

Involuntary Examinations
(also see Law Enforcement)
(See also Professional Credentials)
(See also Transportation)

Criteria & Eligibility

Q. I just received an email from a behavioral managed care company stating “that the Florida Mental Health Act specifically excludes any practitioner/provider to Baker Act an individual who is under the influence of an illicit substance or ETOH at the time of the Baker Act.” Is this correct?

Coexisting thought or mood disorders with addiction is to be expected with large numbers of persons meeting the Involuntary Examination criteria, including the definition of mental illness. As long as the thought or mood disorder is sufficient to justify the need for the voluntary or involuntary examination, it is irrelevant whether there is substance impairment, developmental disability, or antisocial behavior.

The comment requiring “a company Clinical Peer Reviewer after the 23 hour crisis stabilization authorization when the member is admitted as an involuntary admission” or a refusal of reimbursement without pre-authorization would be inappropriate. It appears the Company isn’t aware that the law allows for up to 72-hours for the examination. This doesn’t mean the insurer can’t be asking for additional information from the attending physician, during this period, but continued observation and assessment beyond the 23 hour period is often needed.

Q. I’m a detective with the Sheriff’s Office. I’m getting many calls regarding the Baker Act on people with Autism who are being violent. They all want to know if they can Baker Act if someone has autism. I explained you cannot Baker Act based on the Autism label alone but you can Baker Act if the person is a threat to themselves or someone else. The question then becomes if the violence is a behavioral aspect of the developmental disability can you still Baker Act? My position is a mental health facility would be a better choice than jail. I then suggest they explore all other alternatives that may be available. Can you please give me some guidance?

Regarding your question about initiating involuntary examination under the Baker Act, there must be a diagnosis of mental illness consistent with the definition in the law and refusal or inability to determine exam is needed, and passive or active danger. If any one of these isn’t present, an initiation wouldn’t be appropriate.

Just being a threat to self or others (active danger) wouldn’t be sufficient unless it resulted from a mental illness. Unfortunately, autism is a diagnosis under chapter 393 governing developmental disabilities that is excluded from the legal definition of mental illness:

394.455(18)“Mental illness” means an impairment of the mental or emotional processes that exercise conscious control of one’s actions or of the ability to perceive or understand reality, which impairment substantially interferes with a

person's ability to meet the ordinary demands of living, regardless of etiology. For the purposes of this part, **the term does not include retardation or developmental disability as defined in chapter 393**, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

393.063 Definitions.

For the purposes of this chapter, the term:

(3) "**Autism**" means a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests.

While a person cannot be "Baker Acted" for dangerous behavior resulting from Autism, a law enforcement officer may "have reason to believe" the person has a mental illness in addition to autism. In such a situation, the initiation of involuntary examination may be appropriate. A law enforcement officer isn't expected to be a diagnostician – he/she can be wrong just like a mental health professional is sometimes wrong. The officer just shouldn't document on the form that the basis of the BA-52 is autism. They also need to be aware that the person is only going to be examined and may be released immediately or within 72 hours back to where they came from. If treated, the only treatment available is for psychiatric conditions and not for the developmental disability. Initiating an involuntary examination may alleviate an immediate danger situation, but is unlikely to have any lasting benefit. You are correct that criminalization of a developmental disorder or a mental health diagnosis should be avoided in any possible way.

Q. We have an 81 year old female who was dropped off last evening by the police under a Baker Act. Her primary diagnosis is Dementia with behavioral disturbance. She is from a nursing home and can return. My Medical Director would like to know how to proceed legally with the Baker Act. In the past few months we have seen an increase in Baker Act patients who have a primary diagnosis of Mental Retardation. Our doctor is requesting clarification on how to proceed with medication management for those patients who are MR and under a Baker Act.

The current statutory definition requires that a "mental illness" be present consistent with the following:

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

If your physician has diagnosed a major thought or mood disorder, regardless of etiology, sufficient to warrant a Baker Act, the presence of dementia wouldn't be a barrier to an appropriate involuntary placement. The mental illness could be treated,

even if the dementia cannot. A developmental disability, including retardation, would not suffice for purposes of voluntary or involuntary admission or treatment under the Baker Act because that diagnosis is specifically excluded in the definition above. However, if the individual had a diagnosed major thought or mood disorder sufficient to warrant a Baker Act, in addition to the developmental disability, presence of the developmental disability wouldn't be a barrier to admission or placement.

Generally a person with dementia or retardation wouldn't be on voluntary status because that status requires the person to be competent to provide express and informed consent. The above information on admission and retention in a facility isn't the same as for treatment once in the facility. Express and informed consent for admission and for treatment can only be provided by a competent adult, defined in the law as being competent to provide well-reasoned, willing and knowing medical and mental health decisions. A person with dementia or retardation could be on involuntary status if a mental illness as defined above was diagnosed and the other statutory criteria for involuntary examination or involuntary placement were present. However, such a person would generally lack the competence to provide consent for treatment.

A person unable to provide this consent would require a substitute decision maker such as a guardian advocate appointed by the court. An interim decision-maker such as a health care proxy could be used if a family member or close personal friend was willing to serve.

The question arises as to what medication, if any, is appropriate to treat the mental illness of a person who also has retardation. Retardation and other developmental disabilities usually are addressed through behavioral methods instead of medication. Most Baker Act receiving facilities depend on medications to stabilize mental illnesses and aren't staffed to provide the behavioral specialists qualified to provide the longer term behavioral intervention and training.

Q. Would a patient with a primary diagnosis of Dementia with Delirium and a presentation of impaired judgment meet criteria for a Baker Act hold and evaluation?

The current definition of mental illness in the Baker Act wouldn't automatically make a person ineligible for involuntary admission and treatment because it states "without regard to etiology" except for certain specified conditions.

A person with dementia would not be eligible for voluntary admission because of inability to make well-reasoned, willful and knowing decisions about their medical and mental health treatment – the definition of competence in the Baker Act.

However, there is a proposed bill to amend the Baker Act that will, if enacted by the Legislature, expressly exclude dementia and head injuries from the definition unless the condition co-exists with a legitimate thought or mood disorder.

Q. I wondered if you knew if it is possible to involuntarily hospitalize someone with severe anorexia and if so, what are the criteria used and what type of professional would evaluate and sign the Baker Act forms?

A person must have a “mental illness” as defined in the Baker Act:

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

The **criteria** for involuntary examination is as follows:

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

The person 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

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

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

The involuntary examination can be initiated by a circuit court judge, a law enforcement officer, or by a mental health professional. The mental health professionals authorized to initiate the exam are as follows:

A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based.

A Florida licensed clinical psychologist with at least 3 years of supervised clinical experience who had personally observed how the person met the criteria could certainly initiate such an examination.

Regarding your first question about anorexia as a diagnosis, professionals usually consider a thought or mood disorder diagnosis to be required for the Baker Act. If you as an authorized professional, based on your own evaluation of the person, believe anorexia to be such a thought or mood disorder or that the person has a thought or mood disorder in addition to the anorexia, that would suffice.

Q. Is a client with an Axis II diagnosis of Borderline Personality Disorder considered to be mentally ill as defined in the Baker Act? I see nothing in the definition that references Axis I or excludes mental illness even if the person also has substance abuse and criminal justice involvement?

The legal definition appears to require a serious thought or mood disorder (mental or emotional) as the basis of the mental illness, in addition to a serious functional impairment. It is questionable whether the range of personality disorders would meet that criteria. However, it is fairly common for persons with personality disorders to be hospitalized under the Baker Act, often with a "primary diagnosis" listed of something like depression. The same thing happens with persons who have Alzheimer's, head injuries, autism, retardation, addictions, etc. They are usually considered to be dually diagnosed and there is usually a "convenience" diagnosis listed as primary to pass muster on the diagnosis as well as to make the stay reimbursable by whatever payment source the person has.

Q. A person admitted twice in the last month was determined by our psychiatrist to have no mental illness, only a significant substance abuse problem. He is at high risk that he will inflict injury on himself. The treatment team agreed that Marchman Act was more appropriate, but he was not agreeable to referrals despite meeting the criteria for the Marchman Act. He was discharged from the CSU (since he didn't meet criteria under the Baker Act) and the psychiatrist initiated a Marchman Act. The County Sheriff's Office was notified for transport to the hospital for the jail's "medical clearance" requirement and then he was to go to the jail to be processed for a hearing date. Is this the appropriate way to handle this??

No. Referring the man to the jail was not the best choice since he had already been in the CSU for three days. Protective Custody by law enforcement is intended to secure the immediate safety of the person in order to take him/her to a detox center or hospital for up to 72 hours of stabilization. Only as a last resort would an officer take the person from the streets to jail where, within 8 hours, staff has to start looking for a service provider to accept the person. Collaboration with a substance abuse provider to provide direct referral is preferable.

Q. When our facility is full and we're transporting a suicidal patient to another facility; if the patient is voluntary, should the patient ever be put on a Baker Act? Some here have argued that the patient may be at risk due to labile mood or decision to act on the suicidal thoughts instead of agreeing to an admission, in other words change their mind half way during the transport. But others argue that it is unlawful to Baker Act someone who states they are willing to be admitted.

This is a question you may want to refer to your hospital risk manager as it applies more to federal EMTALA compliance and possibly to federal Conditions of Participation than to the state's Baker Act.

While you never want to falsify a document to allege a person meets criteria for involuntary status simply for purposes of transport if such criteria isn't met, one expert

suggests that your hospital liability remains until the patient is admitted at the destination hospital. Robert Bitterman is both an attorney and an emergency physician – his book “Providing Emergency Care under Federal Law: EMTALA” is published by the American College of Emergency Physicians. Dr. Bitterman believes that any person who is actively suicidal or homicidal has an emergency medical condition under CMS definitions and must remain stabilized during transfer -- chemical, mechanical and legal restraints may be required. By legal restraints, he means “involuntary” status so the patient won’t be able to demand release en route. Some transport firms believe that they must release any person on voluntary status upon demand.

The Baker Act involuntary examination criteria require that a person either “refuse” or be “unable to determine examination is necessary”. A refusal is clear. However, inability to determine the necessity of the examination may include any person who isn’t able to make well-reasoned, willful and knowing decisions about his/her medical/mental health care. It can also be a person who may have severe impulse control problems and be unable to follow through on a request for treatment. It may be a person who rapidly changes his/her mind about care. It may also be a person who is attempting to manipulate staff so as to elope. A person may “agree” to the transfer or admission, but still meet involuntary criteria.

Q. Can an individual whom is non-resident of Florida be legally detained and court committed under the Florida Baker Act?

Yes, any person who is present in the state of Florida is subject to the Baker Act. Such persons, if they meet the criteria for involuntary examination, can be taken into custody and legally examined under the law. If they are found to meet the criteria for involuntary placement, a petition can be filed to further detain the person for treatment. It may be advisable to arrange a return of the person to their own state as soon as possible to ensure appropriate discharge and aftercare planning. Finally, if the person is a foreign national with citizenship in another country (even if with dual citizenship in the US), you need to remember your obligations for Consular Notification and Access.

Q. When I was reviewing the Baker Act BA 52b that I had done over the past few months I noticed I inadvertently put down the incorrect diagnosis on one. All else was correct and the client was admitted by the receiving facility. Is there anyway to correct this after the fact?

Unfortunately, there isn’t any way to retrieve the documents and make the changes in them to the correct the diagnoses. Not only are the forms located in closed medical records at the various receiving/treatment facilities, they may also be in the files of law enforcement agencies that provided transportation. Finally, they have been submitted within one working day of the patients’ arrival at receiving facilities to the Agency for Health Care Administration through the state’s Baker Act Reporting Center.

If the error is only in the DSM coding, it is not likely to be of any great consequence since this code is not inputted in any official documents. While diagnosis is very important, a person’s diagnosis may change from a preliminary diagnosis, to a working diagnosis, to a discharge diagnosis in a single admission. Each may be correct depending on the information known at that point in time and as diagnoses are ruled out.

Q. How is “self-neglect” defined as a criteria for involuntary examination?

The Baker Act doesn't actually define self-neglect but it does state that the person is likely to suffer a real and present threat of substantial harm to his or her well-being that isn't avoidable by intervention from family, friends, or other services. The self-neglect must be a result of mental illness and could take the form of refusing necessary prescription medications, refusing to eat or drink, inability to sleep, placing oneself in imminently dangerous situations, or other high risk behaviors. It would not include refusal of medical intervention by a person with the capacity to make such decisions.

Initiation – General

Q. How does a family member go about having an adult child Baker Acted, when the parties reside in different state? Can they obtain an ex-parte order in Florida that would be enforced in Delaware? Would they be able to have the receiving facility be a V.A. hospital in Delaware, should the subject qualify?

Each state has enacted its own mental health law and each is different. The family would have to contact the Delaware authorities to determine the basis for an involuntary examination in that state. Any initiation of such action would probably have to take place in the state where the person needing the examination actually lives so their due process rights can be protected. It is unknown whether Delaware would permit the family to communicate with the court or others having authority to initiate such intervention by sworn testimony or if their presence would be required – all depends on the requirements of that state's mental health law. Regarding treatment at a VA hospital, such would be permitted in Florida, but whether that would apply in Delaware is unknown.

Q. When a Baker Act is initiated at the hospital or by law enforcement, is the transfer to a receiving facility from the hospital considered an “Initiation of Involuntary Examination” or “Involuntary Placement”? I was under the impression that it was for examination of whether the patient continued to meet the BA52 criteria, whether the person meets voluntary or involuntary status.

If the involuntary examination is initiated prior to arriving at your hospital by law enforcement or at your hospital, you are simply “transferring” the individual within 12 hours after medical stability has been documented to a designated receiving facility that has the capability and capacity to meet the person's needs.

Once at the receiving facility, the person will undergo an Initial Mandatory Involuntary Examination by a physician or clinical psychologist to determine if he/she meets the criteria for involuntary placement. If not, the person is released or converted to voluntary status. If meeting these more stringent criteria, a petition would have to be filed with the circuit court within 72 hours of the time the person was medically cleared at your hospital.

Q. Does an authorized person have a duty to initiate an involuntary examination?

A judge and a mental health professional do not have a statutory duty to initiate the examination when they have reason to believe the criteria have been met. However, they may have a responsibility under their code of ethics or under case law. On the other hand, a law enforcement officer has no discretion as to initiating an involuntary examination if he/she has reason to believe the criteria is met.

Q. I'd like to know more about "reason to believe" the criteria is met – how much discretion an authorized person has. if a court "may" do something (discretionary) like initiating involuntary examination, what criteria is the court to use in determining whether to actually do it? Is it just a matter of general prudence? If you have the right but not the duty to do something, can you just base the decision on whim or are there some implied criteria?

That is correct - a judge and a mental health professional may initiate if they have reason to believe the criteria is met, but have no duty to do so. A law enforcement officer has the duty to do so if he/she has reason to believe the criteria are met. If law enforcement doesn't believe the criteria is met and decline to initiate, they may wish to document at the time on an incident report their reason for not initiating.

Law enforcement is required to initiate if they have reason to believe; judges are not required to initiate even if they do have reason to believe. So a judge could find all the criteria to be met and still decline to initiate examination. The discretion offered by the "may" language comes down to whether the person with the legal authority to make the decision has "reason to believe" each of the criteria is met.

There are judges who will sign almost any petition for emergency action put in front of them (domestic violence, Baker, Marchman, etc) out of fear an adverse event tied to that action may appear in the paper the next day. Other judges won't sign such an order if will deprive a person of their liberty unless it's proved beyond a shadow of doubt the criteria is met. The standard is simply having "reason to believe".

The same issue applies to law enforcement and to mental health professionals -- they must have reason to believe the criteria are met. Any two law officers or any two mental health professionals with the same training can have dramatically different life experiences that may promote liberty / autonomy on the one hand vs. safety of the person / community on the other. Their tolerance of risk may be much different causing them to have differences in their "reason to believe".

The criteria are clearly spelled out in the law. The person with the authority to initiate must rely on those criteria - nothing more or less. However, they all have "filters" through which objective facts are applied against the criteria in determining whether that person has reason to believe the criteria is met.

This includes:

- A belief that both the clinical and functional aspects of the definition of mental illness are met.

- That the person has refused or is unable to determine the exam is needed. Refusal is objective, but the unable to determine may be quite subjective.
- That the person's self neglect is "real, present and substantial"
- That the bodily harm is serious enough and whether the actions upon which that conclusion is based is recent enough or the harm will occur in the near enough future.

These aren't "whims", but individual belief systems. While continued training can add much more consistency by training those persons authorized to initiate involuntary examinations, the conscientious differences in "reasons to believe" will and should remain.

If persons with the authority to initiate an involuntary examination act too far out of their professional standards, they can face discipline from those groups such as licensing boards, the Judicial Qualifications Commission, or Internal Affairs, depending on whether the initiator is a mental health professional, a judge, or a law enforcement officer.

Q. One of the prongs for commitment for Involuntary Examination is "Person is unable to determine for himself/herself whether examination is necessary." Is there any guidance, case law, or criteria that are used to make this determination?

The Zinermon v. Birch case before the U.S. Supreme Court was based on the definitions and other provisions of Chapter 394, Part I, FS as follows:

394.455 Definitions

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

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

394.459 Rights of patients.--

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

(a)1. Each patient entering treatment shall be asked to give express and informed consent for admission or treatment. ..

394.4625 Voluntary admissions.--

(1) AUTHORITY TO RECEIVE PATIENTS.--

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

person age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent.

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

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

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

The Baker Act has always required an adult to be competent to provide express and informed consent in order to be admitted or retained on voluntary status. An involuntary examination is based among other criteria, on the person either refusing the examination or being "unable to determine for himself/herself whether examination is necessary". Refusal is fairly clear. However, the inability to determine whether the exam is necessary can be based on any number of bases, such as:

- A person like Mr. Birch who was willing to go anywhere, do anything, or sign any document because he thought he was in Heaven. The U.S. Supreme Court found this to be de facto evidence of being incompetent to provide express and informed consent.
- A person who repeatedly changes his/her mind.
- A person who may be clearly manipulating a law enforcement officer to avoid an involuntary exam
- A person who may have a severe impulse control problem and is articulating a desire for help, but who may not be able / willing to act on it.

Generally "unable to determine" is someone who fits one or more of the above situations or is determined to be unable to make consistent "well reasoned, willful and knowing decisions about his medical or mental health treatment".

Q. I work at an outpatient crisis center and we recently had a man elope after the Baker Act was initiated. The police were contacted who refused to take possession of the Baker Act form. However, the man is due to return to the center in the near future and I was curious about the "expiration date" of the BA-52. It is my understanding that it holds indefinitely until the individual receives the assessment by a Psychologist or Psychiatrist at a designated receiving facility. Even if the man no longer appears to meet Baker Act criteria upon his return, do

we still have the obligation to contact police and have him transported to the nearest receiving facility for evaluation?

You are indeed correct with regard to law enforcement duty to provide primary transport for persons on involuntary status. You are also correct that a BA-52b Certificate of a Professional Initiating an Involuntary Examination is valid until executed. Since law enforcement never executed the certificate on the day it was signed, it is still valid. Once initiated, the initial mandatory involuntary examination must be actually conducted by a psychologist or a physician at a receiving facility or at an ER.

Q. Can another BA-52 be initiated when an existing one is about to expire to continue to hold a person until a transfer can be accomplished?

No. It would be entirely inappropriate for one BA-52 to be stacked on top of a previous one. It is the patient's right not to have their liberty denied for more than 72 hours for the purpose of psychiatric examination under the Baker Act. In fact, in a non-receiving facility hospital the law requires transfer to a receiving facility within 12 hours after medical stabilization. The law provides no remedy to correct what can't legally occur. A hospital can report the transfer delay to DCF and AHCA to ensure regulatory agencies are aware of the problem and you've documented your good faith effort to comply with the law.

What can't happen is releasing a person who continues to meet the involuntary criteria. You just have to document the danger to the person or others and hope this provides justification if a false imprisonment accusation is made.

Use of a BA-32 petition for involuntary inpatient placement could be initiated at an ED by a psychiatrist, although this is rarely ever done. One of the two psychiatrists signing the form must testify at the person's Baker Act court hearing. The second opinion (could be a psychologist instead) working at the receiving facility could provide this testimony. In any case, the BA-32 petition with both psychiatrists signatures and the signature of the receiving facility administrator would still have to be filed with the clerk of court within the 72-hour examination period.

Q. If a patient has been "re-Baker Acted", is it our responsibility to question the validity of the re-Baker Act (refuse or accept that patient)? The current public defender has warned us that the PD's office will begin challenging our holding patients we originally accepted with more than one BA52.

While the Public Defender can try to challenge an involuntary inpatient placement of a patient based on the non-designated hospital exceeding the legal time limit for an involuntary examination, it is questionable that this will prevail. The assistant state attorney would take the position that the petition for involuntary placement is a totally separate action, based on the patient's condition at the receiving facility. The actions of a previous hospital might be a basis of civil litigation, but shouldn't cause the release of a person documented to meet criteria.

Q. Can a patient who requested voluntary status after coming in under involuntary status be transferred to a public facility under a newly created PC? My thought is that the patient's status should be changed to involuntary and a petition filed. Is this correct?

You are correct. Too frequently people are transferred from involuntary to voluntary status who can't consistently provide well-reasoned, willful, and knowing decisions about their medical and mental health treatment – the very definition of competence to consent. Then when the person requests discharge or refuses treatment, the law requires the person to be released within 24 hours or a petition for involuntary inpatient placement be filed within two court working days of the person's request/refusal.

A Certificate of a Professional is only used to have the person taken into custody and delivered to a designated receiving facility. Once at a receiving facility, the proper procedure is to release the person, convert to voluntary or file the court petition within 72 hours. However, when a petition for involuntary inpatient placement is filed on behalf of a person on voluntary status who requests discharge or refuses treatment, it must be filed within 2 working days of the request or refusal. Any transfer to another facility and re-evaluation at that facility would have to fit within the original 72 hour period in which a person's liberty can be denied for the purpose of involuntary examination.

Initiation – Courts

Q. A judge completed a law enforcement BA form and marked out everywhere it said law enforcement officer and wrote in "Judge". If a judge wanted to Baker Act someone what would be the appropriate form for them to use? Now that the law enforcement officer is at our door with the Baker Act form completed by the judge, what would be the appropriate steps for the receiving facility to take?

A judge doesn't qualify to execute a law enforcement officer's report initiating an involuntary examination under the Baker Act. Only a certified law enforcement officer is authorized to do so – this is defined below:

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

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

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

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

A circuit judge is only authorized to enter an order initiating an involuntary examination under the following circumstances:

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

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

394.463 Involuntary examination.--

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

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination **must be based on sworn testimony**, written or oral. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination. The order of the court shall be made a part of the patient's clinical record. No fee shall be charged for the filing of an order under this subsection. Any receiving facility accepting the patient based on this order must send a copy of the order to the Agency for Health Care Administration on the next working day. The order shall be valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order shall be valid for 7 days after the date that the order was signed.

The correct form to get the statutorily required sworn testimony is the CF-MH 3002 and the Ex Parte Order for Involuntary Examination is the CF-MH 3001.

In any case, if a law enforcement officer delivers a person for involuntary examination, you should accept the person and have a physician or psychologist immediately conduct the examination. If the person doesn't meet involuntary inpatient placement criteria, the person should then be released unless the judge included in the order some type of time frame or required authority of the court prior to release. That shouldn't have happened, but you don't want to be non-compliant with a court order, even if the order wasn't appropriate. If the person currently has criminal charges, he/she should be released back to law enforcement as provided below:

394.463 Involuntary examination.—

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

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

It would be good to work through your agency's attorney to get information to the judge ASAP so this doesn't happen again. Judges are usually grateful for the information. You may wish to inform your attorney of this event in any case.

Q. I am trying to find out the procedure for a family member to petition a judge for an ex-parte order to have someone involuntarily picked up for psychiatric assessment. We have had times when we advise the family to get one but never tell them how to do it. Does it require more than one person to get it? Can a non-relative request an ex-parte for a friend or neighbor if no family is around?

The Baker Act cites the following for an ex parte order:

A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination. The order of the court shall be made a part of the patient's clinical record. No fee shall be charged for the filing of an order under this subsection... The order shall be valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order shall be valid for 7 days after the date that the order was signed.

Any person who has first hand knowledge of the individual's mental health status can file a petition with the probate office of the Clerk of Court. The law just states that it must be based on sworn testimony, but doesn't indicate how many people must file. It generally requires only one petition if the judge believes the criteria to be met. If the judge has any reservations, he/she might require a second petition. The judge is going to want to be assured that the petitioner's reason for filing isn't retaliatory in any way. There is no fee for the filing of the petition.

The 4-page model petition form can be found on the DCF website, but it's possible that the court in your circuit may have modified the form. There is no reason the petitioner couldn't have a copy of the form in advance to know what type of information may be required. The staff in the Clerk's office probably won't assist the petitioner because this has been determined to be "unlicensed practice of law". Once the petitioner completes

the form and swears to the accuracy of the information provided, the Clerk will take the form to the judge and the judge decides whether to sign an ex parte order for examination and a pick-up order for the Sheriff to execute. The whole process shouldn't take more than several hours, assuming that the person can be easily found.

Q. I'm a circuit court judge. I've heard that some judges believe that a judge can enter an order for an involuntary examination in open court of a person who appears in court exhibiting symptoms of a mental illness. I believe this would be unlawful and that a petition must be filed or that law enforcement could make the determination if called to the courtroom but that the judge could not.

You are correct. The law requires that any ex parte order be based upon sworn testimony.

394.463(2) Involuntary Examination.--

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

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. ..

While the law permits oral testimony that could potentially be elicited in a courtroom, the Florida Administrative Code requires use of the model state form "or other form used by the court". Whatever form or method is used, the information included on the petition form is considered by most courts to guide the appropriate application of the law.

65E-5.280 Involuntary Examination.

(1) Court Order. Sworn testimony shall be documented by using recommended form CF-MH 3002, Feb. 05, "Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other form used by the court. Documentation of the findings of the court on recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other order used by the court, shall be used when there is reason to believe the criteria for involuntary examination are met. The ex parte order for involuntary examination shall accompany the person to the receiving facility and be retained in the person's clinical record.

This permits the court the liberty of establishing its own form if desired, but still requires documented sworn testimony. The Baker Act contains the legal definition of mental illness. In summary, it must be a serious thought or mood disorder that substantially impairs a person's ability to meet the ordinary demands of living. There are some exclusions:

394.455(18) "Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology.

For the purposes of this part, the term does not include retardation or developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

Just because a person is showing signs of mental illness, there are additional criteria:

394.463 Involuntary examination.--

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

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

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

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

A person must meet each of these criteria, unless the phrases have an “or” between them. It can’t be just because a person has a mental illness, or won’t do what someone tells him/her to do, or just because he/she is dangerous to self or others. It is a package deal.

Q. Our CSU received two admissions yesterday on orders signed by a County Judge. These orders are “Order Releasing Defendant on His Recognizance for Psychiatric Evaluation.” The patients came to us from the county jail and read “Ordered and Adjudged that the Defendant in the above-styled case is to be released on his/her own recognizance contingent upon the Detention Center personnel delivering him/her to the public receiving facility for evaluation and treatment. The Defendant shall not be released from the facility unless 24 hour advance notice has been provided to this Court in writing so that the Court may further consider his/her custodial status.” Do we treat this as a Baker Act ex parte order and follow Baker Act procedure filing a BA-32 to hold the patient beyond 72 hours or do we consider this Court Order sufficient to hold the patient and treat the patient without further action? Can the patient consent to his/her own treatment if the psychiatrist finds the individual competent to do so? If the patient is found by the psychiatrist to be incompetent to consent to treatment should we petition the Court for a guardian advocate or does the fact the Order we have which includes the word treatment sufficient to treat the patient? We had an order similar to this here some time back and the Public Defender had us file a BA-32 and have a guardian advocate appointed, stating that the Order signed by the Judge denied the patient his rights under the Baker Act. These orders have been very rare in the past, but with the implementation of a new Forensic Program in this county for jail diversion, I anticipate that we may be seeing more of these.

My instruction to staff in the past has been to honor the order and treat the patient, including disposition, according to the Court order.

You must either accept a judge's order or appeal it – otherwise you might be subject to contempt. This is one that you may wish to run by your attorney – perhaps with the DCF circuit legal counsel as well. As you know, only a circuit judge has jurisdiction to enter an ex parte order for involuntary examination under the Baker Act – not a county judge, unless the chief judge has appointed that county judge to sit circuit for a temporary period. It sounds like the judge didn't initiate the involuntary examination under the Baker Act – the civil mental health statute. Instead, it appears to be a forensic competency evaluation – this is usually done while the person is in jail by experts appointed by the court and at the cost to the local judicial system. It is important that the purpose of the examination/evaluation be clarified as quickly as possible because the latter evaluation probably wouldn't be possible at your facility.

If it is intended to be a civil ex parte order, you must release the person back to law enforcement within the 72 hours or file a BA-32 with the court for further "detention". At this point, the person will have a public defender to represent him/her on the Baker Act. The person probably already has a public defender on the criminal matter. Again, if it is a Baker Act issue, the person can consent or refuse to consent to his/her own treatment if found by the physician to be able to make well-reasoned, willful, and knowing decision making about medical and psychiatric treatment. Otherwise, a guardian advocate would have to be requested. Your attorney and the DCF counsel should meet with the local judges about the appropriateness of certain court orders for future reference.

Q. Can a county court judge in a first appearance hearing order a misdemeanor defendant to have an involuntary Baker Act assessment? In our county the judge has been ordering the individual to cooperate with CSU in its Baker Act assessment, not actually ordering the evaluation, but rather leaving that to the discretion of the mental health professional.

No. Only a circuit judge has jurisdiction under the Baker Act to enter an ex parte order for "involuntary" examination. Such an order has to be based on sworn testimony by an individual who has personal observations of the defendant's behavior.

394.463 Involuntary examination.--

(2) Involuntary Examination.--

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

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral.

However, in the circumstance you describe, the defendant is being ordered to be "voluntary" under the law. This involves providing express and informed consent to the examination. Such consent cannot involve any element of force, duress or coercion, as follows:

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

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

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

However, a judge's order prevails unless it is appealed by a party having standing to do so. In such a circumstance, the defendant's public defender or private counsel or the assistant state attorney are probably the parties with such standing. It might be helpful if the attorney representing your agency meet with the judge on the issue for future reference.

Q. When a judge issues a pick-up order for the Sheriff to take a person into custody under the Baker Act, what happens if law enforcement can't find the person within 14 days? Does the petitioner needs to go back to the court house and re-submit the petition or does the Sheriff keep the order indefinitely?

The Baker Act section 394.463(2)(a)1, F.S. states that:

The order shall be valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order shall be valid for 7 days after the date that the order was signed.

This means that the judge can make the order for a period greater or less than 7 days, but if no time is specified by the judge, it expires 7 days after it is signed. In the example you describe, the order was written to provide up to 14 days for law enforcement to find the person and take him/her into custody. If that occurs within 14 days, the order expires upon taking the person into custody and acceptance at the receiving facility. If the person isn't found within the 14 days, the order expires and a new order would have to be sought to take the person into custody.

Q. I am a general magistrate handling BA hearings. We wanted to hear your opinion on whether a hearing is required when an Ex Parte Petition for Involuntary Examination is denied due to legal insufficiency. That is, should an order denying the request for examination provide a hearing date for a Petitioner to address his or her concerns?

