific statute is referenced have been omitted from the side-by-side display and are located in Appendices.

Substance Abuse Website

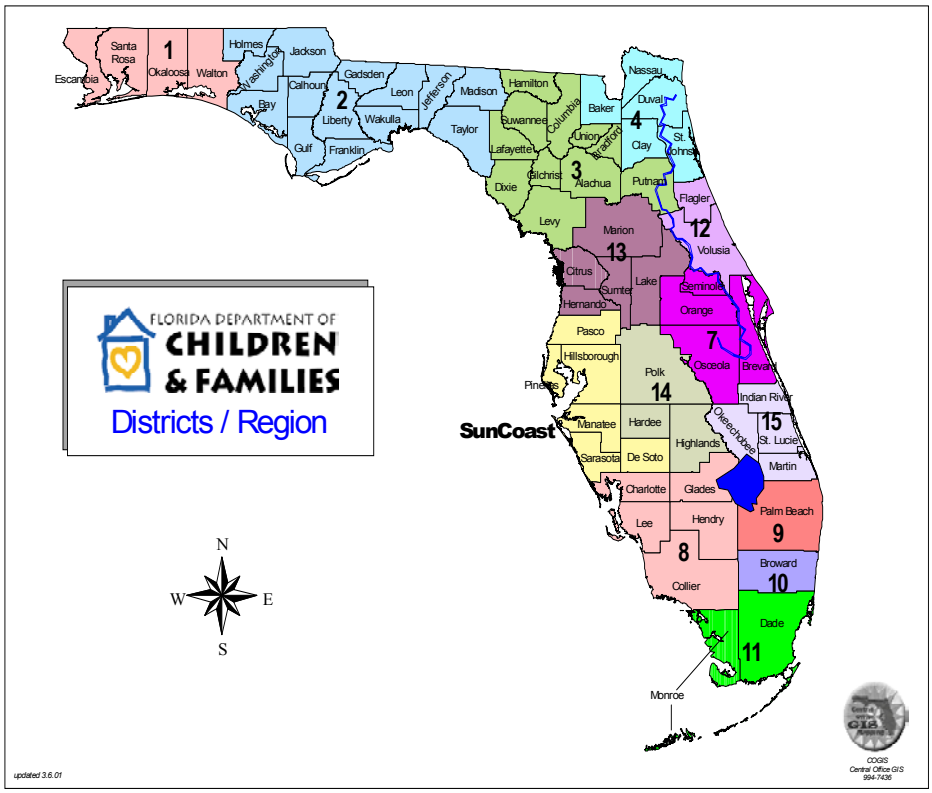
The primary website for Department of Children and Family Services' Substance Abuse Program website is MyFlorida.com

Step 1. Go to www.MyFlorida.com and in the column on the right and click on the category "government"
Step 2. Click on **Executive Branch**
Step 3. Under **State Agencies and Organizations**, click on **Department of Children and Families**.
Step 4. Under Children and Family Services, click **on Substance Abuse and Mental Health**
Step 5. Click on any one of the following subjects:

- **Substance Abuse** for current news and special reports
- Reports and Publications **for plans, rules, policies, forms and other documents**
- **Provider Search** to obtain information on how to contact substance abuse and mental health providers in all of Florida's counties.
- **Links and Resources** to link to state, federal, substance abuse, prevention, and mental health resources.
- **Contact Us** for a list of district personnel, addresses, and telephone numbers.

Marchman Act
Technical Assistance

Should you have questions about the Marchman Act or access to substance abuse information or services, contact the substance abuse program staff at the Department of Children and Family Services, as indicated below.



District Substance Abuse Prevention Coordinators:

District 1	Susan Sweeney 850 595-8366	District 9	Cathy Claud 561 540-5660
District 2	Jonn Shelton 850 488-2419	District 10	954 713-3026
District 3	Cynthia Tyson 352 955-5053	District 11	Karlene Tomlinson 305 349-1322
District 4	Jan Holder 904 723-2014	District 12	Angela Jackson 386 254-3744
Suncoast	.Bob Holm 813 558-5715	District 13	Troy McDermott 352 330-2177
District 7	Eric Butler 407 245-0420	District 14	Jim Mosley 863 619-4171
District 8	Elizabeth Drake 941 338-1272	District 15	George Woodley 561 467-552

Marchman Act
History and Overview

History

In 1970 the Florida Legislature enacted Chapter 397 governing the Treatment and Rehabilitation of Drug Dependents in 1970. The following year, it enacted Chapter 396 titled the Myers Act as the state's "Comprehensive Alcoholism Prevention, Control, and Treatment Act", modeled after the federal Hughes Act. Each of these laws, each governing different aspects of addiction had a different Florida Administrative Code (or rules) promulgated by the state to fully implement the respective pieces of legislation.

Since persons with substance abuse issues often don't contain their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not address the problems faced by Florida's citizens.

In 1993 Representative Steven Wise of Jacksonville introduced legislation to combine chapters 396 and 397 of Florida Statutes into a single law that clearly spelled out legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination, and children's substance abuse services.

The statute was named the Hal S. Marchman Alcohol and Other Drug Services Act of 1993 -- generally referred to as the Marchman Act. The Act was named after Rev. Hal. S. Marchman, a tireless advocate for persons who suffer from alcoholism and drug abuse, who was recognized by the Legislature for his contributions addressing the delivery of substance abuse services. a prominent advocate for improved substance abuse services.

To implement the new chapter 397, Florida Administrative Code was developed to provide the standards that service providers must uphold in order to be licensed to serve persons with addictions. It also provided detailed policies governing the entire licensing process as well as other provisions. These rules are identified as Chapter 65D-30 of the Florida Administrative Code. These rules have specific legislative authority. Since the rules cannot restate language from the statute, it is critical that individuals are aware of the provision from the law AND the rules in order to carry out the law, protect their agencies from liability, and protect their clients from harm.

Related Legislation

(see Appendix A for more detail)

The Marchman Act is the Florida Substance Abuse Impairment Act and it does not serve any other purpose. For many persons, the use of other statutes may be more appropriate. Alternative statutes may include:

The Florida Mental Health Act --The Baker Act Chapter 394, F.S. governs all issues related to mental illness. The definition of mental illness specifically excludes intoxication and substance abuse impairment.

Developmental Disabilities, Chapter 393, F.S., governs all disorders or syndromes that are attributable to retardation, cerebral palsy, autism, spina bifida or Prader-Wili Syndrome and that constitute a substantial handicap that can reasonably be expected to continue indefinitely.

Emergency Examination and Treatment of Incapacitated Persons Act s. 401.445, F.S. governs EMS examination and treatment without consent where an

emergency medical condition is a life-threatening one.

EMTALA/COBRA, 42 USC 1395dd A federal statute prohibiting hospitals to delay or deny emergency medical services, including psychiatric and substance abuse emergencies. The law requires that each patient must have a medical screening conducted within the full capability and capacity of the hospital and must be stabilized before a transfer or discharge takes place.

Access to Emergency Services and Care. 395.1041, F.S. is a state statute, equivalent of the federal EMTALA/COBRA law, prohibiting the denial of emergency services and care by hospitals and physicians and enforcing the ability of persons to get all necessary and appropriate emergency care within the capability and capacity of each hospital. This statute also requires hospitals to adhere to rights and involuntary examination procedures provided by the Baker Act, regardless of whether the hospital is designated as a receiving or treatment facility.

Adult Abuse, Neglect, and Exploitations. 415.1051, F.S. is a state statute that may be appropriate when a vulnerable adult (elderly or disabled) is alleged to be a victim of abuse, neglect, or exploitation and lacks the capacity to consent. This means a mental impairment that causes a person to lack sufficient understanding or capacity to make or communicate responsible decisions concerning his person or property, including whether or not to accept protective services from DCF.

Advance Directive. Chapter 765, F.S. provides that if a person has previously executed an advance directive designating a health care surrogate and a physician has found the person to be incompetent or incapacitated to consent to his/her own treatment, the surrogate may instead be asked to provide such consent. In the absence of an advance directive, a health care proxy may be notified, if a person meeting the degree of relationship is available to serve.

Guardianship. Chapter 744, F.S. governs guardianship procedures. Some persons, due to their incapacity, require either a limited or a plenary guardian appointed by the court to make many life decisions. An incapacitated person is one who has been judicially determined to lack the capacity to manage at least some of his/her property or to meet at least some of the essential health and safety requirements of such person.

Legislative Intent

The 1993 Florida Legislature studied issues surrounding the use and abuse of alcohol and other drugs. The legislators made the following findings:

1. Substance abuse is a major health problem and leads to such profoundly disturbing consequences as serious impairment, chronic addiction, criminal behavior, vehicular casualties, spiraling health care costs, AIDS, and business losses, and profoundly affects the learning ability of children within our schools and educational systems. Substance abuse impairment is a disease, which affects the whole family and the whole society and requires specialized prevention, intervention, and treatment services that support and strengthen the family unit.

2. Provide for a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and treatment services in the least restrictive environment of optimum care that protects and respects the rights of clients, especially for involuntary admissions, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

3, Ensure within available resources a full continuum of substance abuse services based on projected identified needs, delivered without discrimination and with adequate provision for specialized needs.

4. Discourage substance abuse by promoting healthy lifestyles and drug-free schools, workplaces, and communities.

5. Integrate program evaluation efforts, adequate administrative support services, and quality assurance strategies with direct service provision requirements and to ensure funds for these purposes.

6. Require the cooperation of departmental programs, services, and program offices in achieving the goals of this chapter and addressing the needs of clients.

7. Provide, for substance abuse impaired adult and juvenile offenders, an alternative to criminal imprisonment by encouraging the referral of such offenders to service providers not generally available within the correctional system instead of or in addition to criminal penalties.

8. Provide, within the limits of appropriations and safe management of the correctional system, substance abuse services to substance abuse impaired offenders who are incarcerated within the Department of Corrections, in order to better enable these inmates to adjust to the conditions of society presented to them when their terms of incarceration end.

9. Provide for assisting substance abuse impaired persons primarily through health and other rehabilitative services in order to relieve the police, courts, correctional institutions, and other criminal justice agencies of a burden that interferes with their ability to protect people, apprehend offenders, and maintain safe and orderly communities.

10. Establish a clear framework for the comprehensive provision of substance abuse services in the context of a coordinated and orderly system.

11. Freedom of religion of all citizens shall be inviolate. Nothing in this act shall give any governmental entity jurisdiction to regulate religious, spiritual, or ecclesiastical services.

Client Rights

The Marchman Act provides an array of statutorily protected rights of persons seeking and or receiving substance abuse services as well as due process rights of those persons for whom involuntary interventions are sought. These include:

1. **INDIVIDUAL DIGNITY** must be respected at all times and upon all occasions, including any occasion when the client is admitted, retained, or transported. Substance abuse clients who are not accused of a crime or delinquent act may not be detained or incarcerated in jails, detention centers, or training schools of the state, except for purposes of protective custody in strict accordance with this chapter. A client may not be deprived of any constitutional right.

2. **NONDISCRIMINATORY SERVICES** Service providers may not deny a client access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, HIV status, prior service departures against medical advice, disability, or number of relapse episodes. Service providers may not deny a client who takes medication prescribed by a physician access to substance abuse services solely on that basis. Service providers who receive state funds to provide substance abuse services may not, provided space and sufficient state resources are available, deny a client access to services based solely on inability to pay.

3. **QUALITY SERVICES**. Each client 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. Each client in treatment must be afforded the opportunity to participate in the formulation and periodic review of his or her individualized treatment or service plan to the extent of his or her ability to so participate. It is the policy of the state to use the least restrictive and most appropriate services available, based on the needs and the best interests of the client and consistent with optimum care of the client. Each client must be afforded the opportunity to participate in activities designed to enhance self-image.

4. **COMMUNICATION**. Each client has the right to communicate freely and privately with other persons within the limitations imposed by service provider policy. Because the delivery of services can only be effective in a substance abuse free environment, close supervision of each client's communications and correspondence is necessary, particularly in the initial stages of treatment, and the service provider must therefore set reasonable rules for telephone, mail, and visitation rights, giving primary consideration to the well-being and safety of clients, staff, and the community. It is the duty of the service provider to inform the client and his or her family if the family is involved at the time of admission about the provider's rules relating to communications and correspondence.

5. **CARE AND CUSTODY OF PERSONAL EFFECTS**. A client has the right to possess clothing and other personal effects. The service provider may take temporary custody of the client's personal effects only when required for medical or safety reasons, with the reason for taking custody and a list of the personal effects recorded in the client's clinical record.

6. **EDUCATION OF MINORS**. Each minor client in a residential service component is guaranteed education and training appropriate to his or her needs. The service provider shall coordinate with local education agencies to ensure that education and training is provided to each minor client in accordance with other applicable laws and regulations and that parental responsibilities related to such education and training are established within the provisions of such applicable laws and regulations. Nothing in this chapter may be construed to relieve any local education authority of its obligation under law to provide a free and appropriate education to every child.

7. **CONFIDENTIALITY OF CLIENT RECORDS**. 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:

8. **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.

9. **HABEAS CORPUS**. At any time, and without notice, a client involuntarily retained by a provider, or the client's parent, guardian, custodian, or attorney on behalf of the client, may petition for a writ of habeas corpus to question the cause and legality of such retention and request that the court issue a writ for the client's release.

10. **LIABILITY AND IMMUNITY.** Service provider personnel who violate or abuse any right or privilege of a client under this

chapter are liable for damages as determined by law. All persons acting in good faith, reasonably, and without negligence in connection with the preparation or execution of petitions, applications, certificates, or other documents or the apprehension, detention, discharge, examination, transportation, or treatment of a person under the provisions of this chapter shall be free from all liability, civil or criminal, by reason of such acts.

Voluntary Admission

A person, whether adult or minor, who wishes to enter treatment for substance abuse may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, a person of any age 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.

Involuntary Admissions

The Marchman Act encourages persons to seek out treatment on a voluntary basis and to be actively involved in planning their own services with the assistance of qualified professionals. However, denial of addiction is a common symptom, raising a barrier to early intervention and treatment. As a result, treatment often comes as a result of a spouse, employer, doctor, judge or other person with influence over one's life to obtain needed substance abuse services.

The Marchman Act established a variety of methods under which substance abuse assessment, stabilization and treatment could be obtained on an involuntary basis. There are five involuntary admission procedures. Three of the procedures do not involve the court, while two require direct petitions to the circuit court. The three non-court procedures are:

- Protective Custody
- Emergency Admission
- Alternative Involuntary Assessment for Minors

However, the law also offers two court-related procedures, including:

- Involuntary Assessment and stabilization
- Involuntary Treatment

Regardless of the court-involved or non court-involved nature of the proceedings, the same criteria for involuntary admission apply.

Criteria

The criteria for all involuntary admissions includes:

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**

2a. 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.

Each of the five methods of initiating an involuntary admission specified above has different requirements and procedures. Please read the appendices of this document to learn of the specific methods.

Protective Custody

This procedure is used by law enforcement officers when a person is intoxicated in public or brought to the attention of the officer. The purpose is to take the person to a safe environment where the person can be assessed to determine the need for treatment The officer may take the person home, to a hospital, a detoxification center, or addiction receiving facility, or in certain circumstances, to a jail. Minors cannot be taken to jail.

Emergency Admission

This procedure permits a person who appears to meet the criteria for involuntary admission to be admitted to a hospital, and addiction receiving facility or a detoxification facility for emergency assessment and stabilization. This procedure may be initiated by a physician, spouse, guardian, relative, or any responsible adult who has personal knowledge of the person. In the case of a minor, emergency admission can be initiated by a parent, legal guardian or legal custodian. In any case, the application for an emergency admission must be accompanied by the certificate of a physician.

Alternative Involuntary Assessment for Minors

This procedure provides a way for a parent, legal guardian or legal custodian to have a minor admitted to an addiction receiving facility to assess the minor's need for treatment.

Involuntary Assessment & Stabilization

This procedure involves filing a petition with the Clerk of the court. The petition may be filed by the person's spouse, guardian, any relative, a private practitioner, the director of a licensed service provider, or any three adults with knowledge of the person. If the person is a minor, the petition may be filed by a parent, a legal guardian, a legal custodian, or a licensed service provider. The court can schedule a hearing to take place within 10 days or can issue an ex parte order immediately. The person can be admitted to a hospital, an addictions receiving facility or a detoxification facility for assessment and stabilization to determine the person's need for treatment.

Involuntary Treatment

This procedure involves filing a petition with the clerk of court after the person has been involved in at least one of the four previously mentioned procedures. The petition may be filed by the same petitioners as involuntary assessment.

Oversight

The Department of Children and Family Services is designated the "Substance Abuse Authority" of Florida. It is required to adopt rules establishing standards relating to the rights and privileges of persons seeking substance abuse prevention and treatment from licensed service providers.

The Florida Local Advocacy Council is appointed by the Governor to investigate complaints and monitor programs that are operated, funded, licensed, or designated by the Department of Children and Families. is also responsible to oversee the proper implementation of the Marchman Act. Any licensed service provider must allow access to any person and the clinical and legal records of any person by members of the Council.

Matrix
Marchman Act

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NA	NA	65D-30.003(12)	Department Recognition of Certifying Organizations for Addiction Professionals
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NA	NA	65D-30.003(14)	Licensing of Private Practices
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NA	NA	65D-30.007	Standards for Residential Treatment
NA	NA	65D-30.008	Standards for Day or Night Treatment with Host Homes
NA	NA	65D-30.009	Standards for Day or Night Treatment
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Statute & Rule Text

Marchman Act
Chapter 397, F.S.
Part I

General Provisions

397.301 Short title.—This act may be cited as the "Hal S. Marchman Alcohol and Other Drug Services Act of 1993."

397.305 Legislative findings, intent, and purpose.—

(1) Substance abuse is a major health problem and leads to such profoundly disturbing consequences as serious impairment, chronic addiction, criminal behavior, vehicular casualties, spiraling health care costs, AIDS, and business losses, and profoundly affects the learning ability of children within our schools and educational systems. Substance abuse impairment is a disease which affects the whole family and the whole society and requires specialized prevention, intervention, and treatment services that support and strengthen the family unit. This chapter is designed to provide for substance abuse services.

(2) It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and treatment services in the least restrictive environment of optimum care that protects and respects the rights of clients, especially for involuntary admissions, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

(3) It is the intent of the Legislature to ensure within available resources a full continuum of substance abuse services based on projected identified needs, delivered without discrimination and with adequate provision for specialized needs.

(4) It is the goal of the Legislature to discourage substance abuse by promoting healthy lifestyles and drug-free schools, workplaces, and communities.

(5) It is the purpose of the Legislature to integrate program evaluation efforts, adequate administrative support services, and quality assurance strategies with direct service provision requirements and to ensure funds for these purposes.

Florida Administrative Code
65D-30, FAC
Florida Administrative Code

65D-30.001 Title. These rules shall be known as the licensure standards for "Substance Abuse Services". Specific Authority 397.321(5) FS.

65D-30.002 Definitions

(1) "Abbreviated Treatment Plan" means a shorter version of a treatment plan that is developed immediately following placement in an addictions receiving facility or detoxification component and is designed to expedite planning of services typically provided to clients placed in those components.

(2) "Accreditation" means the process by which a provider satisfies specific nationally accepted administrative, clinical, medical, and facility standards applied by an accrediting organization that has been approved by the department.

(3) "Aftercare Plan" means a written plan that specifies goals to be achieved by a client or family involved in aftercare.

(4) "Ancillary Services" means services such as legal, vocational, employment, mental health, prenatal care, diagnostic testing, public assistance, child care, and transportation, that may be either essential or incidental to a client's recovery.

(5) "Assessment" means a process used to determine the type and severity of a client's substance abuse problem and includes a psychosocial assessment and, depending upon the component, a physical health assessment.

(6) "Authorized Agent of the Department" means a qualified person designated by the department to conduct licensing inspections and other regulatory duties permitted in Chapter 397, F.S., Part II.

(7) "Case Management" means a process which is used by a provider to ensure that clients receive services appropriate to their needs and includes linking clients to services and monitoring the delivery and effectiveness of those services.

(8) "Certification" means the process by which an individual achieves nationally accepted standards of competency and proficiency in the field of substance abuse

(6) It is the intent of the Legislature to require the cooperation of departmental programs, services, and program offices in achieving the goals of this chapter and addressing the needs of clients.

(7) It is the intent of the Legislature to provide, for substance abuse impaired adult and juvenile offenders, an alternative to criminal imprisonment by encouraging the referral of such offenders to service providers not generally available within the correctional system instead of or in addition to criminal penalties.

(8) It is the intent of the Legislature to provide, within the limits of appropriations and safe management of the correctional system, substance abuse services to substance abuse impaired offenders who are incarcerated within the Department of Corrections, in order to better enable these inmates to adjust to the conditions of society presented to them when their terms of incarceration end.

(9) It is the intent of the Legislature to provide for assisting substance abuse impaired persons primarily through health and other rehabilitative services in order to relieve the police, courts, correctional institutions, and other criminal justice agencies of a burden that interferes with their ability to protect people, apprehend offenders, and maintain safe and orderly communities.

(10) It is the purpose of the Legislature to establish a clear framework for the comprehensive provision of substance abuse services in the context of a coordinated and orderly system.

(11) It is the intent of the Legislature that the freedom of religion of all citizens shall be inviolate. Nothing in this act shall give any governmental entity jurisdiction to regulate religious, spiritual, or ecclesiastical services.

397.311 Definitions.—As used in this chapter, except part VIII:

(1) "Ancillary services" are services which include, but are not limited to, special diagnostic, prenatal and postnatal, other medical, mental health, legal, economic, vocational, employment, and educational services.

(2) "Assessment" means the systematic evaluation of information gathered to determine the nature and severity of the client's substance abuse problem and the client's need and motivation for services. Assessment entails the use of a psychosocial history through professional experience and a curriculum of study for addiction professionals that has been recognized by the department.

(9) "Client Registry" means a system which is used by two or more providers to share information about clients who are applying for or presently involved in detoxification or maintenance treatment using methadone, for the purpose of preventing the concurrent enrollment of clients with more than one methadone provider.

(10) "Client" or "Participant" means any person who receives substance abuse services from a provider.

(11) "Client or Participant Record" means the record of substance abuse services provided to a client or participant and includes documentation of progress.

(12) "Clinical Services" means services such as screening, assessment, placement, treatment planning, counseling, and case management.

(13) "Clinical Staff" means those employees of a provider who are responsible for providing clinical services to clients.

(14) "Clinical Summary", as used in the context of these rules, means a written statement summarizing the results of the psychosocial assessment relative to the perceived condition of the client and a further statement of possible service needs based on the client's condition.

(15) "Competency and Ability of Applicant" means a determination that an applicant for a license under Chapter 397, F.S., is able or unable to demonstrate, through a background check on education and employment history, the capability of providing substance abuse services in accordance with applicable laws and regulations.

(16) "Component" means the operational entity of a provider that is subject to licensing. The primary components are listed and defined below.
(a)"Addictions Receiving Facility" is a secure, acute-care, residential facility operated 24 hours-per-day, 7 days per-week, designated by the department to serve persons found to be substance abuse impaired as described in Section 397.675, F.S., and who meet the placement criteria for this component.
(b) "Detoxification" is a process involving sub-acute care that is provided on a residential or an outpatient basis to assist clients who meet the placement criteria for this component to withdraw from the physiological and psychological effects of substance abuse.
(c) "Residential Treatment" is provided on a residential

supplemented, as required by rule, by medical examinations, laboratory testing, and psychometric measures.

(3) "Authorized agent of the department" means a person designated by the department to conduct any audit, inspection, monitoring, evaluation, or other duty imposed upon the department pursuant to this chapter. An authorized agent must be identified by the department as:
(a) Qualified by the requisite expertise and experience;
(b) Having a need to know the applicable information; and
(c) Having the assigned responsibility to carry out the applicable duty.

(4) "Beyond the safe management capabilities of the service provider" refers to a client who is in need of:
(a) Supervision;
(b) Medical care; or
(c) Services,
beyond that which the service provider or service component can deliver.

(5) "Client" means a recipient of alcohol or other drug services delivered by a service provider but does not include an inmate pursuant to part VIII unless expressly so provided.

(6) "Client identifying information" means the name, address, social security number, fingerprints, photograph, and similar information by which the identity of a client can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information.

(7) "Court" means, with respect to all involuntary proceedings under this chapter, the circuit court of the county in which the judicial proceeding is pending or where the substance abuse impaired person resides or is located, and includes any general or special master that may be appointed by the chief judge to preside over all or part of such proceeding. Otherwise, "court" refers to the court of legal jurisdiction in the context in which the term is used in this chapter.

(8) "Department" means the Department of Children and Family Services.

(9) "Director" means the chief administrative officer of a service provider.

(10) "Disclose" or "disclosure" means a communication of

basis 24 hours-per-day, 7 days-per-week, and is intended for clients who meet the placement criteria for this component. For the purpose of these rules, there are five levels of residential treatment that vary according to the type, frequency, and duration of services provided.
(d) "Day or Night Treatment with Host Homes" is provided on a nonresidential basis at least three hours each day and at least 12 hours each week and is intended for clients who meet the placement criteria for this level of care. This component also requires that each client reside with a host family as part of the treatment protocol.
(e) "Day or Night Treatment" is provided on a nonresidential basis at least three hours per day and at least 12 hours each week and is intended for clients who meet the placement criteria for this component.
(f) "Intensive Outpatient Treatment" is provided on a nonresidential basis and is intended for clients who meet the placement criteria for this component. This component provides structured services each day that may include ancillary psychiatric and medical services.
(g) "Outpatient Treatment" is provided on a nonresidential basis and is intended for clients who meet the placement criteria for this component.
(h) "Aftercare" involves structured services provided to individuals who have completed an episode of treatment in a component and who are in need of continued observation and support to maintain recovery.
(i) "Intervention" includes activities and strategies that are used to prevent or impede the development or progression of substance abuse problems
(j) "Prevention" includes activities and strategies that are used to preclude the development of substance abuse problems.
(k) "Medication and Methadone Maintenance Treatment" is provided on a nonresidential basis which utilizes methadone or other approved medication in combination with clinical services to treat persons who are dependent upon opioid drugs, and is intended for persons who meet the placement criteria for this component.

(17) "Control of Aggression" means the application of de-escalation and other approved techniques and procedures to manage aggressive client behavior.

(18) "Counseling" means the process, conducted in a facility licensed under Chapter 397, F.S., of engaging a client in a discussion of issues associated with the client's substance abuse and associated problems in an effort to work toward a constructive resolution of those problems and ultimately toward recovery.

(19) "Counselor" means a member of the clinical staff, working in a facility licensed under Chapter 397, F.S.,

client identifying information, the affirmative verification of another person's communication of client identifying information, or the communication of any information of a client who has been identified. Any disclosure made pursuant to this chapter must be limited to that information which is necessary to carry out the purpose of the disclosure.

(11) "Fee system" means a method of establishing charges for services rendered, in accordance with a client's ability to pay, used by providers that receive state funds.

(12) "For profit" means registered as for profit by the Secretary of State and recognized by the Internal Revenue Service as a for-profit entity.

(13) "Habitual abuser" means a person who is brought to the attention of law enforcement for being substance impaired, who meets the criteria for involuntary admission in s. 397.675, and who has been taken into custody for such impairment three or more times during the preceding 12 months.

(14) "Hospital" means a hospital or hospital-based component licensed under chapter 395.

(15) "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.

(16) "Individualized treatment or service plan" means an immediate and a long-range plan for substance abuse or ancillary services developed on the basis of a client's assessed needs.

(17) "Law enforcement officer" means a law enforcement officer as defined in s. 943.10(1).

(18) "Licensed service provider" means a public agency under this chapter, a private for-profit or not-for-profit agency under this chapter, a physician or any other private practitioner licensed under this chapter, or a hospital that offers substance abuse impairment services through one or more of the following licensable service components:
(a) Addictions receiving facility, which is a community-based facility designated by the department to receive, screen, and assess clients found to be substance abuse impaired, in need of emergency treatment for substance abuse impairment, or impaired by substance abuse to such an extent as to meet the whose duties primarily consist of conducting and documenting Services such as counseling, psycho-educational groups, psychosocial assessment, treatment planning, and case management.

(20) "Court Ordered" means the result of an order issued by a court requiring an individual's participation in a licensed component of a provider under the following authority:
(a) Civil involuntary as provided under Sections 397.6811 and 397.693, F.S.;
(b) Treatment of habitual substance abusers in licensed secure facilities as provided under Section 397.702, F.S.; and
(c) Offender referrals as provided under Section 397.705, F.S.

(21) "Department" means the Department of Children and Family Services, created pursuant to Section 20.19, F.S.

22) "Diagnostic Criteria" means prevailing standards which are used to determine a client's mental and physical condition relative to their need for substance abuse services, such as those which are described in the current Diagnostic and Statistical Manual of Mental Disorders.

(23) "Diagnostic Services" means services that are provided to clients who have been assessed as having special needs and that will assist in their recovery such as educational tests, psychometric tests and evaluation, psychological and psychiatric evaluation and testing, and specific medical tests.

(24) "Direct Care Staff" means employees and volunteers of a provider who provide direct services to clients.

(25) "Direct Services" means services that are provided by employees or volunteers who have contact or who interact with clients on a regular basis.

(26) "Discharge Summary" means a written narrative of the client's treatment record describing the client's accomplishments and problems during treatment, reasons for discharge, and recommendations for further services.

(27) "District Office" means a local or regional office of the department.

28) "Dual Diagnosis" means a diagnosis of a substance use disorder and a concurrent diagnosis of a psychiatric disorder.

(29) "Financial Ability" means a provider's ability to secure and maintain the necessary financial resources to provide

criteria for involuntary admission in s. 397.675, and to provide detoxification and stabilization. An addictions receiving facility must be state-owned, state-operated, or state-contracted, and licensed pursuant to rules adopted by the department's Substance Abuse Program Office which include specific authorization for the provision of levels of care and a requirement of separate accommodations for adults and minors. Addictions receiving facilities are designated as secure facilities to provide an intensive level of care and must have sufficient staff and the authority to provide environmental security to handle aggressive and difficult-to-manage behavior and deter elopement.
(b) Detoxification, which uses medical and psychological procedures and a supportive counseling regimen to assist clients in managing toxicity and withdrawing and stabilizing from the physiological and psychological effects of substance abuse impairment.
(c) Residential treatment, which provides a structured, live-in environment within a non-hospital setting on a 24-hours-a-day, 7-days-a-week basis, and which includes:
1. Facilities that provide room and board and treatment and rehabilitation within the primary residential facility; and
2. Facilities that are used for room and board only and in which treatment and rehabilitation activities are provided on a mandatory basis at locations other than the primary residential facility. In this case, facilities used for room and board and for treatment and rehabilitation are operated under the auspices of the same provider, and licensing and regulatory requirements would apply to both the residential facility and all other facilities in which treatment and rehabilitation activities occur.
(d) Day and night treatment, which provides a nonresidential environment with a structured schedule of treatment and rehabilitation services.
(e) Outpatient treatment, which provides individual, group, or family counseling for clients by appointment during scheduled operating hours, with an emphasis on assessment and treatment.
(f) Medication and methadone maintenance treatment that uses methadone or other medication as authorized by state and federal law, in conjunction with medical, rehabilitative, and counseling services in the treatment of clients who are dependent upon opioid drugs.
(g) Prevention, which is a process involving strategies aimed at the individual, the environment, or the substance, which strategies preclude, forestall, or impede the development of substance abuse problems and promote responsible personal and social growth of individuals and families toward full services to clients in compliance with required standards.

(30) "Impairment" means a physical or psychological condition directly attributed to the use of alcohol or other substances of abuse which substantially interferes with an individual's level of functioning.

(31) "Inmate Substance Abuse Programs" include substance abuse services provided within facilities housing only inmates and operated by or under contract with the Department of Corrections.

(32) "Initial Treatment Plan" means a preliminary, written plan of goals and objectives intended to inform the client of service expectations and to prepare the client for service provision.

(33) "Intervention Plan" means a written plan of goals and objectives to be achieved by a client who is involved in intervention services.

(34) "Involuntary" means the status ascribed to a person who meets the criteria for admission under Section 397.675, F.S.

(35) "Licensed Bed Capacity" means the total bed capacity of addictions receiving facilities, residential detoxification facilities, and residential facilities.

(36) "Licensing Fee" means revenue collected by the department from a provider required to be licensed under Section 397.407, F.S.

(37) "Medical Director" means a physician licensed under Chapters 458 or 459, F.S., who has been designated to oversee all medical services of a provider and has been given the authority and responsibility for medical care delivered by a provider.

(38) "Medical History" means information on the client's past and present general physical health, including the effect of substance abuse on the client's health.

(39) "Medical Maintenance" means special clinical protocols that permit extending the amount of consecutive take out medication provided to clients who are involved in medication and methadone maintenance treatment and who qualify through a special exemption from the department for participation under these protocols. Medical maintenance may be either partial (13 consecutive take-outs) or full (27 consecutive take-outs).

(40) "Medication Error" means medication that is administered or dispensed to a client in a dose that is

human potential.
(h) Intervention, which consists of structured services targeted toward individuals or groups at risk and focused on reducing those factors associated with the onset or the early stages of substance abuse, and related problems.

(19) “Not for profit” means registered as not for profit by the Secretary of State and recognized by the Internal Revenue Service as a not-for-profit entity.

(20) “Physician” means a person licensed under chapter 458 to practice medicine or licensed under chapter 459 to practice osteopathic medicine, and may include, if the context so indicates, an intern or resident enrolled in an intern or resident training program affiliated with an approved medical school, hospital, or other facility through which training programs are normally conducted.

(21) “Preliminary screening” means the gathering of initial information to be used in determining a person’s need for assessment or for referral.

(22) “Private practitioner” means a physician licensed under chapter 458 or chapter 459, a psychologist licensed under chapter 490, or a clinical social worker, marriage and family therapist, or mental health counselor licensed under chapter 491.

(23) “Program evaluation” or “evaluation” means a systematic measurement of a service provider’s achievement of desired client or service outcomes.

(24) “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.

(25) “Quality assurance” means the objective and internal systematic monitoring of the appropriateness and quality of client care rendered by a service provider.

higher or lower, with greater or lesser frequency, or that is the wrong medication than that which is prescribed under a physician’s order and has the potential to harm the patient.

(41) “Medication and Methadone Maintenance Treatment Sponsor” means a representative of a medication and methadone maintenance treatment provider who is responsible for its operation and who assumes responsibility for all its employees and volunteers, including all practitioners, agents, or other persons providing services at the provider.

(42) “Nursing Physical Screen” means a procedure for taking a client's medical history and vital signs and recording any general impressions of a client's current physical condition, general body functions, and current medical problems.

(43) “Nursing Support Staff” means persons who assist Registered Nurses and Licensed Practical Nurses in carrying out their duties, but who are not licensed nurses.

(44) “Operating Procedures” means written policies and procedures governing the organization and operation of a provider that include methods of implementation and accountability.

(45) “Organizational Capability” means a provider’s ability to implement written operating procedures in conformance with required standards.

(46) “Overlay” means a component operated within facilities not owned or operated by a provider.

(47) “Physical Examination” means a medical evaluation of the client's current physical condition.

(48) “Physical Health Assessment” means a series of services that are provided to evaluate a client's medical history and present physical condition and include a medical history, a nursing physical screen, a physical examination, laboratory tests, tests for contagious diseases, and other related diagnostic tests.

(49) “Physician” means a person licensed to practice medicine under Chapters 458 or 459, F.S.

(50) “Placement” means the process used to determine client admission to, continued stay in, and transfer or discharge from a component in accordance with specific criteria.

(51) “Prevention Counseling” means a discussion with a participant involved in a prevention component that follows

(26) “Secure facility,” except where the context indicates a correctional system facility, means a provider that has the authority to deter the premature departure of involuntary clients whose leaving constitutes a violation of a court order or community-based supervision as provided by law. The term “secure facility” includes addictions receiving facilities and facilities authorized by local ordinance for the treatment of habitual abusers.

(27) “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.

(28) “Service provider personnel” or “personnel” includes all owners, directors, chief financial officers, staff, and volunteers, including foster parents, of a service provider.

(29) “Stabilization” means:
(a) Alleviation of a crisis condition; or
(b) Prevention of further deterioration,
and connotes short-term emergency treatment.

the objectives established in the prevention plan and is intended to reduce risk factors and increase protective factors.

(52) “Prevention Plan” means a plan of goals to be achieved by a client or family involved in structured prevention activities on a regularly scheduled basis.

(53) “Primary Counselor” means an employee who is part of the clinical staff and who has primary responsibility for delivering and coordinating clinical services for specific clients.

(54) “Private Practice", as used in these rules, means a sole proprietorship, an individual or individuals using shared office space, or other business entity, required to be licensed under Chapter 397, F.S.

(55) “Privately Funded Provider” means a provider which does not receive funds directly from the department, Medicaid, or another public agency, and which relies solely on private funding sources.

(56) “Program Office” means the specific office of the department identified as the single state authority for substance abuse.

(57) “Progress Notes” mean written entries made by clinical staff in the client record that document progress or lack thereof toward meeting treatment plan objectives, and which generally address the provision of services, the client's response to those services, and significant events.

(58) “Protective Factors” means those conditions that inhibit, reduce, or protect against the probability of the occurrence of drug use or abuse.

(59) “Provider” means a public agency, a private for-profit or not-for-profit agency, a person who is in private practice, and a hospital, licensed under Chapter 397, F.S., or exempt from licensure.

(60) “Psychosocial Assessment” means a series of evaluative measures designed to identify the behavioral and social factors involved in substance abuse and its symptoms, and is used in the determination of placement and the development of the treatment plan.

(61) “Publicly Funded Provider” means a provider that receives funds directly from the department, Medicaid, or another public agency or is a state agency or local government agency.

(62) “Qualified Professional” means a physician licensed

under Chapter 458 or 459, F.S., a practitioner licensed under Chapter 490 or 491, F.S., or a person who is certified through a department-recognized certification process as provided for in subsection 397.311(25), F.S., and Section 397.416, F.S. Individuals who are certified are permitted to serve in the capacity of a qualified professional, but only within the scope of their certification.

(63) "Quality Assurance" means a formal method of evaluating the quality of care rendered by a provider and is used to promote and maintain an efficient and effective service delivery system. Quality assurance includes the use of a quality improvement process to prevent problems from occurring so that corrective efforts are not required.

(64) "Restraint" means:

(a) Any manual method used or physical or mechanical device, material, or equipment attached or adjacent to a client's body that he or she cannot easily remove and that restricts freedom of movement or normal access to one's body; and
(b) A drug used to control a client's behavior when that drug is not a standard treatment for the client's condition.

(65) "Risk Factors" means those conditions affecting a group, individual, or defined geographic area that increase the likelihood of a substance use or substance abuse problem.

(66) "Screening" means a process involving a brief review of a person's presenting problem to determine the person's appropriateness and eligibility for substance abuse services and the possible level of services required.

(67) "Seclusion" means the use of a secure, private room designed to isolate a client who has been determined by a physician to pose an immediate threat of physical harm to self or others.

(68) "Services" means assistance that is provided to clients in their efforts to become and remain substance free such as counseling, treatment planning, vocational activities, educational training, and recreational activities.

(69) "Stabilization" means the use of short-term procedures for the purpose of alleviating an acute condition related to impairment or to prevent further deterioration of a client who is impaired.

(70) "Substantial Compliance" means an applicant for a new license that is in the initial stages of developing services, has demonstrated the ability to implement the requirements of these rules through operating procedures,

Part III
CLIENT RIGHTS

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.

(1) RIGHT TO INDIVIDUAL DIGNITY.--The individual dignity of the client must be respected at all times and upon all occasions, including any occasion when the client is admitted, retained, or transported. Substance abuse clients who are not accused of a crime or delinquent act may not be detained or incarcerated in jails, detention centers, or training schools of the state, except for purposes of protective custody in strict accordance with this chapter. A client may not be deprived of any constitutional right.

and is thereby eligible for a probationary license.

(71) "Substantial Noncompliance" means that a provider operating on a regular license has significant violations, or a pattern of violations, which affects the health, safety, or welfare of clients and, because of those violations, is issued an interim license or is subject to other sanctions as provided for in Section 397.415, F.S.

(72) "Summary Notes" means a written record of the progress made by clients involved in intervention services and Level 2 prevention services.

(73) "Supportive Counseling" means a form of counseling that is primarily intended to provide information and motivation to clients.

(74) "Transfer Summary" means a written justification of the circumstances of the transfer of a client from one component to another or from one provider to another.

(75) "Treatment" means specific clinical and services such as individual and group counseling.

(76) "Treatment Plan" means an individualized, written plan of action that directs all treatment services and is based upon information from the assessment and input from the client served. The plan establishes client goals and corresponding measurable objectives, time frames for completing objectives, and the type and frequency of services to be provided.

CLIENT RIGHTS

65D-30.004 Common Licensing Standards.

(29) Client Rights. Individuals applying for or receiving substance abuse services are guaranteed the protection of fundamental human, civil, constitutional, and statutory rights, including those specified in subsections 397.501(1)-(10), F.S.

(a) Provisions. Basic client rights shall include:

1. Provisions for informing the client, family member, or authorized guardian of their rights and responsibilities, assisting in the exercise of those rights, and an accessible grievance system for resolution of conflicts;

2. Provisions assuring that a grievance may be filed for any reason with cause;

3. The prominent posting of notices informing clients of the

(2) RIGHT TO NONDISCRIMINATORY SERVICES.--
(a) Service providers may not deny a client access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, human immunodeficiency virus status, prior service departures against medical advice, disability, or number of relapse episodes. Service providers may not deny a client who takes medication prescribed by a physician access to substance abuse services solely on that basis. Service providers who receive state funds to provide substance abuse services may not, provided space and sufficient state resources are available, deny a client access to services based solely on inability to pay.
(b) Each client in treatment must be afforded the opportunity to participate in the formulation and periodic review of his or her individualized treatment or service plan to the extent of his or her ability to so participate.
(c) It is the policy of the state to use the least restrictive and most appropriate services available, based on the needs and the best interests of the client and consistent with optimum care of the client.
(d) Each client must be afforded the opportunity to participate in activities designed to enhance self-image.

(3) RIGHT TO QUALITY SERVICES.--
(a) Each client 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 client behavior that poses an immediate threat to the client 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 client behavior and must specify by rule the physical facility requirements for seclusion rooms, including dimensions, safety features, methods of observation, and contents.

(4) RIGHT TO COMMUNICATION.--
(a) Each client has the right to communicate freely and privately with other persons within the limitations imposed by service provider policy.
(b) Because the delivery of services can only be effective in a substance abuse free environment, close supervision

grievance system;

4. Access to grievance submission forms;

5. Education of staff in the importance of the grievance system and client rights;

6. Specific levels of appeal with corresponding time frames for resolution;

7. Timely receipt of a filed grievance;

8. The logging and tracking of filed grievances until resolved or concluded by actions of the provider's governing body;

9. Written notification of the decision to the appellant; and

10. Analysis of trends to identify opportunities for improvement.

(b) Providing Information to Affected Parties. Notification to all parties of these rights shall include affirmation of an organizational non-relationship policy that protects a party's right to file a grievance or express their opinion and invokes applicability of state and federal protections. Providers shall post the number of the abuse hotline, the local Florida Advocacy Council, and the district Alcohol, Drug Abuse, and Mental Health Program Office in a conspicuous place within each facility and provide a copy to each client placed in services.

(c) Implementation of Client Rights Requirements by Department of Corrections. In lieu of the requirements of this subsection, and in the case of Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections, the Department of Corrections shall adhere to the requirements found in Chapter 33-103, F.A.C., titled Inmate Grievances.

(d) Implementation of Client Rights Requirements by Department of Juvenile Justice. In lieu of the requirements of this subsection, and in the case of commitment programs and detention facilities operated by or under contract with the Department of Juvenile Justice, the Department of Juvenile Justice policies regarding client grievances shall be followed.

65E-30.005(14), F.A.C. -- Restraint and Seclusion.

Restraint and seclusion can only be used in emergency situations to ensure the physical safety of the client, other clients, staff, or visitors and only when less restrictive interventions have been determined to be ineffective.

of each client's communications and correspondence is necessary, particularly in the initial stages of treatment, and the service provider must therefore set reasonable rules for telephone, mail, and visitation rights, giving primary consideration to the well-being and safety of clients, staff, and the community. It is the duty of the service provider to inform the client and his or her family if the family is involved at the time of admission about the provider's rules relating to communications and correspondence.

(5) RIGHT TO CARE AND CUSTODY OF PERSONAL EFFECTS OF CLIENTS.--A client has the right to possess clothing and other personal effects. The service provider may take temporary custody of the client's personal effects only when required for medical or safety reasons, with the reason for taking custody and a list of the personal effects recorded in the client's clinical record.

(6) RIGHT TO EDUCATION OF MINORS.--Each minor client in a residential service component is guaranteed education and training appropriate to his or her needs. The service provider shall coordinate with local education agencies to ensure that education and training is provided to each minor client in accordance with other applicable laws and regulations and that parental responsibilities related to such education and training are established within the provisions of such applicable laws and regulations. Nothing in this chapter may be construed to relieve any local education authority of its obligation under law to provide a free and appropriate education to every child.

(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:

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 a client.
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 client's name and other identifying information will not be disclosed.
4. In the course of review of records on service provider

Restraint and seclusion shall not be employed as punishment or for the convenience of staff and shall be consistent with the rights of clients, as described in subsection 65D-30.004(29), F.A.C.

(a) Training. All staff who implement written orders for restraint or seclusion shall have documented training in the proper use of the procedures, including formal certification in control of aggression techniques, and this training shall be documented in their personnel file. Training shall occur initially and a minimum of two hours annually thereafter.

(b) Restraint and Seclusion Orders. Providers shall implement the following requirements regarding the use of restraint and seclusion orders.

1. Orders for the use of restraint or seclusion must not be written as a standing order or on an as needed basis.
2. The treating physician, or other medically qualified designee identified in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C., must be consulted as soon as possible, but no longer than one hour after the initiation of restraint or seclusion. Further, in the case of adults, the physician, or other medically qualified designee identified in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C., must conduct a face-to-face evaluation of the client within four hours of the initiation of restraint or seclusion. In the case of children age 17 and under, this shall occur within two hours of initiation of restraint or seclusion.
3. Each written order for restraint or seclusion is limited to 4 hours for adults, 2 hours for children and adolescents ages 9 to 17, and 1 hour for children under 9. The original order may only be renewed in accordance with these time limits for up to a total of 24 hours. After the original order expires, a physician or qualified professional licensed under Chapters 490or 491, F.S., must see and assess the patient before issuing a new order.
4. The use of restraint and seclusion must be implemented in the least restrictive manner possible. In addition, restraint and seclusion must be applied in accordance with safe and appropriate techniques and ended at the earliest possible time.
5. Restraint and seclusion may not be used simultaneously unless a client is continually monitored face-to-face by an assigned staff member, or continually monitored by staff using both video and audio equipment.
6. The condition of the client who is in restraint or seclusion must be assessed, monitored, and reevaluated at least every 15 minutes.

(c) Restraint and Seclusion Log Book. A continuing log book shall be maintained by each provider that will indicate,

premises 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 client names or other identifying information and must be in accord 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 client, to the service provider-client relationship, 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 a client'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 client 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 client 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 client 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 never has been a client.
(e)1. Since a minor acting alone has the legal capacity to voluntarily apply for and obtain substance abuse treatment, any written consent for disclosure may be given only by the minor client. This restriction includes, but is not limited to, any disclosure of client identifying information to the parent, legal guardian, or custodian of a minor client for the purpose of obtaining financial reimbursement.
2. When the consent of a parent, legal guardian, or custodian is required under this chapter in order for a minor to obtain substance abuse treatment, any written consent for disclosure must be given by both the minor and the parent, legal guardian, or custodian.
(f) An order of a court of competent jurisdiction authorizing disclosure and use of confidential information is a unique

by name, the clients who have been placed in restraint or seclusion, the date, and specified reason for restraint or seclusion, and length of time in restraint or seclusion. The log book shall be signed and dated by the R.N. on duty.

(d) Observation of Clients. Staff shall conduct a visual observation of Clients who are placed in restraint or seclusion every 15 minutes. The observation shall be documented in the restraint and seclusion log book, and shall include the time of the observation and description of the condition of the client.

(e) Basic Rights. While in restraint or seclusion, clients shall be permitted to have regular meals, maintain personal hygiene, use the toilet and, as long as there is no present danger to the client or others, permitted freedom of movement for at least 10 minutes each hour.

(f) Post Restraint or Seclusion. Upon completion of the use of restraint or seclusion, the client shall receive a nursing physical screen by an R.N. that will include an assessment of the client's vital signs, current physical condition, and general body functions. The screening shall be documented in the client record. In addition, supportive counseling shall be provided in accordance with the needs of the client in an effort to transition the client from restraint or seclusion.

(**g) Seclusion Room Facility Requirements**. Providers shall have at least one seclusion room located in the facility. Seclusion rooms shall incorporate the following minimum facility standards.

1. Seclusion rooms shall be free from sharp edges or corners and constructed to withstand repeated physical assaults. Walls shall be either concrete block or double layered to provide resistance. The ceilings shall be a minimum of eight feet in clear height, hard-coated, and fixtures shall be recessed and tamper proof. Lighting fixtures shall be non-breakable and shall be installed with tamper-proof screws, as shall any other items in the seclusion room. Seclusion room doors shall be heavy wood or metal at least 36 inches in width and shall open outward. The doorframe shall be resistant to damage~~,~~ and thoroughly secured.
2. A bed in the addictions receiving facility seclusion room is optional. If a bed is included, it shall be sturdily constructed, without sharp edges and bolted to the floor. Its placement in the room shall provide adequate space for staff to apply restraints and shall not permit individuals to tamper with the lights, smoke detectors, cameras, or other items that may be in the ceiling of the room. There shall be a rheostat control mechanism outside the room to adjust the illumination of the light in the seclusion room.

kind of court order. Its only purpose is to authorize a disclosure or use of client 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 client 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 client records are needed to provide evidence. An application must use a fictitious name, such as John Doe or Jane Doe, to refer to any client and may not contain or otherwise disclose any client identifying information unless the client 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 client and the person holding the records from whom disclosure is sought must be given adequate notice in a manner which will not disclose client 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 client identifying information is not disclosed to anyone other than a party to the proceeding, the client, or the person holding the record, unless the client requests an open hearing. The proceeding may include an examination by the judge of the client records referred to in the application.
(j) A court may authorize the disclosure and use of client records for the purpose of conducting a criminal investigation or prosecution of a client 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 client, to the physician-client relationship and to the ability of the program to provide services to other clients is outweighed by the public interest and the need for the disclosure.

3. There shall be a vision panel in the door of the seclusion room, which provides a view of the entire room. This vision panel shall be Lexan or other suitable strong material and it shall be securely mounted in the door. Provisions shall be made to ensure privacy from the public and other clients while providing easy access for staff observation.
4. Seclusion rooms shall be a minimum of 70 square feet with no wall less than 8 feet.
5. Fire sprinkler heads shall be ceiling mounted and either recessed or flush-mounted without a looped spray dispersal head.
6. Each seclusion room will allow for two-way communication and emergency calling.
7. In those instances where the full interior of the seclusion room can not be seen from the nurse's station, the seclusion room shall have an electronic visual monitoring system capable of viewing the entire room from the nurse's station.

65D-30.004(28), F.A.C. 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.

65D-30.004(12), F.A.C. Client/Participant Records.

Record Management System. Client/participant records shall be kept secure from unauthorized access and maintained in accordance with 42 Code of Federal Regulations, Part 2 and subsection 397.501(7), F.S. Providers shall have record management procedures regarding content, organization, and use of records. The record management system shall meet the following additional requirements.

1. Original client records shall be signed in ink and by hand.
2. Record entries shall be legible.
3. In those instances where records are maintained electronically, a staff identifier code will be accepted in lieu of a signature.
4. Documentation within records shall not be deleted.
5. Amendments or marked-through changes shall be initialed and dated by the individual making such changes.

Federal regulations also govern the confidentiality and privacy of medical records and protected alcohol and drug abuse information under 42CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Parts 160 and 164.

(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.

(9) RIGHT TO HABEAS CORPUS.--At any time, and without notice, a client involuntarily retained by a provider, or the client's parent, guardian, custodian, or attorney on behalf of the client, may petition for a writ of habeas corpus to question the cause and legality of such retention and request that the court issue a writ for the client's release.

(10) LIABILITY AND IMMUNITY.--
(a) Service provider personnel who violate or abuse any right or privilege of a client under this chapter are liable for damages as determined by law.
(b) All persons acting in good faith, reasonably, and without negligence in connection with the preparation or execution of petitions, applications, certificates, or other documents or the apprehension, detention, discharge, examination, transportation, or treatment of a person under the provisions of this chapter shall be free from all liability, civil or criminal, by reason of such acts.

397.581 Unlawful activities relating to client assessment and treatment; penalties

(1) Knowingly furnishing false information for the purpose of obtaining emergency or other involuntary admission for any person is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

(2) Causing or otherwise securing, or conspiring with or assisting another to cause or secure, without reason for believing a person to be impaired, any emergency or other involuntary procedure for the person is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

(3) Causing, or conspiring with or assisting another to cause, the denial to any person of any right accorded pursuant to this chapter is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

65D-30.004(25), F.A.C. Special In-Residence
Requirements. Providers that house males and females together within the same facility shall provide separate sleeping arrangements for these clients. Providers which serve adults in the same facility as persons under 18 years of age shall ensure client safety and programming according to age.

(26) Reporting of Abuse, Neglect, and Deaths.
Providers shall adhere to the statutory requirements for reporting abuse, neglect, and deaths of children under Chapter 39, F.S., and of adults under Section 415.1034, F.S., and paragraph 397.501(7)(c), F.S.

(**27) Incident Reporting** Pursuant to paragraph 397.419(2)(f), F.S. Incident reporting is required of all providers and shall be conducted in accordance with Children and Families Operating Procedure 215-6, incorporated herein by reference. Copies of CFOP 215-6 may be obtained from the Department of Children and Families, Substance Abuse Program office, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700. Incident reporting shall include the following:
(a) A broad definition of "incident" to include medication errors, violations of crucial procedures, and actions resulting in physical injury;
(b) A provision that a written incident report must be filed with the district Alcohol, Drug Abuse, and Mental Health Program Office of the department within 1 calendar day of the incident when an action or inaction has a negative affect on the health or safety of the client, or violates the rights of a client;
(c) Employee training in reporting procedures and requirements that includes the affirmative duty requirements and protections of Chapter 415, F.S., and Title V of the Americans with Disabilities Act; and
(d) Reporting, tracking, and responding to incidents in accordance with departmental regulation.

65D-30.004(23) Compulsory School Attendance
For Minors. Providers which admit juveniles between the ages of 6 and 16 shall comply with Chapter 232, F.S., entitled Compulsory School Attendance; Child Welfare.

(30) Client Employment. Providers shall ensure that all work performed by a client is voluntary, justified by the treatment plan, and that all wages, if any, are in accordance with applicable wage and disability laws and regulations.

65D-30.004(37) Persons with a Dual Diagnosis of Substance Abuse and Psychiatric Problems.

Providers shall develop and implement operating procedures for serving or arranging services for persons with dual diagnosis disorders.

PART IV

VOLUNTARY ADMISSIONS PROCEDURES

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 a client 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.

COMMON LICENSING STANDARDS

65D-30.004((36), F.A.C.

(**36) Voluntary and Involuntary Placement** Under Chapter 397, F.S., Parts IV and V.

(a) Eligibility Determination.

1. Voluntary Placement. To be considered eligible for treatment on a voluntary basis, an applicant for services must meet diagnostic criteria for substance abuse related disorders.

PART V

INVOLUNTARY ADMISSIONS PROCEDURES

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.--A person meets the criteria for involuntary admission if there is good faith reason to believe the

COMMON LICENSING STANDARDS

65D-30.004 (36), F.A.C.

(36) Voluntary and Involuntary Placement Under Chapter 397, F.S., Parts IV and V.

(a) Eligibility Determination.

1. Voluntary Placement. To be considered eligible for treatment on a voluntary basis, an applicant for services must meet diagnostic criteria for substance abuse related disorders.
2. Involuntary Placement. To be considered eligible for services on an involuntary basis, a person must meet 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.

397.6751 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, criteria for involuntary placement as specified in Section 397.675, F.S.

(b) Provider Responsibilities Regarding Involuntary Placement.

1. Persons who are involuntarily placed shall be served only by licensed service providers as defined in subsection 397.311(19), F.S., and only in those components permitted to admit clients on an involuntary basis.
2. Providers which accept involuntary referrals must provide a description of the eligibility and diagnostic criteria and the placement process to be followed for each of the involuntary placement procedures described under Sections 397.677, 397.679, 397.6798, 397.6811, and 397.693, F.S.
3. Clients shall be referred to more appropriate services if the provider determines that the person should not be placed or should be discharged. Such referral shall follow the requirements found in paragraphs 397.6751(2)(a)(b)(c) and 397.6751(3)(a)(b), F.S. The decision to refuse to admit or to discharge shall be made by a qualified professional. Any attempts to contact the referral source must be made in accordance with Title 42, Code of Federal Regulations, Part 2.
4. In those cases in which the court ordering involuntary treatment includes a requirement in the court order for notification of proposed release, the provider must notify the original referral source in writing. Such notification shall comply with legally defined conditions and timeframes and conform to confidentiality regulations found in Title 42, Code of Federal Regulations, Part 2, and subsection 397.501(7), F.S.

(c) Assessment Standards for Involuntary Treatment Proceedings. Providers that make assessments available to the court regarding hearings for involuntary treatment must define the process used to complete the assessment. This includes specifying the protocol to be utilized, the format and content of the report to the court, and the internal procedures used to ensure that assessments are completed and submitted within legally specified timeframes. For persons assessed under an involuntary order, the provider shall address the means by which the physician's review and signature for involuntary assessment and stabilization and the signature of a qualified professional for involuntary assessments only, will be secured. This includes the process that will be used to notify affected parties stipulated in the petition.

(d) Provider Initiated Involuntary Admission Petitions. Providers are authorized to initiate petitions under the involuntary assessment and stabilization and involuntary treatment provisions when that provider has direct

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.

397.6752 Referral of involuntarily admitted client for voluntary treatment.--Upon giving his or her written informed consent, an involuntarily admitted client may be referred to a service provider for voluntary admission when the service provider determines that the **client** no longer meets involuntary criteria.

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;

knowledge of the respondent's substance abuse impairment or when an extension of the involuntary admission period is needed. Providers shall specify the circumstances under which a petition will be initiated and the means by which petitions will be drafted, presented to the court, and monitored through the process. This shall be in accordance with Title 42, Code of Federal Regulations, Part 2. The forms to be utilized and the methods to be employed to ensure adherence to legal timeframes shall be included in the procedures.

65D-30.004(13), F.A.C.

(13) Screening. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, medication and methadone maintenance treatment, and intervention.

(a) Determination of Appropriateness and Eligibility for Placement. The condition and needs of the client shall dictate the urgency and timing of screening. For example, in those cases involving an involuntary placement, screening may occur after the client has been placed in a component such as detoxification. Persons requesting services shall be screened to determine appropriateness and eligibility for placement or other disposition. The person conducting the screening shall document the rationale for any action taken.

(b) Consent for Drug Screen. If required by the circumstances pertaining to the client's need for screening, or dictated by the standards for a specific component, clients shall give informed consent for a drug screen.

(c) Consent for Release of Information. Consent for the release of information shall include information required in 42 Code of Federal Regulations, Part 2., and may be signed by the client only if the form is complete.

(d) Consent for Services. A consent for services form shall be signed by the client prior to or upon placement, with the exception of involuntary placements.

(14) Assessment. Each client placed into an addictions receiving facility, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, and medication and methadone maintenance treatment shall undergo an assessment of the nature and severity of their substance abuse problem. The assessment shall include a physical health assessment and a psychosocial assessment.

(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.

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.

B. Noncourt Involved Admissions: 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

(a) Physical Health Assessment. Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the requirements of this paragraph but shall provide such services as required in Chapter 33-19, F.A.C., titled Health Services. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements of this subsection but shall provide such services as required in the policies, standards, and contractual conditions established by the Department of Juvenile Justice.

1. Nursing Physical Screen. A nursing physical screen shall be completed on each person considered for placement in an addictions receiving facility or a detoxification component. The screen shall be completed by an R.N. or by an L.P.N. and countersigned by an R.N. The results of the screen shall be documented by the nurse providing the service and signed and dated by that person. If the nursing physical screen is completed in lieu of a medical history, further action shall be in accordance with the medical protocol established under subsection 65D-30.004(7), F.A.C.
2. Medical History. A medical history shall be completed on each client.
a. For residential treatment, day or night treatment with host homes, and medication and methadone maintenance treatment, the history shall be completed within 30 calendar days prior to placement, or within one calendar day of placement.
b. For day or night treatment, intensive outpatient treatment, and ~~for~~ outpatient treatment, a medical history shall be completed within 30 calendar days prior to or upon placement.
For the components identified in sub-subparagraph a., the medical history shall be completed by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. Further, the history shall be reviewed, signed and dated by the physician in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. For the components identified in sub-subparagraph b., the medical history shall be completed by the client or the client's legal guardian. For all components, the medical history shall be maintained in the client record and updated annually if a client remains in treatment for more than 1 year.
3. Physical Examination. A physical examination shall be completed on each client.

a. For addictions receiving facilities and ~~for~~ detoxification, the physical examination shall be completed within 7

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.

C. Noncourt Involved Admissions; Emergency

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

calendar days prior to placement or 2 calendar days after placement.
b. For residential treatment and ~~for~~ day or night treatment with host homes, the physical examination shall be completed within 30 calendar days prior to placement or 10 calendar days after placement.
c. For medication and methadone maintenance treatment, the physical examination shall be completed prior to administration of the initial dose of methadone. In emergency situations the initial dose may be administered prior to the examination. Within 5 calendar days of the initial dose, the physician shall document in the client record the circumstances that prompted the emergency administration of methadone and sign and date these entries.
For components identified in sub-subparagraphs a.-c., the physical examination shall be completed by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. Further, the examination shall be reviewed, signed and dated by the physician in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C.
4. Laboratory Tests. Clients shall provide a sample for testing blood and urine, including a drug screen.
a. For addictions receiving facilities, detoxification, residential treatment, and day or night treatment with host homes, all laboratory tests will be performed in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. Further, the results of the laboratory tests shall be reviewed, signed and dated during the assessment process and in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C.
b. For medication and methadone maintenance treatment, blood and urine samples shall be taken within 7 calendar days prior to placement or 2 calendar days after placement. A drug screen shall be conducted at the time of placement. If there are delays in the procedure, such as problems in obtaining a blood sample, this shall be documented by a licensed nurse in the client record. The initial dose of medication may be given before the laboratory test results are reviewed by the physician. The results of the laboratory test shall be reviewed, signed and dated by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C.
5. Pregnancy Test. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, and medication and methadone maintenance treatment. Female clients shall be evaluated by a physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C., to determine the necessity of a pregnancy test. In those cases where it is determined necessary, clients shall be provided testing services directly or by referral as soon as possible following placement.

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

6. Tests For Sexually Transmitted Diseases and Tuberculosis. A serological test for sexually transmitted diseases and a screening test for tuberculosis to determine the need for a Mantoux test shall be conducted on each client.
a. For residential treatment and day or night treatment with host homes, tests will be conducted within the time frame specified for the physical examination. The results of both tests shall be reviewed and signed and dated by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C., and filed in the client record.
b. For medication and methadone maintenance treatment, the tests will be conducted at the time samples are taken for other laboratory tests. Positive results shall be reviewed and signed and dated by a physician, or in accordance with the medical protocol established in subsection 65D-30.004(7)., F.A.C.
7. Special Medical Problems. Particular attention shall be given to those clients with special medical problems or needs. This would include referral for medical services. A record of all such referrals shall be maintained in the client record.

(b) Psychosocial Assessment.

1. Information Required. The psychosocial assessment shall include the client's history as determined through an assessment of the items in sub-subparagraphs a.- l. as follows:

a. Emotional or mental health;
b. Level of substance abuse impairment;
c. Family history, including substance abuse by other family members;
d. The client's substance abuse history, including age of onset, choice of drugs, patterns of use, consequences of use, and types and duration of, and responses to, prior treatment episodes;
e. Educational level, vocational status, employment history, and financial status;
f. Social history and functioning, including support network, family and peer relationships, and current living conditions;
g. Past or current sexual, psychological, or physical abuse or trauma;
h. Client's involvement in leisure and recreational activities;
i. Cultural influences;
j. Spiritual or values orientation;
k. Legal history and status;
l. Client's perception of strengths and abilities related to the potential for recovery; and
m. A clinical summary, including an analysis and interpretation of the results of the assessment, as

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.

Noncourt Involved Admissions; Alternative Involuntary Assessment for Minors

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

described in sub-subparagraphs a.-l.

2. Requirements for Components. Any psychosocial assessment that is completed within 30 calendar days prior to placement in any component identified in sub-subparagraphs a.-e. may be accepted by the provider placing the client. Otherwise, the psychosocial assessment shall be completed according to the following schedule.

a. For addictions receiving facilities, the psychosocial assessment shall be completed within 3 calendar days of placement, unless clinically contraindicated.
b. For residential treatment level 1, the psychosocial assessment shall be completed within 5 calendar days of placement.
c. For residential treatment levels 2, 3, 4, 5, day or night with host homes, and day or night treatment, the psychosocial assessment shall be completed within 10 calendar days of placement.
d. For intensive outpatient treatment and outpatient treatment, the psychosocial assessment shall be completed within 30 calendar days of placement
e. For medication and methadone maintenance treatment, the psychosocial assessment shall be completed within 15 calendar days of placement.

3. Psychosocial Assessment Sign-off Requirements. The psychosocial assessment shall be completed by clinical staff and signed and dated. If the psychosocial assessment was not completed initially by a qualified professional, the psychosocial assessment shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion. Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections, shall conduct the review and sign-off within 30 calendar days.

4. Psychosocial Assessment Readmission Requirements. In those instances where a client is readmitted to the same provider for services within 180 calendar days of discharge, a psychosocial assessment update shall be conducted, if clinically indicated. Information to be included in the update shall be determined by the qualified professional. A new assessment shall be completed on clients who are readmitted for services more than 180 calendar days after discharge. In addition, the psychosocial assessment shall be updated annually for clients who are in continuous treatment for longer than one year.

5. Assessment Requirements Regarding Clients Who are Referred or Transferred.

a. A new psychosocial assessment does not have to be completed on clients who are referred or transferred from

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.

Court Involved Admissions, Civil Involuntary Proceedings; Generally

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

(1) JURISDICTION.--The courts have jurisdiction of involuntary assessment and stabilization petitions and involuntary treatment petitions for substance abuse impaired persons, and such petitions must be filed with the clerk of the court in the county where the person is located.

one provider to another or referred or transferred within the same provider if the provider meets at least one of the following conditions:
I. The provider or component initiating the referral or transfer forwards a copy of the psychosocial assessment information prior to the arrival of the client;
II. Clients are referred or transferred directly from a specific level of care to a lower or higher level of care (e.g., from detoxification to residential treatment or outpatient to residential treatment) within the same provider or from one provider to another;
III. The client is referred or transferred directly to the same level of care (e.g., residential level 1 to residential level 1) either within the same provider or from one provider to another.

b. In the case of referral or transfer from one provider to another, a referral or transfer is considered direct if it was arranged by the referring or transferring provider and the client is subsequently placed with the provider within 7 calendar days of discharge. This does not preclude the provider from conducting an assessment. The following are further requirements related to referrals or transfers.
I. If the content of a forwarded psychosocial does not comply with the psychosocial requirements of this rule, the information will be updated or a new assessment will be completed.
II. If a client is placed with the receiving provider later than 7 calendar days following discharge from the provider that initiated the referral or transfer, but within 180 calendar days, the qualified professional of the receiving provider will determine the extent of the update needed.
III. If a client is placed with the receiving provider more than 180 calendar days after discharge from the provider that initiated the referral or transfer, a new psychosocial assessment must be completed.

(c) Special Needs. The assessment process shall include the identification of clients with mental illness and other needs. Such clients shall be accommodated directly or through referral. A record of all services provided directly or through referral shall be maintained in the client record.

(15) Client Placement Criteria and Operating Procedures. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, outpatient treatment, intervention, and medication and methadone maintenance treatment. Providers shall have operating procedures that clearly state the criteria for admitting, transferring, and discharging clients.
This would include procedures for implementing these placement requirements.

The chief judge may appoint a general or special master to preside over all or part of the proceedings. The alleged impaired person is named as the respondent.

(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.

Court Involved Admissions; Involuntary Assessment; Stabilization

397.6811 Involuntary assessment and stabilization.--A person determined by the court to appear to meet the criteria for involuntary admission under s. 397.675 may be admitted for a period of 5 days to a hospital or to a licensed detoxification facility or addictions receiving facility, for involuntary assessment and stabilization or to a less restrictive component of a licensed service provider for assessment only upon entry of a court order or upon receipt by the licensed service provider of a petition. Involuntary assessment and stabilization may be initiated by the submission of a petition to the court.

(1) If the person upon whose behalf the petition is being filed is an adult, a petition for involuntary assessment and stabilization may be filed by the respondent's spouse or guardian, any relative, a private practitioner, the director of a licensed service provider or the director's designee, or any three adults who have personal knowledge of the respondent's substance abuse impairment.

(2) If the person upon whose behalf the petition is being filed is a minor, a petition for involuntary assessment and stabilization may be filed by a parent, legal guardian, legal custodian, or licensed service provider.

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

(16) Primary Counselor, Orientation, and Initial Treatment Plan. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, and medication and methadone maintenance treatment.

(a) Primary Counselor. A primary counselor shall be assigned to each client placed in a component. This standard does not apply to detoxification and addictions receiving facilities.

(b) Orientation. Prior to or upon placement in a component, clients shall receive orientation. The orientation shall include:
1. A description of services to be provided;
2. Applicable fees;
3. Information on client rights;
4. Parental or legal guardian's access to information and participation in treatment planning;
5. Limits of confidentiality;
6. General information about the provider's infection control policies and procedures;
7. Program rules; and
8. Client grievance procedures.

(c) Initial Treatment Plan. An initial treatment plan shall be completed on each client upon placement, unless an individual treatment plan is completed at that time. The plan shall specify timeframes for implementing services in accordance with the requirements established for applicable components. The initial treatment plan shall be signed and dated by clinical staff and signed and dated by the client. This standard does not apply to detoxification and addictions receiving facilities.

(17) Treatment Plan, Treatment Plan Reviews, and Progress Notes.

(a) Treatment Plan. Each client shall be afforded the opportunity to participate in the development and subsequent review of the treatment plan. The treatment plan shall include goals and related measurable behavioral objectives to be achieved by the client, the tasks involved in achieving those objectives, the type and frequency of services to be provided, and the expected dates of completion. The treatment plan shall be signed and dated by the person providing the service, and signed and dated by the client. If the treatment plan is completed by other than a qualified professional, the treatment plan shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion. In the case of Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections, the

an attorney; and must state facts to support the need for involuntary assessment and stabilization, 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. If the respondent has refused to submit to an assessment, such refusal must be alleged in the petition.

