



Baker Act Basics

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Background

In 1971 the Florida legislature made the first revisions in 97 years to the Mental Health Laws in Florida (Florida Statutes, Chapter 394 and 65E-5 Florida Administrative Code). These revisions were comprehensive and dramatic with the intent to bring about a prohibition of indiscriminant admission of persons to state institutions and “retention without cause” as had been the practice for many years. Prior to these revisions, the only requirement for commitment to a state hospital was for three people to sign a petition, present it to the county judge for approval, and the sheriff would pick up the individual and transport them to the state hospital. Once hospitalized, there were no discharge plans, and it was common for individuals to languish in State facilities for years.

The 1971 Mental Health Law or Baker Act was named for its sponsor, State Representative Maxine Baker of Miami. It established criteria for involuntary placement and afforded legal representation for patients. The law also established a patient bill of rights which includes the right to be treated with dignity, participate in their treatment and discharge plan; communicate with persons outside the facility by phone, mail or visitation; send and receive mail, to use their own possessions as long as they are deemed safe; vote while hospitalized, file a petition with the court if they question the legality of the involuntary examination and select or have a representative appointed on

their behalf. Patients found to have the capacity to consent are encouraged to seek psychiatric examination and treatment on a voluntary basis. The law set time limits to perform an involuntary examination (72 hours) and to transfer a patient to a designated receiving facility (12 hours) if taken to a hospital without the capability of performing an involuntary exam. Baker Act patients can also not be incarcerated for their mental illness unless they have committed a crime. The Florida Mental Health Act (Baker Act) is intended to enable a prompt return to community life using available outpatient services whenever appropriate.

In 1996, additional reforms to the law were made increasing protection to individuals voluntarily seeking treatment, the appointment of trained guardian advocates as decision makers for those lacking the capacity to consent to make healthcare decisions. Standards for receiving facilities were more clearly specified and an application process, as well as audits and compliance standards were strengthened.

The most recent revisions in 2004 were significant in providing for court-ordered Involuntary Outpatient Treatment. The intention of this addition to the Baker Act was to encourage treatment compliance in community-based services.

The Baker Act was considered around the country as landmark legislation at the time of its enactment. As perspectives of the disorders, new treatment development, and federal and state budget shifts occur, the intent of Florida’s Mental Health Law is to continually make revisions reflective of these trends, as well as to protect the rights of persons with mental illness.

Purpose of the Baker Act

The purpose of the Baker Act is to assure appro-

appropriate, responsive care for persons with acute mental illness. It cannot be used to justify the examination and treatment of non-psychiatric medical conditions, to conduct diagnostic procedures or laboratory testing without the express and informed consent of the person or a legally authorized substitute decision-maker (Use Health Care Surrogate/HCS or Health Care Proxy HCP, Chapter 765 Part II, and Part IV respectively.) The Baker Act can only be used for initiating psychiatric examination and treatment.

Mental illness is legally defined by the State of Florida as:

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. It 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 Baker Act covers both voluntary and involuntary psychiatric examination of adults and minors (ages 17 and under). An individual, after "conscientious explanation and disclosure of the purpose of the examination," may request voluntary admission for examination. The present law in Florida does not allow minors to consent to examination, nor for their parents to initially consent for them unless a hearing is held with a judge or magistrate who determines the ability of the minor to be voluntary. Only one other state has the requirement for a voluntariness hearing for minors. Until a change is made in the statutes, this requirement will remain.

Criteria for Involuntary Examination (Chapter 394.463(1), F.A.C.)

Criteria for initiating an involuntary examination :

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

It is important to know that an involuntary examination cannot be lifted, rescinded, overturned or abrogated. Once an involuntary examination has been initiated, the exam must be completed to determine whether or not the patient meets involuntary placement criteria.

Professionals who can initiate an involuntary exam:

- law enforcement officer
- judge who issues an ex parte order based upon sworn testimony by one or more interested parties
- mental health professional, which includes a physician, clinical psychologist, psychiatric nurse which includes an ARNP with psychiatry certification, a clinical social worker or a licensed mental health counselor.