A hearing is not needed to deny the petition for legal insufficiency and no such hearings are conducted at the time of or subsequent to a denial anywhere in the state. The Baker Act law and rule governing the ex parte process is as follows.

394.463(2) Involuntary Examination.--

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

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is

based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination. The order of the court shall be made a part of the patient's clinical record. No fee shall be charged for the filing of an order under this subsection. Any receiving facility accepting the patient based on this order must send a copy of the order to the Agency for Health Care Administration on the next working day. The order shall be valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order shall be valid for 7 days after the date that the order was signed.

65E-5.280 Involuntary Examination.

(1) Court Order. Sworn testimony shall be documented by using recommended form CF-MH 3002, Feb. 05, "Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other form used by the court. Documentation of the findings of the court on recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other order used by the court, shall be used when there is reason to believe the criteria for involuntary examination are met. The ex parte order for involuntary examination shall accompany the person to the receiving facility and be retained in the person's clinical record.

The law makes it discretionary on the part of a judge or a mental health professional to initiate an involuntary examination if there is reason to believe the criteria is met -- it is the duty of a law enforcement officer in such circumstances to do so.

If the law and rules governing this process only require an ex parte process (without a hearing) for a court to enter an order denying a person his or her liberty for the purpose of involuntary examination, a higher level of due process such as a hearing wouldn't be required to deny such a petition. The sworn testimony in an affidavit should stand on its own as to whether the information is persuasive or not in convincing a judge that there's reason to believe each of the criteria is met. Unless there are rules of judicial procedure that require such a hearing for denial, I don't believe one is needed. There is no reason why a judge couldn't conduct a hearing with a petitioner if he/she believed it was needed. Neither is there any reason why the petitioner couldn't file a subsequent amended petition providing additional information for the judge's consideration. Finally, if the patient's condition escalated after the petition was filed / denied, the petitioner could contact law enforcement in an emergency to request initiation of the examination.

Initiation – Law Enforcement

Q. A local hospital reported that they were having problems with our officers not completing the Baker Act paperwork when they drop off a patient. Staff gave an example of an officer bringing in a person that the officer told them made suicidal threats however no BA paperwork was completed. Since they didn't have anything on paper their protocol of constant supervision wasn't followed. This

person took a shower and was given a room where he subsequently went in and attempted to hang himself. They were concerned because if the paperwork had been completed this wouldn't have happened. I asked them if they knew if this person was brought in voluntarily. They didn't but stated, "if LEO brings them in doesn't that mean they are always going to be Baker Acted?" We explained that most of our transports don't meet the criteria by statute of a Baker Act because they go with us voluntarily to get help. Staff requested that when our officers transport a patient that we make sure the charge nurse knows whether it is voluntary or involuntary. She also requested that if they are violent that we let them know ahead of time so they can get VA police there. Lastly, I asked her about their hospital being the primary facility for Veterans needing this type of help. She requested that we bring ALL Veterans in need of psychiatric help to their facility because they are more equipped to deal with their issues. She also said that if in doubt if they are a Veteran all we have to do is call them and they can verify. We brought up the statute stating we take BAKER ACT's to the nearest receiving facility, but she said they are the nearest receiving facility for Veterans that need psychiatric services.

There are several pieces of the issue -- the information provided by law enforcement is accurate; the information provided by the VA is not. The VA is authorized to transport veterans who are voluntary -- meaning they are not only willing but able to consent to admission and treatment. This means able to make well-reasoned, willful, and knowing mental health and medical decisions. If records document the veteran is unable to do this and is at risk of active or passive harm as a result of mental illness, the person should be considered "involuntary" even if "compliant".

Law enforcement is required to take people under involuntary status to the nearest receiving facility unless a Transportation Exception Plan has been approved by the Board of County Commissioners and the Secretary of DCF. If a person has an emergency medical condition, he/she should be taken to the nearest hospital regardless of whether it is a designated receiving facility.

VA Hospitals are no longer "designated" by DCF because they are authorized under chapter 394.4672, FS to serve veterans. However, this section of the law doesn't authorize law enforcement or others to take persons on involuntary status to any facility other than the nearest.

If the nearest facility unable to meet the veteran's needs, he/she can then be transferred by the first facility to a more appropriate facility, such as a VA hospital. This is sometimes done due to the age of the person, insurance coverage (or lack thereof), or preference of the person. It isn't the responsibility of law enforcement to take anyone to other than the nearest facility unless a Transportation Exception Plan has been approved -- no such plan has been requested in your area of Florida..

Regarding the initiation of the involuntary examination, a law enforcement officer is mandated to initiate if he/she believes the criteria is met. It is discretionary for a judge or mental health professional. The law requires the officer to complete the initiation form and the transport form. There have been situations in which officers have been told by ED staff not to worry about the form -- it would be completed by the hospital staff. This isn't consistent with the law and may be problematic if the mental health professional at the hospital doesn't personally observe the behavior leading to the initiation (not required

for LEO). Further, if an adverse event occurs at or immediately following the person's exam/treatment at a hospital, there is the risk of disagreement over what was actually said at the time the person was presented. The officer must initiate if he/she believes the criteria is met. If VA personnel, law enforcement and DCF agree that they want veteran's taken directly to the VA hospital instead of to the nearest receiving facility, a Transportation Exception Plan is an easy solution. However, until that is done, transport to the nearest facility is the only legally permitted alternative.

Q. I need your assistance with a situation when a police officer initiates a Baker Act for a person after a suicide attempt. The person's father indicated that the woman had taken a large amount of pills. As a result, she was taken to an ER and was discharged the following day. The psychiatrist certified that the consumer did not meet Baker Act criteria. The consumer blames the police officer for unnecessary Baker Act, contacted the Mayor's office, and is very upset with the police. I have a copy of the itemized bill from the ER. The bill indicated that the consumer paid \$4,429.23 and insurance adjustments \$614.00.

The Baker Act doesn't speak to the issue of who pays for care initiated under the Act. The Legislature appropriates a very limited amount of funding to support public receiving facilities, which are required to charge fees on a sliding scale based on ability to pay. Care at private receiving facilities or other hospitals are the responsibility of the person or their insurer, if any. The law requires law enforcement officers to take any person they have reason to believe meets the criteria of the Act to the nearest receiving facility, unless they believe the person to have an emergency medical condition, in which case the person is to be taken to the nearest ER regardless of whether it is designated as a receiving facility.

Officers aren't expected to be diagnosticians and many people with acute psychiatric conditions have co-occurring substance abuse disorders. Just because this woman was intoxicated doesn't necessarily mean there wasn't reason to believe she met criteria for an involuntary examination under the Baker Act.

The situation you describe sounds as though it was handled appropriately by all concerned – the law enforcement officer and by the receiving facility. Once delivered to the receiving facility a physician or psychologist was required to conduct an Initial Mandatory Involuntary Examination (394.463(2)(f), FS and 65E-5.2801, FAC) , including:

- Thorough review of any observations of the person's recent behavior;
- Review "Transportation to Receiving Facility" form (#3100) and
- Review one of the following:
 - ✓ "Ex Parte Order for Involuntary Examination" or
 - ✓ "Report of Law Enforcement Officer Initiating involuntary Examination" or
 - ✓ "Certificate of Professional Initiating Involuntary Examination"
- Conduct brief psychiatric history; and
- Conduct face-to-face examination in a timely manner to determine if person meets criteria for release.

The criteria for release is documentation that the woman didn't meet at least one of the criteria for involuntary inpatient placement or involuntary outpatient placement. The

approval for release must be provided by a psychiatrist, psychologist, or emergency department physician.

The Florida Attorney General has addressed the issue of payment in several cases, summaries are as follows:

Attorney General Opinion 93-49 Regarding Who is Responsible for the Payment of an Involuntary Baker Act Placement, 1993 WL 384795 (Fla. A.G.) Attorney General Robert A. Butterworth advised the Board of County Commissioners for Lafayette County, FL that the county is not primarily responsible for the payment of hospital costs, however, a county may be liable for hospital costs in the event a person is arrested for a felony involving violence to another person, and the arrested person is indigent. Depending upon the Baker Act patient's ability to pay, the patient is responsible for the payment of any hospital bill for involuntary placement under the Baker Act, however, if the patient is indigent, the Department of Health and Rehabilitative Services (HRS) is obligated to provide treatment at a receiving facility and HRS provides treatment for indigent Baker Act patients without any cost to the county.

Attorney General Opinion 74-271 Regarding Involuntary Hospitalization in Psychiatric Facility. A circuit court judge may order a patient involuntarily hospitalized at a private psychiatric facility not under contract with the State provided that the patient meets the statutory criteria for involuntary hospitalization, the facility has been designated by DCF, and the cost of treatment is to be borne by the patient, if he is competent, or by his guardian if the patient is incompetent. When state funds are to be expended for involuntary hospitalization of a patient in a private psychiatric facility, such facility must be under a contract with the state.

AGO 2007-11 Regarding Hospital Authorities and Illegal Aliens. The Hospital Authority's enabling legislation is to provide medical services to those indigents who live within the district. The term "residents of the district" was intended by the Legislature as a pure residence requirement, and not as a requirement for domicile, legal residence, or citizenship. Any place of abode or dwelling place constitutes a "residence," however temporary it may be, while the term "domicile" relates rather to the legal residence of a person, or his home in contemplation of law. As a result one may be a resident of one jurisdiction although having a domicile in another. Thus, the enabling legislation for the authority would appear to permit the authority to provide services to otherwise qualified indigent illegal aliens living within the district. Inasmuch as Chapter 04-421, Laws of Florida, does not distinguish between the types of indigent residents, it appears that the hospital authority should provide healthcare access to these aliens on the same basis as other indigent residents.

It sounds like the woman's insurance paid very little of the bill. Perhaps the hospital billing department can assist her in obtaining some greater reimbursement, since this was an emergency room visit based on a belief that an emergency medical condition existed. In the absence of the insurance company paying a greater share of cost, perhaps the hospital would be willing to adjust the bill.

Q. I am the former CIT coordinator at our Police Department. We had two Detectives called out for an individual that was depressed over a recent lawsuit judgment against him and sent a suicidal text to his girlfriend. So he became a missing endangered adult. The Detectives observed the text and entered him in the computer. The next morning they were able to track him to a nearby city in our county. That city's Police told us that we needed to do the Baker Act because the man made the text messages in our city, but they would transport him. Our administration's interpretation was that we don't have jurisdiction to Baker Act in a city outside of our jurisdiction. Eventually the other city's officer said if we write out a statement they would Baker Act him. By then the guy said he was just upset and didn't mean the text. The police from that city then refused to Baker Act him as he is no longer a danger. Are Baker Acts bound by jurisdiction or can any state law enforcement officer do a Baker Act in another jurisdiction if the statements or messages were made in their jurisdiction? What if there was a disagreement between the officers in the two jurisdictions and they felt from their investigation that he was a danger to himself, but the next morning officers from the other city didn't think he was.

The Baker Act places a duty on a certified law enforcement to initiate an involuntary examination under the Baker Act if the officer believes the criteria is met. It is discretionary on the part of a circuit court judge or a mental health professional to initiate in the same circumstance. The difference between "shall" and "may" is significant in the law. It is this non-discretionary duty that is cited in several appellate cases that increases your authority for warrantless entry during certain exigent circumstances as well as immunity for liability during transport of involuntary persons. The transport case is as follows:

Donald Pruessman v. Dr. John T. MacDonald Foundation, 589 So. 2d 948 (Fla. 3d DCA 1991). The Third District Court of Appeals held that where a patient was discharged from a hospital and the patient refused to leave, and the hospital administrator contacted an outside doctor to evaluate the patient regarding Baker Acting the patient, the hospital was not legally responsible for any action taken by the outside doctor involved in Baker Acting the patient. The Third District Court of Appeals also held that the actions of the city police officers who were called to the hospital to take the patient into custody, remove the patient from the hospital, and transport the patient to a Baker Act receiving facility based on a doctors certification the patient needed to be Baker acted, **were not discretionary under the Baker Act and the city was not liable for the actions for the city police officers in transporting the patient to a receiving facility.**

With regard to jurisdiction, the law requires law enforcement transport to the "nearest" receiving facility, regardless of city or county lines. However, the law is silent as to jurisdiction of the officer doing the initiation. The definition of a law enforcement officer is defined in the Baker Act [394.455(16)] as a law enforcement officer as defined in s. 943.10. Chapter 943 reads as follows:

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

(1) "Law enforcement officer" means any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose

primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. This definition includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency.

Chapter 943 doesn't appear to limit an officer's authority to his/her own department's jurisdiction. However, your own department may limit the authority of an officer acting outside his/her city or county.

The Baker Act doesn't require an officer to personally observe the action leading up to initiation of an involuntary examination (as it does for a mental health professional) – the officer must describe the circumstances under which the person is taken into custody. This means you can rely on the statements of a credible witness. When this is done, the officer may want to use a witness affidavit to protect his/her good faith should people's statements change over time.

Finally, an officer from either department could have initiated the involuntary examination if that officer had reason to believe the criteria was met, even over the objections of another officer from his/her own or another department. Two persons with the same authority and the same training may have vastly different opinions as to whether the criteria are met and both be correct under the law.

Initiation – Mental Health Professional

Q. Can a Baker Act be initiated on the basis of a phone conversation?

There is no reason why the examination by an authorized professional leading to initiation of the involuntary examination must be conducted face-to-face. The section of the law governing this is as follows:

394.463(2) Involuntary examination.

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

3.A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. ...a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody.

If you know the individual with whom you are speaking by phone and are sure of his/her true identity and there is no conflict with your professional practice standards, an examination conducted by telephone should be sufficient to initiate the involuntary exam.

Q. We are having issues getting patients transferred to other psychiatric facilities when patients are initially placed on a 23 hour hold. This is done when there isn't a licensed professional in house that can initiate a professional certificate. The transferring facilities will only allow us to transfer under a professional certificate. I know that the time starts ticking as soon as someone is placed on a hold, but can a licensed professional (excluding MD and Clinical Psychologist) write the certificate when they come in (prior to the patient seeing a doctor)?

Yes, any of the professionals authorized to initiate an involuntary examination can do so before a patient sees a doctor. This would include a LCSW, LMHC, LMFT, Psychiatric Nurse or PA, in addition to physician, psychiatrist or psychologist. The Baker Act has no "23 hour hold". This is probably in your organization's policies instead. There is a maximum of 24 hours from the time a person who is on voluntary status is released after requesting such a release or refusing treatment. Within the same 24 hours from arrival at your facility, a physical examination must be conducted.

Q. I need a clarification on the BA-52 form. When there is no time documented on the form initiated by the ED physician, is this acceptable and if so, how would the receiving facility determine when the clock starts for the 72-hour hold. Sometimes the ED physician who initiated the BA-52 is off duty by the time the patient is medically cleared for transfer and another physician is not willing to fill in the time. Can we still accept this as a valid BA-52?

The BA-52b is required to be complete – this includes the time at the top of page 1 of the form. In the absence of information to the contrary, you can assume that the form was signed at the same time as the examination was performed. Further, the 72 hour involuntary examination period begins when the patient's emergency medical condition at an ER has been stabilized. You can usually identify this from the ER chart which has probably been faxed to you. In any case, when doubt exists, the 72 hour period should always be calculated in the interest of the patient's liberty. The patient's transfer and examination/treatment at a receiving facility should be expedited whenever possible and not delayed because of administrative omissions.

You would always accept the patient even if the initiator was remiss in correctly completing the form. You are correct that the BA-52a form doesn't have a place for the time of signature at the bottom of the back of the form. In almost all cases, it is the same time as listed at the top of the first page of the form. Again, if the form is incomplete, you would accept the patient and contact the initiator to obtain a corrected form or just note that the initiator had refused to provide it. There should be a printed or typed name of the professional along with an address on the bottom of the form in addition to a signature. If even this is illegible, and the information isn't on the Transport form (BA 3100) all you can do is document that the notice couldn't be sent due to illegibility.

Q. Since judgment is heavily relied upon when deciding whether or not to Baker Act a client, when does a mental health professional "know" when their judgment is "correct?" On what side is it better to err?

The initiating professional just has to have “reason to believe” that each of the criteria is met. Further, a professional “may” (not “shall”) initiate when he/she has reason to believe the criteria is met. This leaves tremendous discretion to the professional to attempt less restrictive interventions when possible. Given this, one must balance the liberty interests of the person against their safety and the safety of their family/community. While the statute and case law support that you don’t have a duty to initiate the examination, you may have responsibility under your code of ethics or license. The “Paddock” appellate case speaks to this issue. The trial court in this case determined that the law did not impose a legal duty on a psychiatrist to involuntarily take a patient into his custody; that he was not legally obligated (nor empowered) to take control of her life away from her against her will to protect her from her self-destructive tendencies. The court agreed that no such duty exists. The language of the Baker Act statute is permissive and suggests no basis for imposing an affirmative obligation on psychiatrists or other mental health professionals. However, where a professional has reason to believe the criteria is met, he/she should consider initiating the examination for the person’s protection as well as that of the professional.

Q. We have a number of individuals who are demanding to be Baker Acted multiple times even within the same month saying the right things and presenting a plan. These individuals almost never follow up with aftercare, outpatient appointments, or case management. If we Baker Act them, it is adversely affecting our relationship with the local receiving facility because the staff there feels abused by these individuals. The people in question will not go directly to the receiving facility knowing that they will be turned down. How should we handle them so that both facilities take proper ethical action and reduce risk factors and abuse of the system?

This issue is of real concern, especially when you feel fairly comfortable that the person won’t act on the threats and that the hospitalization may be counter-therapeutic. You have no duty to initiate – the word is “may” for the circuit judge and the mental health professionals, while it is “shall” for law enforcement if the initiator believes the criteria for involuntary examination is met. The statutory language is as follows

394.463 Involuntary examination.--

(2) Involuntary Examination.--

3. A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker **may execute a certificate** stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based.

Appellate cases uphold this language, although there is greater liability on a facility not to release a person who may be at great risk than to initiate in the first place. The 48 hour period permitted between the professional’s examination of the person and signing the form can permit development of a “safety plan” to avoid hospitalization in some cases. However, the persons you refer to may not be amenable to safety planning either. It might be helpful to determine if there are any patterns to these episodes. Many people report that such events often occur later in the month when benefits have run out, resulting in a request for discharge from a facility just before a new check

arrives. This doesn't mean that on any given month the person may actually be grossly depressed and subject to suicide.

DCF circuit staff may know how other professionals and facilities have dealt with this. It is probably an individual clinical judgment each time it occurs as to whether danger is imminent or not. It would never be appropriate to unilaterally exclude certain individuals from access to care. Assuming you can't document that their requests for help aren't just manipulation, each such request must be carefully evaluated. Hospital staff reaction shouldn't affect what you believe are your professional obligations. The hospital is subject to the federal EMTALA law as well as the state's Baker Act and must accept any person on voluntary or involuntary status for screening who arrives at the hospital. There is no difference if the person shows up on his/her own or whether you initiate an involuntary examination and the person is transported by law enforcement. Once the person is at the hospital, they must provide a psychiatrist or psychologist to examine and release if they don't believe the more stringent criteria under involuntary placement is met.

Q. Can an ARNP initiate involuntary examinations under the Baker Act?

Not necessarily. A psychiatric nurse according to 394.455(23) is defined as "a registered nurse licensed under part I of chapter 464 who has a master's degree or doctorate in psychiatric nursing and 2 years of post-master's clinical experience under supervision of a physician." This would be the needed documentation to verify that an ARNP is also a psychiatric nurse. Some ARNP's were grandfathered in with four year and even two year nursing degrees and other ARNP's may have a master's degree that is not specifically in psychiatric nursing. An ARNP cannot initiate an involuntary examination under the Baker Act unless that ARNP's also a psychiatric nurse as defined in the Baker Act.

Q. I have an LCSW working for me who is refusing to Baker Act suicidal students. He is calling for another LCSW or law enforcement to assess. My question for you is what is his obligation under the law to Baker Act a person he determines to be harmful to self as an LCSW?

The Baker Act doesn't place a duty on a mental health professional or a judge to initiate an involuntary examination as it does for a law enforcement officer.

394.463 Involuntary examination.--

(2) INVOLUNTARY EXAMINATION.--

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

1. A court **may** enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination.
2. A law enforcement officer **shall** take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have

him or her delivered to the nearest receiving facility for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, and the report shall be made a part of the patient's clinical record.

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

The case law on this issue is consistent in supporting that a mental health professional has no duty to initiate such an examination. Further, the 48 hour delay that is permitted for a mental health professional sort of suggests that a professional may institute a "Safety Plan" to protect the well-being of the person in an attempt to use the least restrictive available and appropriate alternative.

I'm concerned that the Social Worker is calling on law enforcement or another mental health professional to do what he clearly believes is the appropriate intervention. Unless he is just seeking a "second opinion" prior to initiating, this makes no sense. Your standards established through a Social Workers Code of Ethics or through the School System may modify the minimum legal requirements found in the Baker Act.

Q. I am an outpatient psychiatrist for the VA. I encourage patients to call me when they are in crisis, and they often do. I often have patients call me and report suicidal or homicidal ideations, and I need to Baker Act them, though I am not seeing them face-to-face, it is a telephone evaluation. The Baker Act form states "I have personally examined..." In this situation, I have called the police and asked them to visit the patient, and I provide my opinion that the patient should be Baker Acted. However, many times the police officer talks to the patient, then decides not to Baker Act the patient, despite whatever opinion I have offered to them. In these situations, is it acceptable for me to complete a Baker Act form based on a telephone evaluation, then fax the Baker Act form to the police station (along with a phone call to the police), rather than asking the police to be the one to make the decision of whether to Baker Act or not? Do you think that a telephone conversation can meet the Baker Act stipulation of having personally examined the patient?

If you have known and treated the person in the past and you now perform an examination by telephone in which the person expresses suicidal or homicidal ideation, this would be sufficient to initiate the involuntary examination certificate for law

enforcement to transport. Law enforcement is obligated to transport if you directly initiate even if they don't agree.

However, If you haven't ever known or treated the person, it would be risky for you to initiate such an involuntary examination because you might not be able to verify that the person had given you a correct name or identifiers. In such cases, you might want to provide a written statement to the law enforcement officer of what the person had said to you by telephone to assist the officer in determining whether he/she has sufficient basis for initiation. The officer doesn't have to directly observe the behavior – just describe the circumstances under which the person is taken into custody. However, the officer still has to have reason to believe the criteria is met in order to initiate the examination. Your written statement might provide enough to protect the officer's good faith reason to believe the criteria is met.

The Florida Legislature has authorized 2nd opinions for involuntary placement by electronic means in some circumstances. Some groups are currently urging the formal adoption of telemedicine methods for initiation of involuntary examinations.

The Baker Act doesn't prescribe the method of the examination as long as it is within the acceptable standards of practice for your profession. It does require that it be your own "observations" – visual or auditory – that leads to your conclusion that the criteria is met; not solely the "observations" of others.

Q. We have three psychological residents on staff with 0-1.5 years post-doctoral experience on staff. If one of the residents is meeting with a client and they assess a person to meet criteria for involuntary examination can a psychologist who is 9 or 10 years post-doc simply sign off on what the psychological resident has assessed and written up or must the psychologist interview the client face to face to assess?

A psychologist not only has to be fully licensed in Florida, but must have the three years of post-doctoral experience in order to perform any of the responsibilities of a psychologist under the Baker Act. The definition is as follows:

394.457(2) "Clinical psychologist" means a psychologist as defined in s. 490.003(7) with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility under this part.

However, in addition to being one of the authorized parties, a psychologist meeting the above definition must have personally examined the individual and must reach his/her conclusion that the individual meets criteria based on his/her own observations:

394.463 Involuntary examination.

(2) Involuntary Examination.

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

3. A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate

stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based

The observations/conclusions must be that of the person authorized by law to make such conclusions – in this case the licensed psychologist with no less than the three years of post-graduate experience. A law enforcement officer can accept credible third party hearsay in describing the circumstances under which the officer takes a person into custody under the Baker Act, but a mental health professional cannot. The professional must have his/her own independent observations / conclusions recorded on the bottom/front of the initiation form. However, the authorized professional can include the resident's statement in the section on the top/back of the initiation form where "other information including source relied upon to reach this conclusion is as follows.." can be recorded.

Q. Can a psychiatrist initiate an involuntary examination, be the 1st opinion on a BA-32, and then act as treating psychiatrist? What if the treating psychiatrist has stated under oath that a specific LCSW contacts her for assistance in filling out the 52 and then sends that resident to a receiving facility that isn't the nearest. The psychiatrist states that the LCSW sometimes acts as her contract employee.

There isn't any statutory or regulatory provision prohibiting the a psychiatrist from initiating an involuntary examination and doing the first opinion for involuntary placement on his or her own patient. The only prohibition is for the preadmission assessment of competency for residents of long-term care facilities seeking voluntary admission. That prohibition prevents any person employed by, under contract with or having a financial interest in either the sending facility or the receiving facility to which the resident would be sent from conducting the assessment. The assessment for voluntary status of these persons must be done by an independent professional prior to the transfer to a receiving facility.

Having multiple roles with regard to involuntary examination/placement isn't an unusual practice, although this practice could certainly be prone to abuse. What could be a severe violation is having persons taken from their residence to a facility that isn't the nearest receiving facility to the person's residence. The doctor would have had to evaluate the resident face-to-face within 48 hours prior to signing the initiation form – she couldn't rely on third party witnesses (such as the social worker) to the behaviors or statements that led to the initiation. There also couldn't be any kind of direct or indirect inducement between the doctor and the LCSW or nursing home to refer such patients – this would be a violation of federal and state law.

The Florida Health Care Association has prepared an excellent policy and procedure for dealing with behavioral management of nursing home residents – it's considered the model for what a good nursing home will do in such situations to avoid out of facility transfers, although many of these interventions aren't necessarily required. The federal OBRA law and Chapter 400, FS govern transfers from nursing homes. The federal law is clear that nursing homes have an obligation to meet the specialized needs of their residents in-place rather than undergoing the risks of transfer trauma.

It also sounds like law enforcement is not being called for transportation of persons on involuntary status as is required by law. If the officer believes the safety of the person is at risk in being transported in a cruiser instead of medical transport, the officer can complete the front and back of the 3100 Transport form and turn the person and the paperwork over to EMS.

The Agency for Health Care Administration and/or the Long-term Care Ombudsman Committee should be asked to investigate whether the facility is doing its job in serving persons in place. If it turns out that the psychiatrist is unnecessarily hospitalizing nursing home residents or is steering them to the hospital where she practices when it isn't the nearest facility, this should be reported to DCF and to DOH Medical Quality Assurance (Board of Medicine).

Q. How do ED physicians best hold a person on involuntary or voluntary status? How should they identify appropriate vs. inappropriate patients? How should they properly separate drug/alcohol issues from psychiatric issues?

Ensure that each patient examined or treated on a voluntary basis is capable of providing well-reasoned, willful and knowing health and mental health decisions. Otherwise, use the involuntary examination provisions. Ensure that each patient for whom an involuntary examination is initiated meets each criteria below.

1. Has a mental illness as defined in the Baker Act (Excludes substance abuse or developmental disability) and because of the mental illness --
2. Has refused or is unable to provide express and informed consent for examination
3. Is either dangerous to self or others or there is a real, present, and substantial threat of self-neglect

Never use the Baker Act as authorization for anything except psychiatric examination and psychiatric treatment. It offers no authority to force medical examination or treatment or to prevent a patient from leaving AMA.

If a person's symptoms are substance abuse instead of mental illness, the Marchman Act should be used instead of the Baker Act: Involuntary admission criteria under the Marchman Act are:

- 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**
 1. Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; **or**
 2. 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.

Q. Does an authorized mental health professional have to actually observe the criteria for an involuntary examination prior to initiating the examination?

YES. The Baker Act requires that the specified professional find that the person meets the criteria for involuntary status based on their own examination and they must describe their observations upon which their conclusion is based. However, a law enforcement officer only needs to describe the circumstances under which the person was taken into custody.

Q. I work for a crisis team and we often discuss the criteria for a Baker Act. Most often times, we discuss a certain set of criteria needing (for suicide) ideation, plan, intent, and a way to complete the task (i.e. a weapon). How do these criteria fall into the law? Is it valid?

Certainly if a person has an ideation, plan, intent, and method, the criteria have been fully met for an involuntary examination to be initiated. However, there may be people who have suicidal ideations but are so depressed at that moment they can't get a plan and method together – they also really need an examination to be conducted.

Another issue is whether the person is refusing the exam. If so, it is clear that the exam can be initiated. However, if the person is “agreeing” to the exam, you have a separate decision to make as to whether the person has the capacity to determine whether the exam is needed. If the person doesn't seem to making well-reasoned, willful, and knowing decisions, you can initiate even if the person is saying “yes”. Even if you believe they might not be able to act on their decision to seek help, you can initiate the involuntary examination.

Q. A patient who was transferred to us from another hospital for a cardiac workup. He had a violent, explosive reaction when he was strapped to a tilt table for the test. He screamed that he didn't want the test, to leave him alone and to let him get out of here. In the process he kicked the doctor and demonstrated other aggressive behavior. Code Green was called. The test was not a matter of life and death and eventually, the doctor decided not to do it. The family reported that the man was a pleasant and cooperative gentleman who did not have such outbursts, but lately, he was appearing to be a bit confused and forgetful. The doctor demanded that we Baker Act the patient. Our psychologist could not break away immediately, so the physician Baker Acted the patient himself. The doctor justified it by saying that if the patient was Baker Acted, it gave him the authority to treat with Haldol and Atavan and to use other methods to restrain the patient. Is this true? Later, our psychiatrist arrived who suggested that the patient might have some organic process going on, like a tumor. I think he would need a workup for that and to stabilize him for the cardiac situation which also could be playing into the picture.

This certainly doesn't sound like the grounds for a Baker Act involuntary examination were present and it was used solely to try to medically treat the man. The Baker Act doesn't offer any authority to perform any medical examination or medical treatment – other statutes would have to be used instead. The doctor initiated an involuntary “examination” – this doesn't authorize administration of any medications that hadn't been authorized by a competent adult, or if not competent, by a guardian or health care surrogate/proxy. Use of chemical restraints for behavioral purposes are not only

governed by the Baker Act, they are governed by JCAHO and by CMS Conditions of Participation. Whichever of the federal or state regulatory standards that applies to your hospital that is most stringent would apply here.

In this case, you might consider:

1. once a physician had determined him to lack competence/capacity to make medical decisions a family member or close personal friend be designated as the man's health care proxy to give consent to whatever they believed he would have wanted if he had been competent to consent on his own. (An independent LCSW referred after review by an ethics committee could also consent).
2. Otherwise, your hospital attorney could assist in getting expedited judicial intervention for medical treatment (Probate Rule 5.900).
3. Finally, if the man was over the age of 60 or disabled and suffered from self-neglect due to his incapacity, a referral to DCF Abuse Registry could have achieved the necessary result.

In any case, the Baker Act is not the right instrument to seek medical care for someone who can't make such decisions on his/her own.

Q. An LCSW asked me if a BA initiation could be rescinded once it is initiated because the person is doing fine now (initiated BA few days ago). Must the police follow through with picking the person up and bringing her in to a CSU for evaluation?

There is no provision in the law for the involuntary examination, once initiated, to be "rescinded". If the woman presents herself to a designated receiving facility with the LCSW and the form, a psychiatrist or psychologist at the facility could probably examine her and release her on the spot. It is possible that law enforcement, assuming the form had been given to them, will just give up on trying to find her. It is also possible that they might be encouraged by the LCSW to not pick up the person.

