US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

**VETERANS HEALTH ADMINISTRATION**

# Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida

**Healthcare Inspection** | **23-03677-237** | **August 28, 2024**

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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an allegation that a patient was "misled" by staff at the North Florida/South Georgia Veterans Health System (system) and incorrectly involuntarily admitted to the inpatient mental health unit. The complainant also alleged that VA staff actions led to the patient's disengagement from VA mental health care and eventual death by suicide.

## Baker Act

The Florida state legislature passed the Florida Mental Health Act, typically referred to as the Baker Act, in 1971, becoming effective the following year, with the purpose of reinforcing the civil rights of patients in mental health facilities.[1] The Baker Act provides criteria for voluntary and involuntary mental health care and encourages voluntary admission, if possible, treatment choice, and the ability to terminate treatment if preferred.[2]

## Synopsis of Patient's Care

In the summer of 2021, the patient established VA care with a St. Marys Community Based Outpatient Clinic (CBOC).[3] After four sessions, the CBOC social worker transitioned from the position and in the summer of 2022, the patient was reassigned to a new CBOC social worker for continuation of therapy. After five sessions with the new CBOC social worker, the patient was told of the social worker's upcoming departure and was scheduled to see a CBOC psychologist for a new initial therapy session in winter 2022. At that appointment, and in response to the patient's expressed concern about being seen by three therapists within the year, the CBOC psychologist informed the patient of the psychologist's upcoming spring 2023 retirement. During

[1] Florida Department of Children and Families, Department of Mental Health Law & Policy, *2014 Baker Act, The Florida Mental Health Act, User Reference Guide*, 2014, https://www.myflfamilies.com/sites/default/files/2023-03/2014%20Baker%20Act%20Manual_0.pdf. This guide was in place during the time of the events discussed in this report. It was replaced by Florida Department of Children and Families, Office of Substance Abuse and Mental Health, *2023 Baker Act User Reference Guide,* August 2023. Unless otherwise specified, the 2023 guide contains the same or similar language regarding the Baker Act as the replaced 2014 guide. The term *Baker Act* will be used in this report.

[2] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014 (*citing*, Fla. Admin. Code Ann. R. 65E-5.140(1) *Rights of Persons*); Florida Court Education Council, *Baker Act Benchguide,* November 2016, https://www.flcourts.gov/content/download/215973/file/Baker-Act-Benchguide.pdf. In Florida, a court, law enforcement officer, physician, or mental health professional can determine that a person meets criteria for voluntary or involuntary examination. Involuntary examination criteria include evidence of a mental illness; due to the mental illness, the person refuses voluntary examination or is not capable of determining if the examination is needed; and without treatment, the person will likely experience neglect or inability to care for self, resulting in significant risk that cannot be mediated by social supports, or there is significant risk of self-harm or danger to others "in the near future, as evidenced by recent behavior."

[3] The St. Marys CBOC is in Georgia.

the appointment, the CBOC psychologist described the patient as logical, goal-oriented, and without suicidal ideation.

In the morning of a day in late winter 2023, the patient presented for an unscheduled appointment to the CBOC mental health clinic and requested an "inpatient stay" for depression and recent suicidal thoughts. The patient was assessed as alert, without hallucinations or delusions, and without impairment of insight or judgment. To mitigate the patient's acute risk, the mental health nurse practitioner discussed a plan with the patient for voluntary inpatient admission at the Malcom Randall VA Medical Center (facility) in Gainesville, Florida, and placed a consult to the system's suicide prevention team.

That same day, the patient presented to the facility's emergency department. Upon evaluation, the emergency department physician (emergency department physician 1) placed the patient under a 72-hour involuntary inpatient Baker Act examination hold for suicidal ideation and depression.

A mental health consult service resident completed an evaluation and determined the patient was at intermediate acute risk of self-harm as evidenced by not having suicidal ideation since the week prior and that the patient appeared motivated to receive mental health treatment. The mental health consult service resident recommended the patient be admitted to the inpatient mental health unit and the mental health consult service attending psychiatrist agreed. Emergency department physician 1 documented communicating with the mental health consult team that the patient was to be admitted to the inpatient mental health unit. Emergency department physician 1 further documented the patient "agrees with admission." The mental health consult service attending psychiatrist wrote admission orders and the patient was transferred to the locked inpatient mental health unit on the involuntary 72-hour hold.

The following day, when seen by the inpatient mental health psychiatrist, the patient queried "I don't understand why i [sic] am here or baker acted." The patient spoke at length with the inpatient mental health psychiatrist and denied current suicidal ideation, noting a struggle with symptoms of depression for the past year resulting in the patient considering suicide and ultimately coming to VA for help. The patient voiced concern about being placed under an involuntary Baker Act hold for fear that it "will stay on [their] record." On examination by the inpatient mental health psychiatrist, the patient was calm and cooperative with good eye contact. At the conclusion of the assessment, the patient signed the inpatient mental health voluntary admission form, thereby removing the involuntary inpatient Baker Act examination hold. Approximately two hours later, the patient filled out and signed the required form requesting to be released from the facility.

Later that day, a facility suicide prevention coordinator (SPC) placed a high-risk for suicide flag in the patient's chart. The patient met with the inpatient mental health social worker who noted the patient was interested in residential treatment for symptoms related to service-connected posttraumatic stress disorder (PTSD) and placed a consult for PTSD community care residential

treatment. After speaking with the family, discharge was planned for the following morning and the inpatient mental health resident placed a consult for aftercare appointments to the outpatient mental health and PTSD specialty clinics at the Jacksonville VA Clinic in Florida.

At discharge, the patient was scheduled for a mental health follow-up appointment with the CBOC psychologist for the following week. However, after discharge, the patient called the CBOC and canceled the scheduled mental health appointment and described frustrations with being involuntarily admitted. The patient also spoke with the SPC and shared similar concerns about the involuntary admission and declined further VA mental health care. Despite additional contacts made by VA staff, the patient continued to decline VA services.

The patient received no further care from any VA healthcare system. In late summer 2023, the suicide prevention supervisor documented a conversation with the patient's father who confirmed the patient died by suicide.

## Incorrect Use of the Baker Act

### Incorrect Involuntary Admission

The OIG substantiated that system staff admitted the patient to the mental health unit under involuntary status despite the patient's request for voluntary admission. The OIG determined staff incorrectly applied the involuntary inpatient Baker Act examination hold criteria set forth by state law when admitting the patient.

The Veterans Health Administration (VHA) requires VA facilities to establish "clear guidelines" for involuntary admission that are congruent with applicable state and local laws and requires consultation with district counsel as needed.[4] At the time of the patient's care, VHA specifically required emergency department and mental health providers to be familiar with state laws for involuntary admission.[5] The system policy also requires compliance with the applicable state laws on inpatient mental health admission processes.[6]

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[4] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding involuntary admission as the rescinded 2013 handbook. Although the rescinded handbook did not require VA facilities to establish involuntary admission policies, it did mandate compliance with state laws. While the language in the rescinded handbook and the current directive regarding consultation with counsel differs slightly, the intent remains the same.

[5] VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics* (September 11, 2008), amended November 16, 2015. This handbook was in place during the time of the patient's inpatient mental health admission. It was rescinded and replaced by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023. The 2023 directive does not contain a specific requirement related to emergency department and mental health providers' familiarity with involuntary admission state laws; System policy 11-54, *Voluntary and Involuntary Admissions for Treatment of Mental Illness (Baker Act)*, April 19, 2021.

[6] System Policy 11-54.

The OIG determined that facility staff failed to honor the patient's request to be voluntarily admitted. Documentation from emergency department staff noted that the patient was "calm and cooperative," and "feeling better and agrees with the admission." However, emergency department physician 1 completed a "Certificate of Professional Initiating Involuntary Examination" and checked off all criteria for involuntary examination, including patient refusal of voluntary examination and inability to determine the need for examination, with supporting evidence of "depression." Emergency department physician 1 did not document within the patient's electronic health record (EHR) that

- the patient refused an offer to be voluntarily admitted to the inpatient mental health unit,
- there was any concern regarding the patient's decision-making capacity or ability to provide consent for an inpatient mental health admission,
- there was any concern that the patient was at risk of physical neglect, or
- the patient expressed thoughts to harm other people.

Emergency department physician 1 reported being unable to remember the patient's case but, in an interview with the OIG, speculated that given initiation of the Baker Act, there were concerns about the patient's safety and the patient possibly leaving.[7] Additionally, emergency department physician 1 reported being told, in prior conversations with VA police, that officers are unable to stop patients from leaving without the state required documentation for involuntary examination.

## Provision of Baker Act Rights

The Baker Act requires that patients receive a written copy of their rights at the time of admission.[8] The OIG determined that the patient did not receive written information on rights under the Baker Act.

[7] The physician was not physically at the VA at the time of the interview. The OIG offered and conducted the interview using an online meeting platform to be able to share the patient's medical record with the physician through a computer or tablet. However, the physician did not use a computer or tablet for the interview and was unable to review the patient's records.

[8] *Baker Act, The Florida Mental Health Act, User Reference Guide* (2014) (*citing*, Fla. Admin. Code Ann. R. 65E-5.140(1) *Rights of Persons*).

## Factors Contributing to the Incorrect Use of the Baker Act

The OIG identified two factors that may have contributed to system staff incorrectly using the Baker Act to involuntarily admit the patient: a lack of training and a concern about patient elopement.

The OIG determined that annual training on the Baker Act required for mental health staff was not provided or tracked by the mental health service, which may have resulted in a lack of understanding regarding Baker Act procedures when caring for the patient. Emergency department physician 1 may have incorrectly applied the Baker Act for involuntary examination based on the understanding the VA police would not intervene to prevent the patient from eloping from the facility without a signed Baker Act form.[9]

## Lack of Oversight

At the time of the review, VHA policy outlined oversight of inpatient mental health policies and adherence to state law responsibilities to the VHA Office of Mental Health Operations staff, the Veterans Integrated Service Network (VISN) Director, and the System Director.[10] Furthermore, VHA policy that was in place at the time of the patient's care indicated that every VHA emergency department was required to have a medical director who ensured that appropriate emergency care was provided and "continually monitored," and that processes adhered to national guidelines and local policies.[11] The policy also outlined the medical director as responsible for orienting new employees to policies and staff responsibilities. However, through interviews, the OIG learned that VHA, VISN, and system level inpatient mental health leaders lacked clarity regarding who was responsible for providing oversight to ensure compliance with the Baker Act.

The OIG determined that system leaders did not have an oversight process in place and that the System Director failed to assign oversight responsibility to ensure adherence to required Baker Act procedures related to involuntary admissions. The OIG identified concerns in oversight specific to roles and responsibilities of staff, completion of monthly reviews of involuntary

[9] *Merriam-Webster.Com Dictionary*, "elope," accessed February 2, 2024, https://www.merriam-webster.com/dictionary/elope. Elope means "to leave a health-care or educational facility without permission or authorization."

[10] VHA Handbook 1160.06.

[11] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. This directive was in effect for a portion of the period of the events discussed in this report. It was rescinded and replaced by VHA Directive 1101.14, *Emergency Medicine*, March 20, 2023. The 2023 directive includes an expectation for VHA emergency departments to establish procedures for responding to patients with high-risk mental health presentations, to include implementation of involuntary hold, as appropriate, that is consistent with state law.

admissions, submission of required forms to the state of Florida Baker Act Reporting Center, and system policy that may be inconsistent with state law.

## Disengagement from VA Care

The OIG substantiated the patient disengaged from VA mental health care after being incorrectly involuntary admitted to the inpatient mental health unit and identified three additional factors that may have contributed to the patient's disengagement.

First, the OIG found that during outpatient mental health appointments prior to admission, the patient was not offered evidence-based psychotherapy for PTSD and that multiple mental health staff failed to inform the patient of available treatment options. Next, the OIG determined that turnover in mental health providers negatively impacted the development of a therapeutic alliance with the patient, a key aspect in recovery from PTSD and contributing factor in the patient's decision to withdraw from mental health care. And last, the OIG determined that despite the patient voicing concerns on multiple occasions about being involuntarily admitted under the Baker Act, staff did not document a response to the patient's concerns, likely contributing to feelings of being "misled" by facility staff. The OIG was unable to determine the extent to which, if any, the substantiated allegation may have contributed to the patient's death.

## Lack of Patient Advocate Policy Adherence

According to VHA policy, the patient advocate is responsible for managing complaints and compliments, to include resolution when needed, and communicating monthly to system leaders on quality improvement initiatives resulting from patient complaint data.[12] Complaint resolution is considered complete after communicating the outcome to the complainant.[13]

The OIG found that patient advocacy staff did not adhere to VHA policy by not following up with the complainant, who filed a complaint with the system's patient advocate.[14] Further, the OIG found that, while not required to do so, the system's process for tracking complaints does not specifically identify those pertaining to the Baker Act, thereby limiting system leaders tracking the frequency and nature of these concerns.

[12] VHA Directive 1003.04, *VHA Patient Advocacy,* February 7, 2018. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1003.04, *VHA Patient Advocacy,* November 9, 2023. The 2023 directive indicates the patient representative supervisor is responsible for monthly patient advocate leadership reporting.

[13] VHA Directive 1003.04, February 7, 2018.

[14] VHA Directive 1003.04, February 7, 2018. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1003.04, November 9, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language involving the patient advocate process.

## Recommendations

The OIG made 12 recommendations to the System Director to ensure system policies, procedures, training, and oversight specific to involuntary admissions under the Baker Act adhere to VHA regulations, provide clear guidance, and are consistent with Florida state law; confirm that staff document the offering of applicable evidence-based therapies to patients with PTSD; ensure staff follow VA policy related to the prevention of patient elopements; and review the patient advocate process for following up with complainants including final resolution until a complaint is closed.

## VA Comments and OIG Response

The Veterans Integrated Service Network and System Directors concurred with recommendations 1, 2, and 4–12 and concurred in principle with recommendation 3. Acceptable action plans were provided (see appendixes D and E). The OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General
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# Contents

# Abbreviations

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| CBOC | community based outpatient clinic |
| CSRE | Comprehensive Suicide Risk Evaluation |
| C-SSRS | Columbia-Suicide Severity Rating Scale |
| EHR | electronic health record |
| MCP | medical center policy |
| OGC | Office of General Counsel |
| OIG | Office of Inspector General |
| PTSD | posttraumatic stress disorder |
| REACH VET | Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment |
| SPC | suicide prevention coordinator |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an allegation that a patient was "misled" by staff at the North Florida/South Georgia Veterans Health System (system) and incorrectly involuntarily admitted to the inpatient mental health unit. The complainant alleged that VA staff actions led to the patient's disengagement from VA mental health care and eventual death by suicide.

## Background

The system is within Veterans Integrated Service Network (VISN) 8. The Veterans Health Administration (VHA) classifies the system as a complexity level 1a—highest complexity system.[1] The system includes two medical centers: the Malcom Randall VA Medical Center (facility) located in Gainesville, Florida, and the Lake City VA Medical Center located in Lake City, Florida. The system provides healthcare services to 26 locations spanning from northern Florida to southern Georgia, including the St. Marys Community Based Outpatient Clinic (CBOC). The St. Marys CBOC is located in Georgia and approximately 110 miles away from the facility. From October 1, 2022, through September 30, 2023, the system served 155,151 patients. The system offers primary care and specialty care services such as mental health intensive care management.

### Involuntary Mental Health Admissions

Involuntary inpatient mental health commitment is a "legal intervention" in the United States that is used to assist with the treatment of individuals with mental health illness.[2] In a review of 25 US states between 2011 and 2018, emergency involuntary hospitalization "rates per 100,000 people ranged from 29 in Connecticut to 966 in Florida."[3] Involuntary mental health admission is a controversial topic in mental health care that requires a careful balance of a patient's rights to

[1] VHA Office of Productivity, Efficiency and Staffing (OPES), "Fact Sheet: Facility Complexity Model," October 1, 2020. The VHA Facility Complexity Model categorizes medical facilities by complexity level. Complexity levels include 1a, 1b, 1c, 2, or 3, with 1a being the most complex. Facilities with a Level 1a complexity rating are described as having "high volume, high risk patients, most complex clinical programs, and large research and teaching programs."