Physician Assistants, ARNPs, and residents in training cannot initiate an involuntary examination under the current law.

The health professional initiating an involuntary examination is required to complete a mandatory 3052B form which requires documentation of their examination and observations to substantiate the need for an involuntary examination. It may include collateral information, but cannot be based solely on collateral information.

Who is qualified to perform the involuntary examination?

1. Any licensed physician with experience in the diagnosis and treatment of mental and nervous disorders (such as a psychiatrist)
2. Clinical Psychologist

Mandatory Components of an involuntary examination:

- A thorough review of any observations of the person's recent behavior;
- A review of the document initiating the involuntary examination and transportation form
- 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.

It is the intent of the law to perform involuntary examinations without unnecessary delay and while there is a time frame of 72 hours in which to do them, they are frequently performed in less time.

If after the exam, it is determined that the patient does not meet criteria for involuntary inpatient or

outpatient placement, the patient can be released.

Other Considerations:

If a patient who has an emergency medical condition in addition to his/her emergency psychiatric condition, the 72 hour time frame for completing the exam and 12 hour time frame for transfer to a designated receiving facility is suspended until the emergency medical condition is stabilized. Once the treating physician documents in the clinical record that the patient's emergency medical condition is stabilized or no longer exists, the clock starts ticking again.

Hospital patients who have been "Baker Acted" are considered to have an emergency psychiatric condition and *requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) apply*. This means that Baker Act patients seen in the ED must receive a medical screening exam, stabilizing treatment within the capability of the facility and appropriately transferred as indicated to a psychiatric receiving facility. This also includes completion of the routine transfer certification form which should be sent to the receiving facility along with any other pertinent patient medical information. It is important to know that not all receiving facilities have the same capabilities for treating a patient's medical conditions and facilities not licensed as a hospital (such as crisis stabilization units) are not required to comply with EMTALA

Contrary to popular belief, Baker Acts initiated by a police officers do not require them to take the patient to a hospital ED to be "medically cleared". If the patient is not visibly hurt or otherwise doesn't appear to need medical attention, the police officer can take the patient directly to the receiving facility.

However, if the police officer presents with the patient to the ED, the hospital must provide a medical screening exam, treat and/or stabilize the patient within their capability and capacity and appropriately transfer the patient to a receiving facility.

The Florida Mental Health Law is available on-line and can be accessed at:

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

The appendices which contain frequently asked questions and responses are very helpful. The Florida Department of Children and Families which has oversight for mental health services, offers training in even numbered years and there is on-line training available through the Louis de la Parte, University of South Florida website providing Continuing Education Units. This interactive training provides an excellent opportunity to increase knowledge and expertise.

References:

Baker Act Handbook and User Reference Guide, 2006. State of Florida Department of Children & Families.

Catalyst: Newsletter of the Treatment Advocacy Center, 3300 N. Fairfax Drive, Arlington, VA 22201



Exercising Restraint

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Health care organizations around the world continue to make strides in the reduction of the use of restraints. In the United States, both the Centers for Medicaid Services (CMS) and the Joint Commission recently revised and tightened the standards for restraint use and seclusion in

health care.

A **physical restraint** is any manual method or physical or mechanical device, material or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

A **chemical restraint** is a medication used to control behavior or to restrict the patient's freedom of movement that is not a standard treatment for the patient's medical or psychiatric condition.

Seclusion is an involuntary confinement of a patient in a room or area alone where the patient is physically prevented from leaving. This is typically limited to inpatient psychiatric units.

There are two primary considerations when determining whether or not a patient should be restrained or placed in seclusion: 1.) Performance of an accurate patient assessment, 2.) Determination of what is the least restrictive measure that would meet the patient's needs and plan of care.

Education and training is an important component of the revised standards and staff need to be adept at identifying behavioral indications, application of restraints (whether chemical or physical), and the risks associated with restraint use for patients who exhibit violent/self destructive as well as nonviolent behaviors.