Q. Physicians at our facility believe that when a patient who has been charged with a crime is brought into the ED by law enforcement, they automatically must be placed under a BA (even if they don't meet BA criteria). If this is so, how should the BA be written?

The physicians are not correct on this. An involuntary examination can't be executed for anyone who doesn't meet the legal criteria. A person with criminal charges can be examined and treated for a mental illness on a voluntary basis if he/she is willing and is able to make well-reasoned, willing and knowing mental health decisions.

The Baker Act is specific that if a person is on involuntary status, he/she cannot be transferred to voluntary status if any criminal charges are present nor can the person be released except back to the custody of law enforcement in such circumstances. This doesn't mean that persons with criminal charges must be on involuntary status under the Baker Act if they don't meet criteria. However, law enforcement may want to remain with the person until cleared for transfer to the jail.

Q. Can an ARNP initiate involuntary examinations under the Baker Act?

Not necessarily. A psychiatric nurse according to 394.455(23) is defined as "a registered nurse licensed under part I of chapter 464 who has a master's degree or doctorate in psychiatric nursing and 2 years of post-master's clinical experience under supervision of a physician." This would be the needed documentation to verify that an ARNP is also a psychiatric nurse. Some ARNP's were grandfathered in with four year and even two year nursing degrees and other ARNP's may have a master's degree that is not specifically in psychiatric nursing. An ARNP cannot initiate an involuntary examination under the Baker Act unless that ARNP's also a psychiatric nurse as defined in the Baker Act.

Q. We have three psychological residents on staff with 0-1.5 year's post-doctoral experience on staff. If one of the residents is meeting with a client and they assess a person to meet criteria for involuntary examination can a psychologist who is 9 or 10 years post-doc simply sign off on what the psychological resident has assessed and written up or must the psychologist interview the client face to face to assess?

A psychologist not only has to be fully licensed in Florida, but must have the three years of post-doctoral experience in order to perform any of the responsibilities of a psychologist under the Baker Act. The definition is as follows:

394.457(2) "Clinical psychologist" means a psychologist as defined in s. 490.003(7) with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility under this part.

However, in addition to being one of the authorized parties, a psychologist meeting the above definition must have personally examined the individual and must reach his/her conclusion that the individual meets criteria based on his/her own observations:

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The observations/conclusions must be that of the person authorized by law to make such conclusions – in this case the licensed psychologist with no less than the three years of post-graduate experience. A law enforcement officer can accept credible third party hearsay in describing the circumstances under which the officer takes a person into custody under the Baker Act, but a mental health professional cannot. The professional must have his/her own independent observations / conclusions recorded on the bottom/front of the initiation form. However, the authorized professional can include the resident's statement in the section on the top/back of the initiation form where "other

information including source relied upon to reach this conclusion is as follows.." can be recorded.

Transport

Q. We are about to open a new VA hospital with psychiatric capability. Does this mean we can initiate an involuntary exam with veterans to our own hospital, and thus allows the VA to direct non-veterans elsewhere? What if there are concurrent medical and psychiatric emergencies? Will ambulance transport do this and honor the involuntary procedure, or are you saying we would need to come up with a Transportation Exception Plan? For example, if there is a history of delusions with schizophrenia and delirium from a medical problem, but unable to keep patient in outpatient setting for safety reasons, ambulance is called and Involuntary Certificate completed.

The law requires persons on involuntary examination status to go to the nearest receiving facility. The Transportation Exception Plan for your county approved by the Board of County Commissioners and the Secretary of DCF permits (but doesn't require) law enforcement to take adults to the Central Receiving Center. An amendment to the existing TEP would permit law enforcement to bring veterans directly to you instead of the CRC. There may be occasions when you discover the veterans brought to you may not be eligible for your hospital and you'll have to arrange safe and appropriate transfer (consistent with EMTALA) to another willing and appropriate facility.

If your VA hospital is a general hospital with a psychiatric unit, it should be able to manage the medical and psychiatric symptoms. You may need to work with your local EMS authority to determine its protocols in medical emergencies. It will probably depend on the nature of the emergency and whether it is a trauma, an emergent condition, or other level of needed care. EMS generally must take to a licensed general hospital per state law rather than a non-hospital facility like the CRC. Whether your VA hospital fits into this protocol, will depend on your local protocols.

Q. I work at an outpatient VA mental health clinic. There are times our veterans are placed on a BA52 status. We work closely with a VA hospital in another part of the state to take our patients. My question is are they able to take our patients who are on a BA52, if the patient is calm, cooperative, medically stable for transfer, transported via secure transport, and a psychiatrist accepts the patient for admission? I believe patients who are placed on BA52's do not have to be transported via the police, if other arrangements are made. My understanding has been that patients can be transported across county lines when they are on a BA52, but not be moved across county lines when they are on a BA32.

If a person is on a BA52, it means they must be transported by certified law enforcement to the nearest receiving facility. In your county, there is an approved Transportation Exception Plan in which adults are taken by law enforcement to a central receiving facility. From the CRC, the person can be transferred by any safe method to a receiving facility, within or outside the county. If the person is calm and cooperative, he/she may be able to be transported on voluntary status. In that case, the transportation can be provided by your staff directly to the VA hospital in the other county.

The appellate courts have confirmed that only a law enforcement officer (with limited exceptions) is authorized to transport a person on involuntary status. The Florida Attorney General has also determined that VA law enforcement is not authorized to initiate an involuntary examination or to provide primary transportation to persons on involuntary status. Patients have the right to request a transfer from one receiving facility to another, even across county lines. It is irrelevant as to whether the person is on a BA 52 or BA 32 status. The only problem is when a person is awaiting an involuntary placement hearing, the logistics of having one of the initiating psychiatrists available to testify can be difficult to overcome until after the hearing is completed.

Q. We had a veteran at our Outpatient Mental Health Clinic who was floridly psychotic and had to be placed on a BA 52. The local authorities were summoned. One of the local facilities was called and they were full. Did we not do the right thing calling law enforcement and they transported him to the nearest receiving facility?

You followed the Baker Act law exactly the way you should have. You initiated the involuntary examination and called law enforcement for transport. The person should have been taken by law enforcement to the nearest receiving facility, regardless of whether the facility was full. The only exception is when the officer believes the person to have an emergency medical condition, in which case the person would be taken by the officer or EMS to the nearest ER, regardless of whether the ER was associated with a designated receiving facility. The nearest receiving facility, if unable to manage the person by virtue of medical condition, age, availability of beds, etc. should have "accepted" the person and transferred the person to another facility that had the capability and capacity.

Q. Can a person be taken for involuntary examination to a facility that is not the nearest at the request of a person, family, mental health professional or the order of a court?

NO. A person must be taken by law enforcement to the nearest designated receiving facility rather than to the preferred facility unless an emergency medical condition exists. After arrival at the facility, the person or legal representative can request a transfer to an alternate facility.

Acceptance

Q. Our general hospital is designated as a receiving facility and we've been receiving some resistance from local receiving facilities regarding the LEO initiated BA-52. We have been told (on occasion) that they cannot accept a patient as a transfer if the second page is not filled out. Is this true? We have never heard of this until recently and quite frankly 85% of BA-52's do not have this page filled out.

This is a bit confusing because the BA-52A form "Report of Law Enforcement Officer Initiating Involuntary Examination" is only a one-page form -- there is no second page.

Since it is a mandatory form, it can't be changed. There is a second mandatory form -- the BA-3100 "Transportation to Receiving Facility". This is a two page form, requiring the law enforcement officer to complete the first page for each involuntary examination. The second page (back side) is only completed when the officer has delegated the transport to EMS or a medical contract transporter funded by the county. This form must be completed regardless of whether the involuntary examination is initiated by law enforcement, the court, or by a mental health professional.

One or more places in the state may have inappropriately consolidated these two forms by putting the first page of the transportation form on the back of the BA-52 initiation form. This is not acceptable for a couple of reasons. Both are mandatory forms in the format promulgated in the Florida Administrative Code. The second reason is that a transport form must be completed even if the Baker Act is initiated by other than a law enforcement officer, such as a circuit court judge or a mental health professional.

Now to your question -- the law specifically requires a receiving facility to accept any person brought by law enforcement for involuntary examination. Any hospital would have to accept a person on voluntary or involuntary status due to federal EMTALA requirements. If there are paperwork discrepancies, these should be corrected in a way and perhaps at a later time that doesn't place the patient in jeopardy or constitute an illegal delay or denial of access to care. This might be as simple as communicating the legal requirements to the law enforcement agencies and the receiving facilities and correcting the forms if necessary.

Q. The local CSU has a policy of not taking people over a certain age (think it was 65). I just want to make sure I am not missing anything like a Transportation Exception Plan? If so, even if a TEP is in place, a public receiving facility cannot refuse anyone on involuntary status brought by law enforcement. Correct? It may have been that this was someone who had been medically cleared and one of the reasons CSU gave for not having a slot was age. Any clarification you can provide on this issue would be helpful.

No designated receiving facility can refuse to "accept" any person brought by law enforcement for involuntary examination regardless of age. Even if a Transportation Exception Plan has been approved by DCF and the BCC authorizing law enforcement to by-pass the "nearest" receiving facility, the nearest facility would still be required to accept and transfer. Your county has a TEP designating a centralized receiving facility, unless a person expresses a choice to go to a different facility. The county also has a contract with a transport company to transport persons under the Baker Act by ambulance in lieu of law enforcement. In any case, a receiving facility doesn't have to accept a transfer from another receiving or hospital unless it has the capability and capacity to manage the person's care. Primary transport and secondary transfer are quite different under the law. Since persons over the age of 65 often have co-existing medical issues as well as are insured by Medicare that won't pay in a non-hospital setting, they are almost always taken to receiving facilities located in general hospitals or freestanding psychiatric hospitals.

Q. I have seen 10 involuntary customers today and we have a holiday coming up!! My supervisor told me we can't hold a person more than 12 hours without

admitting or release. Is this true? What do we do when we can't evaluate within the 12 hours?

This rule was promulgated by DCF many years ago and was intended to prevent persons on voluntary or involuntary status from being backlogged in an admission area for more than 12 hours without being admitted or being examined and released.

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

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

(1)Emergency Screening. All persons who apply for admission pursuant to Section 394.4625, F.S., or for whom involuntary examination is initiated pursuant to Section 394.463, F.S., shall be assessed by the CSU or by the emergency services unit of the public receiving facility. Each receiving facility shall provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and shall have policies and procedures for identifying individuals at high risk. No person can be detained for more than 12 hours without being admitted or released. Everyone for whom involuntary examination is initiated pursuant to Section 394.463, F.S., shall receive a face-to-face examination by a physician or clinical psychologist prior to release. The examination shall include a psychiatric evaluation, including a mental status examination, or a psychological status report.

If admitted, the examination by a physician or psychologist wouldn't have to occur within the 12 hour period – just “without unnecessary delay”, but certainly within the 72-hour period permitted by law. In the past several years, some CSU's have created “recovery rooms” where persons are held for up to 24 hours after arrival at a CSU without being admitted. These are often intoxicated persons who don't appear to need admission. . CSU's may consider this an “admission to the recovery room”, even though a formal admission to the CSU might not take place. These “recovery rooms” have been praised by regional DCF SAMH staff as effective and efficient ways of appropriately managing persons in crisis while reducing admission rates. While this extended period (up to 24 hours) may not be consistent with the rule, it seems to work very well in communities where used and DCF isn't requiring a change because of what may be outdated rules. Hospital-based receiving facilities often retain people for much more than 24 hours in a pre-admit status, but they aren't subject to chapter 65E-12 rules

Q. An Alabama resident with serious criminal charges was brought by law enforcement to our receiving facility for involuntary examination ordered by a judge. Did we have to accept him? The court ordered that he wear an ankle bracelet. Was this legal?

It is assumed that the man from Alabama is under the jurisdiction of Florida courts and that the BA-52 was initiated by a Florida certified law enforcement officer or Florida licensed mental health professional. If not, the initiation may have been unlawful. There may be other factors to be considered governed by criminal laws.

If he was brought by a Florida certified law enforcement officer for involuntary examination under the Baker Act, you have to accept him. The Baker Act has a provision in chapter 394.462(1)(g) regarding persons on felony charges, as follows:

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

The above provision regarding persons facing a felony charge so serious that you are unable to provide adequate security may allow you to not admit, but would still require you to provide the involuntary examination/treatment by your psychiatrist or psychologist as well as file any necessary civil petitions where the person is held – at the jail.

Adults and minors who are facing criminal charges or serving a sentence can still be eligible for civil examination and treatment. It is only if they have been found incompetent to proceed with their charges or found not guilty by reason of insanity that they are considered “forensic” and governed by chapter 916, FS. Many people do go to a civil hearing for involuntary inpatient placement while still under the jurisdiction of a criminal court judge. In fact, chapter 394.463(2), FS (Baker Act) recognizes that persons charged with a crime are eligible under the Baker Act, but alternatives after examination are somewhat different:

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, **unless he or she is charged with a crime,** in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, **unless he or she is charged with a crime,** shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; **or**
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary.... A petition for involuntary inpatient placement shall be filed by the facility administrator.

This simply means that a person with active criminal charges cannot be transferred from involuntary to voluntary status or if released within the 72 hour exam period, must be released back to law enforcement. However, if the person has already been released from jail pre-trial on bail or ROR or is on post-trial probation, these provisions wouldn't apply and such persons would be handled the same as any other person.

You couldn't use any restraints or seclusion unless all provisions of the Baker Act law and rules governing these procedures have been met. Simply wearing an ankle or wrist monitoring device wouldn't meet these requirements. Removal of the device without the prior written approval of the court or a probation officer might be unwise. Removal of the

device might subject the person to additional charges or possibly subject your CSU to criticism as well.

Q. An individual has been warned that he will be arrested for trespassing if he comes back to a facility. The individual was a bit aggressive with another patient and was arrested during one admission. Later he was Baker Acted to the facility and was there for a few days when “someone from administration” came to him and advised him that he was trespassing and he shouldn’t return to that facility. What are folks supposed to do if the facility they have been given a trespass warning from is the nearest BA facility, etc.

A trespass warning wouldn’t relieve a hospital or a CSU from its legal requirements under the Baker Act to “accept” (not necessarily admit) any person on involuntary status and for any hospital to accept and examine any person regardless of legal status under the federal EMTALA law and chapter 395, FS.

The provisions of the Baker Act require a receiving facility to accept any person brought by law enforcement for involuntary examination, as follows:

394.462 Transportation.--

(1) TRANSPORTATION TO A RECEIVING FACILITY.--

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

Once accepted, the receiving facility can then attempt to transfer the person to another public or private receiving facility. These transfers can only be requested by the patient, family, guardian, guardian advocate, or DCF. There is currently no provision in law for a public receiving facility to transfer a person to a private receiving facility over the objections of a patient/representative as there is for a transfer from a private receiving facility to a public one.

394.4685 Transfer of patients among facilities.--

(1) TRANSFER BETWEEN PUBLIC FACILITIES.--

(a) A patient who has been admitted to a public receiving facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public receiving facility. A patient who has been admitted to a public treatment facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public treatment facility. Depending on the medical treatment or mental health treatment needs of the patient and the availability of appropriate facility resources, the patient may be transferred at the discretion of the department. If the department approves the transfer of an involuntary patient, notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. The department shall respond to the request for transfer within 2 working days after receipt of the request by the facility administrator.

(b) When required by the medical treatment or mental health treatment needs of the patient or the efficient utilization of a public receiving or public treatment facility, a patient may be transferred from one receiving facility to another, or one treatment facility to another, at the department's discretion, or, with the express and informed consent of the patient or the patient's guardian or guardian

advocate, to a facility in another state. Notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. If prior notice is not possible, notice of the transfer shall be provided as soon as practicable after the transfer.

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

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.--

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

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

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

Upon acceptance of the person, a psychiatrist or psychologist can perform the legally required Initial Mandatory Involuntary Examination and release any person not meeting the criteria for involuntary inpatient or involuntary outpatient placement, after developing an aftercare plan as prescribed by the Baker Act rules. Such aftercare planning would also be addressed by JCAHO and the federal Conditions of Participation.

Further, if the facility is licensed as a hospital under Chapter 395, it is also governed by the federal EMTALA law which would require it to accept any person brought under voluntary or involuntary status and perform a medical screening examination within the full capability of the facility to provide. A psychiatric or substance abuse emergency is an emergency medical condition under the federal law. Once it documented that it had neither the capability or capacity to meet the person's psychiatric needs, it could transfer the person to another receiving facility that had agreed to accept the transfer. Even chapter 395.1041, FS governing emergency care at licensed hospitals would require a hospital to accept any person requiring emergency psychiatric services.

Q. Can our Baker Act facility (General Hospital) refuse a Baker Act patient because they have a Trespass Warning on a subject? Last night they refused to accept a subject unless we would stay because the last time the subject was there he was rude, unruly and difficult to deal with. There were no criminal charges in this case.

All hospitals that participate in Medicare or Medicaid are required to accept anyone who is presented to the premises of the hospital to conduct a medical screening examination to determine if the person has an emergency medical condition (includes emergency psychiatric conditions or emergency substance abuse conditions, even absent any other medical condition). The federal EMTALA law requires that once the hospital documents the person does have an emergency condition, it is responsible to admit, to discharge, or to transfer the person to another facility that has the capacity and capability of managing the person's condition and that has provided prior approval of the transfer.

Further, the Baker Act states that the nearest receiving facility shall accept any person brought by law enforcement for involuntary examination. [394.462(1)(), FS. Therefore, the hospital cannot refuse to accept a person lawfully brought to its premises. Persons on involuntary status under the Baker Act are generally presumed to be "dangerous to self or others". Behavior such as you describe is quite usual for persons in the middle of a psychiatric crisis and the staff of all receiving facilities should be capable of managing such behavior. The law does have one exception to acceptance where a person is in law enforcement custody due to current felony charges; in which case the public receiving facility is responsible for conducting the examination and providing treatment wherever the person is held.

In this situation, there were no criminal charges and a previous occasion of disruptive behavior wouldn't be sufficient to warrant refusal.

Q. A patient was brought into our ER with an Ex-Parte Order to transport to one hospital, but it was stamped "If deemed violent, transport to ____." Law enforcement officers brought the patient to our facility because the patient was not violent. Of course, we treated the patient but the transporting officer stated that he always transports to the nearest facility regardless of what is written on the Ex-Parte. Could you please clarify?

The model ex parte court order doesn't specify the name of a receiving facility because the Baker Act law requires that persons be taken to the nearest receiving facility, unless a Transportation Exception Plan has been approved by your Board of County Commissioners and the Secretary of DCF. No such Exception plan has been approved and no provision for bypassing receiving facility with violent persons has even proposed.

It is surprising that the court has included this additional provision to the model form. It creates a conflict for the law enforcement officers responsible for executing the order. However, it appears that the officer involved in this case ignores such provisions of orders. Law officers shouldn't be placed in this situation that implies a hospital or other receiving facility wouldn't have the responsibility to accept a person presented for involuntary examination.

It looks as if the officer and your hospital carried out the law appropriately, despite the provisions of the order. All receiving facilities should be prepared to deal with persons who are "dangerous to self or others".

Q. Can our facility refuse to accept a person with a past history of sex crimes?

Receiving facilities couldn't legally avoid serving the person unless the person had current felony charges and the facility could document its inability to provide adequate security. However, a public receiving facility would still be required to provide the exam and treatment wherever the person was held.

On the other hand, other people served on the units deserve protection as well. CSU staff may check the status of each person admitted for past criminal history. While law enforcement officers generally know the history when they pick a person up, this might

not always be communicated to staff. Besides, many people reach a CSU by routes other than law enforcement.

FDLE keeps a website of sex offenders (and predators). Staff could check this website, not to prevent admission, but to take precautions while an individual with this type of history is on the unit

Q. A receiving facility reported that it would not take anyone who came from jail or has any kind of criminal history. Many people served by our ER have spent some time in jail, many for very minor things. Can they do this?

Refusal by receiving facility to accept transfers of anyone who came from jail or who has any kind of criminal history, is totally inappropriate. Chapter 394.462(1) states:

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

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

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

This means that the nearest receiving facility must accept persons with current misdemeanor charges. It can only refuse to accept a person with current felony charges if it is unable to provide adequate security and then must provide the exam and treatment at the jail as an alternative. In the latter case of felony charges, the law specifies the public receiving facility is responsible. A history of criminal offenses, absent current arrest or custody by law enforcement cannot be used as a barrier to any designated facility's responsibility to examine and treat a person under the Baker Act.

Q. A client that was court ordered from the Jail to us for examination has an Axis 1 diagnosis along with anti-social personality disorder (history of assault). He is currently in jail under three felony assault charges, one filed by us when he assaulted a MH tech. His jail psychiatrist petitioned for forced medication, but the Public Defender successfully argued that the client should be sent to us and treated under the Baker Act. We assessed the client, indicated that he had a psychiatric condition, that he had a history of non-compliance with medication, and was too dangerous for our facility. We sent him back to the jail because we

couldn't provide adequate security. We agreed with the request for forced medication and the possible need for Forensic State Hospitalization. The Public Defender is arguing that he wants us to treat him at the jail and file a petition for involuntary placement and request for guardian advocate. What would you recommend?

The Baker Act transportation provisions govern this issue, as follows:

394.462(1) Transportation

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

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

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

A receiving facility is responsible for conducting the involuntary examination regardless of whether the person is held at the jail or transferred to the facility. You are authorized to refuse the transfer only if the person has felony charges and can document that inability to provide adequate security. This probably means some level of dangerousness that dramatically exceeds the danger presented by persons held under involuntary conditions (danger to self and others) who have no criminal charges.

You state that the inmate was sent to you for evaluation on a court order. You cannot ignore a court order without staff risking a criminal charge for contempt. It may be necessary for the your attorney to contact the judge to avoid such charges should a court order involuntary inpatient placement at your facility. Involving your attorney would be appropriate anyway in this situation. Only a receiving facility administrator has standing to file a petition for involuntary inpatient placement. If you file such a petition and a court finds that the criteria are met, an order for involuntary inpatient placement can result in the person being placed in several different alternatives:

394.467(6)(b) If the court concludes that the patient meets the criteria for involuntary inpatient placement, it shall order that the patient be transferred to a treatment facility or, if the patient is at a treatment facility, that the patient be retained there or be treated at any other appropriate receiving or treatment facility, or that the patient receive services from a receiving or treatment facility, on an involuntary basis, for a period of up to 6 months. The order shall specify the nature and extent of the patient's mental illness. The facility shall discharge a

patient any time the patient no longer meets the criteria for involuntary inpatient placement, unless the patient has transferred to voluntary status.

This means that even if the inmate was ordered to involuntary inpatient placement, he could be retained at the jail with services from your facility. You suggest that the inmate should be transferred to state forensic hospitalization. However, you didn't indicate whether the legal proceedings for finding the man "incompetent to proceed" or "not guilty by reason of insanity" under chapter 916 are being sought. This is the only basis for state forensic hospitalization. Otherwise, the inmate could be found guilty of the offenses and receive treatment at DC.

With regard to treatment, it is difficult for a jail to force treatment on an inmate, particularly one who has been determined by a psychiatrist to be competent to refuse consent. A person has a right to refuse treatment in jail just as in a receiving facility unless found to be unable to make well-reasoned, willful, and knowing decisions about his/her health/mental health care. Simple refusal is not an indication of incompetency to consent. Until stabilized on medications, the inmate's condition may further deteriorate, possibly subjecting him and others to greater harm. Once stabilized, he may be manageable on your unit and be considered for civil hospitalization.

Q. We've recently been getting a lot of transfers from jail to our public receiving facility. On the one hand that's good because we're getting people out of jail and appropriately treated, but the trickle is becoming a flood and creating capacity problems. The people being transferred are all charged with misdemeanors and we don't doubt that they actually meet Baker Act criteria. Is there anything in the Baker Act or rules pertaining to jail services?

The Baker Act doesn't specifically address involuntary examinations initiated for persons who are inmates of the jail. The only references in the civil Baker Act to such issues are when the person is taken into custody:

394.462 Transportation.--

(1) Transportation to a Receiving Facility.--

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

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

(i) The costs of transportation, evaluation, hospitalization, and treatment incurred under this subsection by persons who have been arrested for violations of any

state law or county or municipal ordinance may be recovered as provided in s. 901.35.

Persons who are taken to jail for criminal offenses and are later determined by a judge, LEO, or mental health professional to meet the criteria under the civil Baker Act can still be eligible for involuntary examination at a receiving facility. The process would be the same as any other involuntary examination, other than the person would have to be returned to law enforcement at the time of discharge/release because of the pending charges and a person with criminal charges is ineligible to transfer to voluntary status.

Q. I have a question about persons charged with a felony who meet Baker Act criteria, – the section of the law that states a receiving facility is required to provide mental health exam and treatment in the jail (s. 394.462.(1)(g)) m). How is this working in other parts of the state? Who decides if there is proper security or not? Right now the local jail doesn't not want to send anyone to us because we are not a jail. While there are cases we certainly can't handle, I want the ability to take them here rather than sending to the jail where there isn't a physician and the drug formularies are very different. What can you tell me on how this works and when do I have to send staff to the jail?

While the law requires the receiving facility to provide the initial mandatory involuntary examination (by a physician or psychologist) wherever the person charged with a felony is held (jail or receiving facility), I'm not aware of anywhere in the state where this is actually provided at the jail by the receiving facility. Generally, if a person is charged with a serious violent felony, law enforcement doesn't usually initiate an involuntary examination on the person – just the criminal charges followed by booking at the jail. At that point, if the medical personnel at the jail believe the person meets criteria for Baker Act involuntary examination, the examination can then be initiated.

It is always the decision of the receiving facility as to whether it has the capability of providing adequate security for the inmate.

“A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide mental health examination and treatment to the person where he or she is held. “

If you have the ability to provide this security, the jail has no standing to demand that you provide the examination and/or treatment on-site at the jail. Should the jail and the receiving facility believe that the inmate should be held at the receiving facility, the following provision of Florida Administrative Code also applies:

65E-5.150 Person's Right to Individual Dignity.

(2) ...Prison or jail attire shall not be permitted for persons admitted or retained in a receiving facility except while accompanied by a uniformed law enforcement officer, for purposes of security.

Q. Recently we have had two cases where the jail got court orders to have clients charged with felonies transferred from jail to the CSU to return to the jail following

treatment. It has been our procedure to only accept clients from the jail who are released on their own recognizance (ROR). Generally these clients are at the end of their time in jail and meet the criteria for involuntary evaluation. They are placed under the 52 in jail and transported to the receiving facility. This we believe is an appropriate use of the receiving facility. We have become concerned about the transport of inmates who have been in jail for some time then 52 ed to return to the jail. Both jails have contracted in jail medical and psychiatric services. First, while we are locked the facilities are not secure and can't guarantee that the inmate does not elope. Second, if the nearest receiving facility doesn't have capacity this inmate could potentially be sent to a different county, which may be against the desire and explicit order of the judge. We have made the provision in the past that in exceptional cases jail inmates may be transferred to a receiving facility with the agreement of the facility administrator and treating psychiatrist, in cases that are psychiatrically very fragile. The jail then sends guards if requested and pays for the inpatient care. (This has occurred 2-3 times in the past 5 years). The Judges in this circuit have been in agreement with the practice of only ROR clients being released from jail to the receiving facility. We are in the process of re-circulating this memo to the jails and public defenders office. I have re-read the transportation statute as it relates to individuals with previous criminal charges. It appears to assume that misdemeanor and felony clients are coming from the community not from the jails, however is somewhat vague.

If you have a court order to accept the inmates, you need to do so or potentially risk contempt. You should have your organization's attorney discuss the issue with the judge. The judge shouldn't be sending anyone to you as a Baker Act receiving facility except as provided under terms of the Baker Act:

394.462 (1) Transportation to a Receiving Facility.--

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

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

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

While the transportation section above does seem to imply that persons with misdemeanor charges are first brought to the receiving facility prior to booking, the

section governing felony charges suggests that the person be brought to jail first for booking, followed by transfer to the receiving facility for examination and treatment.

Capacity isn't an issue under the Baker Act when delivered by law enforcement for involuntary examination. You've handled capability by having detention deputies accompany the inmate to your facility. Felony charges alone are not enough to constitute a barrier to admission – it is the felony charge tied to your inability to provide adequate security. As a locked facility, you are presumed to be a “secure” facility. If an involuntary examination is initiated, the inmate must be sent to the nearest public receiving facility via law enforcement and you would be unable to decline acceptance of the person due to lack of capacity. Rather than transfer a person specifically court ordered to your facility because of capacity issues, you might want to consider the transfer of another patient if this is needed.

There isn't any reason why a person who is currently an inmate of the jail can't undergo a civil Baker Act examination at a receiving facility and return to the jail after the exam documents that he/she doesn't meet the criteria for involuntary inpatient placement. While subsection (i) above deals with recovery of costs, most counties consider the 25% matching provided for Baker Act funding to be sufficient to purchase occasional inpatient care for inmates.

Q. Have you ever heard of Jails being told that they cannot send inmates to Baker Act Receiving Facilities? On a few occasions, when the local CSU hears the name of the inmate we want to send over, they tell the medical staff here that they will not accept the patient. Is there anything in the law that would allow them to reject Baker Act clients being referred by any Law Enforcement Officer?

This is incorrect. The nearest receiving facility cannot refuse to accept a person brought by law enforcement for involuntary examination. If the facility doesn't have the space or capability, it must accept the person, even a jail inmate, and arrange a transfer to another willing receiving facility.

The only exception is in the following transportation provisions of the law and the CSU may be confused over its responsibilities.

394.462 Transportation.--

(1) TRANSPORTATION TO A RECEIVING FACILITY.--

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

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

adequate security, but shall provide mental health examination and treatment to the person where he or she is held.

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

The above sections have to do with where the officer initially takes the person who has any type of charges. Once a person who has been arrested for a felony offense is booked at the jail, the jail staff is obliged by law to refer the person to the nearest public receiving facility that is then required to conduct the examination by a physician or clinical psychologist. If the public receiving facility believes it cannot provide adequate security for the inmate charged with this felony offense, facility staff can then refuse the admission, but must then provide the examination and treatment to the inmate at the jail. The issue isn't whether or not a person is an inmate of the jail – it is a combination of a felony offense and documentation by the facility of its inability to provide security.

Even if a public receiving facility doesn't have the space or capability of serving an otherwise eligible person, it remains responsible for coordinating the care needed, as follows:

65E-5.351, FAC Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

Q. We had a client brought to the CSU by police after they received information that the client was under a Baker Act from another county hospital and had eloped. Police brought the client to the CSU via Corrections van as we are the nearest receiving facility. Neither police nor I felt the client met Baker Act criteria at the time of arrival. We contacted the hospital that initiated the Baker Act and they refused to come get him. LEO was willing to transport him there, but the client was not able to ambulate and was wheelchair bound. Corrections did police a favor in transporting him. What responsibility should the hospital have in this situation?