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.--At the hearing initiated in accordance with s. 397.6811(1), the court shall hear all relevant testimony. The respondent must be present unless the court has reason to believe that his or her presence is likely to be injurious to him or her, in which

treatment plan shall be reviewed, countersigned, and dated by a qualified professional within 30 calendar days of completion. A written treatment plan shall be completed on each client.

1. For long-term outpatient methadone detoxification and ~~for~~ medication and methadone maintenance treatment, the treatment plan shall be completed prior to or within 30 calendar days of placement.
2. For residential treatment level 1, the treatment plan shall be completed prior to, or within 7 calendar days of placement. For residential treatment levels 2, 3, 4, and 5, and for day or night treatment with host homes, the treatment plan shall be completed prior to or within 15 calendar days of placement.
3. For day or night treatment, the treatment plan shall be completed prior to or within 10 calendar days of placement.
4. For intensive outpatient treatment and outpatient treatment, the treatment plan shall be completed prior to or within 30 calendar days of placement.
5. For detoxification and addictions receiving facilities, an abbreviated treatment plan, as defined in subsection 65D-30.002(1), F.A.C., shall be completed upon placement. The abbreviated treatment plan shall contain a medical plan for stabilization and detoxification, provision for education, therapeutic activities and discharge planning, and in the case of addictions receiving facilities, a psychosocial assessment.

(b) Treatment Plan Reviews. Treatment plan reviews shall be completed on each client.

1. For residential treatment levels 1, 2, and 3, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, and outpatient treatment, treatment plan reviews shall be completed every 30 calendar days.
2. For residential treatment levels 4 and 5, treatment plan reviews shall be completed every 90 calendar days.
3. For medication and methadone maintenance treatment and long-term outpatient methadone detoxification, treatment plan reviews shall be completed every 90 calendar days for the first year and every 6 months thereafter.

For all components, if the treatment plan reviews are not completed by a qualified professional, the review shall be countersigned and dated by a qualified professional within 5 calendar days of the review.

(c) Progress Notes. Progress notes shall be entered into the client record documenting a client's progress or lack of progress toward meeting treatment plan goals and objectives. When a single service event is documented,

event the court shall appoint a guardian advocate to represent the respondent. The respondent has the right to examination by a court-appointed qualified professional. After hearing all the evidence, the court shall determine whether there is a reasonable basis to believe the respondent meets the involuntary admission criteria of s. 397.675.

(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.

(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.

397.6819 Involuntary assessment and stabilization; responsibility of licensed service provider.--A licensed service provider may admit a client for involuntary assessment and stabilization for a period not to exceed 5 days. The client must be assessed without unnecessary delay by a qualified professional. If an assessment is performed by a qualified professional who is not a physician, the assessment must be reviewed by a physician prior to the end of the assessment period.

397.6821 Extension of time for completion of involuntary assessment and stabilization.--If a licensed service provider is unable to complete the involuntary assessment and, if necessary, stabilization of a client within 5 days after the court's order, it may, within the original time period, file a written request for an extension

the progress note will be signed and dated by the person providing the service. When more than one service event is documented, progress notes may be signed by any clinical staff member assigned to the client. The following are requirements for recording progress notes.

1. For addictions receiving facilities, residential detoxification, outpatient detoxification, short-term residential methadone detoxification, short-term outpatient methadone detoxification, progress notes shall be recorded at least daily.
2. For residential treatment, day or night treatment with host homes, day or night treatment, and long-term outpatient methadone detoxification, progress notes shall be recorded at least weekly.
3. For intensive outpatient treatment and outpatient treatment, progress notes shall be recorded at least weekly or, if contact occurs less than weekly, notes will be recorded according to the frequency of sessions.
4. For medication and methadone maintenance treatment, progress notes shall be recorded according to the frequency of sessions.

(18) Ancillary Services. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, aftercare, and medication and methadone maintenance treatment.
Ancillary services shall be provided directly or through referral in those instances where a provider can not or does not provide certain services needed by a client. The provision of ancillary services shall be based on client needs as determined by the treatment plan and treatment plan reviews. In those cases where clients need to be referred for services, the provider shall use a case management approach by linking clients to needed services and following-up on referrals. All such referrals shall be initiated and coordinated by the client's primary counselor or other designated clinical staff who shall serve as the client's case manager. A record of all such referrals for ancillary services shall be maintained in the client record, including whether or not a linkage occurred or documentation of efforts to confirm a linkage when confirmation was not received.

(20) Record of Disciplinary Problems. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, medication and methadone maintenance treatment, aftercare, and intervention. A record of disciplinary problems encountered with clients and specific actions taken to resolve problems shall be

of time to complete its assessment, and shall, in accordance with confidentiality requirements, furnish a copy to all parties. With or without a hearing, 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. The original court order authorizing the involuntary assessment and stabilization, or a request for an extension of time to complete the assessment and stabilization that is timely filed pursuant to this section, constitutes legal authority to involuntarily hold the client for a period not to exceed 10 days in the absence of a court order to the contrary.

397.6822 Disposition of client after involuntary assessment.--Based upon the involuntary assessment, a qualified professional of the hospital, detoxification facility, or addictions receiving facility, or a qualified professional when a less restrictive component has been used, must:
(1) Release the client and, where appropriate, refer the client to another treatment facility or service provider, or to community services;

(2) Allow the client, if the client has consented, to remain voluntarily at the licensed provider; or

(3) Retain the client when a petition for involuntary 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.

Adhering to federal confidentiality regulations, notice of disposition must be provided to the petitioner and to the court.

G. Court Involved Admissions; Involuntary Treatment

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 maintained.

(21) Control of Aggression. This applies to all components with the exception of prevention level 1. Providers shall have written documentation of the specific control of aggression technique(s) to be used. Direct care staff shall be trained in control of aggression techniques as required in paragraph 65D-30.004(31)(b), F.A.C. The provider shall provide proof to the department that affected staff have completed training in those techniques. In addition, if the provider uses physical intervention, direct care staff shall receive training in the specific techniques used.

(a) Justification and Documentation of Use. De-escalation techniques shall be employed before physical intervention is used. In the event that physical intervention is used to restrict a client's movement, justification shall be documented in the client record.

(b) Prohibitions. Under no circumstances shall clients be involved in the control of aggressive behavior of other clients. Additionally, aggression control techniques shall not be employed as punishment or for the convenience of staff. Inmate Substance Abuse Programs operated within Department of Corrections facilities are exempt from this requirement. Juvenile Justice Commitment Programs and detention facilities shall implement this subsection in accordance withFlorida Department of Juvenile Justice Policies and Procedures, policy Number 1508-03, titled Protective Action Response (PAR) Policy that includes policies and procedures on the use of physical force and restraining devices. This policy may be obtained from the Department of Children and Families, Substance Abuse Program Office, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700.

(22) Discharge and Transfer Summaries. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, medication and methadone maintenance treatment, aftercare, and intervention.

(a) Discharge Summary. A written discharge summary shall be completed for clients who complete services or who leave the provider prior to completion of services. The discharge summary shall include a summary of the client's involvement in services and the reasons for discharge and the provision of other services needed by the client following discharge, including aftercare. The discharge summary shall be signed and dated by a primary counselor.

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

(b) Transfer Summary. A transfer summary shall be completed immediately for clients who transfer from one component to another within the same provider and shall be completed within 5 calendar days when transferring from one provider to another. In all cases, an entry shall be made in the client record regarding the circumstances surrounding the transfer and that entry and transfer summary shall be signed and dated by a primary counselor.

65E-30.005(3), F.A.C.
(3) Facility Requirements Related to Screening and Assessment. Providers shall designate an area of the facility that is properly equipped and furnished for conducting screening and assessment. The area shall be conducive to privacy and freedom from distraction, and shall be accessible to transportation, including law enforcement vehicles and ambulances.

(**4) Observation of Clients**. Clients requiring close medical observation, as determined by medical staff, shall be visible and readily accessible to the nursing staff 24 hours per day and 7 days per week. Clients who do not require close medical observation shall be in a bed area that allows for general nursing observation.

(5) Eligibility Criteria. To be considered eligible for placement, a person must be unable to be placed in another component and must also fall into one of the following categories:

(a) A voluntary client who has a substance abuse problem to the extent that the person displays behaviors that indicate potential harm to self or others or who meets diagnostic or medical criteria justifying placement in an addictions receiving facility; or

(b) An involuntary client who meets the criteria specified in Section 397.675, F.S.; or

(c) An adult or juvenile offender who is ordered for assessment or treatment under Sections 397.705 and 397.706, F.S., and who meets diagnostic or medical criteria justifying placement in an addictions receiving facility; or

(d) Juveniles found in contempt as authorized under Section 985.216, F.S.

(6) Exclusionary Criteria for Addictions Receiving Facilities. Persons ineligible for placement include:

(a) Persons found not to be substance abusers or whose substance abuse is at a level which permits them to be

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.--

served in another component, with the exception of those persons placed for purposes of securing an assessment for the court; and

(b) Persons found to be beyond the safe management capability of the provider as defined under subsection 397.311(5), F.S., and as described under paragraph 397.6751(1)(f), F.S.

(7) Placement Procedures. Following the nursing physical screen, the client shall be screened to determine the person's eligibility or ineligibility for placement. The decision to place or not to place shall be made by a physician, a qualified professional, or an R.N., and shall be based upon the results of screening information and face-to-face consultation with the person to be admitted.

(8) Referral. In the event that the addictions receiving facility has reached full capacity or it has been determined that the prospective client can not be safely managed, the provider shall attempt to notify the referral source. In addition, the provider shall provide assistance in referring the person to another component, in accordance with Section 397.6751, F.S.

(9) Involuntary Assessment and Disposition.

(a) Involuntary Assessment. An assessment shall be completed on each client placed in an addictions receiving facility under protective custody, emergency admission, alternative involuntary assessment for minors, and under involuntary assessment and stabilization. The assessment shall be completed by a qualified professional and based on the requirements in paragraph 65D-30.004(14)(b), F.A.C. The assessment shall be directed toward determining the client's need for additional treatment and the most appropriate services.

(b) Disposition Regarding Involuntary Admissions. Within the assessment period, one of the following actions shall be taken, based upon the needs of the client and, in the case of a minor, after consultation with the parent(s) or guardian(s).

1. The client shall be released and notice of the release shall be given to the applicant or petitioner and to the court, pursuant to Section 397.6758, F.S. In the case of a minor that has been assessed or treated through an involuntary admission, that minor must be released to the custody of his parent(s), legal guardian(s), or legal custodian(s).
2. The client shall be asked if they will consent to voluntary treatment at the provider, or consent to be referred to another provider for voluntary treatment in residential treatment, day or night treatment, intensive outpatient

(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.
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 treatment, or outpatient treatment.
3. A petition for involuntary treatment will be initiated.

(**10) Notice to Family or Legal Guardian.** In the case of a minor, the minor's parent(s) or legal guardian(s) shall be notified upon placement in the facility. Such notification shall be in compliance with the requirements of Title 42, Code of Federal Regulations, Part 2.

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.

397.6975 Extension of involuntary substance abuse treatment period.--

(1) Whenever a service provider believes that a client who is nearing the scheduled date of release from involuntary treatment continues to meet the criteria for involuntary treatment in s. 397.693, a petition for renewal of the involuntary treatment order may be filed with the court at least 10 days prior to the expiration of the court-ordered treatment period. The court shall immediately schedule a hearing to be held not more than 15 days after filing of the petition. The court shall provide the copy of the petition for renewal and the notice of the hearing to all parties to the proceeding. The hearing is conducted pursuant to s. 397.6957.

(2) If the court finds that the petition for renewal of the involuntary treatment order should be granted, it may order the respondent to undergo involuntary treatment for a period not to exceed an additional 90 days. 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 continue to exist after 90 days of additional treatment, a new petition requesting renewal of the involuntary treatment order may be filed pursuant to this section.

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.

PART VI

LOCAL ORDINANCE PROHIBITION AND AUTHORIZATION; ADMISSIONS PROCEDURES

397.701 Local ordinances affecting impairment and public impairment offenses forbidden.--A county, municipality, or other political subdivision of the state may not, except pursuant to the provisions of s. 397.702, adopt a local law, ordinance, resolution, or regulation having the force of law which provides that impairment in public in and of itself, or being found in enumerated places in an impaired condition, is an offense, a violation, or the subject of civil or criminal sanctions or penalties of any kind. This section does not affect offenses involving the operation of motor vehicles, machinery, or other hazardous equipment.

397.702 Authorization of local ordinances for treatment of habitual abusers in licensed secure facilities.--

(1) Due to the severity in certain areas of the state of chronic and habitual public impairment which infringes upon the public health, safety, and welfare of the citizens, counties and municipalities are authorized to adopt ordinances in strict compliance with this section, notwithstanding the provisions of s. 397.701.

(2) Ordinances for the treatment of habitual abusers must provide:
(a) For the construction and funding, either individually or jointly with other counties or municipalities, of a licensed secure facility to be used exclusively for the treatment of habitual abusers who meet the criteria in paragraph (b).
(b) That when seeking treatment of a habitual abuser, the county or municipality, through an officer or agent specified in the ordinance, must file with the court a petition which alleges the following information about the alleged habitual abuser (the respondent):
1. The name, address, age, and gender of the respondent.
2. The name of any spouse, adult child, other relative, or guardian of the respondent, if known to the petitioner, and the efforts by the petitioner, if any, to ascertain this information.
3. The name of the petitioner, the name of the person who has physical custody of the respondent, and the current location of the respondent.
4. That the respondent has been taken into custody for impairment in a public place, or has been arrested for an offense committed while impaired, three or more times during the preceding 12 months.
5. Specific facts indicating that the respondent meets the criteria for involuntary admission in s. 397.675.
6. Whether the respondent was advised of his or her right to be represented by counsel and to request that the court appoint an attorney if he or she is unable to afford one, and whether the respondent indicated to petitioner his or her

desire to have an attorney appointed.
(c) That the court with jurisdiction to make the determination authorized by this section shall hear the petition on an emergency basis as soon as practicable but not later than 10 days after the date the petition was filed. If the allegations of the petition indicate that the respondent has requested the appointment of an attorney, or otherwise indicate the absence of any competent person to speak at the hearing on behalf of the respondent, the court shall immediately appoint an attorney to represent the respondent pursuant to s. 397.501(8), and shall provide notice of the hearing to the attorney. When the court sets a hearing date the petitioner shall provide notice of the hearing and a copy of the petition to all of the persons named in the petition pursuant to subparagraph (b)2., and to such other persons as may be ordered by the court to receive notice.
(d) That, upon the court's determination that the allegations of the petition as stated in paragraph (b) are established, the respondent is a habitual abuser and must be detained at the licensed secure facility for a period of up to 90 days as determined by the court for the purpose of participating in a treatment program.
(e) That, if the client still meets the criteria for involuntary admission in s. 397.675 at or near the expiration of the treatment period ordered by the court pursuant to paragraph (d), the agent of the county or municipality may file another habitual abuser petition pursuant to paragraph (b) for a period not exceeding 180 days for each such petition.
(f) That a person who is reasonably suspected of meeting the criteria in paragraph (b) may be detained at a licensed service provider or at a licensed secure facility for a period not exceeding 96 hours for purposes of the preparation and filing of the petition.

(3) When a petition is filed under an ordinance authorized by this section, alleging a reasonable suspicion that the respondent meets the criteria in paragraph (2)(b), the department and any licensed service provider director with relevant information must, upon the court's request and in accordance with federal confidentiality regulations, furnish the court with all information necessary to determine the accuracy of the allegations.

(4) This section does not affect the operation under contract of any licensed secure correctional facility or licensed service provider at a secure correctional facility which is not operating pursuant to an ordinance adopted under authorization of this section.

PART VII

OFFENDER REFERRALS

397.705 Referral of substance abuse impaired offenders to service providers.--

(1) AUTHORITY TO REFER.--If any offender, including but not limited to any minor, is charged with or convicted of a crime, the court or criminal justice authority with jurisdiction over that offender may require the offender to receive services from a service provider licensed under this chapter. If referred by the court, the referral shall be in addition to final adjudication, imposition of penalty or sentence, or other action. The court may consult with or seek the assistance of a service provider concerning such a referral. Assignment to a service provider is contingent upon availability of space, budgetary considerations, and manageability of the offender.

(2) REFERRAL AND TREATMENT.--
(a) An order referring an offender under subsection (1) must be in writing and must be signed by the referral source. The order must specify the name of the offender, the name and address of the service provider to which the offender is referred, the date of the referral, the duration of the offender's sentence, and all conditions stipulated by the referral source. The total amount of time the offender is required to receive treatment may not exceed the maximum length of sentence possible for the offense with which the offender is charged or convicted. A copy of the order must be delivered to the service provider.
(b) The director may refuse to admit any offender referred to the service provider under subsection (1). The director's refusal to admit the offender must be communicated immediately and in writing within 72 hours to the referral source, stating the basis for such refusal.
(c) The director may, after consulting with the referral source, discharge any offender referred to the service provider under subsection (1) when, in the judgment of the director, the offender is beyond the safe management capabilities of the service provider. The director must orally communicate a decision to discharge an offender to the offender and to the referral source, immediately, and must communicate the decision in writing within 72 hours thereafter, stating the basis for the determination that the offender is beyond the safe management capabilities of the facility.
(d) When an offender successfully completes treatment or when the time period during which the offender is required to receive treatment expires, the director shall communicate such fact to the referral source.

COMMON LICENSING STANDARDS
65D-30.004, F.A.C.

(35) Offender Referrals Under Chapter 397, F.S.

(a) Authority to Refer. Any offender, including any minor, who is charged with or convicted of a crime, is eligible for referral to a provider. The referral may be from the court or from the criminal or juvenile justice authority which has jurisdiction over that offender, and may occur prior to, in lieu of, or in addition to, final adjudication, imposition of penalty or sentence, or other action.

(b) Referral Information. Referrals shall be in writing and signed by the referral source.

(c) Provider Responsibilities.

1. If the offender is not appropriate for placement by the provider, this decision must immediately be communicated to the referral source and documented in writing within 24 hours, stating reasons for refusal.

2. The provider, after consultation with the referral source, may discharge the offender to the referral source.

3. When an offender is successful or unsuccessful in completing treatment or when the commitment period expires, the provider shall communicate this to the referral source.

(d) Assessment of Juvenile Offenders.

1. Each juvenile offender referred by the court and the Department of Juvenile Justice shall be assessed to determine the need for substance abuse services.

2. The court and the Department of juvenile Justice, in conjunction with the department, shall establish procedures to ensure that juvenile offenders are assessed for substance abuse problems and that diversion and adjudication proceedings include conditions and sanctions to address substance abuse problems. These procedures must address:

a. Responsibility of local contracted providers for assessment;

b. The role of the court in handling non-compliant juvenile offenders; and

397.706 Screening, assessment, and disposition of juvenile offenders.--

(1) The substance abuse treatment needs of juvenile offenders and their families must be identified and addressed through diversionary programs and adjudicatory proceedings pursuant to chapter 984 or chapter 985.
(2) The juvenile and circuit courts, in conjunction with department district administration, shall establish policies and procedures to ensure that juvenile offenders are appropriately screened for substance abuse problems and that diversionary and adjudicatory proceedings include appropriate conditions and sanctions to address substance abuse problems. Policies and procedures must address:
(a) The designation of local service providers responsible for screening and assessment services and dispositional recommendations to the department and the court.
(b) The means by which juvenile offenders are processed to ensure participation in screening and assessment services.
(c) The role of the court in securing assessments when juvenile offenders or their families are noncompliant.
(d) Safeguards to ensure that information derived through screening and assessment is used solely to assist in dispositional decisions and not for purposes of determining innocence or guilt.
(3) Because resources available to support screening and assessment services are limited, the judicial circuits and department district administration must develop those capabilities to the extent possible within available resources according to the following priorities:
(a) Juvenile substance abuse offenders.
(b) Juvenile offenders who are substance abuse impaired at the time of the offense.
(c) Second or subsequent juvenile offenders.
(d) Minors taken into custody.

(4) The court may require juvenile offenders and their families to participate in substance abuse assessment and treatment services in accordance with the provisions of chapter 984 or chapter 985 and may use its contempt powers to enforce its orders.

PART VIII
INMATE SUBSTANCE ABUSE PROGRAMS

397.752 Scope of part.--An inmate's substance abuse service records are confidential in accordance with s. 397.501(7). No other provision of parts I-VII of this chapter applies to inmates except as indicated by the context or specified.

c. Priority services

3. Families of the juvenile offender may be required by the court to participate in the assessment process and other services under the authority found in Chapter 985, F.S.

397.753 Definitions.--As used in this part:

(1) "Department" means the Department of Corrections.

(2) "Inmate" means any person committed by a court of competent jurisdiction to the custody of the Department of Corrections, including transfers from federal and state agencies under the Interstate Corrections Compact.

(3) "Inmate substance abuse services" means any service component as defined in s. 397.311 provided directly by the Department of Corrections and licensed and regulated by the Department of Children and Family Services pursuant to s. 397.406, or provided through contractual arrangements with a service provider licensed pursuant to part II; or any self-help program or volunteer support group operating for inmates.

397.754 Duties and responsibilities of the Department of Corrections.--The Department of Corrections shall:

(1) To the fullest extent possible provide inmates upon arrival at a Department of Corrections reception center for initial processing with an assessment of substance abuse service needs.

(2) Provide inmates who are admitted to inmate substance abuse services with an individualized treatment plan which is developed on the basis of assessed need for services and which includes measurable goals and specifies the types of services needed to meet those goals.

(3) To the fullest extent possible provide inmates with individualized services.

(4) Develop and maintain systematic methods of research, evaluation, and monitoring of the appropriateness and quality of substance abuse programs.

(5) Provide inmates who have participated in substance abuse programs within 1 month of the date of their final release from the correctional facility in which they are incarcerated with information regarding options for continuing substance abuse services in the community and with referrals for such services as appropriate or upon the inmate's request.

(6) In cooperation with other agencies, actively seek to enhance resources for the provision of treatment services for inmates and to develop partnerships with other state agencies, including but not limited to the Departments of

Children and Family Services, Education, Community Affairs, and Law Enforcement.

(7) To the extent of available funding, provide training to employees whose duties involve the provision of inmate substance abuse services.

(8) The department shall by rule set forth procedures with respect to individual dignity, nondiscriminatory services, quality services, communication for inmates who receive treatment for substance abuse, and confidentiality requirements in accordance with federal law.

Appendix A: Marchman Act and Related Laws

Previous to the creation of the Hal S. Marchman Alcohol and Other Drug Services Act of 1993" by the Florida Legislature, there were two separate laws governing alcohol and other substance abuse. Chapter 396, F.S., referred to as the Myers Act, governed issues related to alcoholism and alcohol abuse, while Chapter 397 governed drug dependency issues. Separate rules governed alcoholism programs from those governing other drug abuse programs. This created confusion for courts, law enforcement, treatment providers, and families seeking help for loved ones.

The Act, usually referred to as the "Marchman Act," was named after Hal Marchman, a businessman from Volusia County who had advocated over a period of many years for improved substance abuse services statewide.

It is important that the Marchman Act only be used in cases where the person is substance impaired. The Marchman Act is the Florida **Substance Abuse Impairment** Act and it does not authorize provision of psychiatric or medical treatment. For many persons, the use of other statutes may be more appropriate. Some alternative statutes may include:

The Florida Mental Health Act
The Baker Act Chapter 394, F.S.

The Florida Mental Health Act, better known as the Baker Act, was enacted in 1971 to provide a bill of rights for persons with mental illnesses and due process rights for those persons for whom voluntary or involuntary procedures were initiated to provide needed treatment in times of acute Illness. Intoxication and substance abuse impairment are expressly excluded under the definition of mental illness and cannot be the basis of an involuntary examination or placement under the Baker Act. Unfortunately, law enforcement officers and mental health professionals sometimes erroneously use the Baker Act instead of the Marchman Act to be able to access care quickly in a secure location. While some persons with substance abuse impairment also have a co-occurring diagnosis of a mental illness, the mental illness must be separately diagnosed as a severe thought or mood disorder.

An adult may apply for voluntary admission under the Baker Act if found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment.

Mental Illness means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. 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.

Express and Informed Consent means consent voluntarily given in writing, by a competent person, after sufficient explanation to enable the person to make a knowing and willful

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

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

In general, a person cannot be admitted as "voluntary" unless competent to provide express and informed consent. Hence, persons who cannot provide express and informed consent, such as persons with guardians or health care surrogates/proxies currently making decisions for them, are admitted only under the heightened protections established for persons on involuntary status. A minor may only be admitted on a voluntary basis upon application by his or her guardian and a hearing to verify the voluntariness of the consent.

A person may be taken to a receiving facility for involuntary examination under the Baker Act if there is reason to believe that he or she is mentally ill, and because of his or her mental illness:

The person has refused voluntary examination or is unable to determine whether examination is necessary; and
Without care or treatment, the person is likely to suffer from **neglect** resulting in real and present threat of substantial harm that can't be avoided through the help of others; or
There is substantial likelihood that without care or treatment the person will cause serious bodily **harm** to self or others in the near future, as evidenced by recent behavior.

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

- A circuit court judge
- A law enforcement officer
- A physician, clinical psychologist, psychiatric nurse, or clinical social worker

Baker Act Transportation

A law enforcement officer must take a person for involuntary examination to the nearest designated Baker Act receiving facility – the facility must accept persons brought by law enforcement officers for involuntary examination. If appropriate under state and federal law, the person may later be transferred to another facility.

Baker Act Examination

Upon arrival at a receiving facility, a person shall be examined without unnecessary delay by a physician or clinical psychologist. A psychiatrist, psychologist, or emergency room physician must approve the person's release. A person may not be held for involuntary examination longer than 72 hours. Within the 72-hour examination period, one of the following must take place:

The person shall be released unless charged with a crime; in which case the patient must be returned to a law enforcement officer;
The person, unless charged with a crime, shall be asked to give express and informed consent to voluntary placement; or
A petition for involuntary placement shall be filed with the circuit court by the facility administrator.

Developmental Disabilities
Chapter 393, F.S.

This statute governs disorders or syndromes that are attributable to retardation, cerebral palsy, autism, spina bifida or Prader-Wili Syndrome and that constitute a substantial handicap that can reasonably be expected to continue indefinitely. Sometimes law enforcement officers and mental health professionals erroneously use the Florida Baker Act when a person with developmental disabilities displays behavior considered neglectful or dangerous. A distinct diagnosis of a severe thought or mood disorder in addition to the developmental disability is required since the definition of mental illness expressly excludes retardation or other forms of developmental disability as these conditions are governed by Chapter 393,

A person may be court-ordered to undergo involuntary treatment under Chapter 393, F.S. if he or she has retardation or autism, in need of residential services, lacks the capacity to give express and informed consent to voluntary admission, and either lacks the basic survival and self-care skills to provide for one's well-being or is likely to physically injure others if allowed to remain at liberty.

Emergency Examination and Treatment of Incapacitated Persons Act
s. 401.445, F.S.

This statute provides insulation from liability in cases where the person's emergency medical condition is a life-threatening one and treatment is provided absent consent. Persons with severe substance abuse impairment often experience severe medical consequences, resulting in the need for emergency medical care.

Emergency Medical Service means the activities or services to prevent or treat a sudden critical illness or injury and to provide emergency medical care and pre-hospital emergency medical transportation to sick, injured, or otherwise incapacitated persons.

A person is **incapable of providing informed consent** if he cannot generally understand the procedure, the medically acceptable alternatives, and the substantial risks and hazards inherent in the proposed treatment or procedures.

EMS personnel may treat without informed consent if the person at the time of exam or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent without fear of having to respond to civil suits.

EMTALA/COBRA
42 USC 1395dd

This federal statute prohibits the delay or denial of emergency medical services, including psychiatric and substance abuse emergencies. This law applies to all hospitals having emergency service capability, including freestanding psychiatric hospitals. Each person suspected of having an emergency medical condition who is presented to a hospital's emergency room must have a medical screening conducted within the full capability and capacity of the hospital and must be stabilized before a transfer or discharge takes place. EMTALA/COBRA governs access to emergency care, transfers

between facilities, and penalties for violation by physicians and hospitals.

Access to Emergency Services and Care
s.395.1041, F.S.

This state statute is the equivalent of the federal EMTALA/COBRA law. It prohibits the denial of emergency services and care by hospitals and physicians and enforces the ability of persons to get all necessary and appropriate emergency care within the capability and capacity of each hospital. This statute governs access to care, transfers from one hospital to other facilities, and establishes penalties for violations by physicians and hospitals.

This statute also requires that a hospital providing emergency services and care to a person who is being involuntarily examined under the Baker Act must adhere to all rights of patients and involuntary examination procedures provided by the Baker Act, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility, and regardless of whether the person is admitted to the hospital.

Adult Abuse, Neglect, and Exploitation
s. 415.1051, F.S.

This statute may be appropriate when an elderly or disabled person is alleged to be a victim of abuse, neglect, or exploitation and lacks the capacity to consent. This means a mental impairment that causes a person to lack sufficient understanding or capacity to make or communicate responsible decisions concerning his person or property, including whether or not to accept protective services from the Department of Children and Families (DCF).

A **vulnerable adult** is a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, physical, or developmental disability or dysfunctioning, or brain damage, or the infirmities of aging.

Where the person's condition is not a life-threatening emergency and no health care surrogate or proxy is available to consent, a report to the Department of Children and Families of the need for non-emergency protective service intervention is required. If the Department has reasonable cause to believe that a disabled adult or elderly person is in need of protective services but lacks the capacity to consent to protective services, the Department must petition the court for an order authorizing the provision of protective services.

The Department of Children and Families and a law enforcement officer may forcibly enter and may remove an incapacitated person who is likely to incur a risk of death or serious physical injury.

Emergency medical treatment (that doesn't violate an advance directive) may be provided without consent for an incapacitated person, after admission to a medical facility. Further treatment without informed consent is subject to a DCF petition and a court order.

Advance Directive
Chapter 765, F.S.

If the person has previously executed an advance directive designating a health care surrogate and a physician has

found the person to be incompetent or incapacitated to consent to his/her own treatment, the surrogate may instead be asked to provide such consent.

In the absence of an advance directive, a health care proxy may be notified, if a person meeting the degree of relationship specified in Chapter 765, Part IV, F.S. is available to serve.

Incapacity or incompetent means the person is physically or mentally unable to communicate a willful and knowing health care decision

A health care facility must notify the surrogate or proxy in writing that his or her authority has begun. The surrogate or proxy has the authority to:

- Make written consent to health care decisions the principal would have made if capable of making such decisions;
- Have access to clinical records;
- Authorize release of records for continuity of care;
- Authorize transfer of principal to or from a health care facility; and
- Apply for public benefits.

Guardianship
Chapter 744, F.S.

Some persons, due to their incapacity, require either a limited or a plenary guardian to make many life decisions. An incapacitated person is one who has been judicially determined to lack the capacity to manage at least some of his/her property or to meet at least some of the essential health and safety requirements of such person.

Both plenary and limited guardianship is initiated by a petition to the court. Any order of a circuit judge must state the nature of the guardianship as either plenary where the guardian exercises all delegable rights or limited where the guardian exercises only those removed from the ward in the order.

*See chart comparing related statutes.

Quick Reference Guide To Related Statutes (Does not substitute for consulting the statutes)

	Baker Act – The Florida Mental Health Act	Developmental Disabilities	Marchman Act	Emergency Medical Services	Adult Abuse, Neglect, and Exploitation	Guardianship	Health Care Surrogate & Proxy
Authorizing Statute	**Chapter 394, Part I, FS**	**Chapter 393.11, FS**	**Chapter 397, F.S.**	**s. 401.445, F.S.**	**s. 415.1051, F.S.**	**Chapter 744, FS**	**Chapter 765, F.S.**
Definitions	**Mental illness** is 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. The term does not include retardation or developmental disability, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.	**Developmental disability** is a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida or Prader-Wili syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely. **Self Injurious behavior** is any chronic behavior that results in injury to the person's own body, which includes but is not limited to, self-hitting, head banging, self-biting, scratching, and the ingestion of harmful or potentially harmful nutritive or nonnutritive substances.	**Substance abuse Impaired**: means a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance to such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior.	**EMS** means the activities or services to prevent or treat a sudden critical illness or injury and to provide emergency medical care and pre-hospital emergency medical transportation to sick, injured, or otherwise incapacitated persons. A person is **incapable of providing informed consent** if he cannot generally understand the procedure, the medically acceptable alternatives, and the substantial risks and hazards of the proposed treatment or procedures.	A **vulnerable adult** is a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, physical, or developmental disability or dysfunctioning, or brain damage, or the infirmities of aging.	An i**ncapacitated person** is one who has been judicially determined to lack the capacity to manage at least some of the property or to meet at least some of the essential health and safety requirements of such person.	**Incapacity or incompetent** means the patient is physically or mentally unable to communicate a willful and knowing health care decision A **health care surrogate** is any competent adult expressly designated by a person to make health care decisions on behalf of the person upon the principal's incapacity. **Proxy** is a competent adult who has not been designated to make health care decisions for An incapacitated person, but who, is one of the authorized persons eligible to make health care decision for the individual.
Initiation	**Ex parte order** of a circuit judge or a **certified law enforcement officer** acting in his or her official capacity, or a **specified professional** (MD, DO, clinical psychologist, clinical social worker, or psychiatric nurse – all as defined in 394).	**Petitioning Commission** of 3 persons, one must be a physician, file petition with circuit court.	3 forms **of court involved** initiation and 3 forms of **non-court**. Protective custody by LEO or emergency with physician's certificate, or petition to circuit court.	**EMS personnel** may treat without informed consent if the patient at the time of exam or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent.	**Court order** upon petition by DCF in non-emergency cases. **DCF and LEO** may forcibly enter and may remove incapacitated person who is likely to incur a risk of death or serious physical injury.	Court petition to determine incapacity filed by an adult. Order of circuit judge stating the nature of the guardianship as either plenary or limited. If limited, order states the rights that have been removed and delegated to guardian.	Determination by **attending physician**, that principal lacks capacity to make own health care decisions . Health care facility notifies surrogate or proxy in writing that authority under advance directive has begun

	Baker Act – The Florida Mental Health Act	Developmental Disabilities	Marchman Act	Emergency Medical Services	Adult Abuse, Neglect, and Exploitation	Guardianship	Health Care Surrogate & Proxy
Authority of Decision Maker	**Guardian Advocate may be appointed by the court for any person found to be incompetent to consent to treatment. This means that a person's judgment is so affected by his or her mental illness that he lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.**	Guardian Advocate is any person or corporation qualified to act as guardian, with the same powers, duties, and responsibilities required of a guardian pursuant to Chapter 744 or those defined in court order.	Guardian Advocate can be appointed only to represent the person during the court hearing if person cannot attend. Otherwise, no substitute decision-maker provided in 397 other than the parent of a minor. Treatment as authorized by the patient, the court order, or the parent of a minor.		Emergency medical treatment (that doesn't violate an advance directive) without consent for incapacitated person, after admission to a medical facility. Further treatment without informed consent is subject to a DCF petition and a court order.	Limited to authority granted by Circuit Court in Letters of Guardianship. Plenary Guardian exercises all delegable rights while Limited Guardian exercises only those removed from ward in order. Must file reports, plans, inventory, and accounting.	Make written consent to health care decisions the principal would have made if capable of making such decisions. Have access to clinical records, authorize release of records for continuity of care, authorize transfer of principal to or from a health care facility, and apply for public benefits.
Limitations of Authority	Guardian Advocate cannot authorize voluntary admission or consent to treatment for a voluntary patient.	Same as under Chapter 744.				Without first obtaining specific authority from Court (744.3725), guardian cannot commit the ward to facility without formal placement proceeding under Chapter 393 (retardation), 394 (mental illness), or 397 (substance abuse), or to experimental procedures, marriage dissolution, termination of parental rights, sterilization, abortion	May not consent to the psychiatric admission or treatment of a voluntary patient. May not provide consent for abortion, sterilization, ECT, psychosurgery, experimental treatment without Court approval or express authority in an advance directive.
See Also				395.1041, F.S. 42USC 1395dd.	Chapter 825, F.S	s. 394.4625 (1)(d), F.S.	s. 394.4625 (1)(e), F.S

Appendix B: CLIENT RIGHTS

Persons receiving substance abuse services from any service provider are guaranteed protection of the rights specified in the Marchman Act, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

Individual Dignity

The individual dignity of the client must be respected at all times and upon all occasions, including any occasion when the client is admitted, retained, or transported. Substance abuse clients who are not accused of a crime or delinquent act may not be detained or incarcerated in jails, detention centers, or training schools of the state, except for purposes of protective custody in strict accordance with the Marchman Act. A client may not be deprived of any constitutional right.

Nondiscriminatory Services

Service providers may not deny a client access to substance abuse services solely on the basis of

- Race
- Gender
- Ethnicity
- Age
- Sexual preference
- HIV status
- Prior service departures against medical advice
- Disability
- Number of relapse episodes
- Medication prescribed by a physician.
- Service providers who receive state funds to provide substance abuse services may not, provided space and sufficient state resources are available, deny a client access to services based solely on inability to pay.

Quality Services

It is the policy of the state to use the least restrictive and most appropriate services available, based on the needs and the best interests of the client and consistent with optimum care of the client.

Each client in treatment must be afforded the opportunity to participate in the formulation and periodic review of his or her individualized treatment or service plan to the extent of his or her ability to so participate. Each client must be afforded the opportunity to participate in activities designed to enhance self-image.

Each client 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.

These services must include the use of methods and techniques to control aggressive client behavior that poses an immediate threat to the client 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.

Communication

Each client has the right to communicate freely and privately with other persons within the limitations imposed by service provider policy.

Because the delivery of services can only be effective in a substance abuse free environment, close supervision of each client's communications and correspondence is necessary, particularly in the initial stages of treatment, and the service provider must therefore set reasonable rules for telephone, mail, and visitation rights, giving primary consideration to the well-being and safety of clients, staff, and the community. It is the duty of the service provider to inform the client and his or her family if the family is involved at the time of admission about the provider's rules relating to communications and correspondence.

Custody Of Personal Effects

A client has the right to possess clothing and other personal effects. The service provider may take temporary custody of the client's personal effects only when required for medical or safety reasons, with the reason for taking custody and a list of the personal effects recorded in the client's clinical record.

Education Of Minors

Each minor client in a residential service component is guaranteed education and training appropriate to his or her needs. The service provider shall coordinate with local education agencies to ensure that education and training is provided to each minor client in accordance with other applicable laws and regulations and that parental responsibilities related to such education and training are established within the provisions of such applicable laws and regulations. Nothing in the Marchman Act may be construed to relieve any local education authority of its obligation under law to provide a free and appropriate education to every child.

Confidentiality Of Client Records

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:

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 a client.
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 client's name and other identifying information will not be disclosed.
4. In the course of review of records on service provider premises 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 client names or other identifying information and must be in accord 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 client, to the service provider-client relationship, and to the service provider itself.

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 a client'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 client status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

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 client 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.

Any answer to a request for a disclosure of client records which is not permissible under state or 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 never has been a client.

Minors Consent:

1. Since a minor acting alone has the legal capacity to voluntarily apply for and obtain substance abuse treatment, any written consent for disclosure may be given only by the minor client. This restriction includes, but is not limited to, any disclosure of client identifying information to the parent, legal guardian, or custodian of a minor client for the purpose of obtaining financial reimbursement.
2. When the consent of a parent, legal guardian, or custodian is required under this chapter in order for a minor to obtain substance abuse treatment, any written consent for disclosure must be given by both the minor and the parent, legal guardian, or custodian.

Court Order:

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 client identifying information, which would otherwise be prohibited by the Marchman Act. 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.

An order authorizing the disclosure of client 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 client records are needed to provide evidence. An application must use a fictitious name, such as John Doe or Jane Doe, to refer to any client and may not contain or otherwise disclose any client identifying information unless the client 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.

The client and the person holding the records from whom disclosure is sought must be given adequate notice in a manner which will not disclose client 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.

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 client identifying information is not disclosed to anyone other than a party to the proceeding, the client, or the person holding the record, unless the client requests an open hearing. The proceeding may include an examination by the judge of the client records referred to in the application.

A court may authorize the disclosure and use of client records for the purpose of conducting a criminal investigation or prosecution of a client 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 client, to the physician-client relationship and to the ability of the program to provide services to other clients is outweighed by the public interest and the need for the disclosure.

HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) which took effect in April 2003, has had a major impact on privacy of patient medical information. While substance abuse clinical information has already been closely protected through federal and state law, some changes have occurred that providers must be aware of.

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.

Habeas Corpus

At any time, and without notice, a client involuntarily retained by a provider, or the client's parent, guardian, custodian, or attorney on behalf of the client, may petition for a writ of habeas corpus to question the cause and legality of such retention and request that the court issue a writ for the client's release.

Liability and Penalties

Service provider personnel who violate or abuse any right or privilege of a client under

this chapter are liable for damages as determined by law.

1. Knowingly furnishing false information for the purpose of obtaining emergency or other involuntary admission for any person is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.
2. Causing or otherwise securing, or conspiring with or assisting another to cause or secure, without reason for believing a person to be impaired, any emergency or other involuntary procedure for the person is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.
3. Causing, or conspiring with or assisting another to cause, the denial to any person of any right accorded pursuant to this chapter is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

Immunity

All persons acting in good faith, reasonably, and without negligence in connection with the preparation or execution of petitions, applications, certificates, or other documents or the apprehension, detention, discharge, examination, transportation, or treatment of a person under the provisions of this chapter shall be free from all liability, civil or criminal, by reason of such acts.

Frequently Asked Questions

1. Can a person be denied admission to a substance abuse facility because he had left against medical advice on multiple occasions?

No. Previous departures AMA and number of relapses cannot, on their own, be used as reasons to refuse admission.

2. Can a person taking psychotropic medications prescribed by a physician be refused admission?

No. The taking of such prescribed medications cannot be used as a reason for refusing admission to a program. However, if the program determines that it is unable to manage the person's condition, such documentation could result in non-admission.

3. Can a licensed substance abuse facility deny clients the right to communicate at will with persons outside the facility?

Yes. Service providers are required to set reasonable rules for telephone, mail, and visitation rights, giving primary consideration to the well-being and safety of clients, staff, and the community. The provider must inform the client about the provider's rules relating to communications and correspondence.

4. Am I allowed to keep my possessions when I enter a substance abuse program?

Yes. The facility is allowed to take temporary custody of your personal effects only when required for medical or safety reasons and the law requires that the reason for taking custody and a list of the personal effects be recorded in your clinical record.

5. If someone tries to get a judge to order me to a facility for examination or treatment, am I entitled to an attorney to represent me?

Yes. The Marchman Act guarantees you the right to an attorney at every stage of legal proceedings to seek your examination or treatment. You also have the right to have an independent substance abuse professional examine you in this process. You also have the right, once on a facility, to file a petition for a writ of habeas corpus questioning the legality of your confinement in a treatment facility.

6. Is my treatment record completely confidential?

Yes, except for certain times when the facility can or must legally release certain information about you. Such circumstances might include, but are not limited to alleged child abuse, crime against the staff of the program or on the premises of the facility, when ordered by a court, medical emergencies, etc.

Appendix C: Voluntary Admissions

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

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.

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. To be considered eligible for treatment on a voluntary basis, an applicant for services must meet diagnostic criteria for substance abuse related disorders.

With regard to minors, 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 a client who has reached the age of majority. Such consent

is not subject to later disaffirmance based on minority.

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.

Transfer from Involuntary Status
(397.6752, F.S.)

Upon giving his or her written informed consent, an involuntarily admitted client may be referred to a service provider for voluntary admission when the service provider determines that the client no longer meets involuntary criteria.

Early Release From Involuntary Substance Abuse Treatment
(397.6971, F.S.)

At any time prior to the end of the 60-day involuntary treatment period, or prior to the end of any extension granted a client admitted for involuntary treatment may be determined eligible for discharge to the most appropriate referral or disposition for the client. A client who no longer meets the criteria for involuntary admission and has given his or her informed consent to be transferred to voluntary treatment status.

Appendix D: Law Enforcement and the Marchman Act Protective Custody

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Law enforcement officers often serve as the front line for many social and health problems of our communities. Although substance abuse is a health problem, it is often a personal and a public safety issue as well. The Legislature in Florida and elsewhere has granted law enforcement certain authority and responsibilities under the Marchman Act.

Protective Custody

A law enforcement officer as defined in s. 943.10(1), F.S. may implement protective custody measures when a minor or an adult who appears to meet the involuntary admission criteria in s. 397.675 is either:

1. Brought to the attention of law enforcement; or

2. Is in a public place.

The purpose of protective custody is to remove the person from their immediate environment and transport the person to an environment which is conducive to their protection and the protection of others

Any adult or minor may request voluntary treatment for substance abuse. The disability of minority for persons under 18 years of age is removed solely for the purpose of obtaining voluntary substance abuse impairment services.

Criteria for Protective Custody

A person meets the criteria for protective custody if:

- There is good faith reason to believe the person is substance abuse impaired, a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior.

- Because of this impairment, the person has lost the power of self-control with respect to substance use; and either:

- Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or

- 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 law enforcement officer may assist the person with or without the person's consent, as follows:

With Consent

A person in circumstances which justify protective custody 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.

Without Consent

However, if a person in circumstances which justify protective custody 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:

1. 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
2. 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. This 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.

Minors

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.
Release of a minor client can only be made to the minor's parent, legal guardian, or legal custodian or to the authorized designee of the Department of children and Families or the Department of Juvenile Justice.

Provider Responsibilities

Unlike the Baker Act where designated receiving facilities must accept a person from law enforcement officer for involuntary examination, the Marchman Act prohibits substance abuse providers from exceeding their licensed capacity or accepting persons beyond the safe management capabilities of the service provider.

It is the responsibility of the service provider to:

- Ensure that a person who is admitted to a licensed service component meets the involuntary admission criteria;
- Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;
- 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;
- Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;
- 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
- 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.

Non-Admission

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.

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.

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

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

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:

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

Clients shall be referred to more appropriate services if the provider determines that the person should not be placed or should be discharged. The decision to refuse to admit or to discharge shall be made by a qualified professional. Any attempts to contact the referral source must be made in accordance with federal and state confidentiality regulations.

Disposition After Protective Custody

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

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

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.

List Of Licensed Facilities

The Department of Children and Families is required to 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. A current list can also be found for each county on tmyflorida.com website.

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

Behaviors to Look For

Individuals with substance abuse addiction who may need further evaluation typically exhibit a combination of the following behaviors, characteristics, or indicators of their illness:

Substance Abuse: abuse of prescribed medications, use of alcohol or illegal substances. .

Psychological/Physical: Eyes glassy, red, dilated, etc. Labile mood (sad/happy, calm/angry), violent, hostile, irritable, lethargic/manic, self-isolative, non-communicative, paranoid, suicidal ideation.

Behaviors: Slurred speech, incoherent can't concentrate, mood changes quickly and frequently. Lengthy and unexplained absences, returning tired and dirty. Changes jobs frequently and unable to maintain employment.

Family: Domestic violence, isolated from family life and activities. Doesn't pay essential bills.

Criminal Activity: Pawning/selling personal or home possessions. Petty theft, trespassing, prowling, solicitation, DUI, and possession.

Self-Care Issues: insomnia or increased sleep, has not eaten for days, not taking prescribed medications, home is in disarray, neglects household, property, or personal hygiene-to the point of putting self'/others at risk.

Suicidal Risks: has weapons or access to weapons, speaks about previous attempts, makes direct comments about dying or hurting self, evidence of previous attempts such as scars on the wrists.

Elderly Issues: wandering at night, leaving things on stove unattended, not eating or sleeping or caring for personal needs, unrealistic fears, uncontrollable anxiety, confusion, quantity and age of unused foods in the home.

There are two important key points to remember:

Your role is not to diagnose. However, if you have reason to believe that someone appears to be substance abuse impaired, you **can** decide whether or not that person may be putting himself/herself or others in danger, and they meet the criteria for protective custody.

You do not need to witness all of the behaviors personally. The Marchman Act doesn't require that you see the behaviors personally, but you must have good faith reason to believe the criteria are met. You can consider credible eyewitness accounts from others as you determine the need for protective custody.

Frequently Asked Questions

1. How does the Marchman Act define a "law enforcement officer?"

A law enforcement officer means a law enforcement officer as defined in s. 943.10(1), F.S. Therefore, as Chapter 943 is revised in future legislative sessions, the Marchman Act will not have to be revised further. [s. 397.311(18), F.S.]

2. Do I have to be acting in my official capacity or "on duty" to initiate Protective Custody or to transport a person for an examination?

The statute doesn't distinguish between official and off-duty actions Department legal counsel should be consulted where

the officer is considered to be "on duty" 24 hours per day, 7 days per week.

3. I'm a law enforcement officer, not a substance abuse or mental health professional. How am I supposed to diagnose such problems?

Law enforcement officers, in the course of their duties, probably have more day-to-day interaction with persons who have serious substance abuse and mental illness than many behavioral health professionals. However, officers are not expected to diagnose substance abuse impairment. Substance abuse impairment is defined in the Marchman Act to mean:

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. [s. 397.305(16), F.S.]

Criteria for Initiating Protective Custody
s. 397.677, F.S.

4. What are the criteria for initiating Protective Custody under the Marchman Act?

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.

5. Do I have to see the behavior myself to justify taking a person into custody under the Marchman Act?

No. Taking a person into custody under the Marchman Act is a civil procedure, not requiring the same probable cause required under criminal law. You may initiate Protective Custody by having "good faith reason to believe" "a person appears to meet the criteria." A law enforcement officer may consider the statements of other credible persons who have seen the behavior.

Transportation to a Facility

6. Are law enforcement officers required to transport people held under the Marchman Act?

No. The Marchman Act permits law enforcement officers to transport persons for substance abuse assessment, but doesn't require it if there is a more appropriate method of transportation, considering the person's condition. In some cases EMS transport may be required, while in others, there may be family members willing and able to provide such transport. In addition, law enforcement is specifically trained in the transportation of persons who are either violent, resisting transportation, or are otherwise unwilling to comply with directions. Others without that training may either injure or be injured by the person.

7. Can I take a person who meets the criteria for involuntary examination to jail instead of a Marchman Act facility if they have committed a misdemeanor?

Yes.

8. Can I use handcuffs and other restraints when transporting persons with mental illness to a Marchman Act receiving facility?

The Marchman Act states that persons held under the Marchman Act must have their right to individual dignity protected at all times and upon all occasions, included when the client is transported. It is not specific as to the use of restraining devices used with criminal suspects, however where the dangerous circumstances are clearly documented, such restraints may be used in accord with the law enforcement agency's written policies.

9. How can I find out which Marchman Act facilities are in my jurisdiction and their addresses?

The District Office of the Department of Children and Family Services can provide you with a list of the names and addresses of all Marchman Act receiving facilities in your locale.

10. Do I have to take the person to the nearest Marchman Act receiving facility or can I take them to another facility where the person, caregiver, or mental health professional has asked me to take them?

The Marchman Act requires you to take all persons to the nearest receiving facility, unless the person is suffering from an emergency medical condition, in which case they should be taken to the nearest emergency room. The person can be later transferred to another facility if requested by the patient or their guardian.

11. Do I have to return to a hospital to transfer the person to another facility?

No. Once the person is taken to the hospital, the state's Marchman Act and the federal COBRA law require the hospital to arrange for appropriate transfer, when necessary.

12. Can the Marchman Act facility refuse to accept the person I bring to them?

At the Facility

Yes. Unlike the Baker Act that requires facilities to accept persons brought by law enforcement officers, the Marchman Act requires facilities to refuse acceptance of persons if it would cause the facility to go over licensed census, to accept responsibility for a person beyond the safe management of the program, or if the person is unable to pay the cost of a private program. However, if the facility is a licensed hospital and the officer believes the person has an emergency medical condition as a result of the substance abuse issues, a hospital must accept the person under the federal EMTALA law and perform a medical screening and stabilization prior to releasing the person or transferring him or her to another appropriate facility.

13. Do I have to wait at a hospital for the person to be medically screened, treated, or have their insurance verified?

No. The officer's only duties are to present the person. However, if the person is acting in a dangerous manner, beyond the ability of the hospital staff to manage, the officer should stay to assist for a very temporary period until hospital clinical or security staff can arrive.

14. Why do the hospitals or crisis stabilization units release people with serious substance abuse problems so soon?

A substance abuse facility is only permitted to hold a person against their will for assessment and stabilization for a maximum period of 72 hours. However, as soon as a determination is made that the conditions for a petition for court ordered assessment or treatment are not met, the person must be released, unless the person is transferred to voluntary status.

See Flow Chart for Protective Custody

PROTECTIVE CUSTODY
NON-COURT PROCEDURE

ELIGIBILITY PROFILE
- Substance abuser who is impaired in a public place or is brought to the attention of a law enforcement officer. Must meet criteria for involuntary admission found in section 397.675, F.S.

PURPOSE
- Remove the person from their immediate environment and transport the person to an environment that is conducive to their protection and the protection of others.

MEANS
- Person is transported by a law-enforcement officer (law enforcement officers report constitutes the authority to hold the person.

WHERE
- With the person's consent: to their home or, if they have no home, to a hospital, or to a licensed detox or addictions receiving facility.
- Without the person's consent: to a hospital, or to a licensed detox or addictions receiving facility.
- Without the person's consent: to a municipal or county jail, or other appropriate detention facility, only if the person is an adult.

SERVICES PROVIDED
- Assessment by physician (unless the person is taken to their home.

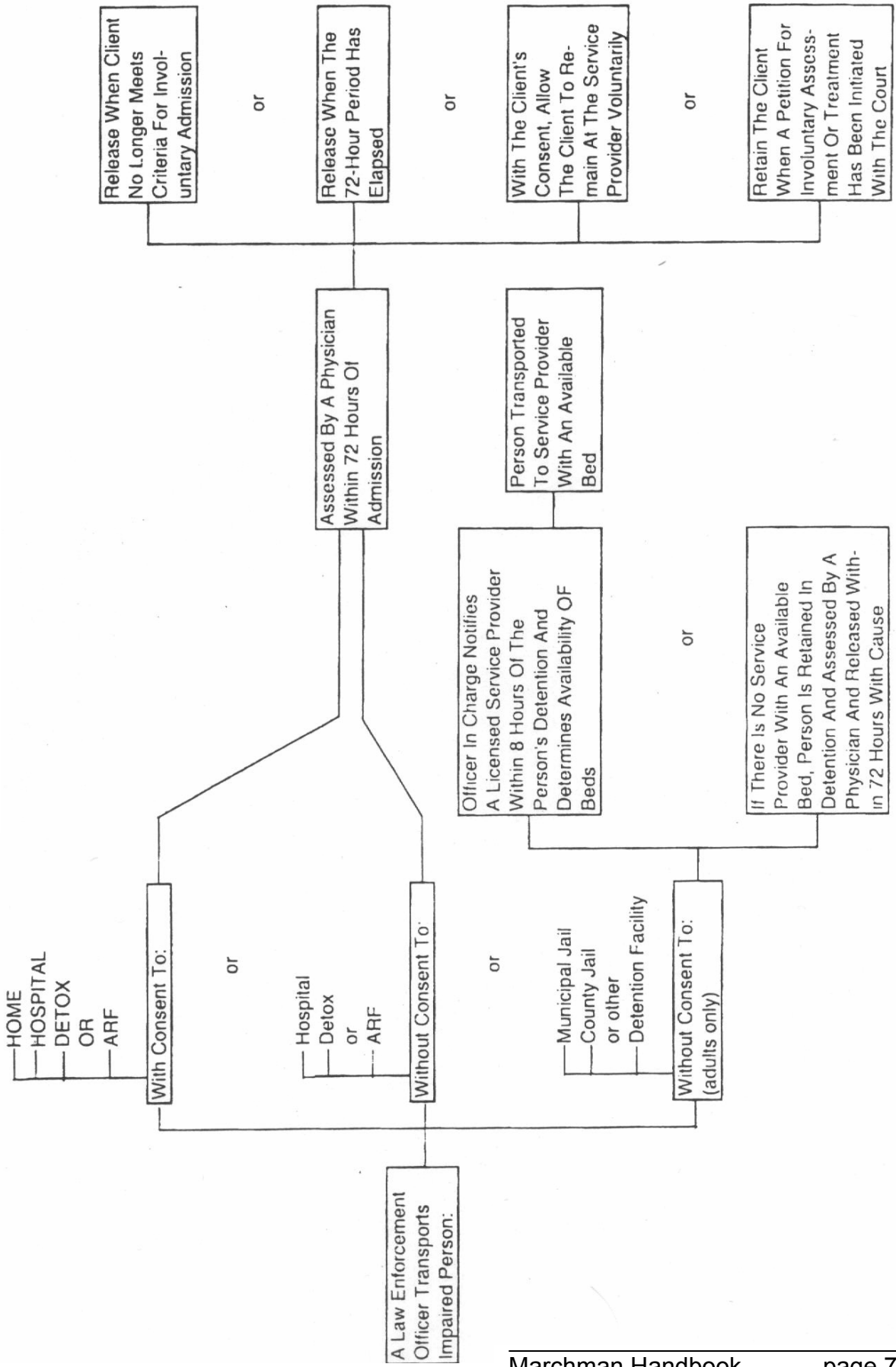
LENGTH OF STAY
- No more than 72 hours from the time of admission.

EXTENSIONS
- None

DISPOSITION ALTERNATIVES
- Release by a qualified professional when the client no longer meets the criteria for involuntary admission; or
- Release by a qualified professional once the 72-hour period has elapsed; or
- With the client's consent, allow the client to remain voluntarily at the licensed service provider; or
- Retain the client when a petition for involuntary assessment or treatment has been initiated with the court and until the petition is heard.

SPECIAL CONDITIONS
- For persons involuntarily admitted to a licensed service provider for the purpose of protective custody, release may be made without further court order only by a qualified professional.
- In the case of minors, release of a minor from protective custody must always be to the client's parent, legal guardian, or legal custodian or the authorized designee thereof.
- For persons admitted to a municipal or county jail or other detention facility for protective custody, the officer in charge must notify a licensed service provider within S hours of the person's detention and, if appropriate and a bed is available, arrange for transportation to the provider.

Noncourt Procedure Protective Custody



Appendix E: Emergency Substance Abuse Admissions and Persons with Emergency Medical Conditions

Introduction

In general, Florida's Marchman Act is designed to assure appropriate, responsive care for persons with substance abuse impairment within a system of protections for the individual.

Many persons with serious substance abuse impairment first come to the attention of law enforcement or emergency medical personnel due to severe medical problems and/or bizarre or abnormal behavior. Through this mechanism, they may eventually get to needed substance abuse treatment. This interrelationship between general medical and substance abuse treatment systems is crucial to appropriate care.

In addition to deaths related to substance abuse impairment, drug related medical emergencies remain significantly high at the national level, and very costly at the state and local levels. Overdoses, or "poisonings" represent the largest category of reasons given for a drug-related visit to the hospital. The Florida Agency for Health Care Administration reported 1,319 cases of poisoning associated with drugs in 1998 and 39,764 cases with drug abuse diagnoses in 1997.

There is a need for all involved parties to work together, within their respective roles. Since implementation of the Marchman Act typically involves a complex configuration of participants (the individual, law enforcement, multiple facilities, substance abuse practitioners, courts, and families), coordination should address:

1. Access to the least restrictive and appropriate services for persons with substance abuse impairment;
2. Better definition of facility roles and utilization of respective facility capabilities; and
3. Optimized cost control, operational, and economic benefit to all involved entities, hospitals, licensed substance abuse service providers, law enforcement, and medical transport services.

Hospital emergency rooms in other states that don't have Florida's system of licensed substance abuse programs and Baker Act receiving facilities must bear the full impact of compliance with EMTALA requirements for emergency psychiatric and substance abuse services. This includes the legal duties imposed, workload, costs, and increased exposure to EMTALA fines and sanctions for violations relating to inappropriate care of persons brought in by local law enforcement officers for evaluation and care.

Persons who are brought to emergency rooms or to physicians in other settings with serious substance abuse impairment may be eligible for involuntary assessment and stabilization under Florida's Marchman Act.

A licensed medical or osteopathic physician (cannot be delegated to physician extenders) is authorized under Florida Law to initiate an emergency admission of a person for assessment and stabilization to a:

- Hospital,
- Licensed detoxification facility; or
- Addictions receiving facility
- To a less intensive component of a licensed service provider (assessment only)

Upon receipt by the facility of the physician's certificate and the completion of

an application for emergency admission, a person can be admitted for involuntary substance abuse assessment and stabilization..

Criteria for Emergency Admissions

The criteria for involuntary Admission is as follows:

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.

Substance Abuse impairment is defined as 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.

Petitioners
397.6791, F.S.

The following persons may request an emergency admission:

Adults:

- 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.

Minors:

- The minor's parent,
- Legal guardian, or
- Legal custodian.

Physician's Certificate
397.6793, F.S.

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,
- 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:

    1. The reason for the physician's belief that the person is substance abuse impaired; and
    2. 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
    3. 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
    4. 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.

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

A signed copy of the physician's certificate must accompany the person, and must 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.

Transportation
397.6795, F.S.

The following persons are authorized to transport a person to a hospital or a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization:

- An applicant for a person's emergency admission, or
- The person's spouse or guardian,
- A law enforcement officer, or
- A health officer

The physician's certificate must indicate whether the person requires transportation assistance for delivery for emergency admission and specify the type of transportation assistance necessary.

Dispositional Alternatives After Emergency Admission
397.6797, F.S.

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:

- Release the client and, where appropriate, refer the client to other needed services; or
- 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.

A **qualified professional** is one of the following:

- Physician licensed under 458 or 459; or
- Professional licensed under chapter 490 or 491 (Psychologist, Clinical SW, Marriage & Family Therapist or Mental Health Counselor); or
- Person who is certified through a DCF recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor's degree.

Frequently Asked Questions

1. Can any licensed professionals, other than physicians, initiate a Marchman Act emergency admission, as can be done under the state's Baker Act?

No. A law enforcement officer or a circuit court judge may initiate, similar to the Baker

Act. However, the only behavioral health professional with standing to initiate the substance abuse involuntary examination is a licensed physician. This cannot be delegated to physician assistants or nurse practitioners working under protocols.

2. Can an emergency admission be made without a physician's certificate?

No.

3. What happens if I can't get my loved one to agree to go to a physician for the certificate to be written?

You can contact law enforcement or can file a petition with the probate office of the Clerk of Courts to have the person who meets the involuntary criteria picked up and taken to a facility for assessment and stabilization.

4. Are law enforcement officers mandated to provide transportation of the person to a facility, as in the Baker Act?

NO. Law enforcement officers are one of several alternative transportation methods permitted in the Marchman Act.

EMTALA

1. Which facilities are subject to the EMTALA law?

Any public, private, or non-profit hospital that offers services for medical, psychiatric or substance abuse emergency conditions is obligated to comply with all of the EMTALA requirements found in CFR 489.20 and 489.24. This would include a freestanding psychiatric hospital that receives persons with emergency psychiatric conditions. All licensed general hospitals are required to comply with section 395.1041, F.S. Conversely, a facility that is not licensed as a hospital, such as a non-hospital based substance abuse program or CSU, is not required to comply with EMTALA or section 395.1041, F.S.

Law Enforcement Responsibilities

2. What is a hospital required to do when a person is brought in by law enforcement under the Marchman Act and there is no room available in an appropriate private or public licensed substance abuse service provider? Would it be proper for a hospital to simply medically stabilize the person and then return the person to the hands of law enforcement and leave it up to local law enforcement officials to find a substance abuse service provider for the person? Clarify whether or not Chapter 395.1041, F.S., and EMTALA require that persons under the Marchman Act be stable before discharge/transfer.

Chapter 395, F.S. and the federal EMTALA/COBRA law, require that a hospital assess and stabilize the person's emergency medical condition (EMTALA includes emergency psychiatric/substance abuse emergencies) of a person under the Marchman Act.

Although the person's medical emergency condition must be stabilized or eliminated prior to the transfer, by virtue of the fact that the person has been placed under the Marchman Act, the person is still suffering from a emergency condition for which the initiating hospital does not have the capability to treat on an involuntary basis.

Therefore, the initiating hospital is required to comply with the emergency access requirements of section 395.1041, F.S., and EMTALA. The hospital must comply with the screening and treatment requirements, as well as the transfer requirements of the law. The initiating hospital that does not licensed substance abuse treatment beds does not have the capability to relieve or eliminate the substance abuse condition of a person on involuntary status, therefore an <u>appropriate</u> transfer to a facility having the

capability and capacity to care for the person must be initiated.

It would not be acceptable for a hospital to return the person to law enforcement personnel for transfer to a licensed substance abuse provider. In the instance when a hospital is unable to place a person on involuntary status due to the unavailability of room, the initiating facility should contact the district office of the DCF Substance Abuse Program Office for assistance in placement of the person (see list of offices and phone numbers at the beginning of this document).

With respect to the stabilization of a person' substance abuse, a hospital should stabilize the person's substance abuse emergency within the capability of the hospital. Then initiate an appropriate transfer to a licensed substance abuse provider

Screening & Stabilization

3. What authority does the Marchman Act or Baker Act provide to administer medical examination and treatment to persons unable or unwilling to provide express and informed consent to such intervention?

The Marchman Act as Florida's Substance Abuse Impairment Act and the Baker Act as Florida's Mental Health Act cannot be used to justify the examination and treatment of medical conditions without the express and informed consent of the person or his/her legally authorized substitute decision-maker. However, other statutes may provide the authority for this, including:

(a) The state's Emergency Examination and Treatment of Incapacitated Persons Act [s. 401.445, F.S.] may provide such authority for EMS personnel in cases where the person's emergency medical condition is a life-threatening one.
(b) Hospital personnel under chapter 395 also have the authority to initiate medical examinations and treatment in cases of life threatening emergencies, assuming no advance directive or DNR form instructs otherwise.

(c) If the person has previously executed an advance directive designating a health care surrogate and a physician has found the person to be incompetent to consent to his/her own treatment, the surrogate may instead be asked to provide such consent. In the absence of an advance directive, a health care proxy may be notified, if a person meeting the degree of relationship specified in s.765, Part IV, F.S. is available to serve. Any health care decisions made by the surrogate or proxy are limited to those that he or she believes the principal would have made if they were capable of making such decisions (Chapter 765, F.S.).

(d) Where the condition is not a life-threatening emergency and no health care surrogate or proxy is available to consent, a report to DCF of the need for non-emergency protective service intervention is required. If the Department has reasonable cause to believe that a vulnerable adult is in need of protective services but lacks the capacity to consent to protective services, the Department shall petition the court for an order authorizing the provision of protective services (s. 415.1051, F.S.).

4. If certain hospital emergency departments are experiencing situations in which they believe that people are being needlessly transported to the emergency department by law enforcement personnel in the name of the Marchman Act or the Baker Act, but these persons do not have emergency medical conditions and do not meet Marchman Act or Baker Act criteria, what is the best course of action for the emergency department personnel to follow to ensure that such apparently

inappropriate use of these Acts is halted?

Prior to the federal EMTALA enforcement regulation's clarification that hospital emergency rooms must provide assessment and stabilization for psychiatric and substance abuse emergencies, persons experiencing these conditions were often turned away from hospital emergency rooms. If emergency departments receive persons from law enforcement for any reason, including persons under the Marchman or Baker Acts, the emergency department must comply with section 395.1041, F.S. and the federal EMTALA law. If a facility does not have the capability to relieve or eliminate the substance abuse impairment or psychiatric condition of a person under involuntary status, an appropriate transfer to a facility having the capability and capacity to care for the person must be initiated.

As always in complex situations, the first efforts to resolve conflict involve communication and exchange of information. The department's district office, in conjunction with AHCA, should be requested to review the situation and the applicable systemic issues, criteria and responsibilities. Often such meetings and resolutions involve several other local parties whose actions or interpretations may be influencing the situation. Typically, the resulting discussions, role clarifications and training of involved personnel have resolved the misunderstandings.

5. If an emergency department receives from law enforcement personnel persons under the Marchman or Baker Acts who clearly do not meet criteria, what is the emergency department's responsibility?

Every person who is transported by law enforcement to the hospital for involuntary Marchman or Baker Act examination MUST be examined and accompanying examination results documented before the individual is released. If there is a pattern of deficiencies, then actions, as described above, may be needed to clarify roles and responsibilities. However, once a person is transported to a hospital's emergency department for examination, the federal EMTALA law also takes effect. The provisions of the EMTALA laws are more encompassing than the Marchman or Baker Act, and minimally require medical assessment and stabilization prior to transfer or discharge of the individual.

6. Is it appropriate for licensed substance abuse providers to routinely utilize emergency departments to provide medical clearance or screening? If not, is there a suggested course of action for the emergency personnel to take?

NO. In rare occasions it is appropriate for a substance abuse provider to request medical clearance prior to admitting a person. These might include cases where there is reason to believe the person has ingested a poison, has suffered an injury, may be suffering an acute medical crisis, may be in need of intensive nursing care, receiving intravenous fluids, or may require a sterile environment, etc. In such cases, admission to such a free-standing substance abuse provider may be inappropriate until a medical clearance rules out such conditions or it is determined that the facility to which the person would be transferred has the capability to manage the person's medical needs. In summary, if a person with an emergency medical condition presents to a substance abuse provider agency that does not have the capability or capacity to treat emergency medical conditions, it would be appropriate to transfer the person to a facility that could provide this service.

However, it is never appropriate for such a substance abuse provider to require all persons be medically screened at an emergency department before admission or to refer all intoxicated persons for blood levels unless an emergency medical

condition was suspected. A nursing assessment of persons is required at detox and ARFs, and, if conditions were noted at that time which requires additional stabilization, the program would be required to refer the person back to the hospital. If a program routinely requires medical clearance of persons from emergency departments, such practice should be documented and reported to DCF for investigation.

7. If a medical screening examination is conducted by qualified medical personnel of the emergency department in accordance with EMTALA and the emergency physician determines that the person is not suffering from a medical emergency, can a licensed substance abuse provider require that the emergency department conduct additional tests, such as blood alcohol or toxicology tests, prior to the provider accepting the person? Is there a suggested course of action in situations where this might be a perceived problem?

If the qualified medical personnel have formally documented the absence of an emergency medical condition, a substance abuse provider cannot require an emergency department to conduct certain tests on a person with an emergency medical condition prior to accepting the person. If a substance abuse facility believes that a person's emergency medical condition has not been stabilized or the emergency medical condition continues to exist, this may be in violation of section 395.1041, F.S. and the EMTALA law. However, a freestanding substance abuse program is prohibited by law from accepting any person for whom it does not have appropriate medical treatment available. This may require provider staff to determine in advance if the person requires services beyond its legal and program capacity. Recurring problems should be documented and reported to districts with contracts for Baker Act, mental health, and substance abuse services.

Transfers

8. Can a licensed substance abuse service provider refuse to accept transfer of an indigent person under the Marchman Act from an emergency department if the program is at full capacity? Is it appropriate for a program to repeatedly refuse to accept transfer of indigent persons under the Marchman Act from an emergency department if the program is utilizing its bed space for paying persons, such as persons with managed care plans? If not, is there a suggested course of action for emergency department personnel to take?

YES. Statutorily, licensed substance abuse providers are not permitted to accept person who are not diagnosed as substance abuse impaired, where the setting Is the not the least restrictive and appropriate, if the admission would cause the program to go over its licensed census, if the person's medical or behavioral condition cannot be safely managed, or if the program is not within the financial means of the person. Violating these requirements would subject persons to a potentially dangerous environment and the provider to loss of license.