[2] Gi Lee and David Cohen, "Incidences of Involuntary Psychiatric Detentions in 25 U.S. States," *Psychiatric Services*, (January 2021): 61–68.

[3] Lee and Cohen, "Incidences of Involuntary Psychiatric Detentions in 25 U.S. States." Rates provided include all ages, minors and adults.

"autonomy and liberty" against illnesses that may undermine autonomy and "amplify risks for violence and suicide."[4]

Physicians' professional responsibilities originate from the ethical principles of nonmaleficence, the duty to "do no harm," and beneficence, which requires that physicians offer beneficial services to patients.[5] An example of nonmaleficence includes demonstrating respect for a patient's autonomy, which can include allowing patients to participate in their decisions regarding health care and, ideally, "consenting in shared decision-making."[6] In cases where a psychiatrist believes mental health treatment would be of great benefit but the patient is rejecting treatment, the psychiatrist must weigh the obligations of nonmaleficence and beneficence when deciding whether to involuntarily admit the patient.[7]

The evaluation of a patient's need for involuntary treatment often involves an assessment of the patient's decision-making capacity, whereby if a patient lacks decision-making capacity, involuntary treatment may be justified.[8] However, the absence of decision-making capacity alone is "not enough" to support involuntary treatment, and additional considerations need to be given to

- the presence of a severe mental disorder,
- the patient's risk of danger to themselves or others, and
- a need for care.[9]

Involuntary treatment that is decided upon after a transparent assessment and evaluation process is more likely to be understood and accepted by the patient.[10] A 2014 study reviewed the principles most important to patients experiencing involuntary hospitalization and determined that patients most value participation in decision-making, safety, and respectful behavior from

[4] Nathaniel P. Morris and Robert A. Kleinman. "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization," *Psychiatric Services* 74, no. 4 (April 2023): 431–33. doi:10.1176/appi.ps.20220296; John S. Rozel, Tara Toohey, and Priyanka Amin. "Legal Considerations in Emergency Psychiatry," *Focus, FOC,* 21, no. 1 (January 16, 2023): 3–7. doi:10.1176/appi.focus.20220071.

[5] Megan Testa and Sara G. West, "Civil Commitment in the United States," *Psychiatry Edgmont,* (October 2010): 30–40.

[6] Testa and West, "Civil Commitment in the United States."; Tilman Steinert, "Ethics of Coercive Treatment and Misuse of Psychiatry," *Psychiatric Services*, (October 2016): 291–294.

[7] Testa and West, "Civil Commitment in the United States."

[8] Marie Chieze et al., "Coercive Measures in Psychiatry: A Review of Ethical Arguments," *Frontiers in Psychology*, (December 2021). Coercive measures are defined as any treatment employed "against the patient's will or in spite of his or her opposition."

[9] Marie Chieze et al., "Coercive Measures in Psychiatry: A Review of Ethical Arguments."

[10] Marie Chieze et al., "Coercive Measures in Psychiatry: A Review of Ethical Arguments."

staff.[11] Additionally, during an involuntary hospitalization, patients who experienced staff as caring and supportive did not experience a change in their self-perception, where as those who perceived the majority of staff interactions as coercive and punitive interpreted the interactions "as evidence supporting negative self-concepts and loss of identity."[12]

Involuntary hospitalizations may threaten a breakdown in the therapeutic relationship and diminish an individual's trust in mental health treatment.[13] Individuals experiencing involuntary hospitalization reported the experience as a breach of their freedom and "physical integrity."[14] Furthermore, a 2020 study found that perceived coercion during a psychiatric admission was associated with increased risk for suicide attempts in the first year following discharge.[15]

Most professionals agree that involuntary treatment is legitimate when the "infringement of some values," such as freedom of choice, is the only way to fulfill other values and goals, such as the patient's safety.[16] According to Chieze et al., clinicians should "consider and weigh all ethically pertinent elements" and "actively search for alternatives" that are more aligned with the patient's wishes and rights.[17]

## Florida Mental Health Act (Baker Act)

State legislature passed the Florida Mental Health Act, typically referred to as the Baker Act, in 1971, becoming effective the following year, with the purpose of reinforcing the civil rights of patients in mental health facilities.[18]

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[11] Emanuele Valenti, et al., "Which Values are Important for Patients During Involuntary Treatment? A Qualitative Study with Psychiatric Inpatients," *Journal of Medical Ethics*, no. 40 (2014): 832–836. https://jme.bmj.com/content/medethics/40/12/832.full.pdf.

[12] Rosalie Hughes, Mark Hayward, and W. M. L. Finlay, "Patients' Perceptions of the Impact of Involuntary Inpatient Care on Self, Relationships and Recovery," *Journal of Mental Health* 18, no. 2 (April 2009): 152-160.

[13] Marianne Wyder, et al., "Therapeutic Relationships and Involuntary Treatment Orders: Service Users' Interactions with Health-Care Professionals on the Ward," *International Journal of Mental Health Nursing*, 24 (2015): 181-189.

[14] Marianne Wyder, et al., "Therapeutic Relationships and Involuntary Treatment Orders: Service Users' Interactions with Health-Care Professionals on the Ward."

[15] Joshua T. Jordan and Dale E. McNiel, "Perceived Coercion During Admission into Psychiatric Hospitalization Increases Risk of Suicide Attempts after Discharge," *Suicide and Life-Threatening Behavior*, (February 2020): 180–188.

[16] Marie Chieze et al., "Coercive Measures in Psychiatry: A Review of Ethical Arguments."

[17] Marie Chieze et al., "Coercive Measures in Psychiatry: A Review of Ethical Arguments."

[18] Florida Department of Children and Families, Department of Mental Health Law & Policy, *2014 Baker Act, The Florida Mental Health Act, User Reference Guide*. This guide was in place during the time of the events discussed in this report. It was replaced by Florida Department of Children and Families, Office of Substance Abuse and Mental Health, *2023 Baker Act User Reference Guide,* August 2023. Unless otherwise specified, the 2023 guide contains the same or similar language regarding the Baker Act as the replaced 2014 guide. The term Baker Act will be used in this report.

The Baker Act is only applicable in cases of mental illness and safeguards several patient rights, such as

- individual dignity,
- timely and appropriate treatment,
- communication with social supports and an attorney or other representative,
- provision of the contact number for local advocacy groups and to report abuse,
- ability to request a court review of detention,
- participation in treatment and discharge planning, and
- confidentiality.[19]

The Baker Act provides criteria for voluntary and involuntary mental health care and encourages voluntary admission, if possible, treatment choice, and the ability to terminate treatment if preferred.[20]

## *Express and Informed Consent*

The Baker Act requires the admitting physician to document in the electronic health record (EHR) within 24 hours after admission that the patient is capable of express and informed consent, and if not capable, care must stop until consent is given by a person legally authorized to do so and if on voluntary admission, transferred to involuntary status.[21] Patients on involuntary status may or may not have the capability of providing express and informed consent. For patients determined to be without the capability of providing express and informed consent, a petition for an appointment of a guardian advocate needs to be filed, except in cases when a court-appointed guardian is already identified.[22]

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[19] *Baker Act, The Florida Mental Health Act, User Reference Guide*,2014; Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47892 (2023).

[20] *Baker Act, The Florida Mental Health Act, User Reference Guide*, 2014; Florida Court Education Council, *Baker Act Benchguide,* November 2016.

[21] "Baker Act Frequently Asked Questions," Florida Department of Children and Families Mental Health Program Office, accessed October 10, 2023, https://www.myflfamilies.com/crisis-services/baker-act/baker-act-frequently-asked-questions. "Express and Informed Consent" https://www.myflfamilies.com/sites/default/files/2022-11/ExpressandInformedConsentFAQs.pdf; Florida Court Education Council; Florida Mental Health Act, FLA. STAT. §§394.451-394.47892 (2023); Florida Department of Children and Families, Department of Mental Health Law & Policy. Express and informed consent is defined as "consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion." Incompetence to consent to treatment is defined as mental illness impacting a person's judgment to the point of lacking "the capacity to make a well-reasoned, willful, and knowing decision concerning medical or mental health treatment."

[22] *Baker Act, The Florida Mental Health Act, User Reference Guide*, 2014.

## Voluntary Admission

For adults seeking voluntary admission, the Baker Act specifies that an individual must show evidence of a mental illness, be appropriate for treatment, and be able to provide express and informed consent (see appendix A).[23] Facility providers are required to discharge patients on voluntary status who have demonstrated improvement such that continued admission is no longer indicated, upon patient request, or upon refusal or revocation of consent.[24] If a voluntarily admitted patient requests discharge, facility staff are required to release the patient within 24 hours, or within three days if additional time is needed for discharge planning, unless the patient meets criteria for involuntary status.[25]

## Involuntary Admission

The Baker Act outlines pathways in which a patient can be admitted to an inpatient mental health unit against his or her will (see appendix B).[26] One pathway is initiated through an "involuntary examination" by a physician or psychiatrist.[27] Another pathway, referred to as an "involuntary placement," may result from the involuntary examination in which a longer-term stay is recommended.[28] All involuntary placements require a judicial hearing to determine that the patient meets criteria for involuntary placement.[29]

### Involuntary Examination

In Florida, a court, law enforcement officer, physician, or mental health professional can determine that a person meets criteria for involuntary examination.[30] Involuntary examination criteria include

- evidence of a mental illness;
- due to the mental illness, the person refuses voluntary examination or is not capable of determining if the examination is needed; and

[23] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47892 (2023)~~)~~; Florida Court Education Council.

[24] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47892 (2023).

[25] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47892 (2023); Florida Court Education Council. Time frames exclude weekends and holidays.

[26] *Baker Act, The Florida Mental Health Act, User Reference Guide*, 2014.

[27] *Baker Act, The Florida Mental Health Act, User Reference Guide*, 2014.

[28] *Baker Act, The Florida Mental Health Act, User Reference Guide*, 2014.

[29] *Baker Act, The Florida Mental Health Act, User Reference Guide*, 2014.

[30] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47892 (2023).

- without treatment, the person will likely experience neglect or inability to care for self, resulting in significant risk that cannot be mediated by social supports, or there is significant risk of self-harm or danger to others "in the near future, as evidenced by recent behavior."[31]

When applicable, the physician or another designated professional must document on the form initiating involuntary examination that the person is not capable of determining if the examination is needed.[32] When this is documented on the form, clinical staff should presume incompetence to consent to treatment until a physician provides documentation of competence in the EHR.[33] Within 24 hours of a patient's arrival, a provider is required to complete a *physical examination* of the patient to ensure symptoms are not resulting from medical illness, injury, or drug toxicity, and notify the patient's designated representative or guardian of the patient's whereabouts.[34] A physician or clinical psychologist at the admitting facility must complete the initial *involuntary examination* within 72 hours of admission.[35]

An involuntary examination is required to include a comprehensive review of recent behavioral observations, the form initiating the involuntary examination, a brief psychiatric history, and an in-person assessment to determine if the patient meets criteria for release.[36] During the period of involuntary examination, patients are able to apply for transfer to voluntary status by completing an "Application for Voluntary Admission of an Adult."[37] The completion of the involuntary examination, as well as a physician's certification of competence to consent, is required to determine if the patient is a candidate for voluntary status.[38] Once the involuntary examination is completed, facility staff must discharge the patient, transfer the patient to voluntary status, or petition the court for involuntary placement.[39]

### *Involuntary Placement*

Should a patient continue to meet criteria for involuntary examination and "all available less restrictive treatment alternatives . . . have been judged to be inappropriate," facilities are required

[31] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47892 (2023); Florida Court Education Council.

[32] *Baker Act User Reference Guide, 2023.*

[33] Florida Court Education Council; "Express and Informed Consent," Florida Department of Children and Families Mental Health Program Office. *Baker Act User Reference Guide, 2023.*

[34] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Court Education Council.

[35] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47892 (2023). While OIG uses the term, 'mental health examination,' the state of Florida uses "initial mandatory involuntary examination."

[36] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Court Education Council.

[37] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014.

[38] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014.

[39] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47892 (2023).

to file a petition for involuntary placement that is supported by a psychiatrist and another healthcare professional, typically another psychiatrist or a clinical psychologist, who are involved with the patient's care during the time frame of the involuntary examination.[40]

## Allegations and Related Concerns

The OIG received an allegation that the patient was "misled" by system staff and was incorrectly admitted under involuntary status to the mental health unit despite seeking voluntary admission, which led to the patient discontinuing use of VA mental health care and may have contributed to the patient's death by suicide in summer 2023.

On September 27, 2023, the OIG opened a healthcare inspection to evaluate

- the use of the Baker Act to admit a patient to an inpatient mental health unit, and
- factors that may have contributed to the patient's disengagement from VA mental health care, to include actions taken by staff.

In addition, the OIG identified concerns with system leaders' oversight for use of the Baker Act and response to Baker Act related concerns.

# Scope and Methodology

The OIG initiated a healthcare inspection on September 27, 2023. An on-site visit was conducted November 28–30, 2023, with virtual interviews concluding February 2, 2024.

The OIG interviewed the complainant, VHA National Mental Health Office leaders, a VHA Senior Security leader, VISN leaders, Office of General Counsel (OGC) regional staff, system executive leaders, emergency department and mental health service leaders and staff, a system deputy chief of police, system patient advocate program leaders, system and facility staff knowledgeable of the issues under review, and a system clinical informaticist.

The OIG reviewed the Baker Act; VHA, VISN, and system policies and procedures related to involuntary mental health admissions, and the assessment and treatment of suicide prevention; VA police authority; and relevant aspects of the patient's care in the EHR relative to the allegations. In addition, the OIG team completed an EHR review of a random sample of 100 patients who were admitted to the facility's inpatient mental health unit from October 1, 2022, through September 30, 2023.

[40] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014; Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47892 (2023); Florida Court Education Council. If the time frame ends on a weekend or holiday, the petition will occur on the next business day.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

# Patient Case Summary

The patient was in their thirties and an honorably discharged veteran with a history of major depressive disorder and service-connected posttraumatic stress disorder (PTSD) who died by suicide in summer 2023.[41]

The patient established care in spring 2021 with a telehealth primary care provider at the St. Marys CBOC. The telehealth primary care provider assessed the patient as having symptoms of depression without suicidal ideation and prescribed an antidepressant medication.

Starting in summer 2021, the patient met with CBOC social worker 1 until early winter 2022, when after four individual mental health therapy sessions, CBOC social worker 1 transitioned from the position and the patient was reassigned to CBOC social worker 2. The patient met with CBOC social worker 2 in summer 2022 for an intake evaluation where the patient discussed feelings of uncertainty regarding the recent change in social workers but denied suicidal ideation and agreed to return for follow-up. CBOC social worker 2 met with the patient for another four therapy sessions until informing the patient of the upcoming departure from the position and

[41] "Post-traumatic stress disorder (PTSD)", Mayo Clinic, accessed February 13, 2024, https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967. "Posttraumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event."

referring the patient for reassignment. An appointment with a third therapist was scheduled for late 2022.

At the late 2022 appointment, a CBOC psychologist met with the patient for an initial therapy session. During that evaluation, the patient expressed concern that this was the third therapist assigned to the patient within the year and, in response, the CBOC psychologist informed the patient of the psychologist's retirement. During that appointment, the CBOC psychologist described the patient as logical and goal-oriented without suicidal ideation. At the conclusion of the appointment the patient was scheduled for a follow-up appointment in late winter 2023.