The 2011 Baker Act User Reference Guide has the following suggestions on how to handle elopements or escapes from receiving facilities:

1. Voluntary not meeting the criteria for involuntary placement, law enforcement will not be notified by the facility.
2. Voluntary but meets the criteria for involuntary placement, a CF-MH 3052b is initiated and law enforcement requested to take person into custody and deliver to the nearest receiving facility. Transfer of person, if appropriate, will then be arranged from facility to facility.
3. Involuntary examination status, within 72 hours of arrival at facility, meets criteria for involuntary placement, but prior to the Petition for Involuntary Placement being filed with the court. Law enforcement given copy of original 3052 (a or b) and requested to take person into custody and deliver to nearest receiving facility. Transfer of the person, if appropriate, will then be arranged from facility to facility.

4. Petition for Involuntary Placement filed with court, law enforcement provided copy of petition (3032) and requested to return person to the facility from which the petition was filed.
5. Under court's Order for Involuntary Placement (3008) and leaves facility without authorization, administrator authorizes search and the return of person. Administrator of facility may request law enforcement to search for and return person and provide copy of order (3008).
6. Persons escaping from hospital ER's should be returned to the hospital for appropriate transfer under federal EMTALA law.

Only #5 above is actually in the Baker Act, while the others are suggested. Your question may apply to #3 above. If so, law enforcement did the correct thing by bringing the man to the nearest receiving facility and leaving transfer to the two facilities. Assuming the person appeared to meet criteria, transfer is usually arranged by the facility having custody of the individual. The Baker Act provision governing transfer from public to private facilities is as follows:

394.4685 Transfer of patients among facilities.--

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

This may not apply in that the person may not have actually requested return to the private receiving facility and may not have been admitted to your CSU. However, in this case, the responsibility for the cost of transfer is that of the patient and only upon acceptance by the private facility.

The biggest concern should be about the circumstances of the person's elopement from the first receiving facility.

1. What safety risks are in place that permit this to happen? Is this a singular occasion or do law enforcement officers indicate that it may be a repeated event from that facility?
2. If the person eloped from the other hospital's ER, this might have represented a violation of the federal EMTALA law if the hospital had failed to stabilize the person with an emergency medical condition, even if only a psychiatric emergency absent any other medical condition.
3. You indicate that the other receiving facility was unwilling to come pick the person up at CSU but it is unclear as to whether the facility was refusing to accept return of the person or only the transport. If the hospital refused to accept the person's return I would be interested in whether the person might have been indigent. If so, this might raise a number of other questions.
4. Finally, since the man is confined to a wheelchair, an ADA question arises since his need for transport and treatment must be accommodated regardless of his disability or risk an ADA violation.

However, since your psychiatrist has examined the person and found him not to meet the criteria for involuntary placement, a release with discharge plans would be in order. Unfortunately, this has fallen on CSU to accomplish.

Q. We are being told that unless law enforcement transports a resident to the CSU that the CSU will refuse to accept the person even though they have been Baker Acted. Often this poses a barrier in that we have a person who needs to go to the CSU because they do not have benefits fully restored and unless law enforcement transports, the admission will be refused. We would like to make sure we get the information straight. Can we resolve this issue by doing a Transportation Exception Plan?

Actually, only law enforcement is legally authorized to transport a person for involuntary examination under the Baker Act statute. This has been confirmed through appellate cases. The law states:

394.463 Involuntary examination.--

(2) Involuntary Examination.--

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

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, **a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination...**

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

3. A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, **a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination...**

The following appellate case affirmed that only a law enforcement officer may transport a "Baker Act" patient to a receiving facility.

Administrator, Retreat Hospital v. Honorable W. Clayton Johnson of the Seventeenth Judicial Circuit In and For Broward County, FL, Alan Schreiber, Broward County Public Defender, and Fredrick A. Goldstein, Special Assistant Public Defender, Respondents, 660 So. 2d 333 (Fla. 4th DCA 1995). In this case, four separate individuals were transported by private individuals to a receiving facility for involuntary placement under the Baker Act. Circuit Court Judge Johnson found that the four individuals being transported by private individuals to a receiving facility did not comport with the requirements of section, 394.463(2), Fla. Stat. which requires that only law enforcement officer may

transport a Baker Act patient to a receiving facility. Judge Johnson ordered the Broward County Sheriff to devise a transportation plan and set a hearing ninety (90) days after the order to discuss the Sheriff's transportation plan. Judge Johnson also entered an administrative order regarding Baker Act transports in Broward County, FL and regarding the necessity of having pre-hospitalization orders. The Fourth District Court of Appeals held that Circuit Court Judge Johnson's administrative order went beyond the petitions filed in the case and beyond the Judge's jurisdiction by requiring a trial court order before a patient is hospitalized. **The Fourth District Court of Appeals affirmed that only a law enforcement officer may transport a Baker Act patient to a receiving facility.**

The Baker Act transportation provisions were amended in 1996 to include the following bolded paragraph:

394.462 Transportation.--

(1) Transportation To A Receiving Facility.—

(d) When a law enforcement officer takes custody of a person pursuant to this part, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.

(h) If the appropriate law enforcement officer believes that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

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

This means that if the person is on voluntary status or brought to other than the nearest receiving facility, or transported by other than law enforcement, a CSU would not be legally required to accept. However, if the person were taken to a licensed hospital, the hospital would have to accept under the federal EMTALA law for the purpose of performing a medical screening. A psychiatric emergency, even absent any other medical conditions, is considered by CMS to be an emergency medical condition.

The Florida Administrative Code also contains legally required implementing language, as follows:

65E-5.260, FAC Transportation.

(1) Each law enforcement officer who takes a person into custody upon the entry of recommended form CF-MH 3001, Feb. 05, "Ex Parte Order for Involuntary Examination," which is incorporated by reference and may be obtained pursuant to Rule 65E- 5.120, F.A.C., of this rule chapter, or other form provided by the court, or the execution of mandatory form CF-MH 3052b, Feb. 05, "Certificate of Professional Initiating Involuntary Examination," which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter or completion of mandatory form CF-MH 3052a, Feb. 05, "Report of a Law Enforcement Officer Initiating Involuntary Examination," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter shall ensure that such forms accompany the person to the receiving facility for inclusion in the person's clinical record.

(2) The designated law enforcement agency shall transport the person to the nearest receiving facility as required by statute, documenting this transport on mandatory form CF-MH 3100, Feb. 05, "Transportation to Receiving Facility," which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter. The designated law enforcement agency may decline to transport the person to a receiving facility only if the provisions of Section 394.462(1), F.S., apply. When the designated law enforcement agency and the medical transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others. Part II of mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E-5.260(2), F.A.C., reflecting the agreement between law enforcement and the transport service shall accompany the person to the receiving facility. The completed form shall be retained in the person's clinical record.

The facility can't ignore the statutorily required role of law enforcement in implementing an involuntary examination. It must either have law enforcement officer defer because of safety issues or presence of an emergency medical condition. The only other two statutorily permitted alternatives are the following:

394.462 Transportation.--

(1) Transportation to a Receiving Facility.--

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

1. **The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities pursuant to this section at the sole cost of the county;** and

2. The law enforcement agency and the emergency medical transport service or private transport company agree that the **continued presence of law enforcement personnel is not necessary for the safety** of the person or others.

394.462 Transportation.--

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

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

(b) The exception may be granted only for:

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

The mandatory 3100 form titled "Transportation to a Receiving Facility" can be downloaded from the DCF website. Neither a Transportation Exception Plan approved by the Board of County Commissioners and the DCF Secretary or a contract by the county to provide such Baker Act transport relieves law enforcement from involvement in the process. However, if the law / rules are followed and the law enforcement officer and medical transport company (authorized by county contract or by a Transportation Exception Plan) complete the second page of the 3100 form, the receiving facility would be required to accept the person even if the person is consigned by law enforcement to the transport company.

Q. What if a person is brought to the CSU by another source for examination (self, family)? I know the facility would initiate the involuntary examination if warranted at that point, but they can't just refuse to assess them?

There isn't anything in the statute that would require acceptance of a person on voluntary status by a CSU, regardless of how they are presented to the facility. It's why a law enforcement officer who brings someone in on a "voluntary Baker Act" and the person is refused will generally go out to the cruiser to quickly complete the form.

This is why there is the "Initial Mandatory **Involuntary** Examination" in the Florida Administrative Code.. There just isn't a corresponding requirement for voluntary. Remember that some of the "CSU's" around the state are actually licensed hospitals. They would have to accept due to EMTALA and conduct the "medical screening examination" within their capability and capacity. Only then could they release or transfer.

Chapter 65E-12.107, FAC applies to CSU's, as follows:

65E-12.107 Minimum Standards for Crisis Stabilization Units (CSUs).
 (1) Emergency Screening. **All persons who apply for admission pursuant to section 394.4625, F.S., or for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall be assessed by the CSU or by the emergency services unit of the public receiving facility.** Each receiving facility shall provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and shall have policies and procedures for identifying individuals at high risk. No person can be detained for more than 12 hours without being admitted or released. Everyone for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall receive a face-to-face examination by a physician or

clinical psychologist prior to release. The examination shall include a psychiatric evaluation, including a mental status examination, or a psychological status report.

Some assessment should be done under the Baker Act, even for voluntary. CSU's may face a great deal of liability if they refuse someone at the door who may subsequently cause harm to self or others.

Q. Do you have any knowledge of any Baker Act receiving facility ever getting an order of no trespass against a person requesting services? We've just run into two situations, one is an adult with mental illness but doctors think he is playing the system so that he won't be homeless or have to go to an ALF. The other is a child whose parent was told by the local hospital based public receiving facility that the child needs long-term institutional care and provided the parent with a contact name and phone number. Additionally, the letter said that they were not to bring the child back to that hospital if he was committed under the Baker Act. Can this be correct?

The provisions of the Baker Act require a receiving facility to accept any person brought by law enforcement for involuntary examination, as follows:

394.462 Transportation.--

(1) TRANSPORTATION TO A RECEIVING FACILITY.--

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

Once accepted, the receiving facility can then attempt to transfer the person to another public receiving facility or to a private receiving facility. These transfers can only be requested by the patient, family, guardian, guardian advocate, or DCF. There is currently no provision in law for a public receiving facility to transfer a person to a private receiving facility over the objections of a patient/representative as there is for a transfer from a private receiving facility to a public one.

394.4685 Transfer of patients among facilities.--

(1) TRANSFER BETWEEN PUBLIC FACILITIES.--

(a) A patient **who has been admitted** to a public receiving facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public receiving facility. A patient who has been admitted to a public treatment facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public treatment facility. Depending on the medical treatment or mental health treatment needs of the patient and the availability of appropriate facility resources, the patient may be transferred at the discretion of the department. If the department approves the transfer of an involuntary patient, notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. The department shall respond to the request for transfer within 2 working days after receipt of the request by the facility administrator.

(b) When required by the medical treatment or mental health treatment needs of the patient or the efficient utilization of a public receiving or public treatment facility, a patient may be transferred from one receiving facility to another, or one

treatment facility to another, at the department's discretion, or, with the express and informed consent of the patient or the patient's guardian or guardian advocate, to a facility in another state. Notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. If prior notice is not possible, notice of the transfer shall be provided as soon as practicable after the transfer.

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

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.--

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

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

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

Upon acceptance of the person, a psychiatrist or psychologist can perform the legally required Initial Mandatory Involuntary Examination and release any person not meeting the criteria for involuntary inpatient or involuntary outpatient placement, after developing an aftercare plan as prescribed by the Baker Act rules. Such aftercare planning would also be addressed by JCAHO and the federal Conditions of Participation.

Further, public receiving facility is licensed as a hospital under Chapter 395. Therefore, it is also governed by the federal EMTALA law which would require it to accept any person brought under voluntary or involuntary status and perform a medical screening examination within the full capability of the facility to provide. A psychiatric or substance abuse emergency is an emergency medical condition under the federal law. Once it documented that it had neither the capability or capacity to meet the person's psychiatric needs, it could transfer the person to another receiving facility that had agreed to accept the transfer.

Even chapter 395.1041, FS governing emergency care at licensed hospitals would require the receiving facility to accept any person requiring emergency psychiatric services.

A copy of the letter received by the parent instructing that the child not be brought back to the receiving facility in case of a future Baker Act involuntary examination be provided to DCF for investigation. This is clearly inappropriate. The receiving facility remains obligated under the Florida Administrative Code

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

Q. We have a patient who comes to our facility and many others in the community. He is very large and has hurt many staff and other patients. He says all of the right things to get himself Baker Acted, normally by police. Once he gets to a receiving facility he goes on his assault spree until he is made voluntary and then he is as nice as can be. The problem that we are having is that when he is Baker Acted police won't intervene (arrest) or allow staff who he has assaulted and threaten to harm after discharge to initiate a stay away order as they believe it is inherent as the risks of their job. Other facilities have been able to get stay away orders because his behaviors came prior to him being Baker Acted. The patient knows this game and after he attacks, he quotes this fact. What is your advice if any? I am concerned about the safety of my staff and other patients as there is no method to his attack or provocation. As a matter of fact his last attack came while the staff were managing another patient who had become physically assaultive.

A restraining order may not be enforceable by hospitals subject to the federal EMTALA law in which they are legally obligated to accept any person brought to their premises. They must at least conduct a medical screening examination to determine if the person has an emergency medical condition (psychiatric and substance abuse emergencies are considered by CMS as EMC's even absent any other medical issues). If the person has such an emergency, he/she must be admitted or transferred if the facility doesn't have the capability or capacity to manage their care.

While all receiving facilities must have the capability of managing persons who are "dangerous to self or others" as a condition of designation and some patients have explosive outbursts that are an uncontrollable part of their illness, this doesn't justify anti-social behavior that is excluded from the definition of mental illness.

Since you have a past history with this individual, you may want to ensure that he is under close observation or even one to one supervision while he is on your unit. This will improve the safety of everyone and reduce your liability should a complaint be made if he subsequently hurts a staff member or another patient.

You indicate that the man's behavior is good once he is converted to voluntary status. If he is willing to be at your facility and is competent to make well-reasoned, willful and knowing decisions about his care, he is eligible for voluntary status. However, this entails a physician conducting the mandatory initial involuntary examination and certifying his competence to consent prior to conversion from involuntary to voluntary status. This could potentially be done by your hospital's ED physician if a psychiatrist isn't available.

When such assaultive behavior occurs by this man, you have the psychiatrist immediately examine him to determine if he was able to form the intent to harm vs. it being a symptom of his illness. Law enforcement may consider the person's ability to form intent to commit a crime as part of "probable cause" – the state attorney must establish this ability before moving to prosecute.

Q. When a Transportation Exception Plan is in place and a private transport service is in use, does a receiving facility still has the responsibility to accept the

patient? I only see it explicitly written that they must accept when transported by law enforcement. Do you know of any receiving facilities ever balking at accepting Baker Act individuals transported by a private service? It seems to me they still must accept the person.

The involuntary examination provisions of the law place an absolute duty on law enforcement, except as provided below, to provide transport to the nearest receiving facility.

394.463 (2) INVOLUNTARY EXAMINATION.--

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

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral... A law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination...

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

3. A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based... a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody...

The Baker Act does permit the County to fund an alternate transport as follows:

394.462(1) TRANSPORTATION TO A RECEIVING FACILITY.--

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

1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities pursuant to this section at the sole cost of the county; and

2. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.

(d) When a law enforcement officer takes custody of a person pursuant to this part, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.

(h) If the appropriate law enforcement officer believes that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

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

While it might take attorneys to argue this out, the duty of law enforcement, when legally consigned to medical transporters, would result in a receiving facility being required to accept the person as though directly presented by a law enforcement officer.

Q. Would a facility violate any regulatory requirements if patients are admitted by another physician who is not a psychiatrist to a Psychiatric unit if the unit is separate from the hospital but is located within the hospital? Would the facility violate any regulatory requirements if patients are admitted and placed in "observation status" in a psychiatric unit by a physician who has hospital admission privileges, but is not a psychiatrist, if the patient is seen by a psychiatrist on the next day?

All parts of a facility located on the premises of the address specified on the designation letter are considered a part of the receiving facility. Specific to your question, there is no prohibition in the Baker Act law or rules against a non-psychiatric physician from being able to admit a patient to a hospital. This would be governed by the hospital's privileging policies and procedures.

The Baker Act doesn't reference "observation status" for hospitals. Crisis stabilization units (non-hospitals) are required to either admit or release a person within 12 hours of arrival at the facility, but this doesn't apply to hospitals. I'm not able to speak to whether chapter 395 FS governing hospital licensure, JCAHO, or federal CMS conditions of participation have any standards regarding observation status.

Q. What is the admit rate (state average) for folks under BA 52s? What do you make of a public CSU that admits near 100% of BA 52s? Can you recommend a program site that does good job with respect to overturning \ diverting BA 52 folks?

There isn't any central source that collects admit rate to various receiving facilities. The Baker Act Reporting Center has information about the number of persons accepted for involuntary examinations by county/facility. However, this has no relations to those admitted. Two public receiving facilities in the Tampa Bay area have between 50% and 60% admitted. Both facilities have "recovery rooms" in which persons are accepted, assessed, and released after exam by a psychiatrist or psychologist if found not to meet the criteria for involuntary placement. Usually, these folks are substance abuse impaired without a major acute mental illness.

It would be highly unusual that any receiving facility would actually admit 100% of persons brought to the facility. However, given that most public facilities don't have a psychiatrist or psychologist on premises 24/7 to conduct the Initial Mandatory Involuntary Examination that is required before a person can be released, admission of all

involuntarily referred persons might be needed during hours when the psychiatrist / psychologist aren't present..

65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

The involuntary examination is also known as the initial mandatory involuntary examination.

(1) Whenever an involuntary examination is initiated by a circuit court, a law enforcement officer, or a mental health professional as provided in Section 394.463(2), F.S., an **examination by a physician or clinical psychologist must be conducted** and documented in the person's clinical record. The examination, conducted at a facility licensed under Chapter 394 or 395, F.S., must contain:

(a) A thorough review of any observations of the person's recent behavior;

(b) A review of mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E- 5.260(2), F.A.C., and recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.

(c) A brief psychiatric history; and

(d) A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

(2) If the physician or clinical psychologist conducting the initial mandatory involuntary examination determines that the person does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the person can be offered voluntary placement, if the person meets criteria for voluntary admission, or released directly from the hospital providing emergency medical services. Such determination must be documented in the person's clinical record.

(3) If not released, recommended form CF-MH 3040, "Application for Voluntary Admission," as referenced in paragraph 65E- 5.1302(1)(b), F.A.C., or recommended form CF-MH 3097, "Application for Voluntary Admission – Minors," as referenced in subsection 65E-5.270(1), F.A.C., may be used if the person wishes to apply for voluntary admission.

(4) If not released and the person wishes to transfer from involuntary to voluntary status, recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E-5.170(1)(c), F.A.C., documenting the person is competent to provide express and informed consent, may be used for this purpose.

(5) All results and documentation of all elements of the initial mandatory involuntary examination shall be retained in the person's clinical record.

(6) If the person is not released or does not become voluntary as a result of giving express and informed consent to admission and treatment in the first part of the involuntary examination, the person shall be examined by a psychiatrist to determine if the criteria for involuntary inpatient or involuntary outpatient placement are met.

However, the examination must be conducted “without unnecessary delay” and the person released if not meeting involuntary placement criteria or converted to voluntary status.

Q. One of my deputies was told by the local CSU that it doesn't accept Alzheimer patients and officers can't Baker Act an Alzheimer's patient. The deputy then took the patient to the county hospital. The deputy told the social worker that the man had beat his wife earlier in the day and then stood out in the street directing traffic. There was no medical issue with this man. Was the CSU correct?

Chapter 394.462(1)(j) states “The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination.” This means that if the facility is the nearest, the person is on involuntary status, and transport is by law enforcement, there is no exception to the receiving facility being required to “accept” the person from the officer. If the facility can't manage the person's medical condition or if the person has public or private insurance that will pay at another facility or for any other reason, it is up to the receiving facility to arrange the person's transfer to a more appropriate facility. It may be true that the facility won't “admit” a person with Alzheimer's or other medical conditions, but it must “accept” the person and arrange for medical transport rather than having the officer put such a person back into the cruiser.

Chapter 394.455(18), F.S. defines the term “mental illness”. This definition excludes developmental disabilities, substance abuse impairment, and antisocial behavior. It has no other exceptions for Alzheimer's or for other conditions. In fact, it states “regardless of etiology” unless it is one of the named exclusions. If a person has Alzheimer's Disease and otherwise meets the criteria for involuntary examination, the person can indeed be “Baker Acted.”

Q. The doctors in our hospital think it is okay to BA 32 patients directly without benefit of a BA 52 first. The recent circumstance happened when a patient was on a medical unit for a time and then needed to come to the psychiatric unit. I explained to the doctor that the patient had to have a BA status first-- ie. voluntary or BA 52. If it is possible to directly BA 32 patients?

Actually, the doctor may be correct on this issue. People arrive at receiving facilities on a voluntary basis, but have to be transferred to involuntary status

394.4625, FS Voluntary admissions.—

(5) TRANSFER TO INVOLUNTARY STATUS.--When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist, or psychiatrist as quickly as possible, but not later than 12 hours after the request is made. **If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made.** If the petition is not filed within 2 court working days, the patient shall be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the written order of a physician, if it is

determined that such treatment is necessary for the safety of the patient or others.

The Baker Act law only references an ex parte order, a report of a law enforcement officer, or a certificate of a professional to take the person into custody for delivery to the nearest designated receiving facility. Once at a receiving facility, there is no particular purpose for such documentation, although many receiving facilities have a practice of creating such documentation. No harm is done by a professional doing a Certificate as an alternate way of documenting that a person is now being held under the involuntary provisions of the law as long as the petition is filed within the two working day time limit as opposed to the 72-hour time limit. Most facilities would use the BA-52 method, even if not required, instead of just documenting this in the chart.

The bigger issue is when a person comes to a receiving facility and hasn't yet signed an application for voluntary admission. This may be because of refusal or because the staff identifies the person's condition makes him/her clearly incompetent to consent. In this case, the statute and rules are silent as to the appropriate procedure. CSU's used to call law enforcement to come to the facility to initiate an involuntary exam if no mental health professional was available to do so. The alternative was to have an on-call professional come to the unit to evaluate the person and initiate involuntary examination. A receiving facility, by virtue of its designation is authorized to accept and hold a person on involuntary status, assuming all due process rights of the person are observed.

394.455, FS Definitions

(26) "Receiving facility" means any public or private facility designated by the department to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail.

The Florida Administrative Code has the following provisions governing this issue:

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

(1) Establishment of Consent.

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

1. If the person is assessed to be competent to consent to treatment and meets the criteria for involuntary inpatient placement, the facility administrator shall file with the court a petition for involuntary placement. Recommended form CF-MH 3032, Feb. 05, "Petition for Involuntary Inpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E- 5.120, F.A.C., of this rule chapter may be used for this purpose.

2. If the person is assessed to be incompetent to consent to treatment, and meets the criteria for involuntary inpatient or involuntary outpatient placement, the facility administrator shall expeditiously file with the court both a petition for the adjudication of incompetence to consent to treatment and appointment of a guardian advocate, and a petition for involuntary inpatient or involuntary outpatient placement. Upon determination that a person is incompetent to consent to treatment the facility shall expeditiously pursue the appointment of a

duly authorized substitute decision-maker that can make legally required decisions concerning treatment options or refusal of treatments for the person. Recommended forms CF-MH 3106, Feb. 05, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," which is incorporated by reference may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or CF-MH 3130, "Petition for Involuntary Outpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

65E-5.270, FAC Voluntary Admission.

(6) When a person on voluntary status refuses treatment or requests discharge and the facility administrator makes the determination that the person will not be discharged within 24 hours from a designated receiving or treatment facility, a petition for involuntary inpatient placement or involuntary outpatient placement shall be filed with the court by the facility administrator. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E- 5.170(1)(d)1., F.A.C., or recommended form CF-MH 3130, "Petition for Involuntary Outpatient Placement", as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. The first expert opinion by a psychiatrist shall be obtained on the petition form within 24 hours of the request for discharge or refusal of treatment to justify the continued detention of the person and the petition shall be filed with the court within 2 court working days after the request for discharge or refusal to consent to treatment was made.

As you can see from the above provisions, the person would be transferred from voluntary status directly to involuntary via a petition for involuntary placement. No involuntary examination is initiated in such circumstances. In any case, you should always follow advice of your facility's attorney

Examination

Q. I was told that the Baker Act starts on admission when the Baker Act is written not after medical clearance ; we usually start the Baker Act after the medical clearance is done but I was told that was incorrect. In the event of a non-psychiatric medical emergency, the 72-hour time frame starts at the time of medical clearance. In the absence of a medical emergency, the 72 hours starts at the time of arrival at the receiving facility - not the time of admission, which may occur later than arrival and may never even occur at all. If a medical emergency arises after arrival at the facility, the 72-hour clock is stopped from the time the medical emergency is documented by a physician until medical clearance.

While the Baker Act states the 72-hour involuntary exam period begins upon the person's arrival at the hospital where taken for exam or treatment of an emergency medical treatment, in reality EMTALA generally presumes everyone who walks through an ED door has such an emergency until examined and found to be medically clear. However, if there is a delay in the medical examination or is held in the ED for admission or transfer after the medical record reflects that the person's emergency is over, that time should be counted against the 72-hours permitted. Admission to a facility is

irrelevant to the timing -- it is 72 hours plus the documented EMC from the first stop until release, conversion to voluntary or filing of petition.

Q. We used to place patients under a 24 hour hold, after they were evaluated by a paraprofessional (if the evaluator felt the patient met criteria) via psychiatrist telephone order. Can this still be done? At times overnight the hospital units (outside ED) will call Behavioral Health to evaluate a patient due to a statement they made, the ED physicians will not intervene. If the evaluator calls the psychiatrist and states they feel the patient meet psychiatric inpatient criteria, can the psychiatrist give the telephone order to hold the patient for 24 hours until they come in and evaluate?

This circumstance isn't specifically stated in the law/rules. The designated receiving facility incorporates the entire premises of the hospital. Once an individual is at a receiving facility, that facility by virtue of its designation, has the right to hold the person against his will/without consent for up to 72 hours for examination, assuming that all applicable due process rights are preserved .

The face-to-face examination by a physician or psychologist required by the law is as follows:

394.463(2) Involuntary examination.

(f) A patient shall be examined by a physician or clinical psychologist at a receiving facility **without unnecessary delay** and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. **The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician** with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. **However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.**

Once at a receiving facility the Initial Mandatory Involuntary Examination required under 65E-5.2801, FAC has to be performed "without unnecessary delay" and must contain:

- (a) A thorough review of any observations of the person's recent behavior;
- (b) A review of mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E-5.260(2), F.A.C., and recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.
- (c) A brief psychiatric history; and
- (d) A **face-to-face examination** of the person in a timely manner to determine if the person meets criteria for release.

While the law/rule doesn't define how long "without unnecessary delay" really is, it should be within 24 hours as that is the maximum period a person on voluntary status can be held before a physician or psychologist sees him/her or is released.

Q. I have a question about Minimum Standards for Initial Mandatory Involuntary Examination and the requirement: *conduct face-to-face examination in a timely manner to determine if person meets criteria for release. Also, do we have 72 hours from the entrance to our facility (barring medical emergency) to conduct the involuntary examination and file the petition if needed? I think we do see our customers in a timely manner. Some we see after all the necessary information is collected on the day they arrived and some, who arrive late in the afternoon or evening and due to their poor mental status we see the next morning early. There is a reference to a 12 hour requirement but my understanding is that applies to a person being treated for a medical condition. So, are we OK if we begin the mandatory evaluation beyond 12 hours after they arrive?

If a person is brought directly to your facility without stopping first at a hospital ED, you have up to 72 hours after the person's arrival at your door to conduct the exam to release, convert to voluntary, or complete the petition. The petition must also be filed within that 72-hour period, unless the period ends after close of court on Friday or on a legal holiday.

Only if the person has been to a hospital first for medical issues do you need to worry about the clock stopping for an emergency medical condition. The clock is ticking for the whole time a person is at an ER once medical clearance / stability is documented and can reduce the period of time you have available to conduct the examination. The 12-hour issue only applies to a hospital not designated under the Baker Act that has performed the examination/treatment of an emergency medical condition and not to any receiving facility.

Regarding your question as to whether you're OK beginning the mandatory evaluation beyond 12 hours after the person's arrival, the answer is yes. Failure of a previous facility to perform its duty to transfer within a particular period of time doesn't lessen your obligation to perform the examination "without unnecessary delay" as required of a receiving facility. This "without unnecessary delay" isn't defined – in some cases it can be immediate if during the day or in other cases it may be later (but within the 72-hour limit) when the physician or psychologist is present to conduct the exam.

Q. If a police officer completing the BA does not fill in the year BA completed, it was left blank, should the psychiatrist at our receiving facility continue with the evaluation? Second question concerns the ER physician forgetting to sign the BA, should the psychiatrist continue with the evaluation?

As a hospital, the federal EMTALA law requires that you must accept anyone presented to you, even if the initiating paperwork isn't sufficient. You would be required at a minimum to conduct a medical screening examination addressing the presenting symptoms. Psychiatric emergencies are defined by the feds as constituting an emergency medical condition even without any accompanying medical problems.

Any time you can get the originating person – law enforcement or ED physician – to provide a corrected document, that is great. However, your hospital is a designated receiving facility which entitles you to hold persons against their will or without their consent for examination. The Baker Act refers to the BA 52a (law enforcement) or 52b (mental health professional) as the basis for law enforcement taking a person into custody and delivering to a receiving facility. Once a person is at a receiving facility, you have the authority to hold and examine within the timeframes established by law.

Q. It's my understanding of the law that: #1. In a receiving or NON-receiving facility that are hospitals, only a psychiatrist, clinical psychologist or ED physician is able to discharge a BA for initial involuntary examination (not placement). In other words, a primary care physician is not authorized to discharge, even though they are authorized to initiate. Also #2. ALL physicians are able to determine competency to provide express and informed consent, not just the "admitting" physician. Please confirm and provide statute and page for reference for each issue.

While any physician or clinical psychologist can perform the Initial Mandatory Involuntary Examination, only a psychiatrist, clinical psychologist or emergency department physician can authorize the individual's release from a designated receiving facility.

394.463(2) Involuntary examination.

(f)A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. **The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician** with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

In a non-receiving facility hospital examining or treating a person for an emergency medical condition, the attending physician is the one who documents the presence of an emergency medical condition and the subsequent stabilization. However, any physician or clinical psychologist can perform the Initial Mandatory Involuntary Examination and authorize the individual's release from the non-receiving facility.

394.463(2) Involuntary examination.

(g)A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the **attending physician** documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services **by a professional qualified to perform an involuntary examination** [any licensed physician or clinical psychologist – see paragraph (f)] and is found as a result of that examination not to meet the criteria for involuntary outpatient

placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding **by the professional** that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met. (h)One of the following must occur within 12 hours after the patient's **attending physician** documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

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

Regarding your question about whether any physician can certify competence, this is addressed as follows:

394.4625 Voluntary admissions.

(1) AUTHORITY TO RECEIVE PATIENTS.—

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

The admitting physician is specified as the one authorized to document the competence, although it doesn't specifically preclude the admitting physician from relying on the examination completed by another physician. The above reference is for certifying competence of a person arriving on a voluntary basis. I believe the law is silent as to whether subsequently certifying a person's competence prior to transferring from involuntary to voluntary status. One would presume this to be the "attending" physician, if different from the admitting physician.

The terms "physician", "admitting physician", and "attending physician" are used throughout this section. It would be up to the facility bylaws to define "admitting" vs. "attending" since these aren't defined in the Baker Act law or rules.

