

Baker Act Data Issues

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Purpose

The purpose of this report is to discuss issues related to Baker Act data. The focus will be on what the current data received can tell us, what they cannot tell us, and on suggestions for possible changes to data submission in the future.

Data Submitted Currently

Examination Data

Changes to the Baker Act that took effect in 1996 required that all Baker Act receiving facilities submit the BA52 (law enforcement and mental health professional) forms and ex-parte orders initiating involuntary examination (Baker Act examination). The Baker Act specifies that these data are to be submitted to the AHCA. The Baker Act Reporting Center at the Florida Mental Health Institute has received these data since 1997. In late 1998 changes to administrative rule 65E.5 took effect that required the submission of a cover sheet with each form. This was important because the cover sheet contains information about consumers. This includes date of birth, gender, race/ethnicity, and social security number. This form was consistently used by Baker Act Receiving Facilities as of July 1999. Addition of date of birth was crucial because it allows us to conduct analyses specific to age (such as the ~16% of Baker Act exams annually for children). Social security number is a crucial variable because it allows us to identify individuals and to count repeated examinations. The active data set used for analyses contains data from July 1999 to present, data on 857,333 forms to date.

Over the past decade the Baker Act Reporting Center has developed an efficient system for processing the average of ~425 paper Baker Act examination forms received every business day from the 100+ receiving facilities. The Baker Act requires that these forms be submitted by receiving facilities within one business day. Mail is opened, sorted (many forms that are not BA52 or ex-parte orders are identified and shredded), stamped with identification numbers, entered, and quality checked. Staff from our Policy and Services Research Data Center have recently enhanced the platform used to store the data base to sql server (necessary due to the large size of the data) and the data entry interface, which has numerous checks of the data as they are entered. While the electronic data are stored indefinitely, the volume of paper data is such that typically only about one year is retained. The rest is shredded, with approval from AHCA and the USF Institutional Review Board.

There is much that the Baker Act data can tell about the person examined and the examination initiation. The readers of this report are encouraged to review the most recent Annual Report of Baker Act data, available at the Baker Act Reporting website (<http://bakeract.fmhi.usf.edu>). That report will provide an overview of the types of variables captured from the forms and how they can be used.

Involuntary Placement Data

Changes that took effect in the Baker Act in 2005 require the submission of involuntary inpatient placement ORDERS and involuntary outpatient placement ORDERS to the AHCA. The Baker Act Reporting Center also receives these on behalf of the AHCA. Further, Florida Clerks of Court were required as of 2005 to submit PETITIONS and TREATMENT PLANS for involuntary outpatient placement to the Florida Department of Children and Families. [The data reporting requirements in the Baker Act are described in more detail in a separate report available on the Baker Act Reporting Center website, under the “Documents” link. That report includes the relevant statutory references.]

There is strong evidence that the Baker Act examination data are being submitted as required [although a caveat to data submission is discussed later]. The same cannot be said for involuntary placement data. The Baker Act Reporting Center has made extensive efforts over the past several years to increase submission of these data. This has included memos to providers, working with DCF district staff, and the assistance of staff from the Florida Association of Clerks and Comptrollers to put out an advisory to Clerks of Court.

Involuntary **Outpatient** Placement Data

We have put the most effort into obtaining involuntary outpatient placement data, given the interest in this topic (i.e., because it is a controversial topic and it was newly implemented in Florida in 2005). Our staff continues to have close contact with providers and DCF district staff to identify involuntary outpatient placement orders. Sometimes this takes multiple phone calls over a period of time to multiple entities to obtain the orders. DCF has worked with us so that we can also have access to the PETITIONS and TREATMENT PLANS. Having these, in addition to the orders is essential for three reasons. First, sometimes the only way we find out about an order is by learning about the treatment plan or the petition. That is, the order is not submitted to us as it should be, but once we learn about it from the petition or treatment plan we can work to obtain the order. Second, some petitions do not result in orders, but we cannot learn about this issue if we do not receive the petitions in addition to the orders. Finally, the information contained in the petitions, treatment plans and orders is needed in order to fully research involuntary outpatient placement.

Involuntary **Inpatient** Placement Data

We do not currently have the resources to track involuntary inpatient placement to the same degree because of the higher volume. The incomplete nature of these data mean that they are not yet useful to use for analyses.

Suggested Changes to Data Submission

1. What precipitates the Baker Act examinations?

The Baker Act examination data only tell us that the exam was initiated. The data do not tell us about the circumstances that led to the exam to the degree that is desirable. A past analysis of textual information about the nature of the situation leading to the examination showed that a) information is often not complete on the forms and b) the information is often not at the level of detail that can address issues. AHCA does not allow for the release of identifiers from the Baker Act data to conduct research that could answer some of these issues. For example, merging Baker Act data with data from the Florida Department of Education could help us to identify schools with high number of

children who have Baker Act exams. Additional information is also needed to determine whether or not the school (or a school resource officer) was involved in initiations for children. There are similar issues trying to learn about the involvement of nursing homes and assisted living facilities in the initiation of Baker Act exams. Also, some initiations may occur at jails, with the individual transferred to the receiving facility. However, we cannot know this from the current data received.

Possible Solution: These issues may be addressed with changes to our ability to merge data sets that are not in house at FMHI and to collect certain data elements on paper forms that are sent to FMHI. It is important to remember that submission of paper data will only take place if a) it is required via statute (administrative rule) and b) if resources are put into following up with facilities that do not comply with data submission. With the exception of the ex-parte order, Baker Act examination forms received at FMHI are mandatory forms, so can only be amended via an administrative rule change.

