BAKER ACT & MARCHMAN ACT

design local crisis systems, review key data, and act as a problem-solving group. is speaks to the guiding principle expressed in previous legislation for communities to work together to develop a plan to reduce the impacts of mental, emotional, and behavioral health disorders. e National Alliance on Mental Illness (NAMI) has identi ed the importance of cross-system and interagency collaboration to reduce barriers to appropriate services, and the right of individuals and families who use these services to participate in planning, decision-making, and evaluating systems of care.

e foundation of a cohesive planning group is to achieve consensus on a contemporary set of values and principles that guide a recovery-oriented system that may include a few of the following values:

- Welcome people to care and listen to their needs and preferences (person-driven)
- Avoid doing harm
- Consideration for a balance between treatment and public safety
- Provide a safe and quality environment
- Address trauma, and avoid imposing any further trauma throughout the crisis response
- Consider the whole person, his/her strengths, family, and other natural supports
- Create an opportunity for hope and a pathway to recovery

As communities embrace a core set of values, a key set of principles should drive the crisis response interventions and best practices. Highly e ective community interventions embrace the following principles:

- ere is “no wrong door” to services for people with co-occurring mental health, substance abuse and/or complex primary care disorders
- Services are o ered in the least restrictive environment, with diversion from inpatient admissions or incarceration a routine method of intervention
  - t erapeutic jurisprudence is supported by NAMI to avoid unnecessary incarceration for non-violent o enses, especially behaviors that are directly related to mental and substance use disorders
  - t is aligns with the language of SB 7068 establishing specialized courts to support post-booking diversion of persons with mental and substance use disorders, including veterans with service-connected disorders
- First responders, law enforcement, treatment providers, persons served, families, and natural supports are partners
- Crisis screening and evaluations are comprehensive, and provided in a manner that is safe, [illegible] individual rights

A. Community Interventions Options

Prevention

Many crisis situations can be resolved in the home and most people “recover at home.” Crises can also be prevented through in-home response teams, case management, supportive housing, substance abuse sponsors and a variety of “wraparound” models of care. e expansion and acceptance of Mental Health First Aid is very encouraging. Mental Health First Aid is a public education program that can help individuals across the community understand mental illnesses and support timely interventions, and has reached a broad spectrum of citizens who help in early identi cation and prevention e orts.

Mobile Crisis Team

program, the Whole Health Action Management (WHAM) is a training program that addresses mental health, addictions and primary care healthcare disorders. Sober homes provide an alternative for many persons addicted to alcohol or drugs and are a viable peer support option rather than formal treatment programs and expensive private settings. ese homes are normally post stabilization and detoxi cation.

Comprehensive Psychiatric Emergency Programs

ese programs are designed as a combination of Mobile Crisis Team, a liation with CIT Teams, Homeless Outreach and access to a CPEP Unit, which may be free standing (resembles a CSU) or based in a hospital emergency room. All have access to inpatient psychiatric either within their own network or purchased by the state (NY, DC).

Hospital In-Reach

Hospital In-Reach brings health care and community-based services together for persons with behavioral health disorders. Models of hospital in-reach include on-call or on-site behavioral health center sta connected to hospital emergency rooms or other access points to assist when individuals with behavioral health disorders are identi ed. e In-Reach worker helps link individuals with treatment for mental or substance use disorders, and ancillary services such as housing, transportation, employment, peer support, and other health, social and economic supports. In some models, they may also provide care coordination for a de ned period of time.

Walk-In Access Center/Transitional Support

Speci c models di er across communities, but common elements include availability of clinical sta and prescribing professionals on a walk-in basis for outpatient assessment. ese programs generally operate for extended hours, up to 24-7. Psychiatric evaluation may be provided through a telemedicine arrangement. ese programs may be freestanding or attached to a CSU. ey provide screening, crisis counseling, referral and linkage, and consultation with an ARNP or physician if indicated. In some communities, programs also have an option for a 23-hour voluntary stay, which gives respite to the person and family and time for care coordination and planning.