DCF contracts, to the extent of its appropriations, with detoxification programs and addiction receiving facilities for the continuous availability of a certain number of beds (capacity), not on an as-used basis. Therefore, a provider may be filled to its contract capacity on a specific day with indigent persons, while still having beds available for purchase from other funders, including managed care organizations. However, if a persistent problem occurs in accessing care for indigent persons, a complaint should be made to the DCF district office.

9. Must written transfer agreements be executed among/between transferring hospitals relative to EMTALA? Is so, are examples available relative to transfers of persons with psychiatric disorders?

No, there is no provision under the EMTALA law or the state law that requires hospitals to enter into written transfer agreements.

10. Can a hospital refuse to accept a transfer of a person solely on the basis of the person's indigency?

NO. If the transfer is being sought from a hospital that doesn't have the capacity or capability of conducting an examination or treatment under the Marchman Act to a general hospital with such services or a free-standing specialty hospital, and that hospital refuses the transfer because of the person's indigency, it would constitute "reverse dumping" under EMTALA.

Insurance/Payor Status

11. Once a person's emergency medical condition has been stabilized, can hospital personnel inquire about the person's insurance even if the hospital has not psychiatrically screened or examined the person's psychiatric condition?

Effective July 1, 1996, section 395.104l(h), F.S. was amended to allow hospital personnel to inquire as to a person's ability to pay as long as the inquiry does not in any way delay the provision of emergency services and care being provided to the person. In such cases, the person may be transferred to an appropriate facility, contingent of his/her ability/inability to pay, assuming all other federal EMTALA transfer requirements are met.

See flow chart on Emergency Admissions

EMERGENCY ADMISSION (Non-Court)

ELIGIBILITY PROFILE

A person undergoing an acute episode of substance abuse impairment. Must meet criteria for involuntary admission found in section 397.675, F.S.

PURPOSE

Remove the person from their immediate environment and place the person in an environment that is conducive to their own safety and the safety of others, and where they may be assessed to determine the need for further services.

MEANS

- Certificate from physician stating that the person has been examined and evaluated regarding need for emergency admission (physician's certificate constitutes the authority to hold person); and
- Application for admission used by the licensed service provider when admitting clients.
  For Adults: Application completed by certifying physician, person's spouse or guardian, relative of the person, or other responsible adult with personal knowledge of the person.
  For Minors: Application completed by a parent, legal guardian or legal custodian
- Person may be transported for admission by the applicant, person's spouse or guardian, a health officer, or a law-enforcement officer.

WHERE

- To a hospital, or licensed detox or additions receiving facility for assessment & stabilization, or to less restrictive environment (e.g., residential, outpatient), for assessment only.

SERVICES PROVIDED

- If admitted to a hospital or to a licensed detox or addictions receiving facility, Assessment by attending physician and stabilization, if necessary
- If admitted to a less restrictive environment, assessment by a qualified professional

LENGTH OF STAY

- If admitted to a hospital or to a licensed detox or addictions receiving facility, no more than 72 hours from the time of admission
- If admitted to a less restrictive environment, no more than 5 days from the date of admission

EXTENSIONS

- None

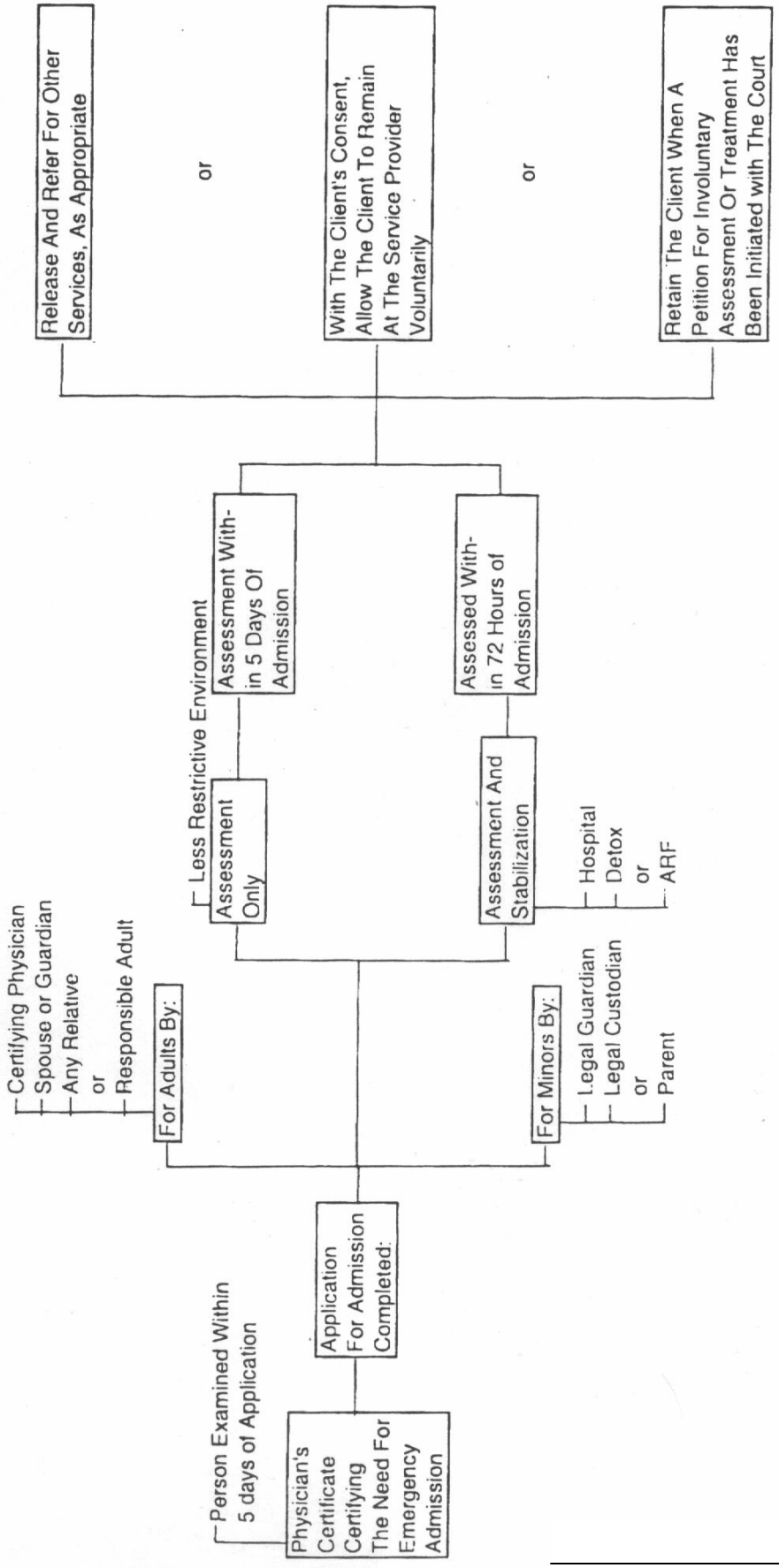
DISPOSITION ALTERNATIVES

- Release by qualified professional and, where appropriate, refer client to other needed services; or
- With the client's consent, allow the client to remain voluntarily at the licensed service provider; or
- Retain the client when a petition for involuntary assessment or treatment has been initiated with the court and until the petition is heard.

SPECIAL CONDITIONS

- For persons involuntarily admitted to licensed service provider for the purpose of emergency services, release may be made without further court order only by a qualified professional.
- Notice of the release must be provided to the applicant.
- In the case of minors, release of a minor from a licensed service provider must always be to the client's parent, legal guardian, or legal custodian or the authorized designee.

Noncourt Procedure Emergency Admission



Appendix F: Alternative Involuntary Assessment for Minors Juvenile Emergency Procedures & Children's Substance Abuse Services

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.

Criteria

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

- Has lost the power of self-control with respect to substance use; and either
- Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or
- 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.

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.

Application

The application must establish the need for involuntary assessment and stabilization based on the criteria for involuntary admission. 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.

A **qualified professional** is one of the following:

- Physician licensed under 458 or 459; or
- Professional licensed under chapter 490 or 491 (Psychologist, Clinical SW, Marriage & Family Therapist or Mental Health Counselor); or
- Person who is certified through a DCF recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor's degree.

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.

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:
- The reason for the applicant's belief that the minor is substance abuse impaired; and
- 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

- 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
- 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.

Parental Participation In Treatment
(397.6759, F.S.)

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

Disposition Upon Completion of Assessment
(397.6799, F.S.)

A minor who has been assessed 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.

Juvenile Emergency Procedures & Children's Substance Abuse Services

The Florida Legislature established its intent that a substance abuse impairment crisis is destroying our youth and is the underlying cause of many juveniles entering the juvenile justice system, and that substance abuse impairment contributes to the crime rate, the school dropout rate, youth suicide, teenage pregnancy, AIDS, and substance-exposed newborns. The economic cost of substance abuse impairment to the state drains existing resources, and the cost to victims, both economic and psychological, is traumatic and tragic. The Legislature also recognizes that substance abuse impairment is a community problem, a family problem, a societal problem, and a judicial problem and that there is a critical need to address this emergency immediately. Therefore, it is the intent of the Legislature that scarce funds be invested in prevention and early intervention programs.

The Legislature authorized the establishment of juvenile addiction receiving facilities in section 397.901, F.S. This law stated that juvenile addictions receiving facilities (JARF) may be designated to provide substance abuse impairment treatment services and community-based detoxification, stabilization, and short-term treatment and medical care to juveniles found to be impaired, in need of emergency treatment as a consequence of being impaired, or incapable of making an informed decision about their need for care. While a flexible range of services is essential, the following services are the core group of services:

- Treatment services.
- Education services.
- Family services.
- Additional services including mental health services, housing assistance, transportation, and nutrition services.

Rules specifying criteria for staffing and services delineated for the provision of graduated levels of care from non-intensive to environmentally secure for the handling of aggressive and difficult-to-manage behavior and the prevention of elopement have been developed by DCF.

Children's Services Provided By Licensed Providers
(397.95, FS)

Each service district of the department shall ensure that all screening, intake, assessment, enrollment, service planning, and case management services provided under this part are provided by children's substance abuse services providers licensed under the Marchman Act and in accordance with standards set forth in department rules.

Treatment and Sanctions
(397.951, F.S.)

The Legislature recognized that the integration of treatment and sanctions greatly increases the effectiveness of substance abuse treatment. It is the responsibility of the department and the substance abuse treatment provider to employ the full measure of sanctions available to require participation and completion of treatment to ensure successful outcomes for children in substance abuse treatment. The Legislature provided for:

1. Substance abuse treatment providers to develop and manage treatment plans that are appropriate to the severity of the substance abuse problem and tailored to the individual needs of the child.

2. Substance abuse treatment providers to employ any and all appropriate available sanctions necessary to engage, motivate, and maintain a child in treatment.

3. Parental participation in treatment for involuntary admission to treatment.

4. Parental authority to involuntarily admit a child for assessment to an addiction receiving facility.

5. Parents and substance abuse providers with civil involuntary procedures to secure court-ordered assessment and treatment for children.

6. Law enforcement authorities to assume custody of a child who is substance abuse impaired and allow placement of a child into the care of a hospital, substance abuse detoxification facility, or addiction receiving facility.

7. Authorize the court or any criminal justice authority with jurisdiction over a child charged or convicted of a crime to require that the delinquent or offender receive substance abuse services.

8. Authority of the court and contempt powers to require parental participation in the treatment of a delinquent or offender.
9. The court to mandate services for children and their families in dependency proceedings under chapter 39, and children and families in need of services under chapter 984.

10. The use, possession, or sale of controlled substances, as defined in chapter 893, or possession of electronic telephone pagers, by any student while such student is upon school property or in attendance at a school function is grounds for disciplinary action by the school and may also result in criminal penalties being imposed

11. Any person under 18 years of age who is found guilty of or delinquent for a violation of s. 562.11(2), s. 562.111, or chapter 893, and is eligible by reason of age for a driver's license or driving privilege, the court shall direct the Department of Highway Safety and Motor Vehicles to revoke or to withhold issuance of his or her driver's license or driving privilege for a period of:

- Not less than 6 months and not more than 1 year for the first violation.
- 2. Two years, for a subsequent violation. 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.

ALTERNATIVE IN VOLUNTARY ASSESSMENT FOR MINORS
NON-COURT PROCEDURE

ELIGIBILITY PROFILE
- A minor who exhibits acute or chronic episodes of substance abuse impairment. Must meet criteria for involuntary admission found in section 397.675, F.S.

PURPOSE

- Placement of a minor in an environmentally secure facility wherein the person can be stabilized, if necessary, and subsequently assessed to determine the need for involuntary treatment.

MEANS
- Application for admission completed by a parent, guardian, or legal custodian.

WHERE

- To an Addictions Receiving Facility (ARF)

SERVICES PROVIDED

- Assessment by a qualified professional.
- Stabilization, where necessary.

LENGTH OF STAY

- No more than 72 hours from the time of admission.

EXTENSIONS

- **No more than 2 additional days, if determined necessary and approved by the attending** physician.

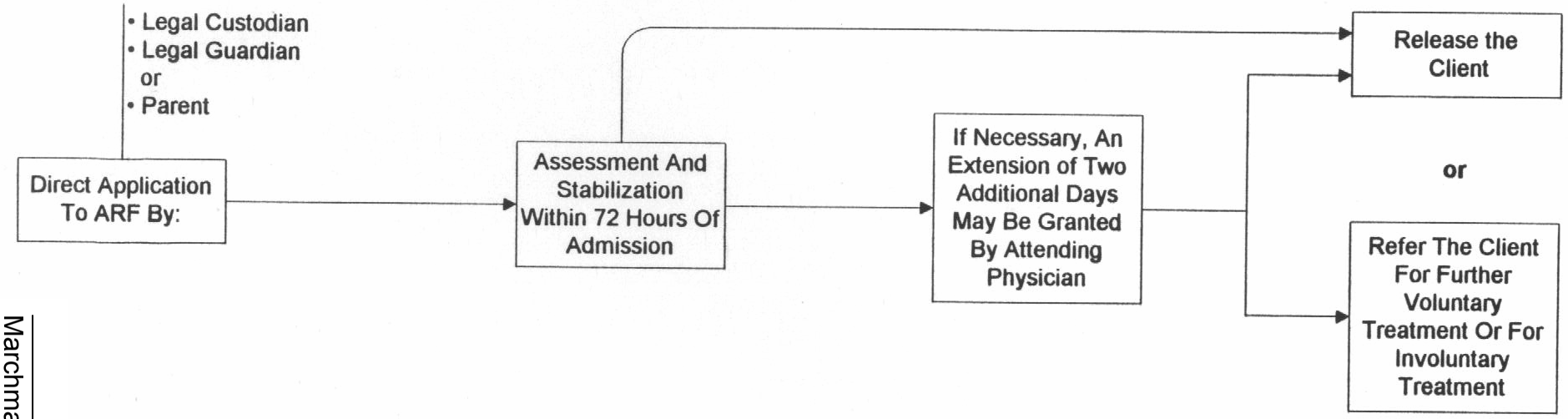
DISPOSITION ALTERNATIVES

- Release of the client by a qualified professional, or;
- Refer the client for further voluntary treatment; or
- Refer the client for involuntary treatment.
    * Application as used in alternative involuntary assessment for minors means the application used by the addictions receiving facility when admitting clients.

SPECIAL CONDITIONS

- Release of a minor involuntarily admitted to an ARF for alternative assessment may be made without further court order only by a qualified professional.
- Notice of the release must be provided to the applicant.
- Release of a minor from an ARF must always be to the client's parent, legal guardian, or legal custodian of the authorized designee.

NONCOURT PROCEDURE
ALTERNATIVE INVOLUNTARY ASSESSMENT
FOR MINORS



Appendix G: Involuntary Substance Abuse Assessment and Stabilization

The Marchman Act encourages persons to seek out treatment on a voluntary basis and to be actively involved in planning their own services with the assistance of qualified professionals. However, denial of addiction is a common symptom, raising a barrier to early intervention and treatment. As a result, treatment often comes as a result of a spouse, employer, doctor, judge or other person with influence over one's life to obtain needed substance abuse services.

The Marchman Act, enacted in 1993 established a variety of methods under which substance abuse assessment, stabilization and treatment could be obtained on an involuntary basis. Some of these can be accomplished without resorting to the courts, including:

- Protective Custody
- Emergency Admission
- Alternative Involuntary Assessment for Minors

However, the law also offers two court-related procedures, including:

- Stabilization
- Involuntary Treatment

Regardless of the court-involved or non-court involved nature of the proceedings, the same criteria for involuntary admission apply.

The **criteria for involuntary admissions** is:

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.

Several definitions are essential to understanding the criteria. These include:

Substance abuse means the use of any substance if such use is unlawful or if such use is detrimental to the user or to others, but is not unlawful.

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.

A **qualified professional** is one of the following:

- Physician licensed under 458 or 459; or
- Professional licensed under chapter 490 or 491 (Psychologist, Clinical SW, Marriage & Family Therapist or Mental Health Counselor); or
- Person who is certified through a DCF recognized certification process for

substance abuse treatment services and who holds, at a minimum, a bachelor's degree.

Assessment means the systematic evaluation of information gathered to determine the nature and severity of the client's substance abuse problem and the client's need and motivation for services. Assessment entails the use of a psychosocial history supplemented, as required by rule, by medical examinations, laboratory testing, and psychometric measures.

Stabilization means alleviation of a crisis condition; or prevention of further deterioration, and connotes short-term emergency treatment.

Substance abuse programs and services applies generally to the broad continuum of prevention, intervention, and treatment initiatives and efforts to limit substance abuse and also includes initiatives and efforts by law enforcement agencies to limit substance abuse.

Court means, with respect to all involuntary proceedings, the circuit court of the county in which the judicial proceeding is pending or where the substance abuse impaired person resides or is located, and includes any general or special master that may be appointed by the chief judge to preside over all or part of such proceeding.

Court Ordered means the result of an order issued by a court requiring an individual's participation in a licensed component of a provider under the following authority:
Civil involuntary as provided under Sections 397.6811 and 397.693, F.S.;

- Treatment of habitual substance abusers in licensed secure facilities as provided under Section 397.702, F.S.; and
- Offender referrals as provided under Section 397.705, F.S.

General Provisions
(397.681, F.S.)

Jurisdiction. The courts have jurisdiction of involuntary assessment and stabilization petitions and involuntary treatment petitions for substance abuse impaired persons. Petitions for involuntary proceedings must be filed with the clerk of the court in the county where the person is located. The chief judge may appoint a general or special master to preside over all or part of the proceedings. The alleged impaired person is named as the respondent.

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, if indigent, to the proceedings without court costs or fees. 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.

Involuntary Assessment and Stabilization
(397.6811, FS)

A person determined by the court to appear to meet the criteria for involuntary admission may be admitted for a period of 5 days to a:

- Hospital or
- Licensed detoxification facility or
- Addictions receiving facility,

For involuntary assessment and stabilization or to a less restrictive component of a licensed service provider for

assessment only upon entry of a court order or upon receipt by the licensed service provider of a petition. Involuntary assessment and stabilization may be initiated by the submission of a petition to the court.

If the person upon whose behalf the petition is being filed is an adult, a petition for involuntary assessment and stabilization may be filed by the respondent's:

- Spouse or guardian
- Any relative
- A private practitioner
- The director of a licensed service provider or the director's designee, or
- Any three adults who have personal knowledge of the respondent's substance abuse impairment.

If the person upon whose behalf the petition is being filed is a minor, a petition for involuntary assessment and stabilization may be filed by a

- Parent,
- Legal guardian,
- Legal custodian, or
- Licensed service provider.

Provider Initiation

Providers are authorized to initiate petitions under the involuntary assessment and stabilization and involuntary treatment provisions when that provider has direct knowledge of the respondent's substance abuse impairment or when an extension of the involuntary admission period is needed. Providers shall specify the circumstances under which a petition will be initiated and the means by which petitions will be drafted, presented to the court, and monitored through the process. The forms to be utilized and the methods to be employed to ensure adherence to legal timeframes shall be included in the procedures. This must be in accordance with Title 42, Code of Federal Regulations, Part 2.

Contents of Petition
(397.6814, FS)

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,
- A statement of the respondent's ability to afford an attorney; and
- Facts to support the need for involuntary assessment and stabilization, 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. 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
  4. 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. If the respondent has refused to submit to an assessment, such refusal must be alleged in the petition.

Procedure
(397.6815, F.S.)

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:

If a **Hearing** is scheduled, provide a copy of the petition and notice of hearing to the:

- Respondent;
- The respondent's attorney, if known;
- The petitioner;
- The respondent's spouse or guardian, if applicable; and
- The respondent's parent, guardian, or legal custodian, in the case of a minor;
- Such other persons as the court may direct.

The petition and notice must be 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, unless an ex parte order is issued by the court.

If a hearing is not scheduled, an **ex parte order** may be issued. 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 Marchman Act prescribes no criteria to govern the court's choice between holding a hearing on the petition and entering an ex parte order granting the petition. The 2nd DCA noted a statutory conflict in a recent appellate case that while the Marchman Act assures that a respondent has the right to counsel "at every stage" of an involuntary admission proceeding, that a court may enter an ex parte order involuntarily admitting the client for assessment and stabilization without the appointment of counsel

Court Hearing
(397.6818, F.S.)

At the hearing, the court shall hear all relevant testimony. The respondent must be present unless the court has reason to believe that his or her presence is likely to be injurious to him or her, in which event the court shall appoint a guardian advocate to represent the respondent. The respondent has the right to examination by a court-appointed qualified professional. After hearing all the evidence, the court shall determine whether there is a reasonable basis to believe the respondent meets the involuntary admission criteria.

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.

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.

Transportation

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.

Responsibility of Licensed Service Provider

(397.6751 and 397.6819, F.S.)

Persons who are involuntarily placed can be served only by licensed service providers and only in those components permitted to admit clients on an involuntary basis.

A licensed service provider may admit a client for involuntary assessment and stabilization for a period not to exceed 5 days. The client must be assessed without unnecessary delay by a qualified professional. If an assessment is performed by a qualified professional who is not a physician, the assessment must be reviewed by a physician prior to the end of the assessment period.

A **Qualified Professional** is a physician licensed under chapter 458 or chapter 459; a professional licensed under chapter 490 or chapter 491 (clinical psychologist, social worker, mental health counselor or a marriage and family therapist); 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 but must meet certification requirements contained in this subsection no later than 1 year after his or her date of employment.

Extension of Assessment Period

(397.6821, F.S.)

If a licensed service provider is unable to complete the involuntary assessment and, if necessary, stabilization of a client within 5 days after the court's order, it may, within the original time period, file a written request for an extension of time to complete its assessment, and shall, in accordance with confidentiality requirements, furnish a copy to all parties. With or without a hearing, 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. The original court order authorizing the involuntary assessment and stabilization, or a request for an extension of time to complete the assessment and stabilization that is timely filed pursuant to this section, constitutes legal authority to involuntarily hold the client for a period not to exceed 10 days in the absence of a court order to the contrary.

Service Provider Responsibilities

(397.6751, F.S.)

It is the responsibility of the service provider to:

- Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;
- Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;
- 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;
- Verify that the admission of the person to the service component does not

result in a census in excess of its licensed service capacity;
- 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
- 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.

Providers that accept involuntary referrals must provide a description of the eligibility and diagnostic criteria and the placement process to be followed for each of the involuntary placement procedures.

Non-Admission
(397.6751(2), F.S.)

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.

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

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

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:

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

Clients shall be referred to more appropriate services if the provider determines that the person should not be placed or should be discharged. The decision to refuse to admit or to discharge shall be made by a qualified professional. Any attempts to contact the referral source must be made in accordance with federal and state confidentiality regulations.

Assessment Standards for Involuntary Treatment Proceedings
(65D-30.004(14), FAC)

Providers that make assessments available to the court regarding hearings for involuntary treatment must define the process used to complete the assessment. This includes:

- Specifying the protocol to be utilized,

- The format and content of the report to the court, and
- The internal procedures used to ensure that assessments are completed and submitted within legally specified timeframes.

For persons assessed under an involuntary order, the provider shall address the means by which the physician's review and signature for involuntary assessment and stabilization and the signature of a qualified professional for involuntary assessments only, will be secured. This includes the process that will be used to notify affected parties stipulated in the petition.

Involuntary Assessment

An assessment must be completed on each client placed in an addictions receiving facility under protective custody, emergency admission, alternative involuntary assessment for minors, and under involuntary assessment and stabilization. The assessment shall be completed by a qualified professional and based on the requirements

The assessment shall be directed toward determining the client's need for additional treatment and the most appropriate. The assessment must include a physical health assessment and a psychosocial assessment, as follows:
:

Physical Health Assessment:

A physical health assessment must include the following components:

- A nursing physical screen must be completed on each person considered for placement in an addiction receiving facility or a detoxification component. The screen shall be completed by an R.N. or by an L.P.N. and countersigned by an R.N. The results of the screen shall be documented by the nurse providing the service and signed and dated by that person. If the nursing physical screen is completed in lieu of a medical history, further action shall be in accordance with the medical protocol
- A Medical History and physical examination must be completed on each client. For addictions receiving facilities and ~~for~~ detoxification, the physical examination shall be completed within 7 calendar days prior to placement or 2 calendar days after placement.
- Laboratory Tests. Clients shall provide a sample for testing blood and urine, including a drug screen.
- Pregnancy Test. Female clients shall be evaluated by a physician, or in accordance with the medical protocol to determine the necessity of a pregnancy test. In those cases where it is determined necessary, clients shall be provided testing services directly or by referral as soon as possible following placement.
- Special Medical Problems. Particular attention shall be given to those clients with special medical problems or needs. This would include referral for medical services. A record of all such referrals shall be maintained in the client record.

Psychosocial Assessment:

The psychosocial assessment shall include the client's history as determined through an assessment of the items as follows:

- Emotional or mental health;
- Level of substance abuse impairment;
- Family history, including substance abuse by other family members;
- The client's substance abuse history, including age of onset, choice of drugs, patterns of use, consequences of use, and types and duration of, and responses to, prior treatment episodes;
- Educational level, vocational status, employment history, and financial status;
- Social history and functioning, including support network, family and peer

relationships, and current living conditions;
- Past or current sexual, psychological, or physical abuse or trauma;
- Client's involvement in leisure and recreational activities;
- Cultural influences;
- Spiritual or values orientation;
- Legal history and status;
- Client's perception of strengths and abilities related to the potential for recovery; and
- A clinical summary, including an analysis and interpretation of the results of the assessment.
- The assessment process shall include the identification of clients with mental illness and other needs. Such clients shall be accommodated directly or through referral. A record of all services provided directly or through referral shall be maintained in the client record.

For **addictions receiving facilities**, the psychosocial assessment shall be completed within 3 calendar days of placement, unless clinically contraindicated. The psychosocial assessment shall be completed by clinical staff and signed and dated. If the psychosocial assessment was not completed initially by a qualified professional, the psychosocial assessment shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion. **Inmate Substance Abuse Programs** operated by or under contract with the Department of Corrections, shall conduct the review and sign-off within 30 calendar days.

Transfers and Readmissions

In those instances where a client is readmitted to the same provider for services within 180 calendar days of discharge, a psychosocial assessment update shall be conducted, if clinically indicated. Information to be included in the update shall be determined by the qualified professional. A new assessment shall be completed on clients who are readmitted for services more than 180 calendar days after discharge. In addition, the psychosocial assessment shall be updated annually for clients who are in continuous treatment for longer than one year.

A new psychosocial assessment does not have to be completed on clients who are referred or transferred from one provider to another or referred or transferred within the same provider if the provider meets at least one of the following conditions:

- The provider or component initiating the referral or transfer forwards a copy of the psychosocial assessment information prior to the arrival of the client;
- Clients are referred or transferred directly from a specific level of care to a lower or higher level of care (e.g., from detoxification to residential treatment or outpatient to residential treatment) within the same provider or from one provider to another;
- The client is referred or transferred directly to the same level of care (e.g., residential level 1 to residential level 1) either within the same provider or from one provider to another.

In the case of referral or transfer from one provider to another, a referral or transfer is considered direct if it was arranged by the referring or transferring provider and the client is subsequently placed with the provider within 7 calendar days of discharge. This does not preclude the provider from conducting an assessment. The following are further requirements related to referrals or transfers.

If the content of a forwarded psychosocial does not comply with the psychosocial requirements of this rule, the information will be updated or a new assessment will be completed.

If a client is placed with the receiving provider later than 7 calendar days following

discharge from the provider that initiated the referral or transfer, but within 180 calendar days, the qualified professional of the receiving provider will determine the extent of the update needed.

If a client is placed with the receiving provider more than 180 calendar days after discharge from the provider that initiated the referral or transfer, a new psychosocial assessment must be completed.

Disposition Of Client
After Involuntary Assessment
(397.6822, F.S.)

Based upon the involuntary assessment, a qualified professional of the hospital, detoxification facility, or addictions receiving facility, or a qualified professional when a less restrictive component has been used, must:

- Release the client and, where appropriate, refer the client to another treatment facility or service provider, or to community services;
- Allow the client, if the client has consented, to remain voluntarily at the licensed provider; or
- Retain the client when a petition for involuntary 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.

Adhering to federal confidentiality regulations, notice of disposition must be provided to the petitioner and to the court.

Transfer to Voluntary Status
(397.6752, F.S.)

Upon giving his or her written informed consent, an involuntarily admitted client may be referred to a service provider for voluntary admission when the service provider determines that the client no longer meets involuntary criteria.

Disposition
(397.6758, F.S.)

Within the assessment period, one of the following three actions shall be taken, based upon the needs of the client and, in the case of a minor, after consultation with the parent(s) or guardian(s).

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

2. The client shall be asked if they will consent to voluntary treatment at the provider, or consent to be referred to another provider for voluntary treatment in residential treatment, day or night treatment, intensive outpatient treatment, or outpatient treatment.

3. A petition for involuntary treatment will be initiated. In those cases in which the court ordering involuntary treatment includes a requirement in the court order for notification of proposed release, the provider must notify the original referral source in writing. Such notification shall comply with legally defined conditions and timeframes and conform to confidentiality regulations found in Title

42, Code of Federal Regulations, Part 2, and subsection 397.501(7), F.S.

Frequently Asked Questions

1. What is the Marchman Act?

The Marchman Act, Florida's substance abuse assessment and treatment statute, allows for a petition to be filed by a family member, guardian, or three citizens to obtain a court order for substance abuse assessment or treatment when the person has refused to voluntarily receive needed care.

2. My husband is hiding empty liquor bottles in the closet and he is passed out much of the time. What can I do?

This person may meet the criteria for a Marchman Act. You, an adult relative, or any three unrelated persons can file a petition to have him examined.

3. How are voluntary and involuntary Marchman Act admissions different?

A voluntary admission is when a person who wishes to enter a facility for substance abuse assessment or treatment and is willing to sign an application for admission. An involuntary admission is when there is good faith reason the person meets the criteria for involuntary assessment or treatment and such a process is initiated by law enforcement, a physician, a court, a family member, or other eligible people.

4. Who can file a petition for an involuntary assessment, stabilization, or treatment?

In addition to a law enforcement officer's authority to take a person into Protective Custody, a physician's authority to cause an emergency admission, and a court's authority to order such admission, a person's spouse, guardian, relative, director of a licensed service provider, or any three adults who have personal knowledge of the person's substance abuse impairment can file a petition on an adult.

5. Who can file a Marchman Act petition on my minor child?

Parents, guardians or legal custodians of a minor can complete the petition necessary to start the case. Generally, the court can give families information about the facilities available to serve the minor. It is usually the parents' responsibility to contact the facility to determine if there is space available and make any financial arrangements that might be necessary.

6. How is a Marchman Act petition filed?

If you have personal knowledge of the person's substance abuse impairment and the other required criteria and you are one of the people who are authorized to initiate a petition, you can file the petition during normal business hours in the Clerk of the Court's Office at the Courthouse.

7. What do I need to bring with me?

You will need to bring some form of identification (including social security number and date of birth) and an address or location where the person can be located by the Sheriff's Office. You will also need to bring information about what service provider has agreed to accept the person.

8. What happens after I file a Marchman Act petition?

After you complete the petition, and swear to the truthfulness of the information, the court will review the information you have provided. If the court agrees that the criteria appears to have been met, either a hearing will be scheduled within 10 days or the judge can order the person picked up immediately without a hearing (ex parte order).

9. What can I expect if a hearing is scheduled?

You and the person must appear in court at the scheduled hearing. An attorney will be appointed for the person if requested and appropriate. Testimony will be taken to determine if there is clear and convincing evidence to support that the legal criteria has been met. The judge can order residential or outpatient assessment or stabilization

10. How long can a person be held on an order for involuntary assessment and stabilization?

The person can be held in a residential setting for up to 5 days. Within that time, the person must be released, transfer to voluntary status, or a petition for involuntary treatment must be filed with the court.

11. Are Marchman Act commitments public records?

No. These types of cases are confidential and are only available to court personnel, the client, and his/her attorney.

12. Who is responsible for the costs associated with any treatment deemed necessary?

Payment for these services may be paid through private insurance, sell payment, or in state/county funding for persons meeting the facility's guidelines.

INVOLUNTARY ASSESSMENT AND STABILIZATION (Court)

ELIGIBILITY PROFILE

- A person who exhibits acute or chronic episodes of substance abuse impairment. Must meet criteria for involuntary admission found in section 397.675, F.S.

PURPOSE

- Placement of a person in an environment wherein the person can be stabilized, if necessary, and assessed to determine the need for involuntary treatment.

MEANS

- Petition filed with court for hearing to **be conducted within 10 days of receipt of petition.**
  For Adults: Petition filed by the respondent's spouse or guardian, any relative, a private practitioner, the director of a licensed service provider or designee, or any three adults with knowledge of the person.
  For Minors: Petition filed by a parent, legal guardian, legal custodian, or licensed provider.
- In lieu of a hearing an, relying solely on the contents of the petition, the court may render an ex parte order authorizing the involuntary assessment and stabilization of the respondent.
- In those cases where a court hearing is conducted and the respondent is ordered to be admitted to a licensed service provider for assessment, the respondent may, if necessary, be transported to the licensed service provider by the sheriff.
- In cases where the court enters an ex parte order directing the person to the admitted to a licensed service provider, the respondent may, if necessary, be transported to the licensed service provider by a law enforcement officer or other designated agent of the court.

WHERE

- To a hospital, or licensed detox or addictions receiving facility for assessment and stabilization, or a less restrictive setting (e.g., residential, outpatient), for assessment only.

SERVICES PROVIDED

- Assessment by qualified professional (If performed by professional other than a physician, assessment must be reviewed by a physician prior to end of assessment period)
- Stabilization, where necessary (not provided in less restrictive environments)

LENGTH OF STAY

- No more than 5 days from the date of admission.

EXTENSIONS

- None

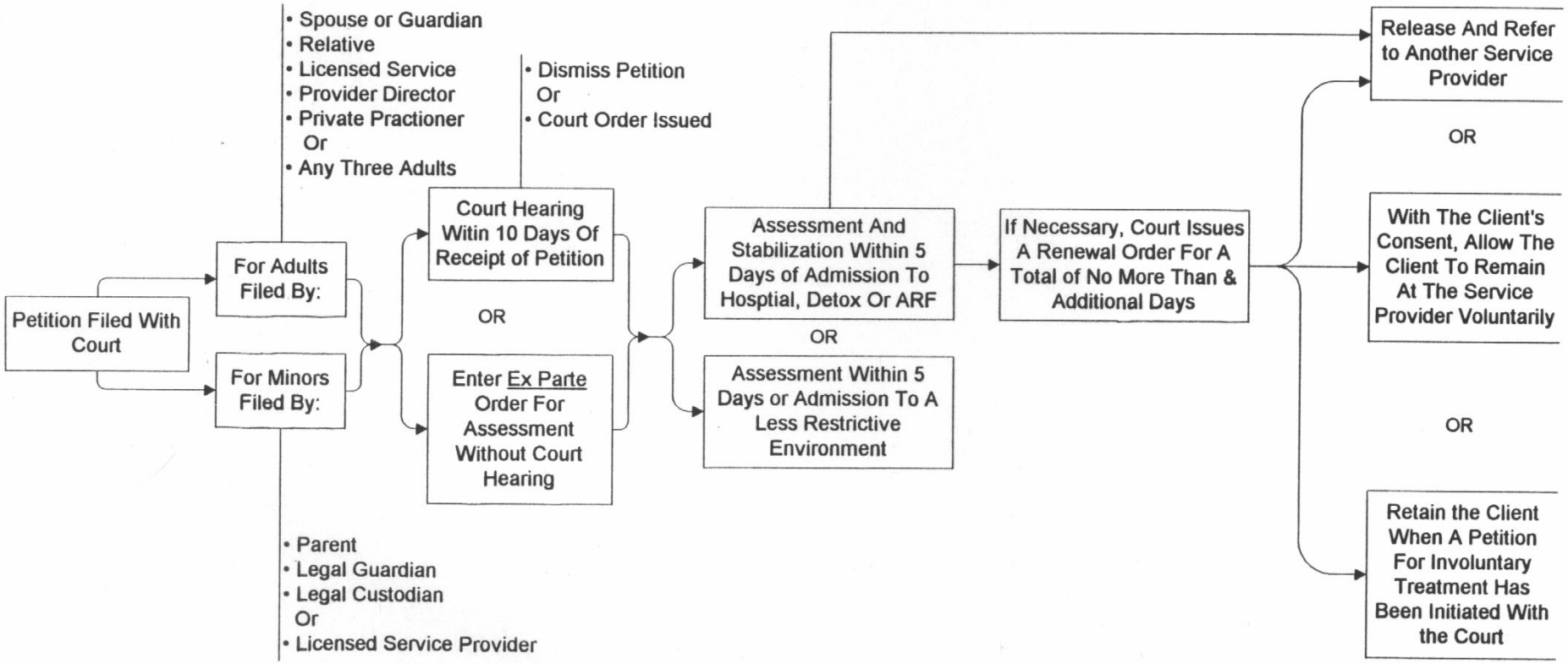
DISPOSITIONAL ALTERNATIVES

- Release of the client by a qualified professional and, where appropriate, refer the client to another treatment facility or service provider, or to other community services; or
- With client's consent, allow client to remain voluntarily at the licensed service provider; or
- Retain client when involuntary treatment petition initiated with court and until petition heard.

SPECIAL CONDITIONS

- For persons involuntarily admitted to licensed service provider for purpose of involuntary assessment and stabilization, release may be made without further court order only by a qualified professional.
- Notice of the release must be given to the petitioner and the court.
- In the case of minors, release of a minor from a licensed service provider must always be to the client's parent, legal guardian, or legal custodian o f the authorized designee.

COURT PROCEDURE
INVOLUNTARY ASSESSMENT AND STABILIZATION



Appendix H: Involuntary Treatment

A person must have undergone a substance abuse assessment before a petition for involuntary treatment can be filed with the court. This two-part procedure is needed in order for the Court to have sufficient professional information to ensure the person meets the legal criteria to place him or her against their will into needed substance abuse treatment.

Criteria

A person may be the subject of a petition for court-ordered involuntary treatment if that person meets the criteria for involuntary admission, as follows:

- There is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

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

- Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or

- 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.

Substance abuse impairment 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.

Further, a person must have been:

- Placed under protective custody within the previous 10 days;
- Subject to an emergency admission within the previous 10 days;
- Assessed by a qualified professional within 5 days;
- Subject to involuntary assessment and stabilization within the previous 12 days; or
- A minor subject to alternative involuntary admission within the previous 12 days.

A **qualified professional** is one of the following:

- Physician licensed under 458 or 459; or
- Professional licensed under chapter 490 or 491 (Psychologist, Clinical SW, Marriage & Family Therapist or Mental Health Counselor); or
- Person who is certified through a DCF recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor's degree.

Persons Who May Petition
(397.695, F.S.)

If the respondent is an **adult**, a petition for involuntary treatment may be filed by the respondent's:

- Spouse
- 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.

If the respondent is a **minor**, a petition for involuntary treatment may be filed by a:

- Parent
- Legal guardian, or
- Service provider

Contents of Petition
(397.6951, F.S.)

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. 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
  4. 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.

Duties Of Court
(397.6955, F.S.)

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.
- Schedule a hearing to be held on the petition within 10 days.
- Provide 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.
- Issue a summons to the person whose admission is sought.

Hearing
(397.6957, F.S.)

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. 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.

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

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.

Court Order
(397.697, F.S.)

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. 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 prior to the end of the 60-day period.

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.

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.

Parental Participation In Treatment
(397.6759, F.S.)

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

Early Release
(397.6971, F.S.)

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

- 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;
- 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
- 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;
- The client is no longer in need of services; or
- The director of the service provider determines that the client is beyond the safe management capabilities of the provider.

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

Disposition Upon Completion Of Treatment
(397.6977, F.S.)

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.

Extension Of Treatment Period
(397.6975, F.S.)

Whenever a service provider believes that a client who is nearing the scheduled date of release from involuntary treatment continues to meet the criteria for involuntary treatment, a petition for renewal of the involuntary treatment order may be filed with the court at least 10 days prior to the expiration of the court-ordered treatment period. The court shall immediately schedule a hearing to be held not more than 15 days after filing of the petition. The court shall provide the copy of the petition for renewal and the notice of the hearing to all parties to the proceeding. The hearing is conducted pursuant to the requirements for the original hearing on involuntary treatment.

If the court finds that the petition for renewal of the involuntary treatment order should be granted, it may order the respondent to undergo involuntary treatment for a period not to exceed an additional 90 days. When the conditions justifying involuntary treatment no longer exist, the client must be released. When the conditions justifying involuntary treatment continue to exist after 90 days of additional treatment, a new petition requesting renewal of the involuntary treatment order may be filed pursuant to this section.

Responsibility of Licensed Service Providers
(397.6751 and 397.6819, F.S.)

Persons who are involuntarily placed can be served only by licensed service providers and only in those components permitted to admit clients on an involuntary basis.

Providers that accept involuntary referrals must provide a description of the eligibility and diagnostic criteria and the placement process to be followed for each of the involuntary placement procedures.

Clients shall be referred to more appropriate services if the provider determines that the person should not be placed or should be discharged. Such referral shall follow the requirements found in the Marchman Act. The decision to refuse to admit or to discharge shall be made by a qualified professional. Any attempts to contact the referral source must be made in accordance with federal and state confidentiality regulations.

In those cases in which the court ordering involuntary treatment includes a requirement in the court order for notification of proposed release, the provider must notify the original referral source in writing. Such notification shall comply with legally defined conditions and timeframes and conform to federal and state confidentiality regulations

It is the responsibility of the service provider to:

- Ensure that a person who is admitted to a licensed service component meets the admission criteria;
- Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe

management capabilities of the service provider;
- 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;
- Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;
- 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
- 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.
- Providers that accept involuntary referrals must provide a description of the eligibility and diagnostic criteria and the placement process to be followed for each of the involuntary placement procedures.

Non-Admission

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,
- His or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or
- Of a lack of available space, services, or
- Lack of 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.

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.

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

- The basis for the refusal to admit the person, and

- 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.

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:

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

Clients shall be referred to more appropriate services if the provider determines that the person should not be placed or should be

discharged. The decision to refuse to admit or to discharge shall be made by a qualified professional. Any attempts to contact the referral source must be made in accordance with federal and state confidentiality regulations.

Frequently Asked Questions

1. Who can file a petition for an involuntary assessment, stabilization, or treatment?
In addition to a law enforcement officer's authority to take a person into Protective Custody, a physician's authority to cause an emergency admission, and a court's authority to order such admission, a person's spouse, guardian, relative, director of a licensed service provider, or any three adults who have personal knowledge of the person's substance abuse impairment can file a petition on an adult.

2. Who can file a Marchman Act petition on my minor child?
Parents, guardians or legal custodians of a minor can complete the petition necessary to start the case. Generally, the court can give families information about the facilities available to serve the minor. It is usually the parents' responsibility to contact the facility to determine if there is space available and make any financial arrangements that might be necessary.

3. How is a Marchman Act petition filed?
If you have personal knowledge of the person's substance abuse impairment and the other required criteria and you are one of the people who are authorized to initiate a petition, you can file the petition during normal business hours in the Clerk of the Court's Office at the Courthouse.

4. What do I need to bring with me?
You will need to bring some form of identification (including social security number and date of birth) and an address or location where the person can be located by the Sheriff's Office. You will also need to bring information about what service provider has agreed to accept the person.

5. What happens after I file a Marchman Act petition?
After you complete the petition, and swear to the truthfulness of the information, the court will review the information you have provided. If the court agrees that the criteria appears to have been met, either a hearing will be scheduled within 10 days or the judge can order the person picked up immediately without a hearing (ex parte order).

6. What can I expect if a hearing is scheduled?
You and the person must appear in court at the scheduled hearing. An attorney will be appointed for the person if requested and appropriate. Testimony will be taken to determine if there is clear and convincing evidence to support that the legal criteria has been met. The judge can order residential or outpatient assessment or stabilization

7. How long can a person be held on an order for involuntary assessment and stabilization?
The person can be held in a residential setting for up to 5 days. Within that time, the person must be released, be transferred to voluntary status, or a petition for involuntary treatment must be filed with the court.

8. Are Marchman Act commitments public records?
No. These types of cases are confidential and are only available to court personnel, the client, and his/her attorney.

9. Who is responsible for the costs associated with any treatment deemed necessary?
Payment for these services may be paid through private insurance, sell payment, or in state/county funding for persons meeting the facility's guidelines.

INVOLUNTARY TREATMENT (Court)

ELIGIBILITY PROFILE

- A person who exhibits acute or chronic episodes of substance abuse impairment and has been involved in protective custody, emergency admission, alternative involuntary assessment, involuntary assessment and stabilization, or assessment by a qualified professional. Must meet criteria for involuntary admission found in section 397.575, F.S.

PURPOSE

- Remove the person from their immediate environment and place the person in an environment where they can receive treatment.

MEANS

- Petition filed with the court for a hearing which is to be conducted within 10 days of receipt of the petition.

  For Adults: Petition filed by the respondents' spouse or guardian, any relative, service provider, or any three adults with prior knowledge of the person.

  For Minors: Petition filed by a parent, legal guardian, or service provider
- The court may direct the sheriff, if necessary, to deliver the respondent.

WHERE

- To a licensed service provider.

SERVICES PROVIDED

- Treatment, Health, and other ancillary services

LENGTH OF STAY

- No more than 60 days from the date of admission.

EXTENSIONS

- With a hearing, court may grant an additional 90 days after the date of the renewal order.
- Additional extensions - none (a new petition is necessary)

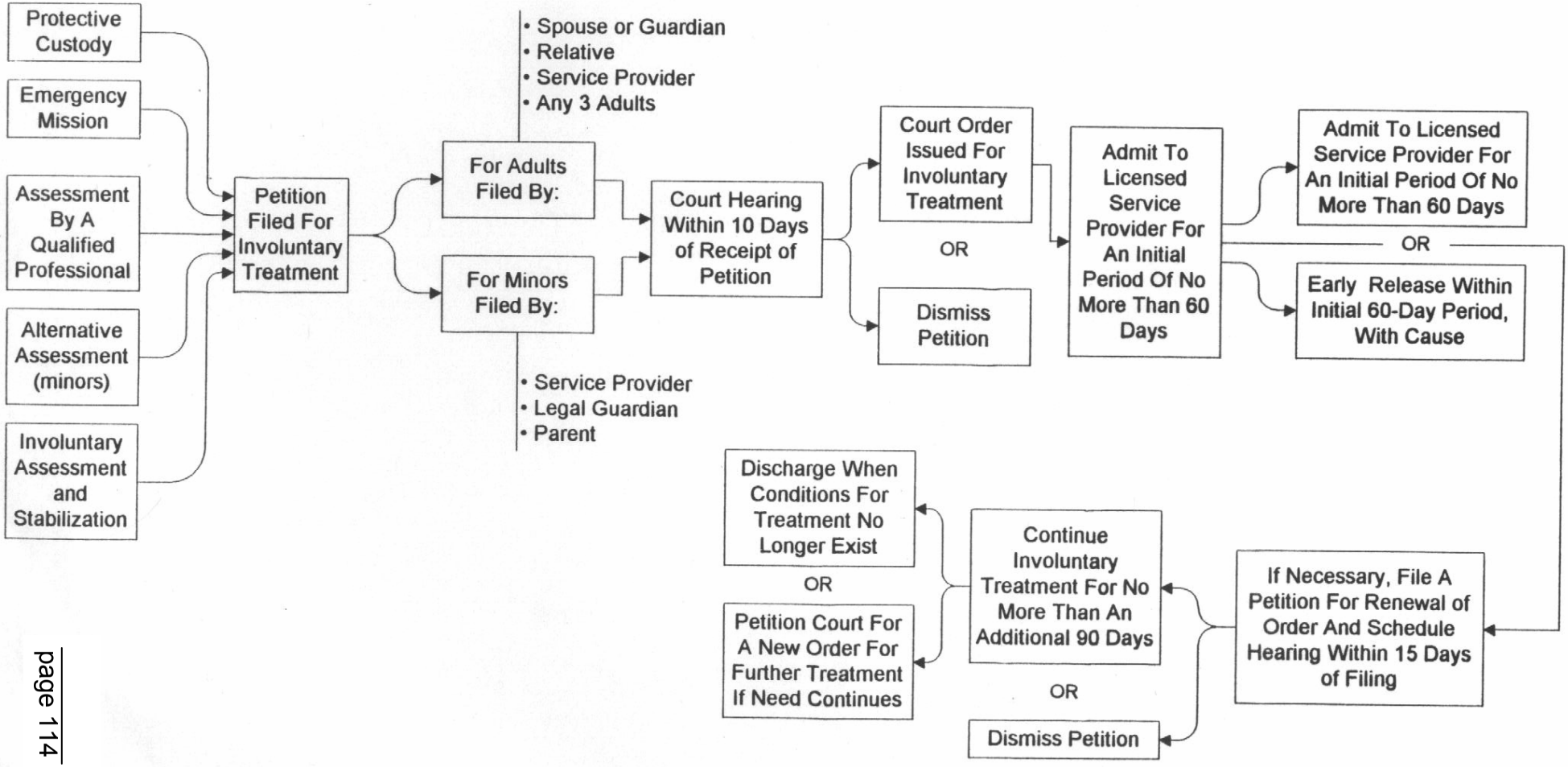
DISPOSITIONAL ALTERNATIVES

- Early release of client.
  - Determined by qualified professional
  - May occur within initial 60-day period or at any time following extension of the initial period, and under the specific conditions as described in section 397.6971, F.S.
  - Licensed service provider must notify all persons specified by the court I the original order of the pending release.
- Discharge of the client by a qualified professional following completion of involuntary treatment at the conclusion of the 60-day period.
- Retain client at end of initial 60-day period if a motion for renewal of the involuntary treatment order has been filed with the court and until a decision has been rendered

SPECIAL CONDITIONS

- For persons involuntarily admitted to licensed service provider for the purpose of involuntary treatment, release may be made without further court order only by a qualified professional.
- With the exception of early release, notice of release under any other conditions must be given to the petitioner and the court.
- In the case of minors, release of a minor from a licensed service provider must always be to the

COURT PROCEDURE
INVOLUNTARY TREATMENT



Appendix I: Consent for Admission and Treatment for Minors

(Substance abuse, mental health, and medical-related statutes)

Introduction

The Marchman Act makes certain distinctions between adults and minors. Where distinctions are not made, adults and minors have the same rights and are to be treated the same. However, a number of other statutes do address minors and their consent for substance abuse, mental health and medical treatment. Specific reference to the admission and treatment of minors in the Marchman Act and these other statutes are summarized here, with the corresponding statutory references. This is a dynamic law that may change after the publication of this Handbook.

Since the Marchman Act contains relatively few specific references to minors, and since this law must be carried out in the context of other coexisting statutes and case law, it is important for each professional and substance abuse provider agency to involve its attorney in reviewing policies and procedures for properly carrying out one's responsibilities. Legal consultation on an on-going basis is necessary to assure responsible and lawful conduct. In each circumstance in which consent to admission and/or treatment is sought for a minor, it is essential that the professional consider the nature and context of the consent, in determining whether the consent is legally sufficient.

Minority Defined

Florida statutes define minority as follows:

- Minor means a person under 18 years of age whose disabilities have not been removed by marriage or otherwise. [s. 744.102(11), F.S.]
- The disability of nonage of a minor who is married or has been married or subsequently becomes married, including one whose marriage is

dissolved, or who is widowed or widowered, is removed. The minor may …perform all acts that he could do if not a minor. [s. 743.01, F.S.] In addition, a circuit court has jurisdiction to remove the disabilities of nonage of a minor age 16 or older residing in Florida upon a petition filed by the minor's natural or legal guardian or, if there is none, by a guardian ad litem. [s. 743.015, F.S.]

Generally, persons under the age of 18 cannot consent to their own treatment because they are presumed to be legally incompetent as a result of their age or presumed immaturity of judgment. When needed, parents usually provide consent on their children's behalf, except where parental consent is not required. The mother and father jointly are natural guardians of their own children and of their adopted children during minority. [s. 744.301, (1) F.S.] However:

- If one parent dies, the natural guardianship passes to the surviving parent, and the right continues even though the surviving parent remarries.
- If the marriage between the parents is dissolved, the natural guardianship belongs to the parent to whom the custody of the child is awarded.
- If the parents are given joint custody, then both continue as natural guardians.
- If the marriage is dissolved and neither the father nor the mother is given custody of the child, neither can act as natural guardian of the child.
- The mother of a child born out of wedlock is the natural guardian of the child and is entitled to primary residential care and custody of the child unless a court enters an order stating otherwise.

- Upon petition of a parent, brother, sister, next of kin, or other person interested in the welfare of a minor, a guardian for a minor may be appointed by the court without appointing an examining committee or adjudicating the child incapacitated. A guardian appointed for a minor, whether of the person or property, has the authority of a plenary guardian. (s. 744.3021 and s. 744,342, F.S.) The court must consider the preference of a minor who is age 14 or over as to who should be appointed guardian. (s. 744.312(3)(a), F.S.)

Legal custody is a legal status created by court order or letter of guardianship which vests in a custodian of the person or guardian, whether an agency or an individual, the right to have physical custody of the child and the right and duty to protect, train, and discipline the child and to provide him or her with food, shelter, education, and ordinary medical, dental, psychiatric, and psychological care. [s. 39.01(33), F.S.]

A guardian appointed by the court does not have the power to admit the minor to a facility, institution, or licensed service provider without formal placement proceeding, pursuant to Chapter 393, Chapter 394, or Chapter 397 without first obtaining specific authority from the court, as described in s. 744.3725. (s. 744.3215, F.S.)

Substance Abuse
Admission and Treatment

The disability of nonage for persons under 18 years of age has been removed solely for the purpose of allowing that child to obtain **voluntary** substance abuse impairment services from a licensed service provider, and consent to such by a minor shall have the same force and effect as if executed by a client who has reached the age of majority. Such consent shall not be subject to later disaffirmance based on minority. [s. 397.601(4)(a), F.S.]

Criteria: A minor may be taken to an addictions receiving facility (ARF) for **involuntary** evaluation if there is, in good faith, reason to believe the minor suffers from 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 who, because of such condition [s. 397.311(16) and s. 397.675, F.S.]:

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

2. Inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or another; **or**

3. Is in need of substance abuse services and, by reason of substance abuse impairment his judgment has been so impaired that he is incapable of appreciating his need for such services and of making a rational decision in regard thereto. However, mere refusal to undergo such services shall not constitute evidence of lack of judgment with respect to his need for such services

Initiation:

Protective custody, emergency admission, and involuntary assessment and stabilization of minors may be initiated through law enforcement (397.677, F.S.) or the courts. A petition for involuntary assessment and stabilization may be filed with the clerk of the court by a parent, legal guardian, legal custodian, or licensed service provider. [s. 397.6811(2), F.S.]

In addition, a juvenile addictions receiving facility (JARF) may admit a minor for involuntary assessment and stabilization upon the filing of an application by the minor's parent, guardian, or legal custodian.

The application must establish the need for such services based on the criteria above. Within 72 hours after involuntary admission of a minor, the minor must be assessed by a qualified professional to determine the need for further services. If criteria for further evaluation is not met, the minor may be released or referred for further voluntary treatment. [s. 397.6798, F.S.]

A **qualified professional** is one of the following:

- Physician licensed under 458 or 459; or
- Professional licensed under chapter 490 or 491 (Psychologist, Clinical SW, Marriage & Family Therapist or Mental Health Counselor); or
- Person who is certified through a DCF recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor's degree.

Disposition: Release of the minor from protective custody, emergency admission, involuntary assessment, involuntary treatment, and alternative involuntary assessment of a minor, upon approval of a qualified professional in a hospital, a detoxification facility, addictions receiving facility, or any less restrictive treatment component must be to the minor's parent, legal guardian, or legal custodian or the authorized designee thereof or to the department. [s. 397.6758, F.S.]

Release of Information: Since a minor acting alone has the legal capacity to voluntarily apply for and obtain substance abuse treatment, any written consent for disclosure may be given only by the minor client. This restriction includes, but is not limited to, any disclosure of client identifying information to the parent, legal guardian, or custodian of a minor client for the purpose of obtaining financial reimbursement. When the consent of a parent, legal guardian, or custodian is required for a minor to obtain substance abuse treatment, any written consent for disclosure must be given by both the minor and the parent, legal guardian, or custodian. [ss. 397.501(7)(e) 1 and 2, F.S.]

Parental Participation in Treatment: A parent, legal guardian, or legal custodian who seeks involuntary admission of a minor is required to participate in all aspects of treatment as determined appropriate by the director of the licensed service provider. [397.6759, F.S.]

Parental Participation/Payment: A parent or legal guardian of a minor is required to contribute toward the cost of substance abuse services in accordance with his ability to pay, unless otherwise provided by law. The parent, legal guardian or legal custodian of a minor is not liable for payment for any voluntary substance abuse services provided to the minor without parental consent, unless the parent, legal guardian, or legal custodian participates or is ordered to participate in the services, and only for the substance abuse services rendered. If the minor is receiving services as a juvenile offender, the obligation to pay is governed by the law relating to juvenile offenders. [s. 397.431(2)(3), F.S.]

Mental Health
Admission and Treatment

Admission

A **facility** may receive for observation, diagnosis or treatment any person age 17 or under who is willing to be admitted and for whom such application is made by his or her guardian. A person age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent. [s. 394.4625(1), F.S.] If the voluntariness of the minor's admission is not confirmed, the minor must be either released or involuntary examination procedures initiated.

A **facility** is defined in the Baker Act as: Any hospital, community facility under contract with the department, public or private facility, or receiving or treatment

facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness.

Hospitals: A minor under the age of 14 who is admitted to any hospital licensed pursuant to Chapter 395, F.S. may not be admitted to a bed in a room or ward with an adult in a mental health unit or share common areas with an adult in a mental health unit. However, a minor 14 years of age or older may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician documents in the case record that such placement is medically indicated or for reasons of safety. Such placement shall be reviewed by the attending physician or a designee or on-call physician each day and documented in the case record. [s. 394.4785(2), F.S.] In addition, all hospitals are required to ensure full compliance with the Baker Act as a condition of licensure. [s. 395.003(5)(a)(b), F.S.]

Children's Crisis Stabilization Units: Minors under the age of 14 years shall not be admitted to a bed in a room or ward with an adult. They may share common areas with an adult only when under direct visual observation by unit staff. Minors who are 14 years of age and older may be admitted to a bed in a room or ward in the mental health unit with an adult, if the clinical record contains documentation by a physician that such placement is medically indicated or for reasons of safety. This shall be reviewed and documented by the physician on a daily basis. [Chapter 65E-12.106(22), F.A.C.]

Outpatient Admission: A judge may order a child to be evaluated or treated by a psychiatrist or a psychologist or to receive mental health, substance abuse, or retardation services from a psychiatrist, psychologist, or other appropriate service provider. If it is necessary to place a child in a residential facility for such evaluation, the criteria and procedures established in s. 394.463, F.S. shall be used. [ss. 39.407(3), (4), and (5) F.S.]

Consent To Psychiatric Treatment:

- **Inpatient:** Each person entering a facility shall be asked to give express and informed consent for admission and treatment. If the person is a minor, express and informed consent for admission and treatment shall also be requested from the person's guardian. Express and informed consent for admission and treatment of a person under 18 years of age shall be required from the person's guardian, unless the minor is seeking outpatient crisis intervention services (see below). [s. 394.459(3)(a), F.S.]

- **Children in Residential Treatment Centers:** Children's rights, as specified in s. 394.459, F.S. for patients, shall be safeguarded. Children shall be informed of their legal and civil rights, including the right to legal counsel and all other requirements of due process. Therefore, the Baker Act controls rights of children in residential treatment. [Chapter 65E-10.021(3(e), F.A.C]

Outpatient Crisis Intervention Services:

The disability of nonage is removed for any minor age 13 years or older to access services under the following circumstances (s. 394.4784, F.S.):

- **Outpatient Diagnostic and Evaluation Services** — When any minor age 13 years or older experiences an emotional crisis to such degree that he or she perceives the need for professional assistance, he or she shall have the right to request, consent to, and receive mental health diagnostic and evaluative services provided by a licensed mental health professional, as defined by Florida Statutes, or in a mental health facility licensed by the state. The purpose of such services shall be to determine the severity

of the problem and the potential for harm to the person or others if further professional services are not provided. Outpatient diagnostic and evaluative services shall not include medication and other somatic methods, aversive stimuli, or substantial deprivation. Such services shall not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

- **Outpatient Crisis Intervention, Therapy and Counseling Services** — When any minor age 13 years or older experiences an emotional crisis to such degree that he or she perceives the need for professional assistance, he or she shall have the right to request, consent to, and receive outpatient crisis intervention services including individual psychotherapy, group therapy, counseling, or other forms of verbal therapy provided by a licensed mental health professional, as defined by Florida Statutes, or in a mental health facility licensed by the state. Such services shall not include medication and other somatic treatments, aversive stimuli, or substantial deprivation. Such services shall not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

- **Liability for Payment** — The parent, parents, or legal guardian of a minor shall not be liable for payment for any such outpatient diagnostic and evaluation services or outpatient therapy and counseling services, as provided in this section, unless such parent, parents, or legal guardian participates in the outpatient diagnostic and evaluation services or outpatient therapy and counseling services and then only for the services rendered with such participation.

- **Provision of Services** — No licensed mental health professional shall be obligated to provide services to minors accorded the right to receive services under this section. Provision of such services shall be on a voluntary basis.

Consent for General Medical Care and Treatment

An **unwed pregnant minor** may consent to the performance of medical or surgical care or services relating to her pregnancy or for her child by a physician licensed under Chapter 458 or 459 and such consent is valid and binding as if she had achieved her majority. [ss. 743.065(1) and (2), F.S.]

Power to Consent: A person who has the power to consent for a minor's medical care and treatment includes a natural or adoptive parent, legal custodian, or legal guardian. Any of the following persons, in order of priority listed, may consent to the "medical care or treatment" of a minor who is not committed to the Department of Children and Families or the Department of Juvenile Justice when, after a reasonable attempt, a person who has the power to consent as otherwise provided by law cannot be contacted by the treatment provider and actual notice to the contrary has not been given to the provider by that person [ss. 743.0645(1) and (2), F.S.]:

1. A person who possesses a power of attorney to provide medical consent for the minor
2. The stepparent
3. The grandparent
4. An adult brother or sister
5. An adult aunt or uncle

"Medical care or treatment" includes ordinary and necessary medical and dental examinations and treatment... but does not include surgery, general anesthesia,

provision of psychotropic medication or other extra-ordinary procedures for which a separate court order, power of attorney, or informed consent as provided by law is required. {743.0645(1)(b), F.S.]

Emergency Care. The absence of parental consent notwithstanding, a physician (licensed under Chapter 458 or 459, F.S.) may render **emergency medical care or treatment** to any minor who has been injured in an accident or who is suffering from an acute illness, disease, or condition if, within a reasonable degree of medical certainty, delay in initiation or provision of emergency medical care or treatment would endanger the health or physical well-being of the minor and provided such emergency medical care or treatment is administered in a hospital licensed by the state under Chapter 395 or in a college health service. This section shall apply only when parental consent cannot be immediately obtained for one of the following reasons [ss. 743.064(1) and (2), F.S.]:

1. The minor's condition has rendered him unable to reveal the identity of his parents, guardian, or legal custodian, and such information is unknown to any person who accompanied the minor to the hospital.
2. The parents, guardian, or legal custodian cannot be immediately located by telephone at their place of residence or business.

Notification shall be accomplished as soon as possible after the emergency medical care or treatment is administered. The hospital records shall reflect the reason such consent was not initially obtained and shall contain a statement by the attending physician that immediate emergency medical care or treatment was necessary for the person's health or physical well-being. The hospital records shall be open for inspection by the person legally responsible for the minor [s. 743.064(3), F.S.].

Delinquent Children
Chapter 985, F.S.

The disability of nonage of a minor adjudicated as an adult and in the custody or under the supervision of the Department of Corrections is removed, as such disability relates to health care services, except in regard to medical services relating to abortion and sterilization.

After a petition for detention or delinquency has been filed, the court may order the child named in the petition to be examined by a physician. The court may also order the child to be evaluated by a psychiatrist or a psychologist… The court may order a child to be treated by a physician or to receive mental health, substance abuse, or retardation services from a psychiatrist, psychologist, or other appropriate service provider. If it is necessary to place a child in a residential facility for evaluation or treatment, the criteria and procedures in Chapter 393 (developmental disabilities), Chapter 394 (mental illness), or Chapter 397 (substance abuse impairment), whichever is applicable, shall be used. [ss. 985.224(1), (2), and (5) F.S.]

When any child is detained pending a hearing, the person in charge of the detention center or facility or designee may authorize a triage examination as a preliminary screening device to determine if the child is need of medical care or isolation or provide or cause to be provided such medical or surgical services as may be deemed necessary by a physician. [s. 985.224(3), F.S.]

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

may, after due notice to the parent, guardian, or person standing in loco parentis, if any, order that a representative of the Department of Juvenile Justice may authorize such care for the child by licensed practitioners as may from time to time appear necessary. [s. 985.224(4), F.S.]
Necessary medical treatment means care which is necessary within a reasonable degree of medical certainty to prevent the deterioration of a child's condition or to alleviate immediate pain of a child. [Chapter 985.03(38), F.S.]

Dependent Children
(DCF Procedure 175-40 1/97)

When any child is taken into custody and is to be detained in **an out-of-home placement**, DCF is authorized to have a medical screening performed without authorization from the court or consent from the parent or legal custodian. This does not authorize DCF to consent to medical treatment. If medical treatment is needed, consent from the parent or court order is required [ss. 39.407(1) and (2), F.S.]

If a parent or guardian of the child is **unavailable** and his whereabouts cannot be reasonably ascertained, and it is after normal working hours so that a court order cannot reasonably be obtained, an authorized agent of DCF shall have the authority to consent to necessary medical treatment for the child. The authority of the department to consent to necessary medical treatment in this circumstance shall be limited to the time reasonably necessary to obtain court authorization. [s. 39.407(2)(b), F.S.] Necessary medical treatment for dependent children means care which is necessary within a reasonable degree of medical certainty to prevent the deterioration of a child's condition or to alleviate immediate pain of a child. [39.01(44), F.S.]

If a parent or guardian of the child is **available but refuses** to consent to the necessary treatment, a court order shall be required unless the situation meets the definition of an emergency in s. 743.064, F.S. or the treatment needed is related to suspected abuse, abandonment, or neglect of the child by a parent or guardian. In such case, DCF shall have the authority to consent to necessary medical treatment. This authority is limited to the time reasonably necessary to obtain court authorization. [s. 39.407(2)(c), F.S.]

A judge may order a child in an out-of-home placement to be examined by a licensed health care professional or by a psychiatrist or psychologist. If it is necessary to place a child in a residential facility for such evaluation or treatment, then the criteria and procedure established in s. 394.463(2), F.S. shall be used. [39.407(3)(a) and (b), F.S.]

Nothing in Chapter 39 eliminates the right of a parent, legal custodian, or the child to consent to examination or treatment for the child where otherwise permitted by law. [s. 39.407(7), F.S.] Nothing in this section alters the authority of DCF to consent to medical treatment for a dependent child when the child has been committed to DCF and DCF has become the legal custodian of the child. [s. 39.407(13), F.S.]

Legal custody results from a court order vesting in a person the right to have physical custody of the child and the right and duty to protect, train, and discipline the child and to provide him or her with food, shelter, education, and ordinary medical, dental, psychiatric, and psychological care. [s. 39.01(33)(41), and (70), F.S.]

The consent of the parent, legal guardian or legal custodian of the minor is always preferred to permission being given by DCF or its representatives. When the child is not in the care, custody or control of the department, the following priority matrix applies:

1. Parent (natural or adoptive), legal guardian or legal custodian

2. Person with written power of attorney given by the parent, legal guardian, or legal custodian specifically permitting the POA to give consent for the child's medical treatment
3. Stepparent
4. Grandparent
5. Adult brother or sister
6. Adult aunt or uncle

Protective Custody: When the child is in the protective custody of the department, the law permits the investigator to refer the child for medical examination, but if treatment is required, consent must be obtained in accord with the following priority matrix:

1. Parent; or guardian
2. Court order
3. DCF when it is unreasonable to obtain a court order and the parent or guardian is unavailable
4. When parent or guardian refuses consent, a court order is needed except in cases of medical emergencies

Shelter Care: Pending a determination of dependency, consent for treatment must be in accord with the following priority matrix:

1. Parent or guardian
2. Court order
3. DCF when it is unreasonable to obtain a court order and the parent or guardian is unavailable
4. When parent or guardian refuses consent, a court order is needed except in cases of medical emergencies

Foster Care: DCF, having all legal rights and responsibilities of being the child's legal custodian by court order, its authority to consent to ordinary medical treatment is not limited. However, the authority of the legal custodian is only to provide ordinary medical, dental, psychiatric and psychological care. A court order would be required for extraordinary care, which includes psychotropic medication.

Post-Termination of Parental Rights: When the child is in the legal custody of DCF following termination of parental rights and pending adoption, consent must be in accord with the following priority matrix:

1. DCF, as the child's legal guardian and custodian may consent only for ordinary medical, dental, psychiatric and psychological care.
2. Absent a life-threatening emergency, consent for extraordinary medical treatment must be obtained from the court. The court may limit its consent or may provide it under such conditions as it thinks proper.

Frequently Asked Questions

1. How is a minor defined?

A minor is any person under 18 years old who has not been married and has not had a court remove the disability of nonage.

2. Who is a child's guardian?

A child's guardian is generally one or both of his or her natural or adoptive parents. After a divorce, guardianship belongs to the parent or parents with custody. The mother of a child born out-of-wedlock is guardian of the child. In the absence of a parent a guardian must be appointed by a court and can be a relative or other person interested in the welfare of the child.

3. Does a foster parent or DCF employee have the authority to consent for a dependent child's voluntary admission to a receiving facility?

No. State law requires that consent for an examination, treatment or placement of a dependent child, when the child's legal guardian is unavailable, be provided by a court.

4. **Does a foster parent or DCF employee have the authority to consent to psychotropic medications for a dependent child in a Baker Act receiving facility or in outpatient treatment?**

   No. See question #3.

Appendix J: Offender Referrals Treatment-Based Drug Courts

A major social cost associated with substance abuse is the cost of drug related crime. Substance abuse is highly correlated with criminal activity for several reasons:

- The behavioral/mental effects of the substances,
- The need for funds to obtain the substances, and
- The criminal nature of some substances.

