The Florida Senate

Interim Project Report 2005-110 *November 2004*

Committee on Children and Families Senator Walter "Skip" Campbell, Jr., Chair

MENTAL HEALTH PROFESSIONS AUTHORIZED TO INITIATE INVOLUNTARY MENTAL HEALTH EVALUATIONS

SUMMARY

In a given year, many Americans are affected by a mental disorder. At times, the symptoms of mental illness may become so acute that the individual is unable to function either socially or adaptively. Under the provisions of Chapter 394, Part 1, F.S., (the Baker Act), mental health services are provided to persons who are experiencing a mental health crisis. These services include admission, involuntary examination, and involuntary placement. This section of the law is designed to protect the rights and liberty interests of persons with mental illness as well as to ensure public safety.

Initiating an involuntary examination of an individual is a critical first step of the Baker Act process that can be made by a mental health professional specified in ch. 394, F.S. Once a decision is made to initiate an involuntary examination and the professional completes a "*Certificate of Professional Initiating an Involuntary Examination*," a process is put into motion that impacts a number of individuals, most significantly the person in mental health crisis.

During the 2004 legislative session, the list of professionals authorized to initiate an involuntary examination was expanded raising renewed interest in the types of professionals who perform this function (ch. 2004-385, L.O.F.). The addition of the mental health counselor to the list of professionals authorized to initiate involuntary examinations raised a number of questions and concerns around the potential for increasing the number of evaluations that are conducted, adding to the cost of completing these evaluations, and putting additional strain on an already stressed public mental health system.

This interim project was conducted in order to assess the practices of mental health professionals who initiate involuntary examinations. Staff examined those professional groups that are authorized to initiate an involuntary examination to determine the appropriateness of these professionals and to determine if the list should be expanded or reduced. Additionally, definitions for these professionals were examined to determine their consistency with other statutory definitions.

The review of the statutory definitions for mental health professionals confirmed that there are inconsistencies between the definitions provided in ch. 394, F.S., and those provided in other statutes. However, the project's examination of the appropriateness of the professionals who are authorized to perform the initiating function was unsuccessful in determining whether this list should be further expanded or reduced. This failure was largely due to the inability to connect client outcomes with professional practices due to data constraints.

However, staff's findings reflected that there were a number of practices pertaining to the involuntary evaluation process that could be improved upon. These findings include the need to expand the current data capacity to link professional decisions to client outcomes, to obtain identifying information from the professionals who are initiating involuntary evaluations, to improve the quality of the professional certificate, to provide more comprehensive training specifically related to the completion of the professional certificate, and to implement quality control mechanisms regarding the Baker Act process among the agencies sharing responsibilities for the process.

As a result of this interim project, a number of recommendations are made. One of these recommendations is to revise the definitions of mental health professionals to become more consistent across statutes, thereby reducing confusion regarding who may initiate an involuntary examination. Other

recommendations include a call for further study of the involuntary examination process to determine the degree to which professionals are inappropriately initiating involuntary examinations, the addition of a requirement that professionals who initiate an involuntary examination provide a legible name and license number, and a strengthening of the current data systems to allow for the evaluation of client outcomes. It is also recommended that a workgroup be convened to recommend changes to the current Baker Act training and to address the development of a new professional certificate. Finally, it is recommended that the Department of Children and Families (DCF), the Agency for Health Care Administration (AHCA), the Florida Mental Health Institute (FMHI), and the Department of Health (DOH) work together to implement quality control mechanisms to better manage the Baker Act process.

BACKGROUND

Introduction

It is estimated that one of five Americans is affected by a mental disorder in a given year.[1] At times, the symptoms of mental illness may become so acute that the individual is unable to function either socially or adaptively. Under the provisions of Chapter 394, Part 1, F.S., (the Baker Act), mental health services are provided to persons who are experiencing a mental health crisis. These services include admission, involuntary examination, and involuntary placement. This part of the law is designed to protect the rights and liberty interests of persons with mental illness as well as to ensure public safety.