## Day 1

In the morning on a day in mid-winter 2023, the patient presented for an unscheduled appointment to the CBOC mental health clinic. A CBOC mental health nurse first assessed the patient, who requested an "inpatient stay" for depression and recent suicidal thoughts. The patient subsequently screened "positive" on the Columbia-Suicide Severity Rating Scale **(**C-SSRS**)** and specifically reported recent thoughts of suicide with intent to act on those thoughts, including how the suicide might be completed.[42] The patient reported having access to firearms and being willing to give the guns to a friend to lock up until "feeling more stable." At the conclusion of the assessment, the CBOC mental health nurse referred the patient for an immediate telehealth evaluation by a mental health nurse practitioner.

On assessment by the mental health nurse practitioner, the patient was tearful and depressed but denied current suicidal thought, intention, or plan. The patient was assessed as alert, without hallucinations or delusions, and without impairment of insight or judgment. The mental health nurse practitioner performed a comprehensive suicide risk evaluation (CSRE) and, although the patient denied current suicidal ideation, was assessed as at both high acute risk and high chronic risk for suicide.[43] To mitigate the patient's acute risk, the mental health nurse practitioner discussed a plan with the patient for voluntary inpatient admission at the facility, and placed a consult to the system's suicide prevention team.

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[42] VA Office of Mental Health and Suicide Prevention, *VA Suicide Prevention Program Guide*, December 2022. The C-SSRS is a brief question-based suicide risk screening tool that includes specific questioning about suicidal ideation, planning, and intent and a history of suicidal behaviors. A positive C-SSRS requires completion of a more detailed suicide risk assessment.

[43] VA Office of Mental Health and Suicide Prevention, *VA Suicide Prevention Program Guide*. The CSRE is required after a positive suicide risk screening and provides a more detailed suicide risk assessment that can inform clinical impressions about acute and chronic suicide risk; VA Rocky Mountain Mental Illness Research, Education, and Clinical Center, "Therapeutic Risk Management – Risk Stratification Table," accessed August 14, 2024, https://www.mirecc.va.gov/visn19/trm/table.asp. High acute risk for suicide indicates an individual who is assessed as having thoughts of death by suicide and typically requires psychiatric hospitalization. High chronic risk for suicide indicates a patient who is assessed as having chronic thoughts of death by suicide and typically requires, among other things, routine mental health follow-up and a well-articulated safety plan.

After the assessment, the mental health nurse practitioner met with the patient, the CBOC mental health nurse and, with the patient's permission, an accompanying friend. All were in agreement with a plan that the patient and the friend return to the patient's home to secure all weapons, gather some belongings, and notify the patient's employer of the upcoming hospitalization. The plan then included that the friend would drive the patient to the facility for a voluntary inpatient admission. Prior to the conclusion of clinical contact, the CBOC mental health nurse called facility emergency department nurse 1 and provided information regarding the patient's desire for assessment and inpatient mental health admission.

In early afternoon, the patient presented to the facility emergency department and emergency department nurse 2 assessed the patient as calm and cooperative and administered the C-SSRS, which was again positive with the patient reporting recent thoughts of suicide with a plan and intent. After the initial assessment, the patient was accompanied directly to the mental health area of the emergency department and emergency department physician 1 placed a consult to the psychiatry service for evaluation of the patient's suicidal ideation. After the consult to psychiatry was placed, emergency department physician 1 documented that the patient had been having suicidal ideation and depression "for the past day."

Midafternoon, emergency department physician 1 placed the patient under a 72-hour involuntary inpatient Baker Act examination hold for suicidal ideation and depression. Emergency department physician 1 certified on the Baker Act paperwork that the patient had refused an offer of voluntary inpatient admission and that the patient was unable to determine whether such an admission was necessary. Emergency department physician 1 further certified that without care or treatment, the patient was likely to suffer from neglect or refuse to care for themselves, and that such neglect or refusal posed a real and present threat of substantial harm to the patient's well-being. Separate from concerns regarding neglect, emergency department physician 1 also documented there was substantial likelihood that without care or treatment, the patient would cause harm to him or herself and to others in the near future as evidenced by recent behavior. Emergency department physician 1 provided "Depression" as the evidence and observations that were supportive of the 72-hour involuntary examination.

Approximately twenty minutes later, the mental health consult service resident assessed the patient and noted the patient was referred to the facility for admission due to severe depression and recent suicidal ideation. The resident documented that the patient reported having a bad day at work last week and that "it felt like the last straw," resulting in the patient thinking of "committing suicide by hanging" until speaking with a family member who encouraged the patient to get help "which is what brought [the patient] here." The patient reported a one-year history of feeling depressed and sad, with crying spells, fatigue, poor sleep and appetite, and trouble engaging in activities that were usually enjoyable. On assessment, the patient denied current suicidal ideation with the most recent thoughts having occurred one week prior.

The mental health consult service resident examined the patient and documented that the patient was alert and in no apparent distress, reporting a "depressed" mood without current suicidal thoughts. The mental health consult service resident assessed the patient's judgment as "fair" and thought processes appeared linear, logical, and goal-oriented. The mental health consult service resident completed a CSRE and determined that the patient was at intermediate acute risk of self-harm as evidenced by not having suicidal ideation since the week prior and that the patient appeared motivated to receive mental health treatment.[44] The mental health consult service resident recommended the patient be admitted to the inpatient mental health unit and the mental health consult service attending psychiatrist agreed after reviewing the chart and discussing the case with the resident.

The mental health consult service resident further documented that the patient was "placed under" the Baker Act by emergency department physician 1. No documentation from either the mental health consult service resident or attending psychiatrist corroborated emergency department physician 1's assessment of the patient refusing an offer of a voluntary admission or being unable to determine the need for such an admission.

Approximately thirty minutes after the mental health consult service resident assessed the patient, emergency department physician 1 documented communicating with the mental health consult team that the patient was to be admitted to the inpatient mental health unit. Emergency department physician 1 further documented the patient **"agrees with admission"** (emphasis added by the OIG). There was no documentation of the patient being offered the opportunity to be voluntarily admitted or that the patient was made aware of the involuntary nature of the admission status.

In the early evening, the patient was transferred to the locked inpatient mental health unit. On arrival, inpatient mental health nurse 1 documented the patient was "in hospital gown, appearing decently kempt and non-malodorous" and was "alert and oriented to person, place, time, and situation . . . directable and obeys commands and ambulates well." The patient denied suicidal ideation. Later that night, inpatient mental health nurse 2 observed the patient resting quietly in bed in no distress.

## Day 2

Shortly before 7:00 a.m., inpatient mental health nurse 2 documented the patient slept well overnight and was alert, oriented, calm, and cooperative with interaction. When seen later in the

[44] VA Rocky Mountain Mental Illness Research, Education, and Clinical Center, "Therapeutic Risk Management – Risk Stratification Table." Intermediate acute risk indicates an individual similar to one at high acute risk but the individual at intermediate acute risk may lack intent. In addition, behaviors preparing for suicide are likely to be absent and the individual can maintain their own safety.

morning by the inpatient mental health psychiatrist, the patient queried "I don't understand why i [*sic*] am here or baker acted." The patient spoke at length with the inpatient mental health psychiatrist and denied current suicidal ideation, noting a struggle with symptoms of depression for the past year, resulting in the patient considering suicide and ultimately coming to the VA for help. The patient voiced concern about being placed under an involuntary Baker Act hold for fear that it "will stay on [the patient's] record."[45] The patient declined an offer to restart antidepressant medication.

On examination by the inpatient mental health psychiatrist, the patient was calm and cooperative with good eye contact. The patient was alert and oriented and speech was of regular rate, rhythm, volume, and tone. The patient reported having a frustrated mood from being involuntarily placed under the "Baker Act" but denied suicidal ideation. The inpatient mental health psychiatrist documented the patient reported feeling uneasy and fearful of another patient on the unit and was requesting discharge. At the conclusion of the assessment, just before noon, the patient signed the inpatient mental health voluntary admission form, thereby removing the involuntary examination. Approximately two hours later, the patient filled out and signed the required form requesting to be released from the facility.

Early in the afternoon of day 2, a facility suicide prevention coordinator (SPC) placed a high-risk for suicide patient record flag in the patient's chart. The flag was placed in response to the suicide prevention consult from the CBOC mental health nurse practitioner the day prior. Shortly after placement of the high-risk for suicide patient record flag, the patient met with the inpatient mental health social worker who noted the patient was interested in residential treatment for symptoms related to service-connected PTSD. In cooperation with the patient, the inpatient mental health social worker placed a consult for PTSD community care residential treatment. Further, the patient requested assistance with discharge planning to the Tampa area in order to be closer to family. The inpatient mental health social worker documented concerns regarding the patient's imminent discharge given the newly placed high-risk flag for suicide and the patient's recent thoughts of suicide. The inpatient mental health resident, with the patient's permission, spoke with a family member in Tampa to whom the patient would be discharged. The family member reported no safety concerns regarding the patient and had already paid for a room at a local hotel in which the patient would stay after arrival to the Tampa area. Discharge was planned for the following morning. In addition to the community care residential PTSD consult, the inpatient mental health resident also placed a consult for aftercare appointments to the outpatient mental health and the outpatient PTSD specialty clinics at the Jacksonville VA Clinic.

In the early evening, inpatient mental health nurse 3 noted the patient was agitated, requesting an immediate discharge. Later that evening, inpatient mental health nurse 4 observed the patient to

[45] The OIG was unable to determine what "record" the patient was referencing in the discussion with the inpatient mental health psychiatrist.

be resting quietly and documented the patient stating a preference to stay in their room as "it makes me anxious being around so many people. I am not accustomed to that."

## Day 3

Just after 6:00 a.m., inpatient mental health nurse 4 noted the patient slept well overnight and was calm and cooperative. Later that morning, the inpatient mental health social worker again documented concerns regarding the safety of the patient's discharge plan noting the patient's recent suicidal ideation with plan, intent, and means. In light of these concerns, the treatment team spoke with the patient's family, who again told the team they had no safety concerns and that they will be checking in on the patient after arrival in the Tampa area. In a discussion with the patient, the inpatient mental health social worker recommended the patient remain on the unit, but the patient declined and, in preparation for discharge, they worked together to complete a suicide safety plan.

The inpatient mental health psychiatrist's discharge note documented staff concerns regarding the discharge given the recent suicidal ideation and notable increase in the patient's anxiety since admission. The team again spoke with the patient to discuss remaining on the unit for treatment, but the patient was adamant about not being suicidal and wanted to be discharged, noting that the increase in anxiety was due to an agitated and psychotic patient who had been bothering the patient since admission. The patient reiterated being upset about the involuntary hospitalization.

Prior to discharge, the inpatient mental health psychiatrist performed a CSRE and noted that the patient was at low acute risk of self-harm. At the time of discharge, the patient was scheduled for a mental health follow-up appointment with the CBOC psychologist for the following week.

## Post-discharge Contacts: Days 8-100

On the morning of day 8, the patient called the CBOC to cancel the scheduled follow-up appointment and spoke with the CBOC mental health nurse who documented,

> Veteran called the clinic to cancel [the patient's] appointment and did not reschedule. This nurse spoke to [the patient] to apologize, but [the patient] was not receptive to the apology and feels the VA failed [the patient]. Veteran previously came to the St Marys clinic [CBOC] requesting inpatient help for [the patient's] PTSD and it was coordinated with the emergency department in Gainesville [facility] for [the patient] to go there voluntarily and be admitted to get the help [the patient] was requesting. When the veteran reported and the admission process was started, rather than admit [the patient] voluntarily as [the patient] was requesting, the veteran was baker acted. This nurse along with the provider that saw the veteran were not happy as the veteran came in willingly asking for help and at no time was this nurse or the provider made aware that the

> veteran would be baker acted. Veteran stated he will be seeking care outside of the VA.

Later on day 8, the SPC contacted the patient to encourage consistent mental health appointments. The patient reported to the SPC feeling "misled by the VA" and "instead of receiving care for [the patient's] PTSD, [the patient] reports [the patient] was Baker Acted." The patient declined further VA mental health care. The patient denied suicidal ideation and reported living in the Tampa area hotel after being discharged five days prior.

On day 22, the SPC attempted a follow-up call with the patient but was unable to make contact and left a privacy compliant voicemail on the patient's phone.

On day 25, the SPC made successful contact with the patient who reported having left the Tampa area and had returned home. The patient reported plans to start a community mental health program the following day and continued to decline further VA mental health services. The patient denied suicidal ideation.

On day 30, a VA Community Care program staff member contacted the patient to schedule admission to a community care PTSD residential program, but the patient declined, and the consult was canceled.

On day 31, the patient was identified as a patient who might benefit from enhanced treatment through the VHA Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) program.[46] On the same day, the newly assigned REACH VET provider contacted the patient and learned that the patient was engaged in community mental health treatment and declined additional VA mental health care. The patient did report a plan to continue accessing primary care through VA but the patient's annual primary care appointment, scheduled for more than three months later, was ultimately canceled by the patient.

On days 74 and 92, the SPC made two unsuccessful attempts at patient contact.

On day 100, the SPC inactivated the patient's high-risk flag for suicide due to the patient's lack of engagement within the prior 30 days.

The patient received no further care from any VA healthcare system. In late summer 2023, the suicide prevention supervisor documented a conversation with the patient's family member who confirmed that in summer 2023 the patient died of a self-inflicted gunshot wound to the head.

[46] U.S. Department of Veterans Affairs, "VA REACH VET Initiative Helps Save Veterans Lives: Program Signals When More Help Is Needed for At-risk Veterans," press release, April 3, 2017, https://news.va.gov/press-room/va-reach-vet-initiative-helps-save-veterans-lives-program-signals-when-more-help-is-needed-for-at-risk-veterans/. The VHA Recovery Engagement and Coordination of Health – Veterans Enhanced Treatment (REACH VET) program was implemented in 2017 to help identify veterans receiving VHA care who are potentially at increased risk for suicide. Once a veteran is identified, his or her VA mental health or primary care provider reaches out to check on the veteran's well-being, review their condition(s) and treatment plans to determine if enhanced care is needed.

# Inspection Results

## 1. Incorrect Use of the Baker Act

The OIG substantiated the patient was incorrectly admitted under involuntary status to the mental health unit. The OIG also determined the facility failed to provide the patient with written information on rights under the Baker Act as required.

VHA requires VA facilities to establish "clear guidelines" for involuntary admission that are congruent with applicable state and local laws and requires consultation with OGC district counsel as needed.[47] At the time of the patient's care, VHA specifically required emergency department and mental health providers to be familiar with state laws for involuntary admission.[48]

The system policy requires compliance with the applicable state laws on inpatient mental health admission processes.[49] The system policy also requires that when a patient presents for voluntary inpatient mental health admission, the emergency department physician contact the on-call psychiatrist to "determine if the patient meets the criteria for voluntary admission." Further, system policy mandates that voluntarily admitted patients who request discharge are released within 24 hours unless transferred to involuntary status.

### Incorrect Involuntary Admission

The OIG substantiated that system staff admitted the patient to the mental health unit under involuntary status despite the patient's request for voluntary admission. The OIG determined staff incorrectly applied the involuntary examination criteria set forth by state law when admitting the patient.

Multiple system staff documented in the EHR or told the OIG the patient was requesting, or in agreement with, voluntary admission to the inpatient mental health unit, including

[47] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding involuntary admission as the rescinded 2013 handbook. Although the rescinded handbook did not require VA facilities to establish involuntary admission policies, it did mandate compliance with state laws. While the language in the rescinded handbook and the current directive regarding consultation with counsel differs slightly, the intent remains the same.

[48] VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics* (September 11, 2008), amended November 16, 2015. This handbook was in place during the time of the patient's inpatient mental health admission. It was rescinded and replaced by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023. The 2023 directive does not contain a specific requirement related to Emergency Department and mental health providers' familiarity with involuntary admission state laws. System policy 11-54, *Voluntary and Involuntary Admissions for Treatment of Mental Illness (Baker Act)*, April 19, 2021.

[49] System Policy 11-54.

emergency department physician 1, who initiated the involuntary examination. Documentation from emergency department staff noted that the patient was "calm and cooperative," and "feeling better and agrees with the admission."