Many crimes are committed under the influence of drugs or are motivated by a need to obtain money for drugs, and it is a well-established fact that drug trafficking and violence go hand in hand. Crimes associated with trafficking and abuse of illicit drugs pose a dangerous threat to the safety and security of Florida's citizens.

In addition to taxing law enforcement resources, those convicted of drug offenses and for the approximately 80% of personal and property crimes related to drugs have a major impact on this system. There are a significant number of offenders who, though not convicted of a drug offense, cost Florida taxpayers close to a billion dollars. In 1998, Florida's Department of Corrections estimated spending $19,000 per year per inmate, totaling more than $1.3 billion. Drug offenders constitute 16% of the total inmate population and 24.4% of the total admissions. DOC reports that of its 68,600 total inmates, 63% are in need of some form of substance about treatment. There are more than 220,000 total offenders in the DOC system, including those in community corrections, on probation, or on parole.

Referral to Providers

Florida's Marchman Act addresses the referral of substance abuse impaired offenders to service providers.

Authority To Refer Offenders

397.705(1), F.S.

If any offender, including but not limited to any minor, is charged with or convicted of a crime, the court or criminal justice authority with jurisdiction over that offender may require the offender to receive services from a licensed service provider. If referred by the court, the referral shall be in addition to final adjudication, imposition of penalty or sentence, or other action. The court may consult with or seek the assistance of a service provider concerning such a referral. Assignment to a service provider is contingent upon availability of space, budgetary considerations, and manageability of the offender.

Referral And Treatment

397.705(2), F.S.

An order referring an offender must be in writing and must be signed by the referral source. The order must specify:

- The name of the offender,
- The name and address of the service provider to which the offender is referred,
- The date of the referral,
- The duration of the offender's sentence, and
- All conditions stipulated by the referral source.
- The total amount of time the offender is required to receive treatment may not exceed the maximum length of sentence possible for the offense with which the offender is charged or convicted.
- A copy of the order must be delivered to the service provider.

The director may refuse to admit any offender referred to the service provider. The director's refusal to admit the offender

must be communicated immediately and in writing within 72 hours to the referral source, stating the basis for such refusal.

The director may, after consulting with the referral source, discharge any offender referred to the service provider when, in the judgment of the director, the offender is beyond the safe management capabilities of the service provider. The director must orally communicate a decision to discharge an offender to the offender and to the referral source, immediately, and must communicate the decision in writing within 72 hours thereafter, stating the basis for the determination that the offender is beyond the safe management capabilities of the facility.

When an offender successfully completes treatment or when the time period during which the offender is required to receive treatment expires, the director shall communicate such fact to the referral source.

Screening, Assessment, And Disposition Of Juvenile Offenders

397.706, F.S.

The substance abuse treatment needs of juvenile offenders and their families must be identified and addressed through diversionary programs and adjudicatory proceedings pursuant to chapter 984 or chapter 985.

The juvenile and circuit courts, in conjunction with DCF district administration, shall establish policies and procedures to ensure that juvenile offenders are appropriately screened for substance abuse problems and that diversionary and adjudicatory proceedings include appropriate conditions and sanctions to address substance abuse problems. Policies and procedures must address:

- The designation of local service providers responsible for screening and assessment services and dispositional recommendations to the department and the court.
- The means by which juvenile offenders are processed to ensure participation in screening and assessment services.

- The role of the court in securing assessments when juvenile offenders or their families are noncompliant.

- Safeguards to ensure that information derived through screening and assessment is used solely to assist in dispositional decisions and not for purposes of determining innocence or guilt.

Because resources available to support screening and assessment services are limited, the judicial circuits and DCF district administration must develop those capabilities to the extent possible within available resources according to the following priorities:

- Juvenile substance abuse offenders
- Juvenile offenders who are substance abuse impaired at the time of the offense
- Second or subsequent juvenile offenders
- Minors taken into custody.

The court may require juvenile offenders and their families to participate in substance abuse assessment and treatment services in accordance with the provisions of chapter 984 or chapter 985 and may use its contempt powers to enforce its orders.
Requirements For Treatment Alternatives For Safer Communities (TASC)

Treatment Alternatives to Safer Communities (TASC)

In addition to other requirements in the Marchman Act rules, the following requirements apply to Treatment Alternatives for Safer Communities.

Client Eligibility. TASC providers shall establish eligibility standards requiring that individuals considered for intake shall be at-risk for criminal involvement, substance abuse, or have been arrested or convicted of a crime, or referred by the criminal or juvenile justice system.

Services:

1. Court Liaison. Providers shall establish liaison activities with the court that shall specify procedures for the release of prospective clients from custody by the criminal or juvenile justice system for referral to a provider. Special care shall be taken to ensure that the provider has flexible operating hours in order to meet the needs of the criminal and juvenile justice systems. This may require operating nights and weekends and in a mobile or an in-home environment.

2. Monitoring. Providers shall monitor and report the progress of each client according to the consent agreement with the client. Reports of client progress shall be provided to the criminal or juvenile justice system or other referral source as required, and in accordance with subsections 397.501(1)-(10), F.S.

3. Intervention Plan. The intervention plan shall include additional information regarding clients involved in a TASC program. The plan shall include requirements the client is expected to fulfill and consequences should the client fail to adhere to the prescribed plan, including provisions for reporting information regarding the client to the criminal or juvenile justice system or other referral source. The plan shall be signed and dated by both parties.

4. Referral. Providers shall refer clients to publicly funded providers within the court's or criminal justice authority's area of jurisdiction, and shall establish written referral agreements with other providers.

5. Discharge/Transfer or Termination Notification. Providers shall report any pending discharge/transfer or termination of a client to the criminal justice or juvenile justice authority or other referral source.

Treatment-Based Drug Court Programs
(397.334, F.S.)

In enacting the Drug Court legislation in 2001, it was the intent of the Legislature to implement treatment-based drug court programs in each judicial circuit in an effort to reduce crime and recidivism, abuse and neglect cases, and family dysfunction by breaking the cycle of addiction, which is the most predominant cause of cases entering the justice system. The Legislature recognized that the integration of judicial supervision, treatment, accountability, and sanctions greatly increases the effectiveness of substance abuse treatment.

The Legislature also sought to ensure that there is a coordinated, integrated, and multidisciplinary response to the substance abuse problem in this state, with special attention given to creating partnerships between the public and private sectors and to the coordinated, supported, and integrated delivery of multiple-system services for substance abusers, including a multiagency team approach to service delivery.

Each judicial circuit is required to establish a model of a treatment-based drug court program under which persons in the justice system assessed with a substance abuse problem will be processed in such a manner as to appropriately address the severity of the identified substance abuse problem through treatment plans tailored to the individual needs of the participant. These treatment-based drug court program models may be established in the misdemeanor, felony, family, delinquency, and dependency divisions of the judicial circuits.

It was the intent of the Legislature to encourage the Department of Corrections,

the Department of Children and Family Services, the Department of Juvenile Justice, the Department of Health, the Department of Law Enforcement, and such other agencies, local governments, law enforcement agencies, and other interested public or private sources to support the creation and establishment of these problem-solving court programs.

Participation in the treatment-based drug court programs does not divest any public or private agency of its responsibility for a child or adult, but allows these agencies to better meet their needs through shared responsibility and resources.

The treatment-based drug court programs must include therapeutic jurisprudence principles and adhere to the following 10 key components, recognized by the Drug Courts Program Office of the Office of Justice Programs of the United States Department of Justice and adopted by the Florida Supreme Court Treatment-Based Drug Court Steering Committee:

- Drug court programs integrate alcohol and other drug treatment services with justice system case processing.
- Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
- Eligible participants are identified early and promptly placed in the drug court program.
- Drug court programs provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
- Abstinence is monitored by frequent testing for alcohol and other drugs.
- A coordinated strategy governs drug court program responses to participants' compliance.
- Ongoing judicial interaction with each drug court program participant is essential.
- Monitoring and evaluation measure the achievement of program goals and gauge program effectiveness.
- Continuing interdisciplinary education promotes effective drug court program planning, implementation, and operations.
- Forging partnerships among drug court programs, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

Treatment-based drug court programs may include pretrial intervention programs as provided in ss. 948.08, 948.16, and 985.306.

Appendix K: Habitual Abusers
Local Ordinance Prohibition And Authorization

Local Ordinances Prohibited
(397.701, F.S.)

A county, municipality, or other political subdivision of the state may not adopt a local law, ordinance, resolution, or regulation having the force of law which provides that impairment in public in and of itself is an offense, a violation, or the subject of civil or criminal sanctions or penalties of any kind. This section does not affect offenses involving the operation of motor vehicles, machinery, or other hazardous equipment.

Local Ordinances Authorized
(397.702, F.S.)

Due to the severity in certain areas of the state of chronic and habitual public impairment which infringes upon the public health, safety, and welfare of the citizens, counties and municipalities are authorized to adopt ordinances in strict compliance with this section.

Ordinances for the treatment of habitual abusers must provide:

1. For the construction and funding, either individually or jointly with other counties or municipalities, of a licensed secure facility to be used exclusively for the treatment of habitual abusers who meet the criteria.

2. That when seeking treatment of a habitual abuser, the county or municipality, through an officer or agent specified in the ordinance, must file with the court a petition which alleges the following information about the alleged habitual abuser:

- The name, address, age, and gender of the respondent.
- The name of any spouse, adult child, other relative, or guardian of the respondent, if known to the petitioner, and the efforts by the petitioner, if any, to ascertain this information.
- The name of the petitioner, the name of the person who has physical custody of the respondent, and the current location of the respondent.
- That the respondent has been taken into custody for impairment in a public place, or has been arrested for an offense committed while impaired, three or more times during the preceding 12 months.
- Specific facts indicating that the respondent meets the criteria for involuntary admission.
- Whether the respondent was advised of his or her right to be represented by counsel and to request that the court appoint an attorney if he or she is unable to afford one, and whether the respondent indicated to petitioner his or her desire to have an attorney appointed.

Detention
(397.702(2)(f), F.S.)

A person who is reasonably suspected of meeting the criteria may be detained at a licensed service provider or at a licensed secure facility for a period not exceeding 96 hours for purposes of the preparation and filing of the petition.

Petition
(397.702(3), F.S.)

When a petition is filed under an ordinance authorized by this section, alleging a reasonable suspicion that the respondent meets the criteria, the department and any licensed service provider director with relevant information must, upon the court's request and in accordance with federal confidentiality regulations, furnish the court with all information necessary to determine the accuracy of the allegations.

Hearing Process
(397.702(2)(c), F.S.)

The court with jurisdiction to make the determination shall hear the petition on an emergency basis as soon as practicable but not later than 10 days after the date the petition was filed. If the allegations of the petition indicate that the respondent has requested the appointment of an attorney, or otherwise indicate the absence of any competent person to speak at the hearing on behalf of the respondent, the court shall immediately appoint an attorney to represent the respondent and shall provide notice of the hearing to the attorney. When the court sets a hearing date the petitioner shall provide notice of the hearing and a copy of the petition to all of the persons named in the petition and to such other persons as may be ordered by the court to receive notice.

Court Order
(397.702(2)(d), F.S.)

Upon the court's determination that the allegations of the petition are established, the respondent is a habitual abuser and must be detained at the licensed secure facility for a period of up to 90 days as determined by the court for the purpose of participating in a treatment program.

Extension of Treatment
397.702(2)(e), F.S.)

If the client still meets the criteria for involuntary admission at or near the expiration of the treatment period ordered by the court, the agent of the county or municipality another habitual abuser petition may be filed for a period not exceeding 180 days for each such petition.

Correctional Facilities
(397.702(4), F.S.)

This section does not affect the operation under contract of any licensed secure correctional facility or licensed service provider at a secure correctional facility, which is not operating pursuant to an ordinance adopted under authorization of this section.

Appendix L: Inmate Substance Abuse Programs

397, Part VII, F.S.

It was the intent of the Legislature in enacting provisions for inmates of the Department of Corrections to provide, within the limits of appropriations and safe management of the correctional system, substance abuse services to substance abuse impaired offenders who are incarcerated within DOC, in order to better enable these inmates to adjust to the conditions of society presented to them when their terms of incarceration end.

Several definitions apply to inmate substance abuse programs:

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.

Inmate Substance Abuse Programs are substance abuse services provided within facilities housing only inmates and operated by or under contract with the Department of Corrections.

Inmate means any person committed by a court of competent jurisdiction to the custody of the Department of Corrections, including transfers from federal and state agencies under the Interstate Corrections Compact.

Inmate substance abuse services means any service component as defined in s. 397.311 provided directly by the Department of Corrections and licensed and regulated by the Department of Children and Family Services pursuant to s. 397.406, or provided through contractual arrangements with a service provider licensed pursuant to part II; or any self-help program or volunteer support group operating for inmates.

The Florida Legislature directed the Department of Corrections:

1. To the fullest extent possible provide inmates upon arrival at a Department of Corrections reception center for initial processing with an assessment of substance abuse service needs.

2. To provide inmates who are admitted to inmate substance abuse services with an individualized treatment plan which is developed on the basis of assessed need for services and which includes measurable goals and specifies the types of services needed to meet those goals.

3. To the fullest extent possible provide inmates with individualized services.

4. To develop and maintain systematic methods of research, evaluation, and monitoring of the appropriateness and quality of substance abuse programs.

5. To provide inmates who have participated in substance abuse programs within one month of the date of their final release from the correctional facility in which they are incarcerated with information regarding options for continuing substance abuse services in the community and with referrals for such services as appropriate or upon the inmate's request.

6. In cooperation with other agencies, actively seek to enhance resources for

the provision of treatment services for inmates and to develop partnerships with other state agencies, including but not limited to the Departments of Children and Family Services, Education, Community Affairs, and Law Enforcement.

7. To the extent of available funding, provide training to employees whose duties involve the provision of inmate substance abuse services.

8. DOC shall by rule set forth procedures with respect to individual dignity, nondiscriminatory services, quality services, communication for inmates who receive treatment for substance abuse, and confidentiality requirements in accordance with federal law.

An inmate's substance abuse service records are confidential in accordance with s. 397.501(7). No other provision of the Marchman Act applies to inmates except as indicated by the context or specified.

Appendix M: Marchman Act and Elders

Elders are at risk for substance abuse due to life-style events that include such things as loss of a spouse, financial difficulties, or medical disabilities. Further, addiction is less likely to be diagnosed in this population.

Most older adults are satisfied with their lives and are adapting well to the many changes that they experience. However, a recent elder task force indicated that about 22% of older adults in general, and over 50% of persons in nursing homes experiencing specific mental disorders that are not part of "normal" aging.

While very few older adults use illicit drugs, people 65 and older consume more prescribed and over-the-counter medications than any other age group. Substance abuse problems in older adults frequently result from the misuse – that is, under use, overuse, or erratic use – of such medications.

Medications taken for physical problems can cause a variety of undesirable side effects. The more medications taken at the same time, the more likely a problem with side effects will result. Depression is sometimes a side effect of certain drugs. When people have more than one doctor, it's likely that each doctor prescribes different medications for different conditions. One doctor may not be aware of what medications the other doctor has prescribed.

One drug that often interacts with others is alcohol. By itself, alcohol overuse is a possible cause of depression in people of all ages. If excessive amounts of alcohol are taken in combination with other drugs, an interaction could occur and depression may be aggravated.

Often older alcohol abusers are referred to as "hidden abusers." Many of the signs and assessment instruments for identifying depression used for younger adults are not appropriate to elders, it is also true with recognizing alcohol abuse in elders; particularly late-life onset alcohol abusers. Thus, abuse and dependence among older adults may be underestimated.

Surveys reflect from 2% to 10% of the general elderly population have alcohol problems. Approximately 21% of hospitalized people age 60 or older have a diagnosis of alcoholism. The prevalence of problem drinking in nursing homes is as high as 49%.

Research shows that although heavy drinking in the United States is less prevalent among older persons, some maintain or increase heavy drinking. Late-onset heavy drinking is believed to be related to stressors of aging, such as retirement or bereavement, particularly when coping resources or social supports are inadequate.

The Center on Addiction and Substance Abuse (CASA) estimates that nationally there are at least 200,000 women in nursing homes who have alcohol problems. It reports that women are more likely to be hospitalized for substance abuse problems than for heart attacks.

Since depression and alcohol abuse are so common in nursing home settings, and there is much misunderstanding about a nursing home's responsibility to meet the specialized needs of their residents, the following information is provided.

Persons of all ages are encouraged to volunteer for needed substance abuse assessment and treatment. However, in some cases, the person is unwilling to volunteer or his/her judgment is so impaired by the substance abuse impairment as to be unable to understand the need for

treatment. The criteria for involuntary admission is as follows:

- There is good faith reason to believe the person is substance abuse impaired and, because of such impairment:
- 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**
- 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.

Substance abuse impairment is defined as 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.

An emergency admission for a person who meets the above criteria can be initiated by any licensed physician. See Appendix E for more information on such initiation.

Nursing Home Residents

Admission

A nursing facility must not admit new residents with mental illness, unless the State mental health authority has determined, based on an independent physical and mental evaluation, prior to admission that because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility.

The State is responsible for conducting the screens, preparing the Pre-Admission Screening and Resident Review (PASRR) report, and providing or arranging the specialized services that are needed as a result of conducting the screens. The State will provide a copy of the PASRR report to the facility. This report will list the specialized services that the individual requires and that are the responsibility of the State to provide. If the State determines that the resident does not require specialized services in the PASRR screening, the facility is responsible to provide all services necessary to meet the resident's mental health needs, including specialized rehabilitation services.

Specialized Rehabilitative Services

If specialized rehabilitative services are required in the resident's comprehensive plan of care, the facility must provide the required services or obtain the required services from an outside resource from a provider of specialized rehabilitative services.

Specialized rehabilitative services must be provided by or coordinated by qualified personnel. These services are included within the scope of facility services. They must be provided to residents who need them even when the services are not specifically enumerated in the State plan. No fee can be charged a Medicaid recipient for specialized rehabilitative services because they are covered facility services.

Rehabilitative services may include, but are not limited to:

- Drug therapy and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness;
- Crisis intervention services;

- Individual, group, and family psychotherapy;

- Formal behavior modification programs;

- Consistent implementation during the resident's daily routine and across settings, of systematic plans, which are designed to change inappropriate behaviors;

- Provision of a structured environment for these individuals who are determined to need such structure

- Development, maintenance and consistent implementation across settings of those programs designed to teach daily living skills they need to be more independent and self-determining including, but not limited to drug therapy, mental health, health, education, grooming, personal hygiene, mobility, and nutrition,

Mental or Psychosocial Adjustment

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being, in accordance with the comprehensive assessment and plan of care. Based on the comprehensive assessment of a resident, the facility must assure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem.

Clinical conditions that may produce apathy, malaise, and decreased energy levels that can be mistaken for depression associated with mental or psychosocial adjustment difficulty include, but are not limited to:

- Metabolic diseases
- Endocrine diseases
- Central nervous system diseases
- Miscellaneous diseases
- Over-medication with anti-hypertensive drugs; and
- Presence of restraints.

Facilities should ensure and AHCA surveyors may, at a minimum, assess:

- What programs/activities the resident has received to improve and maintain maximum mental and psychosocial functioning;
- Whether the resident's mental and psychosocial functioning has been maintained or improved;
- Whether treatment plans and objectives have been re-evaluated;
- Whether the resident received a psychological or psychiatric evaluation to evaluate, diagnose, or treatment his/her condition, if necessary; and
- Whether the individual's mental and psychosocial adjustment difficulties are addressed in the care plan.

Social Services

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

Types of conditions to which the facility should respond with social services by staff or referral include, among others, behavioral symptoms. For example, if a resident strikes out at another resident, the facility should evaluate the resident's behavior rather than immediately initiating a Baker Act examination. The same action is appropriate for depression or difficulty with personal interaction with others and socialization skills. AHCA surveyors will evaluate how well staff responsible or social work monitor the resident's progress in improving physical, mental and psychosocial functioning.

Physician Services

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must

remain under the care of a physician. The facility must assure that the medical care of each resident is supervised by a physician and another physician supervises the medical care of residents when their attending physician is unavailable. This means the physician must participate in the resident's assessment and care planning, monitoring changes in the resident's medical status, and providing consultation or treatment when called by the facility. It also includes, but is not limited to, prescribing new therapy, ordering a resident's transfer to the hospital, conducting required routine visits or delegating and supervising follow-up visits to nurse practitioners or physician assistants. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.

A total program of care includes all care the facility provides residents to maintain or improve their highest practicable mental and physical functional status.

While physician assistants and nurse practitioners are authorized through their scope of practice laws to perform certain tasks, such tasks must be performed in collaboration with a physician. Initiation of an involuntary examination of a resident under the Baker Act cannot be delegated by the physician to another professional, unless that professional is also authorized by the Baker Act to initiate the examination. This includes licensed clinical psychologists, licensed clinical social workers, and psychiatric nurses (must have a master's or doctorate degree in psychiatric nursing and certain specified experience).

Facilities should ensure and AHCA surveyors may review:

- How the supervising physician was involved in the resident's assessment and care planning;
- How the physician responded If staff reported a significant change in medical status to the supervising physician;
- If the facility had a physician on call and if this physician responded appropriately if the supervising physician was unavailable and could not respond;
- The reason residents are sent to hospital emergency rooms;
- If residents are routinely sent to hospital emergency rooms because the facility does not always have a physician on call.
- How services ordered by a physician show a pattern of care to maintain or improve the resident's level of independent functioning;
- Whether documentation reflects continuity of care in maintaining or improving a resident's mental and physical functional status.

Transfer and Discharge

Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility

The facility must permit each resident to remain in the facility and may not transfer or discharge the resident from the facility unless

1. The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility;
2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

3. The safety of individuals in the facility is endangered;

4. The health of individuals in the facility would otherwise be endangered;

5. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility;

6. The facility ceases to operate.

However, before the transfer or discharge occurs, the law requires that the facility notify the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for the transfer, and record the reasons in the clinical record. The facility's notice must include an explanation of the right to appeal the transfer to the state as well as the name, address, and phone number of the State long-term care ombudsman. In the case of a person with mentally illness, the notice must also include the name, address and phone number of the Advocacy Center for Persons with Disabilities, the agency responsible for advocating for mentally ill individuals.

Generally, this notice must be provided at least 30 days prior to the transfer. Exceptions to the 30-day requirement apply when the transfer is effected because of:

- Endangerment to the health or safety of others in the facility;

- When a resident's health has improved to allow a more immediate transfer or discharge;

- When a resident's urgent medical needs require more immediate transfer; and

- When a resident has not resided in the facility for 30 days.

In these cases, the notice must be provided as soon as practicable before the discharge.

Where the transfer is to a hospital or receiving facility for voluntary or involuntary examination under Florida's Baker Act, the Baker Act law must be followed. If the person is to be transferred on a voluntary basis, an independent mental health professional (not employed by, under contract with, or having a financial interest in either the facility or the Baker Act facility) must be conducted to ensure that the resident is capable of making well-reasoned, willful and knowing decisions about their health and mental health care. Otherwise, the resident must meet the involuntary examination criteria and one of the mental health professionals authorized in the Baker Act must initiate the examination, using the "Certificate of a Professional". Only in an emergency should law enforcement be expected to initiate an involuntary examination of a facility resident. This is the responsibility of the physician or other authorized staff of the facility. Residents are not to be sent to emergency rooms for assessment of whether to initiate voluntary or involuntary examination; this must be completed prior to the resident's transfer. After the involuntary examination has been properly initiated, law enforcement must be called to provide transportation of the resident to the nearest Baker Act receiving facility, unless the officer determines that emergency medical personnel and transport are necessary.

Facilities should ensure and surveyors, in determining whether the reasons for transfer/discharge were appropriate, will at a minimum review:

- Whether records document accurate assessments and attempts through care planning to address resident's needs through multi-disciplinary interventions, accommodation of individual needs and attention to the resident's customary routines;

- Whether the records of residents transferred/discharged due to safety reasons reflects the process by which the facility concluded that in each

instance transfer or discharge was necessary;

- Whether the voluntary, involuntary, and transportation provisions of the Baker Act were fully complied with;

- If the entity to which the residents was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident's physician justify why the facility could not meet the needs of the resident.

Bed-Hold Policies

Under Medicaid, a participating facility is required to provide notice to its residents of the facility's bed-hold policies and readmission policies prior to transfer of a resident for hospitalization or therapeutic leave. Upon such transfer, the facility must provide written notice to the resident and an immediate family member, surrogate or representative of the duration of any bed-hold. A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

Nursing Homes
Psychotropic Medication

Usage Issues

The following information applies ONLY to Nursing Homes and regulatory requirements and guidelines as discussed regarding the use of psychotropic medication are based on information in the State Operations Manual governing nursing home care. This information does not apply to Hospitals or Assisted Living Facilities each of which has different federal and state regulations.

Overview

The use of psychotropic medications in the nursing home setting is as appropriate as in any other setting, if the person has a diagnosis associated with the medication used. The physician must justify the use f any medication in the resident's clinical chart as necessary to treat the condition with which the person is diagnosed. Mental Illnesses are highly treatable and persons of any age should have the opportunity to benefit from psychotropic medications, if their use if fully documented by a physician.

Federal and state regulations are not meant to cast a negative light on the use of psychotropic drugs in nursing home facilities. The use of such drugs can be therapeutic and enabling for residents suffering from mental illness such as schizophrenia or depression. The goal is to stimulate appropriate differential diagnosis of "behavioral symptoms" so the underlying cause of the symptoms id recognized and treated appropriately. This treatment may include the use of environmental and/or behavioral therapy as well as psychotropic drugs. The goal of federal and state regulations is to insure the proper use of psychotropic drugs and to prevent the use of these drugs when the "behavior symptom" is caused by conditions such as:

- Environmental stressors (e.g., excessive heat, noise, overcrowding, etc.) or
- Psychosocial stressors; or
- Treatable medical conditions.

Pharmacy Services

Nursing homes must provide routine and emergency drugs and biologicals to its residents, or obtain these under an agreement.

Psychotropic Medication

Each group of psychotropic drugs has a different set of federal regulations regarding the use of anti-psychotic drugs, anti-anxiety drugs, anti-depressant drugs, and

sedative/hypnotic drugs in the nursing home. It is essential that facilities and practitioners be aware of current regulations governing the use of each of these groups of medication. The nursing home regulation and guidelines governing the use of psychotropic drugs are located in the State Operations Manual for Nursing Homes [CFR 483.25(1)] under the regulations F-329, F-330, and F331.

Anti-Psychotic Drugs

Residents in nursing homes who receive treatment and services under the Baker Act often receive anti-psychotic drugs. Based on the nursing home comprehensive assessment of a resident, the facility must assure that residents who receive anti-psychotic drugs are not given these drugs unless there is documentation in the clinical record of their need. This documentation must include an approved indication and identification of associated behaviors based on the Federal Guidelines. In addition, if an anti-psychotic drug or any psychotropic drug is used outside federal and state guidelines there must be justification in the clinical record for this usage and may include but is not limited to:

- A physician note indicating for example, that the dosage, duration, indication, and monitoring are clinically appropriate. The note should why this medication indicated and that risk/benefit of using the drug has been considered.

- A medical or psychiatric consultation of evaluation that confirms that in the physician's judgment the use of this drug outside of the Guidelines is in the best interest of the resident.

- Physician, nursing, or other health professional documentation indicating that the resident is being monitored for possible adverse reaction and side effects.

- Documentation confirming that previous attempts at dosage reduction have been unsuccessful.

- Documentation showing resident's subjective or objective improvement, or maintenance of function while taking the medication.

- Documentation showing that a resident's decline or deterioration has been evaluated by the facility interdisciplinary care team to determine if the drug, dose, or duration may have been the cause of the resident's decline.

- Documentation evaluating why the resident's age, weight, or other factors would require a unique dose, duration, indication, or monitoring.

Anti- Depressant Medications in Nursing Homes

The under-diagnosis and under-treatment of depression in nursing homes has been well documented. It is estimated that over 50 percent of persons in nursing homes suffer with clinical depression. Many things contribute to clinical depression, including life losses, medications, certain medical conditions, and other genetic, cognitive, and biological factors. Clinical depression can be observed through symptoms of irritability, restlessness, changes in appetite or sleep, difficulty in concentrating, remembering or making decisions, among others. Clinical depression is a treatable medical illness, and its treatment can save lives.

CMS and AHCA continue to support the accurate identification and treatment of depression in nursing homes. Antidepressant drug therapy would be considered unnecessary only if a physician failed to adequately document the diagnosis, the need for the medication, or to monitor the resident's response to the medication.

Dosage Reduction

Residents who are given an anti-psychotic drug or any psychotropic drug are not required to receive gradual dose reduction when clinically contraindicated. It is essential that the resident's physician(s) and health care professionals fully document in the clinical record a justification of why the continued use of the drug and dose are clinically appropriate. Current medication usage and dosage reduction guidelines for psychotropic drugs including anti-psychotic, anti-anxiety, and sedative/hypnotic drugs are included in the State Operation Manual for Nursing Homes under the regulation F-329. Anti-depressant usage guidelines are also addressed under the regulation F-329, but dosage reduction is not required for these drugs.

Clinically Contraindicated

Clinically Contraindicated may be defined as:

1. The resident has an appropriate psychiatric diagnosis and has a history of recurrence of psychotic symptoms which have been stabilized with a maintenance dose of a psychotropic drug without incurring significant side effects. or
2. The resident has had a gradual dose reduction attempted and that attempt resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction or a return to the previous dose reduction was necessary.

Summary

The use of psychotropic medications in the nursing home setting must be justified and is as appropriate as in any other health care setting. The physician and health care professionals must document in the resident's clinical record the need for any medication as based on the resident's clinical condition and diagnosis.

Mental illness is highly treatable and persons of any age as well as nursing home residents should have the opportunity to benefit from psychotropic medication. Proper documentation in the clinical record by physicians and health care professionals provides a mechanism for evaluating the need and insuring proper usage of psychotropic medication.

Frequently Asked Questions
Facilities Licensed Under Chapter 400, F.S.

1. If someone in a facility is acting in a manner that appears to be related to substance abuse or mental illness and this behavior is escalating, what should be done?

First there should be an assessment done by the facility to determine if something in the person's environment may be causing this behavior and steps taken to alleviate the circumstances.

If this fails, then consultation should be requested, i.e., psychiatrist, physician, psychologist, social worker, mental health worker, case manager, mental health coordinator in a licensed limited mental health assisted living facility, etc., as appropriate. All appropriate attempts to address the problem by providing care should be taken on-site prior to transfer and documented.

2. What about the person's personal effects and medical record when the person is transferred for substance abuse evaluation or treatment?

The sending facility should do an inventory of the person's personal effects such as eyeglasses, hearing aid, dentures, jewelry, etc. that will accompany the person or should be sent shortly thereafter. A copy of the medical record that shows current medications, dosages, frequencies, and allergies should accompany the person being transferred.

3. Does a facility have to notify anyone about the person's transfer?

Section 400.0255(7), F.S., requires nursing homes to notify the person's legal guardian or representative by telephone or in person before the transfer, or as soon thereafter as practicable, with documentation in the resident's file.

4. Does the person's health care surrogate have the authority to give permission to transfer the person to a psychiatric hospital?

No. The health care surrogate does not have the authority to give permission to transfer a person either voluntarily or involuntary to a psychiatric hospital. However, once admitted on an involuntary basis, the surrogate or proxy has the authority to consent to treatment.

5. Can nursing homes transport a resident who is stable enough and is in agreement to go for treatment?

A person who is able to give well-reasoned decision-making and understands the purpose of and is willing to go to a psychiatric or substance abuse facility meets the criteria for voluntary examination (cannot be a person who has been adjudicated incapacitated or who has a Health Care Surrogate or Proxy currently making decisions for them). .

*Contact the local Agency for Health Care Administration office for more specific information on long-term care facilities.

Appendix N: Marchman Act Notices

There are six references in the Marchman Act involuntary provisions to required notice being provided of hearings and release. These include:

1. When a person is released from protective custody, emergency admission, involuntary assessment, involuntary treatment, and alternative involuntary assessment of a minor. (397.6758, F.S.)

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.

2. When a petition for Involuntary assessment and stabilization is filed (397.6815, F.S.).

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 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…

3. Adhering to federal confidentiality regulations, notice of disposition must be provided to the petitioner and to the court (397.6822, F.S.)

4. Duties of court upon filing of petition for involuntary treatment (397.6955, F.S.)

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.

5. Extension of involuntary substance abuse treatment period (397.6975, F.S.)

Whenever a service provider believes that a client who is nearing the scheduled date of release from involuntary treatment continues to meet the criteria for involuntary treatment in s. 397.693, a petition for renewal of the involuntary treatment order may be filed with the court at least 10 days prior to the expiration of the court-ordered treatment period. The court shall immediately schedule a hearing to be held not more than 15 days after filing of the petition. The court shall provide the copy of the petition for renewal and the notice of the hearing to all parties to the proceeding. The hearing is conducted pursuant to s. 397.6957.

6. Habitual Abusers (397.702(2)(c), F.S.)

The court with jurisdiction to make the determination authorized by this section shall hear the petition on an emergency basis as soon as practicable but not later than 10 days after the date the petition was filed. If the allegations of the petition indicate that the respondent has requested the appointment of an attorney, or otherwise indicate the absence of any competent person to speak at the hearing on behalf of the respondent, the court shall immediately appoint an attorney to represent the respondent pursuant to s. 397.501(8), and shall provide notice of the hearing to the attorney. When the court sets a hearing date the petitioner shall provide notice of the hearing and a copy of the petition to all of the persons named in the petition pursuant to subparagraph (b) 2., and to such other persons as may be ordered by the court to receive notice.

Appendix O: Marchman Act Case Law

There have been no appellate decisions applying, construing, or passing on the constitutionality of the Marchman Act or any of its provisions. Only the two following cases have been found that relate specifically to the Marchman Act:

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.

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.

Department of Health and Rehabilitative Services v. Straight, Inc. Case No. BL-151 October 30, 1986. Appellate Judge Thompson wrote the opinion with Appellate Judges Joanos and Nimmons concurring. The First District Court of Appeal upheld the trial court by saying that the Chapter 397 does not by its express provisions or by implication prevent a parent from placing a minor child with a state licensed drug treatment facility or program without the consent of the child and without judicial review.

Related Baker Act Cases

Baker Act and Criminal Defendants

Randy Thomas v. State of Florida, 748 So. 2d 363 (Fla. 5th DCA 2000). The Fifth District Court of Appeals held that police

officers were justified to search a defendant, who claimed he possessed weapons, had blood on his face, chest, and arms, was speaking loudly and incoherently, and was flailing his arms, due to the police officers testifying at the defendant's trial for possession of cocaine that they detained the defendant to consider whether or not to Baker Act the defendant. The 5th DCA held the initial detention of the defendant by the police officers was justified under the Baker Act. After the police officers searched the defendant, the police officers discovered cocaine. The defendant was charged with possession of cocaine and no Baker Act proceedings occurred.

Baker Act: Notice & Evidence

Jonathan F. Ibur v. State of Florida, 765 So. 2d 275 (Fla. 1st DCA 2000). The First District Court of Appeals decided that a hearing officer committed reversible error by not permitting a Baker Act patient to testify at the patient's hearing for involuntary hospitalization. The DCA held that since an involuntary commitment is a substantial deprivation of liberty at which fundamental due process protections must attach, the patient can not be denied the right to be present, to be represented by counsel, and to be heard. The DCA reversed the order of commitment and remanded the case for further proceedings.

Ryan Joehnk v. State of Florida, 689 So. 2d 1179 (Fla. 1st DCA 1997). The First District Court of Appeals held that the respondent's lawyer informing the trial court that the respondent did not wish to appear at an involuntary commitment hearing was an insufficient waiver of the respondent's fundamental right to be present at an involuntary commitment hearing and while a respondent may waive his/her rights to be personally present and be constructively present through counsel, the trial court must certify through proper inquiry that a respondent's waiver of his/her right to be personally present at an involuntary commitment proceeding be knowing, intelligent, and voluntary. The 1st DCA reversed the trial court's final order of involuntary commitment and remanded the case for further proceedings.

Clarence Williams v. State of Florida, 692 So. 2d 257 (Fla. 1st DCA 1997). The First District Court of Appeals decided that in a Baker Act commitment proceeding the defendant has a fundamental right to be present at the commitment proceeding and while a defendant may waive his/her rights to be personally present and be constructively present through counsel, the court must certify through proper inquiry that the waiver is knowing, intelligent, and voluntary. The 1st DCA reversed and remanded the case for a new commitment hearing since the record did not reflect if the Baker Act patient waived his right to be present at the commitment hearing.

Delora Berry v. State of Florida, 751 So. 2d 764 (Fla. 1st DCA 2000), decided on March 1, 2000. The First District Court of Appeals held that the fact that a Baker Act patient may derive some benefit from further treatment in a structured living arrangement does not justify a Baker Act commitment; the trial court's order of involuntary placement for treatment must be based upon a finding by the trial court by clear and convincing evidence that the Baker Act patient will inflict serious bodily injury/harm on herself or another person. The 1st DCA reversed the trial court's order of involuntary placement for treatment under the Baker Act.

C.N. v State of Florida. 433 So.2d 661 (Fla. 3rd DCA 1983). The Third District Court of Appeals decided that noncompliance with an earlier order, on petition for her involuntary hospitalization under the Baker Act, that she obtain outpatient psychiatric treatment as the "least restrictive means of intervention". The DCA held that the exercise of court's contempt power to compel hospitalization and treatment was inappropriate, and where the court proceeding under the Mental Health

Act has, consistent with legislative intent, ordered out-patient care by private mental health professional as an alternative to involuntary hospitalization, such least restrictive intervention can be revoked and patient deprived of her liberty only in proceedings which substantially meet requirements for involuntary hospitalization. The court further found that where testimony was given that the person had "difficulty in following directions," evidence presented did not support a finding of contemptuous intent because a willful disregard of or disobedience to an order of the court is the essence of contempt. Finally, the 3rd DCA found there was no statutory authority for the court to retain jurisdiction for purpose of modifying action taken on an earlier petition for involuntary hospitalization or imposition of more restrictive intervention.

David W. Hedrick v. Florida Hospital Medical Center, 633 So. 2d 1153 (Fla. 5th DCA 1994). The Fifth District Court of Appeals held that evidence of a Baker Act patient's potential for poor judgment was insufficient to satisfy the statutory test for involuntary examination absent evidence of the present threat of substantial harm to the patient's well being. The 5th DCA reversed the order for involuntary examination and remanded the case for further proceedings.

Barbara Singletary v. State of Florida, 765 So. 2d 180 (Fla. 1st DCA 2000). The First District Court of Appeals held that the State of Florida failed to prove by clear and convincing evidence that a Baker Act patient met the criteria for involuntary placement. The 1st DCA found that testimony that the Baker Act patient may have threatened others at some point in the past, did not amount to clear and convincing evidence that she was a danger to others. In addition, testimony that the Baker Act patient would likely have to be re-hospitalized if she did not take her medication was insufficient to prove a real and present threat of substantial harm to her well- being. And lastly, the State did not present clear and convincing evidence that less restrictive treatment alternatives were unavailable when the patient's mother testified that she wanted to have her daughter live with her in a new neighborhood and that the mother testified that she would ensure that her daughter continued to take her medication and promised to initiate involuntary commitment proceedings if her daughter did not take her medication. The 1st DCA found that the state failed to prove by clear and convincing evidence that the Baker Act patient required involuntary placement and thus reversed the order for involuntary placement.

Carolyn Blue v. State of Florida, 764 So. 2d 697 (Fla. 1st DCA 2000). The First District Court of Appeals held that evidence presented to the trial court that a Baker Act patient was unstable and threatening to others, that her emotional outbursts scared her family, and that she was argumentative and hostile, did not meet the statutory standard of clear and convincing evidence that there was a substantial likelihood in the near future the Baker Act patient will inflict serious bodily injury/harm on herself or another person. The 1st DCA reversed the trial court's order of involuntary placement and treatment under the Baker Act, and remanded the case for further proceedings.

Mabel Lyon v. State of Florida, 724 So. 2d 1241 (Fla. 1st DCA 1999), decided on January 27, 1999. The First District Court of Appeals held that the involuntary commitment of a schizophrenic woman on the grounds that she was likely to suffer from neglect or refusal to care for herself was not warranted since there was no specific showing that any self-neglect posed a real and present threat of substantial harm to her well-being. The 1st DCA reversed the trial court order of involuntary commitment which was based on a doctor's opinion that if the schizophrenic woman did not take her medication, "She would be almost incoherent in her speech, not able to take care of herself, she'll require supervision, she'll require structure," and found that the

trial court's finding was not based on clear and convincing evidence. The 1st DCA reversed the trial court's order of involuntary commitment.

Eric Adams v. State of Florida, 713 So. 2d 1063 (Fla. 1st DCA 1998), decided on July 9, 1998. The First District Court of Appeals held that a Baker Act commitment was not justified by clear and convincing evidence where the order of involuntary placement for treatment referred to a witness who did not testify at the involuntary commitment hearing and the order directly quoted the contents of the petition for involuntary placement. Furthermore, the trial court made oral findings at the conclusion of the hearing regarding the respondent's need for treatment and medication, however, the 1st DCA held that the trial court's oral findings were not supported by clear and convincing evidence and thus were insufficient to support a Baker Act commitment. The 1st DCA reversed the trial court's order of involuntary placement for treatment under the Baker Act.

Sharon Archer v. State of Florida, 681 So. 2d 296 (Fla. 1st DCA 1996). The First District Court of Appeals reversed an order for involuntary placement finding that clear and convincing evidence did not support the assertion in the petition for involuntary placement that the Baker Act patient was incapable for surviving alone and would suffer from neglect or refuse to care for herself if released. The only evidence supporting such an assertion was the psychologist's testimony; however, the psychologist acknowledged that the patient had not threatened to hurt herself or anyone else. The patient also testified that if she were released she would take her medication.

Ezra Wade v. Northeast Florida State Hospital, 655 So. 2d 125 (Fla. 1st DCA 1995). The First District Court of Appeals held that the conclusory statements reciting a patient's potential for aggression and the possibility of the patient causing substantial harm to his well-being did not meet the standard of clear and convincing evidence to support an order of continued involuntary placement for treatment. The order of continued involuntary placement for treatment under the Baker Act was reversed.

Catherine Salter v. State of Florida, 618 So. 2d 352 (Fla. 1st DCA 1993). The First District Court of Appeals held that the testimony of a psychiatrist failed to establish that a Baker Act patient was manifestly incapable of surviving alone or with help of willing and responsible family or friends, and thus, the psychiatrist's testimony was not sufficient to support the patient's involuntary commitment. The 1st DCA reversed the order for involuntary commitment and remanded the case for further proceedings.

Christine Swida v. State of Florida, 596 So. 2d 670 (Fla. 1992). The Supreme Court of Florida in a per curiam opinion held that an appeal from a civil commitment order under the Baker Act does not become moot solely because the person subject to that order has already been released.

Shirley Godwin v. State of Florida, 593 So. 2d 211 (Fla. 1992). The Supreme Court of Florida held that an appeal from a civil commitment order under the Baker Act did not become moot solely because the person subject to that order had already been released. The Supreme Court of Florida held that a former patient appeal of her order of involuntary commitment under the Baker Act was not moot because section 402.33(8), Fla. Stat. (1989) allows for the imposition of a lien for unpaid fees flowing from an involuntary commitment, and the imposition of a lien under section 402.33(8), Fla. Stat. (1989), on the property of an involuntarily committed person is a collateral legal consequence which affects the person beyond the person's initial release. The Supreme Court of Florida recognized the following consequences from an involuntary commitment as being significant but not rising to the level of a collateral legal

consequence: "the stigma that society may attach, as well as, some restrictions on a person's privileges and opportunities, i.e., restriction on drivers' licenses, restriction on right to vote, and restriction on right to carry a concealed weapon."

Baker Act and Guardianship Law

Hugh T. Handley Public Guardian, Second Judicial Circuit of Florida, Guardian, et al. v. Britton B. Dennis, Administrator of Florida State Hospital and Nancy Daniels, Public Defender, Second Judicial Circuit of Florida, 642 So. 2d 115 (Fla. 1st DCA 1994). The First District Court of Appeals held that when there is a conflict with the area of guardianship law, Chapter 744, Fla. Stat., and the Baker Act, Chapter 394, Fla. Stat., both the duty of the guardian and the power of the guardianship court, give way to the ward's rights under the Baker Act to be in the least restrictive environment and if the ward must be moved to a facility outside the circuit to accommodate a ruling in a Baker Act proceeding, the Public Guardian needs to file a motion to withdraw and transfer the case to the appropriate circuit and that circuit will have to appoint a successor guardian.

In Handley, the First District Court of Appeals defined the role of the Public Defender in an involuntary placement proceeding. The 1st DCA stated that, "The Public Defender has a duty under the law to represent indigent mental patients in hearings to determine the need for continued involuntary placement." "In such cases, the duty of the Public Defender is a legal and professional duty that is owed to the patient as a client." "The Public Defender serves as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society".

Baker Act and Minors

M.W., a child v. Arlonia Davis, Director of the Adolescent Programs, Lock Towns Community Mental Health Center, Inc. and Florida Department of Children and Family Services, 756 So. 2d 90 (Fla. 2000). The Supreme Court of Florida held that the Department of Children and Family Services was required to obtain court approval before the Department, acting in its capacity as the dependent child's custodian, could place the dependent child in a locked mental health facility pursuant to section 39.407 (4), Fla. Stat. (1999). The Supreme Court of Florida further held that a Baker Act hearing of kind conducted prior to the involuntary commitment of the dependent child was not required before the Department could place the child a locked mental health facility.

The Supreme Court of Florida held that the Florida Legislature did not intend for the Baker Act procedures to apply to children who have been adjudicated dependent and placed in the temporary legal custody of the Department and who are in need of mental health treatment. The Supreme Court of Florida stated that "The proper procedures exercised by the dependency court pursuant to Chapter 39, Fla. Stat. before placing a dependent child into a residential psychiatric treatment facility will better assure the child's safety and mental health than the procedures required by the Baker Act, Chapter 394, Fla. Stat. which would limit the placing of a dependent child into residential psychiatric treatment only in situations where the child is so disturbed that the child meets the criteria of being manifestly incapable of surviving alone or dangerous."

K.D., a minor v. Florida Department of Juvenile Justice, 694 So. 2d 817 (Fla. 4th DCA 1997). The Fourth District Court of Appeals held that Baker Act section 394.467(2), Involuntary Placement, is inapplicable in determining whether a delinquent juvenile is incompetent to

proceed to trial on a delinquency petition and whether a delinquent juvenile should be involuntarily hospitalized by a juvenile judge. The decision upheld the trial court's order committing the child to the Department of Children and Family Services for placement in a residential program. In doing so, the appellate court held that a determination of involuntary commitment of a juvenile pursuant to Florida Statute 39.0517 (2) (1999) is analogous to a determination of competency of an adult pursuant to Fla. R. Crim. P. 3.210-212 both of which unlike Florida Statute 394.467(2) require the appointment of "experts" to examine the juvenile/defendant and not the receipt of testimony or report of a psychologist (which is needed to involuntarily place a patient in a treatment facility).

Department of Health and Rehabilitative Services v. A.E., a child, 667 So. 2d 429 (Fla. 2d DCA 1996). The trial court found that the Minor A.E. was incompetent to proceed to trial and ordered the ten-year old child committed to DCF for placement in a mental health treatment facility pursuant to section 916.13(2), Fla. Stat. (1993). The Second District Court of Appeals held that the juvenile court did not have jurisdiction to order the involuntary commitment under section 916.13(2), Fla. Stat. (1993) of a child alleged to be delinquent. The Second District Court of Appeals reversed the order for involuntary placement of the minor and remanded the case for further proceedings under sections 39.046, 394.467, and 393.11, Fla. Stat.

Appendix P: Where to Go for Help

There are a number of resources that you may turn to seek help for substance abuse problems or to resolve problems related to the Marchman Act. In most instances, service delivery problems can be resolved with facility staff and ultimately, the facility administrator.

Many communities have adopted the "211" toll-free information programs that can guide a person in seeking any type of health and social service program. Some of these programs are operated on a 24-hour a day, 7-day a week basis.

However, any one of the following resources may be helpful.

State Agencies

Florida Department of Children & Family Services / Substance Abuse and Mental Health
Designated by the Florida Legislature as the State's Substance Abuse Authority responsible for licensing service providers to serve persons under the Marchman Act. District office phone numbers can be found at the front of this Handbook. Visit www.myflorida.com Click on government, then click on Executive Branch; click on State Agencies and Organizations, click on Department of Children and Families; click on Substance Abuse and Mental Health and click on any one of the following subjects:

- **Substance Abuse** for current news and special reports
- **Reports and Publications** for plans, rules, policies, forms and other documents
- **Provider Search** to obtain information on how to contact substance abuse and mental health providers in all of Florida's counties.
- **Links and Resources** to link to state, federal, substance abuse, prevention, and mental health resources.

Louis de la Parte Florida Mental Health Institute
Department of Mental Health Law & Policy
University of South Florida
www.fmhi.usf.edu/mhlp

Florida Department of Juvenile Justice
www.djj.state.fl.us

Florida Department of Corrections
www.dc.state.fl.us

Florida Office of Drug Control Policy
www.myflorida.com/drugcontrol/

National Organizations

National Institute on Alcoholism and Alcohol Abuse (NIAAA)
www.health.org

National Institute on Drug Abuse (NIDA)
www.nida.nih.gov

Center for Substance Abuse Treatment
National Drug & Alcohol Treatment Referral Service
800 662-HELP
www.samhsa.gov

Substance Abuse Treatment Facility Locator
Substance Abuse and Mental Health Service Administration
U.S. Department of Health and Human Services
www.findtreatment.samhsa.gov

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
800 729-6686
http://www.health.org

U.S. Department of Health and Human Services
www.os.dhhs.gov

Center for Substance Abuse Treatment (CSAT)
www.samhsa.gov/centers/csat2002

Office of Juvenile Justice and Delinquency Prevention
www.ojjdp.ncjrs.org

National Criminal Justice Reference Service
www.ncjrs.org

National Family Partnership
www.nfp.org/index

Partnership for a Drug Free America
www.drugfreeamerica.org

Boys and Girls Club of America
www.bgca.org

Society for Prevention Research
www.preventionresearch.org

Social Security Administration
http://www.ssa.gov
U.S. Department of Health & Human Services
http://www.os.dhhs.gov

National Council on Alcoholism and Drug Dependence, Inc. (NCADD)
12 West 21st, 7th Floor
New York, NY 10917
800 NCA-CALL

National Coalition of Hispanic Health & Human Services Organizations
1501 16th Street NW
Washington, DC 20036
202 387-5000

National Health Information Center
P.O. Box 1133
Washington, DC 20013-1133
800 336-4797
http://www.health.gov/nhic

National Rural Institute on Alcohol & Drug Abuse
Arts and Sciences Outreach Office
OL 1142
University of Wisconsin – Eau Claire
Eau Claire, WI 54702-4004
715 836-2031

National Institutes of Health
http://www.nih.gov

National Institute of Mental Health
www.nimh.nih.gov

The Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/cdc.htm

National Institute on Justice
www.ojp.usdoj.gov

Advocacy Organizations

Florida Alcohol and Drug Abuse Association
1030 East Lafayette Street, Tallahassee, FL 32310
www.fadaa.org

Statewide and Local Advocacy Councils
Each district has at least one Florida Local Advocacy Council composed of members of the public, appointed by the Governor, to oversee and investigate the quality of services. The statewide toll-free number is 1-800-342-0825.

Florida Abuse Registry
The Registry accepts calls reporting abuse, neglect or exploitation of vulnerable persons, including children, elders, and disabled adults. The statewide toll-free Registry is available at all times at 1-800-96-ABUSE.

Advocacy Center for Persons with Disabilities
The Advocacy Center is a private non-profit organization that receives federal funding to protect and advocate for the rights of persons of all ages who have disabilities. The Advocacy Center provides a wide range of services to persons who have mental illnesses who believe they have experienced serious incidents of abuse or neglect, or civil rights violations related to their disabilities. The Center prioritizes services to people in institutional, inpatient, or residential treatment settings, but also provides services to individuals living in their communities, as resources allow. The Center has offices in Tallahassee, Tampa, and Ft. Lauderdale, from which it serves the entire state of Florida. The statewide toll-free phone number is 1-800-342-0823.

Professional Regulation
Reports on physicians, nurses, psychologists, social workers, and other mental health professionals can be directed to The Florida Department of Health, Office of Medical Quality Assurance, at a statewide, toll-free number (AHCA Consumer Hotline) 1-888-419-3456, press 2.

Florida Certification Board
The Florida Certification Board certifies addiction professionals. To place a complaint against a certified addiction professional, call 1-850-222-6314.

Recovery & Family Support

Alcoholics Anonymous World Services Inc
475 Riverside Drive
New York, NY 10115
212 870-3400
www.recovery.org/aa/
www.alcoholics-anonymous.org/

Al-Anon/Alateen Family Group Headquarters, Inc.
1600 Corporate Landing Parkway
Virginia Beach, VA 23454
804 563-2666
800 344-2666

Families Anonymous
P.O. Box 35475
Culver City, CA 902313
800 736-9805

Rational Recovery Systems
P.O. Box 899
Lotus, CA 95651
916 621-2667

Depressive and Manic Depressive Association
Check phone book for chapter in your area.

Youth

Freevibe: Site for 12 and up
www.freevibe.com/index.shtml

National Youth Anti-Drug Media Campaign
www.mediacampaign.org

Drug Free America
www.drugfreeamerica.org

NCADI Teen Resources
www.health.org/initiatives

NCADI for Kids:
Offers activities for youth in both English and Spanish
www.health.org/features

American Council for Drug Education
www.acde.org/youth/default

College Students

National Institute on Alcohol Abuse & Alcoholism (NIAAA)
www.collegedrinkingprevention.gov

American Council for Drug Education
www.acde.org

Web of Addictions
www.well.com/user/woa

PREVLINE: Prevention On Line
www.health.org

Facts on Tap
www.factsontap.org

Adults

Southeast Center for the Application of Prevention Technologies
www.secapt.org

Center for Substance Abuse Prevention
www.samhsa.gov/csap

NCAD/PREVLINE: Prevention On Line
www.health.org

CSAP's Prevention Planning Decision Support System
www.preventiondss.org

National Youth Anti-Drug Media Campaign
www.mediacampaign.org

White House Drug Policy/Office of National Drug Control Policy
http://www.Whitehousedrugpolicy.gov

National Institute on Drug Abuse (NIDA)
www.nida.nih.gov/NIDAHome1.html

Community Anti-Drug Coalitions of America
www.cadca.org

Minnesota Institute of Public Health Links
www.miph.org/miph_links.html

Florida Youth Substance Abuse Survey 2000
www.state.fl.us/cf_web

Hazelden Website
www.justsayno.org

Parents

Teen Challenge
www.teenchallenge.com

Partnership for a Drug Free America
www.drugfreeamerica.org

PREVLINE: Prevention On Line
www.health.org

National Parenting Center
www.tnpc.com

American Council for Drug Education
www.acde.org

National Families in Action
www.nationalfamilies.org

Teachers

American Council for Drug Education
www.acde.org

Florida Youth Substance Abuse Survey 2000
www.state.fl.us/cf_web

Monitoring the Future
www.monitoringthefuture.org

CSAP Decision Support System
www.preventiondss.org

Centers for the Application of Prevention Techniques
www.casat.unr.edu/westcapt/

ADACA Coalitions
www.cadca.org

Elders

National Institute on Aging Information Center
P.O. Box 8057
Gaithersburg, MD 20898
800 222-2225

AARP Health Advocacy Services
601 E Street, NW
Washington, DC 20049
202 434-AARP

Clearinghouse on Abuse and Neglect of the Elderly
University of Delaware
College of Human Resources
Newark, DE 19716
302 831-8546

Huffington Center on Aging
www.hcoa.org

Institute for Brain Aging and Dementia
www.alz.uci.edu

Senior Access
www.hooked.net/users/

Aging Related Web Sites
www.geron.uga.edu/

Safety

AAA Foundation for Traffic Safety
1440 New York Avenue NW, Ste. 201
Washington, DC 20005
202 638-5944

National Safety Council
1121 Spring Lake Drive
Itasca, IL 60143-3201
708 285-1121

Appendix Q: Duties of the Department Licensure

397.321 Duties of the department.—The department shall:

(1) Develop a comprehensive state plan for the provision of substance abuse services. The plan must include:
(a) Identification of incidence and prevalence of problems related to substance abuse.
(b) Description of current services.
(c) Need for services.
(d) Cost of services.
(e) Priorities for funding.
(f) Strategies to address the identified needs and priorities.
(g)Resource planning.

(2) Ensure that a plan for substance abuse services is developed at the district level in accordance with the provisions of part IV of chapter 394.

(3) Provide on a direct or contractual basis, within the context of funds made available by appropriation:
(a) Public education programs and an information clearinghouse to disseminate information about the nature and effects of substance abuse.
(b) Training for personnel who provide substance abuse services.
(c) A data collection and dissemination system, in accordance with applicable federal confidentiality regulations.
(d) Basic epidemiological and statistical research and the dissemination of results.
(e) Research in cooperation with qualified researchers on services delivered pursuant to this chapter.

(4) Establish a funding program for the dissemination of available federal, state, and private funds through contractual agreements with community-based organizations or units of state or local government which deliver local substance abuse services.

(5) Assume responsibility for adopting rules as necessary to comply with this chapter, including other state agencies in this effort, as appropriate.

(6) Assume responsibility for licensing and regulating licensable service components delivering substance abuse services on behalf of service providers pursuant to this chapter.

(7) Ensure that each licensed service provider develops a system and procedures for:
(a) Client assessment.
(b) Individualized treatment or services planning.
(c) Client referral.
(d) Client progress reviews.
(e) Client follow-up.

(8) Provide for the systematic and comprehensive program evaluation of substance abuse service providers that are state-owned, state-operated, or state-contracted.

(9) Advise the Governor in the preparation of plans to be submitted for federal funding and support.

(10) Provide a system of documentation and reporting commensurate with the requirements of federal and other agencies providing funding to the state.

(11) Provide, within available funds, training and technical assistance to other state agencies relative to the problem of substance abuse and develop joint agreements with other state agencies to enhance the sharing of information and services.

(12) Develop standards for employee assistance programs for employees of state government, local governments, and private business.

(13) Ensure that service provider personnel have background checks as required in this chapter and meet the minimum standards.

(14) In cooperation with service providers, foster and actively seek additional funding to enhance resources for prevention, intervention, and treatment services, including but not limited to the development of partnerships with:

(a) Private industry.
(b) Intradepartmental and interdepartmental program offices, including, but not limited to, child care services; family safety; delinquency services; health services; economic services; and children's medical services.
(c) State agencies, including, but not limited to, the Departments of Corrections, Education, Community Affairs, Elderly Affairs, and Insurance.

(15) Appoint a substance abuse impairment coordinator to represent the department in efforts initiated by the statewide substance abuse impairment prevention and treatment coordinator established in s. 397.801 and to assist the statewide coordinator in fulfilling the responsibilities of that position.

(16) Recognize a statewide certification process for addiction professionals and identify and endorse one or more agencies responsible for such certification of service provider personnel.

(17) Provide sufficient and qualified staff to oversee all contracting, licensing, and planning functions within each of its district offices, as permitted by legislative appropriation.

(18) Ensure that the department develops and ensures the implementation of procedures between its Substance Abuse Program Office and other departmental programs regarding the referral of substance abuse impaired persons to service providers, information on service providers, information on methods of identifying substance abuse impaired juveniles, and procedures for referring such juveniles to appropriate service providers.

(19) Designate addictions receiving facilities for the purpose of ensuring that only qualified service providers render services within the context of a secure facility setting.

(20) The department may establish in District 9, in cooperation with the Palm Beach County Board of County Commissioners, a pilot project to serve in a managed care arrangement non-Medicaid eligible persons who qualify to receive substance abuse or mental health services from the department. The department may contract with a not-for-profit entity to conduct the pilot project. The results of the pilot project shall be reported to the district administrator, and the secretary 18 months after the initiation. The department shall incur no additional administrative costs for the pilot project.

397.331 Definitions; legislative intent.

(1) As used in this act, the term:
(a) "Substance abuse" means the use of any substance if such use is unlawful or if such use is detrimental to the user or to others, but is not unlawful.
(b) "Substance abuse programs and services" or "drug control" applies generally to the broad continuum of prevention, intervention, and treatment initiatives and efforts to limit substance abuse and also includes initiatives and efforts by law enforcement agencies to limit substance abuse.

(2) It is the intent of the Legislature to establish and institutionalize a rational process for long-range planning, information gathering, strategic decisionmaking, and funding for the purpose of limiting substance abuse. The Legislature finds that the creation of a state Office of Drug Control and a Statewide Drug Policy Advisory Council affords the best means of establishing and institutionalizing such a process.

(3) The Legislature finds that any rational and cost-effective governmental effort to address substance abuse must involve a comprehensive, integrated, and multidisciplinary approach to the problem of substance abuse.

(4) The Legislature further finds that because state resources must be available to address an array of state needs, including the funding of drug control efforts, it is critical that:
(a) A state drug control strategy be developed and implemented;
(b) Decisions regarding the funding of substance abuse programs and services be based on the state drug control strategy;
(c) The state drug control strategy be supported by the latest empirical research and data;
(d) The state drug control strategy require performance-based measurement and accountability;
(e) The state drug control strategy require short-term and long-term objectives;
(f) The development and implementation of the state drug control strategy afford a broad spectrum of the public and private sectors an opportunity to comment and make recommendations; and
(g) Because the nature and scope of the substance abuse problem transcends jurisdictional boundaries of any single government agency, the state drug control strategy be a comprehensive, integrated, and multidisciplinary response to the problem of substance abuse.

397,334 Treatment-based drug court programs.—

(1) It is the intent of the Legislature to implement treatment-based drug court programs in each judicial circuit in an effort to reduce crime and recidivism, abuse and neglect cases, and family dysfunction by breaking the cycle of addiction which is the most predominant cause of cases entering the justice system. The Legislature recognizes that the integration of judicial supervision, treatment, accountability, and sanctions greatly increases the effectiveness of substance abuse treatment. The Legislature also seeks to ensure that there is a coordinated, integrated, and multidisciplinary response to the substance abuse problem in this state, with special attention given to creating partnerships between the public and private sectors and to the coordinated, supported, and integrated delivery of multiple-system services for substance abusers, including a multiagency team approach to service delivery.

(2) Each judicial circuit shall establish a model of a treatment-based drug court program under which persons in the justice system assessed with a substance abuse problem will be processed in such a manner as to appropriately address the severity of the identified substance abuse problem through treatment plans tailored to the individual needs of the participant. These treatment-based drug court program models may be established in the misdemeanor, felony, family, delinquency, and dependency divisions of the judicial circuits. It is the intent of the Legislature to encourage the Department of Corrections, the Department of Children and Family Services, the Department of Juvenile Justice, the Department of Health, the Department of Law Enforcement, and such other agencies, local governments, law enforcement agencies, and other interested public or private sources to support the creation and establishment of these problem-solving court programs.

Participation in the treatment-based drug court programs does not divest any public or private agency of its responsibility for a child or adult, but allows these agencies to better meet their needs through shared responsibility and resources.

(3) The treatment-based drug court programs shall include therapeutic jurisprudence principles and adhere to the following 10 key components, recognized by the Drug Courts Program Office of the Office of Justice Programs of the United States Department of Justice and adopted by the Florida Supreme Court Treatment-Based Drug Court Steering Committee:

(a) Drug court programs integrate alcohol and other drug treatment services with justice system case processing.
(b) Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
(c) Eligible participants are identified early and promptly placed in the drug court program.
(d) Drug court programs provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
(e) Abstinence is monitored by frequent testing for alcohol and other drugs.
(f) A coordinated strategy governs drug court program responses to participants' compliance.
(g) Ongoing judicial interaction with each drug court program participant is essential.
(h) Monitoring and evaluation measure the achievement of program goals and gauge program effectiveness.
(i) Continuing interdisciplinary education promotes effective drug court program planning, implementation, and operations.
(j) Forging partnerships among drug court programs, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

(4) Treatment-based drug court programs may include pretrial intervention programs as provided in ss. 948.08, 948.16, and 985.306.

(5)(a) The Florida Association of Drug Court Program Professionals is created. The membership of the association may consist of drug court program practitioners who comprise the multidisciplinary drug court program team, including, but not limited to, judges, state attorneys, defense counsel, drug court program coordinators, probation officers, law enforcement officers, members of the academic community, and treatment professionals. Membership in the association shall be voluntary.
(b) The association shall annually elect a chair whose duty is to solicit recommendations from members on issues relating to the expansion, operation, and institutionalization of drug court programs. The chair is responsible for providing the association's recommendations to the Supreme Court Treatment-Based Drug Court Steering Committee, and shall submit a report each year, on or before October 1, to the steering committee.

Part II SERVICE PROVIDERS

397.401 License required; penalty; injunction; rules waivers.--

(1) It is unlawful for any person to act as a substance abuse service provider unless it is licensed or exempt from licensure under this chapter.

(2) A violation of subsection (1) is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(3) The department may maintain an action in circuit court to enjoin the unlawful operation of a substance abuse service provider if the department first gives the violator 14 days' notice of its intent to maintain such action and the violator fails to apply for licensure within that 14-day period. If the department determines that the

health, safety, and welfare of clients is jeopardized, the department may move to enjoin the operation at any time during the 14-day period. If the service provider has already applied for licensure under this chapter and has been denied licensure, the department may move immediately to obtain an injunction.

(4) In accordance with this subsection, the department may waive rules adopted pursuant to this chapter in order to allow service providers to demonstrate and evaluate innovative or cost-effective substance abuse services alternatives. Rules waivers may be granted only in instances where there is reasonable assurance that the health, safety, or welfare of clients will not be endangered. To apply for a rules waiver, the applicant must be a service provider licensed under this chapter and must submit to the department a written description of the concept to be demonstrated, including:
(a) Objectives and anticipated benefits.
(b) The number and types of clients who will be affected.
(c) A description of how the demonstration will be evaluated.
(d) Any other information requested by the department.

A service provider granted a rules waiver under this subsection must submit a detailed report of the results of its findings to the department within 12 months after receiving the rules waiver. Upon receiving and evaluating the detailed report, the department may renew or revoke the rules waiver or seek any regulatory or statutory changes necessary to allow other service providers to implement the same alternative service.

(5) The department shall allow a service provider in operation at the time of adoption of any rule a reasonable period, not to exceed 1 year, to bring itself into compliance with the rule.

397.403 License application.--

(1) Applicants for a license under this chapter must apply to the department on forms provided by the department and in accordance with rules adopted by the department. Applications must include at a minimum:
(a) Information establishing the name and address of the applicant service provider and its director, and also of each member, owner, officer, and shareholder, if any.
(b) Information establishing the competency and ability of the applicant service provider and its director to carry out the requirements of this chapter.
(c) Proof satisfactory to the department of the applicant service provider's financial ability and organizational capability to operate in accordance with this chapter.
(d) Proof of liability insurance coverage in amounts set by the department by rule.
(e) Sufficient information to conduct background screening as provided in s. 397.451.
1. If the results of the background screening indicate that any owner, director, or chief financial officer has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to any offense prohibited under the screening standard, a license may not be issued to the applicant service provider unless an exemption from disqualification has been granted by the department as set forth in chapter 435. The owner, director, or manager has 90 days within which to obtain the required exemption, during which time the applicant's license remains in effect.
2. If any owner, director, or chief financial officer is arrested or found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to any offense prohibited under the screening standard while acting in that capacity, the provider shall immediately remove the person from that position and shall notify the department within 2 days after such removal, excluding weekends and holidays. Failure to remove the owner, director, or manager will result in revocation of the provider's license.

(f) Proof of satisfactory fire, safety, and health inspections, and compliance with local zoning ordinances. Service providers operating under a regular annual license shall have 18 months from the expiration date of their regular license within which to meet local zoning requirements. Applicants for a new license must demonstrate proof of compliance with zoning requirements prior to the department issuing a probationary license.
(g) A comprehensive outline of the proposed services for:
1. Any new applicant; or
2. Any licensed service provider adding a new licensable service component.

(2) The burden of proof with respect to any requirement for application for licensure as a service provider under this chapter is on the applicant.

(3) The department shall accept proof of accreditation by CARF--the Rehabilitation Accreditation Commission or the Joint Commission on Accreditation of Health Care Organizations (JCAHCO), or through any other nationally recognized certification process that is acceptable to the department and meets the minimum licensure requirements under this chapter, in lieu of requiring the applicant to submit the information required by paragraphs (1)(a)-(c).

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.

(2) A nursing home facility as defined in s. 400.021.

(3) A substance abuse education program established pursuant to s. 1003.42.

(4) A facility or institution operated by the Federal Government.

(5) A physician 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.

(8) An established and legally cognizable church or nonprofit religious organization or denomination providing substance abuse services, including prevention services, which are exclusively religious, spiritual, or ecclesiastical in nature. A church or nonprofit religious organization or denomination providing any of the licensable service components itemized under s. 397.311(18) is not exempt for purposes of its provision of such licensable service components but retains its exemption with respect to all services which are exclusively religious, spiritual, or ecclesiastical in nature.

(9) Facilities licensed under s. 393.063(8) that, in addition to providing services to persons who are developmentally disabled as defined therein, also provide services to persons developmentally at risk as a consequence of exposure to alcohol or other legal or illegal drugs while in utero.

(10) DUI education and screening services provided pursuant to ss. 316.192, 316.193, 322.095, 322.271, and 322.291. Persons or entities providing treatment services must be licensed under this chapter unless exempted from licensing as provided in this section.

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 licensed under

chapter 458 or chapter 459, a psychologist licensed under chapter 490, or a psychotherapist licensed under chapter 491 who provides substance abuse treatment, so long as the physician, psychologist, or psychotherapist does not represent to the public that he or she is a licensed service provider and does not provide services to clients 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.

397.406 Licensure and regulation of government-operated substance abuse programs.--Substance abuse programs operated directly or under contract by the department, the Department of Corrections, any other state agency, or any local correctional agency or authority, which programs constitute any service provider licensable components as defined in this chapter, are subject to licensure and regulation in accordance with rules jointly developed by the department and the state or local agency operating the program. The department has authority to promulgate rules exempting such government-operated programs from specific licensure provisions of this part, including, but not limited to, licensure fees and personnel background checks, and to enforce the regulatory requirements governing such programs.

397.407 Licensure fees.--

(1) The department shall establish licensure fees by rule. The rule must prescribe a fee range that is based, at least in part, on the number and complexity of programs listed in s. 397.311(18) which are operated by a licensee. The fee range must be implemented over a 5-year period. The fee schedule for licensure of service components must be increased annually in substantially equal increments so that, by July 1, 1998, the fees from the licensure of service components are sufficient to cover at least 50 percent of the costs of regulating the service components. The department shall specify by rule a fee range and phase-in plan for privately funded licensed service providers and a fee range and phase-in plan for publicly funded licensed service providers. Fees for privately funded licensed service providers must exceed the fees for publicly funded licensed service providers. The first year phase-in licensure fees must be at least $150 per initial license. The rule must provide for a reduction in licensure fees for licensed service providers who hold more than one license.

(2) The department shall assess a fee of $100 per license for the late filing of an application for renewal of a license.