Deciding to initiate an involuntary examination of an individual is a critical first step of the Baker Act process that can be made by a mental health professional specified in ch. 394, F.S. Once a decision is made to initiate an involuntary examination and the professional completes a "*Certificate of Professional Initiating an Involuntary Examination*," a process is put into motion that impacts a number of individuals. One of those most impacted is the individual in crisis who experiences a significant loss of personal liberty during and, potentially, beyond the examination process. Further impact is felt by law enforcement which is required to provide transportation of the individual to the receiving facility. Finally, when the individual arrives at a receiving facility, staff must complete an admissions process and further conduct an examination to determine if the individual meets commitment criteria. The process of involuntary examination and the series of steps it puts in motion can result in significant costs to the state. Currently, there is no mechanism to stop or redirect this process once a certificate has been issued.

During the 2004 legislative session, the list of professionals authorized to initiate an involuntary examination was expanded raising renewed interest in the types of professionals who perform this function (Ch. 2004-385, L.O.F.). This interim project looks at the mental health professionals who are authorized to initiate involuntary mental health examinations to determine the appropriateness of the professionals who are currently authorized to perform this function and to consider if the current list needs to be expanded or further limited. Additionally, definitions for these professionals are examined to determine their consistency with other statutory definitions and their appropriateness.

History of the Baker Act

In 1971, the Legislature passed the Florida Mental Health Act, also known as the "Baker Act" (chapter 394[part I], F.S.), which brought about a dramatic and comprehensive revision of Florida's 97 year old laws. At the time of its enactment, the Baker Act substantially strengthened the due process and civil rights of persons in mental health facilities and provided authorization to judges, law enforcement, and physicians to initiate a proceeding for "emergency admission,"[2] the precursor to today's involuntary examination process.

Since 1972, a number of amendments to the Baker Act have been enacted, many of which further protected individuals' civil and due process rights. In 1979, changes were made to definitions that expanded the types of professionals who could initiate proceedings for involuntary examination. This expansion was accomplished by changing the definition of "physician" to "mental health professionals." This term included physicians with mental health experience, licensed psychologists with post-license clinical experience, and registered nurses who had worked under the supervision of an experienced physician. Later changes (1982) resulted in the term "mental health

[1] *Mental Health, A Report of the Surgeon General*, Department of Health and Human Services, U.S. Public health Service, 1999.

[2] An "emergency admission" was the term used for the process by which individuals were taken to a receiving facility for evaluation.

professional" being deleted and replaced with a specific list of professionals who were authorized to initiate an involuntary examination.[3] Clinical social workers were added as one of the professional groups authorized to initiate an involuntary examination.

Currently, s. 394.463(2), F.S., provides for the involuntary examination of an individual to be initiated in one of three ways:

- A court may enter an ex parte order, based upon sworn testimony, directing a law enforcement officer to take the person to the nearest receiving facility.
- A law enforcement officer must take a person who appears to meet the criteria for involuntary examination into custody and deliver the person to the nearest receiving facility.
- A physician, clinical psychologist, psychiatric nurse or clinical social worker as defined in s. 394.455, F.S., 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.[4]

More than 100,000 involuntary examinations are conducted annually in the state of Florida. Reports indicate that the number of examinations has been steadily increasing over the past 7 years, and slightly more than half of these examinations are initiated by mental health professionals.[5] Given the limited funding for mental health services as well as the need to protect individual liberties, it is important that referrals for involuntary examination are completed appropriately and that individuals meet the statutory criteria for involuntary examination.

Inappropriate referrals result in the unnecessary expenditure of staff time, state funding, and deprivation of individual personal liberties. The Florida Sheriffs' Association has reported that providing an individual with transportation to a receiving facility for examination can cost as much as $150 a trip. An involuntary examination that does not result in an involuntary commitment can cost up to $1,500 per individual. When an individual is held for a judicial hearing, the costs per individual can exceed $3,000. Given the volume of referrals that are received by facilities, inappropriate referrals become costly, clog up the system, and can result in the inability of persons in serious need of help to receive inpatient crisis stabilization services in a timely manner.