Emergency department physician 1 completed a "Certificate of Professional Initiating Involuntary Examination" and checked off all criteria for involuntary examination, including patient refusal of voluntary examination and inability to determine the need for examination, with supporting evidence of "depression" (see appendix C). In contrast to the information written by emergency department physician 1 on the certificate, emergency department physician 1 did not document within the patient's EHR that

- the patient refused an offer to be voluntarily admitted to the inpatient mental health unit,
- there was any concern regarding the patient's decision-making capacity or ability to provide consent for an inpatient mental health admission,
- there was any concern that the patient was at risk of physical neglect, or
- the patient expressed thoughts to harm other people.

Emergency department physician 1 reported being unable to remember the patient's case and did not get a chance to review the EHR when meeting with OIG.[50] In response to questions from the OIG about why the patient may have been placed on the Baker Act, emergency department physician 1 speculated that given initiation of the Baker Act, there were concerns about the patient's safety and the patient possibly leaving. Additionally, emergency department physician 1 reported being told, in prior conversations with VA police, that officers are unable to stop patients from leaving without the state required documentation for involuntary examination.

In an interview with the OIG, the National Director, Inpatient Mental Health Services and the National Director, Continuum of Care and General Mental Health reported the expectation that VA facilities follow state and local laws regarding involuntary admission procedures. Facility staff reported to the OIG that patients are often admitted through the Baker Act involuntary examination process when they have suicidal ideation, despite requesting voluntary admission, due to concerns patients could leave before being evaluated and harm themselves, and that the VA police will not stop them from leaving unless they have been placed on an involuntary examination hold under the Baker Act. The associate chief of staff, mental health told the OIG that patients who are seeking

[50] The physician was not physically at the VA at the time of the interview. The OIG offered and conducted the interview using an online meeting platform which enabled sharing of the patient's medical record with the physician through a computer or tablet. However, the physician did not use a computer or tablet for the interview and was unable to review the patient's records.

voluntary admission could be admitted under an involuntary examination if they are high-risk for suicide and at "reasonable risk" of changing their mind about inpatient mental health care.

Emergency department physician 1 further stated that psychiatry providers, as the subject matter experts, may rescind the emergency department provider's decision to initiate the involuntary examination, as they have done in the past. Members of the psychiatry consult team and two emergency department staff members shared their observation that psychiatrists generally do not rescind the involuntary examination hold under the Baker Act, once initiated by emergency department physicians. The inpatient mental health psychiatrist reported to the OIG that the mental health consult team does not typically reverse decisions for involuntary examination unless their assessment determines that the patient can be discharged from the emergency department. The mental health consult service attending psychiatrist stated the patient's involuntary examination hold under Baker Act was not reversed due to the patient having many risk factors for suicide, concern the patient could leave if the involuntary examination hold under the Baker Act was reversed, and wanting to ensure the patient was evaluated on the inpatient unit.

The emergency department chief told the OIG the patient did not appear to need involuntary admission based on documentation in the EHR and stated that consult service mental health staff, based on their assessment and nonconcurrence of involuntary admission, could have reversed the involuntary examination process in the emergency department. The OIG found, in reviewing the EHR, the consulting psychiatrist failed to document the patient's ability to provide informed consent and request for a voluntary admission, thereby seeming to endorse the incorrect involuntary examination certificate.

The OIG determined that facility staff incorrectly admitted the patient to the inpatient mental health unit for involuntary examination. Inconsistent with applicable state regulations and VHA and system policies, facility staff failed to honor the patient's request to be voluntarily admitted. Emergency department physician 1 failed to document a clinical rationale for the selections made on the Certificate of Professional Initiating Involuntary Examination form, including that the patient refused examination or was unable to determine its need. Additionally, inconsistent with system policy, mental health consult service staff failed to adequately assess whether the patient met criteria for voluntary admission.

Disregarding patient preference for voluntary admission without clinical rationale could contribute to infringement on patient autonomy, the absence of patient-centered care, and an increase in stigma related to mental illness and treatment.

## Provision of Baker Act Rights

The OIG determined the patient did not receive written information on rights under the Baker Act.

The Baker Act requires that patients receive a written copy of their rights at the time of admission.[51]

The inpatient mental health psychiatrist reported to the OIG that a discussion with the patient occurred related to the patient's concerns about involuntary admission under the Baker Act. The OIG did not find documented evidence in the EHR that the patient was provided with a written copy on the rights associated with involuntary admission. After admission, the patient was converted to voluntary status, and signed standardized paperwork on day 2 that included a statement indicating written information on Baker Act rights associated with voluntary admission was provided; however, several system staff reported there was no written information on Baker Act rights to provide to patients as required by state regulations.[52]

In conclusion, the OIG is concerned about the accuracy of the signed paperwork and adherence to the state law. The failure to provide a written copy of Baker Act rights could contribute to patients being unaware of the inpatient mental health admission process and resources they can contact if dissatisfied with their care, as well as impact patients' trust in mental health providers and heighten distress associated with hospitalization.

## Factors Contributing to the Incorrect Use of the Baker Act

The OIG identified two factors that may have contributed to system staff incorrectly using the Baker Act to involuntarily admit the patient: a lack of training and a concern about patient elopement.

### *Lack of Training*

The OIG determined that annual training on the Baker Act required for mental health staff was not provided or tracked, which may have resulted in a lack of understanding regarding Baker Act procedures when caring for the patient.

At the time the patient presented to the emergency department for admission, VHA required all mental health and emergency department providers to have familiarity with their respective state laws specific to involuntary admissions.[53] System requirements mandated that all licensed mental health staff receive annual training on system policy and procedures specific to the Baker Act and that records are kept of this training.[54]

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[51] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014 (*noting*, Florida Mental Health Act, FLA. STAT. §§ 394.459; Fla. Admin. Code Ann. 65E-5.140 - Rights of Persons).

[52] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014.

[53] VHA Handbook 1160.01(1).

[54] System Policy 11-54.

In interviews with the OIG, multiple facility emergency department and mental health staff reported a lack of formal training on the Baker Act. The chief of psychiatry told the OIG that the system provides no formal training for staff on the Baker Act and that providers are trained on Baker Act procedures through their educational training programs, supervisors, and colleagues. The associate chief of staff, mental health corroborated that the system does not offer routine training on the Baker Act and that providers may complete training through their continuing education.

The VISN Chief Mental Health Officer and the Chief of Nursing and Quality Manager told the OIG that the VISN offered a safety forum on the Baker Act in July 2023, which was opened to all staff in the network and provided an opportunity to ask questions of subject matter experts. The VISN Chief Mental Health Officer reported multiple questions being asked during the forum and receiving feedback that the forum was helpful, stating the network planned to host similar events in the future. The VISN Chief Mental Health Officer also stated an expectation that facilities provide training to providers who may initiate the Baker Act and that all VISN facilities should have Baker Act coordinators to serve as subject matter experts. In interviews with staff, the OIG learned the system did not have this identified as a position or role at the time of the review.

The OIG found that annual training on the Baker Act for licensed mental health staff was not provided and therefore not tracked, as required by system policy. The system's failure to provide annual formal training on the Baker Act may have contributed to a lack of understanding among staff about Baker Act procedures and requirements, particularly related to the application of involuntary examination admissions.

## *Elopement Concern*

The OIG determined that emergency department physician 1 may have incorrectly initiated the Baker Act for involuntary examination based on the understanding that the VA police would not intervene to help prevent the patient from eloping from the facility without a signed Baker Act form.[55]

Federal law, not state law, governs the authority and duties of VA police officers.[56] VA considers an emergency department as an area of high-risk for staff and patient safety. The presence of VA police within the emergency department, "can serve as a deterrent against violent events, maintaining the safety and security of the clinical care environment."[57] VA and system policy requires police staff to be available to intervene, when requested, "for the management of any patient who presents a danger to self or others."[58] Staff may alert VA police regarding an incident of safety, security, and disruptive behavior issues.[59] When clinical staff have determined a patient is considered harmful to self or others, VA policy states:

> In these situations, facility police are to prevent their departure, consistent with applicable statutes, regulations, or departmental policies. Whenever this occurs, the facility police are to use the minimum amount of force determined necessary to control the situation.[60]

In interviews with the OIG, system staff reported patients, despite requesting voluntary admission, are often admitted through the Baker Act involuntary examination hold process when they have suicidal ideation. System staff explained the decision to admit patients involuntarily was due to staff concerns that patients could leave and harm themselves before being evaluated and that the VA police will not stop them unless they are placed on a Baker Act involuntary examination hold. Further, emergency department and mental health leaders and staff similarly reported that VA police will only intervene after a signed Baker Act involuntary examination form has been completed. When asked, emergency department and mental health leaders were unable to identify a written policy of the above practice and deferred to the police service. A facility VA deputy police chief corroborated the local understanding shared with the OIG in interviews that VA police cannot physically stop patients from leaving unless placed on a Baker

[55] *Merriam-Webster.com Dictionary*, "elope," accessed February 2, 2024, https://www.merriam-webster.com/dictionary/elope. Elope means "to leave a health-care or educational facility without permission or authorization."

[56] 38 U.S.C. § 901; 38 U.S.C. § 902.

[57] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017, rescinded and replaced by VHA Directive 1101.14, *Emergency Medicine,* March 20, 2023. The policies contain similar language related to police presence in the emergency department.

[58] VHA Directive 1101.05(2); System policy 11ES-01, *Emergency Department Medical Center Policy*, July 19, 2021.

[59] VHA Directive 1101.05(2).

[60] VHA Directive 1101.05(2).

Act involuntary examination hold as that would violate the constitutional right to freedom. However, when requested, the facility VA deputy police chief was unable to provide written policy to support the statement. The VHA Senior Security Office told the OIG that there is likely a misinterpretation or misunderstanding by VA police officers regarding the restriction of a person's freedom to help protect the person from harming self or others and that of restricting a person's freedom afforded by the Constitution.

The National Director, Continuum of Care and General Mental Health told the OIG that there is variability between facilities regarding how VA police interpret what they can do in response to patients who are potentially at risk of harm to self or others and want to leave an emergency department. In interviews with the OIG, the VISN Chief Mental Health Officer and Chief Medical Officer acknowledged the use of police intervention to prevent elopements has been a topic of discussion in the past. The VISN Chief Medical Officer added there is an agreement with the VA police that, when a patient is eloping, "you [the police] get the person, we [clinical staff] will sign the document." In an interview with the OIG, VHA's Senior Security Officer referred to VHA policy, which states VA police can participate as support to clinicians, intervening as VA employees to control the situation.

When asked if VA police may intervene to physically restrain a patient from eloping, the Senior Security Officer responded that as long as the request comes from a VA physician and "[the patient's] at risk . . . of danger of [self] or others. Absolutely." The Senior Security Officer further elaborated that the VA police "must help" if an emergency department physician states that a patient is at risk, adding that the requesting physician holds the responsibility of documenting in the patient's EHR to support their request. According to the Senior Security Officer, the VA Law Enforcement Training Center provides annual training on the role of VA police with patient holds. The training states that "when VA police are helping with a medical hold, they are not enforcing state law or invoking the hold under state law." Rather, the training states "they [the VA police] are providing needed assistance to a medical professional in situations where the specialized skills and training of VA police officers are invaluable in controlling the situation" referring to the VA police officers as "part of the patient care team not law enforcement."[61]

The OIG determined that, inconsistent with VA policy, system police will only intervene after the involuntary examination has been initiated and therefore staff are, at times, incorrectly implementing the Baker Act for involuntary examination due to the possibility that a patient may elope from the emergency department.

[61] VA Law Enforcement Training Center, *Medical Holds (Involuntary Mental Health Commitments)*.

## 2. Disengagement from VA Care

The OIG substantiated that the patient disengaged from VA mental health care after being incorrectly involuntary admitted to the inpatient mental health unit. Through a review of the EHR and interviews with facility staff, the OIG learned that, following discharge from the facility inpatient mental health unit, the patient canceled or did not attend scheduled mental health appointments and did not respond to phone calls made by VA staff. Additional factors that may have contributed to the patient's disengagement included

- failure to offer evidence-based treatment for PTSD,
- inconsistent outpatient mental health therapy providers, and
- inadequate response to patient concerns.

The OIG is unable to determine the extent, if any, to which the substantiated allegations contributed to the patient's death.

### Failure to Offer Evidence-Based Treatment for PTSD

The OIG found that the patient was not offered evidence-based psychotherapy for PTSD, and that multiple mental health staff failed to inform the patient of available treatment options.

All VA facilities, including CBOCs, "must provide EBP [evidenced-based psychotherapy] services for the treatment of PTSD," through in-person or telehealth modalities or by referral to the community or a Vet Center.[62] At the time of the patient's care, VHA required that all patients diagnosed with PTSD have access to therapy that is effective for the treatment of PTSD, such as "Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy."[63] In addition, patients' mental health treatment plans include documentation of "consideration of each type of evidence-based intervention for each diagnosis."[64] VHA also mandates that providers document patients'

[62] VHA Directive 1160.03(1), *Programs for Veterans with Posttraumatic Stress Disorder (PTSD),* November 16, 2017, amended April 24, 2019. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.03, *Treatment for Veterans with Posttraumatic Stress Disorder,* October 16, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding PTSD treatment requirements as the rescinded 2017 directive.

[63] VHA Handbook 1160.01(1); "Cognitive Processing Therapy (CPT) for PTSD," VA National Center for PTSD, accessed March 26, 2024; "Prolonged Exposure (PE) for PTSD," VA National Center for PTSD, accessed March 26, 2024, Prolonged Exposure (PE) for PTSD - PTSD: National Center for PTSD (va.gov); Cognitive Processing Therapy (CPT) for PTSD - PTSD: National Center for PTSD (va.gov). Cognitive Processing Therapy and Prolonged Exposure Therapy are two time-limited, cognitive behavioral therapies for the treatment of posttraumatic stress disorder.

[64] VHA Handbook 1160.01(1). This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.01. While the 2023 directive contains similar language regarding treatment requirements as the rescinded 2015 handbook, the 2023 directive does not identify specific PTSD therapies in its requirement for availability of evidence-based therapy and does not require documentation reflecting all evidence-based therapies were considered, rather that "available treatment options" are reviewed.

"treatment preferences for psychotherapy" and use evidence-based therapies to "inform the shared decision-making process" with patients.[65]

Between summer 2021 to fall 2022, the patient met with CBOC social workers 1 and 2 for a total of four and five sessions, respectively. CBOC social worker 1 documented multiple times that the patient had a diagnosis of PTSD and continuation of therapy to address PTSD. Two notes included documentation of "utilized CPT," however, the accompanying language in the notes was inconsistent with the required standardized treatment approach. CBOC social worker 2 similarly documented a diagnosis of chronic PTSD throughout sessions with the patient. CBOC social worker 2 did not document utilizing CPT, but did document other therapeutic approaches with the patient during sessions, including mindfulness, active listening, supportive therapy, and problem-solving. In late 2022, the patient met with the CBOC psychologist for one session, and the CBOC psychologist documented, "current diagnostic impressions: PTSD, Chronic," with a plan to "continue individual therapy."

The OIG reviewed the EHR and did not find documentation that the CBOC social workers or psychologist considered or offered evidence-based therapy for PTSD, such as CPT or Prolonged Exposure Therapy, as treatment options. When initially evaluated by the inpatient mental health psychiatrist, the patient reported inconsistency in previous therapy for PTSD and a preference to "start therapy" before considering medication. In an interview with the OIG, the inpatient mental health psychiatrist reported the patient requested residential PTSD treatment through the Bay Pines VA and that staff informed the patient community care access might be faster, as immediate admission to the VA residential program was not an option. Just prior to the patient's discharge, the inpatient mental health psychiatrist placed a consult for the patient to receive PTSD treatment in the community, but when contacted by scheduling staff a month after discharge, the patient reported no longer needing the care.[66]

The OIG found that, inconsistent with VHA requirements, mental health staff did not document considering evidence-based therapies for the patient's PTSD or the patient's treatment preferences, which contributed to the patient not accessing evidence-based care. The failure to provide patients with information on all available treatment options, particularly evidence-based therapies, prevents patients from receiving effective PTSD treatment, resulting in disengagement from mental health treatment.