(3) Licensure and renewal fees must be deposited in the Operations and Maintenance Trust Fund to be used for the actual cost of monitoring, inspecting, and overseeing licensed service providers.

(4) Each application for licensure or renewal must be accompanied by the required fee, except that a service provider that has an all-volunteer staff is exempt from the licensure and renewal fees.

397.409 Probationary, regular, and interim licenses; issuance and renewal.--

(1) The department may issue probationary, regular, and interim licenses. The department shall issue one license to each facility operated by a service provider. The license must state the specific service components to be provided. A license issued to a residential facility must stipulate the maximum bed capacity of the facility at the time of licensure, and must be amended if there is a change in bed capacity, as specified by rule. The licensed service provider shall apply for a new license at least 30 days prior to the relocation of any of its facilities or licensable service components; failure to apply for a new license may result in denial of a license. Probationary and regular licenses may be issued only after all required information has

been submitted. A license may not be transferred and is valid only for the premises for which it is originally issued. As used in this subsection, "transfer" includes, but is not limited to, transfer of a majority of the ownership interest in the license or transfer of responsibilities under the license to another entity by contractual arrangement.

(2) A probationary license may be issued to a service provider applicant in the initial stages of developing services which are not yet fully operational upon completion of all application requirements itemized in s. 397.403(1)(a)-(g) and upon demonstration of the applicant's ability to comply with all applicable statutory and regulatory requirements. A probationary license expires 90 days after issuance and may be reissued once for an additional 90-day period if the applicant has substantially complied with all requirements for regular licensure or has initiated action to satisfy all requirements. During the probationary period the department must monitor the delivery of services. The holder of a probationary license may be ordered to cease and desist operations at any time it is found to be substantially out of compliance with licensure standards.

(3) A regular license may be issued:
(a) To a new applicant at the end of the probationary period.
(b) To a regularly licensed applicant seeking renewal.
(c) To a facility operating under an interim license that successfully satisfies the requirements for a regular license.

In order to be issued a regular license, the applicant must be in compliance with statutory and regulatory requirements. Standards and timeframes for issuance of regular licenses must be established by rule. An application for renewal of a regular license must be submitted to the department 60 days before the license expires.

(4) The department may issue an interim license to a service provider for a period established by the department which does not exceed 90 days, if the department finds that:
(a) A facility or service component of the service provider is in substantial noncompliance with licensure standards;
(b) The service provider has failed to provide satisfactory proof of conformance to fire, safety, or health requirements; or
(c) The service provider is involved in license suspension or revocation proceedings.

An interim license applies only to the licensable service component of the provider's services which is in substantial noncompliance with statutory or regulatory requirements. An interim license expires 90 days after it is issued; it may be reissued once for an additional 90-day period in a case of extreme hardship in which the noncompliance is not caused by the licensed service provider. If the service provider is appealing the final disposition of license suspension or revocation proceedings, the court before which the appeal is taken may order the extension of the interim license for a period of time specified in the order.

(5) A separate license is required for each facility maintained on separate premises, even though the facility is operated under the same management. However, a separate license is not required for separate buildings on the same grounds.

(6) The license must be displayed in a conspicuous place inside the facility.

397.411 Inspection; right of entry; records.--

(1)(a) An authorized agent of the department may enter and inspect at any time a licensed service provider to determine whether it is in compliance with statutory and regulatory requirements.

(b) An authorized agent of the department may, with the permission of the person in charge of the premises or pursuant to a warrant, enter and inspect any unlicensed service provider it reasonably suspects to be operating in violation of any provision of this chapter.
(c) An application for licensure as a service provider under this chapter constitutes full permission for an authorized agent of the department to enter and inspect the premises of such service provider at any time.

(2) The department shall accept, in lieu of its own inspections for licensure, the survey or inspection of an accrediting organization, if the provider is accredited according to the provisions of s. 394.741 and the department receives the report of the accrediting organization.

(3) Notwithstanding the confidentiality provisions of this chapter, a designated and authorized agent of the department may access the records of the clients of licensed service providers, but only for purposes of licensing, monitoring, and investigation. The department may interview clients, as specified by rule.

(4) The authorized agents of the department shall schedule periodic inspections of licensed service providers in order to minimize costs and the disruption of services; however, such authorized agents may inspect the facilities of any licensed service provider at any time.

(5) The department shall maintain as public information, available to any person upon request and upon payment of a reasonable charge for copying, copies of licensure reports of licensed providers.

397.415 Denial, suspension, and revocation; other remedies.--

(1) If the department determines that an applicant or licensed service provider or licensed service component thereof is not in compliance with all statutory and regulatory requirements, the department may deny, suspend, revoke, or impose reasonable restrictions or penalties on the license or any portion of the license. In such case, the department:
(a) May impose a moratorium on admissions to any component of a licensed service provider if the department determines that conditions within such component are a threat to the public health or safety.
(b) May impose an administrative penalty of up to $500 per day against a licensed service provider operating in violation of any fire-related, safety-related, or health-related statutory or regulatory requirement. Fines collected under this paragraph must be deposited in the Substance Abuse Impairment Provider Licensing Trust Fund.
(c) May suspend or revoke the license if, after notice, it determines that a service provider has failed to correct the substantial or chronic violation of any statutory or regulatory requirement such as impacts the quality of client care.

(2) If a license of a facility or any service component of a facility is revoked, the service provider is barred from submitting any application for licensure of the affected facility or service component to the department for a period of 1 year after the revocation.

(3) Proceedings for the denial, suspension, or revocation of a service provider's license must be conducted in accordance with chapter 120.

(4) The department may maintain an action in court to enjoin the operation of any licensed or unlicensed facility in violation of this chapter or the rules adopted under this chapter.

397.416 Substance abuse treatment services; qualified professional.--

(1) A person who holds a master's degree in a social or behavioral science in a human

services discipline with a minimum of 2 years' experience in the assessment or treatment of substance abuse may perform the duties of a qualified professional with respect to substance abuse treatment services as defined in this chapter until January 1, 2001.

(2) Notwithstanding any other provision of law, a person who was certified through a certification process recognized by the former Department of Health and Rehabilitative Services before January 1, 1995, may perform the duties of a qualified professional with respect to substance abuse treatment services as defined in this chapter, and need not meet the certification requirements contained in s. 397.311(24).

397.419 Quality assurance programs.--

(1) Each service provider must maintain an ongoing quality assurance program to objectively and systematically monitor and evaluate the appropriateness and quality of client care, to ensure that services are rendered consistent with prevailing professional standards, and to identify and resolve problems.

(2) For each service provider, a written plan must be developed with a copy submitted to the department which addresses the minimum guidelines for the provider's quality assurance program, including, but not limited to:
(a) Client care and services standards.
(b) Client records maintenance procedures.
(c) Staff development policies and procedures.
(d) Facility safety and maintenance standards.
(e) Peer review and utilization review procedures.
(f) Incident reporting policies and procedures, including verification of corrective action and provision for reporting to the department within a time period prescribed by rule.

(3) The quality assurance program is the responsibility of the director and is subject to review and approval by the governing board of the service provider.

(4) Each director shall designate a person who is an employee of or under contract with the service provider as the provider's quality assurance manager.

(5) Incident reporting is the affirmative duty of all staff.

(6) A person who files an incident report may not be subjected to any civil action by virtue of that incident report.

(7) The department may access all service provider records necessary to determine compliance with this section. Records relating solely to actions taken in carrying out this section and records obtained by the department to determine a provider's compliance with this section are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such records are not admissible in any civil or administrative action except in disciplinary proceedings by the Department of Business and Professional Regulation or the appropriate regulatory board, and are not part of the record of investigation and prosecution in disciplinary proceedings made available to the public by the Department of Business and Professional Regulation or the appropriate regulatory board. Meetings or portions of meetings of quality assurance program committees that relate solely to actions taken pursuant to this section are exempt from s. 286.011.

(8) The quality assurance program shall be implemented as part of the department's contract management process. The quality assurance program shall:
(a) Track performance measures and standards established by the Legislature as part of the performance-based program budgeting process;

(b) Provide a framework for evaluating outcomes which is separate from the performance-based program budgeting process, including:
1. Output measures, such as capacities, technologies, and infrastructure, that make up the system of care.
2. Process measures, such as administrative and clinical components of treatment.
3. Outcome measures pertaining to the outcomes of services;
(c) Provide for a system of analyzing those factors which have an effect on performance at the local level;
(d) Provide for a system of reporting the results of quality assurance reviews; and
(e) Incorporate best practice models for use in improving performance in those areas which are deficient.

(9) The quality assurance program shall incorporate a peer review process into its protocol, to include:
(a) Reviews of providers by departmental district staff and other providers.
(b) Reviews of individual districts by other districts.

(10) Contingent upon specific appropriation, a quality assurance coordinator position shall be established within each service district to oversee the implementation and operation of the quality assurance program.

397.427 Medication treatment service providers; rehabilitation program; needs assessment and provision of services; persons authorized to issue takeout methadone; unlawful operation; penalty.--

(1) Medication treatment service providers may not be licensed unless they provide supportive rehabilitation programs. Supportive rehabilitation programs include, but are not limited to, counseling, therapy, and vocational rehabilitation.

(2) The department shall determine the need for establishing medication treatment service providers.
(a) Medication treatment service providers may be established only in response to the department's determination and publication of need for additional medication treatment services.
(b) The department shall prescribe by rule the types of medication treatment services for which it is necessary to conduct annual assessments of need. If needs assessment is required, the department shall annually conduct the assessment and publish a statement of findings which identifies each district's need.
(c) Notwithstanding paragraphs (a) and (b), the license for medication treatment programs licensed before October 1, 1990, may not be revoked solely because of the department's determination concerning the need for medication treatment services.

(3) The department shall adopt rules necessary to administer this section, including, but not limited to, rules prescribing criteria and procedures for:
(a) Determining the need for additional medication treatment services.
(b) Selecting medication treatment service providers when the number of responses to a publication of need exceeds the determined need.
(c) Administering any federally required rules, regulations, or procedures.

(4) A service provider operating in violation of this section is subject to proceedings in accordance with this chapter to enjoin that unlawful operation.

(5) Notwithstanding the provisions of s. 465.019(2), a registered nurse, an advanced registered nurse practitioner, or a licensed practical nurse working for a licensed service provider is authorized to deliver takeout methadone to persons enrolled in a methadone maintenance treatment program provided that:
(a) The methadone maintenance treatment program has an appropriate valid permit

issued pursuant to rules promulgated by the Board of Pharmacy;
(b) The medication has been delivered pursuant to a valid prescription written by the program's physician licensed pursuant to chapter 458 or chapter 459;
(c) The medication ordered appears on a formulary and is prepackaged and prelabeled with dosage instructions and distributed from a source authorized under chapter 499;
(d) Each licensed provider adopts written protocols which provide for supervision of the registered nurse, advanced registered nurse practitioner, or licensed practical nurse by a physician licensed pursuant to chapter 458 or chapter 459 and for the procedures by which patients' medications may be delivered by the registered nurse, advanced registered nurse practitioner, or licensed practical nurse. Such protocols shall be signed by the supervising physician and either the administering registered nurse, the advanced registered nurse practitioner, or the licensed practical nurse.
(e) Each licensed service provider maintains and has available for inspection by representatives of the Board of Pharmacy all medical records and patient care protocols, including records of medications delivered to patients, in accordance with the board.

397.431 Client responsibility for cost of substance abuse impairment services.--

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

(2) A client or his or her authorized personal representative, or parent or legal guardian if the client 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 individual clients. 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 a client's ability to pay and, if space and sufficient state resources are available, may not deny a client access to services solely on the basis of the client's inability to pay.

397.451 Background checks of service provider personnel.--

(1) PERSONNEL BACKGROUND CHECKS; REQUIREMENTS AND EXCEPTIONS.--
(a) Background checks shall apply as follows:
1. All owners, directors, and chief financial officers of service providers are subject to

level 2 background screening as provided under chapter 435.
2. All service provider personnel who have direct contact with children receiving services or with adults who are developmentally disabled receiving services are subject to level 2 background screening as provided under chapter 435.
(b) Members of a foster family and persons residing with the foster family who are between 12 and 18 years of age are not required to be fingerprinted but must have their backgrounds checked for delinquency records. Members of the foster family and persons residing with the foster family over 18 years of age are subject to full background checks.
(c) A volunteer who assists on an intermittent basis for fewer than 40 hours per month and is under direct and constant supervision by persons who meet all personnel requirements of this chapter is exempt from fingerprinting and background check requirements.
(d) Service providers that are exempt from licensing provisions of this chapter are exempt from personnel fingerprinting and background check requirements, except as otherwise provided in this section. A church or nonprofit religious organization exempt from licensure under this chapter is required to comply with personnel fingerprinting and background check requirements.
(e) Personnel employed by the Department of Corrections in a substance abuse service component who have direct contact with unmarried inmates under the age of 18 or with inmates who are developmentally disabled are exempt from the fingerprinting and background check requirements of this section.
(f) Service provider personnel who request an exemption from disqualification must submit the request within 30 days after being notified of a pending disqualification. The employment of service provider personnel shall not be adversely affected pending disposition of the request for an exemption. Disapproval of a request for an exemption shall result in the immediate dismissal of the service provider personnel from employment with the provider.

(2) EMPLOYMENT HISTORY CHECKS; CHECKS OF REFERENCES.--The department shall assess employment history checks and checks of references for all owners, directors, and chief financial officers, and the directors shall assess employment history checks and checks of references for each employee who has direct contact with children receiving services or adults who are developmentally disabled receiving services.

(3) PERSONNEL EXEMPT FROM BEING REFINGERPRINTED OR RECHECKED.--
(a) Service provider personnel who have been fingerprinted or had their backgrounds checked pursuant to chapter 393, chapter 394, chapter 402, or chapter 409, or this section, and teachers who have been fingerprinted pursuant to chapter 1012, who have not been unemployed for more than 90 days thereafter and who, under the penalty of perjury, attest to the completion of such fingerprinting or background checks and to compliance with the provisions of this section and the standards contained in chapter 435 and this section, are not required to be refingerprinted or rechecked.
(b) Service provider owners, directors, or chief financial officers who are not covered by paragraph (a) who provide proof of compliance with the level 2 background screening requirements which has been submitted within the previous 5 years in compliance with any other state health care licensure requirements are not required to be refingerprinted or rechecked.

(4) EXEMPTIONS FROM DISQUALIFICATION.--
(a) The department may grant to any service provider personnel an exemption from disqualification as provided in s. 435.07.
(b) Since rehabilitated substance abuse impaired persons are effective in the successful treatment and rehabilitation of substance abuse impaired adolescents, for

service providers which treat adolescents 13 years of age and older, service provider personnel whose background checks indicate crimes under s. 817.563, s. 893.13, or s. 893.147 may be exempted from disqualification from employment pursuant to this paragraph.
(c) The department may grant exemptions from disqualification which would limit service provider personnel to working with adults in substance abuse treatment facilities.

(5) PAYMENT FOR PROCESSING OF FINGERPRINTS AND STATE CRIMINAL RECORDS CHECKS.--The employing service provider or the personnel who are having their backgrounds checked are responsible for paying the costs of processing fingerprints and criminal records checks.

[1](6) DISQUALIFICATION FROM RECEIVING STATE FUNDS.--State funds may not be disseminated to any service provider owned or operated by an owner, director, or chief financial officer who has been convicted of, has entered a plea of guilty or nolo contendere to, or has had adjudication withheld for, a violation of s. 893.135 pertaining to trafficking in controlled substances, or a violation of the law of another state, the District of Columbia, the United States or any possession or territory thereof, or any foreign jurisdiction which is substantially similar in elements and penalties to a trafficking offense in this state, unless the owner's or director's civil rights have been restored.
[1]Note.--Section 4, ch. 2002-212, provides that "[e]xcept as specifically provided otherwise in this act, the provisions reenacted by this act shall be applied retroactively to July 1, 1999, or as soon thereafter as the Constitution of the State of Florida and the Constitution of the United States may permit."

397.461 Unlawful activities relating to personnel; penalties.--It is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:

(1) Inaccurately disclose by false statement, misrepresentation, impersonation, or other fraudulent means, or fail to disclose, in any application for voluntary or paid employment, any fact which is material in making a determination as to the person's qualifications to be an owner, a director, a volunteer, or other personnel of a service provider;

(2) Operate or attempt to operate as a service provider with personnel who are in noncompliance with the minimum standards contained in this chapter; or

(3) Use or release any criminal or juvenile information obtained under this chapter for any purpose other than background checks of personnel for employment.

397.471 Service provider facility standards.--

(1) Each service provider must ensure:
(a) Sufficient numbers and types of qualified personnel on duty and available to provide necessary and adequate client safety and care.
(b) Adequate space for each client of a residential facility.
(c) Adequate infection control, housekeeping, and sanitation.
(d) Adequate disaster planning policies and procedures.

(2) The State Fire Marshal shall, in cooperation with the department, establish and enforce minimum fire safety standards, which standards must be included in the rules adopted by the department.

397.481 Applicability of Community Alcohol, Drug Abuse, and Mental Health Services Act.--All service providers as defined in and governed by this chapter are also subject to part IV of chapter 394, the Community Alcohol, Drug Abuse, and Mental Health Services Act.

Department Licensing and Regulatory Standards 65D-30.003

(1) Licensing.

(a) License Required. All substance abuse components, as defined in subsection 65D-30.002(16), F.A.C., must be provided by persons or entities that are licensed by the department pursuant to Section 397.401, F.S., unless otherwise exempt from licensing under Section 397.405, F.S., prior to initiating the provision of services.

(b) Licenses Issued by Premises. One license is required:

1. For each facility that is maintained on separate premises even if operated under the same management; and

2. Where all facilities are maintained on the same premises and operated under the same management.
In both cases, all components shall be listed on the license.

(c) Display of Licenses. Licenses shall be displayed in a prominent, publicly accessible place within each facility.

(d) Special Information Displayed on Licenses. In the case of addictions receiving facilities, detoxification, and residential treatment, each license shall include the licensed bed capacity. The department shall identify on the license those components provided in each facility that are accredited by a department recognized accrediting organization such as the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and Council on Accreditation (COA). In the case of providers or components of providers that are accredited, licenses shall also include the statement, "THIS LICENSE WAS ISSUED BASED, IN PART, ON THE SURVEY REPORT OF A DEPARTMENT RECOGNIZED ACCREDITING ORGANIZATION." This statement would not be included on the license when issuance is also based on the results of the department's licensing inspections.

(2) Categories of Licenses; issuance.

(a) Probationary License.

1. Conditions Permitting Issuance. A probationary license is issued to new applicants and to licensed providers adding new components, upon completion of all application requirements.

2. Reissuing a Probationary License. A probationary license expires 90 days after it is issued. The department may reissue a probationary license for one additional 90-day period if the department determines that the applicant needs additional time to become fully operational and has substantially complied with all requirements for a regular license or has initiated action to satisfy all requirements.

3. Special Requirements Regarding Probationary Licenses. The following special requirements apply regarding new applicants.

a. A new applicant shall refrain from providing non-exempt services until a probationary license is issued.

b. New applicants that lease or purchase any real property during the application process do so at their own risk. Such lease or purchase does not obligate the department to approve the applicant for licensing. c. In those instances where an applicant fails to admit clients for services during the initial probationary period, the department shall not issue a regular license, even where other standards have been met. However, the department may reissue a probationary license if it finds that the applicant can provide evidence of good cause for not having admitted clients during the initial 90-day probationary period.

4. Issuing New Licenses. In those instances where all licenses issued to a provider have the same expiration dates, any additional licenses that are issued to the provider during the effective period will carry the same expiration date as provider's existing licenses.

(b) Regular License.

1. Conditions Permitting Issuance. A regular license is issued:

a. To a new applicant at the end of the probationary period that has satisfied the requirements for a regular license.

b. To a provider seeking renewal of a regular license that has satisfied the requirements for renewal.

c. To a provider operating under an interim license that satisfies the requirements for a regular license.

2. Applications for Renewal. In regard to applications for renewal of a regular license, the department must receive a completed application no later than 60 days before the provider's current license expires.

Effective Dates. A regular license is considered to be valid for a period of 12 months from the date of issuance. If a regular license replaces a probationary license, the regular license shall be valid for a period of 12 months from the date the probationary license was issued. In cases where a regular license replaces an interim license, the anniversary date of the regular license shall not change.

(c) Interim License.

1. Conditions Permitting Issuance. An interim license will replace a regular license for a period not to exceed 90 days, where the department finds that any one of the following conditions exist.

a. A facility or component of the provider is in substantial noncompliance with licensing standards.

b. The provider has failed to provide proof of compliance with fire, safety, health, or zoning requirements.

c. The provider is involved in license suspension or revocation proceedings.

All components within a facility that are affected shall be listed on the interim license.

Reissuing an Interim License. The department may reissue an interim license for an additional 90 days at the end of the initial 90-day period in the case of extreme hardship. In this case, reissuing an interim license is permitted when inability to reach full compliance can not be attributed to the provider.

(3) Changing the Status of Licenses. Changes to a provider's license shall be permitted under the following circumstances.

(a) If a new component is added to a facility's regular license, the department will issue a separate probationary license for that component. Once the provider has satisfied the requirements for a regular license, the department shall reissue an amended regular license to include the new component.

(b) If a component of a facility operating under a regular license is found to be in substantial noncompliance, a separate interim license will be issued by the department for that component and the provider will return its regular license to the department. The department will reissue an amended regular license. Once the provider has satisfied the requirements of a regular license for that component, the department will reissue another amended regular license to include that component.

(c) A provider's current license shall be amended when a component is discontinued. In such cases, the provider shall send its current license to the department only after receipt of an amended license. Components not affected by this provision shall be permitted to continue operation.

(d) Whenever there is a change in a provider's licensed bed capacity equal to or greater than 10 percent, the provider shall immediately notify the department which shall, within 5 working days of receipt of notice, issue an amended license to the provider.

When there is a change in a provider's status regarding accreditation, the provider shall notify the department in writing within 5working days of such change. In those instances where the change in status will adversely affect the provider's license or requires other sanctions, the department shall notify the provider within 5 working days of receipt of the notice of the department's pending action.

(4) License Non-transferable.

(a) Licenses are not transferable:

1. Where an individual, a legal entity, or an organizational entity, acquires an already licensed provider; and

2. Where a provider relocates or a component of a provider is relocated.

(b) Submitting Applications. A completed application, Form 4024, shall be submitted to the department at least 30 days prior to acquisition or relocation.

1. Acquisition. In addition to Form 4024, the applicant shall be required to submit all items as required in subsection 65D-30.003(6), F.A.C. When the application is considered complete, the department shall issue a probationary license.

2. Relocation. In addition to Form 4024, if there is no change in the provider's services, the provider shall only be required to provide proof of liability insurance coverage and compliance with fire and safety standards established by the State Fire Marshal, health codes enforced at the local level, and zoning. If there is a change in the provider's services, the provider shall be required to submit all items as required in subsection 65D-30.003(6), F.A.C. In this latter case, when the department determines the application to be complete, the department shall issue a probationary license.

(5) Licensing Fees. Applicants for a license to operate as a licensed service provider as defined in subsection 397.311(19), F.S., shall be required to pay a fee upon submitting an application to the district office. The fees paid by privately funded providers shall exceed fees paid by publicly funded providers, as required in subsection 397.407(1), F.S. Applicants shall be allowed a reduction, hereafter referred to as a discount, in the amount of fees owed the department. The discount shall be based on the number of facilities operated by a provider. The fee schedules are listed by component as follows: (fees can be found in Appendix R of this handbook)

(6) Application for Licensing. Applications for licensing shall be submitted initially and annually thereafter to the department along with the licensing required fee. Unless otherwise specified, all applications for licensure shall include the following:

(a) A standard application for licensing, C&F-SA Form 4024, September 2001, titled Application for Licensing to Provide SUBSTANCE ABUSE SERVICES, incorporated herein by reference. Copies of C&F-SA Form 4024 may be obtained from the Department of Children and Families, Substance Abuse Program Office, 1317

Winewood Boulevard, Tallahassee, Florida 32399-0700;

(b) Written proof of compliance with health and fire and safety inspections;

(c) A copy of the provider's occupational license and evidence of compliance with local zoning requirements(Inmate Substance Abuse Programs operated within Department of Corrections facilities are exempt from this requirement);

(d) A copy of the client service fee schedule and policy regarding a client's/participant's financial responsibility (Inmate Substance Abuse Programs operated within Department of Corrections facilities are exempt from this requirement;

(e) A comprehensive outline of the services to be provided, including the licensed bed capacity for addictions receiving facilities, residential detoxification, and residential treatment, to be submitted with the initial application, with the addition of each new component, or when there is a change of ownership;

(f) Information that establishes the name and address of the applicant, its chief executive officer and, if a corporation, the name of each member of the applicant's board, the name of the owner, the names of any officers of the corporation, and the names of any shareholders (Providers that are accredited by department approved accrediting organizations are not required to submit this information);

(g) Information on the competency and ability of the applicant and its chief executive officer to carry out the requirements of these rules (Providers that are accredited by department approved accrediting organizations and Inmate Substance Abuse Programs operated directly by the Department of Corrections are not required to submit this information);

(h) Proof of the applicant's financial ability and organizational capability to operate in accordance with these rules (Providers that are accredited by department approved accrediting organizations and Inmate Substance Abuse Programs operated directly by the Department of Corrections are not required to submit this information);

(i) Proof of professional and property liability insurance coverage (Inmate Substance Abuse Programs operated directly by the Department of Corrections are not required to submit this information);

(j) Confirmation of completion of basic HIV/AIDS education requirements pursuant to Section 381.0035, F.S., for renewal application

(k) A current organizational chart;

(l) Verification of certification from the Substance Abuse and Mental Health Administration relating to medication and methadone maintenance treatment, submitted with the initial application and documented approval from the Substance Abuse and Mental Health Administration and where there is a change of owner, sponsor, or physician;

(m) Verification that a qualified professional is included on staff;

(n) The Drug Enforcement Administration registration for medication and methadone maintenance treatment;

(o) The Drug Enforcement Administration registration for all physicians;

(p) A state of Florida pharmacy permit for medication and methadone maintenance treatment and any provider with a pharmacy;

(q) Verification of the services of a consultant pharmacist for medication and methadone maintenance treatment and any provider with a pharmacy;

(r) Verification of professional licenses issued by the Department of Health;

(s) Verification that fingerprinting and background checks have been completed as required by Chapter 397, F.S., Chapter 435, F.S., and these rules;

(t) Proof of the availability and provision of meals for addictions receiving facilities, residential detoxification, residential treatment, day or night treatment with host homes, and day or night treatment, if applicable in the latter component (Inmate Substance Abuse Programs operated within Department of Corrections facilities are exempt from this requirement);

(u) Verification that a medical director has been designated for addictions receiving facilities, detoxification, residential treatment, and medication and methadone maintenance treatment; and

(v) Verification that the Chief Executive Officer has submitted proof in writing that the provider is following the requirements in Chapter 65D-30, F.A.C.

Items listed in paragraphs (a)-(k) must accompany the application for a license. However, regarding items in paragraph (h), only new applicants will be required to submit this information with the application. Items listed in paragraphs (l)-(v), including items in paragraph (h) for renewal applicants, must be made available for review at the provider facility. In addition, documents listed in paragraphs (a)-(v) that expire during the period the license is in effect shall be renewed by the provider prior to expiration and the department shall be notified by the provider in writing immediately upon renewal or in the event renewal does not occur.

(7) Accredited Providers. This subsection implements Section 394.741, F.S. This subsection applies to licensing inspections of providers or components of providers that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Council onAccreditation (COA), or other department approved accrediting organizations.

(a) Licensing Inspections of Accredited Providers. For those providers or components of providers that are accredited, the department shall conduct a licensing inspection once every 3 years.

(b) License Application. Accredited providers shall submit an application for licensing, Form 4024, to the department annually. The form shall be accompanied by:

1. Proof of compliance with fire and safety standards, health standards, and zoning;

2. A copy of the survey report including any information regarding changes in the provider's accreditation status; and

3. In addition, the provider's Chief Executive Officer shall submit in writing to the department that the provider is following the standards for licensing required in Chapter 65D-30, F.A.C.

(c) Determination of Accreditation. As indicated in paragraph (b), providers shall submit a copy of the accreditation survey report to the department annually. The department shall review the report and confirm that accreditation has been awarded for the applicable components. If the survey report indicates that the provider or any components of the provider have been issued provisional or conditional accreditation, the department shall conduct a licensing inspection as permitted in paragraph (d).

Inspections of Accredited Providers. In addition to conducting licensing inspections every three years, the department has the right to conduct inspections of accredited providers in accordance with subsection

394.741(6), F.S., and subsections 397.411(3), (4), and
(5), F.S. , in those cases where any of the following conditions exist.

1. The accredited provider or component of the provider fails to submit the accreditation report and any corrective action plan related to its accreditation upon request by the department.

2. The accredited provider or component of the provider has not received or has not maintained accreditation as provided for in paragraph (c).

3. The department's investigation of complaints results in findings of one or more violations of the licensing standards of any accredited component.

4. The department has identified significant health and safety problems.

The department shall notify the provider of its intent to conduct an inspection in response to any of the conditions provided for under this paragraph.

(8) Authorized Agents; qualifications. Prior to being designated as an authorized agent of the department a person shall:

(a) Demonstrate knowledge of the state's substance abuse services system;

(b) Demonstrate knowledge of Chapter 397, F.S., Chapter 65D-30, F.A.C., department policy related to licensing and regulation of providers, federal regulations which directly affect the department or providers, accreditation standards from the Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and Council on Accreditation (COA), and other rules and statutes referenced herein;

(c) Demonstrate skill in conducting licensing inspections, the use of licensing instruments, and preparing accurate reports of findings from licensing inspections;

(d) Demonstrate knowledge of the specific services rendered by substance abuse providers within the agent's area of jurisdiction; and

(e) Participate in a formal in-service training program developed and conducted by designated department staff with the commensurate training and experience provided for in paragraphs (a)-(d).

(9) Department Licensing Procedures.

(a) District Office Licensing Procedures. The district offices shall be responsible for licensing providers operating within their geographic boundaries.

1. Application Process. The district office shall process all new and renewal applications for licensing and shall notify both new and renewal applicants in writing within 30 days of receipt of the application that it is complete or incomplete. Where an application is incomplete, the district office shall specify in writing to the applicant the items that are needed to complete the application. Following receipt of the district office's response, the applicant shall have 10 working days to submit the required information to the district office. If the applicant needs additional time to submit the required information it may request such additional time within 5 days of the deadline for submitting the information. That request shall be approved or denied by the district office within 5 days of receipt. Any renewal applicant that fails to meet these deadlines shall be assessed an additional fee equal to the late fee provided for in subsection 397.407(3), F.S., $100 per licensed component.

2. Licensing Inspection. The district office shall notify each applicant of its intent to conduct an on-site licensing inspection and of the proposed date and time of the inspection. The district office shall include

the name(s) of the authorized agents who will conduct the inspection and the specific components and facilities to be inspected. This notification, however, shall not prohibit the district office from inspecting other components or facilities maintained by a provider at the time of the scheduled review. For accredited providers, such inspection is subject to paragraph 65D-30.003(7)(d),F.A.C.

3. Licensing Determination. A performance-based rating system shall be used to evaluate a provider's compliance with licensing standards. Providers shall attain at least 80 percent compliance overall on each component reviewed. This means that each component within a facility operated by a provider is subject to the 80 percent compliance requirement. If any component within a facility falls below 80 percent compliance, an interim license would be issued for that component. In addition, there may be instances where a component is rated at an 80 percent level of compliance overall but is in substantial noncompliance with standards related to health, safety, and welfare of clients and staff. This would include significant or chronic violations regarding standards that do not involve direct services to clients. In such cases, the district office shall issue an interim license to the provider or take other regulatory action permitted in Section 397.415, F.S.

4. Notifying Providers Regarding Disposition on Licensing. In the case of new and renewal applications, the district office shall give written notice to the applicant as required in subsection 120.60(3), F.S., that the district office has granted or denied its application for a license. In the case of new applicants, this shall occur within the 90-day period following receipt of the completed application. In the case of renewal applicants, this shall occur prior to expiration of the current license.

5. Reports of Licensing Inspections. The district offices shall prepare and distribute to providers a report of licensing inspections that shall include:

a. The name and address of the facility;

b. The names and titles of principal provider staff interviewed;

c. An overview of the components and facilities inspected and a brief description of the provider;

d. A summary of findings from each component and facility inspected;

e. A list of noncompliance issues, if any, with rule references and a request that the provider submit a plan for corrective action, including required completion dates;

f. Recommendations for issuing a probationary, a regular, or an interim license and recommendations regarding other actions permitted under Chapter 397, F.S.; and

g. The name and title of each authorized agent of the department.

6. Distribution of Licenses and Notices. For new and renewal applications, district offices shall send providers an original signed license along with the written notice as described in subparagraph 4. Additionally, any adverse action by district offices (e.g., issuance of an interim license, license suspension, denial, or revocation, or fine or moratorium) shall be accompanied by notice of the right of appeal as required by Chapter 120, F.S.

7. Content of Licensing Records. The district offices shall maintain current licensing files on each provider licensed under Chapter 397, F.S. The contents of the files shall include those items listed under paragraphs 65D-30.003(6)(a)-(k) and subparagraph 65D-30.003(9)(a)5., F.A.C.

8. Listing of Licensed Providers. The district offices shall maintain a current listing of all

licensed providers by components, with license expiration dates.

9. Complaint Log. The district offices shall maintain a log of complaints regarding providers. The log shall include the date the complaint was received, dates review was initiated and completed, and all findings, penalties imposed, and other information relevant to the complaint.

(b) Substance Abuse Program Office Licensing Procedures.

1. Records. The Substance Abuse Program Office shall maintain a record of all licensed providers.

2. Monitoring. The Substance Abuse Program Office shall monitor the implementation of the licensing process from a statewide perspective and analyze provider performance relative to the results of licensing reviews.

(10) Closing a Licensed Provider. Providers shall notify the department in writing at least 30 days prior to voluntarily ceasing operation. If a provider, facility, or component is ordered closed by a court of competent jurisdiction pursuant to subsection 397.415(4), F.S., the provider shall maintain possession of all its records until the court order becomes final. The provider remains responsible for giving the department access to its records. In the interim, the provider, with the department's assistance, shall attempt to place all active clients in need of care with other providers. The department shall provide assistance in placing clients. The provider shall return its license to the department by the designated date of closure.

(11) Department Recognition of Accrediting Organizations. The Rehabilitation Accreditation Commission, also known as CARF, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA), and the National Committee on Quality Assurance are department recognized accrediting organizations. Organizations not specified in Chapter 397, F.S., and that desire department recognition shall submit a request in writing to the department. The request shall be made in writing to the Director for Substance Abuse who shall respond in writing to the organization's chief executive officer denying or granting recognition. The department shall maintain a list of recognized organizations. An organization must meet the following criteria in order to be considered for recognition by the department.

(a) The organization shall be recognized by the National Committee on Quality Assurance as an accrediting body for behavioral healthcare services.

(b) The accrediting organization shall have fees and standards which apply to substance abuse services. These standards shall incorporate administrative, clinical, medical, support, and environmental management standards.

(c) The accrediting organization shall have written procedures detailing the survey and accreditation process.

(12) Department Recognition of Certifying Organizations for Addiction Professionals.

(a) An organization which desires recognition by the department as a certifying organization for addiction professionals shall request such approval in writing from the department. Organizations seeking approval shall be non-profit and governed by a Board of Directors that is representative of the population it intends to certify and shall include specific requirements which applicants must meet to be certified as addiction professionals. An organization seeking recognition must include in its certification protocol:

1. Six thousand hours of direct experience as a substance abuse counselor under the supervision of a qualified professional, within the 10 years preceding the application for certification;

2. Three hundred hours of specific supervision under a qualified professional in the core function areas, as described in the International Certification and Reciprocity Consortium role delineation study;

3. Contact education as follows:

a. For certification as a certified addiction professional, 145 hours of addiction counseling education and 125 hours of counseling education;

b. For certification as a certified criminal justice addiction professional, 100 hours in criminal justice education, 90 hours in addiction education, and 80 hours of counseling education;

c. For certification as a certified addiction prevention professional, 200 hours in prevention and early intervention education and 100 hours of addiction education; and

d. For all applicants for certification, 30 hours of ethics, 4 hours of HIV/AIDS, and 2 hours of domestic violence.

4. Completion of the International Certification Reciprocity Consortium written examinations based on a national role delineation study of alcohol and drug abuse counselors;

5. Case presentations which include the development of a case in writing and an oral presentation before a panel of certified counselors; and

6. Continuing education requiring a minimum of 20 continuing education units (CEUs) annually by providers approved by the certifying organization.

(b) Certifying organizations which meet the requirements in paragraph (a) may request review by the department. The request shall be made in writing to the Director for Substance Abuse who shall respond in writing to the organization's chief executive officer denying or granting recognition.

(13) Approval of Overlay Services.

(a) Qualifying as Overlay Services. A provider that is licensed under Chapter 397, F.S., to provide day or night treatment, intensive outpatient treatment, outpatient treatment, aftercare, intervention, or prevention Level 2, is permitted to deliver those component services at locations which are leased or owned by an organization other than the provider. The aforementioned component services may be delivered under the authority of the provider's current license for that component service so that the alternate location will not require a license. To qualify, overlay services shall be provided on a regular or routine basis over time, at an agreed upon location.

(b) Procedure for Approving Overlay Services.

1. The provider shall submit a request to provide overlay services to the department along with:

a. A description of the services to be provided;

b. The manner in which services will be provided;

c. The number of days each week and the number of hours each day each service will be provided;

d. How services will be supervised; and

e. The location of the services.

2. The department shall notify the provider within 30 days of receipt of the request to

provide overlay services of its decision to approve or deny the request and, in the case of denial, reasons for denying the request in accordance with subparagraph 3.

3. The department reserves shall deny the request to provide overlay services if it determines that the provider did not address the specific items in subparagraph 1., or is currently operating under less than an interim license.

4. In those cases where the request to provide overlay services is approved, the department shall add to the provider's current license application, the information required in subparagraph 1., and clearly specify the licensed component that will be provided as overlay.

(c) Special Requirements.

1. Services delivered at the alternate site must correspond directly to those permitted under the provider's current license.

2. Information on each client involved in an overlay service must be maintained in a manner that complies with current licensing requirements.

3. Overlay services are subject to all requirements of the corresponding level of licensure, and are subject to inspection by the department.

4. Overlay services may only be provided within the geographical boundaries of the department's district office that issued the license.

(14) Licensing of Private Practices. The following shall apply to private practices that are not exempt from licensing pursuant to Chapter 397, F.S. Such practices shall:

(a) Comply with the requirements found in Rule 65D-30.004, F.A.C., and are permitted to operate pursuant to Rules 65D-30.009, 65D-30.0091, 65D-30,010, 65D-30.011, 65D-30.012, and 65D-30.013, F.A.C;

(b) Be exempt from subparagraphs 65D-30.004(4)(a)1.-4., F.A.C., if the private practice is operated out of shared office space where there is no employee/employer relationship; and

(c) Provide services only as permitted by the authority granted by statute and Chapter 65D-30, F.A.C., and will be prohibited from providing services outside the scope of the statute and these rules.

(15) Licensing of Department of Juvenile Justice Commitment Programs and Detention Facilities. In those instances where substance abuse services are provided within Juvenile Justice Commitment Programs and detention facilities, such services may be provided in accordance with any one of the four conditions described below.

The services must be provided in a facility that is licensed under Chapter 397, F.S., for the appropriate licensable service component as defined in subsection 65D-30.002(16), F.A.C.

The services must be provided by employees of a service provider licensed under Chapter 397, F.S.

(c) The services must be provided by employees of the commitment program or detention facility who are qualified professionals licensed under Chapters 458, 459, 490, or 491, F.S.

(d) The services must be provided by an individual who is an independent contractor who is licensed under Chapters 458, 459, 490, or 491, F.S.

(16) Licensing of Department of Corrections Inmate Substance Abuse Programs. Inmate substance abuse services shall be provided within inmate facilities operated by or under contract with the Department of Corrections as specifically provided for in these rules. The

inmate facility is licensed under Chapter 397, F.S., in accordance with the requirements in Rule 65D-30.004, F.A.C., and the appropriate component under Rules 65D-30.007, 65D-30.009, 65D-30.0091, 65D-30.010, 65D-30.011, 65D-30.012, or 65D-30.013 F.A.

Appendix R: Common Licensing Standards

65D-30.004, F.A.C.

(1) Operating Procedures. Providers shall demonstrate organizational capability through a written, indexed system of policies and procedures that are descriptive of services and the population served. All staff shall have a working knowledge of the operating procedures. These operating procedures shall be available for review by the department

(2) Quality Assurance. Providers shall have a quality assurance program which complies with the requirements established in Section 397.419, F.S., and which ensures the use of a continuous quality improvement process.

(3) Provider Governance and Management

(a) Governing Body. Any provider that applies for a license, shall be a legally constituted entity. Providers that are government-based and providers that are for-profit and not-for-profit, as defined in Section 397.311, F.S., shall have a governing body that shall set policy for the provider. The governing body shall maintain a record of all meetings where business is conducted relative to provider operations. These records shall be available for review by the department.

(b) Insurance Coverage. In regard to liability insurance coverage, providers shall assess the potential risks associated with the delivery of services to determine the amount of coverage necessary and shall purchase policies accordingly.

(c) Chief Executive Officer. The governing body shall appoint a chief executive officer. The qualifications and experience required for the position of chief executive officer shall be defined in the provider's operating procedures. Documentation shall be available from the governing body providing evidence that a background screening has been completed in accordance with Chapter 397, F.S., and Chapter 435, F.S., and there is no evidence of a disqualifying offense. Providers shall notify the district office in writing when a new chief executive officer is appointed.
Inmate Substance Abuse Programs operated directly by the Department of Corrections are exempt from the requirements of this paragraph. Juvenile Justice Commitment Programs and detention facilities operated by the Department of Juvenile Justice, are exempt from the requirements of this paragraph.

(4) Personnel Policies. Personnel policies shall address recruitment and selection of prospective employees, promotion and termination of staff, ethical conduct, confidentiality of client records, attendance and leave, employee grievance, non-discrimination, and the orientation of staff to the agency's universal infection control procedures. Providers shall also have a drug-free workplace policy for employees and prospective employees.

(a) Personnel Records. Records on all personnel shall be maintained. Each personnel record shall contain:

1. The individual's current job description with minimum qualifications for the position;
2. The employment application;
3. The employee's annual performance appraisal;
4. A signed document indicating that the employee has received new staff orientation and understands the personnel policies, the infectious disease risk of working in the agency, the provider's universal infection

control procedures, standards of ethical conduct including sexual harassment, abuse reporting procedures, and policies regarding client rights and confidentiality;
5. A verified or certified copy of degrees, licenses, or certificates of each employee;
6. Documentation of employee screening as required in paragraph (b); and
7. Documentation of required staff training (Inmate Substance Abuse Programs operated by the Department of Corrections are exempt from the provisions of this subparagraph).

(b) Screening of Staff. Owners, chief financial officers, and directors, and staff, volunteers, and host families who have direct contact with clients as provided for under Section 397.451, F.S., shall be fingerprinted and have a background check completed. In addition, individuals shall be re-screened within 5 years from the date of employment. Re-screening shall include a level II screening in accordance with Chapter 435, F.S.
Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the requirements in this paragraph.

(5) Standards of Conduct. Providers shall establish written rules of conduct for clients. Rules on client conduct shall be given to each client during orientation.

(6) Medical Director. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, and medication and methadone maintenance treatment. Providers shall designate a medical director who shall oversee all medical services. The medical director's responsibilities shall be clearly described. The provider shall notify the district office in writing when there is a change in the medical director and provide proof that the new medical director holds a current license in the state of Florida. In those cases where a provider operates components that are not identified in this subsection, the provider shall have access to a physician who will be available to consult on any medical services required by clients involved in those components and as required by these rules.

(7) Medical Services.
(a) Medical Protocol. For those components identified in subsection 65D-30.004(6), F.A.C., each physician working with a provider shall establish written protocols for the provision of medical services pursuant to Chapters 458 and 459, F.S., and for managing medication according to medical and pharmacy standards, pursuant to Chapter 465, F.S. Such protocols will be implemented only after written approval by the Chief Executive Officer and medical director. The medical protocols shall also include:

1. The manner in which certain medical functions may be delegated to Advanced Registered Nurse Practitioners and Physician's Assistants in those instances where these practitioners are utilized as part of the clinical staff;
2. Issuing orders; and
3. Signing and countersigning results of physical health assessments.

All medical protocols shall be reviewed and approved by the medical director and Chief Executive Officer on an annual basis and shall be available for review by the department.

(b) Emergency Medical Services. All licensed providers shall describe the manner in which medical emergencies shall be addressed.

Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the requirements of subsection 65D-30.004(7), F.A.C., but shall provide such services as required by Chapter 33-19, F.A.C., titled Health Services. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile

Justice are exempt from the requirements of this subsection but shall provide such services as required in the policies, standards, and contractual conditions established by the Department of Juvenile Justice.

(8) State Approval Regarding Prescription Medication. In those instances where the provider utilizes prescription medication, medications shall be purchased, handled, administered, and stored in compliance with the State of Florida Board of Pharmacy requirements for facilities which hold Modified Class II Institutional Permits and in accordance with Chapter 465, F.S. This shall be implemented in consultation with a state-licensed consultant pharmacist, and approved by the medical director. The provider shall ensure that policies implementing this subsection are reviewed and approved annually by a state-licensed consultant pharmacist.

Inmate Substance Abuse programs operated by or under contract with the Department of Corrections are exempt from the requirements of this subsection but shall provide such services as required by Chapter 465, F.S. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements of this subsection, but shall provide such services as required by Chapter 465, F.S.

(9) Universal Infection Control. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, and medication and methadone maintenance treatment.

(a) Plan for Exposure Control.

1. A written plan for exposure control regarding infectious diseases shall be developed and shall apply to all staff, volunteers, and clients. The plan shall be initially approved and reviewed annually by the medical director or consulting physician. The plan shall be in compliance with Chapters 381 and 384, F.S., and Chapters 64D-2 and 64D-3, F.A.C.
2. The plan shall be consistent with the protocols and facility standards published in the Federal Center for Disease Control Guidelines and Recommendations for Infectious Diseases, Long Term Care Facilities.

(b) Required Services. The following Universal Infection Control Services shall be provided:

1. Risk assessment and screening for both client high-risk behavior and symptoms of communicable disease as well as actions to be taken on behalf of clients identified as high-risk and clients known to have an infectious disease;
2. HIV and TB testing and HIV pre-test and post-test counseling to high-risk clients, provided directly or through referral to other healthcare providers which can offer the services; and
3. Reporting of communicable diseases to the Department of Health in accordance with Sections 381.0031 and 384.25, F.S.

Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the requirements of this subsection but shall provide such services as required by Chapter 945, F.S., titled Department of Corrections. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements of this subsection but shall provide such services as required in the policies, standards, and contractual conditions established by the Department of Juvenile Justice.

(10) Universal Infection Control Education Requirements for Employees

and Clients. Providers shall meet the educational requirements for HIV and AIDS pursuant to Section 381.0035, F.S., and all infection prevention and control educational activities shall be documented.
Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the requirements of this subsection but shall provide such services as required by Chapter 945, F.S., titled Department of Corrections. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements of this subsection but shall provide such services as required in the policies, standards, and contractual conditions established by the Department of Juvenile Justice.

(11) Meals. At least three meals per day shall be provided to clients in addictions receiving facilities, residential detoxification, residential treatment, and day or night treatment with host homes. In addition, at least one snack shall be provided each day. For day or night treatment, the provider shall make arrangements to serve a meal to those clients involved in services a minimum of five hours at any one time. Clients with special dietary needs shall be reasonably accommodated. Under no circumstances may food be withheld for disciplinary reasons. The provider shall document and ensure that nutrition and dietary plans are reviewed and approved by a Florida registered dietitian at least annually.

Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the requirements of this subsection but shall provide such services as required by Chapter 33-204, F.A.C., titled Food Services. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements of this subsection but shall provide such services as required in the policies, standards, and contractual conditions established by the Department of Juvenile justice.

(12) Client/Participant Records.
(a) Record Management System. Client/participant records shall be kept secure from unauthorized access and maintained in accordance with 42 Code of Federal Regulations, Part 2 and subsection 397.501(7), F.S. Providers shall have record management procedures regarding content, organization, and use of records. The record management system shall meet the following additional requirements.

1. Original client records shall be signed in ink and by hand.
2. Record entries shall be legible.
3. In those instances where records are maintained electronically, a staff identifier code will be accepted in lieu of a signature.
4. Documentation within records shall not be deleted.
5. Amendments or marked-through changes shall be initialed and dated by the individual making such changes.

(b) Record Retention and Disposition. In the case of individual client/participant records, records shall be retained for a minimum of seven years. The disposition of client/participant records shall be carried out in accordance with Title 42, Code of Federal Regulations, Part 2, and subsection 397.501(7), F.S. In addition, records shall be maintained in accordance with Children and Families Operating Procedures (CFOP) 15-4, Records Management, and Children and Families Pamphlet (CFP) 15-7, Records Retention Schedule used by Children and Families, incorporated herein by reference. Copies of CFOP 15-4 and CFP 15-7 may be obtained from the Department of Children and Families, Substance Abuse Program Office, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700.

Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the time period specified for the retention of records and from applying the Children and Families Operating Procedures (CFOP) 15-4, Records Management, and Children and Families Pamphlet (CFP) 15-7, Records Retention Schedule. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements found in the Children and Families Operating Procedures (CFOP) 15-4, Records Management, and the Children and Families Pamphlet (CFP) 15-7, Records Retention Schedule.

(c) Information Required in Client/Participant Records.

1. The following applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, and medication and methadone maintenance treatment. Information shall include:

a. Name and address of the client and referral source;
b. Screening information;
c. Voluntary informed consent for treatment or an order to treatment for involuntary admissions and for criminal and juvenile justice referrals;
d. Informed consent for a drug screen, when conducted;
e. Informed consent for release of information;
f. Documentation of client orientation;
g. Physical health assessment;
h. Psychosocial assessment, except for detoxification;
i. Diagnostic services, when provided;
j. Client placement information;
k. Abbreviated treatment plan, for addictions receiving facilities and detoxification;
l. Initial treatment plans, where indicated, and treatment plans, and subsequent reviews, except for addictions receiving facilities and detoxification;
m. Progress notes;
n. Record of disciplinary problems, when they occur;
o. Record of ancillary services, when provided;
p. Record of medical prescriptions and medication, when provided;
q. Reports to the criminal and juvenile justice systems, when provided;
r. Copies of service-related correspondence, generated or received by the provider, when available;
s. Transfer summary, if transferred; and
t. A discharge summary.

In the case of medical records developed and maintained by the Department of Corrections on inmates participating in inmate substance abuse programs, such records shall not be made part of information required in subparagraph 1. Such records shall be made available to authorized agents of the department only on a need-to-know basis.

2. The following applies to aftercare. Information shall include:

a. A description of the client's treatment episode;
b. Informed consent for services;
c. Informed consent for drug screen, when conducted;
d. Informed consent for release of information;
e. Aftercare plan;
f. Documentation assessing progress;
g. Record of disciplinary problems, when they occur;
h. Record of ancillary services, when provided;
i. A record of medical prescriptions and medication, when provided;
j. Reports to the criminal and juvenile justice systems, when provided;

~~k.~~ Copies of service-related correspondence, generated or received by the provider;
l. Transfer summary, if transferred; and
m. A discharge summary.

3. The following applies to intervention. Information shall include:

a. Name and address of client and referral source;
b. Screening information;
c. Informed consent for services;
d. Informed consent for a drug screen, when conducted;
e. Informed consent for release of information;
f. Client placement information, with the exception of case management;
g. Intervention plan, when required;
h. Summary notes;
i. Record of disciplinary problems, when they occur;
j. Record of ancillary services, when provided;
k. Reports to the criminal and juvenile justice systems, when provided;
l. Copies of service-related correspondence, generated or received by the provider;
m. A transfer summary, if transferred; and
n. A discharge summary.

4. The following applies to Level II prevention. Information shall include:

a. Identified risk and protective factors for the target population;
b. Record of activities including description, date, duration, purpose, and location of service delivery;
c. Tracking of individual participant attendance;
d. Individual demographic identifying information;
e. Informed consent for services;
f. Prevention plan;
g. Summary notes;
h. Informed consent for release of information;
i. Completion of services summary of participant involvement and follow-up information; and
j. Transfer summary, if referred to another placement.

(13) Screening. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, medication and methadone maintenance treatment, and intervention.

(a) Determination of Appropriateness and Eligibility for Placement. The condition and needs of the client shall dictate the urgency and timing of screening. For example, in those cases involving an involuntary placement, screening may occur after the client has been placed in a component such as detoxification. Persons requesting services shall be screened to determine appropriateness and eligibility for placement or other disposition. The person conducting the screening shall document the rationale for any action taken.

(b) Consent for Drug Screen. If required by the circumstances pertaining to the client's need for screening, or dictated by the standards for a specific component, clients shall give informed consent for a drug screen.

(c) Consent for Release of Information. Consent for the release of information shall include information required in 42 Code of Federal Regulations, Part 2., and may be signed by the client only if the form is complete.

(d) Consent for Services. A consent for services form shall be signed by the client prior to or upon placement, with the exception of involuntary placements.

(14) Assessment. Each client placed into an addictions receiving facility, detoxification, residential treatment, day or

night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, and medication and methadone maintenance treatment shall undergo an assessment of the nature and severity of their substance abuse problem. The assessment shall include a physical health assessment and a psychosocial assessment.

(a) Physical Health Assessment. Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the requirements of this paragraph but shall provide such services as required in Chapter 33-19, F.A.C., titled Health Services. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements of this subsection but shall provide such services as required in the policies, standards, and contractual conditions established by the Department of Juvenile Justice.

1. Nursing Physical Screen. A nursing physical screen shall be completed on each person considered for placement in an addictions receiving facility or a detoxification component. The screen shall be completed by an R.N. or by an L.P.N. and countersigned by an R.N. The results of the screen shall be documented by the nurse providing the service and signed and dated by that person. If the nursing physical screen is completed in lieu of a medical history, further action shall be in accordance with the medical protocol established under subsection 65D-30.004(7), F.A.C.

2. Medical History. A medical history shall be completed on each client.
a. For residential treatment, day or night treatment with host homes, and medication and methadone maintenance treatment, the history shall be completed within 30 calendar days prior to placement, or within one calendar day of placement.
b. For day or night treatment, intensive outpatient treatment, and ~~for~~ outpatient treatment, a medical history shall be completed within 30 calendar days prior to or upon placement.

For the components identified in sub-subparagraph a., the medical history shall be completed by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. Further, the history shall be reviewed, signed and dated by the physician in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. For the components identified in sub-subparagraph b., the medical history shall be completed by the client or the client's legal guardian. For all components, the medical history shall be maintained in the client record and updated annually if a client remains in treatment for more than 1 year.

3. Physical Examination. A physical examination shall be completed on each client.
a. For addictions receiving facilities and ~~for~~ detoxification, the physical examination shall be completed within 7 calendar days prior to placement or 2 calendar days after placement.
b. For residential treatment and ~~for~~ day or night treatment with host homes, the physical examination shall be completed within 30 calendar days prior to placement or 10 calendar days after placement.
c. For medication and methadone maintenance treatment, the physical examination shall be completed prior to administration of the initial dose of methadone. In emergency situations the initial dose may be administered prior to the examination. Within 5 calendar days of the initial dose, the physician shall document in the client record the circumstances that prompted the emergency administration of methadone and sign and date these entries.

For components identified in sub-subparagraphs a.-c., the physical

examination shall be completed by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. Further, the examination shall be reviewed, signed and dated by the physician in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C.

4. Laboratory Tests. Clients shall provide a sample for testing blood and urine, including a drug screen.
a. For addictions receiving facilities, detoxification, residential treatment, and day or night treatment with host homes, all laboratory tests will be performed in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. Further, the results of the laboratory tests shall be reviewed, signed and dated during the assessment process and in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C.
b. For medication and methadone maintenance treatment, blood and urine samples shall be taken within 7 calendar days prior to placement or 2 calendar days after placement. A drug screen shall be conducted at the time of placement. If there are delays in the procedure, such as problems in obtaining a blood sample, this shall be documented by a licensed nurse in the client record. The initial dose of medication may be given before the laboratory test results are reviewed by the physician. The results of the laboratory test shall be reviewed, signed and dated by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C.

5. Pregnancy Test. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, and medication and methadone maintenance treatment. Female clients shall be evaluated by a physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C., to determine the necessity of a pregnancy test. In those cases where it is determined necessary, clients shall be provided testing services directly or by referral as soon as possible following placement.

6. Tests For Sexually Transmitted Diseases and Tuberculosis. A serological test for sexually transmitted diseases and a screening test for tuberculosis to determine the need for a Mantoux test shall be conducted on each client.
a. For residential treatment and day or night treatment with host homes, tests will be conducted within the time frame specified for the physical examination. The results of both tests shall be reviewed and signed and dated by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C., and filed in the client record.
b. For medication and methadone maintenance treatment, the tests will be conducted at the time samples are taken for other laboratory tests. Positive results shall be reviewed and signed and dated by a physician, or in accordance with the medical protocol established in subsection 65D-30.004(7)., F.A.C.

7. Special Medical Problems. Particular attention shall be given to those clients with special medical problems or needs. This would include referral for medical services. A record of all such referrals shall be maintained in the client record.

8. Additional Requirements for Residential Treatment and Day or Night Treatment with Host Homes. If a client is readmitted within 90 calendar days of discharge to the same provider, a physical examination shall be conducted as prescribed by the physician. If a client is readmitted to the same provider after 90 calendar days of the discharge date, the client shall receive a complete physical examination.

9. Additional Requirements for Medication and Methadone Maintenance Treatment.

a. The client's current addiction and history of addiction shall be recorded in the client record by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. In any case, the record of the client's current addiction and history of addiction shall be reviewed, signed and dated by the physician, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C.

b. A physical examination shall be conducted on clients who are placed directly into treatment from another provider unless a copy of the examination accompanies the client and the examination has been completed within the year prior to placement. In those instances where a copy of the examination is not provided because of circumstances beyond the control of the referral source, the physician shall conduct a physical examination within 5 calendar days of placement.

(b) Psychosocial Assessment.

Information Required. The psychosocial assessment shall include the client's history as determined through an assessment of the items in sub-subparagraphs a.- l. as follows:

a. Emotional or mental health;
b. Level of substance abuse impairment;
c. Family history, including substance abuse by other family members;
d. The client's substance abuse history, including age of onset, choice of drugs, patterns of use, consequences of use, and types and duration of, and responses to, prior treatment episodes;
e. Educational level, vocational status, employment history, and financial status;
f. Social history and functioning, including support network, family and peer relationships, and current living conditions;
g. Past or current sexual, psychological, or physical abuse or trauma;
h. Client's involvement in leisure and recreational activities;
i. Cultural influences;
j. Spiritual or values orientation;
k. Legal history and status;
l. Client's perception of strengths and abilities related to the potential for recovery; and
m. A clinical summary, including an analysis and interpretation of the results of the assessment, as described in sub-subparagraphs a.-l.

2. Requirements for Components. Any psychosocial assessment that is completed within 30 calendar days prior to placement in any component identified in sub-subparagraphs a.-e.may be accepted by the provider placing the client. Otherwise, the psychosocial assessment shall be completed according to the following schedule.

a. For addictions receiving facilities, the psychosocial assessment shall be completed within 3 calendar days of placement, unless clinically contraindicated.
b. For residential treatment level 1, the psychosocial assessment shall be completed within 5 calendar days of placement.
c. For residential treatment levels 2, 3, 4, 5, day or night with host homes, and day or night treatment, the psychosocial assessment shall be completed within 10 calendar days of placement.
~~d.~~ For intensive outpatient treatment and outpatient treatment, the psychosocial assessment shall be completed within 30 calendar days of placement
e. For medication and methadone maintenance treatment, the psychosocial assessment shall be completed within 15 calendar days of placement.

3. Psychosocial Assessment Sign-off Requirements. The psychosocial assessment shall be completed by clinical staff and signed and dated. If the

psychosocial assessment was not completed initially by a qualified professional, the psychosocial assessment shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion. Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections, shall conduct the review and sign-off within 30 calendar days.

4. Psychosocial Assessment Readmission Requirements. In those instances where a client is readmitted to the same provider for services within 180 calendar days of discharge, a psychosocial assessment update shall be conducted, if clinically indicated. Information to be included in the update shall be determined by the qualified professional. A new assessment shall be completed on clients who are readmitted for services more than 180 calendar days after discharge. In addition, the psychosocial assessment shall be updated annually for clients who are in continuous treatment for longer than one year.

5. Assessment Requirements Regarding Clients Who are Referred or Transferred.

a. A new psychosocial assessment does not have to be completed on clients who are referred or transferred from one provider to another or referred or transferred within the same provider if the provider meets at least one of the following conditions:

i. The provider or component initiating the referral or transfer forwards a copy of the psychosocial assessment information prior to the arrival of the client;

ii. Clients are referred or transferred directly from a specific level of care to a lower or higher level of care (e.g., from detoxification to residential treatment or outpatient to residential treatment) within the same provider or from one provider to another;

iii. The client is referred or transferred directly to the same level of care (e.g., residential level 1 to residential level 1) either within the same provider or from one provider to another.

b. In the case of referral or transfer from one provider to another, a referral or transfer is considered direct if it was arranged by the referring or transferring provider and the client is subsequently placed with the provider within 7 calendar days of discharge. This does not preclude the provider from conducting an assessment. The following are further requirements related to referrals or transfers.

i. If the content of a forwarded psychosocial does not comply with the psychosocial requirements of this rule, the information will be updated or a new assessment will be completed.

ii. If a client is placed with the receiving provider later than 7 calendar days following discharge from the provider that initiated the referral or transfer, but within 180 calendar days, the qualified professional of the receiving provider will determine the extent of the update needed.

iii. If a client is placed with the receiving provider more than 180 calendar days after discharge from the provider that initiated the referral or transfer, a new psychosocial assessment must be completed.

(c) Special Needs. The assessment process shall include the identification of clients with mental illness and other needs. Such clients shall be accommodated directly or through referral. A record of all services provided directly or through referral shall be maintained in the client record.

(15) Client Placement Criteria and Operating Procedures. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, outpatient treatment, intervention, and medication and methadone maintenance treatment.

Providers shall have operating procedures that clearly state the criteria for admitting, transferring, and discharging clients. This would include procedures for implementing these placement requirements.

(16) Primary Counselor, Orientation, and Initial Treatment Plan. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, and medication and methadone maintenance treatment.

(a) Primary Counselor. A primary counselor shall be assigned to each client placed in a component. This standard does not apply to detoxification and addictions receiving facilities.

(b) Orientation. Prior to or upon placement in a component, clients shall receive orientation. The orientation shall include:

1. A description of services to be provided;
2. Applicable fees;
3. Information on client rights;
4. Parental or legal guardian's access to information and participation in treatment planning;
5. Limits of confidentiality;
6. General information about the provider's infection control policies and procedures;
7. Program rules; and
8. Client grievance procedures.

(c) Initial Treatment Plan. An initial treatment plan shall be completed on each client upon placement, unless an individual treatment plan is completed at that time.
The plan shall specify timeframes for implementing services in accordance with the requirements established for applicable components. The initial treatment plan shall be signed and dated by clinical staff and signed and dated by the client. This standard does not apply to detoxification and addictions receiving facilities.

(17) Treatment Plan, Treatment Plan Reviews, and Progress Notes.

(a) Treatment Plan. Each client shall be afforded the opportunity to participate in the development and subsequent review of the treatment plan. The treatment plan shall include goals and related measurable behavioral objectives to be achieved by the client, the tasks involved in achieving those objectives, the type and frequency of services to be provided, and the expected dates of completion. The treatment plan shall be signed and dated by the person providing the service, and signed and dated by the client. If the treatment plan is completed by other than a qualified professional, the treatment plan shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion. In the case of Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections, the treatment plan shall be reviewed, countersigned, and dated by a qualified professional within 30 calendar days of completion. A written treatment plan shall be completed on each client.

1. For long-term outpatient methadone detoxification and ~~for~~ medication and methadone maintenance treatment, the treatment plan shall be completed prior to or within 30 calendar days of placement.
2. For residential treatment level 1, the treatment plan shall be completed prior to, or within 7 calendar days of placement. For residential treatment levels 2, 3, 4, and 5, and for day or night treatment with host homes, the treatment plan shall be completed prior to or within 15 calendar days of placement.
3. For day or night treatment, the treatment plan shall be completed prior to or within 10 calendar days of placement.
4. For intensive outpatient treatment and outpatient treatment, the treatment plan

shall be completed prior to or within 30 calendar days of placement.

5. For detoxification and addictions receiving facilities, an abbreviated treatment plan, as defined in subsection 65D-30.002(1), F.A.C., shall be completed upon placement. The abbreviated treatment plan shall contain a medical plan for stabilization and detoxification, provision for education, therapeutic activities and discharge planning, and in the case of addictions receiving facilities, a psychosocial assessment.

(b) Treatment Plan Reviews. Treatment plan reviews shall be completed on each client.

1. For residential treatment levels 1, 2, and 3, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, and outpatient treatment, treatment plan reviews shall be completed every 30 calendar days.
2. For residential treatment levels 4 and 5, treatment plan reviews shall be completed every 90 calendar days.
3. For medication and methadone maintenance treatment and long-term outpatient methadone detoxification, treatment plan reviews shall be completed every 90 calendar days for the first year and every 6 months thereafter.

For all components, if the treatment plan reviews are not completed by a qualified professional, the review shall be countersigned and dated by a qualified professional within 5 calendar days of the review.

(c) Progress Notes. Progress notes shall be entered into the client record documenting a client's progress or lack of progress toward meeting treatment plan goals and objectives. When a single service event is documented, the progress note will be signed and dated by the person providing the service. When more than one service event is documented, progress notes may be signed by any clinical staff member assigned to the client. The following are requirements for recording progress notes.

1. For addictions receiving facilities, residential detoxification, outpatient detoxification, short-term residential methadone detoxification, short-term outpatient methadone detoxification, progress notes shall be recorded at least daily.
2. For residential treatment, day or night treatment with host homes, day or night treatment, and long-term outpatient methadone detoxification, progress notes shall be recorded at least weekly.
3. For intensive outpatient treatment and outpatient treatment, progress notes shall be recorded at least weekly or, if contact occurs less than weekly, notes will be recorded according to the frequency of sessions.
4. For medication and methadone maintenance treatment, progress notes shall be recorded according to the frequency of sessions.

(18) Ancillary Services. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, aftercare, and medication and methadone maintenance treatment.

Ancillary services shall be provided directly or through referral in those instances where a provider can not or does not provide certain services needed by a client. The provision of ancillary services shall be based on client needs as determined by the treatment plan and treatment plan reviews. In those cases where clients need to be referred for services, the provider shall use a case management approach by linking clients to needed services and following-up on referrals. All such referrals shall be initiated and coordinated by the client's

primary counselor or other designated clinical staff who shall serve as the client's case manager. A record of all such referrals for ancillary services shall be maintained in the client record, including whether or not a linkage occurred or documentation of efforts to confirm a linkage when confirmation was not received.

(19) Prevention Plan, Intervention Plan, and Summary Notes.

(a) Prevention Plan. For clients involved in Level 2 prevention as described in paragraph 65D-30.013(1)(b), F.A.C., a prevention plan shall be completed within 45 calendar days of placement. Prevention plans shall include goals and objectives designed to reduce risk factors and enhance protective factors. The prevention plan shall be reviewed and updated every 60 calendar days from the date of completion of the plan. The prevention plan shall be signed and dated by staff who developed the plan and signed and dated by the client.

(b) Intervention Plan. For clients involved in intervention on a continuing basis, an intervention plan shall be completed within 45 calendar days of placement. Intervention plans shall include goals and objectives designed to reduce the severity and intensity of factors associated with the onset or progression of substance abuse. The intervention plan shall be reviewed and updated at least every 60 days. The intervention plan shall be signed and dated by staff who developed the plan and signed and dated by the client.

(c) Summary Notes. Summary notes shall be completed in level 2 prevention and intervention services where individual client records are required. Summary notes shall contain information regarding a participant or client's progress or lack of progress in meeting the conditions of the prevention or intervention plans described in paragraphs (a) and (b). Summary notes shall be entered into the client record at least weekly for those weeks in which services are scheduled. Each summary note shall be signed and dated by staff delivering the service.

(20) Record of Disciplinary Problems. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, medication and methadone maintenance treatment, aftercare, and intervention. A record of disciplinary problems encountered with clients and specific actions taken to resolve problems shall be maintained.

(21) Control of Aggression. This applies to all components with the exception of prevention level 1. Providers shall have written documentation of the specific control of aggression technique(s) to be used. Direct care staff shall be trained in control of aggression techniques as required in paragraph 65D-30.004(31)(b), F.A.C. The provider shall provide proof to the department that affected staff have completed training in those techniques. In addition, if the provider uses physical intervention, direct care staff shall receive training in the specific techniques used.

(a) Justification and Documentation of Use. De-escalation techniques shall be employed before physical intervention is used. In the event that physical intervention is used to restrict a client's movement, justification shall be documented in the client record.

(b) Prohibitions. Under no circumstances shall clients be involved in the control of aggressive behavior of other clients. Additionally, aggression control techniques shall not be employed as punishment or for the convenience of staff. Inmate Substance Abuse Programs operated within Department of Corrections facilities are exempt from this requirement.

Juvenile Justice Commitment Programs and detention facilities shall implement this

subsection in accordance with Florida Department of Juvenile Justice Policies and Procedures, policy Number 1508-03, titled Protective Action Response (PAR) Policy that includes policies and procedures on the use of physical force and restraining devices. This policy may be obtained from the Department of Children and Families, Substance Abuse Program Office, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700.

(22) Discharge and Transfer Summaries. This requirement applies to addictions receiving facilities, detoxification, residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, medication and methadone maintenance treatment, aftercare, and intervention.

(a) Discharge Summary. A written discharge summary shall be completed for clients who complete services or who leave the provider prior to completion of services. The discharge summary shall include a summary of the client's involvement in services and the reasons for discharge and the provision of other services needed by the client following discharge, including aftercare. The discharge summary shall be signed and dated by a primary counselor.

(b) Transfer Summary. A transfer summary shall be completed immediately for clients who transfer from one component to another within the same provider and shall be completed within 5 calendar days when transferring from one provider to another. In all cases, an entry shall be made in the client record regarding the circumstances surrounding the transfer and that entry and transfer summary shall be signed and dated by a primary counselor.

(23) Compulsory School Attendance For Minors. Providers which admit juveniles between the ages of 6 and 16 shall comply with Chapter 232, F.S., entitled Compulsory School Attendance; Child Welfare.

(24) Data. Providers shall report data to the department pursuant to paragraph 397.321(3)(c), F.S.

(25) Special In-Residence Requirements. Providers that house males and females together within the same facility shall provide separate sleeping arrangements for these clients. Providers which serve adults in the same facility as persons under 18 years of age shall ensure client safety and programming according to age.

(26) Reporting of Abuse, Neglect, and Deaths. Providers shall adhere to the statutory requirements for reporting abuse, neglect, and deaths of children under Chapter 39, F.S., and of adults under Section 415.1034, F.S., and paragraph 397.501(7)(c), F.S.