Array of Services

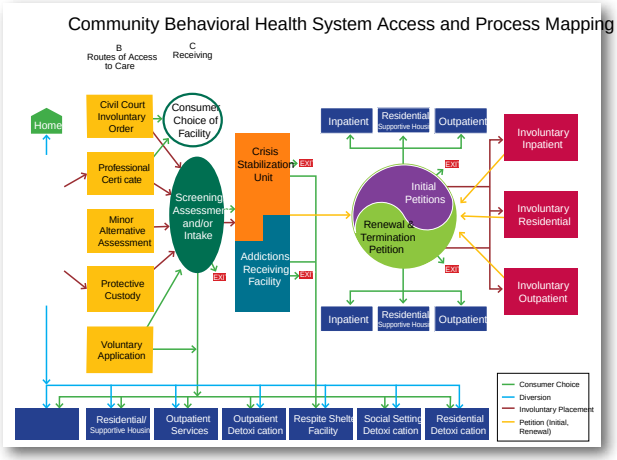
e seven boxes at the bottom of the process map illustrate the array of treatment and supportive services encompassed in a comprehensive community-based system of care. ese include integrated behavioral health and primary care clinics/medical homes, supportive housing, respite shelters, non-secure detoxi cation programs, and outpatient services.

ese services are also appropriate disposition alternatives for law enforcement when they encounter individuals who require protective custody, but not involuntary placement. In an e ective system of community behavioral health, jail is not an appropriate or necessary disposition, except in cases of violent crime.

Additional documents

» Client Rights

B. Routes of Access to Emergency Assessment



Behavioral health disorders are diseases of the brain, and as such, can cause temporary or relatively enduring e ects on the individual's ability to reason, exercise good judgment, recognize the need for services, and su ciently provide self-care. is requires societal responses where responsibility for the individual's care must be assumed by third parties, and/or vested in the authorities of behavioral health programs and practitioners.

Current statutes establish ve routes to crisis services for persons with mental or substance use disorders, four of them involuntary. e Baker and Marchman Acts di er signi cantly in addressing involuntary assessment. is includes de ning who may utilize speci c means, criteria, time frames, and disposition alternatives. Revising the statutes to align the process and standardize the forms for petitions and certi cates, while retaining the ability to identify whether the primary basis is a mental or substance use disorder, would signi cantly reduce bureaucratic barriers to accessing crisis evaluations and still protect individual rights through due process in any involuntary proceedings.

A signi cant unintended consequence of the di erences in the Baker and Marchman Acts is that the true capacity needs for stabilization and treatment for substance use disorders has been suppressed. Individuals who are clinically appropriate for addictions receiving facilities or detoxi cation instead end up in jails, emergency rooms, or CSUs because the Marchman Act restricts professional emergency admissions to physicians, and excludes the risk of self-neglect in the criteria for ex parte orders for assessment.

Transportation

A signi cant unintended consequence of the di erences in the Baker and Marchman Acts is that the true capacity needs for stabilization and treatment for substance use disorders has been suppressed. Individuals who are clinically appropriate for addictions receiving facilities or detoxi cation instead end up in jails, emergency

» Without treatment there is substantial likelihood that the person will cause serious

Voluntary Application

Individuals may request assessment and evaluation at a central receiving facility or program of their choice at any time. However, in practice, capacity issues limit the ability of programs to accept individuals who present voluntarily to crisis units, addictions receiving facilities, or detoxi cation programs. Particularly in ARFs or detox programs, persons voluntarily seeking help are too often "bumped" from their scheduled admission when the facility has to accept a person under an involuntary Marchman Act. A robust system of community intervention services is necessary to provide viable alternatives for persons in need of care.

When a person seeks voluntary admission to a receiving facility or other crisis service, it is important to determine the ability of the person to give informed consent. F.S. Ch. 394 de nes "incompetent to consent to treatment" to mean that a person's judgment is so a ected by mental illness that he/she "…lacks the capacity to make a well-reasoned, willful, and knowing decision concerning medical or mental health treatment." e statutes de ne "incapacitated" in a strictly legal sense, that is, that an individual has been legally adjudicated incapacitated and a guardian of person has been appointed. SB 7068 limited the ability to make the determination of capacity to give informed consent to physicians. For psychiatric disorders, it is recommended that this be extended to an ARNP and to professionals licensed under Ch. 491 (LCSW, LMHC, LMFT) with appropriate training and experience in diagnosing mental disorders.

For substance use disorders, incapacity is often temporary and directly related to the in uence of drugs or alcohol. Quali ed professionals as de ned in F.S. Ch. 397 should have the training and experience to evaluate whether such individuals have the ability to give informed consent at admission. Guidance in evaluating capability to give consent when persons are under the in uence of substance intoxication may be found in the DSM-5 criteria. Key factors in a clinical evaluation of capacity are recent substance use accompanied by one or more of the following:

- Disturbances in perception
- Impaired judgment
- Clinically signi cant problematic interpersonal behavior
- Physiological e ects and/or psychomotor disturbances
- Mood lability
- Impaired reality testing

Voluntary Application by Minors: Florida statutes remove the disability of minority for persons under age 18 who request an evaluation for mental disorders or treatment for substance use disorders, although the law does not require providers to render any services to minors without parental consent. In practice, providers who are willing to o er services to minors without parental consent limit this to adolescents, and generally to an initial evaluation or brief outpatient counseling. When a minor presents for voluntary services, providers bear responsibility to assess and document the capacity of the minor to give informed consent, with due consideration of maturity, family and psychosocial context, severity of disorders, and the level of care that is most appropriate.