[65] VHA Directive 1160.03(1). This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.03, *Treatment for Veterans with Posttraumatic Stress Disorder,* October 16, 2023. The 2023 directive contains similar language regarding PTSD treatment requirements as the rescinded 2017 directive, although the 2023 directive does not specify a requirement for documentation of treatment preferences; VHA Directive 1160.05, *Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions*, June 2, 2021.

[66] No further detail was provided in the EHR; therefore, it is unclear why the patient reported no longer needing the referral.

## Inconsistent Outpatient Mental Health Therapy Providers

The OIG determined the patient had three different mental health providers within a 17-month period due to staff turnover.

The bond between a mental health provider and patient, as well as mutual agreement on the tasks and goals of treatment, facilitate the creation of a therapeutic alliance. Patients with PTSD may exhibit avoidance and distrust of others that contribute to difficulty forming relationships. "The creation of a healthy therapeutic alliance . . . is therefore particularly important among people with PTSD and forms part of their recovery."[67] Further, "studies have found higher alliance to be associated with improved PTSD outcomes posttherapy."

Prior to the patient being involuntarily admitted in 2023, the OIG found the patient had three different mental health providers from early summer 2021 through early winter 2022. The patient received care from CBOC social worker 1 from early summer 2021 until mid-winter 2022. In mid-winter 2022, CBOC social worker 1 notified the patient of transitioning out of the system and provided the patient with options for a new provider. The patient "vocalized potentially speaking [with] a male provider." A late winter appointment scheduled with CBOC social worker 1 was canceled by the clinic. CBOC social worker 2 saw the patient for the first time in early summer 2022. According to EHR documentation, the patient expressed feeling "uncertainty about the change in providers." In mid-fall 2022, CBOC social worker 2 notified the patient of an upcoming change in providers and completed a discharge note.[68]

As documented in the EHR, the patient again requested a male provider and was immediately scheduled to be seen in early winter 2022 with a male CBOC psychologist. When the CBOC psychologist saw the patient, the patient shared that the provider was "the third therapist that [the patient] has seen this year." The CBOC psychologist shared with the patient plans to retire in spring 2023. The patient opted to continue services with the CBOC psychologist.

The OIG determined that turnover in mental health providers negatively impacted the development of a therapeutic alliance with the patient, a key aspect in recovery from PTSD and a probable contributing factor in the patient's decision to withdraw from mental health care.

## Inadequate Response to Patient Concerns

The OIG determined that despite the patient voicing concerns on multiple occasions about being involuntarily admitted under the Baker Act, staff did not document a response to the patient's concerns, likely contributing to feelings of being "misled" by facility staff.

[67] Howard, R., et al., "Therapeutic alliance in psychological therapy for posttraumatic stress disorder: A systematic review and meta-analysis," *Clinical Psychology & Psychotherapy* 29(2), (2022): 373–399.

[68] This change of provider was due to CBOC social worker 2 transferring to another service.

VHA's Veterans Patient Experience Framework contains processes, including service recovery, to provide veterans with an experience that "meets customers' expectations and satisfaction in a manner in which Veterans feel honored and valued in their interactions."[69] Service recovery "empowers all staff to quickly acknowledge concerns, clearly communicate the plan for resolution, and make needed amends to fulfill VA's duty to Veterans. . . ."[70] Principles of service recovery include fairness, true veteran satisfaction, anticipation and correction of problems before they occur, acknowledgment of mistakes without placing blame or making excuses, taking corrective actions in a timely manner, and follow-up.[71]

VHA's Patient Advocacy Program is a model for addressing patient concerns. The program is "an important aspect of patient satisfaction."[72] Each VA facility has a patient advocate who is responsible for assisting staff in their understanding of "the complaint process and options that are available to assist Veterans and their families regarding unresolved complaints," and their role as an advocate for the patient.[73]

In mid-winter 2023, while an inpatient, the patient's chief complaint to the inpatient mental health psychiatrist was, "I don't understand *why* [emphasis added by the OIG] I am here or baker acted."[74] The inpatient mental health psychiatrist documented the patient "was worried that the baker act will stay on [the patient's] record" and "signed [the patient] in as voluntary." On the day of discharge, the patient talked to the inpatient mental health psychiatrist and was still upset about being placed on the Baker Act, and the patient's understanding of being sent to the facility "to get a referral to the long term treatment program and instead got baker acted." During an interview with the OIG, the inpatient mental health psychiatrist reported an explanation was given to the patient that the Baker Act would not become a part of the patient's permanent EHR; however, this explanation was not documented.

Approximately a week later, the CBOC mental health nurse received a phone call from the patient canceling the patient's appointment without rescheduling. The CBOC mental health nurse wrote a narrative that the patient had previously come to the clinic "requesting inpatient help for [the patient's] PTSD and it was coordinated with the emergency department in Gainesville for [the patient] to go there voluntarily and be admitted to get the help [the patient] was requesting." The note further states that "rather than admit [the patient] voluntarily as [the patient] was requesting, the veteran was baker acted." During the call, the patient stated that future care would be sought outside of the VA. The CBOC mental health nurse attempted to apologize to the

[69] VHA Directive 1003, *VHA Veteran Patient Experience,* April 14, 2020.
[70] VHA Directive 1003.
[71] VHA Directive 1003.
[72] VHA Directive 1003.4, *VHA Patient Advocacy*, February 7, 2018.
[73] VHA Directive 1003.4.
[74] VHA Directive 1003.4. In the context of this report, the term "Baker Acted," refers to an involuntary admission.

patient who was not receptive to the apology and, reported feeling failed by the VA. Later the same day, the SPC spoke with the patient who reported feeling "misled by the VA about [the patient's] care and instead of receiving care for [the patient's] PTSD," reported being "Baker Acted." The last contact with the patient documented in the EHR by a clinician was in late winter.

The OIG did not find documentation of the patient receiving contact numbers for local advocacy organizations listed on the patient rights under the Baker Act or referral to the patient advocate and, other than the apology offered by the CBOC mental health nurse, found no additional attempts to address the patient's complaint of being involuntarily admitted. The OIG found that staff's failure to adequately respond to the patient's concerns contributed to the patient feeling misled by staff.

## 3. Lack of Oversight

The OIG found that system leaders did not have an oversight process in place to ensure adherence to required Baker Act procedures related to involuntary admissions. The OIG identified concerns in oversight specific to roles and responsibilities of staff, completion of monthly reviews of involuntary admissions, submission of required forms to the state of Florida Baker Act Reporting Center, and system policy contradicting state law.

In a sample of Baker Act documentation in the EHRs of 100 patients admitted to the facility's inpatient mental health unit between October 1, 2022, and September 30, 2023, the OIG determined 61 were admitted for an involuntary examination and 60 had the expected state required paperwork scanned into the EHR. Of those, 15 percent of the records had inaccuracies in the completion of the state required paperwork, as well as the inconsistent presence of EHR documentation of the rationale for the involuntary examination. The OIG found that for nearly 28 percent of the patients admitted for an involuntary examination, staff failed to take appropriate action within 72 hours.

### Roles and Responsibilities

The OIG found that VHA, VISN, and system level inpatient mental health leaders lacked clarity regarding who was responsible for providing oversight to ensure compliance with the Baker Act.

VHA policy that was in effect at the time of the patient's care required that VHA Office of Mental Health Operations staff ensure that all VA medical centers were in compliance with

national inpatient mental health policy.[75] According to VHA policy, VISN directors had the responsibility of ensuring inpatient mental health programs, within their respective VISNs, were "in compliance with relevant law, regulation, policy, and procedures."[76] VHA policy also stated that the health system director is responsible for "providing and maintaining inpatient mental health program oversight to ensure. . . compliance with VHA policy and procedures" and that the system mental health lead is responsible for "timely completion of all mandated reporting."[77] A second VHA policy that was in place at the time of the patient's care indicated that every VHA emergency department was required to have a medical director who ensured that appropriate emergency care was provided, care was "continually monitored," and that processes adhered to national guidelines and local policies.[78] The policy also outlined the medical director as responsible for orienting new employees to policies and staff responsibilities.[79]

According to system policy, the mental health service line is expected to provide annual training to all licensed mental health staff on policy related to the Baker Act.[80] In addition, all staff who initiate involuntary examinations are responsible for adhering to the "appropriate state requirements" and system policy on use of the Baker Act.[81]

An additional system policy outlines the chief of staff as responsible for "the overall provision of services" in the emergency department and the emergency department chief, assistant chief, emergency department nurse manager, and assistant nurse manager as responsible for both

[75] VHA Handbook 1160.06. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06. The 2023 directive does not contain responsibilities for VHA Office of Mental Health Operations staff, as the Office of Mental Health Operations was consolidated into the Office of Mental Health and Suicide Prevention in 2017. GAO, *VA Health Care: Organization of the Office of Mental Health and Suicide Prevention,* GAO-24-106023, February 2024.

[76] VHA Handbook 1160.06. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06. Unless otherwise specified, the 2023 directive contains the same or similar language regarding VISN directors ensuring compliance as the rescinded 2013 handbook.

[77] VHA Handbook 1160.06. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06. Unless otherwise specified, the 2023 directive contains the same or similar language regarding health system director responsibilities as the rescinded 2013 handbook, except that in the 2023 directive, the health system director, rather than the mental health lead, is responsible for mandated reporting.

[78] VHA Directive 1101.05(2). This directive was in effect for a portion of the period of the events discussed in this report. It was rescinded and replaced by VHA Directive 1101.14. The 2023 directive does not include these broader responsibilities of emergency department directors but includes an expectation that VHA emergency departments establish procedures for responding to patients with high-risk mental health presentations, to include implementation of involuntary hold, as appropriate, that is consistent with state law.

[79] VHA Directive 1101.05(2). This directive was in effect for a portion of the period of the events discussed in this report. It was rescinded and replaced by VHA Directive 1101.14. The 2023 directive does not include the responsibility for emergency department directors to ensure new employee orientation.

[80] System Policy 11-54.

[81] System Policy 11-54.

supervision of staff in the emergency department and the identification of staff educational needs.[82]

In response to questions about oversight, the OIG heard a variety of responses that were inconsistent with policy (see table 1).[83]

**Table 1. VHA Understanding of Baker Act Oversight Responsibility**

| VHA Source | Baker Act Compliance Oversight Responsibility |
|---|---|
| National Director, Continuum of Care and General Mental Health | VISN or system level in consultation with OGC, possibly system risk management staff member |
| VISN Chief Medical Officer | VISN leaders provide oversight to inpatient units through issue briefs, action items, and through safety |
| VISN Chief Mental Health Officer | VISN is consultative, system mental health chiefs and system Baker Act Coordinators are subject matter experts |
| System Director | Was not sure, suggested Chief of Staff or the associate chief of staff, mental health |
| System Chief of Staff | System peer review process, "mental health," associate chief of psychiatry, and inpatient mental health psychiatrist |
| Facility emergency department chief | Emergency department chief and chief nurse for critical care for emergency department staff adherence to Baker Act procedures |
| System associate chief of staff, mental health | Chief of psychiatry, associate chief of psychiatry |
| System chief of psychiatry | Chief of Staff and chief of each service |
| System associate chief of psychiatry | Individual clinician's responsibility to follow policy and law, chief ward clerk is responsible for monitoring management of paperwork |

*Source: Office of Healthcare Inspections analysis of interviews.*

[82] System Medical Center Policy 11ES-01, *Emergency Department Medical Center Policy*, July 19, 2021.

[83] VHA Handbook 1160.06. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06. Unless otherwise specified, the 2023 directive contains the same or similar language regarding inpatient mental health as the rescinded 2013 handbook.

## Monthly Reviews

The OIG determined that the system lacked a process to complete the required monthly reviews of involuntary admissions and therefore, the reviews were not done.

The VHA handbook that was in effect at the time of this inspection required the system to follow state laws "regarding the frequency of any required formal administrative reviews" of involuntary admissions, and at the minimum, to conduct monthly reviews.[84] VHA policy did not provide guidance as to the elements to be reviewed.[85]

According to the chief and associate chief of psychiatry, the system did not track any Baker Act data such as percentages of involuntary admissions, monitoring of the 72-hour time requirement for status conversion, or court filings. The National Director, Inpatient Mental Health Services indicated that at the national level no tracking was occurring for involuntary admissions, but they would consider discussing the possibility with the program evaluation center. During the same interview, the National Director, Continuum of Care and General Mental Health clarified that there was not an automatic way, even at the national level, to track involuntary admissions through the EHR.

## Submission of Forms

The OIG found the system did not submit forms to the Baker Act Reporting Center.

Florida Statutes Chapter 394 mandates submission of completed Baker Act forms, specifically those used to initiate an involuntary examination, order involuntary placement, and related face sheets to the Baker Act Reporting Center.[86] The forms are submitted by Baker Act receiving facilities, which are facilities designated by the Florida Department of Children and Families (DCF) to "receive and hold" involuntary patients for emergency psychiatric evaluation and mental health treatment.[87] Such designated facilities include crisis stabilization units and

[84] VHA Handbook 1160.06. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06. The 2023 directive does not contain a requirement for monthly reviews. Florida state law does not require organizations to conduct internal reviews on involuntary admissions.

[85] VHA Handbook 1160.06. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06.

[86] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014. The Florida Agency for Health Care Administration has identified the Louis de la Parte Florida Mental Health Institute to be the Baker Act Reporting Center. It is unclear whether the state of Florida's designation as a "receiving facility" and reporting requirements for receiving facilities applies to federal healthcare facilities.

[87] Florida Mental Health Act, FLA. STAT. § 394.455.

hospitals.[88] Other facilities within Florida, such as a federal facility, may be designated by DCF but only upon agreement by the facility's authoritative body.[89]

According to the facility associate chief of psychiatry, the mental health ward clerks manage the Baker Act paperwork but do not submit to the Baker Act Reporting Center. The chief ward clerk stated inpatient mental health ward clerks submit Baker Act 32s, the forms for involuntary placement, to the county court but have never been instructed to submit Baker Act 52s, the forms for involuntary examinations, to the Baker Act Reporting Center. The VISN Chief Medical Officer and the VISN Chief Mental Health Officer reported that VA facilities do not report Baker Act data directly to the state, but rather report it to their local court, who, in turn, hand it over to the state, per guidance by the VHA privacy officer.

System policy was not clear on whether the facility is a state designated receiving facility and had to report data to the Baker Act Reporting Center.[90] In communications with the OIG, OGC attorneys were unable to provide a definitive response about whether such reporting was required, noting that VA facilities can only report data to the state if it does not conflict with federal restrictions on release of information as determined by the VHA privacy office.

In an email provided to the OIG, the VISN Chief Mental Health Officer asserted that, based on consultation with "[VHA] Federal Privacy," Baker Act information will not be provided to the Florida State DCF "due to the risk of privacy and HIPPA [Health Insurance Portability and Accountability Act] violation." However, the VISN Chief Mental Health Officer further explained that in cases involving involuntary placements, the "information is submitted directly to the court due to the legal requirements that are in place." In written correspondence to the OIG, the system assistant chief of medical administration service clarified that only partial information on the Baker Act is reported to the court, specifically the facility ward clerks submit the petitions for involuntary placement, not information on patients admitted for involuntary examination.

## Deficient Medical Center Policies

The OIG identified that the System Director failed to ensure the system policy specific to inpatient mental health admissions included all elements from the VHA template required for use when creating a medical center policy (MCP).[91] Specifically, the policy failed to assign oversight responsibilities, which likely contributed to the lack of clarity by staff regarding who is

[88] "Baker Act Resources for Individuals & Families," Florida Department of Children and Families, www.myflfamilies.com/crisis-services/baker-act/baker-act-resources-individuals-families.

[89] Florida Mental Health Act, FLA. STAT. § 394.461(1).

[90] System Policy 11-54.