Q. If a person admitted to a community hospital on an involuntary status is transferred to our facility on an involuntary status, do we start the 72 hour clock over or does it start from the time/date of the admission in the first facility? If we do not receive a copy of the coversheet that was to be sent by the original facility, should we go ahead and send a coversheet to AHCA?

The 72-hour period for involuntary examination begins at the time of the person's arrival at the first hospital or receiving facility. It only stops when a physician documents the person has an emergency medical condition. Yes, you should send a copy of the cover sheet to AHCA – if two are submitted within a three day period, the AHCA Baker Act Reporting Center assumes that the second one was a duplicate of the same event. This under-counts the number of involuntary examinations because a person could legitimately be released from one involuntary exam and “Baker Acted” again within the three day period. However, this is probably much less frequent than transfers between receiving facilities.

Q. Can you clarify when the 72 hour clock starts? Is it when the person is admitted to the psychiatric unit or when they are being evaluated in the ED? They usually go from the ER directly to inpatient psychiatry.

The 72-hour clock begins when the person arrives at the facility – not when admitted to the psychiatric unit. If the person had been held at another receiving facility or hospital prior to transfer to your facility, that time would also be deducted from the total of 72 hours. It is the right of the person not to have his/her liberty denied for more than 72 hours without converting to voluntary status or having a petition filed with the court; not the right of the facility to have a full 72 hours in which to complete the examination.

Q. Patient on the medical floor has been Baker Acted and the psychiatrist finds the patient doesn't meet the involuntary criteria. However he didn't document the findings. The patient is medically cleared the next day and the nursing supervisor asks the psychiatrist to come back in and evaluate the patient and write an order that the patient may be discharged, rather than just giving a telephone discharge order. Can the psychiatrist just give a telephone order to discharge the patient or does he need to physically come in and evaluate the patient again, documenting his findings in the chart?

You are correct that the clinical record must contain the physician's documented examination – not just an order for discharge. A “physician” or psychologist must conduct the “Initial Mandatory Involuntary Examination “without unnecessary delay”, documenting the required elements. There is no form for this – just must be documented in some fashion in the clinical record. If found to not meet the criteria for involuntary placement, the physician or psychologist can authorize the release of the patient. Since your hospital isn't a receiving facility at this time, the law doesn't require a psychiatrist to authorize the release. There is no problem with a telephone order for release, but it must be based upon a face-to-face examination of the individual that is documented in the clinical record. If the psychiatrist could dictate his/her clinical findings over the phone to authorized staff, he/she wouldn't necessarily have to come back into the hospital for this purpose.

The requirements for the Initial Mandatory Involuntary Examination are found in 394.463(2)(f), FS and 65E-5.2801, FAC, as follows:

- Thorough review of any observations of the person's recent behavior;
- Review “Transportation to Receiving Facility” form (#3100) **and**
- Review one of the following:
 - ✓ “Ex Parte Order for Involuntary Examination” or

- ✓ “Report of Law Enforcement Officer Initiating involuntary Examination” or
- ✓ “Certificate of Professional Initiating Involuntary Examination”
- Conduct brief psychiatric history; and
- Conduct face-to-face examination in a timely manner to determine if person meets criteria for release.

Q. Can any Hospitalist or any other physician (outside of the ED physician) working in a medical hospital that is NOT a receiving facility do the examination and upon the results and completion of that exam release a person who is currently on a Baker Act (BA52a or b)?"

Yes. In a hospital that isn't designated as a receiving facility, the law only requires that:

- An "attending physician" document the person has an emergency medical condition.
- While at the hospital examining or treating an individual for an emergency medical condition, any physician licensed under chapter 458 or 459, FS (or psychologist) can conduct the "Initial Mandatory Involuntary Examination".
- Any physician licensed under chapters 458 or 459, FS (or psychologist) can offer voluntary placement or release the person directly from the hospital.

It is only in a designated receiving facility where the documented approval of a psychiatrist, psychologist or attending emergency department physician is required for a person on involuntary status to be released.

Q. Can a Registered Nurse complete and sign a Baker Act based on a verbal order from a doctor? For example, if a patient comes into the ER and is seen by the doctor but then the doctor leaves during the course of the medical clearance evaluations, could the doctor then call back in to the ER nurse and have her sign the Baker Act based on his verbal order and evaluation from a few hours earlier?

It wouldn't be proper for a nurse to sign a telephone order for involuntary examination from a physician. The form can only be signed by an authorized professional who has evaluated the person against the statutory criteria.

If the physician had left the hospital before completing the form, there would be no problem for the physician to complete and sign a BA-52 form, documenting his/her findings and faxing the form back to the hospital, but only if the individual's medical record at the ED fully documented that the physician had personally examined the individual, documented his/her findings, and identified the physician's conclusions as to how the individual actually met the criteria for involuntary examination.

A faxed copy of the form with the above documentation, rather than an original, would be acceptable if signed by the physician and if fully documented in the medical record.

Q. Can a typical ED doctor really complete a Baker Act to release a patient or is it just too potentially risky / litigious?

The Baker Act allows any Florida licensed physician or psychologist to conduct the involuntary examination and either release the person from the ED or convert to voluntary status if the person doesn't meet involuntary placement criteria.

Q. Please clarify for us whether the Baker Act Involuntary examination "just runs out" after 72 hours without having to file with the court-sort of like a 72 hour "hold" and then patients are either converted to voluntary or discharged?

Some time during the 72-hour period, one of the following has to take place and be documented in the clinical record:

394.463 Involuntary examination.--

(2) Involuntary Examination.--

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

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

If the person is released, the chart should reflect that the Initial Mandatory Involuntary Examination was conducted by a physician or psychologist and that the person's release was authorized by a psychiatrist or psychologist:

394.463 Involuntary examination.--

(2) Involuntary Examination.--

(f) A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders

and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

65E-5.2801, FAC Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

The involuntary examination is also known as the initial mandatory involuntary examination.

(1) Whenever an involuntary examination is initiated by a circuit court, a law enforcement officer, or a mental health professional as provided in Section 394.463(2), F.S., an examination by a physician or clinical psychologist must be conducted and documented in the person's clinical record. The examination, conducted at a facility licensed under Chapter 394 or 395, F.S., must contain:

(a) A thorough review of any observations of the person's recent behavior;
(b) A review of mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E- 5.260(2), F.A.C., and recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.

(c) A brief psychiatric history; and

(d) A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

(2) If the physician or clinical psychologist conducting the initial mandatory involuntary examination determines that the person does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the person can be offered voluntary placement, if the person meets criteria for voluntary admission, or released directly from the hospital providing emergency medical services. Such determination must be documented in the person's clinical record.

If the person isn't released because the person is willing and clinically able to transfer to voluntary status, the Florida Administrative Code goes on to state:

65E-5.2801, FAC Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

(3) If not released, recommended form CF-MH 3040, "Application for Voluntary Admission," as referenced in paragraph 65E- 5.1302(1)(b), F.A.C., or recommended form CF-MH 3097, "Application for Voluntary Admission – Minors," as referenced in subsection 65E-5.270(1), F.A.C., may be used if the person wishes to apply for voluntary admission.

(4) If not released and the person wishes to transfer from involuntary to voluntary status, recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E- 5.170(1)(c), F.A.C., documenting the person is competent to provide express and informed consent, may be used for this purpose.

(5) All results and documentation of all elements of the initial mandatory involuntary examination shall be retained in the person's clinical record.

If the person is neither released nor permitted to convert to voluntary status, the Florida Administrative Code goes on to state:

65E-5.2801, FAC Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

(6) If the person is not released or does not become voluntary as a result of giving express and informed consent to admission and treatment in the first part of the involuntary examination, the person shall be examined by a psychiatrist to determine if the criteria for involuntary inpatient or involuntary outpatient placement are met.

(8)(d) If the facility administrator, based on facts and expert opinions, believes the person meets the criteria for involuntary inpatient or involuntary outpatient placement or is incompetent to consent to treatment, the facility shall initiate involuntary placement within 72 hours of the person's arrival by filing a petition for involuntary placement. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or CF-MH 3130, "Petition for Involuntary Outpatient Placement" as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. Such petition shall be signed by the facility administrator or designee within the 72-hour examination period. The petition shall be filed with the court within the 72-hour examination period or, if the 72 hours ends on a weekend or legal holiday, no later than the next court working day thereafter. A copy of the completed petition shall be retained in the person's clinical record and a copy given to the person and his or her duly authorized legal decision-maker or representatives.

The Code defines what must be in the clinical record and additional steps after the Initial Mandatory Involuntary Exam is completed, as follows:

(7) After the initial mandatory involuntary examination, the person's clinical record shall include:

- (a) An intake interview;
- (b) The mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E-5.260(2), F.A.C., and recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.; and
- (c) The psychiatric evaluation, including the mental status examination or the psychological status report.

(8) Disposition upon Initial Mandatory Involuntary Examination.

(a) The release of a person from a receiving facility requires the documented approval of a psychiatrist, clinical psychologist, or if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician after the completion of an initial mandatory involuntary examination. Recommended form CF-MH 3111, Feb. 05, "Approval for Release of Person on Involuntary Status from a Receiving Facility," which is incorporated

by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. A copy of the form used shall be retained in the person's clinical record.

(b) In order to document a person's transfer from involuntary to voluntary status, recommended form CF-MH 3040, "Application for Voluntary Admission," as referenced in paragraph 65E-5.1302(1)(b), F.A.C., or recommended form CF-MH 3097, "Application for Voluntary Admission – Minors," as referenced in subsection 65E-5.270(1), F.A.C., completed prior to transfer, may be used.

(c) A person for whom an involuntary examination has been initiated shall not be permitted to consent to voluntary admission until after examination by a physician to confirm his or her ability to provide express and informed consent to treatment. Recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E-5.170(1)(c), F.A.C., may be used for documentation.

(d) If the facility administrator, based on facts and expert opinions, believes the person meets the criteria for involuntary inpatient or involuntary outpatient placement or is incompetent to consent to treatment, the facility shall initiate involuntary placement within 72 hours of the person's arrival by filing a petition for involuntary placement. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or CF-MH 3130, "Petition for Involuntary Outpatient Placement" as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. Such petition shall be signed by the facility administrator or designee within the 72-hour examination period. The petition shall be filed with the court within the 72-hour examination period or, if the 72 hours ends on a weekend or legal holiday, no later than the next court working day thereafter. A copy of the completed petition shall be retained in the person's clinical record and a copy given to the person and his or her duly authorized legal decision-maker or representatives.

(e) When a person on involuntary status is released, notice shall be given to the person's guardian or representative, to any individual who executed a certificate for involuntary examination, and to any court which ordered the person's examination with a copy retained in the person's clinical record. Recommended form CF-MH 3038, Feb. 05, "Notice of Release or Discharge," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

Q. Can you explain the timeframes for involuntary examination under the Baker Act and when the petition for involuntary placement must be filed with the court?

The 72-hour clock starts when the person under the Baker Act arrives at a hospital or receiving facility for involuntary examination. This means if the person is delivered to your ER by law enforcement -- that is when the clock starts ticking. It only stops if the doctor documents that an emergency medical condition exists and starts back up again as soon as the doctor documents that the emergency medical condition has stabilized or doesn't exist. If the involuntary examination is initiated at your facility, the 72-hour period begins at the time the initiation form is signed.

If a person is first taken to another ER or another receiving facility and is subsequently transferred to TGH, the entire period of time from the individual's arrival at the first facility

is included in the 72 hours, other than a documented period of an emergency medical condition. It is a person's right not to be detained for involuntary psychiatric examination longer than 72 hours – not the right of a facility to have a full 72 hours in which to conduct the examination. In such circumstances, you may want to request completion of the BA-3102 form that includes documentation of the date/times these events occurred at the originating hospital.

The BA-32 petition for involuntary placement must be filed with the court within the 72 hours period, unless the 72 hour period ends on a weekend or legal holiday. No mention is made of week nights. Therefore, if a person arrives at 5 a.m. on a Monday morning, you would have to file the petition before close of court on Wednesday. Otherwise, the filing would exceed the 72-hour period from the point of arrival. However, if the person arrives at 5 a.m. on Thursday morning, the petition must still be completed (signatures of both experts and the administrator) within 72 hours, but it doesn't need to be actually filed with the court until Monday (the next working day).

Q. I am a Risk Manager for an acute care hospital that is not a designated receiving facility. Is the psychiatrist/psychologist the only authorized parties to be able to rescind a Baker Act? Are any of the attending physicians or ER physicians able to rescind a Baker Act? Can you also provide me with the source of this information for educational purposes for staff?

The Baker Act requires that the initial mandatory involuntary examination be conducted by a physician or a psychologist. It does not require a psychiatrist. The release of a person from a designated receiving facility requires the approval of a psychiatrist, psychologist, or emergency physician. If the hospital is not designated as a receiving facility, the approval can be provided by a physician or psychologist – no psychiatrist is required. The provisions of law governing this issue are included in s.394.463(2)as follows:

(f) A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary

inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

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

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

The initial mandatory involuntary examination is required under 65E-5.2801, F.A.C. and includes:

- Thorough review of any observations of the person's recent behavior;
- Review "Transportation to Receiving Facility" form (#3100) and
- Review one of the following:
 - "Ex Parte Order for Involuntary Examination" or
 - "Report of Law Enforcement Officer Initiating involuntary Examination" or
 - "Certificate of Professional Initiating Involuntary Examination"
- Conduct brief psychiatric history; and
- Conduct face-to-face examination in a timely manner to determine if person meets criteria for release.

There is no specific form for the initial mandatory involuntary examination – it can just be documented in the chart. There are two forms you may want to reference from the DCF website – 3101 when your physician releases the person directly and the 3102 when you are seeking to transfer the person to a receiving facility for additional examination and treatment.

Q. When a person is Baker Acted, who can rescind it? The MD in the ER that did it? A psychiatrist? The current Attending Physician? Is there a required form or can they do it on a MD's order sheet? Do they need to write a note in progress note?

At a hospital, that is not a Baker Act receiving facility, the following sections of the Baker Act apply:

394.463(2)(g) Involuntary examination.

A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour

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

Subparagraph (f) of this same section defines a professional qualified to perform an involuntary examination as any licensed physician or clinical psychologist. In a non-receiving facility, this same physician can authorize the release of the person from the ER as well.

The following sections of the Florida Administrative Code apply to the situation you describe:

65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

The involuntary examination is also known as the initial mandatory involuntary examination.

(1) Whenever an involuntary examination is initiated by a circuit court, a law enforcement officer, or a mental health professional as provided in Section 394.463(2), F.S., **an examination by a physician or clinical psychologist must be conducted and documented in the person's clinical record.** The examination, conducted at a facility licensed under Chapter 394 or 395, F.S., must contain:

- (a) A thorough review of any observations of the person's recent behavior;
- (b) A review of mandatory form CF-MH 3100, "Transportation to Receiving Facility," and the Baker Act initiation form
- (c) A brief psychiatric history; and
- (d) A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

(2) If the physician or clinical psychologist conducting the initial mandatory involuntary examination determines that the person does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the person can be offered voluntary placement, if the person meets criteria for voluntary admission, or released directly from the hospital providing emergency medical services. Such determination must be documented in the person's clinical record.

65E-5.280 Involuntary Examination.

- (4) Emergency Medical Conditions.
 - (a) Recommended form CF-MH 3101, Feb. 05, "Hospital Determination that Person Does Not Meet Involuntary Placement Criteria," which is incorporated by

reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used to document the results of the examination prescribed in Section 394.463(2)(g), F.S.

(b) Receiving facilities shall develop policies and procedures that expedite the transfer of persons referred from non-designated hospitals after examination or treatment of an emergency medical condition, within the 12 hours permitted by Section 394.463(2)(h), F.S.

(c) The 72-hour involuntary examination period set out in Section 394.463(2)(f), F.S., shall not be exceeded. In order to document the 72-hour period has not been exceeded, recommended form CF-MH 3102, Feb. 05, "Request for Involuntary Examination After Stabilization of Emergency Medical Condition," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. The form may be sent by fax, or otherwise, to promptly communicate its contents to a designated receiving facility at which appropriate medical treatment is available.

While the 3101 form has been adopted for this purpose and I've attached it to this message, the usual method of documenting this examination is done in the ED chart. I have also attached the 3102 form that can be used to transfer a person from an ED to a designated Baker Act receiving facility in cases where the person is not released directly from the ED.

Q. Who can release a Baker Act patient following the assessment and determination that they do not meet involuntary admission criteria? I am of the belief that only psychiatrists, licensed clinical psychologists and ER physicians associated with a receiving facility with the training and experience can perform this act. A doctor (a non-psychiatrist) here believes that any physician can release the patient regardless of their specialty from the medical floors. Also can an ER physician release patients from anywhere within the receiving facility or only the ER?

You are correct. Any physician or psychologist can perform the mandatory initial involuntary examination. However, the release from a designated receiving facility can only be authorized by a with the approval of a psychiatrist, psychologist, or emergency department physician.

Q. We received a call from a hospital in our area wanting to know if individuals under the Baker Act have the right to refuse admission to a receiving facility after being medically cleared?

If a person is on involuntary status, his or her willingness to consent to admission is irrelevant. Any designated receiving facility has the right to accept and admit a person without consent. Admission for involuntary examination is solely based on the initiation of a circuit court, a law enforcement officer, or an authorized mental health professional.

A hospital that doesn't have the capability of providing psychiatric care (a non-receiving facility) can transfer a person under EMTALA and 395, FS who has an emergency psychiatric condition if the physician documents that the benefit of the transfer outweighs the risk of the transfer. Of course, other conditions of transfer under EMTALA must be

met including sharing medical records, obtaining the prior consent of the receiving facility approving the transfer, arranging safe/appropriate method of transport, etc.

Once admitted, the person if competent, or a legal representative (guardian, guardian advocate, or health care surrogate/proxy) is authorized to request transfer of the person to a different receiving facility, but not to request discharge from involuntary status. Only the facility administrator/designee has the authority to discharge.

However, the issue of treatment once admitted is a different matter. No treatment, short of situations of imminent danger in which an ETO may be required, may be administered without the express and informed consent of a competent adult patient or a legally authorized substitute decision-maker.

Q. Is there any reason why a ED physician or the PCP from “lifting” a Baker Act after it has been initiated by a law enforcement officer?

Regardless of whether a judge, law enforcement officer, or authorized mental health professional initiates the examination, it is the sole authority of the attending physician or a clinical psychologist to conduct the examination, and in your hospital, to authorize the person’s release.

Q. What constitutes the initial mandatory involuntary examination required by the Florida Administrative Rules for all persons for whom an involuntary examination is initiated?

A physician or clinical psychologist must do a thorough review of any observations of the person’s recent behavior; review the “Transportation to Receiving Facility,” completed by the law enforcement officer and one of the three types of forms initiating the involuntary examination. The physician or clinical psychologist must conduct a brief psychiatric history and a face-to-face examination of the person in a timely manner to determine if the person meets criteria for release. The results of this initial mandatory involuntary examination must be documented in the person’s chart.

Q. What are the first things a receiving facility must do when a person is presented for an involuntary examination?

The person needs to be examined as quickly as possible by a physician or clinical psychologist to determine if he/she meets the criteria for involuntary placement, including all required elements of an initial mandatory involuntary examination. If not, the person must be released even if it is less than the maximum period of 72 hours and even if the person could benefit from treatment (unless the person is willing and competent to provide consent for voluntary admission and treatment). The person must have a physical examination within 24 hours and must be assessed by a physician as to his/her capacity to provide informed consent to his/her own treatment.

Q. Does the law limit who can conduct an involuntary examination to only a physician or clinical psychologist? If not, what types of licensed individuals can perform the examination?

You are correct that the only professionals who are authorized to conduct involuntary examinations (following the initiation by a wider group of professionals) are physicians and clinical psychologists, as defined in the Baker Act. This cannot be delegated to physician extenders such as nurse practitioners.

However, the Baker Act addresses the “approval” for release a little differently from conducting the examination. From a designated receiving facility, the only professionals who can approve the release of a person after an involuntary examination is a psychiatrist, a clinical psychologist, and an emergency department physician. In a hospital that has provided emergency medical care to a person under the Baker Act, the law permits a physician or clinical psychologist to approve the discharge as well as to conduct the involuntary examination.

Q. Does the Baker Act require a face to face evaluation by a psychiatrist or clinical psychologist or can other licensed mental health professionals release the person after performing their face to face evaluation and then initiate a phone consultation with an on-call psychiatrist? The actual hospital discharge order would then be written by the attending physician.

The Baker Act involuntary examination must be done by either a physician or a licensed clinical psychologist. Other mental health professionals are authorized to initiate an examination, but are not authorized to perform it. The face to face examination must be done by a physician or psychologist, not one of the other professionals. In addition to documenting the exam, the physician or clinical psychologist must document that the person doesn't meet at least one of the criteria for involuntary inpatient or involuntary outpatient placement under the Baker Act.

Q. I need to clarify the 12 hour rule: Patient is brought into a Baker Act Receiving Facility on a Baker Act to the ED by Law Enforcement at 7am. Patient is evaluated by the ED Physician and medical conditions are ruled out- patient is then medically cleared at 11am. Am I to understand that the 12 hours started at 7am when the patient arrived or at 11am after the medical conditions are ruled out and the patient is now “medically cleared” please? How is the 12 hour rule applied when the patient is brought to an ED at a Baker Act Receiving facility but the patient does not meet criteria for admission to the Inpatient Psychiatric Unit at that facility please...?

The 12-hour rule would have no application to your hospital or any other hospital that is a designated receiving facility. For your hospital, the only time frame that applies is the 72-hour examination period. The patient must be examined within 72 hours of arrival or released or converted to involuntary status. The only event that would stop this 72-hour clock is if a doctor documents the presence of an emergency medical condition. If your hospital doesn't have the capability or capacity to manage the person's condition, once all conditions of the federal EMTALA law are addressed, you can follow the transfer provisions of the Baker Act

394.4685 Transfer of patients among facilities.--

(3) Transfer From Private To Public Facilities.--

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

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

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

(4) Transfer Between Private Facilities.--A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

The 12-hour provision you reference is for hospital ERs that are not part of designated Baker Act receiving facilities. Since they, by definition, don't have the capacity or capability of treating an acute psychiatric condition, they must transfer the patient within 12 hours after the person has been determined to be medically stable for transfer.

Q. If a person under an involuntary examination status is admitted to a medical hospital for an emergency medical condition and becomes medically cleared, who has the ability to release the person from the Baker Act on the medical floor? This would be not be a patient in the emergency room.

If the medical hospital is not a designated receiving facility, a physician or clinical psychologist can perform the examination and approve the person's release from the hospital. If the medical hospital is a designated receiving facility, a physician or clinical psychologist can perform the examination but the approval for release of the person can only be done by a psychiatrist, clinical psychologist, or emergency room physician.

Q. When is a Baker Act considered to be lifted, overturned, rescinded, or abrogated?

Use of the terms "lifted, overturned, rescinded, or abrogated" suggest that a physician or psychologist at a receiving facility or ED can just make the "Baker Act" go away. A more appropriate term is that a physician or psychologist performs the examination that has been initiated. After the initial mandatory involuntary examination is conducted and documented by a physician or psychologist, the person can be released. If release is from a designated receiving facility, the approval of a psychiatrist, psychologist or ED physician is required. If from a non-receiving facility, the approval for release can be given by any physician or psychologist. A psychiatrist, physician and psychologist are defined in the Baker Act and these definitions – not those in the licensing statutes prevail.

Q. Does a psychiatrist have to have a face-to-face examination of a person before the person is released from a receiving facility?

NO. The Baker Act only requires that a psychiatrist, clinical psychologist, or physician in a hospital's emergency department document his/her approval of the person's release, not perform a face-to-face examination, which can be done by a physician or clinical psychologist. However, most authorized professionals would want to personally confirm another person's judgment prior to extending this approval.

Q. There is a lot of confusion about the Baker Act "clock". I believe the clock doesn't start until the person arrives at a Baker Act receiving facility. Is that correct?

Actually, for a person on an involuntary examination initiated by any one of the legally authorized parties (court, law enforcement, or mental health professional) who is brought first to an ED for examination or treatment of a possible medical issue, the 72-hour clock starts when the person arrives at the ED. Chapter 394.463(2)(g) reads as follow:

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

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

1. The patient must be examined by a designated receiving facility and released;
or

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

Telepsychiatry

Q. Are you familiar with Telepsychiatry? Can a Receiving Facility use this service for evaluation and assessment if it becomes necessary?

The 2009 Florida Legislature amended the Baker Act to permit the second opinion for involuntary inpatient placement and involuntary outpatient placement to be conducted by electronic means. That is defined as:

394.455(38)“Electronic means” means a form of telecommunication that requires all parties to maintain visual as well as audio communication.

The material involving the second opinion is as follows:

394.467(2) ADMISSION TO A TREATMENT FACILITY.—A patient may be retained by a receiving facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the receiving facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met. However, in a county that has a population of fewer than 50,000, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse. **Any second opinion authorized in this subsection may be conducted through a face-to-face examination, in person or by electronic means.** Such recommendation shall be entered on an involuntary inpatient placement certificate that authorizes the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

The involuntary outpatient placement provision is identical with regard to the 2nd opinion. The Baker Act is otherwise silent as to the use of Telepsychiatry.

Q. What is telepsychiatry?

Telepsychiatry is the delivery of psychiatric examination and consultation services via a live videoconference between a doctor and a person receiving services. Telepsychiatry is one example of telemedicine.

Q. What can you tell us about the use of tele-psychiatry to implement the Baker Act?

The 2009 Florida Legislature added provisions for the 2nd opinion for involuntary inpatient placement and involuntary outpatient to be conducted by “electronic means. “Electronic means” was defined to mean a form of telecommunication that requires all parties to maintain visual as well as audio communication. While the Baker Act law and rule offer little assistance in this area, the National Association of Social Workers has provided substantial guidance to its members. NASW attorney points out that there are

a number of factors to take into consideration when engaging in therapy through a distance modality. Here are just a few:

- By what mechanism is an initial assessment conducted?
- Is there an option that includes videoconferencing to permit fact-to-face contact, or telephone contact?
- What are the arrangements for emergency intervention, if needed?
- Is complete demographic, contact information required for participation?
- Is there any means to verify the patients' age (to determine that they are of legal age to consent to treatment)?
- Is the therapy being conducted across state lines?
- Would the patient otherwise be unable or unlikely to access services, but for the electronic communication?
- Are any in-person services available from the agency should the patient need or choose to access them?
- Does the agency rely on any research to support the use of this technology to provide the type of service offered?
- Are social workers trained on special needs or protocols that may arise with this treatment modality?
- Are clients asked to sign an informed consent prior to treatment that explains the limitations of this form of intervention?

Sherri Morgan and Carolyn I. Polowy published the following article titled "Social Workers and e-Therapy" in NASW April 2007

Introduction

More than one hundred years after the invention of the telephone, its use in clinical treatment is still being debated by mental health professionals, including social workers. The re-emergence of technology debates has been fueled by an increase in research as to the efficacy of counseling services delivered via various electronic modes, the lack of services in rural areas, the push for low-cost forms of delivering health care, and the ever-expanding uses of the Internet in modern society. This Legal Issue of the Month article will review developments in law, practice standards, and social work practice and marketing related to electronic communications and service delivery.

Electronic Modalities of Treatment

Telephone therapy or counseling sessions are offered to clients in a wide range of treatment approaches. In some clinical social work practices, telephone sessions are offered as an adjunct to a primarily face-to-face therapeutic relationship, available when transportation or life emergencies prevent clients from attending their scheduled office visits. In other settings, a social work practice may offer telephone therapy as the primary mode of treatment for specified clients, such as the mobility-impaired, or rural clients with transportation barriers, while continuing to provide office sessions to other clients. Some social workers may provide telephone counseling as case management or for psychosocial education on matters related to primary healthcare diagnosis and treatment, such as diabetes or cancer. In such situations, the telephone sessions may be used for information sharing, problem solving, and support, rather than mental health diagnosis and psychotherapy.

Telemedicine and telehealth, as structured by the Medicare regulations requires the use of designated sites that provide videoconferencing capabilities (Coleman, 2002). Thus, a rural patient would need to come to a local site at an appointed time to access the services provided by the professional who is available electronically at a remote location. This process is more structured than either telephone therapy or online therapy, but is required for Medicare reimbursement.

Internet, online or e-therapy is conducted with a range of methods, which have not all been subjected to the rigors of scientific research as to their efficacy. These include scheduled electronic “chat” sessions which consist of real time information exchanged via a computer keyboard, structured email exchanges, and group online “chat” sessions that are accessible only to approved members of the group, or open chat sessions moderated by a therapist. Online self-help groups for various mental and physical health conditions are too numerous to catalog here, but health care researchers are exploring the efficacy of these interventions as well.

Research

Health research on telemedicine and electronic therapy offers a vast array of professional journal articles indicating few limitations on the potential scope of telemedicine. Although the mental health professions may have qualms about distance counseling, physical medicine is pushing the boundaries of remote care by providing services across long distances using electronic technology for procedures such as monitoring blood pressure and fetal heart rates, evaluating wounds, overseeing dental treatment, providing teleradiology, and robotic surgery, to name a few.

A search of the professional health literature available through the National Center for Biotechnology Information at the U.S. National Library of Medicine (“NLM”) on the topic “telemedicine” returned 8,715 results, with 795 from January 2006 – March 2007 alone (NLM, 2007). A scan of the 2006 – 2007 titles shows the use of telemedicine across the most remote portions of the globe, into areas of military conflict, and into outer space. Research addresses the use of telemedicine in localities as diverse as Afghanistan, Chechnya, the Amazonian rainforest, Iceland, South India, China, Japan, Korea, Jordan, Ecuador, Singapore, and manned space stations outside of Earth’s atmosphere, as well as rural areas of the United States, such as Appalachia and the Dakotas.

Social Work Practice Standards

The National Association of Social Workers (“NASW”) & Association of Social Work Boards (“ASWB”) Standards for Technology and Social Work Practice (“Technology Standards”), published in 2005, provide guidance for the use of technology-mediated social work practice. The Preface indicates that the Standards should apply to “the use of technology as an adjunct to practice, as well as practice that is exclusively conducted with technology.” Specific issues addressed include:

- social work advocacy for technology access by clients with special needs or limited access

- compliance with applicable laws and regulations in all states where the social work services are provided
- appropriate matching of online methods, skills and techniques to the cultural and ethnic characteristics of the treatment population
- accurate marketing practices and verification of client identity
- privacy protection requirements
- knowledge about appropriateness of certain types of online technologies for specific clients
- development of security policies and procedures, as well as contingency plans for electronic failures or emergencies
- retention of technology consultants.

Far from repudiating the use of technology in social work practice, the Standards remind social workers that high practice standards are particularly required when the lack of face-to-face contact may increase the “potential for harm or abuse of vulnerable people.” In addition, social workers “should advocate for both themselves and for clients to resolve access [to technology] problems.”

An informal review of online social work services available to the public offers a snapshot of creative means of addressing best practices requirements. For example:

- requiring pre-session information from new clients to save time and reduce clients costs, such as a personal history, or answering a brief questionnaire related to treatment needs;
- providing nationwide services by making licensed practitioners available in each state;
- requiring clients to provide identifying information and emergency contacts;
- providing electronic links to a wide range of supportive resources; and
- providing clear payment policies, treatment expectations and limitations, and privacy policies on the therapist’s Web site in easy to understand language.