Although there has been a continued upward trend in the number of certificates issued over the last several years, the funding for Crisis Stabilization Unit (CSU) beds has not kept pace. It has been reported that, due to the inadequate number of CSU beds[6] in many parts of the state, individuals are forced to stay in waiting rooms and halls while awaiting formal admission. However, the 2004 Legislature provided a lump sum appropriation to the Department of Children and Families and provided funding for specific local entities to expand CSU capacity. The need for CSU bed capacity continues to be greater than the funding appropriated.

Concerns

Amendments to the Baker Act during the 2004 legislative session raised a number of concerns as well as questions. The addition of the licensed mental health counselor to those who can initiate an involuntary examination raised concerns regarding the potential increase in the number of evaluations that would be initiated as a result of the increased number of authorized professionals. The time and costs of conducting these evaluations would be likely to produce additional strain on an already stressed public mental health system. Other concerns included the potential for unnecessary limitation of individual freedom that stems from inappropriate referrals, leading to the bigger question concerning whether the licensed mental health counselors and the other currently authorized professionals possess the necessary educational and experiential background to perform this function and whether the inclusion of the licensed mental health counselor opens the door for additional professionals to seek authorization to initiate involuntary examinations.

[3] The term "involuntary examination" was created in 1982 along with more stringent criteria replacing the term "emergency admission."

[4] The 2004 Legislature established a pilot project in District 4 allowing licensed mental health counselors to initiate involuntary examinations. This change will become effective January 1, 2005 (ch. 2004- 385 L.O.F.)

[5] The Florida Mental Health Act (The Baker Act) 2002 Annual Report prepared for the Florida Agency for Health Care Administration by the Louis de la Parte Florida Mental Health Institute.

[6] Page 21 of Exhibit D-3A submitted by the Department of Children and Families indicated that 847 additional CSU beds were needed to address the state's unmet need.

In order to assess the impact of adding licensed mental health counselors to the list of authorized professionals, an interim project was conducted. This interim project looked at the mental health professionals who are authorized to initiate involuntary mental health examinations to determine their appropriateness to perform this function and to consider whether the current list needs to be expanded or further limited. Additionally, definitions found in chapter 394, F.S., for these professionals are examined to determine their consistency with other statutory definitions and their appropriateness.

METHODOLOGY

With this interim project, staff attempted to assess the quality of decisions made by mental health professionals by examining the outcomes for persons who were referred for involuntary examination, including such outcomes as whether the individuals were determined to need further treatment, were immediately discharged, or were committed to one of the state mental health treatment facilities. However, this information was maintained in two separate data bases and, within the time frame of this interim project, could not be linked to determine individual client outcomes by professional group.

Following this and other determinations that our initial research strategy could not be pursued due to data and time constraints, information for the project was obtained from a variety of sources and reviewed by staff. Literature relating to the licensing requirements for each of the authorized mental health professional groups, including mental health counselors, was reviewed and compared. Additionally, articles relating to the scope of practice for these professionals were reviewed. Research for this project also included a review of the history of Florida's involuntary mental health treatment laws, specifically relating to changes since 1972, and staff analyses corresponding to these changes. The Baker Act training documents and associated forms were also reviewed.

Data sources used for this interim project included the Baker Act reporting data that was collected during the 2002 – 2003 calendar year, client service data collected by the Department of Children and Families, and the licensing data bases that are maintained by Department of Health. Additionally, more than 400 randomly selected mental health professionals who had initiated at least one involuntary examination during the 2002 – 2003 calendar year were surveyed.