(27) Incident Reporting Pursuant to paragraph 397.419(2)(f), F.S. Incident reporting is required of all providers and shall be conducted in accordance with Children and Families Operating Procedure 215-6, incorporated herein by reference. Copies of CFOP 215-6 may be obtained from the Department of Children and Families, Substance Abuse Program office, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700. Incident reporting shall include the following:

(a) A broad definition of "incident" to include medication errors, violations of crucial procedures, and actions resulting in physical injury;

(b) A provision that a written incident report must be filed with the district Alcohol, Drug Abuse, and Mental Health Program Office of the department within 1 calendar day of the incident when an action or inaction has a negative affect on the health or safety of the client, or violates the rights of a client;

(c) Employee training in reporting procedures and requirements that includes the affirmative duty requirements and

protections of Chapter 415, F.S., and Title V of the Americans with Disabilities Act; and

(d) Reporting, tracking, and responding to incidents in accordance with departmental regulation.

(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.

(29) Client Rights. Individuals applying for or receiving substance abuse services are guaranteed the protection of fundamental human, civil, constitutional, and statutory rights, including those specified in subsections 397.501(1)-(10), F.S.

(a) Provisions. Basic client rights shall include:

1. Provisions for informing the client, family member, or authorized guardian of their rights and responsibilities, assisting in the exercise of those rights, and an accessible grievance system for resolution of conflicts;
2. Provisions assuring that a grievance may be filed for any reason with cause;
3. The prominent posting of notices informing clients of the grievance system;
4. Access to grievance submission forms;
5. Education of staff in the importance of the grievance system and client rights;
6. Specific levels of appeal with corresponding time frames for resolution;
7. Timely receipt of a filed grievance;
8. The logging and tracking of filed grievances until resolved or concluded by actions of the provider's governing body;
9. Written notification of the decision to the appellant; and
10. Analysis of trends to identify opportunities for improvement.

(b) Providing Information to Affected Parties. Notification to all parties of these rights shall include affirmation of an organizational non-relationship policy that protects a party's right to file a grievance or express their opinion and invokes applicability of state and federal protections. Providers shall post the number of the abuse hotline, the local Florida Advocacy Council, and the district Alcohol, Drug Abuse, and Mental Health Program Office in a conspicuous place within each facility and provide a copy to each client placed in services.

(c) Implementation of Client Rights Requirements by Department of Corrections. In lieu of the requirements of this subsection, and in the case of Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections, the Department of Corrections shall adhere to the requirements found in Chapter 33-103, F.A.C., titled Inmate Grievances.

(d) Implementation of Client Rights Requirements by Department of Juvenile Justice. In lieu of the requirements of this subsection, and in the case of commitment programs and detention facilities operated by or under contract with the Department of Juvenile Justice, the Department of Juvenile Justice policies regarding client grievances shall be followed.

(30) Client Employment. Providers shall ensure that all work performed by a client is voluntary, justified by the treatment plan, and that all wages, if any, are in accordance with applicable wage and disability laws and regulations.

(31) Training. Providers shall develop and implement a staff development plan. At least one staff member with skill in developing staff training plans shall be assigned the responsibility of ensuring that

staff development activities are implemented. In those instances where an individual has received the requisite training as required in paragraphs (a) and (b) during the year prior to employment by a provider, that individual will have met the training requirements. This provision applies only if the individual is able to produce documentation that the training was completed and that such training was provided by persons who or organizations that are qualified to provide such training.

(a) Training Requirements for New Staff. Each new employee must have two hours of HIV/AIDS training within the first six months of employment. This training must also be provided for no less than two hours every two years.

(b) Training Requirements for New Direct Care Staff. For those staff working in component services identified in subsection 65D-30.004(21), F.A.C., two hours of training in control of aggression techniques must occur within the first six months of employment and two hours annually thereafter. In addition, all new direct care staff shall have CPR training within the first six months of employment.

(c) Training Requirements for New Clinical Staff. All new clinical staff who work at least 20 hours per week or more must receive 20 hours of educational and competency-based training within the first year. Training may include HIV/AIDS and control of aggression techniques.

(d) Special Training Requirements for Prevention. In addition to paragraphs (a) and (b), new staff providing prevention services shall receive basic training in science-based prevention within the first year of employment. Prevention staff shall receive additional training related to their duties and responsibilities for a total of 20 hours, inclusive of the topics listed in this subsection.

(e) General Training Requirements. All staff and volunteers who provide clinical or prevention services and whose work schedule is at least 20 hours per week or more, shall participate in a minimum of 16 hours of documented training per year related to their duties and responsibilities. Persons who are licensed or certified are exempt from the training requirements in this paragraph providing they have proof of documentation of certified education units and any training that is required by their discipline.

(32) Clinical Supervision. A qualified professional shall supervise ~~all~~ clinical services, as permitted within the scope of their qualifications. In the case of medical services, medical staff may provide supervision within the scope of their license. Supervisors shall conduct regular reviews of work performed by subordinate employees.

(33) Scope of Practice. Unless licensed under Chapters 458, 459, 464, 490 or 491, F.S., non-medical employees providing clinical services specific to substance abuse are limited to the following tasks:

a. Screening;
b. Psychosocial assessment;
c. Treatment planning;
d. Referral;
e. Service coordination and case management;
f. Consultation;
g. Continuing assessment and treatment plan reviews;
h. Counseling, including;
1. Individual counseling;
2. Group counseling; and
3. Counseling with families, couples, and significant others;
i. Client, family, and community education;
ii. Documentation of progress; and
iii. Any other tasks permitted in these rules and appropriate to that licensable component.

(34) Facility Standards. Facility standards in paragraphs (a)-(k) apply to addictions

receiving facilities, residential detoxification facilities, and residential treatment facilities. Facility standards in paragraphs (f)-(k) apply to medication and methadone maintenance treatment.

(a) Grounds. Each facility and its grounds shall be designed to meet the needs of the clients served, the service objectives, and the needs of staff and visitors. Providers shall afford each client access to the outdoors. Access may be restricted in those cases where the client presents a clear and present danger to self or others or is at risk for elopement.

(b) Space and Equipment. Provisions shall be made to ensure that adequate space and equipment are available for all of the service components of the facility, and the various functions within the facility.

(c) Personal Possessions. Provisions shall be made which will ensure that clients have access to individual storage areas for clothing and personal possessions.

(d) Laundry Facilities. Laundry facilities or services shall be available which ensure the availability of clean clothing, bed linens, and towels.

(e) Personal Hygiene. Items of personal hygiene shall be provided if the client is unable to provide these items.

(f) Safety. Providers shall ensure the safety of clients, staff, visitors, and the community to the extent allowable by law.

(g) Managing Disasters. Providers shall have written plans for managing and preventing damage and injury arising from internal and external disasters. Providers shall review these plans at least annually. Providers shall be prepared to handle internal and external disasters such as natural and man-made disasters. The written plan shall incorporate evacuation procedures and shall be developed with the assistance of qualified experts. All such plans shall be provided to the district office upon request. Providers shall conduct at least one disaster drill every year.

(h) Housekeeping and Maintenance. Provisions shall be made to ensure that housekeeping and maintenance services are capable of keeping the building and equipment clean and in good repair.

(i) Hazardous Conditions. Buildings, grounds, equipment, and supplies shall be maintained, repaired, and cleaned so that they are not hazardous to the health and safety of clients, staff, or visitors.

(j) Hazardous Materials. Providers shall ensure that hazardous materials are properly identified, handled, stored, used, and dispensed.

(k) Compliance with Local Codes. All licensed facilities used by a provider shall comply with fire and safety standards enforced by the State Fire Marshall, pursuant to Section 633.022, F.S., rules established pursuant to Rule 4A-44.012, F.A.C., and with health, and zoning codes enforced at the local level. All providers shall update and have proof of compliance with local fire and safety and health inspections annually. Inmate Substance Abuse Programs operated within Department of Corrections facilities are exempt from this requirement

(35) Offender Referrals Under Chapter 397, F.S.

(a) Authority to Refer. Any offender, including any minor, who is charged with or convicted of a crime, is eligible for referral to a provider. The referral may be from the court or from the criminal or juvenile justice authority which has jurisdiction over that offender, and may occur prior to, in lieu of, or in addition to, final adjudication, imposition of penalty or sentence, or other action.

(b) Referral Information. Referrals shall be in writing and signed by the referral source.

(c) Provider Responsibilities.

1. If the offender is not appropriate for placement by the provider, this decision must immediately be communicated to the referral source and documented in writing within 24 hours, stating reasons for refusal.
2. The provider, after consultation with the referral source, may discharge the offender to the referral source.
3. When an offender is successful or unsuccessful in completing treatment or when the commitment period expires, the provider shall communicate this to the referral source.

(d) Assessment of Juvenile Offenders.

1. Each juvenile offender referred by the court and the Department of Juvenile Justice shall be assessed to determine the need for substance abuse services.
2. The court and the Department of juvenile Justice, in conjunction with the department, shall establish procedures to ensure that juvenile offenders are assessed for substance abuse problems and that diversion and adjudication proceedings include conditions and sanctions to address substance abuse problems. These procedures must address:
   a. Responsibility of local contracted providers for assessment;
   b. The role of the court in handling non-compliant juvenile offenders; and
   c. Priority Services.
3. Families of the juvenile offender may be required by the court to participate in the assessment process and other services under the authority found in Chapter 985, F.S.

(36) Voluntary and Involuntary Placement Under Chapter 397, F.S., Parts IV and V.

(a) Eligibility Determination.

1. Voluntary Placement. To be considered eligible for treatment on a voluntary basis, an applicant for services must meet diagnostic criteria for substance abuse related disorders.
2. Involuntary Placement. To be considered eligible for services on an involuntary basis, a person must meet the criteria for involuntary placement as specified in Section 397.675, F.S.

(b) Provider Responsibilities Regarding Involuntary Placement.

1. Persons who are involuntarily placed shall be served only by licensed service providers as defined in subsection 397.311(19), F.S., and only in those components permitted to admit clients on an involuntary basis.
2. Providers which accept involuntary referrals must provide a description of the eligibility and diagnostic criteria and the placement process to be followed for each of the involuntary placement procedures described under Sections 397.677, 397.679, 397.6798, 397.6811, and 397.693, F.S.
3. Clients shall be referred to more appropriate services if the provider determines that the person should not be placed or should be discharged. Such referral shall follow the requirements found in paragraphs 397.6751(2)(a)(b)(c) and 397.6751(3)(a)(b), F.S. The decision to refuse to admit or to discharge shall be made by a qualified professional. Any attempts to contact the referral source must be made in accordance with Title 42, Code of Federal Regulations, Part 2.
4. In those cases in which the court ordering involuntary treatment includes a requirement in the court order for notification of proposed release, the provider must notify the original referral source in writing. Such notification shall comply with legally defined conditions and timeframes and conform to

confidentiality regulations found in Title 42, Code of Federal Regulations, Part 2, and subsection 397.501(7), F.S.

(c) Assessment Standards for Involuntary Treatment Proceedings. Providers that make assessments available to the court regarding hearings for involuntary treatment must define the process used to complete the assessment. This includes specifying the protocol to be utilized, the format and content of the report to the court, and the internal procedures used to ensure that assessments are completed and submitted within legally specified timeframes. For persons assessed under an involuntary order, the provider shall address the means by which the physician's review and signature for involuntary assessment and stabilization and the signature of a qualified professional for involuntary assessments only, will be secured. This includes the process that will be used to notify affected parties stipulated in the petition.

(d) Provider Initiated Involuntary Admission Petitions. Providers are authorized to initiate petitions under the involuntary assessment and stabilization and involuntary treatment provisions when that provider has direct knowledge of the respondent's substance abuse impairment or when an extension of the involuntary admission period is needed. Providers shall specify the circumstances under which a petition will be initiated and the means by which petitions will be drafted, presented to the court, and monitored through the process. This shall be in accordance with Title 42, Code of Federal Regulations, Part 2. The forms to be utilized and the methods to be employed to ensure adherence to legal timeframes shall be included in the procedures.

(37) Persons with a Dual Diagnosis of Substance Abuse and Psychiatric Problems. Providers shall develop and implement operating procedures for serving or arranging services for persons with dual diagnosis disorders.

Licensure Fees

	Publicly Funded Providers	Private Provider
Addictions Receiving Facility	325	NA
Detoxification	325	375
Residential Treatment	300	350
Day or Night Treatment/Host Home	250	300
Day or Night Treatment	250	300
Intensive Outpatient Treatment	250	300
Outpatient Treatment	250	300
Medication and Methadone Maintenance Treatment	350	400
Aftercare	200	250
Intervention	200	250
Prevention	200	250

Schedule of Discounts

Number of Licensed Facilities	Public Discount	Private Discount
2-5	10%	5%
6-10	15%	10%
11-15	20%	15%
16-20	25%	20%
20+	30%	25%

Appendix S: Substance Abuse Program Standards
65E-30.005, F.A.C.

Standards for Addictions Receiving Facilities. In addition to Rule 65D-30.004, F.A.C., the following standards apply to addictions receiving facilities.

(1) **Designation of Addictions Receiving Facilities**. The department shall designate addictions receiving facilities. The process of designating such facilities shall begin with a written request from a provider and a written recommendation from the department's District Administrator to the department's Director for Substance Abuse. The Director for Substance Abuse shall submit written recommendations to the Secretary of the department approving or denying the request. The Secretary shall respond in writing by certified letter to the chief executive officer of the requesting provider. If the request is denied, the response shall specify the reasons for the denial. If the request is approved, the response shall include a statement designating the facility.

(2) Services.

(a) No Change

(b) Supportive Counseling. Each client shall participate in supportive counseling on a daily basis, unless a client is not sufficiently stabilized as defined in subsection 65D-30.002(69), F.A.C. Supportive counseling sessions shall be of sufficient duration to enable staff to make reasonable decisions regarding the client's need for other services. Services shall be directed toward assuring that the client's most immediate needs are addressed and that the client is encouraged to remain engaged in treatment and to follow up on referrals after discharge.

(c) Daily Schedule. The provider shall develop a daily schedule that shall include recreational and educational activities. Participation by the client shall be documented in the client's record.

(3) Facility Requirements Related to Screening and Assessment. Providers shall designate an area of the facility that is properly equipped and furnished for conducting screening and assessment. The area shall be conducive to privacy and freedom from distraction, and shall be accessible to transportation, including law enforcement vehicles and ambulances.

(4) Observation of Clients. Clients requiring close medical observation, as determined by medical staff, shall be visible and readily accessible to the nursing staff 24 hours per day and 7 days per week. Clients who do not require close medical observation shall be in a bed area that allows for general nursing observation.

(5) Eligibility Criteria. To be considered eligible for placement, a person must be unable to be placed in another component and must also fall into one of the following categories:

(a) A voluntary client who has a substance abuse problem to the extent that the person displays behaviors that indicate potential harm to self or others or who meets diagnostic or medical criteria justifying placement in an addictions receiving facility; or

(b) An involuntary client who meets the criteria specified in Section 397.675, F.S.; or

(c) An adult or juvenile offender who is ordered for assessment or treatment under Sections 397.705 and 397.706, F.S., and who meets diagnostic or medical criteria justifying placement in an addictions receiving facility; or

(d) Juveniles found in contempt as authorized under Section 985.216, F.S.

(6) Exclusionary Criteria for Addictions Receiving Facilities. Persons ineligible for placement include:

(a) Persons found not to be substance abusers or whose substance abuse is at a level which permits them to be served in another component, with the exception of those persons placed for purposes of securing an assessment for the court; and

(b) Persons found to be beyond the safe management capability of the provider as defined under subsection 397.311(5), F.S., and as described under paragraph 397.6751(1)(f), F.S.

(7) Placement Procedures. Following the nursing physical screen, the client shall be screened to determine the person's eligibility or ineligibility for placement. The decision to place or not to place shall be made by a physician, a qualified professional, or an R.N., and shall be based upon the results of screening information and face-to-face consultation with the person to be admitted.

(8) Referral. In the event that the addictions receiving facility has reached full capacity or it has been determined that the prospective client can not be safely managed, the provider shall attempt to notify the referral source. In addition, the provider shall provide assistance in referring the person to another component, in accordance with Section 397.6751, F.S.

(9) Involuntary Assessment and Disposition.

(a) Involuntary Assessment. An assessment shall be completed on each client placed in an addictions receiving facility under protective custody, emergency admission, alternative involuntary assessment for minors, and under involuntary assessment and stabilization. The assessment shall be completed by a qualified professional and based on the requirements in paragraph 65D-30.004(14)(b), F.A.C. The assessment shall be directed toward determining the client's need for additional treatment and the most appropriate services.

(b) Disposition Regarding Involuntary Admissions. Within the assessment period, one of the following actions shall be taken, based upon the needs of the client and, in the case of a minor, after consultation with the parent(s) or guardian(s).

1. The client shall be released and notice of the release shall be given to the applicant or petitioner and to the court, pursuant to Section 397.6758, F.S. In the case of a minor that has been assessed or treated through an involuntary admission, that minor must be released to the custody of his parent(s), legal guardian(s), or legal custodian(s).
2. The client shall be asked if they will consent to voluntary treatment at the provider, or consent to be referred to another provider for voluntary treatment in residential treatment, day or night treatment, intensive outpatient treatment, or outpatient treatment.
3. A petition for involuntary treatment will be initiated.

(10) Notice to Family or Legal Guardian. In the case of a minor, the minor's parent(s) or legal guardian(s) shall be notified upon placement in the facility. Such notification shall be in compliance with the requirements of Title 42, Code of Federal Regulations, Part 2.

(**11) Staffing.** Providers shall conduct clinical and medical staffing of persons admitted for services. All staffing shall include participation by a physician, nurse, and primary counselor. Participation in staffing shall be dictated by client needs.

(12) Staff Coverage. A physician, P.A., or A.R.N.P. shall make daily visits to the facility

for the purpose of conducting physical examinations and addressing the medical needs of clients. A full-time R.N. shall be the supervisor of all nursing services. An R.N. shall be on-site 24 hours per day, 7 days per week. At least one qualified professional shall be on staff and shall be a member of the treatment team. At least one member of the clinical staff shall be available on-site between the hours of 7:00 a.m. and 11:00 p.m. and on-call between 11:00 p.m. and 7:00 a.m.

(13) Staffing Requirement and Bed Capacity. The staffing requirement for nurses and nursing support personnel for each shift shall consist of the following:

Licensed Bed	Nursing	Support
1-10	1	1
11-20	1	2
21-30	2	2

The number of nurses and nursing support staff shall increase in the same proportion as the pattern described above. In those instances where a provider operates a crisis stabilization unit and addictions receiving facility within the same facility, the combined components shall conform to the staffing requirement of the component with the most restrictive requirements.

(14) Restraint and Seclusion. Restraint and seclusion can only be used in emergency situations to ensure the physical safety of the client, other clients, staff, or visitors and only when less restrictive interventions have been determined to be ineffective. Restraint and seclusion shall not be employed as punishment or for the convenience of staff and shall be consistent with the rights of clients, as described in subsection 65D-30.004(29), F.A.C.

(a) Training. All staff who implement written orders for restraint or seclusion shall have documented training in the proper use of the procedures, including formal certification in control of aggression techniques, and this training shall be documented in their personnel file. Training shall occur initially and a minimum of two hours annually thereafter.

(b) Restraint and Seclusion Orders. Providers shall implement the following requirements regarding the use of restraint and seclusion orders.

1. Orders for the use of restraint or seclusion must not be written as a standing order or on an as needed basis.
2. The treating physician, or other medically qualified designee identified in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C., must be consulted ~~with~~ as soon as possible, but no longer than one hour after the initiation of restraint or seclusion. Further, in the case of adults, the physician, or other medically qualified designee identified in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C., must conduct a face-to-face evaluation of the client within four hours of the initiation of restraint or seclusion. In the case of children age 17 and under, this shall occur within two hours of initiation of restraint or seclusion.
3. Each written order for restraint or seclusion is limited to 4 hours for adults, 2 hours for children and adolescents ages 9 to 17, and 1 hour for children under 9. The original order may only be renewed in accordance with these time limits for up to a total of 24 hours. After the original order expires, a physician or qualified professional licensed under Chapters 490 or 491, F.S., must see and assess the patient before issuing a new order.
4. The use of restraint and seclusion must be implemented in the least restrictive manner possible. In addition, restraint and seclusion must be applied in accordance with safe and appropriate techniques and ended at the earliest possible time.
5. Restraint and seclusion may not be used simultaneously unless a client is continually monitored face-to-face by an assigned staff member, or continually monitored by staff using both video and audio equipment.

6. The condition of the client who is in restraint or seclusion must be assessed, monitored, and reevaluated at least every 15 minutes.

(c) Restraint and Seclusion Log Book. A continuing log book shall be maintained by each provider that will indicate, by name, the clients who have been placed in restraint or seclusion, the date, and specified reason for restraint or seclusion, and length of time in restraint or seclusion. The log book shall be signed and dated by the R.N. on duty.

(d) Observation of Clients. Staff shall conduct a visual observation of Clients who are placed in restraint or seclusion every 15 minutes. The observation shall be documented in the restraint and seclusion log book, and shall include the time of the observation and description of the condition of the client.

(e) Basic Rights. While in restraint or seclusion, clients shall be permitted to have regular meals, maintain personal hygiene, use the toilet and, as long as there is no present danger to the client or others, permitted freedom of movement for at least 10 minutes each hour.

(f) Post Restraint or Seclusion. Upon completion of the use of restraint or seclusion, the client shall receive a nursing physical screen by an R.N. that will include an assessment of the client's vital signs, current physical condition, and general body functions. The screening shall be documented in the client record. In addition, supportive counseling shall be provided in accordance with the needs of the client in an effort to transition the client from restraint or seclusion.

(g) Seclusion Room Facility Requirements. Providers shall have at least one seclusion room located in the facility. Seclusion rooms shall incorporate the following minimum facility standards.

1. Seclusion rooms shall be free from sharp edges or corners and constructed to withstand repeated physical assaults. Walls shall be either concrete block or double layered to provide resistance. The ceilings shall be a minimum of eight feet in clear height, hard-coated, and fixtures shall be recessed and tamper proof. Lighting fixtures shall be non-breakable and shall be installed with tamper-proof screws, as shall any other items in the seclusion room. Seclusion room doors shall be heavy wood or metal at least 36 inches in width and shall open outward. The doorframe shall be resistant to damage, and thoroughly secured.
2. A bed in the addictions receiving facility seclusion room is optional. If a bed is included, it shall be sturdily constructed, without sharp edges and bolted to the floor. Its placement in the room shall provide adequate space for staff to apply restraints and shall not permit individuals to tamper with the lights, smoke detectors, cameras, or other items that may be in the ceiling of the room. There shall be a rheostat control mechanism outside the room to adjust the illumination of the light in the seclusion room.
3. There shall be a vision panel in the door of the seclusion room, which provides a view of the entire room. This vision panel shall be Lexan or other suitable strong material and it shall be securely mounted in the door. Provisions shall be made to ensure privacy from the public and other clients while providing easy access for staff observation.
4. Seclusion rooms shall be a minimum of 70 square feet with no wall less than 8 feet.
5. Fire sprinkler heads shall be ceiling mounted and either recessed or flush-mounted without a looped spray dispersal head.
6. Each seclusion room will allow for two-way communication and emergency calling.
7. In those instances where the full interior of the seclusion room cannot be seen from the nurse's station, the seclusion room shall have an electronic visual monitoring system

capable of viewing the entire room from the nurse's station.

65D-30.006 Standards for Detoxification. In addition to Rule 65D-30.004, F.A.C., the following standards apply to detoxification.

(1) General Requirements. Detoxification protocols shall be developed by the medical director, or in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C., and implemented upon placement according to the physiological and psychological needs of the client.

(2) Residential Detoxification.

(a) Services.

1. Stabilization. Stabilization services shall be provided as an initial phase of detoxification.
2. Supportive Counseling. Each client shall participate in supportive counseling on a daily basis unless the client is not sufficiently stable. Supportive counseling sessions shall be of sufficient duration to enable staff to make reasonable decisions regarding the client's need for other services. Services shall be directed toward assuring that the client's most immediate needs are addressed and encouraging the client to remain engaged in treatment and to follow up on referrals after discharge.
3. Daily Activities. The provider shall develop a schedule of daily activities that will be provided based on the detoxification protocols. This shall include recreational and educational activities and participation shall be documented in the client's record.
4. Involuntary Assessment and Disposition. Clients who are involuntarily placed into a detoxification unit under protective custody, emergency admission or involuntary assessment and stabilization pursuant to Section 397.6772, 397.6797, or 397.6811, F.S., shall be assessed and referred as in subsection 65D-30.005(9), F.A.C.

(b) Observation of Clients. Clients requiring close medical observation, as determined and documented by medical staff, shall be visible and readily accessible to nursing staff. Clients who do not require close medical observation shall be in a bed area that allows for general nursing observation.

(c) Staff Coverage. Each facility shall have a physician on call at all times to address medical problems and to provide emergency medical services. The physician's name, telephone number, and schedule for this arrangement shall remain current and clearly posted at the nurse's station. An R.N. shall be the supervisor of all nursing services and shall be on-call 24 hours per day, 7 days per week. An L.P.N. or R.N. shall be on-site 24 hours per day, 7 days per week. All staff shall have immediate access to a nurse supervisor or physician for consultation.

(d) Staffing Requirement and Bed Capacity. The staffing requirement for nurses and nursing support personnel for each shift shall be as follows:

Licensed Bed Capacity	Nurses	Nursing Support
1-15	1	1
16-20	1	2
21-30	2	2

The number of nurses and nursing support staff shall increase in the same proportion as the requirement described above. In those instances where a residential detoxification component and a licensed crisis stabilization unit are co-located, the staffing requirement for the combined components shall conform to the staffing requirement of the component with the more restrictive requirements.

(3) Outpatient Detoxification. The following standards apply to outpatient detoxification.

(a) Eligibility for Services. Eligibility for outpatient detoxification shall be determined from the following:

1. The client's overall medical condition;
2. The client's family support system, for the purpose of observing the client during the detoxification process, and for monitoring compliance with the medical protocol;
3. The client's overall stability and behavioral condition;
4. The client's ability to understand the importance of managing withdrawal utilizing medications and to comply with the medical protocol; and
5. An assessment of the client's ability to abstain from the use of substances, except for the proper use of prescribed medication.

(b) Drug Screening. A drug screen shall be conducted at admission. Thereafter, the program shall require random drug screening for each client at least weekly.

(c) Services.

1. Supportive Counseling. Each client shall participate in supportive counseling on a weekly basis. Counseling sessions shall be of sufficient duration to enable staff to make decisions regarding the client's need for other services and to determine progress.
2. Referral to Residential Detoxification. Providers shall refer clients to residential detoxification when there is evidence that the client is unable to comply with the outpatient protocol.

(d) Staffing Requirement. Staffing for outpatient detoxification shall minimally consist of the following:

1. A physician, or an A.R.N.P. or a P.A. working under the supervision of a physician, available and on-call during operating hours;
2. An R.N., or an L.P.N. working under the supervision of an R.N., on-site during operating hours; and
3. A counselor, on-site during operating hours.

(e) Training. All direct services staff working in outpatient detoxification shall be trained in the outpatient detoxification protocol prior to having contact with clients.

(4) Additional Requirements for the Use of Methadone in Detoxification. In those cases where a provider uses methadone in the detoxification protocol, the provider shall comply with the minimum standards found under subsection 65D-30.006(2), F.A.C., if methadone is provided as part of residential detoxification, and subsection 65D-30.006(3), F.A.C., if methadone is provided as part of outpatient detoxification. In either case, methadone may be used short-term (no more than 30 days) or long-term (no more than 180 days). Short-term detoxification is permitted on a residential and an outpatient basis while long-term detoxification is permitted on an outpatient basis only. A provider shall not place a client in more than two detoxification episodes in one year. The physician shall assess the client upon admission to determine the need for other forms of treatment. Providers shall also comply with the standards found under subsection 65D-30.014(4), F.A.C., with the exception of the following conditions.

(a) Take-home methadone is not allowed during short-term detoxification.

(b) Clients involved in long-term detoxification shall have a drug screen initially and at least monthly thereafter.

(c) Clients involved in short-term detoxification shall have at least one initial drug screen.

65D-30.007 Standards for Residential Treatment. In addition to Rule 65D-30.004, F.A.C., the following standards apply to residential treatment.

(1) Facilities Not Required to be Licensed as Residential Treatment. Licensure as residential treatment as defined in paragraph 65D-30.002(16)(c), F.A.C., shall not apply to facilities operated by a provider that provides only housing, meals, or housing and meals to individuals who are substance abuse impaired or in recovery and where the provider:

(a) Does not mandate that the individuals live in the residential facility as a condition of treatment in a separate facility owned and operated by the provider; and

(b) May make available or provide support groups such as Alcoholics Anonymous and Narcotics Anonymous as the only services available to the residents in the facility where housing, meals, or housing and meals are provided.

All other facilities that provide housing to residents that are substance abuse impaired and provide services as defined in paragraph 397.311(19)(c), F.S., and as described in subsections 65D-30.007 (2) and (3), F.A.C., either at the facility or at alternate locations, must be licensed under this rule.

(2) Categories of Residential Treatment. For the purpose of this rule, there are five levels of residential treatment. In each level, treatment shall be structured to serve clients who need a safe and stable living environment in order to develop sufficient recovery skills for the transition to a less restrictive level of care or reintegration into the general community in accordance with placement criteria. Treatment shall also include a schedule of services provided within a positive environment that reinforce the client's recovery, and clients will be placed in a level of residential treatment that is based upon their treatment needs and circumstances.

(a) Level 1 programs include those that provide services on a short-term basis. This level is appropriate for persons who have sub-acute biomedical problems or behavioral, emotional, or cognitive problems that are severe enough that they require inpatient treatment, but do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program. Typically, clients have a job and a home to support their recovery upon completion of this level of care. The emphasis is clearly on an intensive regimen of clinical services using a multidisciplinary team approach. Services may include some medical services based on the needs of the client.

(b) Level 2 programs include those that are referred to as therapeutic communities or some variation of therapeutic communities and are longer term than level 1. This level is appropriate for persons characterized as having chaotic and often abusive interpersonal relationships, extensive criminal justice histories, prior treatment episodes in less restrictive levels of care, inconsistent work histories and educational experiences, and anti-social behavior. In addition to clinical services, considerable emphasis is placed on services that address the client's educational and vocational needs, socially dysfunctional behavior, and need for stable housing upon discharge. It also includes services that assist the client in remaining abstinent upon returning to the community.

(c) Level 3 programs include those that are referred to as domiciliary care and are generally longer term than level 2. This level is appropriate for persons whose cognitive functioning has been severely impaired from the chronic use of substances, either temporarily or permanently. This would include persons who have varying degrees of organic brain disorder or brain injury or other problems that require extended care. The emphasis is on providing services that work on cognitive problems and activities of daily living, socialization, and specific skills to restore and maintain independent living. The services are typically slower paced, more

concrete and repetitive. There is considerable emphasis on relapse prevention and reintegration into the community. This involves considerable use of case management and networking residents into ancillary or wrap-around services such as housing, vocational services, transportation, and self-help meetings.

(d) Level 4 programs include those that are referred to as transitional care and are generally short-term. This level is appropriate for persons who have completed other levels of residential treatment, particularly levels 2 and 3. This includes clients who have demonstrated problems in applying recovery skills, a lack of personal responsibility, or a lack of connection to the world of work, education, or family life. Although clinical services are provided, the main emphasis is on services that are low-intensity and typically emphasize a supportive environment. This would include services that would focus on recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education, and family life.

(e) Level 5 programs are those that provide only housing and meals to clients who are mandated to receive services at alternate locations in facilities that are owned and operated by the same provider. This level is appropriate for persons who need room and board while undergoing treatment. This level would utilize clinical services and other services that would be largely oriented and directed toward the client's lifestyle and the client's attitudinal and behavioral issues.

(3) Services. Each client shall receive services each week. The services shall include a specified number of hours of counseling as provided for in subsection 65D-30.007(4), F.A.C. Clinical staff shall provide those services. Each provider shall be capable of providing or arranging for the services listed below. With the exception of counseling, it is not intended that all services listed below be provided. Services shall be provided in accordance with the needs of the client as identified in the treatment plan as follows:

(a) Individual counseling;

(b) Group counseling;

(c) Counseling with families;

(d) Substance abuse education, such as strategies for avoiding substance abuse or relapse, health problems related to substance abuse, and motivational enhancement and strategies for achieving a substance-free lifestyle;

(e) Life skills training such as anger management, communication skills, employability skills, problem solving, relapse prevention, recovery training, decision-making, relationship skills, and symptom management;

(f) Non-verbal therapies such as recreation therapy, art therapy, music therapy, or dance (movement) therapy to provide the client with alternative means of self expression and problem resolution;

(g) Training or advising in health and medical issues;

(h) Employment or educational support services to assist clients in becoming financially independent; and

(i) Mental health services for the purpose of:

1. Managing clients with disorders who are stabilized;
2. Evaluating clients' needs for in-depth mental health assessment;
3. Training clients to manage symptoms; and
4. Timely referral to an appropriate provider for mental health crises or the emergence of a primary mental health disorder when the

provider is not staffed to address primary mental health problems.

For clients participating under subsections 65D-30.003(16) and 65D-30.004(35), F.A.C., services shall be provided according to the conditions of the Department of Corrections' contract with the provider. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements of this subsection but shall provide such services as required in the policies, standards, and contractual conditions established by the Department of Juvenile Justice.

(4) Required Hours of Services.

(a) For level 1, each client shall receive services each week in accordance with subsection 65D-30.007(3), F.A.C., including at least 14 hours of counseling.

(b) For level 2, each client shall receive services each week in accordance with subsection 65D-30.007(3), F.A.C., including at least 10 hours of counseling.

(c) For level 3, each client shall receive services each week in accordance with subsection 65D-30.007(3), F.A.C., including at least 4 hours of counseling.

(d) For level 4, each client shall receive services each week in accordance with subsection 65D-30.007(3), F.A.C., including at least 2 hours of counseling.

(e) For level 5, each client shall receive services each week in accordance with the requirements of the licensed component service in which the client is required to participate.
In those instances in which it is determined that a client requires fewer hours of counseling in any of the levels of residential treatment, this shall be described and justified in the client's treatment plan and approved by the qualified professional.

(5) Transportation. Each provider shall arrange for or provide transportation services to clients who are involved in activities or in need of services that are provided at other facilities.

(6) Staff Coverage. Providers shall maintain awake, paid staff coverage 24 hours-per-day, 7 days per week.

(7) Caseload. No primary counselor may have a caseload that exceeds 15 currently participating clients.

65D-30.008 Standards for Day or Night Treatment with Host Homes. In addition to Rule 65D-30.004, F.A.C., the following standards apply to day or night treatment with host homes.

(1) Requirements for Host Family. Providers sponsoring the utilization of host families for the care of their clients shall establish requirements for the homes of such families. The department shall review and approve the requirements during licensure inspections. These requirements shall include:

(a) That an evening snack be available to all clients;

(b) That the host family shall notify the sponsoring provider immediately of an emergency or incident, which shall then be submitted in writing to the department within 24 hours by the provider;

(c) That the sponsoring provider shall establish consequences for host homes which are in non-compliance with applicable requirements under these rules;

(d) That the cleanliness of the host home shall be ensured by the host parents;

(e) That each client shall have his or her own bed;

(f) That all clients will be afforded privacy when using the bathroom and showering and that the clients shall have ready access to the bathroom regardless of the hour;

(g) That all host family members shall complete a biographical application to be filed in the host family record;

(h) That all host family members shall adhere to the requirements for client rights as provided in subsection 65D-30.003(30), F.A.C.

(2) Responsibility Agreement. A written agreement between the day or night sponsoring provider and the host family, signed and dated by all parties involved, shall be executed. As used in this subsection, host family includes parents, stepparents, siblings, grandparents, stepsiblings, or any other family member participating in the program or living in the host home. The agreement shall state the responsibilities and liabilities of each party. The name, address, and telephone number of all host family members shall be included on the agreement. Host parents shall acknowledge, in writing, their agreement to protect the rights of clients in accordance with subsections 397.501(1)-(10), F.S.

(3) Inspection. Providers shall conduct inspections of host family homes initially and semiannually thereafter. Reports on these inspections shall be kept on file at the sponsoring provider. The department reserves the right to review all documents related to host home inspections and to conduct on-site inspections of host homes.

(4) Records. The sponsoring provider shall maintain records on each host family. These records shall contain:

(a) The agreement between the provider and the host family, signed and dated by both parties;

(b) A copy of the host family procedures, signed and dated by the host family;

(c) All required background screening information;

(d) Copies of any incident reports from each home;

(e) The application of each host family member;

(f) Copies of all host home inspections; and

(g) Documentation of training in accordance with subsection 65D-30.004(31), F.A.C., within 15 days of becoming a host family.

(5) Services. Each client shall receive services each week. The services shall include a specified number of hours of counseling as provided for in subsection 65D-30.008(6), F.A.C. Clinical staff shall provide those services. Each provider shall be capable of providing or arranging for the services listed below. With the exception of counseling, it is not intended that all services listed be provided. Services shall be provided in accordance with the needs of the client as identified in the treatment plan, as follows:

(a) Individual counseling;

(b) Group counseling;

(c) Counseling with families;

(d) Substance abuse education, such as strategies for avoiding substance abuse or relapse, health problems related to substance abuse, and motivational enhancement and strategies for achieving a substance-free lifestyle;

(e) Life skills training such as anger management, communication skills, employability skills, problem solving, relapse prevention, recovery training, decision-making, relationship skills, and symptom management;

(f) Non-verbal therapies such as recreation therapy, art therapy, music therapy, or dance (movement) therapy to provide the client with alternative means of self expression and problem resolution;

(g) Training or advising in health and medical issues;

(h) Employment or educational support services to assist clients in becoming financially independent; and

(i) Mental health services for the purpose of:

1. Managing clients with disorders who are stabilized;
2. Evaluating clients' needs for in-depth mental health assessment;
3. Training clients to manage symptoms; and
4. Referral to an appropriate provider for mental health crises or the emergence of a primary mental health disorder when the provider is not staffed to address primary mental health problems.

(6) Required Hours of Services. For day or night treatment with host homes, each client shall receive services each week in accordance with subsection 65D-30.008(5), F.A.C., including at least 10 hours of counseling. In those instances in which it is determined that a client requires fewer hours of counseling, this shall be described and justified in the client's record.

(7) Staff Coverage. Providers of day or night host home services are required to have awake, paid staff on-site at the sponsoring provider's facility during the hours when one or more clients are present. Individual host homes must have adult supervision when clients are present.

(8) Caseload. No primary counselor may have a caseload that exceeds 15 clients.

65D-30.009 Standards for Day or Night Treatment. In addition to Rule 65D-30.004, F.A.C., the following standards apply to day or night treatment.

(1) Services. Each client shall receive services each week. The services shall include counseling as provided for in subsection 65D-30.009(2), F.A.C. Clinical staff shall provide those services. Each provider shall be capable of providing or arranging for the services listed below. With the exception of counseling, it is not intended that all services listed be provided. For clients participating under subsection 65D-30.003(16), F.A.C., and subsection 65D-30.004(35), F.A.C., services shall be provided according to the conditions of the Department of Corrections' contract with the provider. Otherwise, services shall be provided in accordance with the needs of the client as identified in the treatment plan, as follows:

(a) Individual counseling;

(b) Group counseling;

(c) Counseling with families;

Substance abuse education, such as strategies for avoiding substance abuse or relapse, health problems related to substance abuse, and motivational enhancement and strategies for achieving a substance-free lifestyle;

(e) Life skills training such as anger management, communication skills, employability skills, problem solving, relapse prevention, recovery training, decision-making, relationship skills, and symptom management;

(f) Non-verbal therapies such as recreation therapy, art therapy, music therapy, or dance (movement) therapy to provide the client with alternative means of self expression and problem resolution;

(g) Training or advising in health and medical issues;

(h) Employment or educational support services to assist clients in becoming financially independent; and

(i) Mental health services for the purpose of:

1. Managing clients with disorders who are stabilized;
2. Evaluating clients' needs for in-depth mental health assessment;
3. Training clients to manage symptoms; and
4. Timely referral to an appropriate provider for mental health crises or the emergence of a primary mental health disorder when the provider is not staffed to address primary mental health problems.

(2) Required Hours of Services. For day or night treatment, each client shall receive a minimum of 12 hours of services per week in accordance with subsection 65D-30.009(1), F.A.C. This shall include individual counseling, group counseling, or counseling with families. In those instances where a provider requires fewer hours of client participation in the latter stages of the treatment process, this shall be clearly described and justified as essential to the provider's objectives relative to service delivery.

(3) Staff Coverage. Each facility shall have an awake, paid employee on the premises at all times when one or more clients are present.

(4) Caseload. No primary counselor may have a caseload that exceeds 15 clients.

65D-30.0091 Standards for Intensive Outpatient Treatment. In addition to Rule 65D-30.004, F.A.C., the following standards apply to intensive outpatient treatment.

(1) Services. Each client shall receive services each week. The services shall include counseling as provided for in subsection 65D-30.0091(2), F.A.C. Clinical staff shall provide those services. Each provider shall be capable of providing or arranging for the services listed below. With the exception of counseling, it is not intended that all services listed be provided. For clients participating under subsections 65D-30.003(16) and 65D-30.004(35), F.A.C., services shall be provided according to the conditions of the Department of Corrections' contract with the provider. Otherwise, services shall be provided in accordance with the needs of the client as identified in the treatment plan, as follows:

(a) Individual counseling;

(b) Group counseling;

(c) Counseling with families;

(d) Substance abuse education, such as strategies for avoiding substance abuse or relapse, health problems related to substance abuse, and motivational enhancement and strategies for achieving a substance-free lifestyle;

(e) Life skills training such as anger management, communication skills, employability skills, problem solving, relapse prevention, recovery training, decision-making, relationship skills, and symptom management;

(f) Training or advising in health and medical issues;

(g) Employment or educational support services to assist clients in becoming financially independent; and

(h) Mental health services for the purpose of:

1. Managing clients with disorders who are stabilized;
2. Evaluating clients' needs for in-depth mental health assessment;
3. Training clients to manage symptoms; and
4. Timely referral to an appropriate provider for mental health crises or the emergence of a primary mental health disorder when the

provider is not staffed to address primary mental health problems.

(2) Required Hours of Services. For intensive outpatient treatment, each client shall receive at least nine hours of services per week, in accordance with subsection 65D-30.0091(1), F.A.C., including counseling.

(3) Psychiatric and Medical Services. The need for psychiatric and medical services shall be addressed through consultation or referral arrangements. Providers shall develop formal agreements with health and mental health professionals for provision of such services, and shall accommodate the needs of clients on a case-by-case basis. Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the requirements of this subsection.

(4) Caseload. No full-time counselor shall have a caseload that exceeds 50 clients participating in individual counseling at any given time.

(5) Hours of Operation. Providers shall post their hours of operation and this information shall be visible to the public. Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from the requirements of this subsection. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements of this subsection but shall provide such services as required in the policies, standards, and contractual conditions established by the Department of Juvenile Justice.

65D-30.010 Standards for Outpatient Treatment. In addition to Rule 65D-30.004, F.A.C., the following standards apply to outpatient treatment.

(1) Services. Each client shall receive services each week. The services shall include counseling as provided for in subsection 65D-30.010(2), F.A.C. Clinical staff shall provide those services. Each provider shall be capable of providing or arranging for the services listed below. With the exception of counseling, it is not intended that all services listed be provided. For clients participating under subsections 65D-30.003(16) and 5D-30.004(35), F.A.C., services shall be provided according to the conditions of the Department of Corrections' contract with the provider. Otherwise, services shall be provided in accordance with the needs of the client as identified in the treatment plan, as follows:

(a) Individual counseling;

(b) Group counseling;

(c) Counseling with families; and

(d) Substance abuse education, such as strategies for avoiding substance abuse or relapse, health problems related to substance abuse, and motivational enhancement and strategies for achieving a substance-free lifestyle.

(2) Required Hours of Services. For outpatient treatment, each client shall receive services each week in accordance with subsection 65D-30.010(1), F.A.C., including a minimum of one counseling session. If fewer sessions are indicated, clinical justification must be documented in the client record.

(3) Caseload. No full-time counselor shall have a caseload that exceeds 50 clients participating in individual counseling at any given time.

(4) Hours of Operation. Providers shall post their hours of operation and this information shall be visible to the public. Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections are exempt from

the requirements of this subsection. Juvenile Justice Commitment Programs and detention facilities operated by or under contract with the Department of Juvenile Justice are exempt from the requirements of this subsection.

65D-30.011 Standards for Aftercare. In addition to Rule 65D-30.004, F.A.C., the following standards apply to aftercare.

(1) Client Eligibility. Clients who have successfully completed residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, or medication and methadone maintenance treatment are eligible for aftercare services.

(2) Services. For clients participating under subsection 65D-30.003(16), F.A.C., and subsection 65D-30.004(35), F.A.C., services shall be provided according to the conditions of the Department of Corrections' contract with the provider. Otherwise, the following services shall be provided.

(a) Relapse Prevention. Providers shall specify the type, frequency, and duration of counseling services to be provided to clients who are eligible for aftercare. Special care shall be taken to ensure that the provider has flexible hours in order to meet the needs of clients.

(b) Aftercare Plan. An aftercare plan shall be developed for each client and the plan shall provide an outline of the goals to be accomplished during aftercare including regular counseling sessions and the need for ancillary services.

(c) Monitoring Progress. Providers shall monitor and document the progress of clients involved in aftercare and shall review and update the aftercare plan to determine the need for additional services. Clients shall be monitored with respect to attending appointments, potential for relapse, and results of counseling sessions and other contacts.

(d) Referral. Providers shall refer clients for other services that are needed by the client as specified in the aftercare plan. This shall include follow-up on all referrals.

65D-30.012 Standards for Intervention. In addition to Rule 65D-30.004, F.A.C., the following standards apply to intervention.

(1) General Intervention.

(a) Target Group, Outcomes, and Strategies. Providers shall have current information which:

1. Describes services to be provided, including target groups;
2. Identifies specific client outcomes to be achieved; and
3. Describes strategies for these groups or individuals to access needed services.

(b) Supportive Counseling. In those instances where supportive counseling is provided, the number of sessions or contacts shall be determined through the intervention plan. In those instances where an intervention plan is not completed, all contacts with the client shall be recorded in the client record.

(c) Referral. Providers must have the capability of referring clients to other needed services within 48 hours, or immediately in the case of an emergency.

(2) Requirements for Treatment Alternatives for Safer Communities (TASC). In addition to the requirements in subsection 65D-30.012(1), F.A.C., the following requirements apply to Treatment Alternatives for Safer Communities.

(a) Client Eligibility. TASC providers shall establish eligibility standards requiring that individuals considered for intake shall be at-risk for criminal involvement, substance abuse, or have been arrested or convicted of a crime, or referred by the criminal or juvenile justice system.

(b) Services.

1. Court Liaison. Providers shall establish liaison activities with the court that shall specify procedures for the release of prospective clients from custody by the criminal or juvenile justice system for referral to a provider. Special care shall be taken to ensure that the provider has flexible operating hours in order to meet the needs of the criminal and juvenile justice systems. This may require operating nights and weekends and in a mobile or an in-home environment.
2. Monitoring. Providers shall monitor and report the progress of each client according to the consent agreement with the client. Reports of client progress shall be provided to the criminal or juvenile justice system or other referral source as required, and in accordance with subsections 397.501(1)-(10), F.S.
3. Intervention Plan. The intervention plan shall include additional information regarding clients involved in a TASC program. The plan shall include requirements the client is expected to fulfill and consequences should the client fail to adhere to the prescribed plan, including provisions for reporting information regarding the client to the criminal or juvenile justice system or other referral source. The plan shall be signed and dated by both parties.
4. Referral. Providers shall refer clients to publicly funded providers within the court's or criminal justice authority's area of jurisdiction, and shall establish written referral agreements with other providers.
5. Discharge/Transfer or Termination Notification. Providers shall report any pending discharge/transfer or termination of a client to the criminal justice or juvenile justice authority or other referral source.

(3) Requirements for Employee Assistance Programs. In addition to the requirements in subsection 65D-30.012(1), F.A.C., the following requirements apply to Employee Assistance Programs.

(a) Consultation and Technical Assistance. Consultation and technical assistance shall be provided by Employee Assistance Programs which includes the following:

1. Policy and procedure formulation and implementation;
2. Training and orientation programs for management, labor union representatives, employees, and families of employees; and
3. Linkage to community services.

(b) Employee Services. Employee Assistance Programs shall provide services which include linking the client to a provider, motivating the client to accept assistance, and assessing the service needs of the client. The principal services include:

1. Supportive counseling to motivate clients toward recovery; and
2. Monitoring.

(c) Resource Directory. Providers shall maintain a current directory of substance abuse, mental health, and ancillary services. This shall include information on Alcoholics Anonymous, Narcotics Anonymous, public assistance services, and health care services.

(4) Requirements for Case Management. In addition to the requirements in subsection 65D-30.012(1), F.A.C., the following requirements apply to case management in those instances where case management is provided as a licensable sub-component of intervention.

(a) Case Managers. Providers shall identify an individual or individuals responsible for carrying out case management services.

(b) Priority Clients. Priority clients shall include persons receiving substance abuse services who have multiple problems and needs and require multiple services or resources to meet those needs.

(c) Case Management Requirements. Case management shall include the following:

1. On-going assessment and monitoring of the client's condition and progress;
2. Linking and brokering for services as dictated by client needs;
3. Follow-up on all referrals for other services; and
4. Advocacy on behalf of clients.

(d) Contacts. Each case manager shall meet face-to-face with each client at least monthly unless otherwise justified in the client record.

65D-30.013 Standards for Prevention. In addition to Rule 65D-30.004, F.A.C., the following standards apply to prevention.

(1) Categories of Prevention. For the purpose of these rules, prevention is provided under the categories entitled level 1 and level 2.

(a) Level 1. Level 1 prevention services are typically directed at the general population or specific sub-populations. Level 1 services offer one or more of the services listed in paragraphs 65D-30.013(2)(a)-(f), F.A.C., at an intensity and duration appropriate to the strategy and target population.

(b) Level 2. Level 2 prevention services are typically directed toward individuals who are manifesting behavioral effects of specific risk factors for substance abuse. Level 2 services offer one or more of the strategies listed in paragraphs 65D-30.013(2)(a)-(g), F.A.C., at an intensity and duration appropriate to the strategy and the risk and protective factors of the participants. This level offers counseling for non-drug treatment issues, geared at reducing risk factors and increasing protective factors. Each participant has a prevention plan in this level of prevention.

(2) Specific Prevention Strategies. The following is a description of the specific prevention strategies that are provided as specified in subsection 65D-30.013(1), F.A.C., regarding levels 1 and 2 prevention services.

(a) Information Dissemination. The intent of this strategy is to increase awareness and knowledge of the risks of substance abuse and available prevention services.

(b) Education. The intent of this strategy is to improve skills and to reduce negative behavior and improve responsible behavior.

(c) Alternatives. The intent of this strategy is to provide constructive activities that exclude substance abuse and reduce anti-social behavior.

(d) Problem Identification and Referral Services. The intent of this strategy is to identify children and youth who have indulged in the use of tobacco or alcohol and those who have indulged in the first use of illicit drugs, in order to assess whether prevention services are indicated or referral to treatment is necessary.

(e) Community-Based Process. The intent of this strategy is to enhance the ability of the community to more effectively provide prevention and treatment services.

(f) Environmental. The intent of this strategy is to establish or change local laws, regulations, or rules to strengthen the general community regarding the initiation and support of prevention services.

(g) Prevention Counseling. The intent of this strategy is to provide problem-focused counseling approaches toward the resolution of risk factors for substance abuse. Such factors include conduct problems, association with antisocial peers, and problematic family relations. The goal is to enhance the protection of the client from identified risks. This strategy does not involve treatment for substance abuse.

(3) General Requirements.

(a) Program Description. Providers shall describe generally accepted prevention practices that will be available to groups or individuals. For all prevention programs offered, this description shall include:

1. The target population, including relevant demographic factors;
2. The risk and protective factors to be addressed;
3. The specific prevention strategies identified in subsection 65D-30.013(2), F.A.C., to be utilized;
4. The appropriateness of these services to address the identified risk and protective factors for the group or individuals to be served; and
5. How the effectiveness of the services will be evaluated.

(b) Staffing Patterns. Providers shall delineate reporting relationships and staff supervision. This shall include a description of staff qualifications, including educational background and experience regarding the prevention field.

(c) Referral. Providers shall have a plan for assessing the appropriateness of prevention services and conditions for referral to other services. The plan shall include a current directory of locally available substance abuse services and other human services for referral of prevention program participants, or prospective participants.

(d) Evaluation. Providers shall evaluate the effectiveness of all prevention services described in subsection 65D-30.013(2), F.A.C., at least annually. The department shall review the results of providers' program evaluation efforts annually and all technical materials used by providers to ensure consistency with current research in the prevention field.

(4) Activity Logs for Level 1 Prevention. Providers shall maintain records of all level 1 prevention activities, including the following:

(a) A description of the characteristics of the target population;

(b) The risk and protective factors to be addressed;

(c) A description of the activities;

(d) The duration of the activities;

(e) The number of participants;

(f) The location of service delivery; and

(g) Tracking of individual participant attendance when a course or series of sessions are required by the prevention curriculum or strategy.

65D-30.014 Standards for Medication and Methadone Maintenance Treatment. In addition to Rule 65D-30.004, F.A.C., the following standards apply to Medication and Methadone Maintenance Treatment.

(1) State Authority. The state authority is the department's Substance Abuse Program Office.

(2) Federal Authority. The federal authority is the Center for Substance Abuse Treatment.

(3) Determination of Need.

(a) Criteria. New providers shall be established only in response to the department's determination of need, which shall occur annually. The determination of need shall only apply to medication and methadone maintenance treatment programs. In its effort to determine need, the department shall examine information on treatment, the consequences of the use of opioids (e.g., arrests, deaths, emergency room mentions, other incidence and prevalence data that may have relevance at the time, etc.), and data on treatment accessibility.

(b) Procedure. The department shall publish the results of the assessment in the Florida Administrative Weekly by June 30. The publication shall direct interested parties to submit applications for licensure to the department's district office where need has been demonstrated and shall provide a closing date for submission of applications. The district office shall conduct a formal rating of applicants on a form titled MEDICATION AND METHADONE MAINTENANCE TREATMENT NEEDS ASSESSMENT September 6, 2001, incorporated herein by reference. The form may be obtained from the Department of Children and Families, Substance Abuse Program Office, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700. Should the number of responses to the publication for a new provider exceed the determined need, the selection of a provider shall be based on the following criteria:

1. The number of years the respondent has been licensed to provide substance abuse services;
2. The organizational capability of the respondent to provide medication and methadone maintenance treatment in compliance with these rules; and
3. History of substantial noncompliance by the respondent with departmental rules.

(4) General Requirements.

(a) Medication or Methadone Maintenance Sponsor. The sponsor of a new provider shall be a licensed health professional and shall have worked in the field of substance abuse at least 5 years.

(b) Medical Director. The medical director of a provider shall have a minimum of 2 years experience in the field of substance abuse.

(c) Special Permit and Consultant Pharmacist.

1. Special Permit.

a. All facilities that distribute methadone or other medication shall obtain a special pharmacy permit from the State of Florida Board of Pharmacy. New applicants shall be required to obtain a special pharmacy permit prior to licensure by the department.
b. Providers obtaining a special pharmacy permit shall hire a consultant pharmacist licensed by the state of Florida.
2. Consultant Pharmacist. The responsibilities of the consultant pharmacist include the following:
a. Develop operating procedures relative to the supervision of the compounding and dispensing of all drugs dispensed in the clinic;
b. Provide pharmaceutical consultation;
c. Develop operating procedures for maintaining all drug records and security in the area within the facility in which the compounding, storing, and dispensing of medicinal drugs will occur;
d. Meet face-to-face, at least quarterly with the medical director to review the provider's pharmacy practices. Meetings shall be documented in writing and signed and dated by both the consultant pharmacist and the medical director;
e. Prepare written reports regarding the provider's level of compliance with established pharmaceutical procedures. Reports shall be prepared at least semi-annually and submitted, signed and dated to the medical director; and
f. Visit the facility at least every 2 weeks to ensure that established procedures are being followed, unless otherwise stipulated by the state Board of Pharmacy. A log of such visits shall be maintained and signed and dated by the consultant pharmacist at each visit.
3. Change of Consultant Pharmacist. The provider's medical director shall notify the Board of Pharmacy within 10 days of any change of consultant pharmacists.

(d) Pregnancy and Medication and Methadone Maintenance.

1. Use of Methadone. Prior to the initial dose, each female client shall be fully

informed of the possible risks from the use of methadone during pregnancy and shall be told that safe use in pregnancy has not been established in relation to possible adverse effects on fetal development. The client shall sign and date a statement acknowledging this information. Pregnant clients shall be informed of the opportunity for prenatal care either by the provider or by referral to other publicly or privately funded health care providers. In any event, the provider shall establish a system for referring clients to prenatal care. If there are no publicly funded prenatal referral resources to serve those who are indigent, or if the provider cannot provide such services, or if the client refuses the services, the provider shall offer her basic prenatal instruction on maternal, physical, and dietary care as part of its counseling service. The nature of prenatal support shall be documented in the client record. If the client is referred for prenatal services, the practitioner to whom she is referred shall be notified that she is undergoing methadone maintenance treatment. If a pregnant client refuses prenatal care or referral, the provider shall obtain a signed statement from the client acknowledging that she had the opportunity for the prenatal care but refused it. The physician shall sign or countersign and date all entries related to prenatal care.

2. Use of Other Medication. Providers shall adhere to the prevailing federal and state requirements regarding the use of medication other than methadone in the maintenance treatment of clients who are or become pregnant.

(e) Minimum Responsibilities of the Physician. The responsibilities of the physician include the following:

1. To ensure that evidence of current physiological addiction, history of addiction, and exemptions from criteria for admission are documented in the client record before the client receives the initial dose of methadone or other medication;

2. To sign or countersign and date all medical orders, including the initial prescription, all subsequent prescription changes, all changes in the frequency of take-home methadone, and the prescription of additional take-home doses of methadone in cases involving the need for exemptions;

3. To ensure that justification is recorded in the client record for reducing the frequency of visits to the provider for observed drug ingesting, providing additional take-home methadone in cases involving the need for exemptions, or when prescribing medication for physical or emotional problems; and

4. To review, sign or countersign, and date treatment plans at least annually.

5. To ensure that a face-to-face assessment is conducted with each client at least annually, including evaluation of the client's progress in treatment, and justification for continued maintenance or medical clearance for voluntary withdrawal or a dosage reduction protocol. The assessment shall be conducted by a physician or a P.A. or A.R.N.P. under the supervision of a physician. If conducted by other than a physician, the assessment shall be reviewed and signed by a physician in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C. The protocol shall include criteria and the conditions under which the assessment would be conducted more frequently.

(f) Client Registry.

1. Providers shall participate in regional registry activities for the purpose of sharing client identifying information with other providers located within a 100-mile radius, to prevent the multiple enrollment of clients in more than one provider. Each regional registry shall be conducted through an automated system where this capability exists. In those instances where the development and implementation of an automated system would require additional technology, an alternative method shall be used on an interim basis, as long as the

alternative is implemented in compliance with 42 Code of Federal Regulations, Part 2, and approved by the state authority.
2. Providers may volunteer to coordinate the registry activities or, in the event that no provider volunteers, the state authority shall designate a provider.
3. Providers shall submit, with the application for licensure, written plans for participating in registry activities.
4. Methadone or other medication shall not be administered or dispensed to a client who is known to be currently participating in another provider.
5. The client shall always report to the same provider unless prior approval is obtained from the original provider for treatment at another provider. Permission to report for treatment at the facility of another provider shall be granted only in exceptional circumstances and shall be noted in the client record.
6. Individuals applying for maintenance treatment shall be informed of the registry procedures and shall be required to sign a consent form before receiving services. Individuals who apply for services and do not consent to the procedures will not be placed in maintenance treatment.
7. If an individual is found trying to secure or has succeeded in obtaining duplicate doses of methadone or other medication, the client shall be referred back to the original provider. A written statement documenting the incident shall be forwarded to the original provider. The physician of the original provider shall evaluate the client as soon as medically feasible for continuation of treatment. In addition, a record of violations by individual clients shall become part of the record maintained in an automated system and permit access by all participating providers.

(g) Operating Hours and Holidays. Providers shall post operating hours in a conspicuous place within the facility. This information shall include hours for counseling and medicating clients. All providers shall be open Monday through Saturday. Providers shall have medicating hours and counseling hours that accommodate clients, including 2 hours of medicating time accessible daily outside the hours of 9:00 a.m. to 5:00 p.m. Providers are required to medicate on Sundays according to client needs. This would include clients on Phase 1, clients on a 30 to 180-day detoxification regimen, and clients who need daily observation. The provider shall develop operating procedures for Sunday coverage. When holidays are observed, all clients shall be given a minimum of a 7-day notice. When applying for a license, providers shall inform the respective district offices of their intended holidays. In no case shall two or more holidays occur in immediate succession unless the provider is granted an exemption by the federal authority. Take-out privileges shall be available to all methadone clients during holidays, but only if clinically advisable. On those days during which the provider is closed, services shall be accessible to clients for whom take out methadone is not clinically advisable. Clients who fall into this category shall receive adequate notification regarding the exact hours of operation.

(5) Maintenance Treatment Standards.

(a) Standards for Placement.

1. A person aged 18 or over shall be placed in treatment as a client only if the physician determines that the person is currently physiologically addicted to opioid drugs and became physiologically addicted at least 1 year before placement in maintenance treatment. A 1-year history of addiction means that an applicant for placement in maintenance treatment was physiologically addicted to opioid drugs at least 1 year before placement and was addicted continuously or episodically for most of the year immediately prior to placement in a provider. In the event the exact date of physiological addiction cannot be determined, the physician may admit the person to maintenance treatment if, by the evidence presented and observed, it is

reasonable to conclude that the person was physiologically addicted during the year prior to placement. Such observations shall be recorded in the client record by the physician. Participation in treatment must be voluntary.
2. A person under 18 is required to have had two documented unsuccessful attempts at short-term detoxification or drug-free treatment within the last year to be eligible for maintenance treatment. The physician shall document in the client's record that the client continues to be or is again physiologically dependent on opioid drugs. No person under 18 years of age shall be placed in maintenance treatment unless a parent, legal guardian, or responsible adult provides written consent.
3. In determining the current physiological addiction of the client, the physician shall consider signs and symptoms of drug intoxication, evidence of use of drugs through a urine drug screen, and needle marks. Other evidence of current physiological dependence shall be considered by noting early signs of withdrawal such as lachrymation, rhinorrhea, pupilary dilation, pilo erection, body temperature, pulse rate, blood pressure, and respiratory rate.

(b) Exemption from Minimum Standards for Placement.

1. A person who has resided in a penal or chronic-care institution for 1 month or longer may be placed in maintenance treatment within 14 days before release or within 6 months after release from such institution. This can occur without documented evidence to support findings of physiological addiction, providing the person would have been eligible for placement before incarceration or institutionalization, and in the reasonable clinical judgment of the physician, treatment is medically justified. Documented evidence of prior residence in a penal or chronic-care institution, evidence of all other findings, and the criteria used to determine the findings shall be recorded by the physician in the client record. The physician shall sign and date these recordings before the initial dose is administered.
2. Pregnant clients, regardless of age, who have had a documented addiction to opioid drugs in the past and who may be in direct jeopardy of returning to opioid drugs with all its attendant dangers during pregnancy, may be placed in maintenance treatment. For such clients, evidence of current physiological addiction to opioid drugs is not needed if a physician certifies the pregnancy and, in utilizing reasonable clinical judgment, finds treatment to be medically justified. Pregnant clients may be placed on a maintenance regimen using a medication other than methadone only upon the written order of a physician who determines this to be the best choice of therapy for that client. Documented evidence of current or prior addiction and criteria used to determine such findings shall be recorded in the client record by the admitting physician. The physician shall sign and date these recordings prior to administering the initial dose.
3. Up to 2 years after discharge or detoxification, a client who has been previously involved in maintenance treatment may be readmitted without evidence to support findings of current physiological addiction. This can occur if the provider is able to document prior maintenance treatment of 6 months or more and the physician, utilizing reasonable clinical judgment, finds readmission to maintenance treatment to be medically justified. Evidence of prior treatment and the criteria used to determine such findings shall be recorded in the client record by the physician. The physician shall sign and date the information recorded in the client record. The provider shall not place a client on a maintenance schedule unless the physician has determined that the client is unable to be admitted for services other than maintenance treatment.

(c) Denying a Client Treatment. If a client will not benefit from a treatment regimen that includes the use of methadone or other

medication, or if treating the client would pose a danger to other clients, staff, or other individuals, the client may be refused treatment. This is permitted even if the client meets the standards for placement. The physician shall make this determination and shall document the basis for the decision to refuse treatment.

(d) Take-home Privileges.

1. Take-home doses are permitted only for clients participating on a methadone maintenance regimen.
2. Take-home doses of methadone may be granted if the client meets the following conditions:
a. Absence of recent abuse of drugs as evidenced by drug screening;
b. Regularity of attendance at the provider;
c. Absence of serious behavioral problems at the provider;
d. Absence of recent criminal activity of which the program is aware, including illicit drug sales or possession;
e. Client's home environment and social relationships are stable;
f. Length of time in methadone maintenance treatment meets the requirements of paragraph (e);
g. Assurance that take-home medication can be safely stored within the client's home or will be maintained in a locked box if traveling away from home;
h. The client has demonstrated satisfactory progress in treatment to warrant decreasing the frequency of attendance; and
i. The client has a verifiable source of legitimate income.
3. When considering client responsibility in handling methadone, the physician shall consider the recommendations of other staff members who are most familiar with the relevant facts regarding the client.
4. The requirement of time in treatment is a minimum reference point after which a client may be eligible for take-home privileges. The time reference is not intended to mean that a client in treatment for a particular length of time has a right to take-home methadone. Thus, regardless of time in treatment, the physician, with cause, may deny or rescind the take-home methadone privileges of a client.

(e) Take-home Phases. To be considered for take-home privileges, clients shall be in compliance with subparagraph (d)2. No take-homes shall be permitted during the first 30 days following placement unless approved by the state authority.

1. Phase I. Following 30 consecutive days in treatment, the client may be eligible for 1 take-home per week from day 31 through day 90, provided that the client has had negative drug screens for the preceding 30 days.
2. Phase II. Following 90 consecutive days in treatment, the client may be eligible for 2 take-homes per week from day 91 through day 180, provided that the client has had negative drug screens for the preceding 60 days.
3. Phase III. Following 180 consecutive days in treatment, the client may be eligible for 3 take-homes per week with no more than a 2-day supply at any one time from day 181 through 1 year, provided that the client has had negative drug screens for the preceding 90 days.
4. Phase IV. Following 1 year in treatment, the client may be eligible for 4 take-homes per week with no more than a 2-day supply at any one time through the second year of treatment, provided that the client has had negative drug screens for the preceding 90 days.
5. Phase V. Following 2 years in treatment, the client may be eligible for 5 take-homes per week with no more than a 3-day supply at any one time, provided that the client has had negative drug screens for the preceding 180 days.
6. Phase VI. Following 3 years in treatment, the client may be eligible for 6 take-homes per week provided that the client has passed all negative drug screens for the past year.

(f) Medical Maintenance. Providers must receive prior approval in writing from the

State Authority to use the medical maintenance protocol. The provider may place a client on medical maintenance in those cases where it can be demonstrated that the potential benefits of medical maintenance to the client far exceed the potential risks. Only a physician may authorize placement of a client on medical maintenance. The physician shall provide justification in the client record regarding the decision to place a client on medical maintenance. The following conditions shall apply to medical maintenance.

1. To qualify for partial medical maintenance a client may receive no more than 13 take homes and must have been in treatment with the same clinic for four years with at least two years of negative drug screens.
2. To qualify for full medical maintenance a client may receive no more than 27 take homes and must have been in treatment with the same clinic for five years with at least three years of negative drug screens.
3. All clients in medical maintenance will receive their medication in tablet form only.
4. All clients will participate in a "call back" program by reporting back to the provider upon notice.
5. All criteria for take homes as listed under paragraph (d) shall continue to be met.

The provider shall develop operating procedures for medical maintenance.

(g) Transfer Clients and Take Home Privileges. Any client who transfers from one provider to another within the state of Florida shall be eligible for placement on the same phase provided that verification of enrollment is received from the previous provider within two weeks of placement. The physician at the previous provider shall also document that the client met all criteria for their current phase and are at least on Phase I.

Any client who transfers from out-of-state is required to meet the requirements of subparagraph (d)2., and with verification of previous client records, the physician shall determine the phase level based on the client's history.

(h) Transfer Information. When a client transfers from one provider to another, the referring provider shall release the following information:

1. Results of the latest physical examination;
2. Results of the latest laboratory tests on blood and urine;
3. Results of drug screens for the past 12 months;
4. Medical history;
5. Current dosage level and dosage regimen for the past 12 months;
6. Documentation of the conditions which precipitated the referral; and
7. A written summary of the client's last 3 months of treatment.

This information shall be released prior to the client's arrival at the provider to which he or she is transferred. Providers shall not withhold a client's records when requested by the client for any reason, including client debt. The referring provider shall forward the records directly to the provider of the client's choice.

(i) Exemptions from Take Home Privileges and Phasing Requirements for Methadone Maintained Clients.

1. If a client is found to have a physical disability which interferes with the client's ability to conform to the applicable mandatory schedule, the client may be permitted a temporarily or permanently reduced schedule by the physician, provided the client is also found to be responsible in handling methadone. Providers shall obtain medical records and other relevant information as needed to verify the physical disability. Justification for the reduced schedule shall be documented in the client record by the physician who shall sign and date these entries.
2. A client may be permitted a temporarily reduced schedule of attendance because of

exceptional circumstances such as illness, personal or family crises, and travel or other hardship which causes the client to become unable to conform to the applicable mandatory schedule. This is permitted only if the client is also found to be responsible in handling methadone. The necessity for an exemption from a mandatory schedule is to be based on the reasonable clinical judgment of the physician and such determination of necessity shall be recorded in the client record by the physician who shall sign and date these entries. A client shall not be given more than a 14-day supply of methadone at any one time unless an exemption is granted by the state methadone authority and by the federal government.

3. In those instances where client access to a provider is limited because of travel distance, the physician is authorized to reduce the frequency of a client's attendance. This is permitted if the client is currently employed or attending a regionally approved educational or vocational program or the client has regular child-caring responsibilities that preclude daily trips to the provider.

The reason for reducing the frequency of attendance shall be documented in the client record by the physician who shall sign and date these entries.

4. Any exemption that is granted to a client regarding travel shall be documented in the client's record. Such documentation shall include tickets prior to a trip, copies of boarding passes, copies of gas or lodging receipts, or other verification of the client's arrival at the approved destination. Clients who receive exemptions for travel shall be required to submit to a drug test on the day of return to the facility.

(j) Random Drug Screening.

1. At least one drug screen, random and monitored, shall be performed on each client each month. The drug screen shall be conducted so as to reduce the risk of falsification of results. This shall be accomplished by direct observation or by another accurate method of monitoring.