A variety of questionable social work practices is also displayed to the public online, such as making unfounded claims of successful outcomes; use of unprofessional photographs; failure to identify the professional by name and licensure status; single-state therapy practices providing “nationwide” therapy services without indicating licensure in the states where the clients are located; providing services to “anonymous” clients; and permitting public Internet posting of client’s comments where confidentiality is not assured.

State Social Work Law and Regulation

A primary legal issue regarding electronic social work practice is defining the location where services occur, when services are provided across state lines. The ASWB Model Social Work Act (“Model Act”), Section 301 (e), defines social work services as those provided to an individual in the state where the client is located. At least one state, Oklahoma, has adopted the ASWB provision as written: “The provision of social work services to an individual in this state, through telephonic, electronic or other means, regardless of the location of the social worker, shall constitute the practice of social work and shall be subject to regulation” (Oklahoma, 2007). The ASWB commentary to this section points out that “practice other than in-person service is limiting to both the practitioner and

client” and advises “extreme caution” in offering electronic services. It also calls for further study.

Consistent with the Model Act, the Technology Standards admonish social workers to “abide by all regulation of their professional practice with the understanding that their practice may be subject to regulation in both the jurisdiction in which the client receives services as well as the jurisdiction in which the social worker provides services,” (NASW & ASWB, 2005). This highlights the requirement that social work practices that operate in more than one state must review and interpret the laws and regulations for social work practice in each state and determine how the practice should be structured to avoid conflicting requirements and afford clients the greatest level of protection from unregulated practice.

The California Board of Behavioral Sciences is seeking clarification as to the applicability of medical practice standards for “telemedicine” to social work and other mental health licensees through its committee process, according to a statement on its Web site. The relevant provision of California law does not apply to telephone conversations with clients nor e-mail communications, but does apply to interactive audio, video, or data communications in real time or near real time transfer of information. Detailed standards for offering such services are provided in the California Business and Professions Code Section 2290.5, including:

- advance written consent to treatment from the patient or patient’s legal representative
- description of risks, consequences and benefits of telemedicine
- applicability of existing confidentiality protections
- applicability of existing laws regarding medical records and copies of records. (California Board of Behavioral Sciences, 2006).

Texas authorized the creation of a pilot program to offer telehealth or telemedicine services for mental health services to certain Medicaid recipients; however, it was primarily limited to professional consultations between non-physician providers and physicians, (Vernon’s Texas Code Annotated, 2006).

South Carolina law makes it clear that a South Carolina social work license is required in order to provide social work services via telephone or electronic means to any residents of that state. (Code of Laws of South Carolina 1976 Annotated, 2006). Minnesota law requires social workers who provide services through electronic means to “take the steps necessary, such as consultation or supervision, to ensure the competence of the social worker’s work and to protect clients from harm.” (Minnesota Statutes Annotated, 2007).

Other Health Professions

Other health professions have responded to the provision of services across state lines by various means. Within nursing, twenty states have joined the Nurse Licensure Compact, whereby participating states pass legislation permitting recognition of licensure in one state for purposes of practicing in another state or states (National Council of State Boards of Nursing, 2007). Although this has

been received with conflict within the nursing profession, it provides one model for assuring that interstate licensure concerns are addressed in telemedicine.

The Federation of State Medical Boards (FSMB) adopted the Model Act to Regulate the Practice of Telemedicine Across State Lines in 1995. At least 10 states have passed the Model Act by statute or regulation (FSMB, 2007). The American Medical Association (AMA), in a review of physician licensure trends, identified several other possible alternatives to facilitate interstate telemedicine (Robertson, 2005). These include medical consulting, endorsement, mutual recognition, reciprocity, registration, limited licensure, and national licensure. Robertson confirmed the AMA's clear preference for state-based licensure and opposition to a national licensure approach.

Analysis and Conclusions

Practice is ahead of legislation and regulation in the area of electronic therapy services. For the most part, telephone services have in the past been used in a limited manner, in conjunction with in-person client contacts. Several states have exceptions to licensure requirements that would permit brief contact with clients across state lines (e.g. Indiana, Montana, Wyoming). The expanded use of the Internet in everyday society has pushed the boundaries of traditional uses of information technology beyond previous conceptions, including new uses for "old" technologies, such as the telephone. Research on technology-mediated counseling services is continuing at a fast pace; however, much of the research addresses telephone and cyber counseling as an adjunct to other medical services, as social support, psycho-education, or case management, rather than comparing traditional face-to-face psychotherapy with a solely electronic counseling modality. Thus, the historic understanding that face-to-face therapy is the most effective modality for providing counseling has not been refuted.

Social workers who provide services electronically should apply the practice standards available from the profession when making decisions about how to present their practice online, and when developing office policies and procedures. Social workers need to carefully assess the licensure requirements for each state where clients will receive services. Many state licensing boards do not have the authority to discipline unlicensed practitioners. Thus, current law or regulation may not provide effective remedies for consumers participating in electronic therapy across state lines. Social work leaders may need to consider new regulatory or legislative alternatives to effectively protect consumers, recognizing that telehealth, cybertherapy or telephone counseling may be the only access to mental health treatment for some clients, or that it may serve as an initial linkage for clients who would otherwise never engage in a therapeutic relationship.

Social workers with questions about this can refer to the ASWB & NASW Standards for Technology and Social Work Practice and the Standards for Clinical Social Work, available at:

<https://www.socialworkers.org/practice/standards/NASWTechnologyStandards.pdf>
<https://www.socialworkers.org/practice/standards/NASWClinicalSWStandards.pdf>

Q. What does Chapter 458, Florida Statutes (F.S.), which governs medical practice, say about telepsychiatry?

Chapter 458, F.S. (2009), places no restrictions on the use of telemedicine by physicians licensed in Florida. The statute prohibits anyone who is not licensed in Florida as a physician from providing telemedicine services.

Q. Is telepsychiatry covered by Medicaid?

Not currently, but the draft 2010 Florida Medicaid Community Behavioral Health Handbook allows for reimbursement at the rate of \$60 per event for telepsychiatry services, described as "[p]sychiatric medication management services through use of interactive telecommunications equipment." After telepsychiatry has been added to the Handbook, fee-for-service Medicaid will be able to receive reimbursement for it for services other than an initial psychiatric examination. The Medicaid PSN, Pre-paid and HMO Plans do not currently reimburse for telepsychiatry.

Q. What does the American Psychiatric Association (APA) say about telepsychiatry?

"Telepsychiatry, or telemedicine, is a specifically defined form of video conferencing that can provide psychiatric services to patients living in remote locations or otherwise underserved areas. It can connect patients, psychiatrists, physicians, and other healthcare professionals through the use of television cameras and microphones. Telemedicine currently provides an array of services, including but not limited to diagnosis and assessment; medication management; and individual and group therapy. It also provides an opportunity for consultative services between psychiatrists, primary care physicians and other healthcare providers. Telepsychiatry is also being used to provide patients with second opinions in areas where only one psychiatrist is available.

Telepsychiatry has been shown to improve collaborative services between professionals. Studies indicate that healthcare professionals feel telepsychiatry has given them an opportunity to work more effectively as a team.

Patients surveyed say they felt that the communication between their physicians had improved their outcomes. There are a few barriers to providing telepsychiatry services. Reimbursement is still difficult to receive, especially through third-party payers, and licensure [for psychiatrists to provide services across state lines] can be difficult to obtain.

Overall, telepsychiatry provides increased access to services and has helped enhance the provision of services to families with children and other patients who are homebound. Patients participating in telepsychiatry say they are satisfied with the care they are receiving and that they feel telepsychiatry is a reliable form of practice."
(Retrieved from: American Psychiatric Association)

Q. May telepsychiatry be used for an examination that forms the basis of a professional certificate initiating Baker Act involuntary examination?

Yes. All that is required in statute for an authorized professional to initiate involuntary examination by certificate is that the professional "has examined a person within the preceding 48 hours (s. 394.463(2)(a)3, F.S., (2009))," and concludes that the individual meets criteria for examination. However, professionals should exercise caution to ensure that their clinical decisions meet appropriate standards of care.

Q. May an involuntary examination be completed at an emergency department (ED) that is not part of a hospital designated as a Baker Act receiving facility?

Yes, if the individual examined is receiving emergency medical services at the emergency department (ED) and the involuntary examination is completed by a professional authorized to complete such examinations.

- If the ED is part of a Baker Act receiving facility, these professionals would include psychiatrists, clinical psychologists, or ED attending physicians.
- If the ED is not part of Baker Act receiving facility, then these authorized professionals would include any physician.

The Baker Act authorizes law enforcement to transport an individual to an emergency department (ED) that is not a Baker Act receiving facility if the individual has a concurrent non-psychiatric medical emergency (s. 394.462(1)(h), F.S.(2009)). In this event, a psychiatrist, clinical psychologist, or ED attending physician who examines the individual at the hospital has authority to determine that the individual does not meet criteria for involuntary placement, and therefore to approve the individual's release directly from the ED (s. 394.463(2)(g), F.S.(2009)).

Q. May telepsychiatry be used for the initial mandatory involuntary examination that is part of the Baker Act involuntary examination process?

Yes. The Baker Act requires an initial examination by a physician (not necessarily a psychiatrist) or clinical psychologist at the receiving facility "without unnecessary delay" (s. 394.463(2)(f), F.S.(2009)). Applicable rule requires that this be a "face-to-face examination of the person in a timely manner to determine if the person meets criteria for release (65E-5.2801, F.A.C.)." Telepsychiatry permits face-to-face visual and audio contact without an in-person examination. Interpreting this requirement to prohibit telepsychiatry could create the kind of unnecessary delay that the Legislature hoped to avoid.

Q. May telepsychiatry be used in an examination that forms the basis for approval of release from involuntary examination?

Yes. All that is required for release is that the individual meet criteria for release as established by "the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician (s. 394.463(2)(f), F.S., (2009))." Since telepsychiatry is an accepted part of psychiatric practice, there is nothing to prevent a psychiatrist from basing his or her approval for release on a telepsychiatric examination.

Q. May telepsychiatry be used for the examination that forms the basis of the first opinion supporting involuntary inpatient placement?

No. The Baker Act requires that the petition for involuntary inpatient placement "must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours." The phrase "personally examined" is not defined, and, in isolation, could conceivably be interpreted to include telepsychiatry. However, the same subparagraph goes on to specify that "[a]ny second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means." (s. 394.467(2), F.S.(2009)) "Electronic means" is defined as "a form of telecommunication that requires all parties to maintain visual as well as audio communication (s. 394.455(38), F.S.(2009))." This is clearly a reference to telepsychiatry. Since telepsychiatry is authorized explicitly for the second opinion, but not mentioned with regard to the first opinion, the Legislature appears to have considered the appropriateness of telepsychiatry for both opinions and only deemed it appropriate for the second opinion.

Q. May telepsychiatry be used for the examination that forms the basis of the first opinion supporting involuntary outpatient placement?

No. The same language regarding "electronic means" used to authorize telepsychiatry for the second (but not first) opinion supporting involuntary inpatient placement is used to authorize the use of telepsychiatry for the second (but not first) opinion supporting involuntary outpatient placement. (s. 394.465(2)(a), F.S.(2009))

Conversion to Voluntary Status

Q. I have a question about clients in our facility who are jail holds being unable to sign in voluntarily to the CSU.

The Baker Act limits a person being held for involuntary examination for a period of up to 72 hours unless he/she is transferred to voluntary status or a petition for involuntary placement is filed with the court. However, if a person is charged with a crime, he/she cannot be transferred to voluntary status and if released, must be returned to the custody of law enforcement. This section is as follows:

394.463(2) Involuntary examination.

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, **unless he or she is charged with a crime**, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;

3. The patient, **unless he or she is charged with a crime**, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

DCF has proposed changes to the Baker Act for legislative consideration. One of the changes is to permit a person charged with a crime to be transferred to voluntary status under the Baker Act, but not released except to law enforcement. This is still a suggested amendment and wouldn't take effect unless authorized by the Legislature.

Q. If we have a patient on the unit that has come from jail and is to return to jail on discharge, is this patient allowed to sign voluntary after the 72 hours if the need for further treatment is evident and the patient is willing to sign? We currently have a patient on the unit who came in as a voluntary and law enforcement has served a warrant on the patient here, can patient remain here voluntarily?

If a person arrives at your facility on a voluntary basis, there is no legal prohibition against the person remaining on voluntary status even if he/she has legal charges. However, if the person is brought to you on involuntary status, you can't convert the person to voluntary status if he/she has any type of criminal charges. The current law reads as follows:

394.463 Involuntary examination.

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, **unless he or she is charged with a crime**, in which case the patient shall be returned to the custody of a law enforcement officer;

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

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

A person with criminal charges who is presented to your facility for involuntary examination must either be released back to law enforcement within the 72-hour period for have a petition for involuntary inpatient placement filed with the court.

DCF has proposed legislative changes that would permit, if enacted by the Legislature, a person with criminal charges to be converted to voluntary status, but would still require that such a person be released only to law enforcement.

Q. Can a screener at the admissions office of a hospital or crisis stabilization unit change a person's legal status from involuntary to voluntary?

NO. Once an involuntary examination been initiated by a court, law enforcement officer, or mental health professional, the person's legal status cannot be changed until after a physician or clinical psychologist has performed the initial mandatory involuntary examination, has certified the person can give express and informed consent, and the person has made application for voluntary admission.

Q. If a doctor has a patient under involuntary status for several days, can the patient go straight from that to discharge or is there a process/procedure that needs to be followed to get from one to the other?

At any time the physician documents that the person doesn't meet the criteria for involuntary placement, the patient must be released or converted to voluntary status. The physician (or psychologist) must document that the initial mandatory involuntary examination was completed:

65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

The involuntary examination is also known as the initial mandatory involuntary examination.

(1) Whenever an involuntary examination is initiated by a circuit court, a law enforcement officer, or a mental health professional as provided in Section 394.463(2), F.S., an examination by a physician or clinical psychologist must be conducted and documented in the person's clinical record. The examination, conducted at a facility licensed under Chapter 394 or 395, F.S., must contain:

- (a) A thorough review of any observations of the person's recent behavior;
- (b) A review of mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E- 5.260(2), F.A.C., and recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.
- (c) A brief psychiatric history; and
- (d) A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

(5) All results and documentation of all elements of the initial mandatory involuntary examination shall be retained in the person's clinical record.

(8) Disposition Upon Initial Mandatory Involuntary Examination.

(a) The release of a person from a receiving facility requires the documented approval of a psychiatrist, clinical psychologist, or if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician after the completion of an initial mandatory involuntary examination. Recommended form CF-MH 3111, Feb. 05, "Approval for Release of Person on Involuntary Status from a Receiving Facility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. A copy of the form used shall be retained in the person's clinical record.

(e) When a person on involuntary status is released, notice shall be given to the person's guardian or representative, to any individual who executed a certificate for involuntary examination, and to any court which ordered the person's examination with a copy retained in the person's clinical record. Recommended form CF-MH 3038, Feb. 05, "Notice of Release or Discharge," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

Release from Involuntary Examination

Q. Who is authorized to discharge a person on involuntary status?

Other than a circuit court judge, only the Administrator of a receiving or treatment facility has the authority to discharge a person on involuntary status once a psychiatrist or psychologist has determined the person to not meet involuntary placement criteria. A person held under the involuntary examination or involuntary placement cannot be removed AMA from a facility.

Q. Our VA Baker Act receiving facility just developed a policy that allows for involuntary examination and release by our Psychiatrist. However, there is a caveat. The potential patient would be released to his own recognizance as a voluntary patient. The ED staff under our new facility policy is to maintain a 1:1 line of sight on voluntary patients that were seen under the Baker Act until discharged. There was a specific incident which led to a change in local policy that I would like your input to see if the policy needs to be revisited.

The distinction you're making between converting a person from involuntary to voluntary status before releasing him/her "on own recognizance" vs keeping ED patients on voluntary status on a 1:1 line of sight until discharge isn't clear. Your entire facility is designated as the "receiving facility", include the psychiatric unit(s), ED, and all other units on the premises.

A person wouldn't be transferred from involuntary to voluntary status unless an Initial Mandatory Involuntary Examination had been completed by a physician or psychologist and documented in the chart in addition to a certification of competency being completed by a physician. These two steps would document that the individual was able to make well-reasoned, knowing and willful decisions about his/her medical and mental health

care and didn't meet criteria for involuntary placement. At this point, the individual must be advised of his/her right to **request** discharge.

If the person does indeed request discharge or refuses consent to treatment, the receiving facility can detain the person for up to 24 hours before release, allowing time to contact a physician or psychologist to assess the person against the involuntary criteria.

During this time, the individual on voluntary status can be retained on a secured unit or on 1:1 line of sight to prevent the person from leaving the facility prior to the discharge taking place. The discharge signifies that the person doesn't meet involuntary criteria and is competent to make his/her own decisions.

Q. If doctor's orders are written to discharge the individual during business hours and discharge arrangements are made. Then, after-hours it turns out that the person's ride couldn't get there for unforeseen reasons until the next morning. The 72 hours has not expired on the Baker Act. We contacted the doctor and had him change the orders that the individual would be picked up the next morning. Was this necessary to have the doctor's orders modified or could the situation be documented in the progress notes that the person's ride couldn't get there until the next business day? How long do we have to get the person discharged once orders are written? If it goes into the next day, do we need to modify the doctor's orders? Please clarify this type of discharge situation.

The issue you raise isn't directly addressed in the Baker Act law or rule. One presumes that that individual has been found by the physician to not meet the involuntary placement criteria and is then on voluntary status. If the individual agrees to a delayed release due to the travel arrangements, there would be no problem with accommodating that request in light of the physician's discharge order. If the individual -- now on voluntary status doesn't agree and requests discharge, you have up to 24 hours in which release the person. You just wouldn't want to hold the person against his/her will past the 72-hour period.

Q. What if someone has been in a facility for 72 hours, still meets criteria for involuntary exam, but does not meet criteria for involuntary placement (and therefore no petition has been filed). Are they to be released at the 72 hour mark, or not?

If they don't meet the criteria for voluntary admission (or refuse), they must be released. The criteria for involuntary exam and involuntary placement are essentially the same, with the exception that placement requires that no less restrictive placement exists. Therefore, if the person meets exam criteria and not placement criteria, there must be a less restrictive and appropriate placement available.

The problem exists when a person clinically needs more treatment than the exam period allows, but either cannot or will not apply for conversion to voluntary status. The law is explicit that within the 72-hour exam period, the only options are to release the person, convert to voluntary, or file a petition with the court:

394.463(2)(i) Involuntary Examination

Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

Q. I am the Social Services Coordinator at a free-standing psychiatric hospital, a Baker Act receiving facility. Does the doctor have to complete a 3101 form when he discharges a patient who is on involuntary status or if it is not a requirement when discharging an involuntary patient.

The 3101 form is only intended to be used by physicians or psychologists at hospital ED's that aren't designated as receiving facilities. This is noted in bold print in the first paragraph of the form. Instructions for use of the form are found in the box at the bottom. This form is only used by an ED to directly release a person after an emergency medical condition has been stabilized and the person is found not to meet the criteria for involuntary placement.

Since your hospital is a designated receiving facility, the equivalent form for your use is the 3038 titled "Notice of Release or Discharge". While this form is signed by the Administrator/Designee, your chart should reflect the documentation by a physician that the individual does not meet the involuntary placement criteria -- such approval for discharge must be approved by a psychiatrist or psychologist.

Q. A question has come up regarding the use of the CF-MH 3111 form titled "Approval for Release of Person on Involuntary Status from a receiving facility". Are the psychiatrists seeing patients in our main medical facility next door required to complete the Approval for Release form or is that form intended for use at our receiving facility?

The entire complex is considered to be the receiving facility, not just the psychiatric facility. However, I'm not sure that the above really matters. The Florida Administrative Code states that:

65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

(8) Disposition Upon Initial Mandatory Involuntary Examination.

e) When a person on involuntary status is released, notice shall be given to the person's guardian or representative, to any individual who executed a certificate for involuntary examination, and to any court which ordered the person's examination with a copy retained in the person's clinical record. Recommended form CF-MH 3038, Feb. 05, "Notice of Release or Discharge," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

The above paragraph doesn't make a distinction between the ER and the psychiatric unit. Since the 3111 form is recommended, not mandatory, its use isn't required although documentation in the chart is required from the physician or psychologist who performed the involuntary examination and released the patient.

Q. A petition for involuntary inpatient placement was recently dismissed in our county because more than 72 hours had passed between the law enforcement officer taking the patient into custody and the filing of the petition for placement. The law states [394.463(2)(f)] that "a patient may not be held in a receiving facility for involuntary examination longer than 72 hours". In addition, the law [394.463(2)(g)] states A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition.

You have found two of three citations in the Baker Act that impact on this question. In addition to the citations you listed in your email message, the last one is as follows:

394.463 (2) Involuntary Examination.--

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

The date/time the person was taken into custody is not referenced in the law/rules. In every case, the clock starts when the person arrives at the first facility (either ER or receiving facility). It is important to remember that all parts of a hospital, not just the psychiatric unit, are part of the receiving facility.

Transfers

Q. I was speaking with one of our area hospitals yesterday, which is not a receiving facility. They asked if they have a client that they have been unable to transfer to a receiving facility and the 72 hours of the Baker act is up (meaning they have had the client for at least 3 days not including medical treatment time), can they re-Baker Act the client?

“Re-Baker Acting” a person is not appropriate. Some ED’s would like to stretch the maximum amount of time. It is the individual’s right not to have their liberty denied for more than 72 hours (plus the time during which a medical emergency exists) for the purpose of psychiatric examination – not for a facility to have whatever time is involved in arranging for such an examination.

There is no remedy in the law for what shouldn’t ever happen – having persons held for more than 12 hours after medical clearance at a non-receiving facility, much less 72 hours. I’ve learned from attorneys, through the many wrongful death law suits I’ve been involved in, that allowing a person to depart who hasn’t been determined by a physician or psychologist to no longer meet the involuntary criteria is the ultimate danger.

While the person is at the hospital, the record should reflect a continuous status of meeting those criteria – this may be a hospital’s only defense against a possible false imprisonment complaint. If the clinical record documents that a person isn’t meeting the criteria any longer, the person should be released. As I’ve suggested on numerous occasions, if the ER physician isn’t willing to conduct the examination, the hospital(s) should contract with and privilege a clinical psychologist to conduct the examinations. You’ll find that a large percentage will be able to be released directly without requiring a transfer to a receiving facility.

Licensed hospitals must protect the rights of persons held under the Baker Act as required by Florida’s hospital licensing law.

Q. A patient on a BA52 in the ER is awaiting admission somewhere because we have no empty beds. The patient doesn't have capacity to sign voluntary. The ER staff is concerned that the BA52 will expire. The Psych MD will do a BA32 but should they do both opinions at our hospital because if the patient is transferred to another facility our MDs won't be there to testify? Can the other facility accept a patient on a BA32 with both opinions completed by another hospital's MDs? Do other facilities accept a patient with just the first opinion done or will they want to turn down the patient?

Your entire hospital is considered a receiving facility – not just the psychiatric unit. You have the option of placing the person on a medical unit with a sitter and providing a psychiatric overlay. You have just 72 hours in which the psychiatric examination of an

involuntary patient is to be conducted, beginning at the time of the person's arrival at the ER. The only thing that stops this clock is the documentation of an emergency medical condition. Within the 72-hour period the person must be released or a petition filed with the court, unless the person is documented as both able and willing to provide express and informed consent to voluntary status/treatment.

If you can't locate another receiving facility to accept the person waiting in your ER, you may just have to initiate the BA-32 with your own psychiatrists (second opinion could be by a psychologist). You should admit the person to your first available bed on your psychiatric unit – there is generally some turnover during any 72-hour period. Remember that if you ever go over licensed census for any patient you must do so for an indigent patient as well. One of the two experts signing the BA-32 must be available to testify at the person's hearing. You may want your attorney to check to see if the court and public defender would accept telephonic testimony in such a rare event.

There is no legal reason why another receiving facility couldn't accept the transfer with both opinions done by your physicians, but might have to have the petition actually signed by the administrator/designee of the facility to which the patient is being transferred. The destination facility would probably require, as a condition of accepting the transfer, that the issue of testimony be resolved.

Having just the first opinion done by the transferring facility, leaving the second opinion and administrator to sign at the destination facility, may be possible. However, this would have to be acceptable to the destination facility and there would have to be sufficient time remaining in the 72 hours to obtain the 2nd opinion and to process the petition with the Clerk of Court. If there is not sufficient time to file the petition in a timely way, your hospital may have to hold the person until after the hearing is conducted.

Q. It is getting extremely difficult to transfer Baker Act patients to receiving facility within by the 72 hour cut off time. Unfortunately, what we are seeing is that patient's are being discharged home with outpatient psychiatric follow-up instructions. Can a Baker Act be reinstated after the initial 72 hours is up?

While the Baker Act requires a non-designated hospital to transfer a patient under a Baker Act involuntary examination within 12 hours of medical stabilization and the exam period actually expires after 72 hours, most risk managers would advise you not to release a person who appears to still meet the criteria for involuntary placement. It sometimes comes down to a dilemma of exceeding the maximum period permitted under the law or risking a wrongful death. There is no remedy in Baker Act for failure to transfer within the 12 hour period.

Your practice of discharging people home with follow-up instructions is entirely appropriate if the persons no longer appear to meet the criteria for involuntary placement. In fact, sending persons who don't appear to meet criteria on to a receiving facility for examination makes the problem even more serious by having them compete for scarce beds with persons who actually do need to be in a locked psychiatric facility for examination. Many people stabilize quickly without necessitating such a transfer.

It is the patient's right not to have his/her liberty denied for the purpose of Baker Act involuntary examination for longer than 72 hours. Stacking one BA-52 on top of another doesn't legally extend the period under which you're authorized to hold the patient.

You have a number of options:

- You can transfer the person to any receiving facility; not just the nearest one.
- Your own emergency physicians are authorized to perform the examination and release the person directly when psychiatrically stable
- You can contract with a clinical psychologist to come to your ER to perform the examination and release the patient if he/she doesn't meet criteria Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so.
- Have the psychiatric consultant used by your hospital examine and treat the person in the ER to psychiatrically stabilize & release.
- Request that the receiving facility conduct the involuntary examination on site at your hospital and release.
- Have receiving facility psychiatrist or psychologist examine the person at your hospital and file the BA-32 petition with the court, placing top priority for admission of the person to the first available bed.
- If person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient". [394.4599(2)(c)4]

Any hospital that is unable to meet its legal duty to transfer the patient within the 12 hours permitted by law should contact DCF and/or AHCA to self-report. This report can result in any one of several outcomes: It documents good faith effort to comply with law (log date/time of each call, person spoken to, exact response received), they may be able to help in expediting the needed transfer, and it informs them of receiving facility bed shortages. DCF and AHCA can also verify the actual census at receiving facilities in your area to ensure that correct information about availability of beds is accurate.

Q. As one of the hospital's Risk Specialist we get calls related to the Baker Act. This question is relates to the 72 hour clock for Baker Acts. When a person is Baker Acted and a medical condition exist (eg. heart attack) or arises during the hospital stay what happens to the 72 hour clock? We know it stops until the patient is stabilized and when the physician documents the condition has been stabilized or didn't exist, the clock restarts. We seem to have a difference of opinion as to the patient being stabilized verses medically cleared. A patient could be in an ICU and stabilized, but not medically cleared to be transferred out to a floor unit. So would the clock restart when the pt was in ICU and stable or after they are medically cleared and able to transfer out to a step down unit?

It is presumed that when a person has an emergency medical condition, he/she cannot be psychiatrically evaluated. Regardless of where that person is held in the hospital (ICU, ED, or elsewhere), as soon as that emergency medical condition no longer exists, the clock is ticking. An EMC is defined in chapter 395, the hospital licensing statute as follows:

395.002(8) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

It is possible that multiple “emergency medical conditions” can occur during a person’s admission if additional serious symptoms are observed. As you indicated in your question, the law refers to the date/time the patient’s attending physician documents that the patient’s medical condition has stabilized or that an emergency medical condition does not exist: If a person is medically stabilized and just waiting for transfer to the psychiatric unit, the 72-hour clock is ticking. If the condition still exists as defined above, the 72-hour clock is still on hold.

Q. A person involuntarily placed in our state treatment facility required emergency medical treatment and was sent to the local ER where he was treated and admitted to CCU prior to his return here. While in the ER, the physician initiated an involuntary examination even though the individual was still under court order to us and will return to our treatment facility. What happens to that Involuntary Exam? The implication is around screening and reporting and other issues that I may not be familiar with.

When the person was transferred from the treatment facility to the medical hospital for examination and treatment of the emergency medical condition, it is assumed that documentation of the person’s legal status was transferred at the same time. This would have ensured that the medical hospital knew that the person was already on an involuntary inpatient placement order and that no new involuntary examination would be necessary. Of equal or greater importance would be knowledge of any guardian or guardian advocate appointed by the court who could provide decision-making for the person to the limits of the authority granted by the court. Some orders are just for psychiatric treatment and others have authority to consent to medical treatment as well, depending on the contents of the court order.

The only provisions in the Baker Act law and rules dealing with this issue are as follows:

394.4573, F.S. Continuity of care management system; measures of performance; reports.--

(1) For the purposes of this section:

(d) Require that any public **receiving** facility initiating a patient transfer to a licensed hospital for acute care mental health services not accessible through the public receiving facility shall notify the hospital of such transfer and send all records relating to the emergency psychiatric or medical condition.

65E-5.1304, F.A.C. Discharge Policies of Receiving and Treatment Facilities. Receiving and treatment facilities shall have written **discharge** policies and procedures which shall contain:

- (1) Agreements or protocols for transfer and transportation arrangements between facilities;
- (2) Protocols for assuring that current medical and legal information, including day of discharge medication administered, is transferred before or with the person to another facility; and
- (3) Policy and procedures which address continuity of services and access to necessary psychotropic medications.

As you can see from the statutory provision, this only references public receiving facilities – not treatment facilities (state hospitals). The FAC reference only references discharge policies and procedures, not transfers. Both fall short of addressing your issue directly. However, the two references give good guidance in any case. Confidentiality of the legal status of the person should not be a barrier to sharing this information with the medical hospital. HIPAA allows for release of information for the treatment of the person without prior consent. The Baker Act also permits such release as follows:

394.4615 Clinical records; confidentiality.--

(3) Information from the clinical record may be released in the following circumstances:

(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

With regard to what happens to the BA-52 initiation form, it would remain in the medical hospital's record and be noted that it was completed in error since the person had already been court-ordered for placement. The existing order of the court for involuntary inpatient placement would still be valid until such time as the treatment facility "discharged" the patient as not meeting criteria or the patient was transferred to voluntary status.

Baker Act Reporting

Q. If a person is admitted involuntary and within the first 24 hours, signs voluntary - do we still send the Cover Sheet to AHCA? Do we still notify next of kin?

All persons "accepted" by a receiving facility on involuntary status must have the form submitted to the BA Reporting Center. It is irrelevant whether the person transfers to voluntary status after arrival at the facility.

Q. Why do receiving facilities have to send copies of the involuntary examination initiation forms and cover sheet initiating involuntary examinations to the Agency for Health Care Administration?