2. What occurs after the Baker Act examination?

The Baker Act examination data also do not reveal what occurred after the initiation of the exam. A number of scenarios are possible, including

- release after less than 72 hours because the person no longer meets criteria
- completion of the 72 hour exam, with release into the community
- filing of a petition for involuntary inpatient placement
- filing for a petition for involuntary outpatient placement
- signing in as a voluntary client with additional inpatient care

Possible Solution: Completion of a form within a set period of time (for example two weeks) following the submission of every BA52 or ex-parte order for involuntary examination that has check box options to indicate the basic outcomes would provide data on this issue. This form would likely not be used unless it is mandatory and if resources are put into tracking form completion and submission. This could be a labor intensive task given the volume of forms received annually (approximately 125,000).

Also worth mentioning are the difficulties using administrative data to answer some of these questions. The SAMH and Medicaid data cannot adequately address these issues for a number of reasons. First, Medicaid data are limited only to those Medicaid enrolled. Past analyses have indicated that slightly less than half of Baker Act exams were for people enrolled in Medicaid during the year of their Baker Act exam. There are also further limitation in claims data for those enrolled in a Medicaid HMO. Second, **about half** of Baker Act exams occur in PRIVATE receiving facilities. This means that data for these individuals is less likely to be reported into the SAMH system. Although DCF may have more of an interest in publicly funded receiving facilities and services, it is quite possible that people with Baker Act exams are clients of the public system, but have their exam in a private receiving facility because it is the nearest receiving facility. For this and other reasons, understanding Baker Act exams cannot adequately be accomplished only by looking at publicly funded services. Finally, Medicaid and SAMH do not allow for identification of legal status (in on a Baker Act exam? Involuntary placement? Voluntary?). In sum, analyses using currently available archival data have many limitations and do not allow us to adequately address these questions.

3. What is the extent of the problem of people on a Baker Act exam who are medically cleared (not at a receiving facility) not reaching a receiving facility (and the form not being submitted)?

This is the one caveat to submission of Baker Act examination data alluded to earlier. If someone subject to a Baker Act exam is in need of medical attention he/she may be taken to the nearest hospital, which may not be a receiving facility. Baker Act receiving facilities are not required to take these individuals once they are medically cleared. We have received anecdotal reports that this occurs, such that people on a Baker Act examination may spend their examination period in an emergency room. This means that the Baker Act Reporting Center will not receive the form for this exam. It may also have implications for the care such individuals receive.

Possible Solution: Forms submission would be improved with a requirement that facilities (such as hospital emergency rooms) submit the Baker Act examination form, a cover sheet and a form indicated the reason for no transfer if the person is not transferred to a receiving facility. This would help us to determine the nature and scope of this issue. However, implementing such a requirement statewide and tracking submission would be difficult, given the large number of facilities. A pilot in one or several counties could help in the development of forms submission and in the understanding of this issue.

4. What petitions, treatment plans and orders are completed for involuntary outpatient placement? What petitions and orders are completed for involuntary inpatient placement? How often do petitions not result in orders, and why?

Data submission for placement is complicated. The clerks of court are to submit certain elements to DCF and providers are to submit certain elements to the AHCA (via the Baker Act Reporting Center). This is confusing.

For example, Clarification to the clerks of court by efforts of the Baker Act Reporting Center and an advisory from the Association of Clerks and Comptrollers was required to inform the 67 Clerks of court of their data reporting requirements. For example, Baker Act Reporting Center staff compiled a list of contact names, addresses and phone numbers for DCF district offices so Clerks of Court know where to submit the information. Our work obtaining involuntary outpatient placement orders included contacts with offices of Clerks of Court. It is evident that there is still confusion about what is supposed to be submitted. Basic knowledge about what involuntary inpatient vs. outpatient placement is may be needed. Some treatment plans for involuntary outpatient placement are not labeled in such a way that it is easy to identify that they are treatment plans for such placements (leading to difficulty in submission).

For example, some providers are confused about the difference between a petition and an order and what they are supposed to submit. For example, we sometimes receive petitions for involuntary inpatient placement, but not the order.

Possible Solution: This process may be improved with a) simplification of the submission of data, b) education, and c) tracking of submission with follow-up education. One idea is to implement changes to mandate that data be reported to the Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center (“TA Center”), such as the following:

- Continued submission of Baker Act examination data to the Baker Act Reporting Center, as part of the TA Center, by providers
- Submission by Clerks of Court of petitions, treatment plans and orders for involuntary outpatient placement and petitions and orders for inpatient placement to the TA Center (rather than providers submitting certain forms via AHCA to FMHI and the Clerks of Court submitting other forms to DCF)
- Submission of forms developed in the future (such as suggested above) to the TA Center

In sum, the only forms submitted by providers would be the examination forms, because the Clerks of Court do not receive the majority of these forms. The rest of the forms (petitions, treatment plans, and orders) would be submitted by one entity (the Clerks of Court) to one entity (the TA Center). Follow-up on data submission and education for the examination forms would continue with providers. This is functioning well. Follow-up on data submission and education for what is not functioning well (that is, placement), could be centralized to focus on Clerks of Court.

Our efforts to obtain dedicated state funding for the Baker Act Reporting Center have not been successful. This has included an LBR through AHCA and inclusion in a DCF LBR, both unsuccessful. The Department of Mental Health Law and Policy at the Florida Mental Health Institute has supported these efforts with departmental funds. We are dedicated to this effort, conducting this work for a decade without dedicated state funding. This includes the generation of multiple ad hoc analyses and reports each year for various entities (including DCF). However, a discussion of funding is a necessary component of the process of furthering these efforts.

Finally, it is important to acknowledge that there are multiple issues not addressed in this report that relate to suggestions in the report. These include issues related to Clerks of Court, HIPAA and particulars of changes in statutory language and administrative rules. These are all important issues, but are not discussed here because of the targeted nature of this report.