Finally, two separate expert panels were convened to assist in the identification of specific skills or competencies that are needed by mental health professionals to properly initiate an involuntary examination. The first expert panel was comprised of persons with a broad array of mental health backgrounds and expertise, including experts with a background in training, risk assessment, community mental health practices, and the Baker Act reporting data. This group reviewed the current criteria for involuntary examination, the training and the professional certificate. A "*Certificate of Professional Initiating an Involuntary Examination"* is a mandatory form that is completed by the mental health professional who initiates an involuntary mental health examination. Then the group agreed upon the skills and competencies that a mental health professional would need to properly apply the statutory criteria when making a decision to initiate an involuntary examination.

The second panel consisted of licensed clinical experts who had experience providing evaluation and treatment services to persons suffering from severe mental illness. This group reviewed the contents of over 400 professional certificates and assigned a score to each certificate indicating the overall quality of the certificate. This score was later correlated to the type of professional completing the referral and an aggregate score calculated for each professional group. Finally, this group of experts identified specific actions that would help to improve the quality of information that is provided on the professional certificate.

FINDINGS

This interim project's review of the statutory definitions for mental health professionals confirmed that there are inconsistencies between the definitions provided in ch. 394, F.S., and those provided in other statutes. Making revisions to both ch. 394, F.S., and the respective licensing statutes could provide additional clarification and cross references that may reduce confusion regarding the professionals authorized to initiate involuntary examinations. However, the project's examination of the appropriateness of the professionals who are currently authorized to perform this function was not able to determine whether this list should be further expanded or reduced largely due to the inability to connect client outcomes with

professional practices using the available data systems and within the time constraints of this project.

Somewhat ancillary but certainly critical to the primary focus of the project, staff findings indicated that there are a number of practices pertaining to the involuntary evaluation process that could be improved upon. These findings related to the quality of the data, the information provided on the professional certificate, the need for additional training, and the management of the current Baker Act processes.

Definitions

An examination of statutory definitions for mental health professionals revealed that those provided in the Baker Act are not consistent with those provided in other statutes and, for some, reflect requirements that exceed those provided by the respective licensing statutes. The definitions provided by the Baker Act for "physician," "clinical psychologist," and "psychiatric nurse" specify experiential requirements beyond those that are required to become licensed. However, the definition provided for "clinical social worker" in the Baker Act references the definition provided by the licensing statute, ch. 491, F.S., and does not specify any additional requirements. The review further noted that certain terms used in the Baker Act, specifically "clinical psychologist" and "psychiatric nurse," are not defined in the respective licensing statutes.

The inconsistency of definitions has contributed to confusion regarding the requirements for professionals who are authorized to initiate involuntary examinations. Further, there are currently no mechanisms in place to assure that professionals who initiate involuntary examinations actually meet these additional requirements.

Data

Based upon the available data, it cannot be determined whether the list of professionals authorized to initiate an involuntary placement should be expanded or further limited. Currently, information pertaining to involuntary examinations is maintained in a data base that is separate from client services data. At the time this interim project was conducted, the data from the two data bases could not be linked in order to evaluate client outcomes by the type of professional who initiated the involuntary examination.

The Baker Act reporting data is maintained by the Florida Mental Health Institute (FMHI)[7] and does not allow for a determination of what occurred with the individual after the initial examination, including the individual's length of stay at the receiving facility, whether involuntary commitment occurs, or the type of discharge for the individual. The data set that better reflects client services is maintained by The Department of Children and Families and includes enrollment dates for services, admission date, discharge date and service event data. However, the data is not sensitive to specific admission and discharge dates when an individual who is already receiving mental health services is admitted to a receiving facility, nor can it identity the professional who initiated the involuntary examination.

The characteristics of the Baker Act reporting data impacted staff's ability to fully explore practice differences by professional types. This data contains many certificates that are missing license numbers and professional identification. Further, a number of certificates contained illegible license numbers. When legible license numbers were matched against the licensing data base maintained by the Department of Health, it was found that many of the license numbers provided were invalid. Further, it appears that a number of examinations were initiated by professionals who were unauthorized to do so. When license numbers on the certificate were matched against the licensure data base, it was revealed that examinations had been initiated by professionals who are not authorized by the Baker Act to perform this function.