AHCA, through the University of South Florida, Louis de la Parte Florida Mental Health Institute, is required by the Florida Legislature to receive these forms (mailed within one working day after each person's admission). AHCA is required to prepare an annual report analyzing the data obtained from these documents and submit the report to the Department of Children and Families and to legislative leaders. No patient identifying data is included in these reports.

Q. How many involuntary examinations are initiated throughout the state each year?

There were more than 136,000 involuntary examinations initiated in 2009. This number has increased most years since this reporting system was initiated in 1996. The increase doesn't necessarily imply an increase in involuntary examinations, but could be a result of improved compliance with the law by receiving facilities and those persons initiating involuntary examinations.

Nursing Home/ALF Initiations

Q. Officers were dispatched to nursing home about a 90 year old male patient with Dementia who was acting violent towards staff. The staff member who called it in used the words "a danger to himself and others", obviously schooled in the wording for BA 52. Our officers arrived and found the patient sitting in a chair, with staff members close by. The patient was not acting out at this time. They spoke to the nurse -- the conversation was tense due to the fact the Officers ask the nurse why the on-call Doctor could not Baker Act the patient or the facility medicate the patient. The nurse explained the Doctor was three counties away and said the patient was not cooperative enough to be medicated as well as he was a new patient and she was not sure what meds he was prescribed. It was agreed upon by all parties, including the nurse that the patient would voluntarily go to the receiving facility hospital to be treated for some minor cuts and be psychiatrically evaluated. The patient indicated he would go to the hospital. We believed that while the patient was at the hospital, a doctor would review the patients file and complete a BA 52. EMS took the patient to the hospital. We later heard from the nurse that the patient was cooperative at the hospital and was going to be released because he did not qualify for any evaluation and his medical concerns were addressed. The hospital indicated that the nursing home was just as equipped to handle him as the hospital was. The nurse said the responding officers that they couldn't Baker Act a patient with Dementia – she wants the statute number for their report. The nurse seemed angry because the patient was going to be returned and they were going to have to deal with him. Was the law enforcement response appropriate?

This is complicated, but that doesn't justify why your officers have been treated this way. Your jobs are hard enough without having to put up with this. I'm a little confused

– thought the facility at this location that we’ve discussed on several occasions is a nursing home – not an ALF. Specifically:

1. The definition of mental illness doesn’t currently preclude a diagnosis of dementia or Alzheimer’s Disease. It must be a serious thought or mood disorder regardless of cause, with the exception of developmental disabilities, substance impairment, or anti-social behavior. [394.455(18), FS]
2. The Baker Act is only for psychiatric examination and short-term psychiatric treatment. If a licensed facility staff know the resident’s diagnosis, a psychiatric examination might not be needed. If the resident’s dementia cannot be helped by short-term psychiatric treatment, no purpose is served by the transfer. The federal OBRA law requires that a resident’s specialized needs be met in place whenever possible, rather than undergoing a transfer to a different facility.
3. I find it problematic that the physician with whom the nursing home contracts is three counties away and unavailable to meet the needs of the residents. Most physicians have on-call back up for when they cannot meet their obligations. I find it just as problematic that the facility accepted the resident, but didn’t know what medications he was on. Neither of these is acceptable and should be reported to AHCA.
4. Since 1996, a nursing home cannot transfer a person age 60 or older to a hospital or other receiving facility for **VOLUNTARY** admission under the Baker Act unless it has first arranged an independent evaluation by an authorized mental health professional to certify that the resident is able to make well-reasoned, willful and knowing medical and mental health decisions. This professional cannot be employed by, under contract with, or have a financial interest in either the nursing home or the hospital/receiving facility to which the resident is to be sent. Failure to have this done must be reported by the receiving facility to AHCA by certified mail within one working day. [394.4625(1)(b) and (c), FS] Chapter 400, FS that governs nursing homes states that failure to comply with the criteria and procedures for voluntary, involuntary or transportation provisions of the Baker Act shall be grounds for action by AHCA against the nursing [home](#). [s.400.102(3), FS or s.429.14(1)(d), FS]
5. Regarding **INVOLUNTARY** examination, this can be initiated by any one of the authorized mental health professionals (physicians, clinical psychologists, LCSW, licensed mental health counselor, marriage & family therapist or psychiatric nurse – each as defined in the Baker Act). [394.463(2)(a)3, FS] It doesn’t need to be a physician to initiate and I’m sure the nursing home has a social worker or psychologist under contract. There is no requirement for the mental health professional initiating an involuntary examination to be independent from the nursing home. Only in cases of active danger should law enforcement be called to initiate. The officer only has a duty to initiate if he/she has reason to believe that each of the criteria is met – if not, there is no duty to do so. If the nursing home doesn’t agree, it can send an individual who has witnessed the behavior to the Clerk’s Office at the courthouse to file a petition for an ex parte order or it can get one of its other authorized professionals to conduct an evaluation to see if each of the criteria is met [394.463(2)(a)(1) or (3), FS]. The professional would have to observe the behavior directly in order to reach a conclusion the criteria is met.

6. Once the examination has been initiated by any of the three methods, law enforcement will be called for transport. If the officer believes for the safety of the officer or the resident that medical transport should be provided instead, the back of the 3100 Transport form can be jointly completed by the officer and EMS.[394.462(1)(d), FS]
7. It didn't sound as if the minor cuts required hospitalization and that the purpose of the transfer was actually for the psychiatric examination. If so, the transfer by the nursing home for voluntary admission was illegal. Expecting a mental health professional at the hospital to initiate the involuntary examination is not appropriate. The physician would have had to personally observe the behaviors to conclude that each of the criteria appeared to be met. Apparently that didn't happen and the hospital had no choice but to release the man back to the nursing home.
8. If the nursing home is unable to meet the resident's needs, it should arrange his transfer to another nursing home that can meet his needs. A Baker Act receiving facility isn't a destination as it can only perform an examination and short-term treatment. The examination is for transfer – not discharge.

It sounds like your officers handled the situation very well under difficult circumstances. If the facility is licensed as an ALF instead of a nursing home, certain statutes are different. The federal OBRA law doesn't apply and ALF's do have a right, after notice is given, to discharge a resident.

Q. I was under the impression that there could not be a financial gain for the person signing the Baker Act involuntary placement. I have tried searching 394 F.S. but couldn't find this. I would appreciate your advice on this matter.

Certain persons from long-term care settings must have an assessment of competence to consent to voluntary admission and to treatment **before** they are moved from their residence. Competence to consent is defined in the law as being able to make well-reasoned, willful and knowing medical and mental health decisions. This section is as follows:

394.4625 Voluntary admissions.

(1)AUTHORITY TO RECEIVE PATIENTS.—

(b)A mental health overlay program or a mobile crisis response service or a licensed professional who is authorized to initiate an involuntary examination pursuant to s. 394.463 and is employed by a community mental health center or clinic must, pursuant to district procedure approved by the respective district administrator, conduct an initial assessment of the ability of the following persons to give express and informed consent to treatment before such persons may be admitted voluntarily:

- 1.A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility, adult day care center, or adult family-care home, when such person has been diagnosed as suffering from dementia.
- 2.A person 60 years of age or older for whom transfer is being sought from a nursing home pursuant to s. 400.0255(12).

3. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under chapter 765.

(c) When an initial assessment of the ability of a person to give express and informed consent to treatment is required under this section, and a mobile crisis response service does not respond to the request for an assessment within 2 hours after the request is made or informs the requesting facility that it will not be able to respond within 2 hours after the request is made, the requesting facility **may arrange for assessment by any licensed professional authorized to initiate an involuntary examination pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.**

As you can see, it is only for **voluntary** admissions that this independent prior evaluation of competence must be done. I don't see it happening often because the very lack of competence to make these decisions is typically the reason why a long-term facility would be seeking hospitalization for the resident.

If a resident isn't found by this independent licensed professional to be competent, an involuntary **examination** can be initiated by any one of the authorized professionals – physician, psychologist, psychiatric nurse, social worker, MH Counselor, or Marriage & Family Therapist (PA authorized by AG Opinion, not in statute). There is no prohibition on an authorized professional from initiating the **involuntary** examination on a person with whom he/she has a financial interest. There continues to be some interest in adding this prohibition to the involuntary examination section of the law as it is in the voluntary admission, but this could create significant problems.

The term Involuntary **Placement** is used by statute after the individual has been examined at a facility by two psychiatrists and a petition is filed within 72 hours with the court for continued treatment. In this case, the two psychiatrists could both be employed by the facility or be in practice together.

Q. We have an 82 y/o patient from a nursing home in our ED under a BA. The LCSW documented the patient is severely cognitively impaired, refusing care and food, is severely agitated and attempting to exit out of her wheelchair despite the fact she cannot walk independently. She stated she will find a way to kill herself. She has a diagnosis of depression, psychosis and dementia. Is this an appropriate BA?

As you know, the definition of mental illness requires a serious thought or mood disorder that impairs a person from being able to meet their ordinary demands of living, regardless of etiology (cause). While substance impairment, developmental disabilities, and antisocial behavior are the only exceptions, many individuals have co-existing diagnoses. As long as a person has a severe mental illness, it is irrelevant for the purpose of voluntary or involuntary admission under the Baker Act as to whether they may also have one of these other diagnoses. In addition to having a mental illness, the individual must suffer from passive danger (serious self-neglect) or active danger to self or others. The individual you describe appears to have a several serious diagnoses of mental illness as well as expressing a threat of suicide and is neglectful by refusing food

and care. It appears from what you describe that the LCSW was appropriate in initiating the involuntary examination.

Q. Can a person be sent from a nursing home or an assisted living facility to an emergency room for psychiatric assessment to determine if voluntary or involuntary examination is warranted?

NO. A person shouldn't be sent to an emergency room unless he/she has a medical emergency. If the person has a severe psychiatric disorder requiring hospitalization, facilities licensed under Chapter 400, F.S. must follow the voluntary, involuntary, and transportation requirements of the Baker Act as a condition of licensure. In such situations, before sending a resident out for a voluntary examination an assessment by an independent professional is generally required. Before sending a resident out for an involuntary examination, the initiation must be performed by an authorized mental health professional, a judge, or a law enforcement officer.

Q. I work as a clinical social worker in a nursing home. If there is a situation going on, and I get there later, can I still do a Baker Act based on what was reported to me - not what I actually saw? By the time I arrive, the resident may be calmed down. Please explain the 48 hour time frame. Can you still have the person Baker Acted if they are not actively showing the signs/symptoms when you assess?

No. A mental health professional authorized by law to initiate an involuntary examination under the Baker Act must reach their conclusion that the person meets all criteria based on their own observations. The back of the initiation form permits the professional to describe any additional information relied upon to reach this conclusion. However, such hearsay without the professional's own observations, would not suffice to initiate the examination. If you, as an authorized mental health professional, observed the behavior during an evaluation, you could postpone signing the form for up to 48 hours if a safety plan could be devised/monitored in order to avoid an unnecessary transfer of a resident who could be stabilized in place. This is always preferred to the damage that so frequently occurs resulting from transfers. If you haven't observed the behavior within the most recent 48-hour period, and when the situation is of imminent danger, the staff can call law enforcement to request initiation. If not of imminent danger, staff who witnesses the behavior can file a petition with the Clerk of Court to get an ex parte order for the person's examination.

Notices

Q. To whom does a notice of release need to be sent when a person arrived at or was placed on involuntary examination status? Our CSU sends the Sheriff's Office a certified letter for each person Baker Acted by the Sheriff's Office advising of the release date and information from the form CF-MH 3038. Is there some reason the other hospitals and receiving facilities are not sending us these forms? It's my understand from the CSU is that these are required by statute, is that correct?

The whole issue of release notices has come under some scrutiny in the last few years. As you noted, Chapter 394.463, FS governing involuntary examination has the following provision:

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

This speaks to a person who has "executed a certificate", but law enforcement officers don't do this. A law enforcement officer completes a "report" so I don't think the law ever actually required notices to law enforcement, although many facilities have done so over the years. I checked back on the notice form 3038 that I revised in 2005 and confirmed that I removed law enforcement from the form. It still lists "initiating person" on the bottom table of this recommended form, as well as the circuit court.

A few years back, a Baker Act receiving facility consulted with its legal counsel about sending notices to mental health professionals who completed the Certificate leading to the person's admission as required by state law. They were advised not to send such notices without the consent of the patient or it could result in a federal HIPAA violation. If federal and state law are in conflict, the law most protective of the patient's privacy would prevail.

Q. Baker Act/72 hour examination period: what if no guardian? Does the rule still apply? Can we in good faith let someone know that their loved one is in the hospital or gather information for the well-being and safety of the patient?

There is no reason why a parent or next of kin can't be provided with basic information on the person's current condition, without going into any excessive level of detail. You may wish to discuss this with your hospital attorney or compliance officer to ensure that you don't have any policies or procedures that may conflict with this. The HIPAA.gov website has many FAQ's that will help you

Q. When a non-US citizen (i.e. a British citizen) is involuntary for examination, are there any other notifications of his/her admission that need to take place in addition to AHCA and the LAC?

Yes, one additional notification is required for Foreign Nationals. These are individuals who are citizens of another country, even if they have dual citizenship with the United States. The Vienna Convention is clear in the treaty itself that the consulate must be notified anytime a foreign national is detained by law enforcement. The "Blue Book" that provides all the procedures allegedly is even more explicit in that such notification must be made even when any hospital (such as a Baker Act receiving facility) detains a person under any legal or administrative hold.

There is even more documentation supporting such notification for British citizens in the Anglo-American Agreement of 1953 which is a bi-lateral treaty between Britain and the United States that governs arrests of British nationals by American law enforcement.

Rebecca Budgen is with the British Consulate Office in Orlando -- should you need to reach Rebecca directly, her phone number is 407 254-3300.

The State Department's website on Consular Notification and Access provides all the information you could need on this subject. However, I've listed two of the FAQ's below that are most critical:

Q. If we have a foreign national detained in a hospital, do we have to provide consular notification?

A. Yes, if the foreign national is detained pursuant to governmental authority (law enforcement, judicial, or administrative) and is not free to leave. He/she must be treated like a foreign national in detention, and appropriate notification must be provided.

Q. When we notify the consulate, should we tell them the reasons for the detention?

A. Generally you may use your discretion in deciding how much information to provide consistent with privacy considerations and the applicable international agreements. Under the VCCR, the reasons for the detention do not have to be provided in the initial communication. The detainee may or may not want this information communicated. Thus we suggest that it not be provided unless requested specifically by the consular officer, or if the detainee authorizes the disclosure. Different requirements may apply if there is a relevant bilateral agreement. (Some of the bilateral agreements require that the reasons for the detention be provided upon request.) If a consular official insists that he/she is entitled to information about an alien that the alien does not want disclosed, the Department of State can provide guidance.

You can get any information from the State Department website at:

The State Department website is:

http://travel.state.gov/law/consular/consular_753.html or The U.S. State Department website is at www.state.gov Please check the following specific website www.state.gov/law/consular/consular_636.html

It has extensive information about Consular Notification and Access for foreign nationals, including great Frequently Asked Questions on every possible issue, phone and fax numbers for foreign embassies and consulates in the US, a poster with the legal notice in many languages, training materials, etc.

The home page has a great deal of information on Consular Notification and Access, part of which includes official instructions for Federal, State, and Local law enforcement and other officials concerning the rights of Foreign Nationals in the United States. You'll also find numerous free tools and resources designed to increase public awareness of our consular notification and access obligations.

You'll find information and guidance regarding:

- The arrest and detention of foreign nationals
- The deaths of foreign nationals
- The appointment of guardians for minors or incompetent adults who are foreign nationals

- Related issues pertaining to consular services to foreign nationals in the US

All levels of law enforcement must ensure that foreign governments can extend appropriate consular services to their nationals in the U.S. and that the U.S. complies with its legal obligations to such governments. It is essential that U.S. citizens be offered the same consular services when they are detained abroad. To require that of other countries, it is equally important that we provide this courtesy here.

These instructions must be followed by all federal, state, and local government officials, whether law enforcement, judicial, or other, insofar as they pertain to foreign nationals subject to such officials' authority or to matters within such officials' competence.

Your cooperation in ensuring that foreign nationals in the United States are treated in accordance with these instructions permits the U.S. to comply with its consular legal obligations domestically and will ensure that the U.S. can insist upon rigorous compliance by foreign governments with respect to U.S. citizens abroad.

To read further, please click on the links below:

- Consular Notification and Access
- Basic Instructions
- Detailed Instructions
- Mandatory Notification Countries and Jurisdictions
- Frequently Asked Questions
- Foreign Language Translations of Consular Notification Statements
- Legal Material
- Contact Information for Foreign Consular Offices in the U.S.
- Suggested Fax Sheet for Notifying Consular Officers of Arrests or Detentions
- Suggested Fax Sheet for Notifying Consular Officers of Death/Serious Injuries
- Identification of Foreign Consular Officers in the U.S.
- Training Resources
- All Consular Notification Requirements Remain in Effect
- Training and Outreach: State Department Activities to Advance CNA Awareness and Compliance
- CNA Process flowchart in .pdf format (Color version) and (Black and White version)

There is extensive training and educational materials on the website.

Q. Who has to receive a notice of the persons release from a receiving facility after an involuntary examination?

Notice has to be given to the person's guardian or representative, to any person who executed a certificate admitting the person to the receiving facility, and to any court that ordered the person's evaluation.

Medical Conditions

Q. If a person is brought in on a Baker Act and is admitted to a medical unit or transferred from inpatient psych to a medical unit, does the clock stop for the period they are in medical?

No, the clock doesn't stop when a person is on a medical unit, unless a physician has documented that the person has an emergency medical condition. It is accepted that a person can't be psychiatrically examined while having a medical emergency, but simple treatment of a medical condition wouldn't necessarily be a barrier to being examined psychiatrically while being examined or treated for a medical condition.

Q. A patient under the Baker Act is admitted to the hospital (which is a designated private receiving facility) with a medical crisis. While the medical crisis resulting from a suicide attempt was over in 3 days, she wasn't "medically cleared for 7 days as she continued to require medical treatment. The crisis might be over, but the patient is not medically cleared. She must be either discharged or transferred to a psych unit "somewhere". She is still depressed / suicidal and not able to be discharged home. The hospital has been unable to transfer her to a CSU or other psychiatric hospital bed due to other issues (beds full, medical complexities, etc.) within the 12 hours. Can a hospital file the Petition for Involuntary Placement from a medical floor?

The "involuntary examination" period of up to 72 hours can be extended for the period a physician has documented the presence of an emergency medical condition. It isn't extended simply for medical needs of the patient. It also doesn't affect the statutory requirement that once the petition for involuntary placement is filed, the hearing must be conducted within 5 days unless the patient, with concurrence of counsel, requests a continuation (delay) of the hearing.

Your entire hospital is designated as a receiving facility. A person held under the Baker Act can be placed in whatever unit of the hospital that would best meet his/her needs. This may require a medical overlay on the psychiatric unit or a psychiatric overlay on a medical unit.

The "12-hour" provision has no application to your hospital because it is a receiving facility and the patient is already at the facility. The 12-hour provision only has to do with hospitals that aren't designated.

There is no reason why a BA-32 petition for Involuntary placement couldn't be timely filed by the receiving facility administrator on a person held on a med-surg unit of the facility, based on the opinions of two psychiatrist who had examined the patient within the time frames required by law. If the patient remained in the medical unit on the day of hearing, the hearing would take place in the patient's room as opposed to the usual location. If a "change of venue" was required by the court for a simple change of location within the same facility, this is permitted in the Baker Act "that the patient, the patient's guardian or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the patient."

All parts of any licensed hospital, regardless of whether it is designated as a receiving facility, is required by Chapter 395 (hospital license law) to comply with all requirements of the Baker Act regarding a person held under that law.

Q. We are seeking some guidance in clarifying some issues related to medical clearance and the Baker Act. Our facility is a private receiving facility. We have had several patients on a medical floor at our facility under a Baker Act that require some on-going inpatient medical treatment but are medically stable. Would the clock start at this time or when their inpatient medical treatment is complete and they are ready to be discharged from a medical floor? Can you please clarify the definitions of medical clearance and medically stable? Can you please clarify when the clock stops and starts per medical clearance purposes? What is our facility's responsibility when we have a medically cleared Baker Act and no psych bed to transfer in the community or our facility? What happens when we go beyond the 12 hour window?

The 72-hour involuntary examination clock is ticking from the time a person arrives at the door of your hospital (or at the time the exam is initiated at your hospital). The only event that stops the clock is an "emergency medical condition" as defined in the hospital licensing law:

395.002, FS

(8) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

The clock stops when a physician documents that an emergency medical condition exists and starts again when the physician documents that the emergency medical condition has been stabilized. It is possible that an emergency could recur during the time of the patient's inpatient stay. The clock doesn't stop for mere medical procedures – just for an emergency as defined above.

Medical clearance and medical stability are defined by physicians or other authorized medical professionals. The Baker Act doesn't address this issue.

The 12-hour issue is not applicable to your hospital because your whole hospital is considered the designated receiving facility. That section of the law only applies to hospitals that aren't designated. In your situation, you have up to 72 hours in which to conduct the examination before releasing the person, converting to voluntary or filing the

petition with the court. The Baker Act law and rules don't direct where the patient is to be held while in your receiving facility. If you can't locate a psychiatric bed in your own facility or in another community based receiving facility, you can provide a psychiatric overlay to the person while in a medical bed.

Q. Recently our facility has had to send a couple of patients to the hospital for various illnesses. If the patient is on a 52, 32, or committed, does that order still stand when that patient returns to our facility? It is my understanding that if the physician "transfers" the patient for medical attention and not "discharge" the order stays the same, unless the physician say's that the patient is no longer incompetent or does not meet the criteria for placement. There is some confusion as to whether the physician should discharge the patient to the hospital for treatment, then readmit the patient after being medically cleared.

You are correct that a person under involuntary status who continues to meet the criteria for involuntary examination or placement should not be "discharged". The Baker Act gives the facility the power to discharge a person who no longer meets criteria. Persons continuing to meet criteria who need a service unavailable through your receiving facility such as medical care or care at a state mental health facility should be "transferred" for this purpose to retain the legal status as well as the guardian advocate who may have been appointed by the court.

In the case of involuntary examination status, the 72-hour exam period may be extended if the person has an emergency medical condition. In cases of involuntary placement, the term of the order is not extended for purposes of medical emergency.

A person continuing to meet involuntary examination/placement can be further transferred back to your receiving facility under the same order. This prevents a person from having his/her liberty denied for a period not permitted under the law.

Q. As our hospital is a Baker Act receiving facility. Are we required to initiate the Petition for Involuntary Placement if a baker act patient is not medically cleared for transfer to our psych unit or does the 72hrs stop until such time that the patient is medically cleared?

The 72-hour clock starts to tick as soon as the person arrives at the hospital. It stops when a physician documents that an emergency medical condition exists and starts back up again as soon as the emergency medical condition has been stabilized or determined not to exist. Any time sitting in the ER waiting for a bed is counted against the 72 hour maximum as is the time sitting on a medical unit waiting for transfer. Even a person who has a medical condition that isn't of an emergency nature is presumed to be able to undergo the psychiatric examination for which he/she was brought to the facility.

394.463 Involuntary examination.--

(2)(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency

medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

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

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available.

The above provisions don't link together well since they were actually written to address circumstances when a person was taken to an ER of a non-designated hospital and still required the involuntary examination at a receiving facility. However, to read it any differently would mean that a hospital designated as a receiving facility wouldn't be able to stop the clock at all for an emergency medical condition.

The determination that the person's "medical condition has stabilized or that an emergency medical condition does not exist" is left to the person's attending physician. This is a clinical decision that is not defined in the Baker Act. You may have some individuals with a continuing medical condition who require a medical overlay on the psychiatric unit or a psychiatric overlay on a medical unit. Assuming that the person doesn't have an emergency medical condition, the clock is ticking and a petition for involuntary placement would have to be filed with the clerk of court within 72 hours of stabilization of the person's medical condition.

Q. I am working with the hospital regarding the fact that the entire hospital is a receiving facility not just the inpatient unit. The main question that I am being asked is, (for Baker Acted patients); When does the clock start ticking when the patient has been admitted to a medical floor? My response was; when the medical condition has been stabilized and the patient can participate in the evaluation. Who decides when the condition has stabilized? My second question is somewhat more complicated in that regardless of whether the patient has been medically stabilized, if they are Baker Acted and in need of psychotropic medication then don't we have to follow 394 and file the legal documentation as we would any patient that was on the inpatient psych unit?

DCF has always considered the entire premises at the address of the designation letter as the receiving facility. This has been part of the official training and has been included in many responses provided by DCF. DCF has not designated only a certain number of

beds in the past and it has always interpreted the law to mean the whole facility, not just a certain number of beds or only one unit (not others), DCF is confirming with AHCA this position now and we expect to hear confirmation soon.

With regard to your two specific questions:

1. When does the clock start ticking when the patient has been admitted to a medical floor? My response was; when the medical condition has been stabilized and the patient can participate in the evaluation. Who decides when the condition has stabilized?

The 72-hour clock starts to tick as soon as the person arrives at the hospital. It stops when a physician documents that an emergency medical condition exists and starts back up again as soon as the emergency medical condition has been stabilized or determined not to exist. Any time sitting in the ER waiting for a bed is counted against the 72 hour maximum as is the time sitting on a medical unit waiting for transfer. Even a person who has a medical condition that isn't of an emergency nature is presumed to be able to undergo the psychiatric examination for which he/she was brought to the facility.

394.463 Involuntary examination.--

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

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

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available.

The above provisions don't link together well since they were actually written to address circumstances when a person was taken to an ER of a non-designated hospital and still required the involuntary examination at a receiving facility. However, to read it any

differently would mean that a hospital designated as a receiving facility wouldn't be able to stop the clock at all for an emergency medical condition.

The determination that the person's "medical condition has stabilized or that an emergency medical condition does not exist" is left to the person's attending physician. This is a clinical decision that is not defined in the Baker Act.

You may have some individuals with a continuing medical condition who require a medical overlay on the psychiatric unit or a psychiatric overlay on a medical unit.

2. Regardless of whether the patient has been medically stabilized, if they are Baker Acted and in need of psychotropic medication then don't we have to follow 394 and file the legal documentation as we would any patient that was on the inpatient psych unit?

Yes. If the person is being held under the Baker Act, express and informed consent for all psychiatric medications would have to be in accord with the requirements of the Baker Act statute and rules, wherever the patient was being held in the receiving facility.

Even hospitals that aren't designated as receiving facilities are required to comply with all aspects of chapter 394, FS for persons held under the Baker Act, as follows:

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

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

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

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

Assuming that the person doesn't have an emergency medical condition, the clock is ticking and a petition for involuntary placement would have to be filed with the Clerk of Court within 72 hours of stabilization of the person's medical condition.

Q. If a patient is on a medical unit under a Baker Act and it is documented the patient is medically cleared, when does the clock start ticking -- when the doctor writes the patient is medically clear in the chart or when the patient leaves the medical hospital?

The clock actually starts back up as soon as the physician documents that the emergency medical condition has stabilized or doesn't exist.

394.463 (2) Involuntary examination.--

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

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

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

These provisions were enacted by the Legislature after a widely reported problem was documented in which people in one area of the state were stacked up in ER's waiting for transfer to receiving facilities. It was intended to ensure a rapid transfer was done so the person's liberty wouldn't be unnecessarily denied while awaiting the involuntary examination.

Q. We are in the middle of a dilemma between a local hospital and a receiving facility. A client (with severe anorexia) was BA'd by a PsyD at the hospital and the nearest receiving facility was contacted. The receiving facility was unable to place the client within 12 hours and could not take her themselves because the receiving psychiatrist felt the client was too medically complex for a CSU. The receiving facility sent a PsyD to the hospital to re-evaluate the involuntary status

of the client as per the Baker Act law. The receiving facility PsyD rescinded the BA and documented her reasons quite well. When the hospital PsyD learned of the BA being rescinded, he got very upset and declared that the client was in fact still involuntary (although a new BA-52 was not signed). The hospital physician is not willing to release the patient to her husband. There is concern about her safety in terms of the eating disorder. She is not voicing suicidality, but she is certainly doing harm to herself. (She was only 58 pounds when she was admitted 11 days ago...now up to 70 pounds.) The client has an outpatient therapist and a dietician, and the receiving facility is willing to provide case management. Is the patient now voluntary or involuntary (or neither)? Is the receiving facility still obligated to take the patient or find placement? Is there any other help you could offer in this difficult situation?

The PsyD at the medical hospital completed his role by “initiating” the involuntary examination. It was entirely up to a physician or clinical psychologist at a receiving facility to “perform” or “conduct” that examination. If the initiating psychologist believes that the patient’s condition has deteriorated since the time of the earlier examination, he can initiate a new BA-52b. However, it appears that the patient’s condition has in fact improved. If a new BA-52b was initiated now, it might be inappropriate. The woman’s medical condition would definitely appear to be inappropriate for a CSU and her psychiatric needs would require a different type and much more extensive period of treatment than available in a CSU.

With regard to your specific questions:

1. Is the patient now voluntary or involuntary (or neither)? She would not be either voluntary (unless she is willing and able to agree to voluntary at the hospital) or involuntary. The legal limbo she is in isn’t permitted under the law. Since she isn’t appropriate under the Baker Act, the hospital should seek out other alternatives such as self neglect under chapter 415 or Expedited Judicial Intervention Concerning Medical Treatment Procedures under probate Rule 5.900. If the patient believes her liberty rights are violated, she would be able to file a petition of habeas corpus. The medical hospital, although not designated as a receiving facility, is obligated to protect the rights of any person

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

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

395.1055(5) governing rules and enforcement states “The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with

respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment”.

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

2. Is the receiving facility still obligated to take the patient or find placement? A receiving facility isn't required to accept a person for which it is unable to provide care. This is particularly true if the patient has been found not to meet the criteria for involuntary examination or involuntary placement under the Baker Act. If the patient had met the criteria for involuntary status, the public receiving facility would have the following responsibility:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

3. Is there any other help you could offer in this difficult situation? I have given the hospital some contact information for Eating Disorder treatment facilities. I have also contacted another hospital with a psychiatric unit and asked them to consider taking the client now that they have a bed. I just don't know if the client should be considered voluntary or involuntary.

You appear to have met your obligation under the law. Further, it appears to me that you've extended a great deal of assistance already, given that the client has an out-patient therapist and a dietician, and the receiving facility is willing to provide case management. .

Q. It was my understanding that if a patient is medically clear and in a hospital bed, the 72 hours begins. If the 72 hours ends prior to the patient getting to a psychiatric bed, a psychiatrist can examine the patient and write a new Baker Act based on current presentation. Please advise regarding the part about the legality of the psychiatrist's re-evaluation and writing a new Baker Act.

The Baker Act limits the period of time a person's liberty can be restricted for the purpose of involuntary examination to 72-hours plus the period in which a physician has documented the presence of an emergency medical condition.

394.463 Involuntary examination.--

(2) INVOLUNTARY EXAMINATION.--

(f) A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the

release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. **However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.**

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

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

There is no provision in law for subsequent BA-52's to be initiated as this would result in depriving the person of their liberty beyond the period allowed by law. Stacking one "Baker Act" on top of another doesn't extend the lawful period. This will be apparent to the Public Defender should a petition for involuntary placement be subsequently filed with the court. It would also be apparent to any plaintiff attorney who would review the record.