2. Clients who are on Phase VI shall be required to submit to one random drug screen at least every 90 days.

3. Each specimen shall be analyzed for methadone, benzodiazepines, opiates, cocaine, and marijuana.

4. The physician shall review all positive drug screens in accordance with the medical protocol established in subsection 65D-30.004(7), F.A.C.

(k) Employment of Persons on a Maintenance Protocol. No staff member, either full-time, part-time or volunteer, shall be on a maintenance protocol unless a request to maintain or hire staff undergoing treatment is submitted with justification to and approved by the federal and state authorities. Any approved personnel on a maintenance regimen shall not be allowed access to or responsibility for handling methadone or other medication.

(l) Caseload. No full-time counselor shall have a caseload that exceeds the equivalent of 32 currently participating clients. Participating client equivalents are determined in the following manner. A client seen once per week would count as 1.0 client equivalent. A client seen bi-weekly would count as a .5 client equivalent. A client seen monthly or less would count as a .25 client equivalent. As an example, a counselor has 15 clients that are seen weekly (counts as 15 equivalent clients), 30 clients seen biweekly (counts as 15 equivalent clients), and 8 clients seen monthly (counts as 2 equivalent clients). The counselor would have a total caseload of 53 individual clients equaling 32 equivalent clients.

(m) Termination from Treatment.

1. There will be occasions when clients will need to be terminated from maintenance treatment. Clients who fall into this category are those who:

a. Attempt to sell or deliver their prescribed drugs;
b. Become or continue to be actively involved in criminal behavior;
c. Consistently fail to adhere to the requirements of the provider;
d. Persistently use drugs other than methadone; or
e. Do not effectively participate in treatment programs to which they are referred.

Such clients shall be withdrawn in accordance with a dosage reduction schedule prescribed by the physician and referred to other treatment, as clinically indicated. This action shall be documented in the client record by the physician.
2. Providers shall establish criteria for involuntary termination from treatment that describe the rights of clients as well as the responsibilities and rights of the provider. All clients shall be given a copy of these criteria upon placement and shall sign and date a statement that they have received the criteria.

(n) Withdrawal from Maintenance.

1. The physician shall ensure that all clients in maintenance treatment receive an annual assessment. This assessment may coincide with the annual assessment of the treatment plan and shall include an evaluation of the client's progress in treatment and the justification for continued maintenance. The assessment and recommendations shall be recorded in the client record.
2. A client being withdrawn from maintenance treatment shall be closely supervised during withdrawal. A dosage reduction schedule shall be established by the physician.

(o) Services.

1. Comprehensive Services. A comprehensive range of services shall be available to each client. The type of services to be provided shall be determined by client needs, the characteristics of clients served, and the available community resources.
2. Counseling.
a. Each client on maintenance shall receive regular counseling. A minimum of one counseling session per week shall be provided to new clients through the first 90 days. A minimum of two counseling sessions per month shall be provided to clients who have been in treatment for at least 91 days and up to one year. A minimum of one counseling session per month shall be provided to clients who have been in treatment for longer than one year.
b. If fewer sessions are clinically indicated for a client, this shall be justified and documented in the client record. In no case shall sessions be scheduled less frequently than every 90 days. This would apply to those clients who have been with the program longer than three years and have demonstrated the need for less frequent counseling in accordance with documentation in the treatment plan.
c. A counseling session shall be at least 30 minutes in duration and shall be documented in the client record.

(6) Satellite Maintenance.

(a) A satellite maintenance dosing station must be operated by a primary, licensed comprehensive maintenance provider and must meet all applicable regulations in Rule 65D-30.004 and subsection 65D-30.014(4), F.A.C.
(b) In addition to the application for licensure for satellite maintenance, the comprehensive maintenance provider must submit a written protocol containing, at a minimum, a detailed service plan, a staffing pattern, a written agreement with any other organization providing facility or staff, operating procedures, and client eligibility and termination criteria.

Appendix T: Marchman Act Tools

Attached are several documents that may be used to assist in communicating the requirements of the Marchman Act involuntary admission provisions. These documents include:

1. A flyer explaining the involuntary admission provisions of the Marchman Act that can be used for public education or placed at the Clerk of the Courts. This flyer can be two-sided copied.

2. A one-page Quick Reference Guide to the Involuntary Admission procedures under the Marchman Act. This document can be laminated and kept as a ready reference to most critical provisions of the law.

3. A PowerPoint presentation (77 slides copied four to a page) for use in training persons on the client rights, provider responsibilities, and involuntary admission provisions of the Marchman Act.

Each of these documents can be modified to reflect local needs and resource information.

SECOND PETITION AND HEARING REQUIRED FOR TREATMENT

- In the involuntary assessment results identify a need for involuntary treatment, a second separate petition and hearing is required.
- The evaluator who conducted the involuntary assessment is required to be present at the hearing to provide testimony. Testimony by telephone may be permitted by the court.
- The judge or Master will review the completed assessment and all other relevant evidence. The burden is on the petitioner to prove by clear and convincing evidence that the criteria for involuntary treatment is met.
- At the end of the hearing, the court can either dismiss the petition or grant the petition and order up to 60 days of involuntary treatment .
- The treating facility may ask the court to request extensions of time after the first order if the person continues to meet the involuntary treatment criteria.

HOW CAN THE CLERK OF THE COURT HELP ME?

Staff in the Clerk of the Court's office can explain the procedures of the Marchman Act. They can provide forms for you to complete in seeking involuntary assessment and treatment for substance abuse. While the Clerk's staff cannot provide legal advice, they can guide you in the necessary steps to initiate Marchman Act proceedings.

WHERE TO GO FOR HELP

For information about what licensed substance abuse service providers exist in your community, contact: _____
_____

If a petitioner fails to properly prepare a petition or to provide valid evidence in the court hearing, the court may dismiss the petition. Assistance to explain the criteria for a petition and to plan where the person should go for assessment can be obtained by contacting:
_____
_____

To find out where to file a petition for involuntary substance abuse assessment and any costs involved, contact: _____
_____

Marchman Act
Florida's Substance Abuse Impairment Act
Chapter 397, Florida Statutes

The Marchman Act enacted in 1993 by the Florida Legislature, provides for voluntary admissions and involuntary assessment, stabilization, and treatment of adults and youth who are severely impaired due to substance abuse.

While the Marchman Act encourages persons with substance abuse impairment to seek treatment voluntarily, it also permits a law enforcement officer, a physician, or a judge to put a person in a licensed substance abuse facility for assessment and stabilization on an involuntary basis. A guardian can also apply for a minor's involuntary admission

Any adult or minor who seeks **voluntary** admission and meets a service provider's criteria for admission can apply for and receive care.

For **involuntary** admissions, there must be a good faith reason to believe the person is substance abuse impaired and because of the impairment, meets the following **criteria**:

- Has lost the power of self-control with respect to substance use; **and either:**
- Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; **or**
- 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.

Substance abuse impaired means a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance (illegal drugs or misuse of medications or other substances) in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior.

HOW TO INITIATE AN INVOLUNTARY ASSESSMENT

- A law enforcement officer can initiate protective custody for adults and youth in public places or who are brought to their attention.
- A physician who has personally observed the person may complete a certificate for involuntary admission upon application by concerned family members, and others.
- A minor's parent, guardian, or legal custodian may file an application at a Juvenile Addiction Receiving Facility.
- A Circuit Judge may enter an order for involuntary assessment, based on evidence given in a petition.

HOW TO ASK A JUDGE TO ORDER A SUBSTANCE ABUSE INVOLUNTARY ASSESSMENT

A petition for involuntary assessment and stabilization may be filed with the Clerk of the Court (Probate Office) at the local courthouse. If the petition is for an adult, it may be filed by a spouse or guardian, any relative, a private practitioner, the director of a licensed substance abuse agency, or any three adults who have personal knowledge of the person's substance abuse impairment. If the petition is for a minor, it can be filed by a parent, guardian, legal custodian, or licensed service provider.

BEFORE YOU FILL OUT A PETITION,

It is necessary to provide the following information when filing a petition about the person believed to have a substance abuse problem:

- Date of birth and physical description and distinguishing characteristics;
- Phone number and address (it is not possible to serve a notice on a missing person or on someone who is not in the county).
- The name of the person's attorney if any or his/her financial ability to hire one
- Name and address of parent, guardian, or spouse, if any.

WHAT INFORMATION IS REQUIRED ON A PETITION?

The criteria listed on page 1 of this pamphlet must be fully explained, including:

- The reason you believe the person is substance abuse impaired
- How he/she has lost the power of self-control over substance use
- How he/she is at risk of causing physical harm, or whose judgment is so impaired that the person is incapable of making rational decisions about the need for treatment.

WHERE WILL THE ASSESSMENT TAKE PLACE?

The petitioner must work out a plan as to where the person will be taken for assessment, based on the person's age, individual needs, and ability/inability to pay for care. There is no single receiving facility for assessments, but you may find help on page 4 of this pamphlet.

COURT HEARING PROCESS

After a petition has been filed, a Circuit Judge or Master may issue an order without a hearing (ex parte) or the judge may schedule a hearing within 10 days. At every stage of the process the person is entitled to be represented by an attorney.

If a hearing is scheduled:

- The petitioner and the person believed to have the substance abuse problem will be served with a Notice of Hearing.
- The petitioner must be present at the hearing and be prepared to testify about the facts stated in the petition.
- An attorney may be retained by the petitioner to ensure that the petition is filed correctly and that evidence is properly presented at the hearing.
- An attorney may be retained by the person or appointed by the court to represent him or her and an independent qualified professional can be appointed by the court.
- Witnesses must be present at the hearing to testify to having personally seen the person using drugs/alcohol, as well as other dangerous behaviors.
- The Judge will determine whether the criteria for involuntary assessment is present, and if so, the least restrictive setting for the assessment (inpatient or outpatient).
- At the hearing, information must be presented to the judge as to where the person may be taken for the assessment.

ASSESSMENT RESULTS / INVOLUNTARY TREATMENT

Within 5 days after a judge orders an involuntary inpatient admission for assessment (3 days for outpatient assessment), the person must be assessed to determine the need for further involuntary treatment. If the criteria is not met, the person may be discharged or transfer to voluntary status.

Quick Reference Guide to the Marchman Act

Admission	How Initiated	Means	Requirements	Length of Stay	Disposition
Protective Custody	Law Enforcement	LEO Report Initiating Protective Custody	Physician Assessment Release by Qualified Professional*	Up to 72 hours	• Discharge/Refer • Voluntarily Remain • Retain if petition filed
Emergency Admission	Adult: physician, spouse, guardian, relative, or other responsible adult Minor: parent, guardian, or legal custodian	Application and Physician's Certificate	Physician assessment qualified professional assessment to determine need for further services and approve release	Up to 72 hours or 5 days to a non-residential component	• Discharge/Refer • Voluntarily Remain • Retain if petition filed
Alternative Involuntary Admission for Minors	Minor's parent, guardian, or legal custodian	Application by eligible person	Assessment by qualified professional	Up to 72 hours – can be extended to 5 days total upon physician assessment.	• Discharge to parent, guardian, custodian, DCF, or DJJ • Voluntarily Remain • Retain if Petition Filed
Court-Ordered Assessment	Adult: spouse, guardian, relative, private practitioner, director of licensed provider, or 3 adults. Minor: parent, guardian, legal custodian or licensed service provider	Civil Order from a Circuit Judge – can be ex parte or following a scheduled hearing. Sheriff may be ordered to transport.	Assessed by qualified professional and by a physician.	Up to 5 days	• Discharge/Refer • Voluntarily Remain • Retain if petition filed
Involuntary Treatment	Adult: spouse, guardian, relative, service provider, or any 3 adults Minor: parent, legal guardian, or service provider	Civil Order from a Circuit Judge. Sheriff may be ordered to transport.	Authorizes the provider to require client to undergo treatment that will be beneficial until released by qualified professional.	Up to 60 days	• Discharge/Refer • Voluntarily Remain • Retain if extension requested
Extension of Involuntary Treatment	Service Provider at least 10 days prior to end of order	Hearing within 15 days an order from a Circuit Judge	Same as involuntary treatment.	Each extension up to 90 days	Same as involuntary treatment
Habitual Abusers	Agent specified in local ordinance files petition	Hearing within 10 days	Participation in treatment program	Up to 90 days in licensed secure facility with extensions of 180 days each	• Discharge/Refer • Voluntarily Remain • Retain if extension requested
Offender Referral	Court	Court order in addition to any other penalty or sentence.	Screening, assessment, and treatment services from licensed service provider	Up top maximum length of sentence for the offense.	
Inmate Programs	Federal and State Departments of Correction		Individualized treatment	Up top maximum length of sentence for the offense	One month before EOS given options for continuing services

* Qualified Professional: Physician licensed under 458 or 459; or Professional licensed under chapter 490 or 491 (Psychologist, Clinical SW, Marriage & Family Therapist or Mental Health Counselor); or Person who is certified through a DCF recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor's degree.

Marchman Act Power Point Presentation

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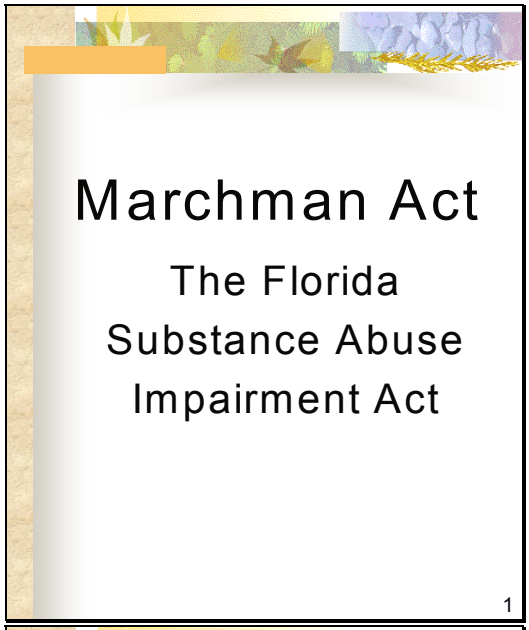

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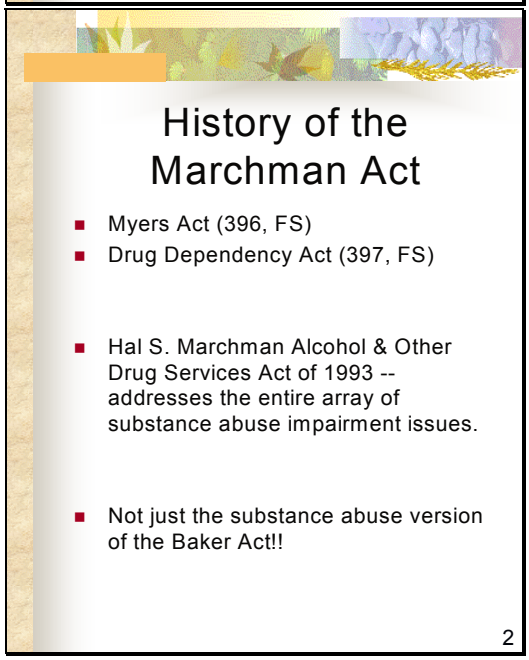

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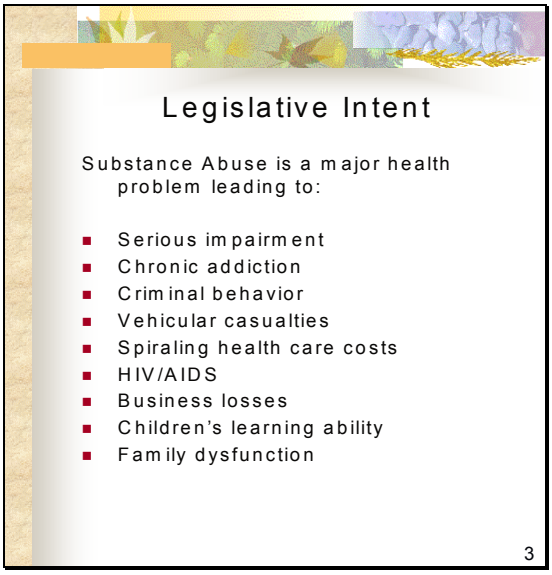

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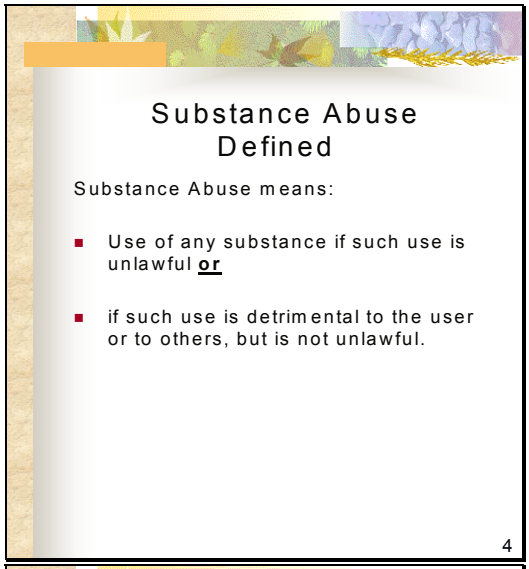

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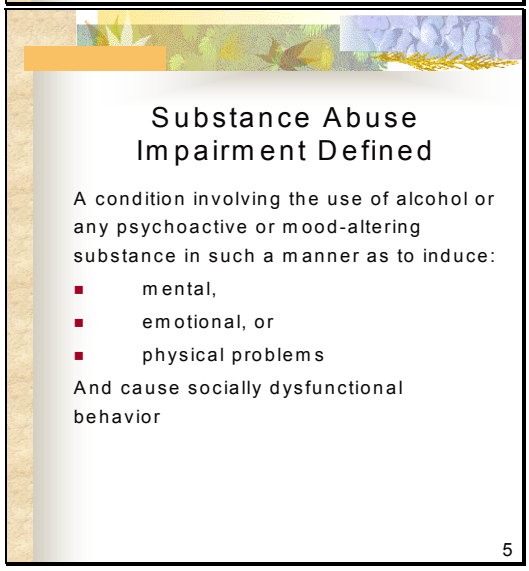

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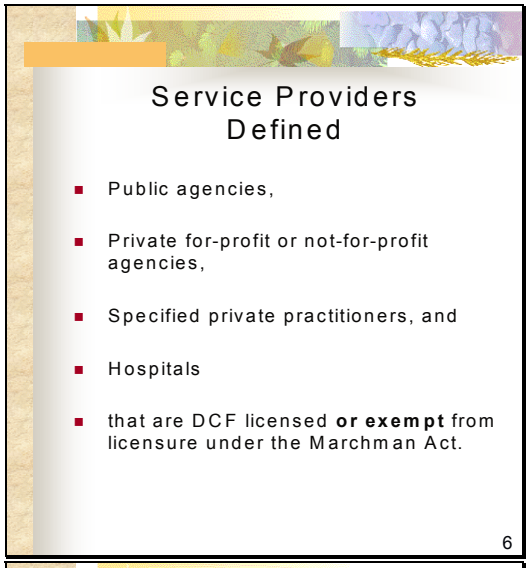

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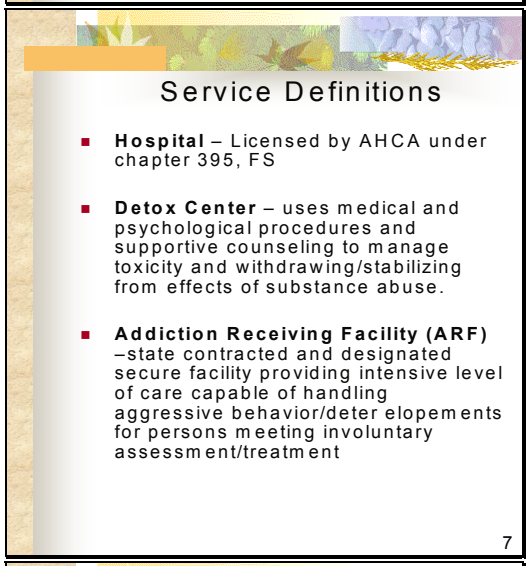

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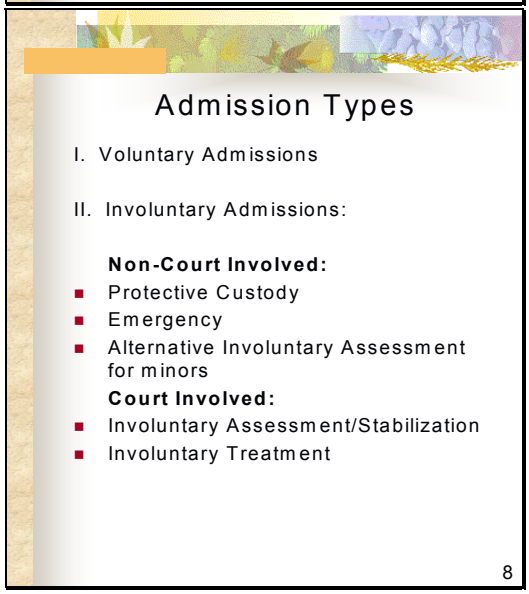

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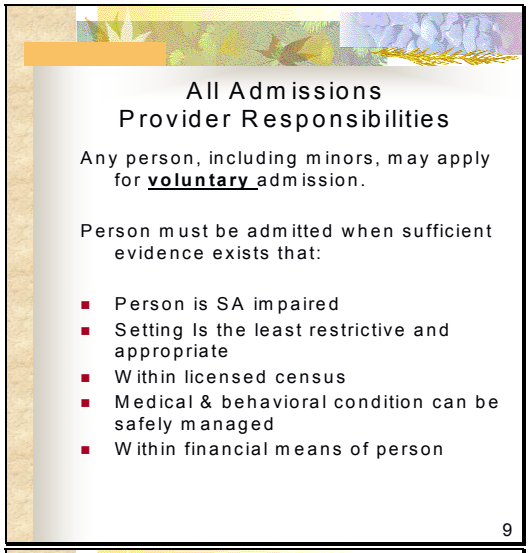

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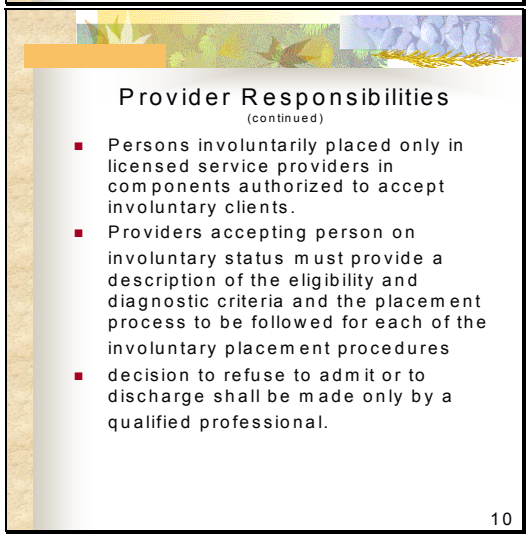

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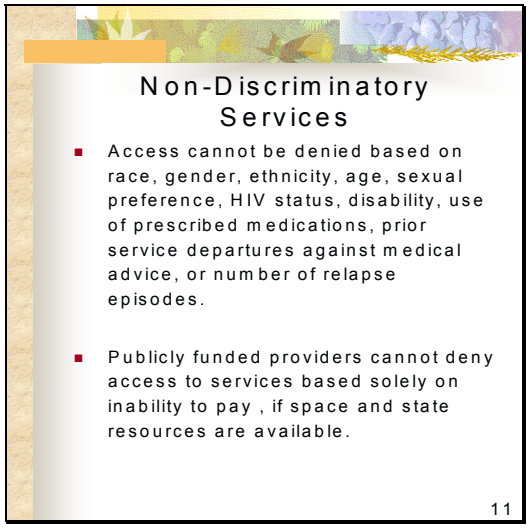

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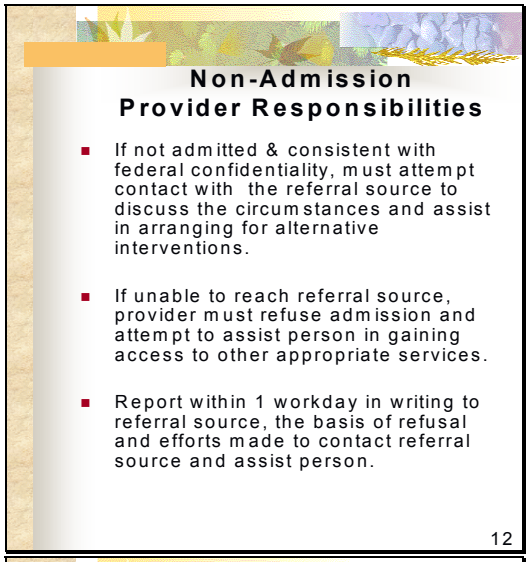

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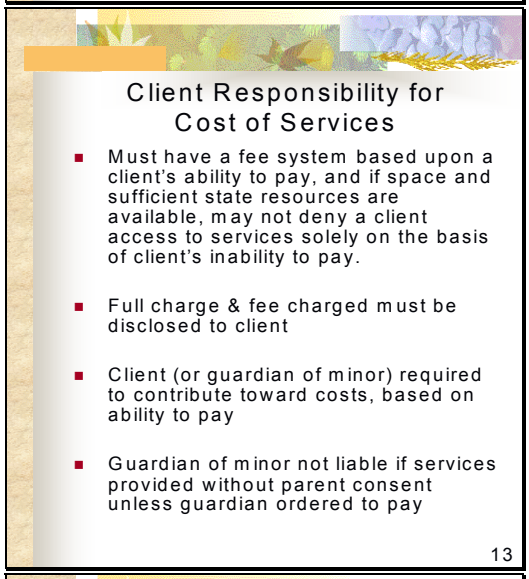

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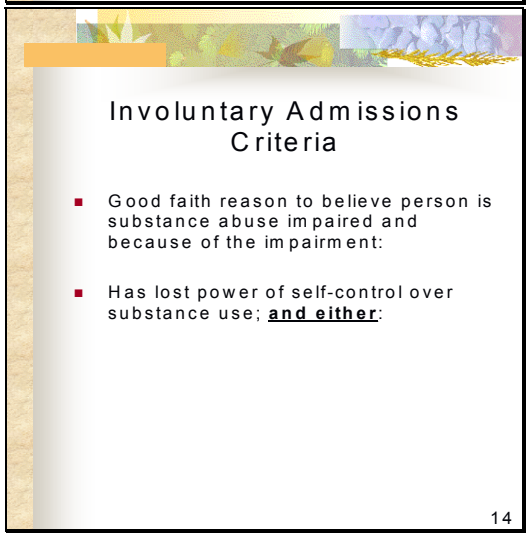

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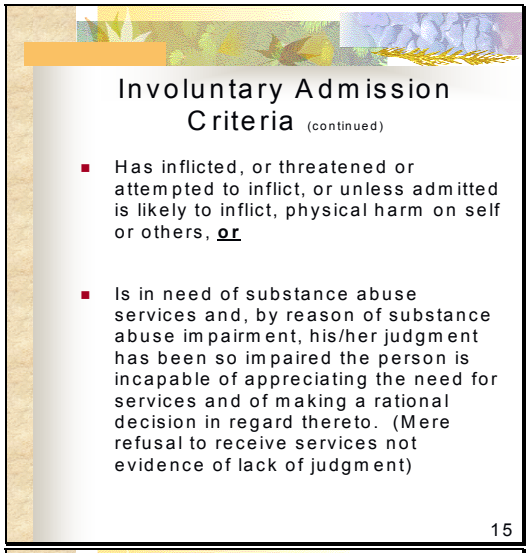

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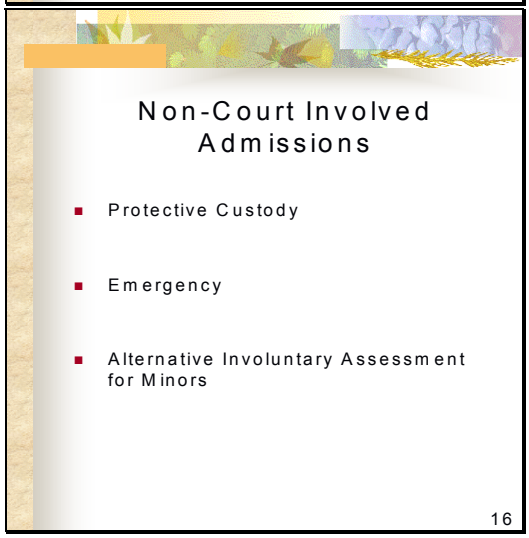

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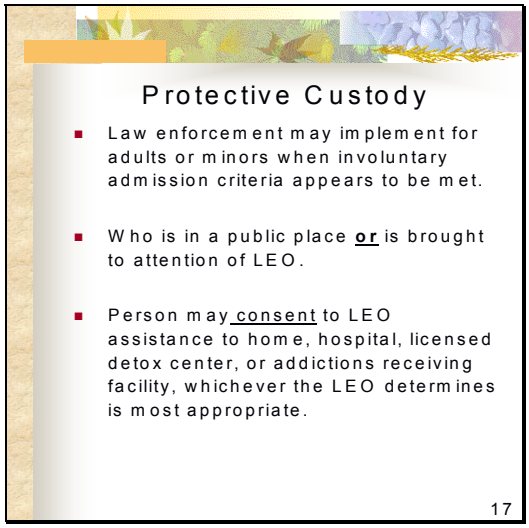

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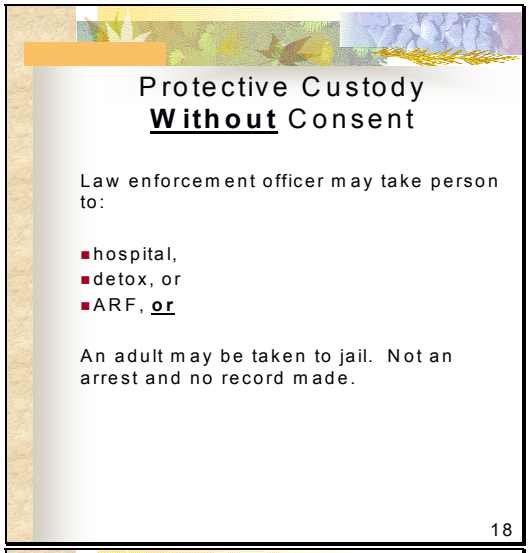

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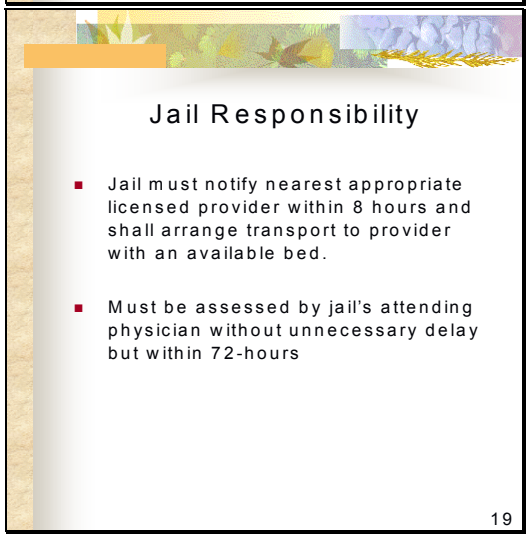

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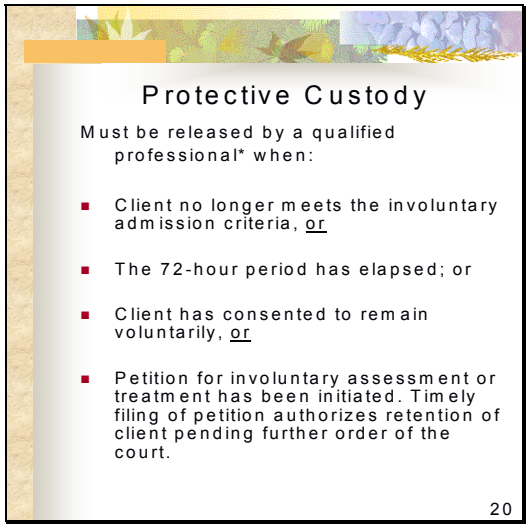

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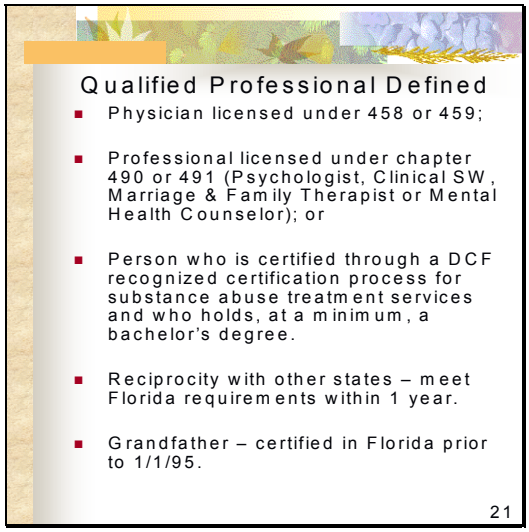

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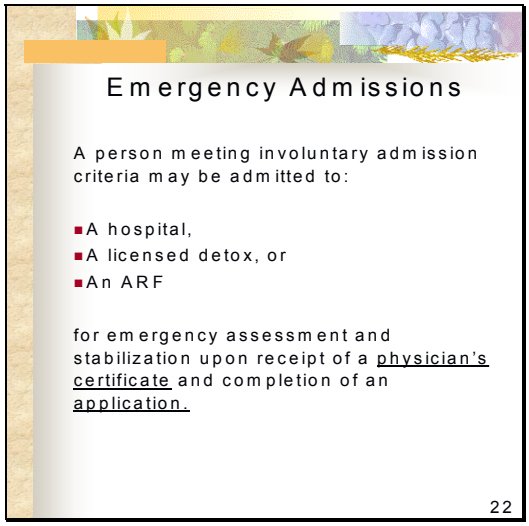

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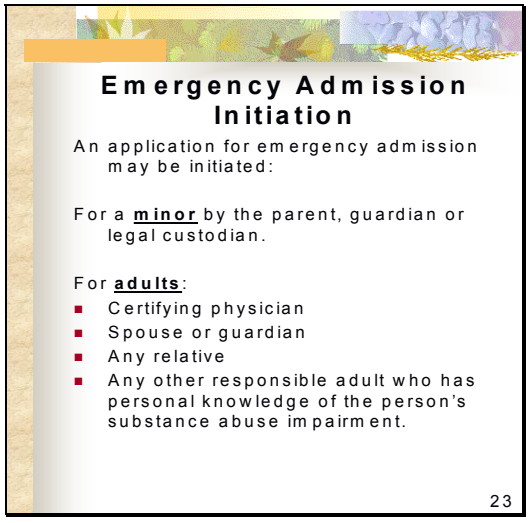

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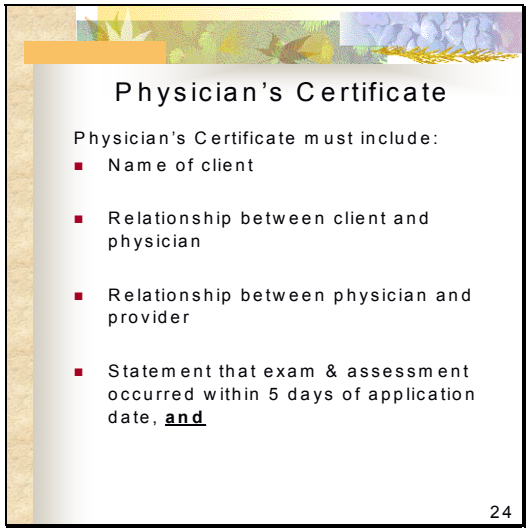

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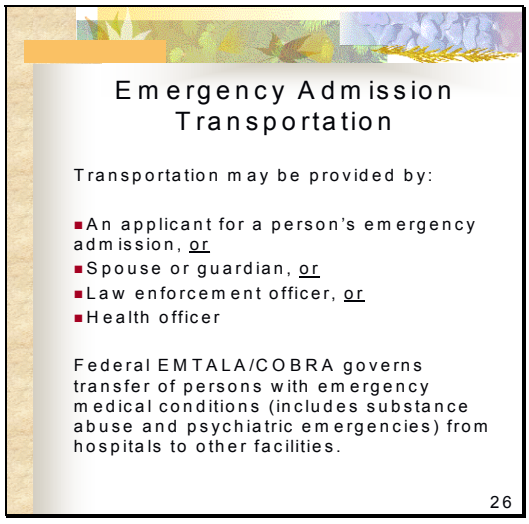

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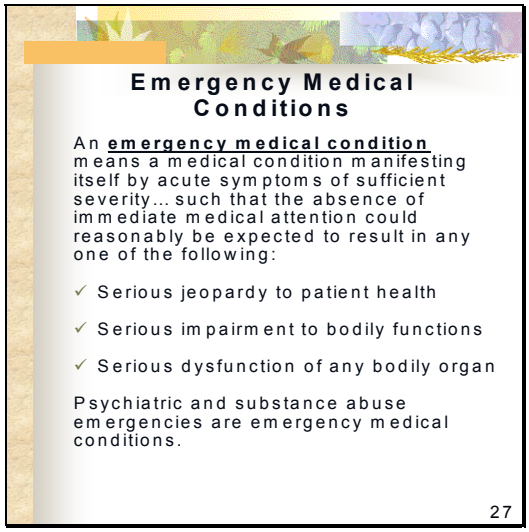

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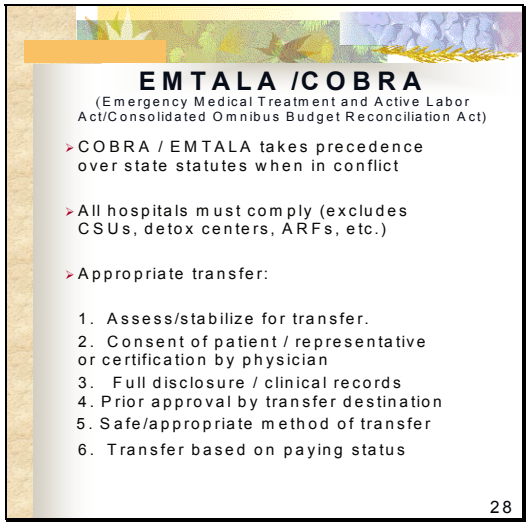

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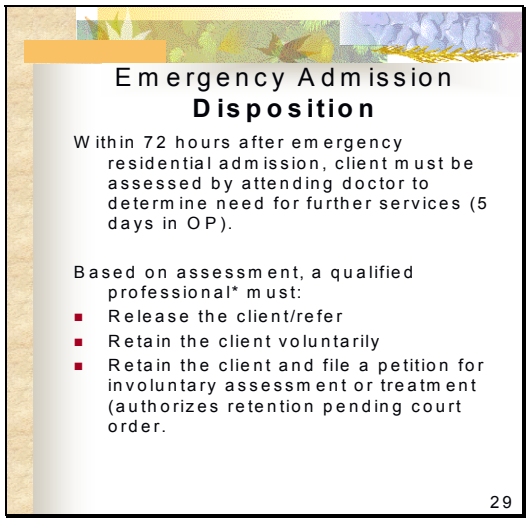

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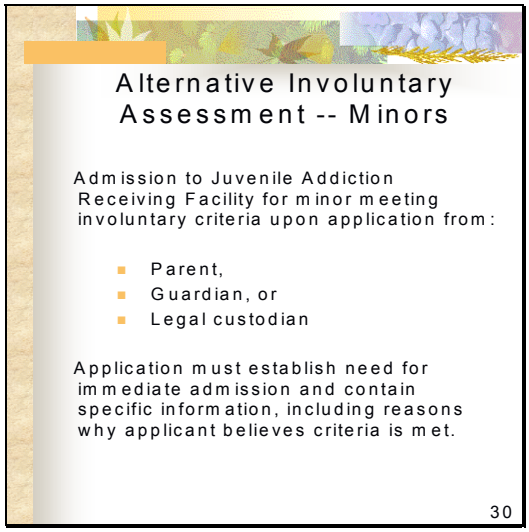

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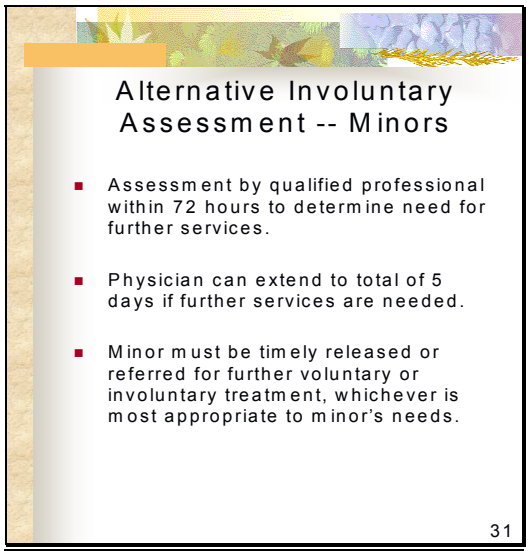

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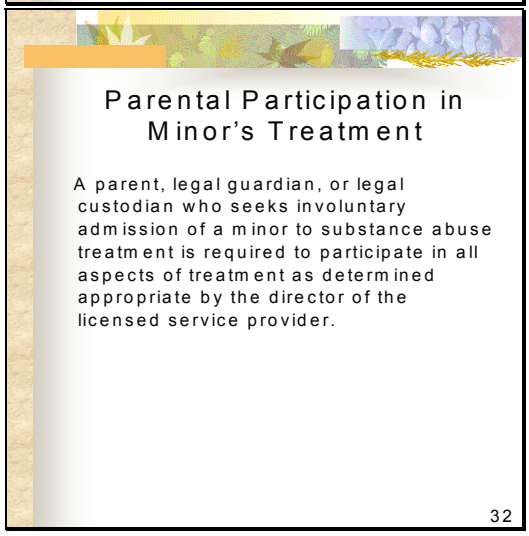

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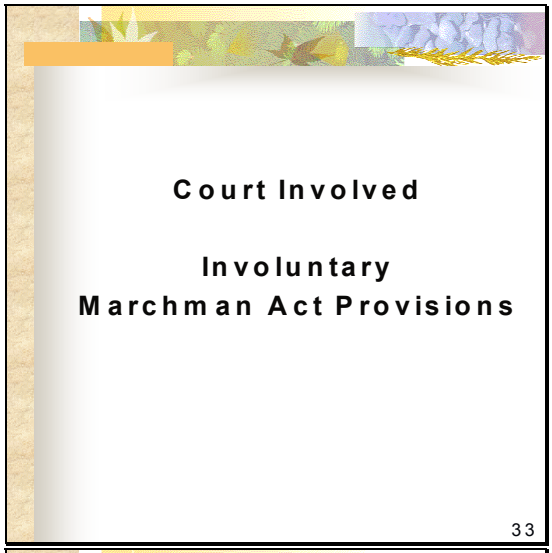

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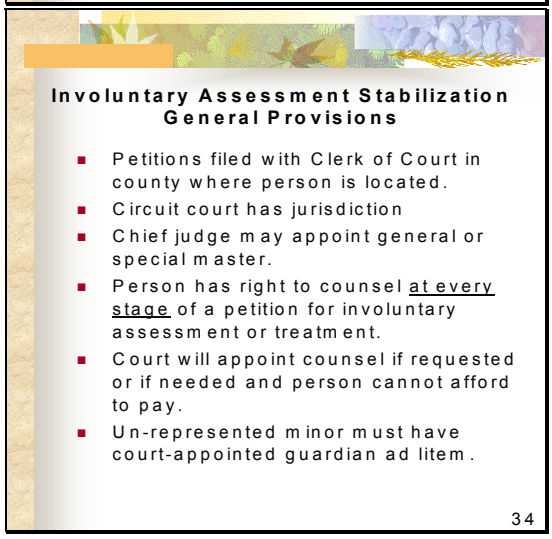

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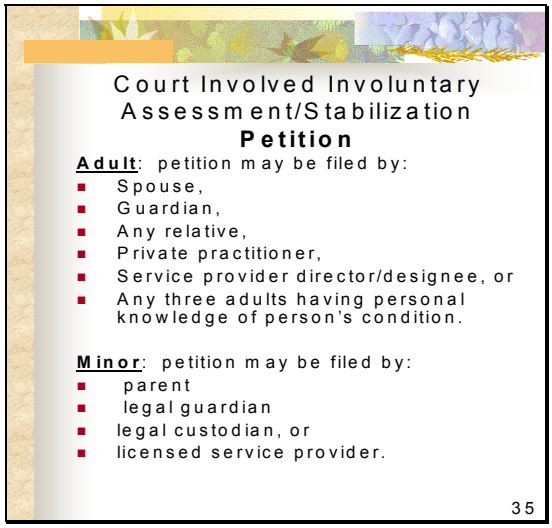

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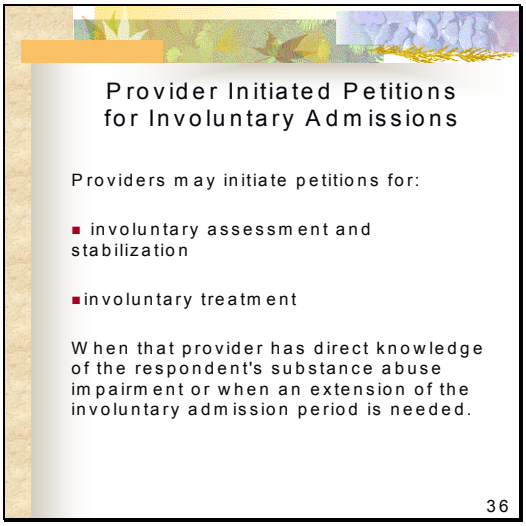

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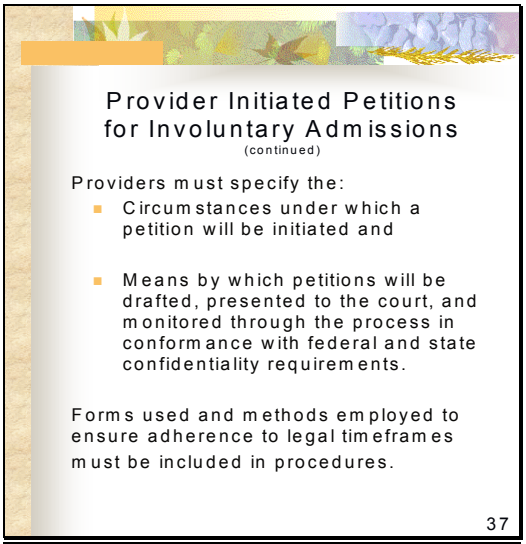

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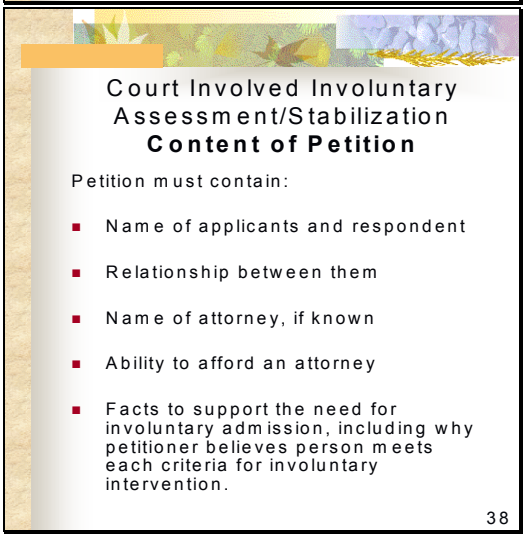

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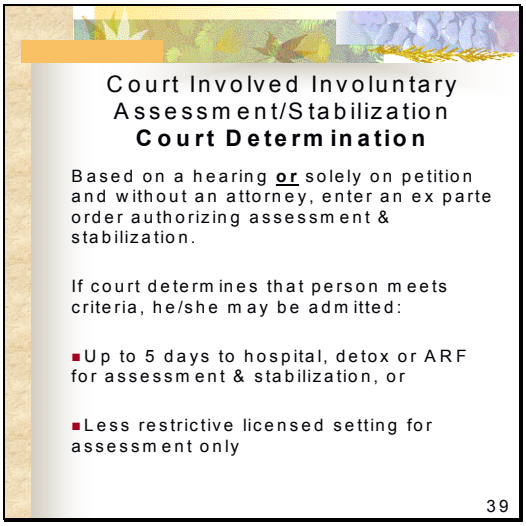

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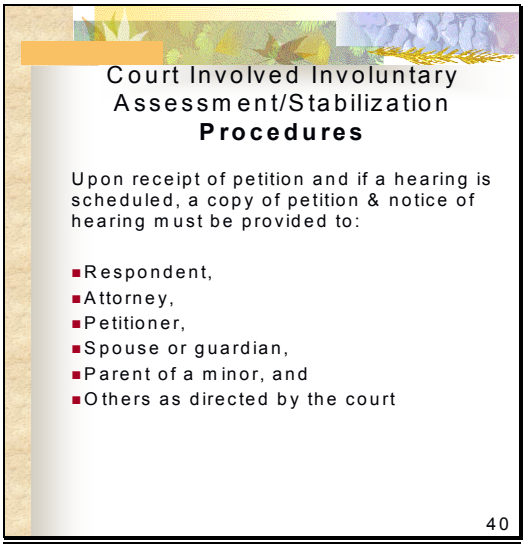

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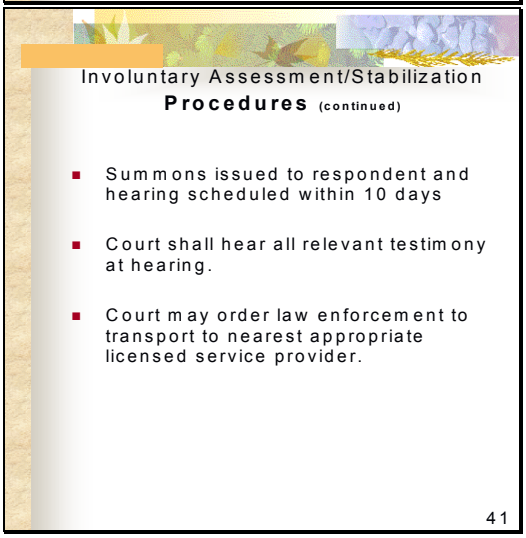

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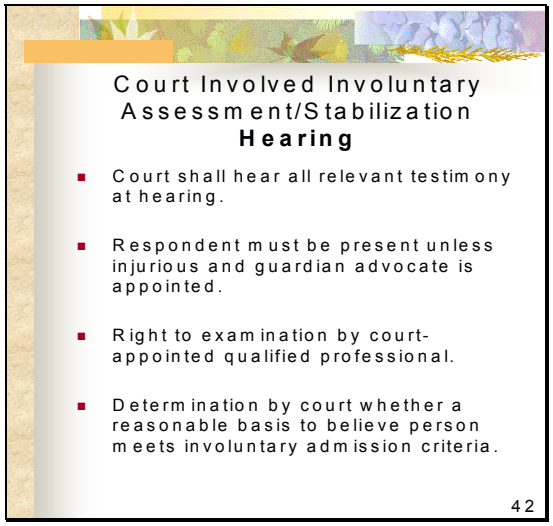

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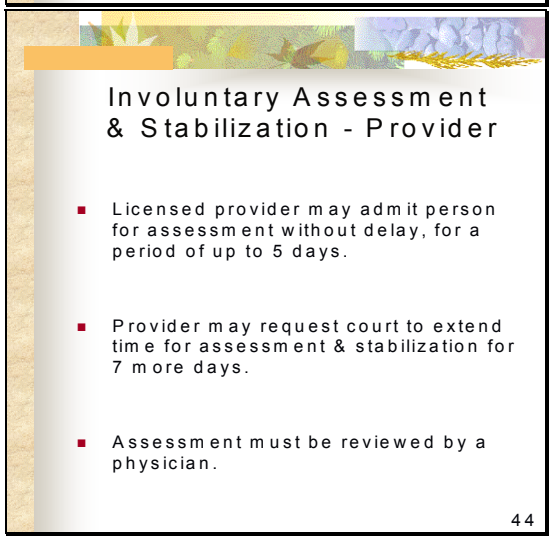

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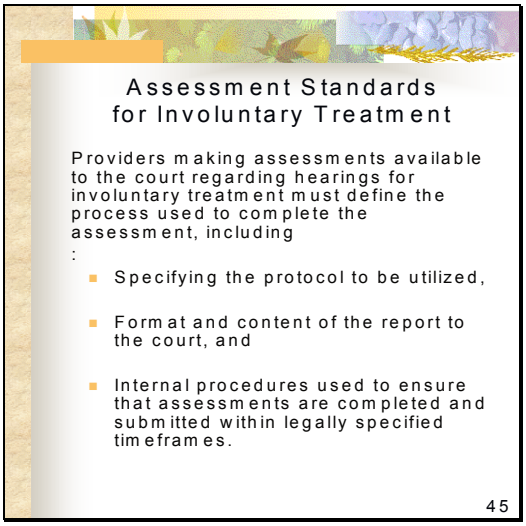

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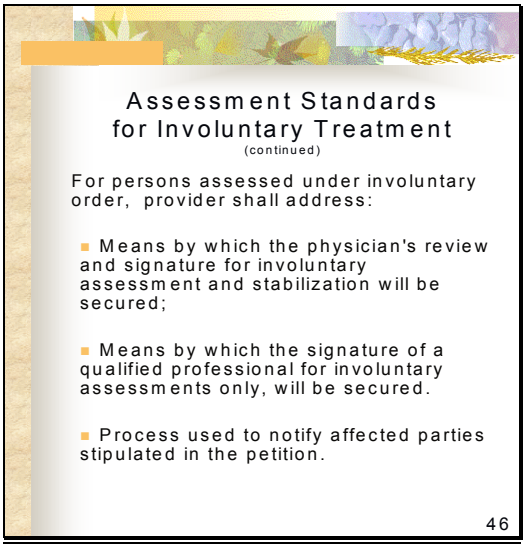

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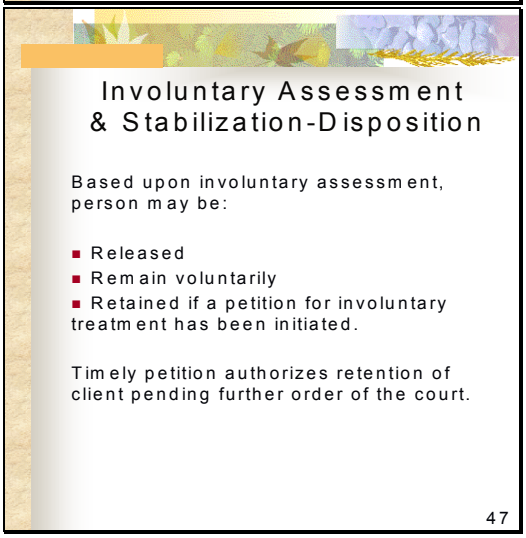

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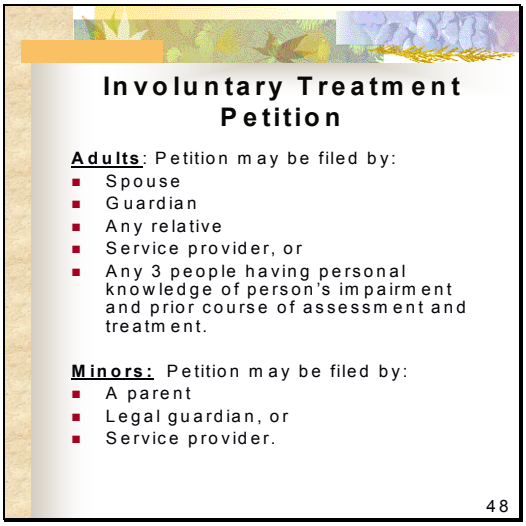

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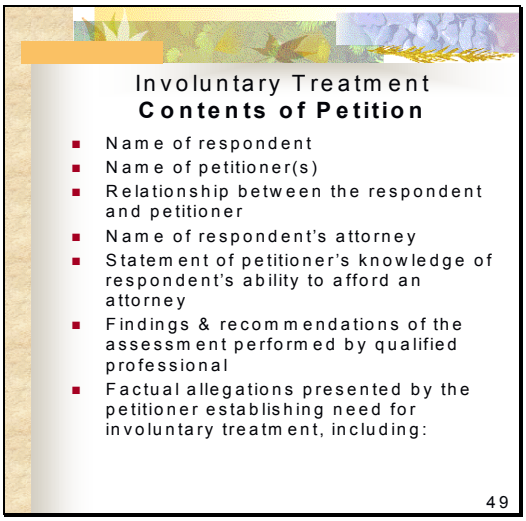

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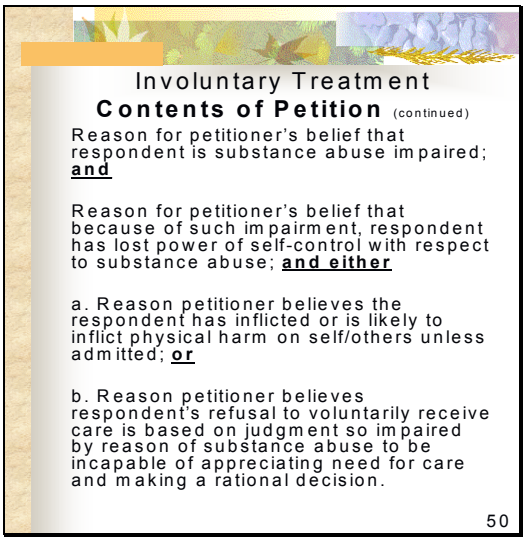

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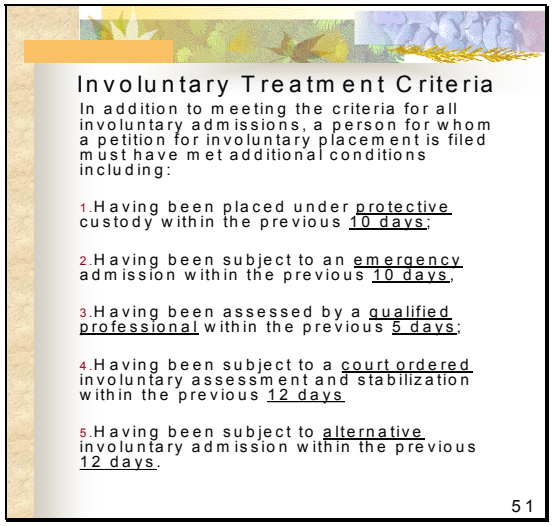

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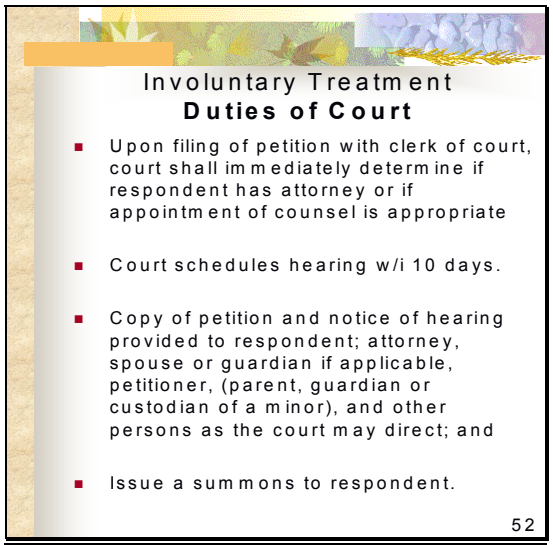

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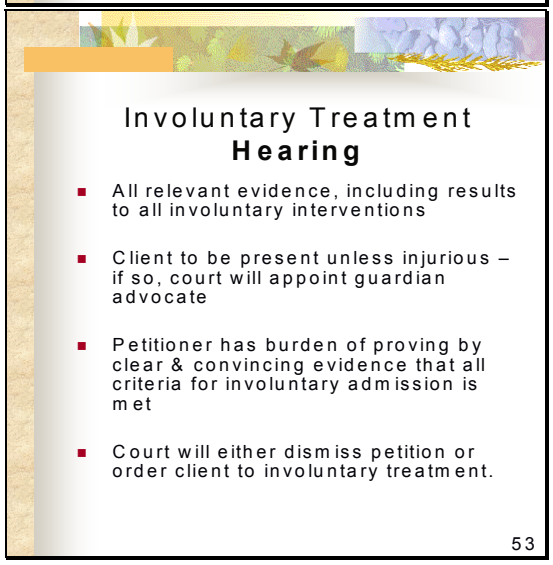

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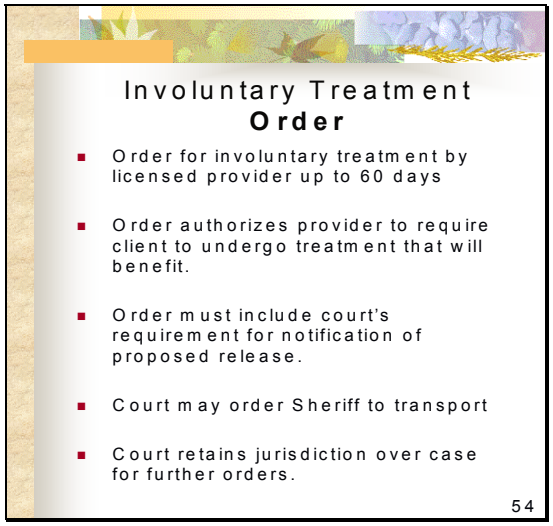

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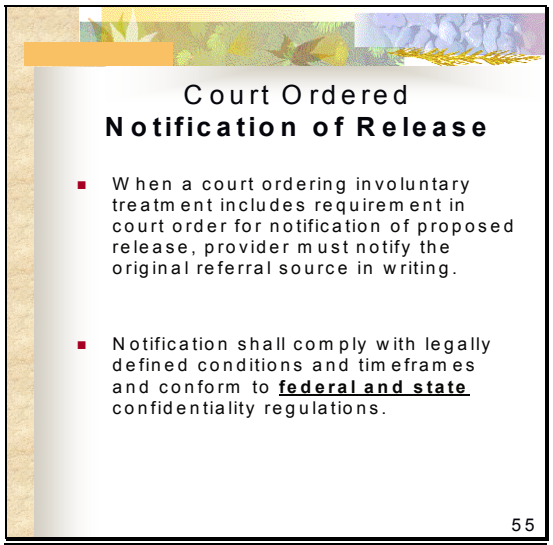

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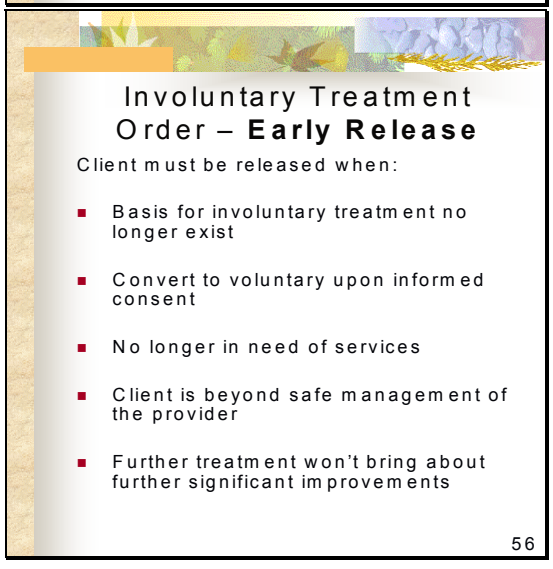

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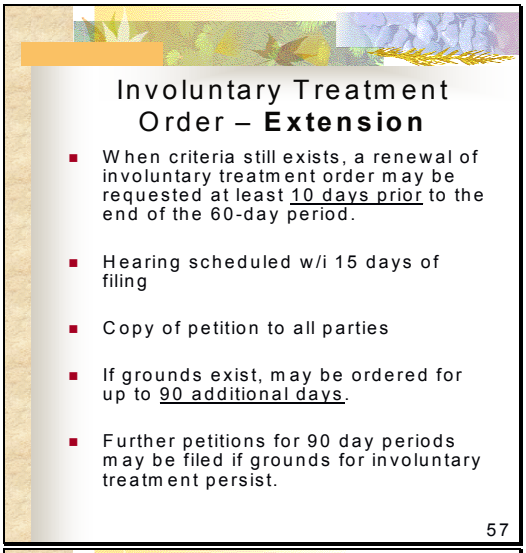

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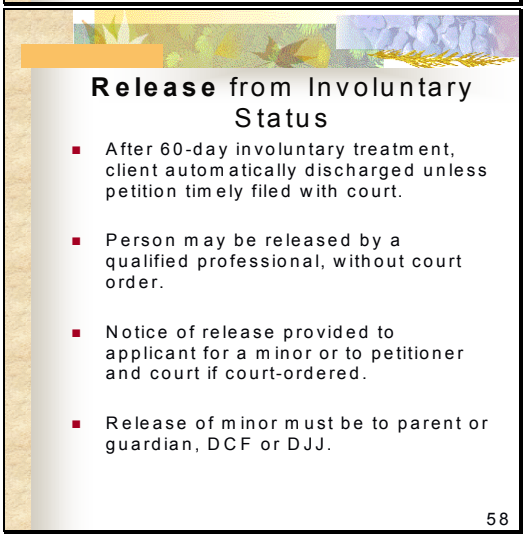

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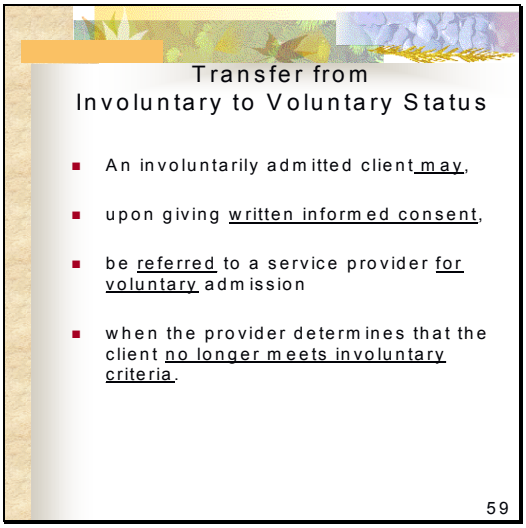

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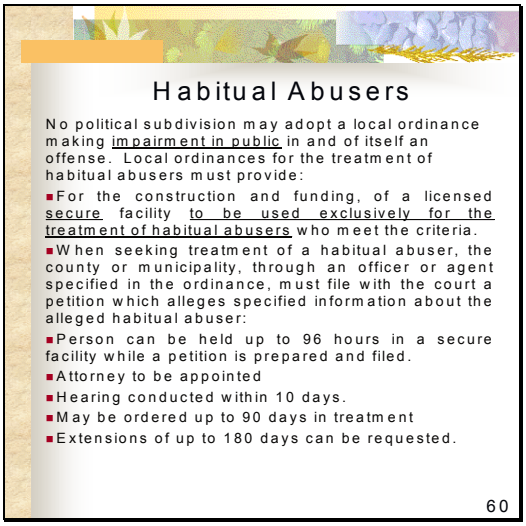

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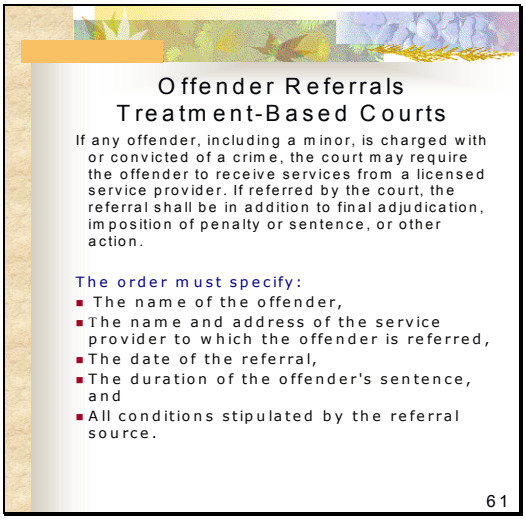

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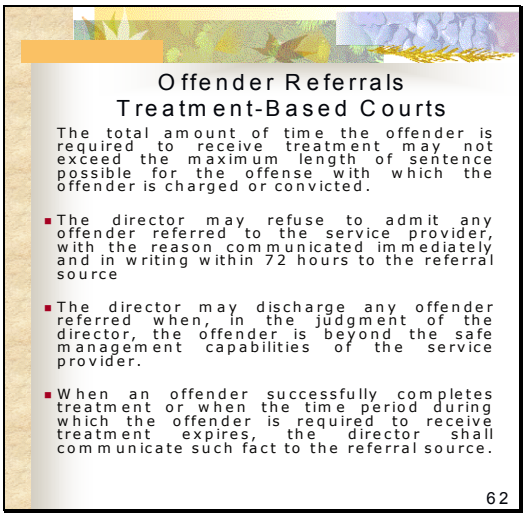

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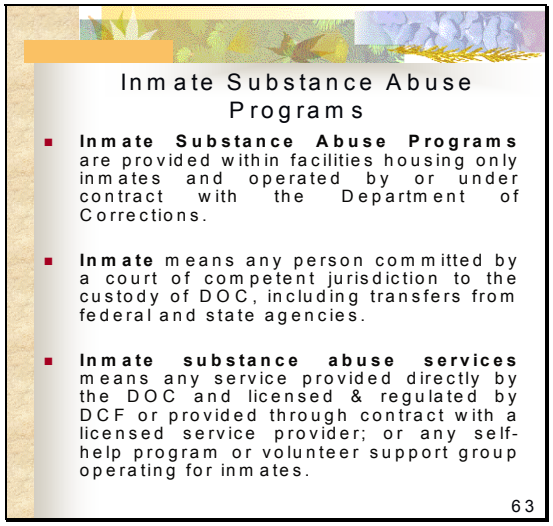

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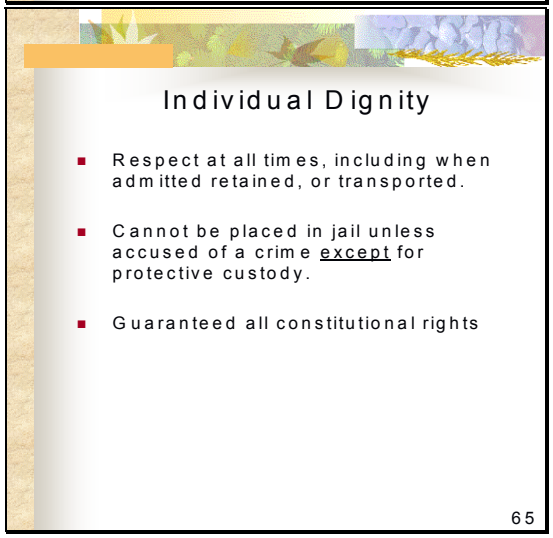

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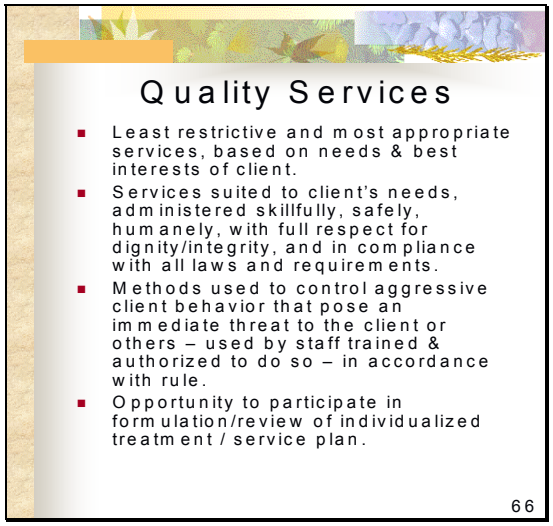

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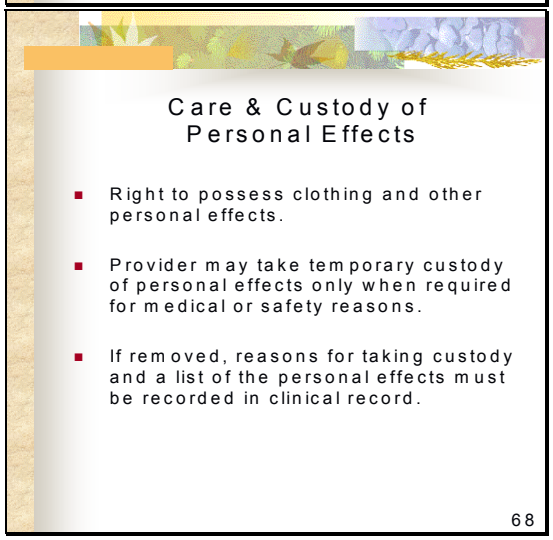

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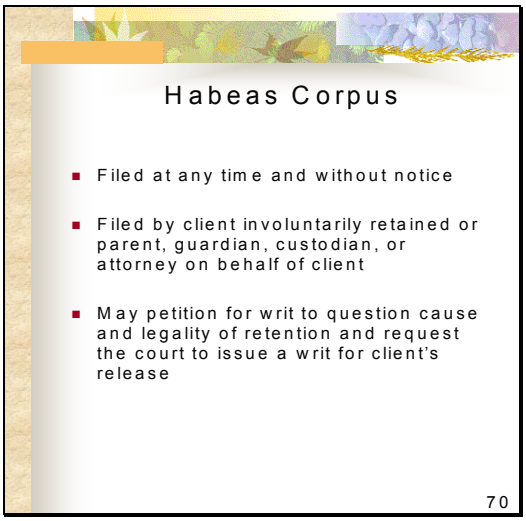

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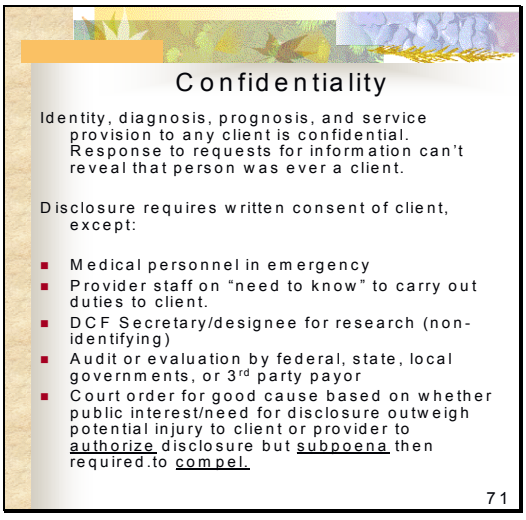

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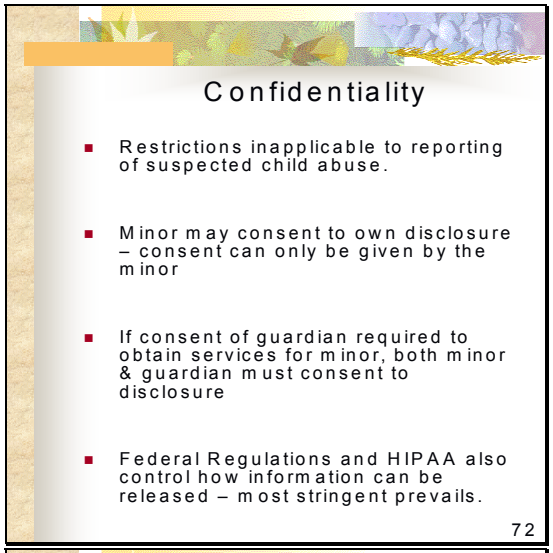

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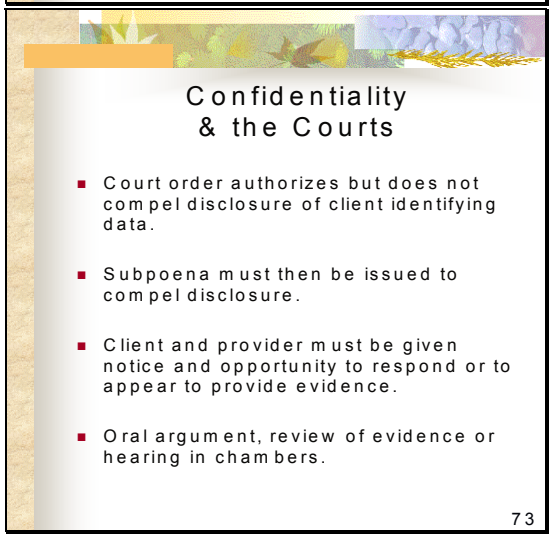

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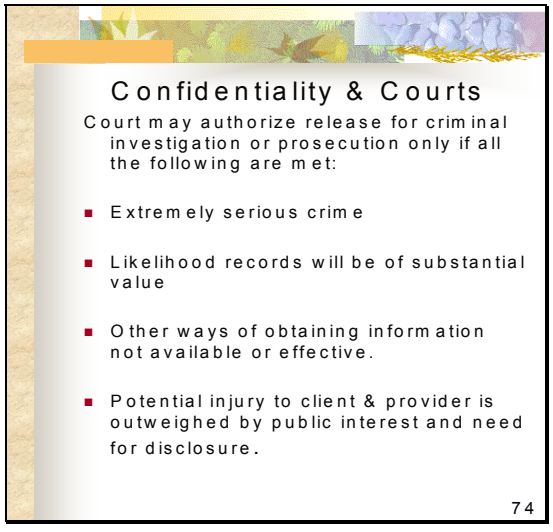

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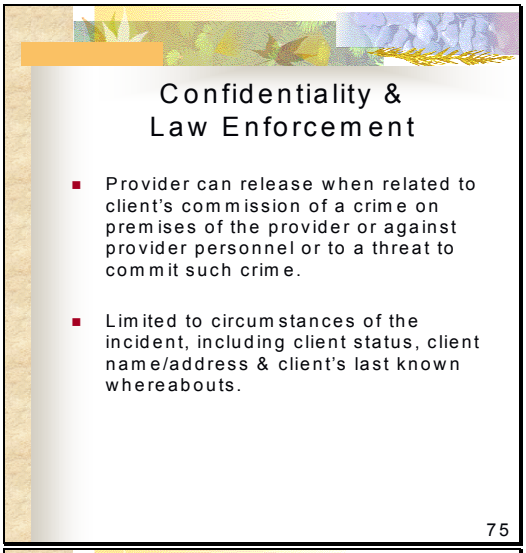

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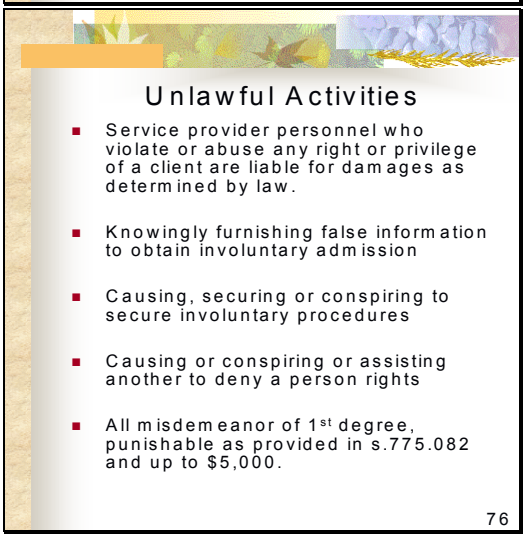

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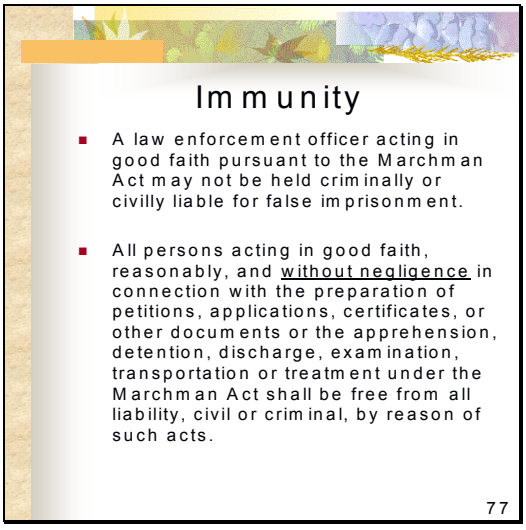

Marchman Act Forms

The Marchman Act forms included in this Handbook are recommended, but not required. Persons and organizations using these forms may adapt them to local needs.