The legible numbers included in the Baker Act reporting data were used to randomly select mental health professionals to receive a survey. These professionals had initiated at least one certificate during the 2002 - 2003 calendar year. However, many of the license numbers provided could not be linked to the licensing data base.

The reasons that license numbers could not be linked included the absence of and inaccurate license prefixes as well as incomplete and inaccurate license numbers. It cannot be determined if these problems stem from data entry errors or if the professional inaccurately entered his/her license number on the certificate. One effect of all of these problems with the data, however, is that critical questions relating to the validity of

[7] The Baker Act reporting data is maintained by FMHI for the Agency for Health Care Administration which has statutory responsibility for this function.

current and future statutory policy regarding the professionals authorized to perform this important function cannot be answered.

Professional Skills versus Licensure

There is a significant difference between the licensure requirements of physicians or psychologists and social workers. However, there is virtually no difference in the licensing requirements of clinical social workers and mental health counselors. Yet, each group has equal authority to initiate involuntary examinations. Based upon the analysis and feedback obtained from both expert panels, however, it appears that the area of professional licensure is less important to the quality of the process of initiating involuntary examinations than is the possession of certain skills and competencies. The panel members agreed that there is a disconnect between professional licensure and competence to initiate an involuntary examination. However, licensure requirements appear to establish a base level of knowledge and diagnostic ability across professional groups. When asked to identify specific skills and competencies that are needed in order to make a good quality decision to initiate an involuntary examination, the experts identified the following skills:

- The ability to identify acute symptoms relative to a broad category of mental illness such as depression or schizophrenia.
- The ability to assess dangerousness while being knowledgeable about the correlates to harmful behavior.
- The ability to assess the individual's capacity to make decisions.
- The ability to assess risk for self neglect.
- The knowledge of Baker Act law and form requirements.

These skills were also identified by professionals who responded to the survey and identified what they believe to be the three most important skills when deciding to initiate an involuntary evaluation. The skills identified, in order of importance, included the ability to assess dangerousness to self, the ability to assess dangerousness to others, and, in a tie for third, the ability to determine the individual's capacity to make decisions and knowledge of the current Baker Act law and criteria.

Training

Although mental health professionals must attend ongoing training in order to retain licensure, Baker Act training is not one of the required topics. In addition, Baker Act training is voluntary and is not required prior to initiating an involuntary examination under the Act. The expert panels agree that specific training is a way professionals can improve their referral skills.

Baker Act training is provided by the Florida Mental Health Institute under contract with the Department of Children and Families. This training is free to participants who sign up and attend, but typically there are no continuing education credits provided to the professionals who attend.

Training data reflects that approximately three to four thousand individuals receive this training annually. However, survey responses received as part of this project indicate that the majority of mental health professionals initiating involuntary examinations either attend Baker Act training only periodically (49%) or never (36%).

Survey respondents indicate that the training that has been most helpful in preparing them to make a determination to initiate an involuntary examination includes suicide risk assessment, violence risk assessment, and decision making capacity.

Professional Certificate

Since the professional certificate reflects critical information supporting the decision to initiate an involuntary examination, it was hypothesized that an analysis of submitted forms would provide information that would shed light on differences in the referral practices of the professional groups. However, staff could not determine professional differences based upon the contents of the professional certificate.

When reviewed by the expert panels, both groups identified issues with the format of the certificate that is used by mental health professionals to initiate an involuntary examination. There are no directions provided for the completion of the certificate, and the format of the certificate lends itself to subjective information. The contents of the certificate reflect the statutory criteria required to initiate an involuntary examination, but the certificate does not reflect the clinical decision-making process that is involved in deciding to initiate an examination.