Linked documents

» Initiation and Case Disposition

Professional only when the primary diagnosis and reason for admission is a substance use disorder.

To ensure common understanding of the mental capacity of persons who present with behavioral health impairments, it is recommended that a set of de nitions be developed that can be used consistently to di erentiate persons speci cally referred to, or impacted by, various policies and interventions.

ose de nitions make clear distinctions as to whether the condition is:

- Temporary in nature: Can be addressed and stabilized through crisis intervention, e.g., substance intoxication, acute stress disorders
- Emerging/early stage: Initial manifestation of symptoms or behaviors, requires identi cation, diagnosis, and brief treatment, e.g., mild depression, anxiety, mild substance use disorders
- Chronic/relapsing: Degree of impairment varies during course of disorder, requires ongoing voluntary or involuntary treatment, supportive services, and recovery support/ relapse prevention oriented interventions, e.g., anorexia, moderate or severe substance use disorders
- Severe and persistent conditions: Usually associated with signi cant impairment in psychosocial functioning, requires long-term, supportive, maintenance oriented services that may include the appointment of a guardian, e.g., schizophrenia, severe substance use disorders

Whatever terminology is decided on should be synchronized with other statutes intended to similarly address the needs of populations with behavioral health disorders.

Time Frames

Involuntary assessment, whether initiated by court order, professional certi cate, or law enforcement, is limited to a total of 72 hours, inclusive of time at both the receiving facility and the CSU or ARF, if applicable. A physician or ARNP may authorize up to 48 additional hours without further court action based on determination of medical necessity after a face-to-face evaluation. e administrator of a receiving facility, CSU, or ARF may petition the court for continued involuntary placement up to an additional ve days if an evaluation by a physician or ARNP documents that this additional time is required for stabilization and safety.

Administrative Functions

is process map is based on the model of a Central Receiving Facility (CRF), which is very similar to the Access Center model described in the Department of Children and Families (DCF) Crisis Stabilization Reimbursement Transition Plan (Jan. 2013). In addition to initial assessment and disposition with linkage to voluntary or involuntary services as appropriate, in this model the CRF assumes several administrative responsibilities listed below.

- Maintain a database of the names and contact information of authorized or responsible third parties (e.g., parents or legal guardians, guardian advocates, health care proxies or representatives, case managers, or attorneys) and provide required noti cations to these individuals
  - Authorization requirements for noti cation will di er for persons with a primary diagnosis of substance use disorders, due to the stronger protections for con dentiality in 42 CFR Part Two
- Maintain a copy of advance directives and make them available to other treatment providers, with proper authorization
- Serve as a transportation hub from the receiving facility to crisis stabilization units and addictions

- Provide over ow capacity, and a system for triage to other providers, when all private and public CSU and ARF programs are at licensed maximum census
- Perform utilization management for CSU and ARF bed days
- Manage the logistics for involuntary treatment hearings, including scheduling, noti cations, and meeting space
- Provide care coordination for persons who meet criteria established by the state for high need/high utilization of crisis services

Care Coordination

ere are di erent de nitions of care coordination. In this model, care coordination is conceptualized as a multimodal intervention that integrates a care manager to work with the person served and other providers to develop a shared assessment and treatment plan; to support and educate the person to optimize self-management; and to navigate treatment and ancillary services on behalf of the individual. Care coordination involves primary care, formal behavioral health care, peer and natural supports, services to address economic, housing, educational or vocational needs, and coordination and advocacy with other systems, including civil and criminal courts. e state should establish a uniform de nition of "high need/high utilization" that quali es persons for these services, e.g., three or more CSU, ARF, or Detox admissions within the preceding six months.

Central receiving facilities are in a strong position to provide e ective care coordination, as they are the "front door" to crisis services, collect data from di erent providers on crisis episodes and outcomes, and are actively engaged with and responsible to a broad range of stakeholders in the system of care.

ere are three possible models for care coordination based on community needs and the structure and governance of the CRF. e CRF can operate its own care management unit; contract with a community agency for those services, which might include o ce space at the CRF; or, establish written agreements with one or more providers to accept referrals of persons eligible for care coordination, and share service and outcome data. In any model, the community planning process should include the development of speci c performance targets and monitoring.