The only event that stops the 72-hour clock is the documentation by a physician of an emergency medical condition. Once the EMC is stabilized or found not to exist, the

clock is ticking even if the patient continues to have medical needs or remains in a medical bed. An EMC is presumed to preclude an examination from taking place, but the mere presence of a medical condition or retention in a medical bed wouldn't preclude the psychiatric examinations from taking place.

Since your hospital is designated as a receiving facility – not just the psychiatric unit – it is essential that the patient be examined within the 72 hour period allowed by law even if this means that a psychiatric overlay is provided on the medical unit or a medical overlay be provided on the psychiatric unit. In this way, the person's due process rights can be protected while their medical and psychiatric needs are met.

Q. I have been faced with an ongoing question from the emergency room of our local hospital. A patient is admitted to our facility on a form 52. If the patient for some reason has to be transported to the ED for treatment, admitted there, then later on is ready for discharge, what happens to the initial form 52? Will a physician at the hospital have to address the 52 or will the patient need to be reevaluated and placed on another 52?

Regarding the application of the Baker Act to persons who have emergency medical conditions, the 72-hour period permitted by law for the Baker Act involuntary examination to be conducted is tolled – the clock stops from the time a physician at a hospital examining the patient for the emergency condition determines the emergency exists to the time a physician documents that the emergency has stabilized or doesn't exist. Therefore, there is 72 hours plus the term of the emergency medical condition before the examination period runs out and the patient must be released, transferred to voluntary status or an involuntary placement petition is filed with the clerk of court.

The period of the emergency medical condition isn't addressed – it could be an hour, a day, or a week. The original BA-52 is still valid as long as the period of time the person was in your facility for psychiatric examination prior to transfer and the period of time at the ER after the emergency medical condition was stabilized doesn't exceed 72 hours. The patient can be returned to your hospital for continuation of the Baker Act examination for the time still remaining or if the emergency physician believes the patient doesn't meet criteria for involuntary placement, the ER physician can transfer the patient to voluntary status or can release the patient directly.

The provisions of law governing this issue are as follows:

394.463 Involuntary examination.--

(2) INVOLUNTARY EXAMINATION.--

- (f) A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may

not be held in a receiving facility for involuntary examination longer than 72 hours.

- (g) A person for whom an involuntary examination has been initiated who is being **evaluated or treated at a hospital for an emergency medical condition** specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. **If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination** (a physician or psychologist) and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), **the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services.** The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.
- (h) **One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:**
1. The patient must be examined by a designated receiving facility and released; or
 2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.
- (i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:
1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
 2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
 3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
 4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

The appendices of the Baker Act Handbook are intended to pull the law, rules, forms, and practices together, but they don't substitute for the statutory language.

Q. Where can a medical hospital without a psychiatric unit send a patient who needs medical treatment but is aggressive, combative and unmanageable? If, for instance, a person with severe mental retardation is brought to our ED, are there any facilities which can manage such a patient's behavior and also provide medical treatment, like IVs, injections, biopsies, surgical repair, etc.? A few years ago, we had a real psychiatric patient in our ED who was also combative. We tried to transfer to a nearby hospital with a psychiatric unit but they sent the patient back. We were later told by AHCA that we needed to be able to manage any patient that came into our ED. Our action plan was to get the appropriate medications in the ED and to train our security on take down, etc. I am wondering if we must generalize this advice to all patients and admit them as well.

Any form of developmental disability such as retardation, is excluded from the Baker Act definition of "mental illness". Therefore, unless the person has a legitimate co-existing diagnosis of mental illness that is the basis of the problem exhibited, he/she can't be placed under Baker Act involuntary examination or placement. Even if a co-existing condition did exist, the Baker Act doesn't authorize medical treatment – only psychiatric exam and psychiatric treatment.

Many people with very low IQ scores end up with psychiatric diagnoses solely because public and private insurance isn't going to pay for care of the retardation and its associated behaviors. They require a different diagnosis that is reimbursable. As a result, "convenience" diagnoses are created and a history of psychiatric hospitalizations result – often for behavioral control or caregiver respite. Chapter 393, FS governs developmental disabilities. There doesn't seem to be any provisions to deal with the situation you describe. However, the person may have a guardian or health care proxy to provide substitute decision making on behalf of the person. Such a decision-maker could possibly consent to medications that would permit medically necessary procedures to be accomplished at a general hospital without harm to the patient or the healthcare professionals.

While the Baker Act requires your ER to medically stabilize a person prior to seeking transfer of the person for psychiatric exam, you are also subject to the federal EMTALA law. When these two laws are in conflict, the federal law takes precedence. You would have to perform the required medical screening and if the person is found to have an emergency medical condition (including a psychiatric emergency or substance abuse emergency without other medical conditions), you would have to stabilize the person before transfer. Stabilization doesn't mean "treatment" – simply assuring the person doesn't deteriorate during or as a result of the transfer. You would also have to get a physician certification, share all medical records, get the other hospital's prior consent to the transfer, and arrange safe/appropriate method of transport. If you do all of these steps, you can assure full compliance with federal and state laws governing transfers.

This shouldn't imply that you have to admit persons for purpose of psychiatric examination and treatment, since you have no licensed psychiatric beds and don't have the capability to provide this specialty care. Some discussion with AHCA might need to occur to ensure no citations result.

Q. We have had a patient in our ED on five different suicide attempts in less than three weeks. He was transferred to a receiving facility each time and quickly released. The psychiatrist noted the patient had been admitted to psych facilities 20-30 times. Is there anything that can be done to stop this pattern or do we continue to go thru normal protocol?

The DCF Circuit Office will be following up on the care the man received at the receiving facility where he was sent and so quickly released each time. Without knowing more about the man's psychiatric condition, it's hard to tell whether the receiving facility had the authority to keep him longer – it must release persons when their psychiatrist or psychologist have documented that the individual doesn't meet involuntary placement criteria and who are unwilling to transfer to voluntary status. However, in every situation, the receiving facility is required to provide documented discharge/aftercare planning including linkage to an aftercare provider and access to needed psychotropic medications, among other things. If the receiving facility to which the man is being sent is a licensed hospital instead of a publicly funded CSU, you may also want to request AHCA review the hospital's practices for compliance with federal Conditions of Participation regarding discharge planning.

Each of these emergency psychiatric events runs the risk of the man suffering great harm and the pattern he demonstrates is a clear sign that the aftercare planning is not meeting his needs.

You, of course, need to continue to accept this man each time he is presented to you in order to meet your obligations under EMTALA. If your ED physicians believe him to meet the more stringent criteria for involuntary placement, they should continue to arrange appropriate transfers to receiving facilities. However, DCF may be in a position to assist in determining if he has a case manager currently assigned and to ensure a more appropriate aftercare plan is implemented.

Q. When does the 72-hour clock start to tick at a receiving facility that is NOT designated as a Hospital (under 395) for the involuntary examination? (no medical emergency issues needing clearance) Does the 72 hour clock start ticking upon the person's arrival at the locked receiving facility? OR does the 72 hour clock start ticking only after the doctor gives admission orders to the CSU?

The 72-hour examination period begins at the time of the person's arrival at the receiving facility. The receiving facility is everything on the premises of the address listed on the designation letter. If the person is first medically examined or treated at an ER, the clock starts when the person arrives at the ER and only stops for the period of time when an emergency medical condition exists.

The following statutory and regulatory provisions apply:

394.463(2) INVOLUNTARY EXAMINATION.--

(f) A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is

necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

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

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

The involuntary examination is also known as the initial mandatory involuntary examination.

(8) Disposition Upon Initial Mandatory Involuntary Examination.

(d) If the facility administrator, based on facts and expert opinions, believes the person meets the criteria for involuntary inpatient or involuntary outpatient placement or is incompetent to consent to treatment, the facility shall initiate involuntary placement within 72 hours of the person's arrival by filing a petition for involuntary placement... Such petition shall be signed by the facility administrator or designee within the 72-hour examination period. The petition shall be filed with the court within the 72-hour examination period or, if the 72 hours ends on a weekend or legal holiday, no later than the next court working day thereafter...

There may be circumstances in which there are less than 72 hours from the point of arrival to complete the examination and file the petition with the court. It must be filed within the 72-hour period unless the 72 hours ends on a weekend or legal holiday. If that 72-hour period ends after close of business at the court on a weekday, the petition would have to be filed early.

All references in law and rule limit any deprivation of liberty for the purposes of involuntary examination to the 72-hour period, in addition to any period in which an emergency medical condition is documented. This period of deprivation is not extended waiting for doctor's orders.

Q. I understand that once an involuntary examination under the Baker Act has been initiated that there is a 'pause' in the countdown of time if the client is sent out to a hospital from a free-standing receiving facility such as ours. However, if the client meets criteria for admission to that acute care hospital, are we able to complete a discharge on the client? Or are we expected to carry them on our census to hold the bed for them? We have several clients that have been at medical hospitals for days and the staff and physician are reluctant to discharge the patient.

You are correct that the 72-hour clock for involuntary examination under the Baker Act can stop when an emergency medical condition exists and starts back up when the EMC has been stabilized. It is also important that the person be "transferred" to the medical hospital instead of "discharged" to the hospital. As a receiving facility, you have the power to discharge a person who is found not to meet the criteria for involuntary placement. If the patient you transfer to a medical hospital still meets the criteria for involuntary status, the "transfer" instead of a "discharge" maintains his/her legal status and any substitute decision maker that may have been designated. It is recognized that some type of administrative or financial "discharge" must take place on the day of transfer to prevent incurring charges for the same person at two different facilities for the same day of care. However, your Baker Act chart would reflect a transfer – just as you do when a person is transferred to a state hospital.

It doesn't seem to be appropriate to keep a CSU bed reserved for a person transferred to a medical hospital when it might be needed by other persons. When the person is ready to return to your CSU after medical stabilization, you can then place priority on assuring the person the first available bed. Resources are so scarce these days that the greatest benefit needs to be derived from these publicly funded beds.

Q. I am the Emergency Services Coordinator of a rural CSU. One of our lead medical doctors is concerned about liability when it comes to any medical issues of someone who has been Baker Acted. He requests that everyone be seen by a medical doctor for screening before the psychiatrist calls in admission orders. My understanding is that we can NOT postpone admission due to "medical clearance", but can only postpone due to a medical emergency. We have set up a brief questionnaire to rule out any medical emergencies, such as chest pain, active bleeding, possible overdose, etc. but he does not feel that this is good enough and wants everyone to see the medical doctor before being admitted. I feel that if a person has a medical emergency, then we call 911 whether the person is admitted yet or not, but we should not postpone admission orders.

Your physician concern about the physical health of the patients is commendable; especially to rule out medical causes of what may appear to be psychiatric conditions. The Baker Act law requires that a physical examination take place within 24 hours of a person's arrival at your facility – since a psychiatrist is a physician, he/she can assess

the patient's medical condition. You must "accept" a person on involuntary status immediately, but "admission" may be delayed for up to 12 hours. The law and rule language governing this issue is as follows:

394.459 Rights of patients.--

(2) RIGHT TO TREATMENT.--

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

65E-5.160 Right to Treatment.

(3) The physical examination required to be provided to each person who remains at a receiving or treatment facility for more than 12 hours must include:

(a) A determination of whether the person is medically stable; and

(b) A determination that abnormalities of thought, mood, or behavior due to non-psychiatric causes have been ruled out.

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

(1) Emergency Screening. All persons who apply for admission pursuant to section 394.4625, F.S., or for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall be assessed by the CSU or by the emergency services unit of the public receiving facility. Each receiving facility shall provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and shall have policies and procedures for identifying individuals at high risk. No person can be detained for more than 12 hours without being admitted or released.

Not only are the above established in law and rule, but they are the standard practice in place for free-standing psychiatric programs throughout the state. Those designated receiving facilities that are part of general hospitals typically have patients delivered to their ED's where persons get their physical examination prior to admission. This is due to the federal EMTALA law requirements governing emergency medical conditions. Absent an apparent emergency medical condition that would, as you've indicated, require a call to 911, the purpose of the physical examination that may occur up to 24 hours after arrival is to confirm medical stability and rule out these non-psychiatric causes.

Q. Please explain the "12 hour" terminology in the law as it relates to "examination must take place within 12 hours of medical clearance".

Within 12 hours after medical clearance at an ER, a person on involuntary examination must either be transferred to a designated receiving facility that has the capability and capacity to manage the persons needs or examined by a physician or psychologist at the ER and released. A person must undergo a mandatory initial involuntary examination within 72 hours of arrival at an ER for treatment of an emergency medical condition (EMC). The 72 hour clock stops when an EMC is declared and starts back up again as soon as the emergency physician determines the person to be medically stable. There is then 12 hours for that hospital to transfer the person to a receiving facility for that psychiatric examination to take place.

Q. Can persons be re-Baker Acted (stacking one BA-52 on top of another) to extend the period of time our ER can legally hold them?

No. The law only permits a maximum of 72 hours to conduct the involuntary examination under the Baker Act. It is the patient's right not to have his/her liberty denied for longer than this period of time for purpose of examination -- not the physician's right to have more time to conduct the examination. If your hospital is not designated as a receiving facility by DCF, you have only 12 hours (not 72) to hold the person after the emergency medical condition has been stabilized or found not to exist. The only event that can stop the 72-hour clock is the documented presence of an emergency medical condition as defined in the hospital statute (395.002, F.S.)

While "stacking" one BA-52 on top of another to illegally extend a person's detention beyond the permitted time frame for psychiatric examination could potentially result in criminal, civil, administrative, or licensing issues for the doctor and the hospital, releasing a person who continues to be acutely dangerous to self or others could also result in liability. Your hospital's Compliance Officer, Risk Manager or attorney should assist physicians.

Q. Can a CSU or other free-standing psychiatric facility require "medical clearance" before accepting a person for involuntary examination?

CSU's shouldn't ever require "medical clearance" unless it is after a hospital has already examined/treated a person and a transfer from the hospital to the CSU is requested. CSU's, per 65E-12.107(1)(b), can refer persons requiring treatment for an acute physical condition to a hospital for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures. If a person is presented by law enforcement to a CSU and the facility staff believe the person requires treatment for such an acute physical condition, staff should call EMS for transport rather than having the law enforcement officer provide this transport. Neither the law nor the rule allows referral for "medical clearance" – just for an acute physical condition. Chapter 65E-12.107(1) establishes minimum standards for CSU's and states:

Referral. Individuals referred, or to be referred, to a receiving facility, who also require treatment for an acute physical condition shall be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures. Medical clearance shall be documented in the clinical record.

Chapter 65E-12 that governs CSU's and Chapter 65E-5 that governs all receiving facilities regarding medical oversight requirements and a reference from the Baker Act statute governing physical examinations are as follows:

65E-12.107, F.A.C. Minimum Standards for CSU's

(1)(b) Referral. Individuals referred, or to be referred, to a receiving facility under chapter 394, part I, F.S., who also require treatment for an acute physical condition shall be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures. Medical clearance shall

be documented in the clinical record. (This rule only permits referral for emergency medical treatment that has been identified by the CSU as needed – not medical clearance. When the emergency medical condition has been medically stabilized, the hospital staff shall then provide documentation of medical clearance.)

65E-5.107(2), F.A.C. Admission.

(b) 2. Initial Assessment. All persons admitted to a CSU shall be provided a nursing assessment, begun at time of admission and completed within 24 hours, by a registered nurse as part of the assessment process.

(c) Physical Examination. All persons admitted to a CSU shall be provided a physical examination within 24 hours of admission, based on program policies and procedures. The physical examination shall include a complete medical history and documentation of significant medical problems. It shall contain specific descriptive terms and not the phrase, "within normal limits." General findings shall be written in the clinical records within 24 hours.

65E-12.105, F.A.C. Minimum Staffing Standards.

(2)(a) Every CSU and SRT shall have at least one psychiatrist as primary medical coverage as defined in section 394.455(24), F.S. Back-up coverage may be a physician who will consult with the psychiatrist. The psychiatrist or physician shall be on call 24-hours-a-day and will make daily rounds...

(2)(b) The psychiatrist shall be responsible for the development of general medical policies, prescription of medications, and medical treatment of persons receiving services. Each person shall be provided medical or psychiatric services as considered appropriate and such services shall be recorded by the physician or psychiatrist in the clinical record.

(3) Sufficient numbers and types of qualified staff shall be on duty and available at all times to provide necessary and adequate safety and care. The program policies and procedures shall define the types and numbers of clinical and managerial staff needed to provide persons with treatment services in a safe and therapeutic environment.

(4) At least one registered nurse shall be on duty 24-hours-a-day, 7-days-a-week. The CSU physician should be prepared to provide for routine medical care as part of the CSU services. It should be referring persons to a hospital who require treatment for acute physical conditions.

Q. We are small community hospital and only have one psychiatrist on staff. We are not a receiving facility. Can any physician sign approval for release of a Baker Act? In other words, if a patient comes in through the ER and is Baker Acted either by law enforcement or the emergency physician, and the patient is transferred to a medical floor and to an admitting general practitioner either because of a medical condition or we are unable to get a receiving facility in a timely matter, is it true that only a psychiatrist, clinical psychologist, or emergency physician can authorize this approval? Or can the primary care physician approve the release of the patient? There is also times that the receiving facility or our physician will want the patient "medically cleared" before the transfer occurs.

The law states that a physician or clinical psychologist is qualified to perform an involuntary examination. However, for a person on involuntary status to be released

from a designated receiving facility, the release must be approved by a psychiatrist, clinical psychologist, or if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician.

However, since your hospital isn't designated as a receiving facility, the above provision doesn't apply. Instead, a Florida licensed physician or clinical psychologist are authorized to conduct the examination and approve the persons release after documenting the results of the examination. In the scenario you presented, the general practice physician is authorized to conduct the exam and authorize the patient's release from your hospital.

394.463(2) Involuntary examination.--

(f) A patient shall be **examined by a physician or clinical psychologist** at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be **released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician** with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. **If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record.**

Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

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

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

Elopement

Q. We had a Veteran transported from a CSU to the VA and after she got out of the transport she ran off. Please advise if the BA-52 still in effect until patient is evaluated or does it expire?

When a person on involuntary status elopes from a facility (before or after admission), law enforcement should be requested to assist in finding and returning the person to the facility. Until the Initial Mandatory Involuntary Examination is conducted by a physician or a clinical psychologist, the involuntary status is still in effect – it doesn't expire. It only expires at the end of the 72-hour examination period if no petition is filed with the court to extend involuntary status until the hearing or when a physician or clinical psychologist determine the criteria for involuntary placement don't exist, whichever is sooner.

If an extended period elapses before the individual is found and returned to the facility or the individual arrives back at the facility on his/her own accord, a mental health professional authorized to initiate an involuntary examination should assess the person for the purpose of determining whether the criteria for involuntary examination still exist and, if so, initiate a new BA-52b form.

Q. If a psychiatrist at our outpatient clinic initiates an involuntary examination (52b) and the patient left the clinic before law enforcement arrived to take the patient to the receiving facility and the patient can't be found because a spouse assisted the patient in leaving; then how long is this involuntary examination certificate good for? How long do the police have to pick up the patient and transport to the nearest receiving facility? Does a professional certificate expire?

There is no expiration of a Mental Health Professional's Certificate like there is for an ex parte order entered by a court. The Baker Act rule once had a 7-day limit imposed to limit the liability of law enforcement to continue to search for the person. Within this period the person would probably have been Baker Acted some other way, arrested, or stabilized on his or her own. However, this provision was removed several years ago because there was no specific statutory authority for such an expiration period. DCF has incorporated such a limit in proposed Baker Act legislation, but it hasn't been adopted by the Legislature.

Q. As an assistant state attorney, I have been approached by the local VA hospital with a questions regarding professional certificates and their need in an emergency situation. The scenario is as follows: Person presents at the VA, whether the E/R or for a scheduled visit and begins to present with signs and symptoms of mental illness – in the case they mentioned the person is having suicidal thoughts. The person listening begins to prepare a PC for involuntary examination but the person attempts to leave before it has been completed and handed to the VA police. The police are refusing to detain the person while the PC is being completed. Should the physician's verbal statement to the VA police officer that responds be sufficient to detain the person while the PC is being completed? or will the facility be forced to let the person leave the premises?

VA hospitals are subject to the federal EMTALA law that states that anything within 250 yards of the facility itself is included in the premises. The entire VA facility is considered a “receiving facility” for purposes of the Baker Act, not just the psychiatric unit or the ED. However, it is my understanding that VA hospitals aren’t being designated by DCF any more – that a different section of the Baker Act provides for VA, as follows:

394.4672 Procedure for placement of veteran with federal agency.

(1)Whenever it is determined by the court that a person meets the criteria for involuntary placement and it appears that such person is eligible for care or treatment by the United States Department of Veterans Affairs or other agency of the United States Government, the court, upon receipt of a certificate from the United States Department of Veterans Affairs or such other agency showing that facilities are available and that the person is eligible for care or treatment therein, may place that person with the United States Department of Veterans Affairs or other federal agency. The person whose placement is sought shall be personally served with notice of the pending placement proceeding in the manner as provided in this part, and nothing in this section shall affect his or her right to appear and be heard in the proceeding. Upon placement, the person shall be subject to the rules and regulations of the United States Department of Veterans Affairs or other federal agency.

(2)The judgment or order of placement by a court of competent jurisdiction of another state or of the District of Columbia, placing a person with the United States Department of Veterans Affairs or other federal agency for care or treatment, shall have the same force and effect in this state as in the jurisdiction of the court entering the judgment or making the order; and the courts of the placing state or of the District of Columbia shall be deemed to have retained jurisdiction of the person so placed. Consent is hereby given to the application of the law of the placing state or district with respect to the authority of the chief officer of any facility of the United States Department of Veterans Affairs or other federal agency operated in this state to retain custody or to transfer, parole, or discharge the person.

(3)Upon receipt of a certificate of the United States Department of Veterans Affairs or such other federal agency that facilities are available for the care or treatment of mentally ill persons and that the person is eligible for care or treatment, the administrator of the receiving or treatment facility may cause the transfer of that person to the United States Department of Veterans Affairs or other federal agency. Upon effecting such transfer, the committing court shall be notified by the transferring agency. No person shall be transferred to the United States Department of Veterans Affairs or other federal agency if he or she is confined pursuant to the conviction of any felony or misdemeanor or if he or she has been acquitted of the charge solely on the ground of insanity, unless prior to transfer the court placing such person enters an order for the transfer after appropriate motion and hearing and without objection by the United States Department of Veterans Affairs.

(4)Any person transferred as provided in this section shall be deemed to be placed with the United States Department of Veterans Affairs or other federal agency pursuant to the original placement.

While the above provisions seem to address “involuntary placement”, they don’t seem to address “involuntary examination” at a receiving facility.

In most circumstances, the law enforcement officer could stop the person and initiate the involuntary examination based on the circumstances of the incident – law doesn't require a LEO to personally observe the behavior – just to have reason to believe the criteria is met. However, the Florida Attorney General in Opinion Number: AGO 99-68 dated November 8, 1999 regarding the subject of Baker Act and federal law enforcement officers stated that since VA law enforcement officers don't meet the definition of "law enforcement officer" in the Baker Act, they can't initiate involuntary examinations or provide primary transport to receiving facilities. My presumption is that they can provide whatever other law enforcement duties permitted or required by their federal policies and procedures.

The VA policies and procedures govern their own law enforcement officers. However, it seems inappropriate to risk a wrongful death solely because of fear of a "false imprisonment" or "battery" charge if a veteran has eloped from the hospital before the PC can be promptly completed. The VA Risk Manager or attorney at the facility could probably answer this best.

Q. I'm a VA Police Officer stationed at an out-patient clinic. If a patient is put on a Baker Act by one of our doctors and then attempts to leave the clinic prior to the local police getting to the clinic, can I physically stop the person?

This isn't addressed under the Baker Act. It may well be covered under the VA Policies and Procedures. However, it makes sense that if you can safely intercept the person to prevent them from leaving the building or the property, that is always preferable to risking the person's life or safety through an elopement. However, if that isn't possible, you should immediately call local law enforcement that is responsible for the person's transport to a receiving facility anyway to locate the person and take him/her into custody.

Q. Since the Baker Act is silent on elopements from involuntary examination (and doesn't even use the word elopement or anything like it), what is the legal basis of law enforcement taking a person into custody who has eloped from examination? It would seem to me that it would be necessary to initiate a new examination in order to do this.

While the Baker Act is silent as to a law enforcement officer taking a person into custody after an elopement from a receiving facility (other than under an involuntary placement order), the following transportation and involuntary examination provisions of the Baker Act address the law enforcement transport issue.

394.462 Transportation.--

(1) TRANSPORTATION TO A RECEIVING FACILITY.--

(a) Each county shall designate a single law enforcement agency within the county, or portions thereof, to take a person into custody upon the entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the nearest receiving facility for examination.

394.463 Involuntary examination.--

(2) INVOLUNTARY EXAMINATION.--

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

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, **shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination.** The order of the court shall be made a part of the patient's clinical record. No fee shall be charged for the filing of an order under this subsection. Any receiving facility accepting the patient based on this order must send a copy of the order to the Agency for Health Care Administration on the next working day. The order shall be valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order shall be valid for 7 days after the date that the order was signed.
2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and **deliver the person or have him or her delivered to the nearest receiving facility for examination.** The officer shall execute a written report detailing the circumstances under which the person was taken into custody, and the report shall be made a part of the patient's clinical record. Any receiving facility accepting the patient based on this report must send a copy of the report to the Agency for Health Care Administration on the next working day.
3. A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall **take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination.** The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any receiving facility accepting the patient based on this certificate must send a copy of the certificate to the Agency for Health Care Administration on the next working day.

In none of these citations is the officer's responsibility specifically over after the first execution of the order or certificate. The key point is that the involuntary examination has not ended simply because the person has eloped - it is still in effect, because the person has not been released.

Q. I'm a hospitalist and do consultations in various medical services, at times for patients under Baker Act involuntary examinations. Occasionally these patients try to elope and leave the hospital. Does the staff on the medical floor have the authority to prevent them from leaving the floor under the Baker Act?

The Baker Act cannot be used to hold a person against their will for medical purposes in a hospital. However, if the Baker Act has been properly used to initiate involuntary psychiatric examination (72 hours + time person documented as being in an emergency medical condition), the person can be held against their will or without their consent so the psychiatric examination can be performed. This doesn't provide any authorization for medical treatment while at the hospital, but the person may be receiving medical treatment at the hospital concurrent with the psychiatric examination. Unfortunately, the Baker Act is misused frequently for a variety of purposes. It is no more and no less than Florida's Mental Health Act and can't be legally used for any other purposes. There is a risk of battery or false imprisonment for such misuse.

Q. A law enforcement officer asked if a Missing Person adult is at a facility under involuntary status and the person leaves the facility prior to being admitted, and is recovered more than 48 hours later, does the officer have the right to take the Missing Person into custody and transport him/her to a receiving facility?

Yes, if no more than 72 hours (rather than the 48 hours in your situation) has elapsed from the person's arrival at the facility. However, if the 72-hour time period has elapsed, the officer always has the option of initiating a new Baker Act involuntary examination if he/she believes the person appears to meet the criteria. If the facility from which the individual departed while on involuntary status has this occurring frequently, the DCF Circuit staff should follow-up to ensure the facility institutes immediate corrective action to prevent such departures.

Q. Escape or Elopement of Patients is addressed in Appendix F 3 of the Baker Act Handbook. If a patient is on an involuntary examination status and within 72 hours of arrival at the facility appears to meet the criteria for involuntary placement, but prior to the Petition for Involuntary Placement petition being filed with the court, the patient elopes, Appendix F states that the law enforcement agency should be provided with a copy of the original ex parte, or Baker Act and requested to take the patient into custody. How long is that ex parte order or Baker Act Certificate valid? is there a time limit? If the law enforcement agency knows exactly where to find the patient, it might not be an issue. However, if the patient's whereabouts are unknown, and there is no prescriptive timeframe, how long is it valid?

The Baker Act doesn't address any stopping of a clock because of an elopement as it does when a medical emergency arises during an involuntary examination. The ex parte order is only valid until it is executed. Since it would have been executed when the person was brought to your hospital for examination, it would only be valid to document for law enforcement the need to complete the examination. If the person cannot be found and returned within the original 72 hours, a new BA-52b could be completed by a law enforcement officer or a mental health professional. This wouldn't be considered to be stacking one Baker Act on top of another because a period of freedom would have occurred between the two episodes of hospitalization.

Q. Yesterday we had an involuntary admission with a Report of Law Enforcement. The document had the veteran's alias name on it (different first name, same last name as our records). Do we need to take any extra steps legally?

No extra steps are needed. You would just note in your clinical record that the Report of Law Enforcement included an incorrect first name, but was indeed for your veteran, regardless of the alias. You might want to include the correct first name of the veteran on the cover sheet submitted to AHCA – Baker Act reporting Center even though it differs from the first name on the Report of Law Enforcement.

Miscellaneous

Q. Our county jail has an individual found incompetent to proceed and scheduled to be sent to a state forensic hospital; a hearing is scheduled next week. The Clerk of Court has asked our hospital to admit the individual to our psychiatric unit for evaluating him for appropriateness of care in our setting. We evaluated the individual and found this person didn't meet criteria for admission. Then we were unsure of what to do because the patient came into the facility with a court order titled: Order Adjudging Defendant Incompetent to proceed and commitment to DCF. Our attorney/risk manager was unsure of what to do. We were advised by DCF/MH that since the person didn't meet criteria for inpatient psychiatric stay to contact the jail to pick her up. Shortly after this, we received another call from the public defender stating that the judge was going to write an ex parte for commitment. We did receive that order via fax, however, we were full and had psychiatric patients in our ED that we were referring to other facilities. We explained to the public defender that we had no available beds, however there were beds in the surrounding county, to which we were making referrals. This person was accepted by another facility that had open beds. Is this proper?

There is no reason why a person awaiting for transfer to a forensic unit couldn't be appropriate for a voluntary or involuntary admission under the civil Baker Act law. If the person otherwise meets criteria for admission, you could admit but would only discharge back to law enforcement because of the criminal charges. However, an admission doesn't equate to permission to treat the person. If competent to consent (different than competence to proceed with criminal charges), he/she could consent or refuse consent to treatment after full disclosure. If unable to make well-reasoned, willful and knowing decisions about care, no treatment can be provided short of an emergency treatment order if imminent danger is documented. The only other alternative for treatment is if an involuntary examination has been initiated and a family member or close personal friend is available and willing to serve as a health care proxy.

You are correct that you can't just keep a person against his will or without his express and informed consent in a civil mental health facility unless an involuntary examination has been initiated by a circuit court judge via the exparte process prescribed in the law, by a law enforcement officer, or by one of the authorized mental health professionals. In any case, there would have had to be reason to believe that each of the statutorily required criteria was met. The circuit judge would have been authorized to enter an ex parte order only if it were based on sworn testimony in the court file, as follows:

394.463(2) Involuntary examination.

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

1.A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral...

If your attorney questions the validity of a court order, he/she should contact the court and request reconsideration of the court's actions. The order can't be ignored. The other problem existing is that of your obligations under the federal EMTALA law to "accept" anyone brought for services and to provide a screening to determine if an emergency medical condition (even a psychiatric emergency absent any other medical condition) existed. If so, a transfer to another willing facility with the capability and capacity to meet the individual's specialized needs would have been appropriate if you didn't have the capacity or capability in your own facility. It appears that you did all you could do under the circumstances on behalf of the individual and your facility. You may be able to avoid future incidents like this if your corporate attorney communicates with the court.