[91] VHA Directive 0999(1), *VHA Policy Management,* March 29, 2022, amended January 10, 2024.

responsible for ensuring adherence to the Baker Act. In addition, the OIG identified a concerning statement related to the Baker Act in a system emergency department policy.

## Incomplete MCP

VHA policy requires providers to follow applicable state laws governing involuntary mental health evaluation and treatment.[92] The VHA directive on policy management requires system directors to use a standardized template when creating new MCPs and provides the system director is responsible for ensuring use of the template.[93]

The template includes a paragraph entitled "Responsibilities" and a section for a "responsible owner" for the identified purpose of "oversight and guidance" of the policy. The VHA directive states

> Oversight refers to the actions taken to guide, control, monitor and evaluate the organization to help ensure policies are being implemented as intended . . . .[and in] compliance with applicable laws . . . [94]

System policy states

> Voluntary and involuntary admission of patients for treatment of mental illnesses will be completed in accordance with the appropriate state requirements of The Florida Mental Health Act (The Baker Act) VA Procedure Guide and The Georgia Mental Health Act Procedure Guide.[95]

The policy lists the "responsible owner" as the associate chief of staff for mental health but does not assign the responsible owner, or anyone else, oversight and guidance responsibilities to ensure compliance with applicable laws.[96]

The OIG concluded that the System Director's failure to assign oversight and guidance responsibilities to the "responsible owner" of the policy provided a gap which contributed to the overall lack of oversight related to the Baker Act process and clarity regarding who is responsible for ensuring adherence to the Baker Act.

## Emergency Department Policy

The OIG identified the following concerning statement related to the Baker Act in a system emergency department policy:

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[92] VHA Handbook 1160.06. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06. Unless otherwise specified, the 2023 directive contains the same or similar language regarding involuntary mental health admissions as the rescinded 2013 handbook.

[93] VHA Directive 0999(1).

[94] VHA Directive 0999(1).

[95] System Policy 11-54.

[96] System Policy 11-54.

> Any [mental health] patient with [suicidal or homicidal ideation] or with otherwise incapacitating psychosis transferred to an outside facility [non-VA institution/hospital] will be placed under a Baker Act 52 order. This is not applicable to patient transferred for detox.[97]

As written, the OIG found this statement to be lacking inclusion of key criteria to use when applying the Baker Act.[98] For example, requiring all patients with suicidal ideation to be placed on the Baker Act bypasses the potential for a patient to exercise autonomy and agree to voluntary transfer.[99] References cited in the policy do not include Florida state law related to the Baker Act.[100] Utilizing inaccurate policies can lead to staff implementing practices that pose a risk of causing harm to the patient.[101]

The OIG determined that system leaders did not have a formal oversight process for monitoring the use of the Baker Act and concluded the System Director failed to assign oversight responsibility to ensure staff compliance with the Baker Act. In addition, the OIG identified a system policy inconsistent with Florida state law, as it pertains to the Baker Act. Without designated oversight of staff compliance with the Baker Act and accurate policies, the facility is unable to correctly apply, and the system is unable to assess, compliance with state regulations.

## 4. Lack of Patient Advocate Policy Adherence

During the review, the OIG found that the system patient representative did not act in accordance with the VHA patient advocacy policy when responding to the complainant's concerns. Further, the OIG found that, while not required to do so, the system's process for tracking complaints does not specifically identify those pertaining to the Baker Act, thereby limiting system leaders tracking the frequency and nature of these concerns.

The patient advocate is responsible for managing complaints and compliments to include resolution when needed, and communicating monthly to system leaders on quality improvement initiatives resulting from patient complaint data.[102] When receiving a complaint, the patient advocate is required to enter the complaint in VHA's Patient Advocate Tracking System (PATS)

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[97] System Policy 11ES-01.

[98] *Baker Act, The Florida Mental Health Act, User Reference Guide*, 2014.

[99] *Baker Act, The Florida Mental Health Act, User Reference Guide,* 2014.

[100] System Policy 11ES-01; Baker Act, *The Florida Mental Health Act, User Reference Guide*, 2014.

[101] James O'Donnell, and F. Randy Vogenberg, "Policies and Procedures: Enhancing Pharmacy Practice and Limiting Risk," *Health Care and Law* 37, no. 6 (June 2012): 341-344, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3411206/.

[102] VHA Directive 1003.04, *VHA Patient Advocacy,* February 7, 2018. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1003.04, *VHA Patient Advocacy,* November 9, 2023. The 2023 directive indicates the patient representative supervisor is responsible for monthly patient advocate leadership reporting.

and ensure final decisions are completed[103] Complaint resolution is considered complete after communicating the outcome to the complainant.[104] All system staff are responsible for engaging in service recovery to ensure patients receive positive experiences and interactions.[105] The System Director must ensure that system staff complete trainings and understand the required responsibilities related to customer service principles and are "empowered to assist Veterans, Servicemembers, their families, caregivers, and survivors" with quality healthcare."[106]

In an interview with the OIG, the complainant indicated contacting the system patient advocate's office in summer 2023, prior to contacting the OIG, to voice concerns about the patient's experience at the facility on the day of and during the involuntary admission. Two days later, a family member of the patient, listed as the patient's next of kin and emergency contact, contacted the patient advocate's office regarding the patient's care, and reported that the patient's weapons "were confiscated during [the patient's] inpatient stay."

The patient representative from the patient advocate office assigned the complainant's request to the mental health service line for follow-up with a resolution to occur by the beginning of the following month. The patient representative initiated a "warm transfer to police services" to address the patient's family member's questions and concerns. One day after the complainant's contact with the patient representative, a psychologist documented in the PATS not making contact with the complainant due to concerns about violating the Health Insurance Portability and Accountability Act (HIPAA) since the complainant was not listed as a next of kin or emergency contact and the status of the concern was listed as resolved.[107] There was no documentation in the PATS report to indicate what actions, if any, the police took to respond to the family member or to show that the patient representative confirmed action by the police.

The patient representative supervisor reported that individuals who are not listed as a patient's next of kin or emergency contact, if not contacted by telephone, will be contacted by a mailed letter acknowledging the inquiry and providing reasoning that HIPAA regulations prevent staff from discussing patient information. Nonetheless, the patient representative and the patient

[103] VHA Directive 1003.04, February 7, 2018, VHA Directive 1003.04, November 9, 2023.

[104] VHA Directive 1003.04, February 7, 2018.

[105] Service recovery is a process to directly attempt to "recover dissatisfied or lost customers or patients" at the point of service that originated the complaint and includes "identifying and fixing the problem or making amends for the failure in customer service." VHA Directive 1003.04. February 7, 2018. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1003.04, November 9, 2023. The 2023 directive removes the definition for the term service recovery; VHA Directive 1003, *VHA Veteran Patient Experience,* April 14, 2020.

[106] VHA Directive 1003.

[107] CDC Public Health Professionals Gateway, *Health Insurance Portability and Accountability Act of 1996 (HIPAA),* https://www.cdc.gov/phlp/publications/topic/hipaa.html (accessed January 16, 2024). HIPAA is a federal law that prohibits disclosure of sensitive health information without the patient's authorization or consent.

representative supervisor confirmed that neither patient advocate staff, nor service line staff, contacted the complainant before resolving the complaint as required by VHA.

During the review, the OIG found that system staff routinely relied on the patient advocate's staff to respond to patient concerns related to involuntary admissions under the Baker Act. The associate chief of psychiatry and inpatient mental health unit staff told the OIG that patients with concerns about the Baker Act and involuntary admissions are encouraged to direct those concerns to the patient advocate. The SPC also told the OIG that patients with concerns are directed to the patient advocate. The patient representative told the OIG that no process was in place to escalate concerns to a higher level when the service level cannot provide a resolution and also stated that the veteran experience officer or patient representative supervisor can get involved at times.

In an interview with the OIG, the patient representative supervisor reported being responsible for conducting quarterly audits of randomly selected entries in the PATS to ensure processes are followed. In an interview with the OIG, the chief veteran experience officer indicated reporting data monthly to system leaders on the "top five concerns trending." Patient advocate staff organized complaint data into different categories, none of which specifically identify the Baker Act.

In a review of the complaints submitted related to the emergency department and mental health, the OIG identified multiple codes that could contain concerns related to the Baker Act, thereby limiting the system's ability to accurately monitor these types of complaints. In an interview with the OIG, the System Director reported not being aware of any complaints or concerns related to the Baker Act.

In conclusion, the OIG found that patient advocate staff did not adhere to VHA policy by not following up with the complainant and family member who filed a complaint with the system's patient advocate. Additionally, the OIG found that, while not required, complaints pertaining to the Baker Act are not uniquely tracked and communicated to system leaders.

# Conclusion

The OIG found that facility staff failed to honor the patient's request to be voluntarily admitted and determined that facility staff incorrectly admitted the patient to the inpatient mental health unit for involuntary examination. In addition, the OIG determined the patient did not receive written information on rights under the Baker Act.

Two factors that may have contributed to the staff incorrectly using the Baker Act to involuntarily admit the patient were identified. First, the OIG found that annual training on the Baker Act for licensed mental health staff was not provided and therefore not tracked, as required by system policy. The lack of training may have resulted in an incomplete understanding regarding Baker Act procedures related to the application of involuntary

examination admissions. Second, the OIG determined that, inconsistent with VA policy, system police will only intervene after the involuntary examination has been initiated. Therefore staff, at times, are incorrectly implementing the Baker Act for involuntary examination due to the possibility that a patient may elope from the emergency department.

The OIG substantiated that the patient disengaged from VA mental health care after being improperly admitted to the inpatient mental health unit under an involuntary status. Although the patient continued to express feeling upset to staff, facility staff failed to explain the reason for the involuntary admission to the patient. The OIG identified three additional factors that may have contributed to the patient's disengagement. First, the patient was not offered evidence-based psychotherapy for PTSD as multiple mental health staff failed to inform the patient of available treatment options. This could have contributed to continued or worsening symptoms and disengagement with mental health treatment. Next, the patient's documented concerns about the changing providers suggests it could be a contributing factor to the patient's decision to withdraw from mental health care. And last, despite the patient voicing concerns about being involuntarily admitted under the Baker Act on multiple occasions, staff did not document a response to the patient's concerns, likely contributing to feelings of being "misled" by facility staff. The OIG is unable to determine the extent to which, if any, the substantiated allegations contributed to the patient's death.

System leaders did not have an oversight process, such as required monthly reviews, in place to ensure adherence to required Baker Act procedures related to involuntary admissions. The OIG concluded the System Director failed to assign oversight responsibilities in the system policy addressing mental health unit admissions. This failure likely contributed to the lack of processes for ensuring adherence to the Baker Act. Without designated oversight of staff compliance with the Baker Act and accurate policies, the facility was unable to correctly apply, and the system was unable to assess, compliance with state regulations.

During the review, the OIG found patient advocate staff did not adhere to VHA policy by not following up with the complainant who filed a complaint. Additionally, while not required, the OIG learned that complaints pertaining to the involuntary admission process are not uniquely tracked and communicated to system leaders.

# Recommendations 1–12

1. The VA North Florida/South Georgia Health System Director consults with the Office of General Counsel to ensure system and service line policies and practices related to voluntary and involuntary admissions under the Baker Act provide clear guidance and are consistent with Florida state law as allowed by federal law and Veterans Health Administration regulations.

2. The VA North Florida/South Georgia Health System Director ensures that providers document their rationales for initiating involuntary examinations under the Baker Act within a patient's electronic health record and monitors compliance.

3. The VA North Florida/South Georgia Health System Director verifies that a process is in place to provide patients who are admitted for an involuntary examination under the Baker Act with written information on their rights and monitors compliance.

4. The VA North Florida/South Georgia Health System Director confirms that mental health staff document offering evidence-based therapies during treatment planning with patients diagnosed with posttraumatic stress disorder, as required by Veterans Health Administration policy, and monitors compliance.

5. The VA North Florida/South Georgia Health System Director ensures that all licensed mental health staff receive annual training on the Baker Act and tracks compliance.

6. The VA North Florida/South Georgia Health System Director determines if there is a need for non-mental health providers in the emergency department to complete Baker Act training and takes action as warranted.

7. The VA North Florida/South Georgia Health System Director, in consultation with Veterans Health Administration's Senior Security Officer, ensures system police, emergency department, and mental health staff follow VA policy specific to assisting staff in the prevention of patient elopements prior to an involuntary mental health evaluation and tracks compliance.

8. The VA North Florida/South Georgia Health System Director develops a process to provide oversight of compliance with all elements required by state law for use of the Baker Act as permitted by federal law and Veterans Health Administration policy.

9. The VA North Florida/South Georgia Health System Director, in consultation with the Office of General Counsel, determines whether Baker Act reporting by the system is required and provides clear guidance for applicable reporting processes.

10. The VA North Florida/South Georgia Health System Director develops a process to ensure system policies adhere to Veterans Health Administration Directive 0999(1), medical center policy standardized template as it pertains to assignment of oversight responsibilities.

11. The VA North Florida/South Georgia Health System Director directs a review of current patient advocate processes for follow-up and resolution with complainants, updates the process as warranted, and monitors compliance.

12. The VA North Florida/South Georgia Health System Director considers having the patient advocate process for tracking and monitoring trends capture complaints specific to involuntary admissions for leaders' awareness and follow-up.

# Appendix A: Voluntary Admission Flowchart

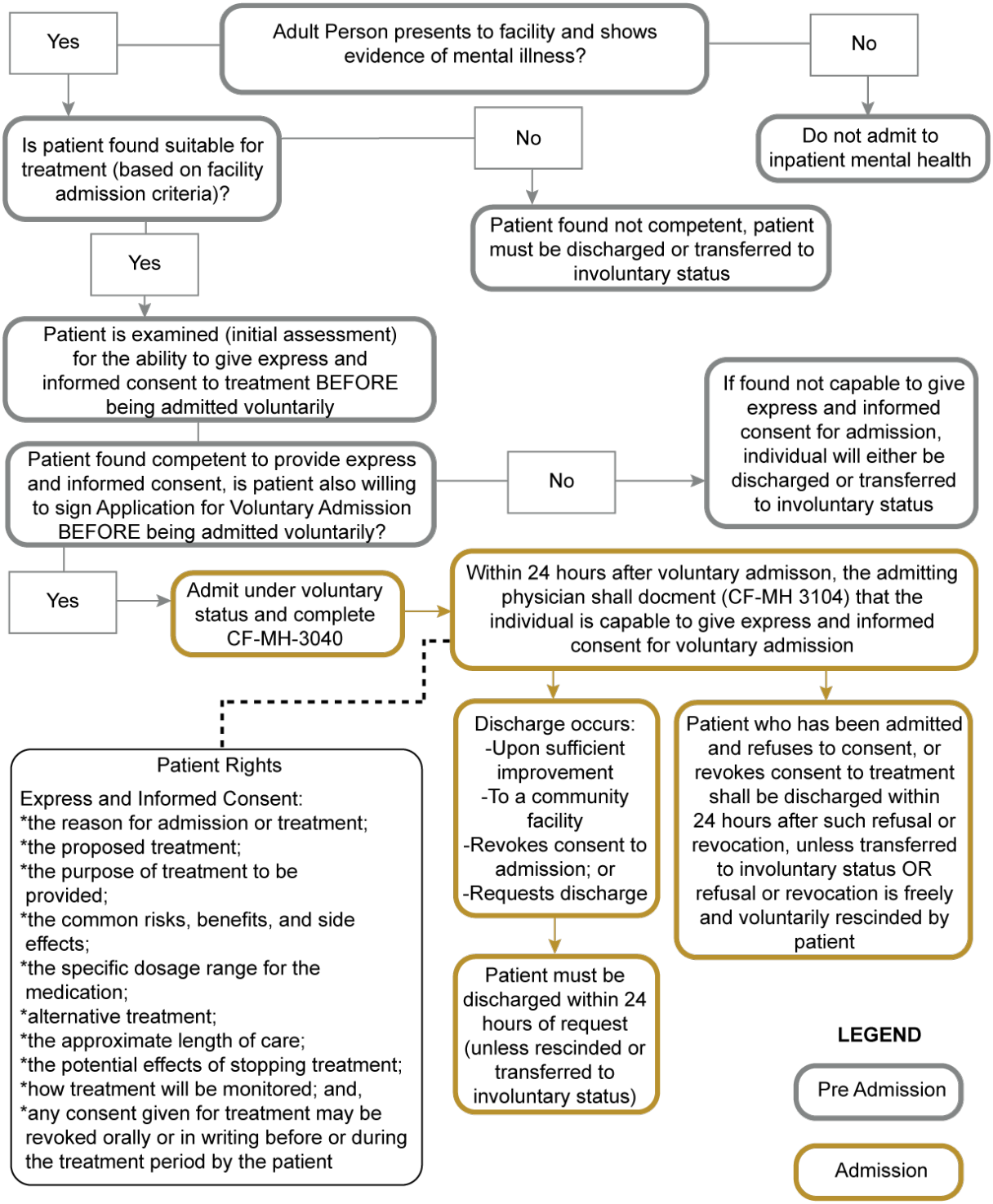



***Figure A.1.*** *Voluntary admission flowchart. Figure developed based on team's analysis of process described in the Florida Mental Health Act, User Reference Guide.*
*Source: OIG analysis based on content from Mental Health Program Office & Department of Mental Health Law & Policy, Baker Act, The Florida Mental Health Act, User Reference Guide, 2014.*