Training should address underlying causes of escalating behavior by patients which may include medical reasons such as pain, low blood glucose, increased intracranial pressure, drug toxicity; psychiatric reasons such as hallucinations, dementia, psychosis; emotional reasons such as fear, anger, frustration; psychosocial reasons such concerns about finances, relationships or housing and other

issues such as communication deficits or poor impulse control. These precipitating factors for patients in combination with visitors, discouraging news from health care providers, environmental factors such as noise or lighting, a staff member's response to the patient's behavior provide the milieu in which behavior develops.

Some early signs of escalating behavior may include anxiety such as pacing, tapping fingers, or any noticeable change from, or increase in, a patient's normal behavior. One appropriate response at this stage would be to be supportive, and listen to the concerns of the patient.

When behavior continues to escalate, e.g. the patient is asking a lot of questions, refusing to cooperate, raising his or her voice or ventilating about perceptions or feelings, verbal de-escalation techniques should be employed. Staff should be skilled in these techniques which include answering questions rationally, setting limits, and allowing patients to verbally vent, as long as it is in a place/situation where the patient, staff, and others are safe. Additional effective de-escalation techniques include distraction, encouraging patients to breathe deeply or to participate in activities which calm them, involving family members, or a 30 minute or less time-out in an unlocked room.

If verbal behavior escalates into threats, name calling or foul language, staff should seek assistance and not deal with the threatening behavior alone. If the patient's behavior becomes physically threatening, utilizing the chain of command including contacting security would be appropriate.

When patients exhibit violent behavior and non-restrictive interventions have been attempted and are unsuccessful, staff should follow their internal restraint and seclusion policy. (See Shands

Healthcare Core Policy 2.21.)

Facility restraint policies and procedures should address obtaining orders for restraints, physician evaluation of patients, initiation and application of restraints, restraint monitoring time frames, release of restraints and requirements for clinical record documentation.

Patients and families should also be educated on the facility's philosophy relative to restraints which should be reflected in the Patient's Rights and Responsibilities. It is also recommended, as early as possible in the restraint or seclusion process, that patients be informed of the behavior that caused their restraint and the behavior and conditions necessary for restraint release.



Case Reviews involving Restraints and Seclusion of Involuntarily Committed Patients

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On December 8, 2006, the Centers for Medicare and Medicaid Services (CMS) finalized the Patients' Rights Conditions of Participation applicable to all Medicare and Medicaid hospitals. The purpose of the rule is to require minimum protections for patient's physical and emotional health and safety. The regulation specifically supports patients' rights to be free from inappropriate use of restraint and seclusion. It does, however, recognize that there

are legitimate uses for restraint and seclusion. In light of these regulations, this comment will review and discuss two cases where restraints were used on involuntarily committed mental health patients and one case where seclusion was improperly used on a mental health patient.

The regulations provide, in part, that "The use of a restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient...and authorized to order restraint or seclusion by hospital policy in accordance with state law." It also states, "when restraint or seclusion is used, there must be documentation in the patient's medical record of the following: (i) the 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior..." The following cases discuss restraint and seclusion and point out the liability of hospitals and providers when they do not comply with the patient protections provided in the regulations.

Rohde v. Lawrence General Hospital (Mass. Ct. App. 1993)

On Nov. 12, 1987, believing him to have "some kind of mental problem" after being found at the scene of a minor car accident expressing "strange and irrational" thoughts, the local police brought Mr. Rohde into the hospital ED. While being examined, Mr. R jumped off the carrier and assaulted a clinician, after which he was handcuffed to the bed by the police.

After being successfully examined, he was diagnosed as having an acute psychotic episode. The examining MD admitted him to the hospital pending return of certain test results before transferring him to a mental health facility and entered an order for leather restraints. The primary nurse on duty at the time of his admission documented the removal of handcuffs and placement of 4-point

leather restraints.

A little over an hour later, Mr. R managed to free himself from the restraints and he left the hospital, hopped into an unlocked parked car in the hospital lot with the engine running, drove off, and crashed into a fence causing himself serious injuries.