The clinical expert group reviewed more than 400 completed professional certificates and assigned a score to each certificate based upon the quality of information that it provided. The majority of these certificates were completed by physicians (66 %),

social workers (6%) and psychologists (2%).[8] This distribution by professional type is consistent with the distribution by professional type statewide. Based upon their review, the clinical experts identified several issues relating to the quality and usefulness of the information that had been provided. Many of the certificates contained no information supporting the decision to initiate an involuntary examination, and when narrative was provided, it often failed to provide behavioral information supporting the need for a Baker Act evaluation. Further, a number of certificates contained inconsistent referral information. For example, the box may be checked as self neglect but the narrative reflected suicidal behaviors. Certificate ratings also reflected that each professional group was equally weak in completing the certificate. Regardless of such problems, when given to a receiving facility, every referral is treated the same.

Agency Responsibilities

There are statutory and rule requirements that reflect the responsibilities of DCF and ACHA in the Baker Act process. However, there is no systemic way for these entities to interface with the professional licensure boards to ensure that mental health professionals are appropriately initiating involuntary examinations. Further, it is not clear that the Baker Act reporting process is a priority concern for AHCA. While staff from AHCA have been responsive to requests to access the data, there have been no systematic efforts to address the timeliness or the accuracy of the information submitted by community mental health providers.

Conclusions

While this project's findings do not lead to a recommendation concerning whether the current group of professionals who may authorize an involuntary examination should be further expanded or reduced, a number of areas are identified that, if addressed, could contribute to a better analysis of this question and related issues. These findings include the need to expand the current data capacity to link professional decisions to client outcomes, the need to obtain identifying information from the professionals who are initiating involuntary evaluations, the need to improve the quality of the professional certificate used to initiate an involuntary examination, the need to provide more comprehensive training specifically related to the completion of the professional certificate, and the need to implement quality control mechanisms regarding the Baker Act process across the agencies that share responsibilities for this process.

[8] Many of the certificates (16%) did not indicate which professional it was completed by.

RECOMMENDATIONS

The Legislature should consider revising the current definitions provided for the mental health professionals defined in ch. 394, F.S., to be consistent with the terminology used in the licensure statutes. The Legislature should further consider revising the respective licensing laws to reference the requirements in ch. 394, F.S., for mental health professionals who are authorized to initiate Baker Act evaluations.

The Legislature should consider amending the current licensure laws to require mental health professionals who are authorized to initiate an involuntary examination to provide a legible name and license number on the completed professional certificate.

The Legislature should consider changing the current licensing laws to require nurses, social workers, and mental health counselors who initiate involuntary examinations to attend Baker Act training including training that is specific to the completion of the certificate.

The Legislature should consider directing the Agency for Health Care Administration to conduct or contract for a study to determine if appropriately licensed and experienced professionals are authorizing involuntary examinations and to determine the extent to which non-authorized professionals initiate examinations. A report of these findings should be provided to the Legislature and the respective licensing boards of these professionals.

The department should be directed to establish a workgroup to recommend changes to the current Baker Act training including the development of a specific training component and a revised certificate that better address the clinical decision-making and risk assessment process that should be used when making a determination to initiate an involuntary examination. This group should also explore the feasibility of providing continuing education credits for this training program and transitioning the training to a fee-based program. The recommendations from this group should be provided to the Legislature.

The Department of Children and Families, the Agency for Health Care Administration, and the Department of Health should be directed to cooperatively develop

quality control mechanisms to assure that only authorized professionals initiate involuntary examinations and that the information required by statute supporting the need for evaluation is provided on the certificate. These mechanisms should include random sampling of the professionals who initiate involuntary examination to verify that the professional meets the criteria to perform this function, reporting inappropriate practices to the respective licensing boards, and the initiation of sanctions for professionals who act outside their legal practice parameters.

In order to draw conclusions regarding individual outcomes, the department and FMHI should be directed to work together to make changes to the current data systems to allow comparisons of client outcomes by the referring professional.