# Appendix B: Involuntary Admission Flowchart

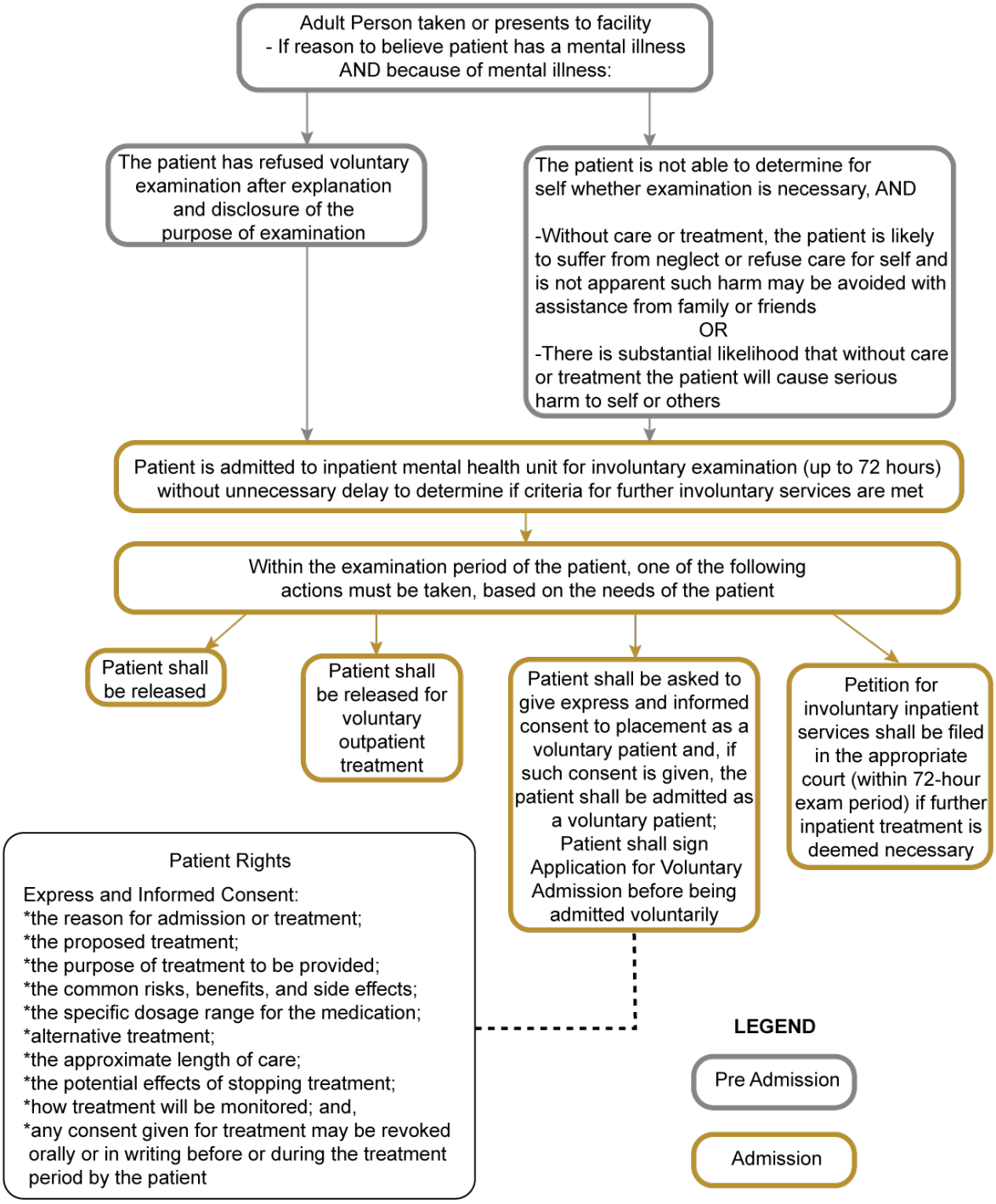
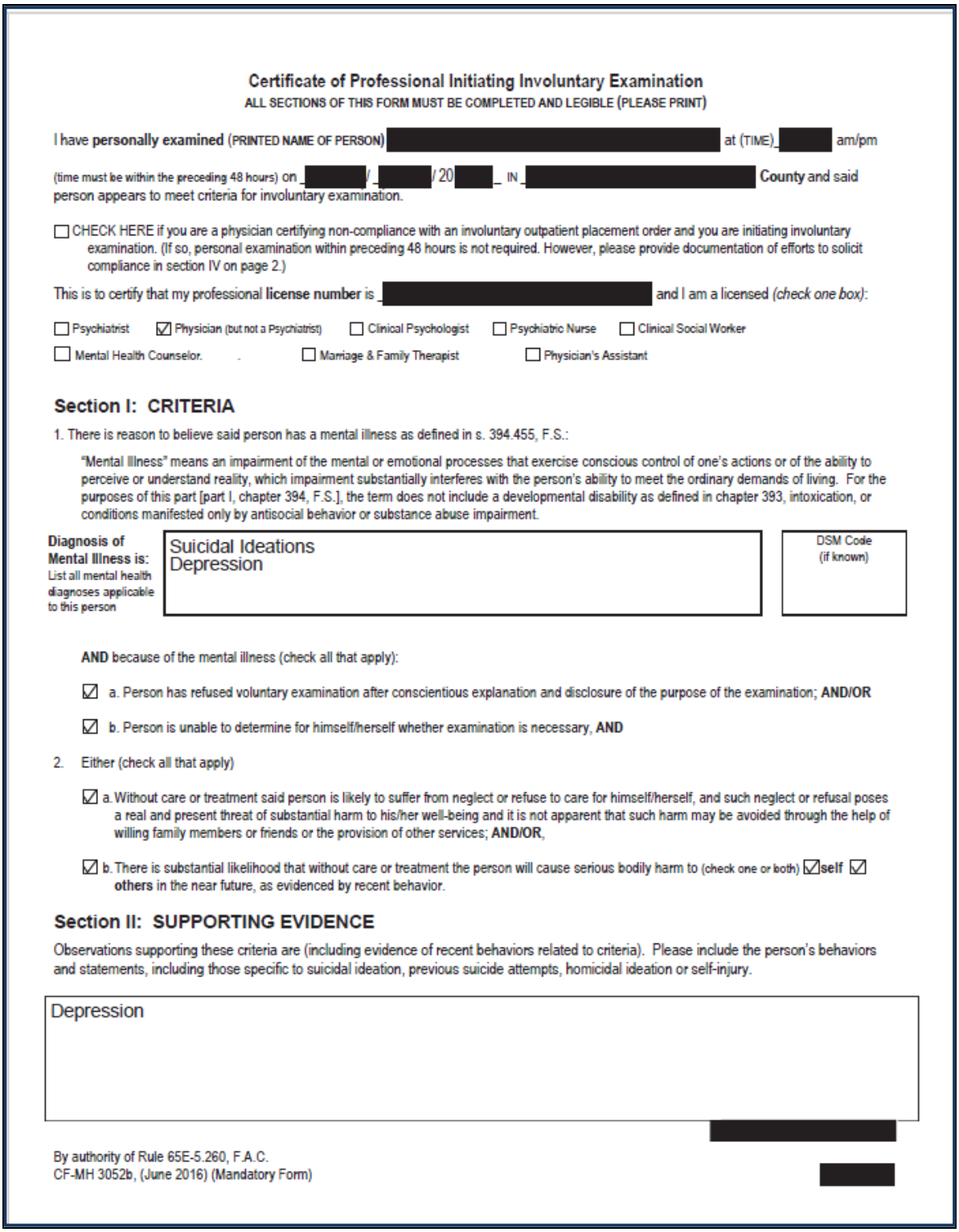



***Figure B.1.*** *Involuntary admission flowchart. Figure developed based on team's analysis of process described in the Florida Mental Health Act, User Reference Guide.*
*Source: OIG analysis based on content from Mental Health Program Office & Department of Mental Health Law & Policy, Baker Act, The Florida Mental Health Act, User Reference Guide, 2014.*

# Appendix C: Baker Act Forms



**Certificate of Professional Initiating Involuntary Examination**
ALL SECTIONS OF THIS FORM MUST BE COMPLETED AND LEGIBLE (PLEASE PRINT)

I have **personally examined** (PRINTED NAME OF PERSON) [redacted] at (TIME) [redacted] am/pm

(time must be within the preceding 48 hours) on [redacted] / [redacted] / 20[redacted] IN [redacted] **County** and said person appears to meet criteria for involuntary examination.

☐ CHECK HERE if you are a physician certifying non-compliance with an involuntary outpatient placement order and you are initiating involuntary examination. (If so, personal examination within preceding 48 hours is not required. However, please provide documentation of efforts to solicit compliance in section IV on page 2.)

This is to certify that my professional **license number** is [redacted] and I am a licensed *(check one box)*:

☐ Psychiatrist ☑ Physician (but not a Psychiatrist) ☐ Clinical Psychologist ☐ Psychiatric Nurse ☐ Clinical Social Worker
☐ Mental Health Counselor. ☐ Marriage & Family Therapist ☐ Physician's Assistant

**Section I: CRITERIA**

1. There is reason to believe said person has a mental illness as defined in s. 394.455, F.S.:

"Mental Illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part [part I, chapter 394, F.S.], the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

**Diagnosis of Mental Illness is:** List all mental health diagnoses applicable to this person: Suicidal Ideations, Depression — DSM Code (if known):

**AND** because of the mental illness (check all that apply):

☑ a. Person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **AND/OR**

☑ b. Person is unable to determine for himself/herself whether examination is necessary, **AND**

2. Either (check all that apply)

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

☑ b. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) ☑ **self** ☑ **others** in the near future, as evidenced by recent behavior.

**Section II: SUPPORTING EVIDENCE**

Observations supporting these criteria are (including evidence of recent behaviors related to criteria). Please include the person's behaviors and statements, including those specific to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury.

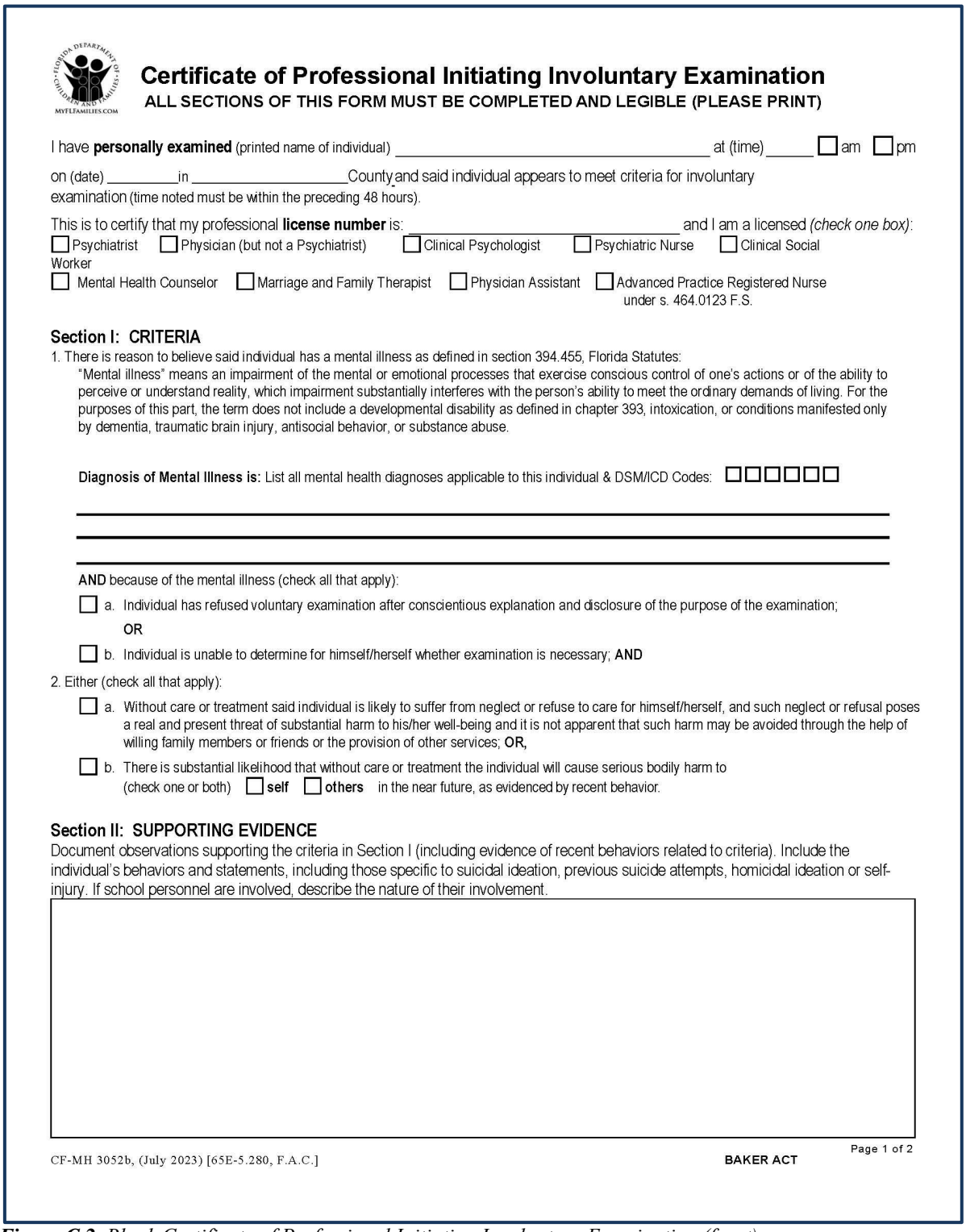
Depression

[redacted]

By authority of Rule 65E-5.260, F.A.C.
CF-MH 3052b, (June 2016) (Mandatory Form)

[redacted]

***Figure C.1***. *Patient's completed Certificate of Professional Initiating Involuntary Examination (front).*
*Source: Reproduced from patient's EHR.*



## Certificate of Professional Initiating Involuntary Examination

**ALL SECTIONS OF THIS FORM MUST BE COMPLETED AND LEGIBLE (PLEASE PRINT)**

I have **personally examined** (printed name of individual) _____ at (time) _____ ☐ am ☐ pm

on (date) _____ in _____ County and said individual appears to meet criteria for involuntary examination (time noted must be within the preceding 48 hours).