Application for Voluntary Admission

I, _____ do hereby apply for admission to:

_____
Fill in name of facility

for assessment, stabilization or treatment of my substance abuse impairment, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for my admission to this facility is:

_____

_____

_____

_____

I have been provided with a written explanation of my rights and they have been fully explained to me. I understand that I may be billed for the cost of my treatment.

_____	_____	_____ am/pm
Client's Signature	Date (mm/dd/yyyy)	Time
_____	_____	_____am/pm
Signature of Witness	Date (mm/dd/yyyy)	Time

FORM MA-1 See s. 397.601, Florida Statutes MARCHMAN ACT

Notice of Voluntary Client's Right To Request Discharge
Part I

A voluntary client may request discharge either orally or in writing at any time following admission to the facility. If the request for discharge is made by a person other than the client, the discharge may depend on the express and informed consent of the client.

If you request discharge you will be discharged within ____ hours after your request unless you withdraw your request or you meet the criteria for involuntary treatment. If you meet the criteria for involuntary treatment, the facility administrator may file a petition with the court and you will be detained without your consent, pending a court hearing.

If you wish to request discharge at any time during your stay at this facility, complete the Application for Discharge below. No action on your part is required, unless you wish to make arrangements for release.

The procedure for requesting discharge has been explained to me and I have had the opportunity to ask questions and receive answers about my right to request discharge.

_____	_____	_____	_____ am pm
Printed Name of Client	Signature of Client	Date (mm/dd/yyyy	Time
_____	_____	_____	_____ am pm
Printed or Typed Name of Witness	Signature of Witness	Date (mm/dd/yyyy)	Time

Part II Application for Discharge

I, _____hereby apply for my release.

_____	_____	_____ am pm
Signature of Client or Authorized Person	Date (mm/dd/yyyy)	Time

---

Part III Withdrawal of Application for Discharge

I, _____, freely and voluntarily rescind my previous oral or written Application for Discharge. No force, fraud, deceit, duress, or other form of constraint or coercion were used to obtain this withdrawal of my Application for Discharge.

_____	_____ _____ am pm
Signature of ClientDate (mm/dd/yyyy)	Time

_____	_____	_____ _____ am pm
Signature of Witness	Credentials of Witness	Date (mm/dd/yyyy) Time

FORM MA-2 See s. 397.601, Florida Statutes MARCHMAN **ACT**

Report of Law Enforcement Officer Initiating Protective Custody
State of Florida, County of _____, Florida

I,_____, am a law enforcement officer certified by the State of Florida. I have good faith reason to believe that _____ appears to meet the following criteria for protective custody:

☐. He/she is substance abuse impaired and, because of such impairment:

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

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

☐ 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.

Circumstances which support this opinion: _____

_____

_____

_____

_____ _____ ____ am pm

Signature of Law Enforcement Officer | Date (mm/dd/yyyy) | Time

_____ _____

Printed Name of Law Enforcement Officer | Full Name of Law Enforcement Agency

_____ _____

Badge or ID Number | Law Enforcement Case Number

Transportation to Substance Abuse Provider

Location Found:	Taken To:		
Family members or others present when person was taken into custody			
Name	Address	Relationship	Phone Number
Next of Kin (if known)			

Indicate personal knowledge by family members and others about the person's condition

_____

_____

FORM MA-3 By Authority of s. 397.677, Florida Statutes **MARCHMAN ACT**

Application for Involuntary Emergency Admission
For Substance Abuse

I, _____ have personally observed the behavior of _____
(applicant) (person whose care is sought)
And believe he/she meets the criteria for emergency admission for substance abuse assessment and stabilization under chapter 397.6791 F.S. (Marchman Act).

INVOLUNTARY EMERGENCY ADMISSION CRITERIA:

I believe the person is substance abuse impaired because: _____

_____

_____

AND

I believe that because of such impairment, the person has lost the power of self control with respect to substance abuse for these reasons: _____

_____

_____:

AND EITHER

I believe that the person has inflicted or is likely to inflict physical harm on himself/herself or others unless admitted because: _____

_____

_____:

OR,

I believe that the persons refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable of appreciating his/her need for care and of making a rational decision regarding his/her need for care because: _____

_____

_____:

Involuntary Emergency Admission Request:

I request that the above named person be admitted for involuntary emergency admission due to substance abuse and a Physician's Certificate is attached. The information given in this application is true and correct.

Signature of Applicant: _____Date: _____Time _____

Witness Signature:_____ Date _____ Time _____

A signed copy of the Physician's Certificate must accompany the person and shall be made a part of the person's clinical record, together with a signed copy of the application. See back of form for Law Enforcement assistance

Application for Involuntary Emergency Admission for Substance Abuse
(continued)

TRANSPORTATION ASSISTANCE

The applicant, the person's spouse or guardian ( ) are able or ( ) are not able to provide transportation to deliver the person for emergency admission. The person may be found at: _____ _____. The following information is provided if needed to find the person so they may be taken into custody for involuntary emergency admission:

County of Residence:_____ Street Address:_____

Age:_____ Race:_____ Sex: _____ SS# _____

Height: _____ Weight _____ Hair Color_____ Eye Color: _____

Does person have access to any weapons? ☐ yes ☐ no If yes, describe:

_____

Is the person violent now? ☐ yes ☐ no If yes, describe _____

Does the person have any pending criminal charges against him/her? ☐ yes ☐ no If yes, describe_____

Does the person have a legal guardian? ☐ yes ☐ no If yes, who _____

FORM MA-4 See s.397.6791, 397.6793, and 397.6795, Florida Statutes MARCHMAN ACT

Physician Certificate for Emergency Admission

I certify that I have personally examined _____

on _____ at _____am/pm. Based on my examination, I conclude that the above
(date) **(time)**
named person is substance abuse impaired and is appropriate for emergency admission for substance abuse. This examination was performed within 5 days of the date of the application for admission.

My relationship to the person is:_____

My relationship to the applicant is:_____

My relationship to the licensed service provider is:_____

The person named above meets the following criteria for emergency admission:

1. The person named above is substance abuse impaired because:_____

_____

AND

2. Because of such impairment, the person has lost the power of self-control with respect to substance abuse for these reasons:

_____

_____

AND EITHER

3. The person has inflicted or is likely to inflict physical harm on himself or others unless admitted because:
_____

OR

4. The person's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable to appreciating his/her need for care or of making a rational decision regarding his/her need for care because: _____

Recommended Level of Care:

☐Hospital ☐Detoxification Center ☐Addiction Receiving Facility ☐Less Restrictive (assessment only)

Signature of Physician:_____ Date:_____ Time _____an/pm

Printed Name of Physician:_____ Phone #_____License #_____

A signed copy of the Physician's Certificate must accompany the person and shall be made a part of the person's clinical record, together with a signed copy of the application. See back of form for Law Enforcement assistance.

See 397.769, FS **MARCHMAN ACT**

Physician Certificate for Emergency Admission

A law enforcement officer is requested to provide transportation assistance for the said person for emergency substance abuse admission to the following facility: _____
Located at _____.
The person's present location is at: _____
If the person's present location is unknown, the following information is provided to assist law enforcement in finding the person so they may be taken into custody for involuntary emergency substance abuse admission:

County of Residence:_____ Street Address:_____
Age:_____ Race:_____ Sex: _____ SS# _____
Height: _____ Weight _____ Hair Color_____ Eye Color: _____
Does person have access to any weapons? ☐ yes ☐ no If yes, describe: _____
Is the person violent now? ☐ yes ☐ no If yes, describe _____
Does the person have any pending criminal charges against him/her? ☐ yes ☐ no If yes, describe_____
Does the person have a legal guardian? ☐ yes ☐ no If yes, who _____

FORM MA-5 See chapter 397.6793 and 397.6795, Florida Statutes MARCHMAN ACT

APPLICATION FOR ALTERNATIVE INVOLUNTARY ASSESSMENT FOR A MINOR IN ADDICTIONS RECEIVING FACILITY

By authority of Chapter 397.6798, Florida Statutes

I, _____, hereby state that I have personally observed the behavior of _____, and have a good faith reason to believe that he/she is a minor and substance abuse impaired and allege:

The Minor meets the criteria for involuntary admission as provided below in that:

(a) Applicant believes that the Minor is substance abuse impaired, as evidenced by (check all that apply):

___ Drug related law violation
___Stealing to support drug use
___Drug-related incident at school
___Obvious signs of impairment
___Found drugs with belongings
___Possesses paraphernalia
____Drug-related weight loss
____Aggressive or violent behavior
____Severe mood sings
____Stealing parent's liquor
____Taking parent's medication
Other: _____
_____

(b) Because of such impairment the Minor has lost the power of self-control with respect to substance abuse, (such as disruptions caused in school, with the law, with peers, and/or with family) as evidenced by: _____
_____
_____
__**AND**

(c) _____ The Minor has inflicted or is likely to inflict physical harm on himself or others unless admitted, as evidenced by: _____
_____
_____**OR,**

_____The Minor's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the Minor is incapable of appreciating his/her need for care and making a rational decision regarding his/her need for care (what you have done to get your son or daughter into treatment), as evidenced by:

_____
_____.

Applicant's Name: _____ Signature: _____
(Please Print) ☐Parent ☐Guardian ☐Legal Custodian

Address: _____
Phone Number: _____

NOTE: All information pertaining to the person is confidential and is protected from disclosure under the authority found in s. 397. 501 (7), Florida Statutes, and 42 Code of Federal Regulations, Part 2.

FORM MA-6 See 397.6798, Florida Statutes MARCHMAN ACT

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

IN RE: CASE NO.:

_____
Respondent:
_____/

Petition and Affidavit Seeking Involuntary Substance Abuse Assessment and Stabilization

I, _____ being duly sworn, am filing this sworn statement requesting a court order
(Print Name of Petitioner)
for the involuntary assessment of _____ (hereinafter referred to as PERSON).
(Print Name of Person

The PERSON is 18 years of age or older? ☐ yes or ☐ no Age of PERSON: _____

This petition and affidavit will be included in the PERSON's clinical record and may be viewed by the PERSON. I understand that by filling out this form, the PERSON may be taken by law enforcement to a hospital or licensed substance abuse facility for assessment and stabilization.

I SWEAR that the answers to the following questions are given honestly, in good faith, and to the best of my knowledge.

1. a. I live at: (Print Your Full Residence Address and Phone Number) Phone: (____) _____

   Street Address: _____ City _____ ST _____ Zip _____

   b. The PERSON lives at, or may be found at, the following address(es):

   Street Address: _____City _____

   Street Address: _____ City _____

2. I have the following relationship with the PERSON: _____
3. I am on good terms with the PERSON at the present time. (Check one box) ☐ Yes ☐ No If "no", please explain: _____

   _____
4. (Check the box that applies)
   ☐ a. I or a family member☐ have or ☐ have not previously made allegations to law enforcement involving this PERSON on _____ (Date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, etc. as described: _____

   _____

   ☐ b. This PERSON ☐ has or ☐ has not previously made allegations to law enforcement about me or my family on _____ (Date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, etc. as described: _____

   _____

☐ c. This PERSON ☐has or ☐ has not previously or currently criminal/delinquency charges.

5. (Check the one box that applies)
☐ a. I or a family member are not now, and have not in the past, been involved in a court case with the PERSON.
☐ b. I or a family member am now, or was, involved in a court case with the PERSON. This case is/was a _____ in _____
(type of case) (when)
Explain:_____
_____

6. I have known the PERSON for _____ (how long).
☐ a. The PERSON has only recently displayed behavior related to substance abuse.
☐ b. The PERSON has, over a period of time, had a substance abuse problem. Specify how long:
_____

COMPLETE THE FOLLOWING ONLY IF THE SECTION APPLIES TO THIS CASE:

7. I believe that the PERSON is substance abuse impaired (defined in the law as 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):_____
_____
_____
_____

8. I believe that the PERSON has lost the power of self-control with respect to substance use because:
_____
_____
_____

9. I have seen the following behavior, which causes me to believe that the that the PERSON has inflicted, or threatened or attempted to inflict, or unless admitted for assessment is likely to inflict, physical harm on himself or herself or someone else On_____ at approximately_____ am pm, I saw the PERSON:
Date Time
_____
_____
_____

10. Other similar behavior I have personally seen is as follows: _____
_____
_____

11. I believe the PERSON is in need of substance abuse services because his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision about services because (a mere refusal to receive services is not enough to constitute lack of judgment): _____
_____

12. ☐ To my knowledge or belief, I do not believe these actions were a result of mental illness, retardation, developmental disability, or conditions resulting from antisocial behavior.

CHECK AND/OR ANSWER APPLICABLE SECTIONS

13. ☐ a. I have attempted to get the PERSON to agree to seek assistance for a substance abuse problem(s) as follows: _____
_____
_____

☐ b. I did not try to get the PERSON to agree to a voluntary assessment or treatment because: _____
_____
_____

☐ c. The PERSON refused a voluntary assessment or treatment because: _____
_____

14. ☐I have made arrangements for the PERSON to be admitted to _____Facility located at _____ for voluntary assessment and stabilization.

15. The name of the PERSON's attorney is (if any): _____

16. PERSON ☐ can ☐cannot afford an attorney. If not, petitioner requests the court to appoint an attorney to represent the PERSON.

Provide the following identifying information about the person (if known) if it is determined necessary to take the person into custody for examination:
County of Residence: Social Security No.: Date of Birth
Sex : ☐ Male ☐ Female Race: _____ Attach a picture of the PERSON if possible -Picture attached: ☐ No ☐ Yes
Height: Weight: Hair Color: Eye Color:
Does the PERSON have access to any weapons? ☐ No ☐ Yes If yes, describe:
Is the PERSON violent now? ☐ No ☐ Yes Has the PERSON t been violent in the recent past? ☐ No ☐ Yes If Yes, Describe:
Does the PERSON have any pending criminal charges against him/her? ☐ No ☐ Yes If yes, describe:
1) Does the PERSON have a legal guardian? ☐ No ☐ Yes 2) Is there a pending petition to determine the PERSON's capacity and to appoint a guardian? ☐ No ☐ Yes If YES to either of the above, provide the name, address and phone number of the current or proposed guardian. Name: _____ Phone: (_____) _____ Address: _____City: _____ Zip: _____ **Physician's** Name: :_____ Phone: (_____) _____ Provide name of medications, if known._____

I understand that this sworn statement is given under oath and will be treated as though it was made before a judge in a court of law. I understand that any information in this sworn statement which is not to the best of my knowledge and done in good faith may expose me to a penalty for perjury and other possible penalties under the statutes of the State of Florida. Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

Signature of Affiant/Petitioner: _____

SWORN TO AND SUBSCRIBED before me this _____ day of _____, _____ by _____ who is personally known to me or presented _____ as identification.

_____
Notary Public - State of Florida
My Commission expires: Date _____

OR

SWORN TO AND SUBSCRIBED before me this _____ day of _____ clerk of Circuit Court _____County, Florida

By: _____
Deputy Clerk

A copy of this petition must be attached to an Order for Involuntary Substance Abuse Assessment and Stabilization and accompany the PERSON to a licensed hospital or substance abuse facility that has agreed to accept the PERSON.

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

IN RE:

Case No: _____

Respondent:
_____/

EX-PARTE
ORDER FOR INVOLUNTARY ASSESSMENT AND STABILIZATION FOR SUBSTANCE ABUSE
(Pursuant To Sec. 397.6815(2), Florida Statutes)

Pursuant to Florida Statutes Chapter 397, the Court finds there is a reasonable basis to believe the Respondent meets the criteria for involuntary assessment and stabilization based on the following:

(a) The Petition for Involuntary Assessment and Stabilization was filed by: _____
_____
_____, who is/are given the authority by Florida Statues Chapter 397.6811(1), to file.

(b) The Respondent is substance abuse impaired, as defined by Florida Statues Chapter 397.311 (16), as evidenced by: _____
_____**.**

(c) The Respondent meets the involuntary admission criteria of s.397.675, Florida Statues, as evidenced by
_____
_____.

(d) The most appropriate and available, least restrictive alternative is the Designated Service Provider named below:
_____
_____. _____

(e) The Respondent:
☐Waived the right to an attorney.
☐Was represented by an attorney.

(f) The Respondent:
☐Was present at the hearing.
☐Was not present at the hearing.

IT IS ORDERED that based on the above findings:

☐The Petition for Involuntary Assessment and Stabilization is **GRANTED.**
☐The Petition for Involuntary Assessment and Stabilization is **DENIED**.
☐A law enforcement officer take the Respondent, _____ into custody and deliver the Respondent to the licensed service provider listed above. If not

otherwise specified, the law enforcement officer is to transport respondent to the nearest appropriate licensed service provider, for an involuntary assessment for a period not to exceed five days.

a.) The Facility shall notify the Court in writing under oath if the Respondent fails to appear for the assessment.

b.) The Respondent is subject to contempt of court and a jail sentence for failure to comply with this Order.

c.) The assessment period begins when the Respondent is admitted to the Facility pursuant to this Order.

DONE AND ORDERED IN _____, _____County,
(Town) (County)

Florida, this _____ day of _____, 20___.
(Day) (Month)

_____
Signature: Circuit Judge

Note: All information pertaining to the person is confidential and is protected from disclosure under the authority found in s. 397.501 (7), Florida Statutes, and 42 Code of Federal Regulations, Part 2.

Copies to be furnished To: Respondent
Respondent's Attorney
Petitioner(s)
Service Provider
Law Enforcement

IN THE CIRCUIT COURT OF THE

_____ JUDICIAL CIRCUIT,

IN AND FOR _____

COUNTY, FLORIDA

IN RE: CASE NO.:

_____

Respondent:

_____/

Notice of Right to Counsel and Request for Appointment of Counsel

YOU ARE HEREBY NOTIFIED that a petition for a hearing on involuntary substance abuse assessment and/or treatment on your behalf has been filed with the Court. Chapter 397, Florida Statutes requires that you be informed of your right to be represented by counsel at any stage of an involuntary proceeding for assessment, stabilization, or treatment and that you may apply immediately to the court to have an attorney appointed if you cannot afford one. If you are a minor, your parent, legal guardian, or legal custodian may apply for the appointment of an attorney. .

If you desire counsel and are unable to afford private counsel you have the right request to court-appointed counsel. If the court believes that you need the assistance of counsel, the court shall appoint such counsel for you without regard to your wishes. If you are a minor not otherwise represented in the proceeding, the court will immediately appoint a guardian ad litem to act on your behalf.

Please check the boxes below, as appropriate:

1. I am an adult ☐ minor ☐

2 I do ☐ do not ☐ wish to have counsel appointed on my behalf

3. I do☐ do not ☐ have private counsel

4. I can ☐ cannot ☐ afford private counsel

WHEREFORE, I respectfully request that this Court appoint counsel to represent me. I am filing this REQUEST FOR APPOINTMENT OF COUNSEL with the Clerk of Court prior to my hearing scheduled on the following date _____ so that an attorney can be appointed in time for the hearing. I certify that I do not have assets which would suffice for the payment of an attorney's fee for representing me in a hearing on the question of confinement for the purpose of involuntary assessment/stabilization or treatment.

_____	_____	_____
Printed Name of Respondent	**Signature of Respondent**	**Date (mm/dd/yyyy)**

FORM MA-9 See s. 397501(8) and 397.681(2), Florida Statutes **MARCHMAN ACT**

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

IN RE: CASE NO.:

_____

Respondent:

_____/

Order Setting Hearing on Involuntary Assessment and Stabilization, Order of Referral to General Master and Order Appointing Attorney

THIS CAUSE coming on to be heard before the Court's own motion upon receipt of a petition for substance abuse involuntary assessment and stabilization of _____, it is ORDERED:

1) That a hearing will be conducted on the Petition for involuntary assessment and stabilization at, _____on the ____day of _____, 20____, at ___:___M. The basis for this hearing and the possible involuntary detention which may result therefrom is a Petition for Involuntary Assessment and Stabilization executed by _____, alleging that the criteria required by Florida Statute are satisfied.

2) That absent further Order of this Court, all matters not specifically set before the Judge are hereby referred to the presiding General Master of this Court for further proceedings pursuant to Rule 1.490 of the Florida Rules of Civil Procedure and current Orders of the Court, and said General Master is authorized to require such investigations and examinations and hold such hearings as may be deemed necessary, and shall report back to this Court the Master's findings and recommendations, as soon as practicable.

3) That
_____UPON THE COURT'S OWN MOTION, the above named person, appearing to be indigent and needing the assignment of counsel, thereupon, it is,

_____HAVING RECEIVED AN AFFIDAVIT OF INDIGENCY, signed by the above named person requesting the assignment of counsel, thereupon, it is,

ORDERD AND ADJUDGED THAT _____, is hereby appointed to represent the person for all proceedings that arise under this petition for substance abuse involuntary assessment and stabilization.

DONE AND ORDERED on this ____day of _____, 20__, in _____County, Florida.

_____
CIRCUIT JUDGE

CC: Hearing Master
Public Defender
Respondent

FORM MA-10 See section 397.6818, Florida Statutes MARCHMAN ACT

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

IN RE: CASE NO.:

_____
Respondent:

_____/

Order to Appear at Hearing, and Denying Ex Parte Assessment/Stabilization

THIS MATTER came to be considered pursuant to sections 397.6814, and 397.6815, Florida Statutes, upon a petition for ex parte order authorizing the involuntary assessment and/or stabilization of the above-named person. The Court, having considered the petition, finds as follows:

1. An ex parte order directing a law enforcement officer to take the above-named person into custody and deliver said person to the nearest appropriate licensed service provider should not be entered at this time, because:

____ The petition does not demonstrate that the above-named person meets the criteria for involuntary admission set forth in section 397.675, Florida Statutes.
____ The petition is not shown to have been executed by a relative, guardian, private practitioner as defined in the law, the director or director's designee of a licensed service provider, or three adults with personal knowledge.
____ Other: _____

Whereupon, it is

ORDERED

____ No ex parte order requiring stabilization and/or assessment shall be entered at this time; any request for such order is DENIED.

____Hearing will be scheduled and will be conducted within 10 days hereof.

____ Hearing on this matter, and specifically on the issue of whether the above-named person should be assessed and/or stabilized, shall be conducted at _____a.m./p.m., on _____. _____ at _____.

____ A copy of the petition and this order shall be provided to the above-named person shall be summoned to appear and is hereby ORDERED TO APPEAR at said hearing. A copy of this order shall be served on the petitioner(s), and the above-named person's spouse or guardian, if known, and the parent(s) if the above named person is a minor. **Failure of the above-named person to appear at the hearing may result in an order to detain and contempt proceedings.**

ORDERED in _____ County, Florida, this _____ day of _____, _____.

_____ _____
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

FORM MA-11 See section 397.6815, Florida Statutes MARCHMAN ACT

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

IN RE: CASE NO.:

_____

Respondent:
_____/

Notification to Court of Withdrawal of Petition For Hearing on Involuntary Substance Abuse Assessment and Stabilization

Please withdraw my Petition filed on_____. For involuntary substance abuse
Date (mm/dd/yyyy)

assessment and stabilization for _____
Client

This petition is being withdrawn for the following reasons: _____

:_____

_____

_____

_____ _____ _____ am pm
Signature of Petitioner Date (mm/dd/yyyy) Time

_____
Printed Name of Petitioner

cc: ☐ Clerk of the Court (Probate Division) ☐ Client ☐ Guardian ☐ Client's Attorney

Telephone notification to all parties, including family members and other persons expected to attend or testify should occur immediately after the decision to withdraw the petition is made.

FORM MA-12 See s. 397.693, Florida Statutes **MARCHMAN ACT**

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

IN RE: CASE NO.:

_____
Respondent:
_____/

Order Requiring Involuntary Examination under the Baker Act and Discharge of Person under the Marchman Act

THIS MATTER came to be heard pursuant to s. 397.6811, F.S., on the issue of whether the above-named person should be ordered into involuntary assessment and stabilization for substance abuse, and the court having considered testimony and evidence and having heard the argument of counsel, has concluded as follows:

However, there is reason to believe that the above-named person is mentally ill, and, because of such mental illness, has

☐ Refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or the person is unable to determine for himself or herself whether examination is necessary; and

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

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

The above-named person is ordered to undergo an involuntary examination pursuant to s. 394.4637(2), Florida Statutes at the nearest designated receiving facility.

Whereupon, it is ORDERED

☐ That the above-named person shall be discharged this date from any involuntary detention or treatment for substance abuse impairment pursuant to Chapter 397, Florida Statutes.
☐ That the above-named person shall be admitted to the nearest receiving facility for involuntary examination
☐ _____ shall take the above-named person into custody and deliver said person to the nearest receiving facility for involuntary examination.

DONE AND ORDERED in _____County, Florida, this___ day of _____, _

_____ _____
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

FORM MA-13 See s. 397.6818(1), Florida Statutes **MARCHMAN ACT**

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

IN RE: CASE NO.:

_____
Respondent:
_____/

Order for Involuntary Assessment and Stabilization – Marchman Act

THIS CAUSE came to be heard by the Court pursuant to Chapter 397, Florida Statutes, upon a petition for court-ordered involuntary assessment and stabilization. The Court, being fully advised in the premises, finds as follows:

1. The petition was executed by a relative, guardian, private practitioner as defined In the Marchman Act, the director or director's designee of a licensed service provider, or three adults with personal knowledge of the above-named person's impairment and condition.

2. The above-named person, having been duly and properly summoned, did appear at the hearing.
   ____ Said person was represented by counsel (or)
   ____ The appointment of counsel was not deemed appropriate, or was waived.

3.. The above-named person meets the criteria for involuntary admission for assessment and stabilization pursuant to section 397.675, and 397.6811, Florida Statutes:
   There is good faith reason to believe the person is substance abuse impaired, and, because of such impairment:
   (a) Has lost the power of self-control with respect to substance use, and either:
   (b) Has inflicted, threatened or attempted to inflict, or unless admitted is likely to inflict physical harm on himself/herself or another, or
   (c) Is in need of substance abuse services and, by reason of substance abuse impairment, is incapable of appreciating the need for such services and of making a rational decision in regard thereto.

4. The nature and extent of the alleged or existing substance use/abuse is briefly summarized as follows:

5. Less restrictive alternatives with respect to stabilization and assessment than are ordered herein below have been considered and are judged to be inappropriate.

Whereupon, it is
ORDERED
____ The above-named person shall appear and undergo an assessment and stabilization at _____
_____ on _____.
____ The Sheriff of _____ County shall take the above-named person into custody and shall immediately deliver him/her to _____ for involuntary assessment and stabilization for a period of up to 5 days.
ORDERED in _____ County, Florida this _____ day of _____, _____.

_____ _____
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

FAILURE TO COMPLY WITH THIS ORDER WILL RESULT IN CONSIDERATION AND ACTION BY THE CIRCUIT COURT, WHICH MAY INCLUDE A CONTEMPT PROCEEDING. CONTEMPT OF COURT MAY RESULT IN INCARCERATION, A FINE, AND OTHER SANCTIONS.

FORM MA-14 See section 397.6818, Florida Statutes MARCHMAN ACT

MARCHMAN ACT ASSESSMENT

PATIENT DEMOGRAPHIC INFORMATION

Patient Name:

Date of Birth	Age	Sex	Race	SS Number	Marital Status	Current Living Situation
				– –		

SUBSTANCE ABUSE INFORMATION

Brief Hx. of Substance Abuse

Current Use (Frequency & Duration)

Drug(s) of Choice: ☐ Alcohol ☐ Cocaine ☐ Marijuana ☐ Opiates ☐ Opioids

☐ Amphetamines ☐ Tranquilizers ☐ Inhalants ☐ Other:_____

Significant Family History. of Drug or Alcohol Abuse? ☐ Yes ☐ No

Prior Substance Abuse or Mental Health Treatment

Diagnosis

Code(s)	Description(s)

Current Medical and/or Psychiatric Status

Cultural, Social or Spiritual Issues

Family or Relationship Issues

Other Relevant Issues

DIMENSIONAL ADMISSIONS CRITERIA (ASAM)

I. Withdrawal Risk: ☐Severe☐ Moderate ☐ Mild ☐ None

II. Biomedical: ☐ Stable w/self-administration of meds.
☐ Stable w/Medical monitoring or mobility assistance

III. Emotional/Behavioral: A. Impulse Control: ☐ Very Poor ☐ Poor ☐ Not a Problem
B. Drug Related Behavior (Significant & Recent): ☐ Significant Hx. ☐Moderate ☐Insubstantial
C. Diagnosed Personality Disorder:_____Code:_____
D. Behavioral Stability Poor by Hx: ☐ Short Term ☐Moderate Term ☐ Long Term

IV. Treatment Attitude: ☐ Denies Abuse of Drugs ☐ Denies Consequences of Use
☐ Denies Endangering Others ☐ Denies Endangering Self
☐ Denies Need of Treatment

Motivation: ☐ Patient Recently Failed Lower Level of Treatment☐Within past year
☐ Patient Relapsed Shortly After Tx. ☐Patient is Chronic Relapser Post Tx.

V. Relapse Potential:☐No Knowledge of Triggers ☐ No Commitment to Treatment
☐ Imminent Potential of Harm to Self or Others ☐ Current Drug Cravings
☐ Unable to Sustain Sobriety Post Tx. ☐Patient Showing Relapse Signs

VI. Recovery Environment: ☐ High Risk of Physical, Emotional or Sexual Abuse
☐ Endemic Substance Abuse ☐Criminal Behavior, Violence, Abuse, Etc. in Environment
☐ Client Prone to Isolation Enhanced by Environment

Level of Care Determination: ☐ No Tx. ☐ Outpatient ☐ Intensive Outpatient
☐Day Treatment ☐ Residential Treatment: ☐ Short Term ☐ Long Term

Detox. Recommended: ☐ Yes ☐ No

SPECIFIC RECOMMENDATION

_____
_____
_____

_____
ASSESSING CLINICIAN:_____DATE:_____
Signature & Credentials
PHYSICIAN'S CONCURRENCE:_____DATE:_____
Signature & Credentials

FORM MA-15 See 397. 397.681, F.S. MARCHMAN ACT

IN THE CIRCUIT COURT OF THE
_____JUDICIAL CIRCUIT,
IN AND FOR _____
_____COUNTY, FLORIDA

IN RE: Case No: _____
Respondent:
_____/

PETITION FOR INVOLUNTARY TREATMENT
By authority of Chapter 397, Florida Statutes

I (We)_____ being duly sworn, hereby state that I(We) have personally observed the behavior of _____, Respondent, and have a good faith reason to believe that said person is substance abuse impaired as defined under Florida Statutes Section 397, and allege:

1. Respondent is an ☐ adult/ ☐ a minor.

2. Petitioner alleges that the Respondent meets the criteria for involuntary admission as provided in Florida Statutes Section 397.675 in that:

(a) Respondent is substance abuse impaired, as evidenced by:_____
_____
_____**AND**

(b) Because of such impairment the Respondent has lost the power of self-control with respect to substance abuse, as evidenced by: _____
_____
_____**AND**

(c) _____ Respondent has inflicted or is likely to inflict physical harm on himself or others unless admitted, as evidenced by: _____
_____
_____**OR,**
_____ 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/her need for care and making a rational decision regarding his/her need for care, as evidenced by: _____
_____
_____

3. Petitioner further alleges: (Petitioner must allege at least one of the following:)
_____ Respondent has been placed under protective custody pursuant to F.S. 397.677 within the previous 10 days;
_____ Respondent has been subject to an emergency admission pursuant to F.S. 397.679 within the previous 10 days;
_____ Respondent has been assessed by a qualified professional within 5 days;
_____ Respondent has been subject to involuntary assessment and stabilization pursuant to F.S. 397.6818 within the previous 12 days; or
_____ Respondent has been subject to alternative involuntary admission pursuant to F.S. 397.6822 within the previous 12 days.

4. The respondent is:
; Represented by an attorney:
Name: _____ Phone Number: _____
Address: _____
; Not represented by an attorney.
; Unknown whether Respondent is represented by an attorney.

5. Respondent
; Has assets sufficient to pay attorney fees.
; Does not have assets sufficient to pay attorney fees.
; Unknown whether the Respondent has assets sufficient to pay attorney fees.

6. If an assessment was performed on Respondent by a qualified professional, the findings and recommendations of the assessment are:
; Attached.
; As follows:

_____
_____
_____
_____
_____
_____

I/We hereby petition this Court to enter an Order for Involuntary Treatment of the Respondent. Under penalties of perjury I (we) declare that I (we) have read the foregoing and the facts alleged are true and correct to the best of my (our) knowledge and belief.

Completed this _____ day of _____, _____.

Relationship of Petitioner to Respondent:

; Spouse ; Parent (Minors) ; Guardian ; Legal Guardian(of Minor)
; Relative ; Director of Licensed Service Provider
; Three Adults with Personal Knowledge of Respondent's Impairment and Prior Assessment and Treatment.

Petitioners:

Name:_____ Name:_____ Name:_____

Signature:_____ Signature:_____ Signature:_____

Address:_____ Address:_____ Address:_____

_____ _____ _____

Phone:_____ Phone:_____ Phone:_____

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was executed before me this _____day of _____, _____, by _____, who is personally known to me and who has produced _____, as identification and who ; did / ;did not take an oath.

_____
Typed or printed or stamped name of Notary

_____
Signature of Notary

OR

Witness by my hand and seal on the _____day of _____, _____.
Clerk of Court.

_____
Deputy Clerk

NOTE: All information pertaining to the person is confidential and is protected from disclosure under the authority found in s. 397. 501 (7), Florida Statutes, and 42 Code of Federal Regulations, Part 2.

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

IN RE: CASE NO.:

_____

Respondent:

_____/

Application for Appointment of Qualified Substance Abuse Professional

I, _____ hereby petition the Court to appoint an independent Qualified Substance Abuse Professional, pursuant to Section 397.6818, Florida Statutes. I hereby certify that I do not have assets which would suffice for the payment of examination fees, and I request that the said examination costs be provided by this court.

_____ _____
Signature of Client Date (mm/dd/yyyy)

_____
Typed or Printed Name of Client

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided (mm/dd/yyyy)	Time Copy Provided	Initials of Who Provided Copy
☐ Patient		am pm	
☐ Guardian		am pm	

FORM MA-17 See s. 397.6818, Florida Statutes MARCHMAN **ACT**

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

IN RE: CASE NO.:

_____
Respondent:

_____/

Order Setting Hearing on Involuntary Treatment, Order of Referral to General Master and Order Appointing Attorney

THIS CAUSE coming on to be heard before the Courts own motion upon receipt of a petition for substance abuse involuntary treatment of _____, it is

ORDERED:
1) That a hearing will be conducted on the Petition for involuntary assessment and stabilization at, _____on the ____day of _____, 20____, at ___:___M. The basis for this hearing and the possible involuntary detention which may result therefrom is a Petition for Involuntary Treatment executed by _____, alleging that the criteria required by Florida Statute are satisfied.

2) That absent further Order of this Court, all matters not specifically set before the Judge are hereby referred to the presiding General Master of this Court for further proceedings pursuant to Rule 1.490 of the Florida Rules of Civil Procedure and current Orders of the Court, and said General Master is authorized to require such investigations and examinations and hold such hearings as may be deemed necessary, and shall report back to this Court the Master's findings and recommendations, as soon as practicable.

3) That
_____UPON THE COURT'S OWN MOTION, the above named person, appearing to be indigent and needing the assignment of counsel, thereupon, it is,
_____HAVING RECEIVED AN AFFIDAVIT OF INDIGENCY, signed by the above named person requesting the assignment of counsel, thereupon, it is,

ORDERD AND ADJUDGED THAT _____, Public Defender of _____County, Florida is hereby appointed to represent the person for all proceedings that arise under this petition for substance abuse involuntary treatment.

DONE AND ORDERRD on this ____day of _____, 20__, in _____County, Florida.

_____
CIRCUIT JUDGE
CC: Hearing Master☐ Public Defender☐ Respondent☐

FORM MA-18 See section 397.6818 MARCHMAN ACT

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

IN RE: CASE NO.:

_____
Respondent:
_____/

Notification to Court of Withdrawal of Petition For Hearing on Involuntary Treatment

YOU ARE HEREBY INFORMED THAT _____
Client

at _____
Facility Name and Address

☐ has made application by express and informed consent for voluntary admission, due to an improvement in his/her condition.

☐ was discharged on_____ to _____
Date (mm/dd/yyyy) Destination (if known)

☐ was transferred on_____ to _____
Date (mm/dd/yyyy) Destination (if known)

☐ was converted to Baker Act on _____
Date (mm/dd/yyyy)

☐ Other

Specify):_____

_____

_____

Please withdraw my Petition for Involuntary Treatment filed on _____.
Date (mm/dd/yyyy)

_____ _____ _____ am pm
Signature of Administrator or Designee Date (mm/dd/yyyy) Time

_____
Printed Name of Administrator or Designee

cc: ☐ Clerk of the Court (Probate Division) ☐ Client ☐ Guardian ☐ Client's Attorney

Telephone notification to all parties, including family members and other persons expected to attend or testify should occur immediately after the decision to withdraw the petition is made.

FORM MA-19 See s. 397.693, Florida Statutes **MARCHMAN ACT**

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

IN RE: CASE NO.:

_____
Respondent:
_____/

Order for Involuntary Treatment – Marchman Act

THIS CAUSE came to be heard by the Court pursuant to Chapter 397, Florida Statutes, upon a petition for court-ordered involuntary treatment for substance abuse. The Court, being fully advised in the premises, finds as follows:

1. The petition was executed by a relative, guardian, private practitioner as defined In the Marchman Act, the director or director's designee of a licensed service provider, or three adults with personal knowledge of the above-named person's impairment and condition.

2. The above-named person, having been duly and properly summoned, did appear at the hearing.
____ Said person was represented by counsel (or)
____ The appointment of counsel was not deemed appropriate, or was waived.

3. The above-named person meets the criteria for involuntary admission for involuntary treatment for substance abuse, in that there is clear and convincing evidence that the above-named person is substance abuse impaired, and, because of such impairment: has lost the power of self-control with respect to substance use, and either:
(a) Has inflicted or is likely to inflict physical harm on himself/herself or others unless involuntarily treated; or
(b) The refusal to voluntarily receive treatment is based on judgment so impaired by reason of substance abuse that the above-named person is incapable of appreciating the need for care and treatment and of making a rational decision regarding that need.

4. The nature and extent of the alleged or existing substance use/abuse is briefly summarized as follows: _____
_____.

Whereupon, it is
IT IS ORDERED
1. The above-named person will enter into, participate in, and successfully complete the _____
_____
2. The above-named person will not use alcohol and will not use drugs unless prescribed by a physician.
3. This Order shall be effective for 60 days from the date hereof.
4. _____
_____
_____

DONE AND ORDERED in _____ County, Florida this _____ day of _____, _____.

_____ _____
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

FAILURE TO COMPLY WITH THIS ORDER WILL RESULT IN CONSIDERATION AND ACTION BY THE CIRCUIT COURT, WHICH MAY INCLUDE A CONTEMPT PROCEEDING. CONTEMPT OF COURT MAY RESULT IN INCARCERATION, A FINE, AND OTHER SANCTIONS.

FORM MA-20 See section 397.6818, Florida Statutes MARCHMAN ACT

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

IN RE: CASE NO.:

_____
Respondent:
_____/

Petition Requesting Renewal of Involuntary Treatment Order

The petition of _____ who is the

Administrator of _____

Facility shows that:

1. The above named client, _____ of _____ County, Florida, is a client in the aforesaid facility and was admitted to this facility on _____ .
   Date (mm/dd/yyyy)
2. That according to the provisions of Section 397.6975, F.S., this client may not be retained after _____, (Date) without an order authorizing an extension of the involuntary substance abuse treatment period.
3. That the client continues to meet the criteria for involuntary treatment pursuant to Section 397.675, F.S., and that legally authorized period will expire on: _____.
4. Attached is a report summarizing substance abuse assessments and treatment conducted during the period of involuntary treatment.

Wherefore, it is requested an Order be issued authorizing this Facility to retain the client for a period not to exceed ninety (90) days.

_____ _____ am pm
Signature of Administrator or Designee Date (mm/dd/yyyy) Time

_____
Printed or Typed Name of Administrator or Designee

This petition must be filed with the court at least ten (10) days prior to the expiration of the court-ordered treatment period. The court shall immediately schedule a hearing to be held not more than 15 days after the filing of the petition.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided (mm/dd/yyyy)	Time Copy Provided	Initials of Who Provided Copy
☐ Client		am pm	
☐ Guardian		am pm	
☐ Public Defender or ☐ Private Attorney		am pm	

FORM MA-21 See s. 3976975, Florida Statutes **MARCHMAN ACT**

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

IN RE: CASE NO.:

_____
Respondent:
_____/

Order Authorizing Renewal of Involuntary Treatment Order

This matter coming on to be heard, pursuant to the requirements of Section 397.6975, Florida Statutes, that the respondent continues to meet the criteria for involuntary substance abuse treatment be periodically reviewed, and the client having ☐ appeared in person ☐ appeared through counsel,

the following findings of fact are made from the evidence designated:

1. The client, on _____, was ordered to undergo involuntary substance abuse treatment.
   Date (mm/dd/yyyy)

2. The client continues to be obligated to undergo substance abuse treatment under the original order.
   This finding is determined from the testimony of _____
   and _____. As evidenced by: _____
   _____
   _____

Based on the above findings of fact, the Court makes the following conclusions:

On the basis of the above, it is hereby
ORDERED

The client be returned to involuntary treatment pending the next periodic review required by Section 397.6975, Florida Statutes for a period of up to 90 days, beginning on the date the original treatment order expires.

ORDERED at

this _____ day of _____ , _____.
Date Month Year

_____ _____
Printed Name of Circuit Judge Signature of Circuit Judge

cc: Check when applicable
☐ Client ☐ Guardian ☐ Public Defender ☐ Facility Administrator

FORM MA-22 See s. 397.6975, Florida Statutes **MARCHMAN ACT**

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

IN RE: CASE NO.:

_____
Respondent:
_____/

Order Dismissing Action on Petition for
Involuntary Substance Abuse Assessment and/or Treatment

THIS CAUSE having come before the Court on a petition, pursuant to Chapter 397, Florida Statutes for:

☐ Involuntary Assessment and Stabilization

☐ Involuntary Treatment

☐ Renewal of Involuntary Treatment

The Court being fully advised in the premises, finds and orders as follows:

1._____
_____
_____
_____

2. This action should be dismissed.

Whereupon, it is

ORDERED that the above-described Petition, and this action, be and the same are DISMISSED.

DONE AND ORDER in _____ County, Florida this _____ day of _____, _____.

_____ _____
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

Notice of Early Release From Involuntary Substance Abuse Treatment

IN RE: _____ CASE NO. _____

YOU ARE HEREBY NOTIFIED that

_____ , ordered for

☐ Involuntary Assessment and Stabilization

☐ Involuntary Treatment

has this_____ day of_____ ,_____ been released from this facility.
Date Month Year

_____ _____ _____ am pm
Signature of Administrator/designee Date (mm/dd/yyyy) Time

_____ _____
Printed Name of Administrator or Designee Name of Facility

cc: Check when applicable and initial/date/time when copy provided to persons specified by the court in the original treatment order:

Individual	**Date Copy Provided** (mm/dd/yyyy)	**Time Copy Provided**	**Initials of Who Provided Copy**
☐ Client		am pm	
☐ Guardian		am pm	
☐ Client's Attorney		am pm	
☐ Circuit Court		am pm	
☐ Clinical Record		am pm	
☐			
☐			

FORM MA-24 See s. 397.6971, Florida Statutes **MARCHMAN ACT**

Rights of Clients in Substance Abuse Facilities

The following rights are guaranteed to you under Florida law. These will be fully explained to you at the time of and following admission to this facility. A copy of this form will be given to you to keep. You have the right to read the Marchman Act law and rules at any time. Your signature on the form, if you choose to sign, only acknowledges that you have had the rights explained and that a copy of this form was provided to you.

RIGHT TO INDIVIDUAL DIGNITY. Your individual dignity must be respected at all times and upon all occasions, including any occasion when you are admitted, retained, or transported. Unless you are accused of a crime or delinquent act, you can't be detained or incarcerated in jail, except for purposes of protective custody. You can't be deprived of any constitutional right.

RIGHT TO NONDISCRIMINATORY SERVICES. You can't be denied access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, HIV status, prior service departures against medical advice, disability, number of relapse episodes, or it you take medication prescribed by a physician. Service providers who receive state funds to provide substance abuse services may not, provided space and sufficient state resources are available, deny you access to services based solely on inability to pay. You must be given the opportunity to participate in developing and reviewing your individualized treatment or service plan. You must be in the least restrictive and most appropriate services available, based on your needs and best interests and consistent with optimum care.

RIGHT TO QUALITY SERVICES. You must have services suited to your needs, administered skillfully, safely, humanely, with full respect for your dignity and personal integrity.

RIGHT TO COMMUNICATION. You have the right to communicate freely and privately with other persons. In order to ensure a substance free environment, close supervision of your communications and correspondence is necessary, particularly in the initial stages of treatment, and the service provider must therefore set reasonable rules for telephone, mail, and visitation rights, giving primary consideration to the well-being and safety of clients, staff, and the community. You will be informed at the time of admission about the provider's rules relating to communications and correspondence.

RIGHT TO CARE AND CUSTODY OF PERSONAL EFFECTS. You have the right to possess clothing and other personal effects. The service provider may take temporary custody of your personal effects only when required for medical or safety reasons, with the reason for taking custody and a list of the personal effects recorded in your clinical record.

RIGHT TO EDUCATION OF MINORS. Each minor client in residential services is guaranteed education and training appropriate to his or her needs.

RIGHT TO CONFIDENTIALITY OF CLIENT RECORDS. The records of service providers regarding the identity, diagnosis, and prognosis of and services to any client are confidential under federal and state laws. 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 in very limited circumstances. This does not restrict reporting of abuse, neglect or exploitation of children or vulnerable adults, commission of a crime on premises or against staff, or other disclosures required or permitted by federal and state law.

RIGHT TO COUNSEL. You must be informed that you have the right to be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment and if you are a minor your parent, legal guardian, or legal custodian, may apply immediately to the court to have an attorney appointed if he or she cannot afford one.

RIGHT TO HABEAS CORPUS. At any time, and without notice, a client involuntarily retained by a provider, or the client's parent, guardian, custodian, or attorney on behalf of the client, may petition for a writ of habeas corpus to question the cause and legality of such retention and request that the court issue a writ for the client's release.

_____	_____	_____
Client's Signature	Date (mm/dd/yyyy)	Time
_____	_____	_____
Witness Signature	Date (mm/dd/yyyy)	Time

FORM MA-25 See s. 397.501, Florida Statutes **MARCHMAN ACT**

Authorization for Disclosure of Confidential Information – General

I, _____, DOB: _____ SS#_____PH#_____

Authorize _____ to disclose to _____
_____

The following information: Note: Draw a line through information **NOT** needed.

Assessments History & Physical Medication Administration Records Treatment Plan
Progress Notes Lab Results Discharge Summary & Continuing Care Plan
Other: _____
_____

Purposes for the disclosure – Be specific: _____

OPTIONAL: I also agree to the disclosure of HIV testing information and AIDS diagnosis: _____(client initials)

Information will be disclosed in writing and/or verbally. Client initials for FAX approval: _____

I understand that my records are protected under federal and state regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse information under 42CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated here: Date, event or condition of expiration: _____

I understand that generally this agency may not condition treatment on whether I sign an authorization, but that in certain limited circumstances I may be denied treatment if I do not sign this authorization. I also hereby release this agency from liability that may arise as a result of information disclosed under an authorization, if such information is disclosed is later used to my detriment.

Date: _____ Signature of Client: _____

Date: _____ Signature of Witness: _____

Date: _____ Signature (if applicable)_____ _____
(Authorized Representative) (Legal Authority to Act)

For Office Use: Authorized Information released by _____ Date released: _____
Information released: _____

FORM MA-26 See 397. 501(7), Florida Statutes MARCHMAN ACT

Authorization for Treatment

I, the undersigned, a ☐ client, ☐ guardian hereby authorize the staff of this facility to administer assessment and treatment specified below.

☐ Routine medical care _____ (Initials of Client or Authorized Decision Maker)

☐ Substance Abuse Assessment _____ (Initials of Client or Authorized Decision Maker)

☐ Substance Abuse Treatment _____(Initials of Client or Authorized Decision Maker)

☐ Other (Specify & Initial)_____ _____

_____ _____

_____ _____

I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

_____	_____	_____am pm
Signature of Client	Date (mm/dd/yyyy)	Time
_____	_____	_____ am pm
Signature of Witness for Client	Date (mm/dd/yyyy)	Time
_____	_____	_____ am pm
Signature of: (check one when applicable) ☐ Parent or Guardian when required	Date (mm/dd/yyyy)	Time
_____	_____	_____ am pm
Signature of Witness for Parent or Guardian	Date (mm/dd/yyyy)	Time

FORM MA-27 See s. 397, Florida Statutes **MARCHMAN ACT**

Inventory of Personal Effects

The following person _____
has, for medical and safety reasons, placed the following articles in the temporary custody of this facility:
(Attach additional sheets if necessary)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The following personal effects were retained by the person:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This is a correct listing of my personal effects and belongings which I hereby place in custody of the facility.

_____	_____	_____ am pm
Signature of Client	Date (mm/dd/yyyy)	Time
_____	_____	____ am pm
Signature/Title of Witness to Inventory	Date (mm/dd/yyyy)	Time

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided (mm/dd/yyyy)	Time Copy Provided	Initial of Who Provided Copy
☐ Client		am pm	
☐ Guardian		am pm	

FORM MA-28 See s. 397.501(5), Florida Statutes **MARCHMAN ACT**

Restriction of Communication or Visitors

Notice is hereby given to _____
Full Name of Client

this date, that under the provisions of Section 397501(4), Florida Statutes, a restriction on communications has been placed for a period of _____ days, starting at _____ am pm on [Date (mm/dd/yyyy)] _____ and ending at _____ am pm on [Date (mm/dd/yyyy)] _____

The nature of the restriction is as follows: _____

_____

_____

_____

_____

_____

The restriction has been ordered because _____

_____

_____

_____

_____

_____

This restriction of communication shall be reviewed at least every 7 days and lifted as soon as possible.

_____ _____ ____ am pm
Signature of Administrator or Designee Date (mm/dd/yyyy) Time

cc: Check when applicable and initial/date/time when copy provided:

Individual	**Date Copy Provided** (mm/dd/yyyy)	**Time Copy Provided**	**Initial of Who Provided Copy**
☐ Client		am pm	
☐ Guardian		am pm	

FORM MA-29 See s. 394.459(5)(c), Florida Statutes **MARCHMAN ACT**

Notice of Right to Petition for Writ of Habeas Corpus

To: _____

PLEASE BE ADVISED that you may petition the Circuit Court for a Writ of Habeas Corpus to question the cause and legality of your detention.

A Petition for Writ of Habeas Corpus may be used for this purpose. You, your parent, guardian, custodian, or attorney may sign the petition.

Staff of this facility will provide a copy of the Writ form to you immediately upon your request. Staff will assist you in completing this Writ form if you request such help. The Petition for a Writ will be submitted by the staff to the Circuit Court.

_____	_____	_____
am pm Signature of Administrator or Designee	Date (mm/dd/yyyy)	Time

This completed form must be given to all clients and to those persons listed below as applicable.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided (mm/dd/yyyy)	Time Copy Provided	Initials of Who Provided Copy
☐ Client		am pm	
☐ Guardian		am pm	

FORM MA-30 See s. 397.501(9), Florida Statutes **MARCHMAN ACT**

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

IN RE: CASE NO.:

_____/
Petitioner, vs.

_____,
Administrator,

_____,
Facility Respondent.

Petition for Writ of Habeas Corpus

1. This Court has jurisdiction pursuant to Section 397501(9), Florida Statutes.
2. Petitioner is being held by _____(Administrator) in _____, (Facility), in _____ (City), Florida.
3. ☐ Petitioner believes that he/she is being deprived of her/his freedom for invalid and illegal reasons.
   Petitioner believes that her/his confinement is illegal because: _____
   _____
   _____
   _____
   _____
4. Petitioner is unable to afford counsel and would like the Office of the Public Defender or other counsel to be appointed to represent her/him in the above captioned matter.

   WHEREFORE, Petitioner respectfully requests that this Court:

☐ Appoint the Office of Public Defender or other counsel to represent your Petitioner in these proceedings; and

☐ Enter an Order setting a return hearing on this Petition for Writ of Habeas Corpus for respondent to show by what legal authority he/she holds petitioner.

I HEREBY CERTIFY that the above stated matters In the Petition for Writ of Habeas Corpus are true and correct to the best of my information, knowledge, and belief.

_____ _____ _____ am pm
Signature of Petitioner Date (mm/dd/yyyy) Time

_____
Printed Name of Petitioner

There ☐ is or ☐ is not a petition for involuntary substance abuse treatment pending.

The petitioner ☐ is or ☐ is not currently represented by counsel.

Facilities must provide this form to any client making a verbal request for access to the Court. The completed form must be promptly filed with the Clerk of the Court and a copy retained in the client's clinical record. A copy of the completed Petition for Writ must be provided immediately to the client and copies of the Petition provided to those listed below, as applicable.

cc: Check when applicable and initial/date/time when copy provided:

Individual	**Date Copy Provided** (mm/dd/yyyy)	**Time Copy Provided**	**Initials of Who Provided Copy**
☐ Client		am pm	
☐ Guardian		am pm	
☐ Attorney		am pm	

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

IN RE: _____ CASE NO.: _____

_____/

Ex Parte Order for Involuntary Assessment and/or Stabilization

THIS MATTER having been considered by the Master appointed by the Chief Judge of the _____ Judicial Circuit, pursuant to Sections 397.6811 and 397.6815, Florida Statutes, and upon a sworn petition for involuntary assessment and stabilization, the Master finds as follows:

1. A sworn petition has been filed with the clerk of the circuit court in _____ County, the county where the above-named person is located. The petition was executed by the above-named person's relative, guardian, a "private practitioner" as defined (including physician), the director or director's designee of a licensed service provider, or three adults with personal knowledge of the above named person's impairment and condition.
2. The above-named person meets the criteria for involuntary admission, because there is good faith reason to believe that said person is substance abuse impaired, and, because of such impairment, has lost the power of self control with respect to substance abuse; and either

____ (a) has inflicted, threatened or attempted to inflict, or unless admitted is likely to inflict physical harm on himself/herself or another **or**

____ (b) is in need of substance abuse services, and, by reason of substance abuse impairment, is incapable of appreciating the need for such services and of making a rational decision in regard thereto.

Whereupon, it is

ORDERED that the Sheriff of _____ County or other law enforcement officer shall take the above-named person into custody and deliver or arrange for the delivery of said person to_____ _____, for involuntary assessment and stabilization for a period of up to 5 days. If a petition for treatment is thereafter timely initiated and filed, the above-named person may be detained at said facility until further order of the Court. Said law enforcement officer or agent may serve and execute this order on any day of the week, at any time of the day or night, and may use reasonable physical force as is necessary to gain entry to the premises, and any dwellings, buildings, or other structures located on the premises, and to take custody of the person who is the subject of this ex parte order.

This order expires in _____ days.

ORDERED in _____ County, Florida this _____ day of _____, _____.

_____ _____
Printed Name of Master Signature of Master

FORM MA-32 See 397.6815(2), F.S. MARCHMAN ACT

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

IN RE: _____ CASE NO.: _____

_____/

Order for Involuntary Assessment and Stabilization

THIS CAUSE came to be heard by the undersigned Master appointed by the Chief Judge of the _____Judicial Circuit, pursuant to Chapter 397, F.S., upon a petition for court-ordered involuntary assessment and stabilization. The undersigned Master, being fully advised in the premises, finds as follows:

1. The petition was executed by a relative, guardian, "private practitioner" as defined (including physician), the director or director's designee of a licensed service provider, or three adults with personal knowledge of the above-named person's impairment and condition.
2. The above-named person , having been duly and properly summoned, did appear at the hearing.
3. The above-named person meets the following criteria for involuntary admission for assessment and stabilization pursuant to section 397.675, and 397.6811, Florida Statute:

There is good faith reason to believe that 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
(a) has inflicted, threatened or attempted to inflict, or unless admitted is likely to inflict physical harm on himself/herself or another, **or**
(b) is in need of substance abuse services and, by reason of substance abuse impairment, is incapable of appreciating the need for such services and of making a rational decision in regard thereto.

4. The nature and extent of the alleged or existing substance use/abuse is briefly summarized as follows:
_____.
5. Less restrictive alternatives with respect to stabilization and assessment than are ordered herein below have been considered and are judged to be inappropriate, and there is no need for the appointment of an attorney to represent the above-named person at this time.

Whereupon, it is
ORDERED
_____ The above-named person shall appear and undergo an assessment and stabilization at _____ _____on _____.
_____ The Sheriff of _____ County shall take the above-named person into custody and shall immediately deliver him/her to _____, for involuntary assessment and stabilization for a period of up to 5 days.

ORDERED in _____ County, Florida this ____ day of _____, _____

_____ _____
Printed Name of Master Signature of Master

FAILURE TO COMPLY WITH THIS ORDER WILL RESULT IN CONSIDERATION AND ACTION BY THE CIRCUIT COURT, WHICH MAY INCLUDE A CONTEMPT PROCEEDING.
CONTEMPT OF COURT MAY RESULT IN INCARCERATION, A FINE, AND OTHER SANCTIONS.

FORM MA-33 See 397.6818, F.S. MARCHMAN ACT

IN THE CIRCUIT COURT, _____JUDICIAL CIRCUIT,
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

_____/

Order for Involuntary Treatment

THIS CAUSE came to be heard by the undersigned Master appointed by the Chief Judge of the _____ Judicial Circuit, pursuant to Chapter 397, F.S., upon a petition for court-ordered involuntary treatment for substance abuse. The undersigned Master, being fully advised in the premises, finds as follows:

1. The petition was executed by a relative, guardian, "private practitioner" as defined (including physician), the director or director's designee of a licensed service provider, or three adults with personal knowledge of the above-named person's impairment and condition.
2. The above-named person, having been duly and properly summoned, did appear at the hearing.
3. The above-named person meets the criteria for involuntary treatment for substance abuse, in that there is clear and convincing evidence that the above-named person is substance abuse impaired, and because of such impairment has lost the power of self-control with respect to substance abuse, and either
   a. Has inflicted or is likely to inflict physical harm on himself/herself or others unless involuntarily treated; or
   b. The refusal to voluntarily receive treatment is based on judgment so impaired by reason of substance abuse that the above-named person is incapable of appreciating the need for care and treatment and of making a rational decision regarding that need.
4. The nature and extent of the substance use/abuse is briefly summarized as follows:
   _____
   _____

IT IS ORDERED

1. The above-named person will enter into, participate in, and successfully complete the _____
   _____
2. The above-named person will not use alcohol and will not use drugs unless prescribed by a physician.
3. _____
   _____
   _____.

DONE AND ORDERED in _____ County, Florida this ____ day of _____, _____

_____ _____
Printed Name of Master Signature of Master

FAILURE TO COMPLY WITH THIS ORDER WILL RESULT IN CONSIDERATION AND ACTION BY THE CIRCUIT COURT, WHICH MAY INCLUDE A CONTEMPT PROCEEDING. CONTEMPT OF COURT MAY RESULT IN INCARCERATION, A FINE, AND OTHER SANCTIONS.

FORM MA-34 See 397.696, F.S. MARCHMAN ACT

IN THE CIRCUIT COURT, _____JUDICIAL CIRCUIT,

IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

_____/

Order Dismissing Action

THIS CAUSE having come before the Master on a Petition for Involuntary Assessment and Stabilization, and/or a Petition for Involuntary Treatment for Substance Abuse, pursuant to Chapter 397, F.S., and the Master having been fully advised in the premises, finds and orders as follows:

1. _____
   _____
   _____
2. This action should be dismissed.

Whereupon, it is

ORDERED that the above-described Petition, and this action, be and the same are DISMISSED.

DONE AND ORDERED in _____County, Florida this _____ day of _____, _____.

_____ _____
Printed Name of Master Signature of Master

FORM MA-35 See 397.6818, F.S. MARCHMAN ACT

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

IN RE: _____ CASE NO.: _____

_____/

Order of Circuit Court
Approving Order of Master and Directing Compliance

THIS MATTER came to be heard pursuant to Chapter 397, F.S., and the petition filed in accordance with said statute, on the issue of whether the above-named person should be involuntarily stabilized and assessed or involuntarily treated for substance abuse, and hearing was conducted by the Master pursuant to court order. This court having reviewed the findings and order of the Master, and being otherwise fully advised in the premises, it is:

ORDERED:

1. The order of the Master entered in connection with this cause is hereby adopted and approved by this court.

2. The above-named person shall comply with the provisions of the order entered in this matter by the Master.

DONE AND ORDERED in _____County, Florida this ____ day of _____, ____

_____ _____
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

FORM MA-36 See 397.6818 and 397.697, F.S. MARCHMAN ACT

IN THE CIRCUIT COURT_____ JUDICIAL CIRCUIT
IN AND FOR _____COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

_____/

Order Denying Ex Parte Assessment/Stabilization, and Notice of Hearing

THIS MATTER came to be considered pursuant to sections 397.6811, 397.6814, and 397.6815, Florida Statutes, upon a petition for ex parte order authorizing the involuntary assessment and/or stabilization of the above-named person. The Master appointed by the Chief Judge of the _____ Judicial Circuit, having considered the petition, finds as follows:

An ex parte order directing a law enforcement officer to take the above-named person into custody and deliver said person to the nearest appropriate licensed service provider should not be entered at this time, because:

____ The petition does not demonstrate that the above-named person meets the criteria for involuntary admission set forth in section 397.675, Florida Statutes.

____ The petition is not shown to have been executed by a relative, guardian, "private practitioner" as defined (including physician, psychologist), the director or director's designee of a licensed service provider, or three adults with personal knowledge.

____ Other. _____

Whereupon, it is

ORDERED

____ No ex parte order requiring stabilization and/or assessment shall be entered at this time; any request for such order is DENIED.

____ Hearing will be scheduled and will be conducted within 10 days hereof.

____ Hearing on this matter, and specifically on the issue of whether the above-named person should be stabilized and/or assessed, shall be conducted at _____a.m./p.m., on _____, _____ at _____.

____ A copy of the petition and this order shall be provided to the above-named person and his/her attorney, if known. The above-named person shall be summoned to appear and is hereby **ORDERED TO APPEAR** at said hearing. A copy of this order shall be served on the petitioner(s), and the above-named person's spouse or guardian, if known, and the parent(s) if the above-named person is a minor. **Failure of the above-named person to appear at the hearing may result in an order to detain and contempt proceedings.**

ORDERED in _____ County, Florida, this _____ day of _____, _____.

_____ _____
Printed Name of Master Signature of Master

FORM MA-37 See 397.6818, F.S. MARCHMAN ACT