Then he sued the hospital for negligently failing to secure the restraints, and failing to supervise him. The court stated that "the case could hardly be clearer for the responsibility of the hospital to place restraints on Rohde, as ordered by [the physician], and to provide the necessary supervision of Rohde while under restraints. This is a 'garden-variety case where...attendance was needed but lacking at the time.'"

Marvel v. County of Erie (N.Y. App. Div. 2003)

Mr. Marvel was involuntarily committed to Erie County Medical Center in July 1997. In the ED of ECMC, a nurse assessed Mr. M, found him to be intoxicated and since he was in involuntary status and threatening to leave, placed him in wrist restraints until he could be seen by a physician. After spending some time in restraint, Mr. M was examined by a resident; 15 minutes after which he freed himself, ran through the hospital, hung off the balcony, and fell 20 feet to the ground, injuring himself.

While the RN was aware of the hospital's policy requiring "constant supervision," she alleged that "constant supervision" did not require 1 on 1 supervision, merely that the patient be "in eyesight." Nevertheless, she admitted that Mr. M had not been continually kept in view of the staff prior to the physician's arrival.

Hospital policy also required that restraints be checked every 30 minutes and an assessment of the patient condition be made at least every 15 minutes and recorded. No such documentation was made. Further, contrary to both hospital policy and state

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law, the RN did not immediately summon a physician upon initiating the restraint. When the resident did arrive, he did not check the patient's restraints while with him. Additionally, the resident testified he was not even aware that the hospital had a restraint policy. Considering both the statutory requirement for constant supervision of involuntarily committed patients in restraints and the hospital's policies, and based on the nurses testimony and other evidence that Mr. M was left alone for a period long enough to undo his restraints and run through the hospital to the balcony, the court found that the hospital did not provide the requisite constant supervision.

Dohilite v. Maughon et al (11th Circuit, M.D. Alabama 1996)

David Dohilite, the minor son of the plaintiffs, was involuntarily committed to a state mental health facility because of problematic behavior at school and at home. During his initial assessment it was determined that David reported having attempted suicide, had frequent suicidal ideations, was obsessed with writing poetry about death, and had some family history of suicide. After his initial evaluations, David was assessed as giving the "diagnostic impression of conduct disorder solitary aggressive type."

The patient exhibited self-destructive behavior while at the facility, including making suicidal threats and gestures. At one point David told the nurse that he "was going to cut his arm off and kill himself." David was placed on continuous observation, i.e., one-on-one observation, until the next day when he was seen by a social worker who moved him to close observation with one-hour checks. In David's Progress Notes, the social worker indicated that his re-

ported suicidal thoughts were intermittent and without genuine intent and that he continued to enjoy the "shock value" of talking about suicide.

On numerous occasions, David was placed in seclusion after he destroyed facility property, threatened to cut himself with a piece of glass, and stated he was going to hurt himself if he got the chance. While in seclusion, David beat his head on a wall, cursed loudly and was described as "totally out of control."

The record reflects that during David's days at the facility, he was secluded for a period of fourteen hours, on dorm restriction for ten days, and in time-out for sixty-four hours. He was only seen by a psychiatrist twice.

About 70 days after his admission, he hung himself. He was resuscitated, but his injuries left him severely brain-damaged. His parents brought suit against the facility and all health care providers involved in his care for denying their son his constitutional rights. The case centered around the issue of whether the defendants actions were within their discretionary authority and so protected by sovereign immunity. The court allowed the case to proceed as to one of the defendants who, it determined, was not protected by immunity because of her failure to properly monitor the patient.

Risk Reduction Tips:

The primary risk reduction tip to be learned from these cases is to follow your hospital policy, which should reflect the governing legal and accreditation standards. The policy should specify, among other requirements, who is allowed to order restraints and seclusion for a patient, the monitoring requirements, and that least restrictive interventions are attempted and documented. It is also im-

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portant to be especially careful with patients who are involuntarily committed for mental health treatment. The threat of escape and injury, not injury from the restraints but from subsequent behavior, are elevated. Always provide appropriate supervision of at-risk patients. When necessary, go up the chain of command in the facility to ensure that the patient and the hospital are protected.



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