Models of Central Receiving Facilities

No single model of a Central Receiving Facility can adequately serve all the diverse communities across

D. Crisis Stabilization Units and Addictions Receiving Facilities

Behavioral health is a specialty area of health care, and the CSU and ARF are considered subspecialty providers within behavioral health. ese providers continue the stabilization process initiated at the Central Receiving Facility. ey provide interventions

It is recommended that evidence-based assessments and clinical criteria be established to guide CSU and ARF programs in determining the need to petition the court for involuntary treatment and the appropriate level of care to recommend. is is discussed in detail in the narrative section on Court Rulings.

Administrative Functions

e CSU and ARF are partners with the Central Receiving Facility and other community stakeholders in the system of care. As such, these entities need to develop Business Associate/ Quali ed Service Organization Agreements to allow two-way exchange of relevant data with the Central Receiving Facility for reporting to the State, the managing entity or AHCA as applicable, and to facilitate care coordination for persons identi ed as high need/high utilizers of crisis services.

provide for specialized needs and recovery support. It is recommended that when the petition is for an order to those less restrictive levels of care for mental health or substance use disorders, that the second opinion may be rendered by physicians, psychiatric ARNPs, and/or licensed mental health professionals under Ch. 491 (LCSW, LMFT, LMHC), in addition to clinical psychologists.

Time Frames

It is recommended to standardize time frames. Involuntary treatment hearings take place no more than ve court working days after the petition is led. If granted, orders authorize treatment for up to 90 days, with judicial discretion to order more frequent reviews. Renewal petitions must be led at least ten days prior to the expiration of the existing order, and may request authorization of additional treatment for periods of up to 90 days.

Court Proceedings

Court orders need to include medication use, if applicable, and provisions to permit noti cation to appropriate parties throughout the duration of the order to assure that substance abuse treatment providers may participate in care coordination while remaining in compliance with 42 CFR Part Two.

Clinical criteria relevant to involuntary assessment and treatment

It is important that decisions to pursue petitions for involuntary assessment and especially for involuntary treatment employ evidence-based criteria. For involuntary treatment, this is also vital in determining the appropriate level of care for the individual. ere are di erent methodologies available, but this section will focus on the Diagnostic and Statistical Manual (DSM-5); the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R); the Level of Care Utilization System (LOCUS); and the Minko co-occurring disorders quadrant. Taken together, these resources o er signi cant evidence-based guidance to professionals in determining whether to initiate petitions for involuntary assessment or treatment for substance use disorders, and to courts in ruling on civil petitions, or ordering treatment as a diversion or alternative to incarceration in criminal cases involving substance use disorders.

DSM-5

e DSM describes speci c behavioral indicators of inability to determine one's need for services, risk of self-neglect, and risk of harm to self or others for persons with substance use disorders. Behaviors described in diagnostic criteria for substance use disorders that align with Baker Act criteria for involuntary assessment and treatment are those related to social impairment, risky use, and pharmacological criteria. ese include:

- Recurrent use resulting in failure to ful ll major role obligations
- Continued use despite recurrent social or interpersonal problems caused or exacerbated by the substance
- Recurrent use in physically hazardous situations
- Continued use despite known physical or psychological problems caused or exacerbated by the substance
- Tolerance, if using a substance in amounts known to be life threatening
- Withdrawal, if there are known health risks (e.g., alcohol, benzodiazepines)

e speci c behavioral indicators and the degree of impairment in role functioning in the DSM-5 diagnostic criteria for mental illness di er more than those for substance use disorders and unfortunately provide less clear guidance.

ASAM PPC-2R

e ASAM describes physical, behavioral, and

Criteria

e Treatment Advocacy Center rates Florida's current criteria in the Baker Act for involuntary outpatient treatment as excellent.* is is based on the fact that the criteria recognizes factors beyond imminent danger to self or others, including the person's ability to survive in the community, their degree of motivation to change, and previous history of willingness to engage in services; uses speci c measures such as the number of previous involuntary episodes of care or incidents of harm to self or others; and considers the likelihood that the person will bene t from treatment. is also aligns with principles advocated by NAMI, including that involuntary treatment criteria be based on previous history and risk of deterioration as well as imminent danger. It is recommended that these criteria also be applied to involuntary outpatient treatment for substance use disorders.

*(http://www.treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws).

Linked Documents

» ASAM PPC-2R

» LOCUS

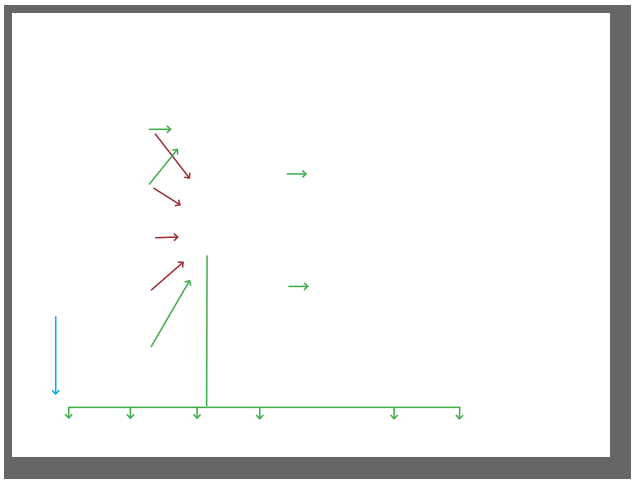
F. Involuntary Treatment Placement

Current policy discussions suggest that involuntary short-term residential and outpatient treatment may become more desirable and utilized options. is supports the principles expressed in SB 7068 and the policy recommendations of NAMI to provide treatment in the least restrictive setting possible, to be available and accessible so as to engage families and natural support systems, and to provide for specialized needs and recovery support in the context of integrated care.

Placement Options

In addressing the rights of persons served, NAMI emphasizes the right not only to placement in the appropriate level of care, but also the right to e ective treatment. e State should establish requirements for treatment providers, to include:

- Accreditation by a nationally recognized organization (Joint Commission, CARF)
  - Accreditation replaces the need for licensure in state-funded residential and outpatient programs, which are monitored by both the accrediting body and the managing entity
- Documented policies and procedures to credential and privilege licensed and certi ed providers for speci c programs, modalities, and services
- Policy and procedures to assure sta maintain current required training
- Processes to implement and evaluate evidence-based and promising practices
- Procedures for systematic incident reporting, tracking, and trending, and for data-driven formal improvement processes when indicated
- Grievance procedures that are readily accessible to persons and families or representatives, with timely responses and appeal options



Alternatives to State Hospitals

Establishing and funding options for residential treatment for mental disorders beyond state hospital placement is recommended to expand capacity and to keep individuals closer to their communities and natural support systems. ese alternatives could also alleviate current situations where individuals remain on a CSU awaiting availability of a bed after being court ordered to a state hospital. e CSU is not intended to provide the level of treatment that the person requires, and the crisis environment may be stressful to a vulnerable individual. is also creates additional liability for the provider and limits the bed capacity of the CSU.

Funding

Consideration needs to be given to the requirements and standards the state develops for health care plans, including Managed Medical Assistance (MMA) plans. NAMI clearly articulates the responsibility of government to fund a behavioral health care safety net, and of health care plans to o er parity between physical and mental health coverage.

e state has established a de nition of medical necessity in F.S. 409.9131, which reads:

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the e ects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or su ering, or results in illness or in rmity, which goods or services are provided in accordance with generally accepted standards of medical practice.

is de nition clearly addresses prevention and precluding deterioration as determinants of medical necessity. Supporting NAMI recommendations, individuals should not be required to be at imminent risk of harm to self or others to be ordered into treatment or to have treatment services covered by health plans. ere also needs to be additional clari cation of the responsibility of the state and health plans in regard to funding for social rehabilitative services, setting criteria for which of those types of services "prevent, correct, or preclude deterioration of a condition" and should be covered.

NAMI advocates against requirements from health care plans for "fail rst" or step therapy. is forces people to attempt less intensive and expensive treatment modalities or medications, even when a treating clinician believes such treatment is likely to be ine ective. Although intended to manage costs, some research has suggested that while these requirements may save money on prescriptions, they can lead to higher overall costs due to emergency room or crisis services and delays in the person's recovery. NAMI emphasizes the right of persons served and their families or other representatives to le grievances with health care plans related to any funding decisions, and the state should support an accessible and understandable grievance process.

As part of its responsibility to provide a behavioral health safety net that serves individuals without regard to ability to pay, the state must consider the contemporary context of health care plan deductibles and copays. Managing entities often refuse to fund persons with insurance, even if the individuals are unable to pay deductibles or co-pays, which may be several thousand dollars. Providers are advised to set up payment plans, but realistically many individuals who receive care in the community behavioral health system are simply unable to make such payments. Since providers are prohibited from denying services based

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