This is to certify that my professional **license number** is: _____ and I am a licensed *(check one box)*:

☐ Psychiatrist ☐ Physician (but not a Psychiatrist) ☐ Clinical Psychologist ☐ Psychiatric Nurse ☐ Clinical Social Worker

☐ Mental Health Counselor ☐ Marriage and Family Therapist ☐ Physician Assistant ☐ Advanced Practice Registered Nurse under s. 464.0123 F.S.

**Section I: CRITERIA**

1. There is reason to believe said individual has a mental illness as defined in section 394.455, Florida Statutes:
"Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by dementia, traumatic brain injury, antisocial behavior, or substance abuse.

**Diagnosis of Mental Illness is:** List all mental health diagnoses applicable to this individual & DSM/ICD Codes: ☐☐☐☐☐☐

_____

_____

_____

**AND** because of the mental illness (check all that apply):

☐ a. Individual has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination;
**OR**

☐ b. Individual is unable to determine for himself/herself whether examination is necessary; **AND**

2. Either (check all that apply):

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

☐ b. There is substantial likelihood that without care or treatment the individual will cause serious bodily harm to (check one or both) ☐ **self** ☐ **others** in the near future, as evidenced by recent behavior.

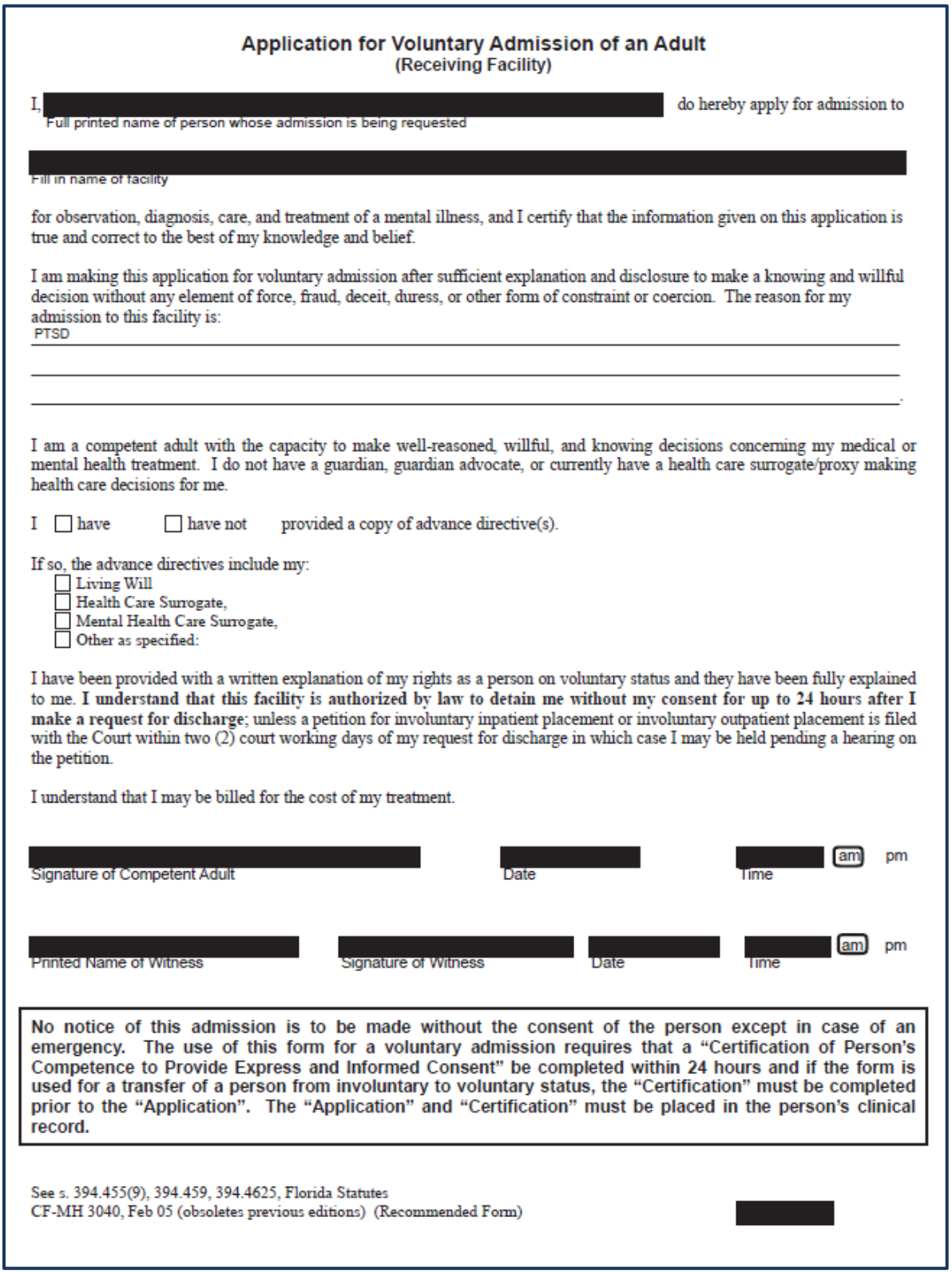
**Section II: SUPPORTING EVIDENCE**

Document observations supporting the criteria in Section I (including evidence of recent behaviors related to criteria). Include the individual's behaviors and statements, including those specific to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury. If school personnel are involved, describe the nature of their involvement.

Page 1 of 2

CF-MH 3052b, (July 2023) [65E-5.280, F.A.C.] **BAKER ACT**

***Figure C.2.*** *Blank Certificate of Professional Initiating Involuntary Examination (front)*
*Source: Florida DCF website (www.myflfamilies.com/crisis-services/baker-act/baker-act-forms).*



**Application for Voluntary Admission of an Adult**
(Receiving Facility)

I, [redacted] do hereby apply for admission to
Full printed name of person whose admission is being requested

[redacted]
Fill in name of facility

for observation, diagnosis, care, and treatment of a mental illness, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for my admission to this facility is:
PTSD

I am a competent adult with the capacity to make well-reasoned, willful, and knowing decisions concerning my medical or mental health treatment. I do not have a guardian, guardian advocate, or currently have a health care surrogate/proxy making health care decisions for me.

I ☐ have ☐ have not provided a copy of advance directive(s).

If so, the advance directives include my:
☐ Living Will
☐ Health Care Surrogate,
☐ Mental Health Care Surrogate,
☐ Other as specified:

I have been provided with a written explanation of my rights as a person on voluntary status and they have been fully explained to me. **I understand that this facility is authorized by law to detain me without my consent for up to 24 hours after I make a request for discharge**; unless a petition for involuntary inpatient placement or involuntary outpatient placement is filed with the Court within two (2) court working days of my request for discharge in which case I may be held pending a hearing on the petition.

I understand that I may be billed for the cost of my treatment.

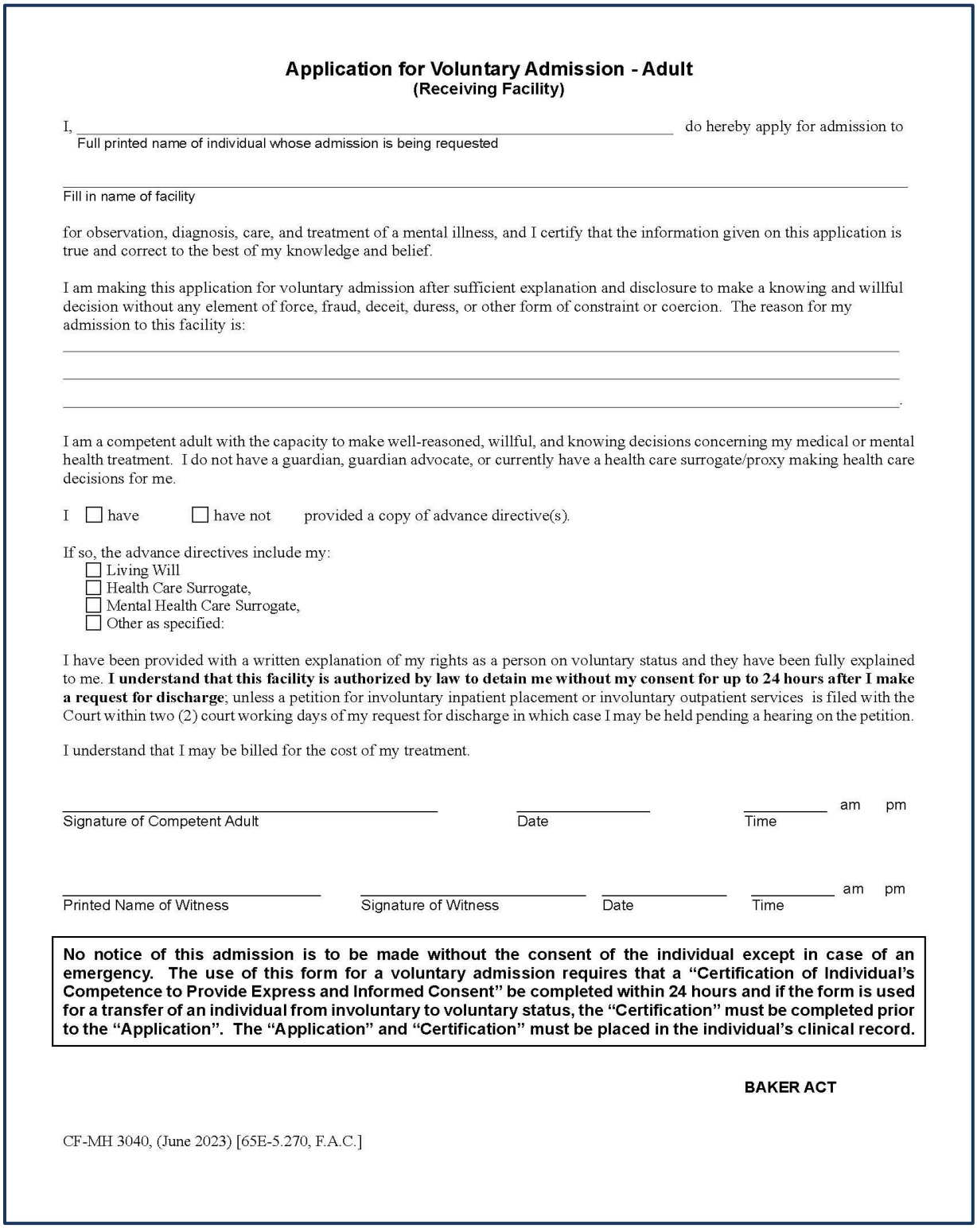
[redacted] [redacted] [redacted] am pm
Signature of Competent Adult Date Time

[redacted] [redacted] [redacted] [redacted] am pm
Printed Name of Witness Signature of Witness Date Time

**No notice of this admission is to be made without the consent of the person except in case of an emergency. The use of this form for a voluntary admission requires that a "Certification of Person's Competence to Provide Express and Informed Consent" be completed within 24 hours and if the form is used for a transfer of a person from involuntary to voluntary status, the "Certification" must be completed prior to the "Application". The "Application" and "Certification" must be placed in the person's clinical record.**

See s. 394.455(9), 394.459, 394.4625, Florida Statutes
CF-MH 3040, Feb 05 (obsoletes previous editions) (Recommended Form) [redacted]

***Figure C.3.*** *Patient's completed Application for Voluntary Admission of an Adult.*
*Source: Reproduced from patient's EHR.*



**Application for Voluntary Admission - Adult**
**(Receiving Facility)**

I, _____ do hereby apply for admission to
Full printed name of individual whose admission is being requested

_____
Fill in name of facility

for observation, diagnosis, care, and treatment of a mental illness, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for my admission to this facility is:

_____

_____

_____.

I am a competent adult with the capacity to make well-reasoned, willful, and knowing decisions concerning my medical or mental health treatment. I do not have a guardian, guardian advocate, or currently have a health care surrogate/proxy making health care decisions for me.

I ☐ have ☐ have not provided a copy of advance directive(s).

If so, the advance directives include my:
☐ Living Will
☐ Health Care Surrogate,
☐ Mental Health Care Surrogate,
☐ Other as specified:

I have been provided with a written explanation of my rights as a person on voluntary status and they have been fully explained to me. **I understand that this facility is authorized by law to detain me without my consent for up to 24 hours after I make a request for discharge**; unless a petition for involuntary inpatient placement or involuntary outpatient services is filed with the Court within two (2) court working days of my request for discharge in which case I may be held pending a hearing on the petition.

I understand that I may be billed for the cost of my treatment.

_____ _____ _____ am pm
Signature of Competent Adult Date Time

_____ _____ _____ _____ am pm
Printed Name of Witness Signature of Witness Date Time

**No notice of this admission is to be made without the consent of the individual except in case of an emergency. The use of this form for a voluntary admission requires that a "Certification of Individual's Competence to Provide Express and Informed Consent" be completed within 24 hours and if the form is used for a transfer of an individual from involuntary to voluntary status, the "Certification" must be completed prior to the "Application". The "Application" and "Certification" must be placed in the individual's clinical record.**

**BAKER ACT**

CF-MH 3040, (June 2023) [65E-5.270, F.A.C.]

***Figure C.4.*** *Blank Application for Voluntary Admission - Adult.*
*Source: Florida DCF website (www.myflfamilies.com/crisis-services/baker-act/baker-act-forms).*

# Appendix D: VISN Director Memorandum

## Department of Veterans Affairs Memorandum

Date: July 25, 2024

From: Director, VA Sunshine Healthcare Network 8 (10N8)

Subj: Healthcare Inspection—Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida

To: Director, Office of Healthcare Inspections (54HL05)
Executive Director, Office of Integrity and Compliance (10OIC)

1. We are deeply saddened by the passing of this Veteran and our sympathies go out to the Veteran's loved ones. I appreciate the partnership with the VA Office of the Inspector General. I have reviewed the report and support the North Florida/South Georgia Veterans Health System Director's response and the action plan.

2. For questions or other point of contact needs, contact the VISN 8 Quality Management Officer.

(*Original signed by:*)

Verana Richardson
Deputy Network Director

For

David Isaacks, FACHE
VISN 8 Network Director

[OIG comment: The OIG received the above memorandum from VHA on July 25, 2024.]

# Appendix E: System Director Memorandum

## Department of Veterans Affairs Memorandum

Date: July 25, 2024

From: Executive Health System Director, North Florida/South Georgia Veterans Health System, Gainesville, FL (573/00)

Subj: Healthcare Inspection—Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida

To: VISN 8 Network Director (10N8)

1. Preventing Veteran suicides is our top priority. Our thoughts go out to the Veteran's family and loved ones during this tragic time. We are using this review to strengthen processes for improved suicide prevention at our facility.

2. I appreciate the Office of Inspector General's recommendations and look forward to closing them timely. Our mission at the VA reminds us all how important it is to focus on continuous improvement activities in the delivery of care provided to our Veterans.

3. If you have any additional questions or need further information, please contact the Acting Chief, Office of High Reliability.

(*Original signed by*:)

Wende K. Dotter
Executive Health System Director
North Florida/South Georgia Veterans Health System

[OIG comment: The OIG received the above memorandum from VHA on July 25, 2024.]

# System Director Response

## Recommendation 1

The VA North Florida/South Georgia Health System Director consults with the Office of General Counsel to ensure system and service line policies and practices related to voluntary and involuntary admissions under the Baker Act provide clear guidance and are consistent with Florida state law as allowed by federal law and Veterans Health Administration regulations.

__X__Concur

____Nonconcur

Target date for completion: September 2024

### Director Comments

The Medical Center Policy will be amended to include involuntary and voluntary admission flow charts. This revised policy will be submitted to the Office of General Counsel (OGC) to ensure the Baker Act guidance is consistent with Florida state law.

## Recommendation 2

The VA North Florida/South Georgia Health System Director ensures that providers document their rationales for initiating involuntary examinations under the Baker Act within a patient's electronic health record and monitors compliance.

__X__Concur

____Nonconcur

Target date for completion: November 2024

### Director Comments

An electronic health record template was created and activated that incorporates all element fields of the Certificate of Professional initiating Involuntary Examination form. A periodic review of Involuntary Baker Act patient charts will be conducted to validate all elements of the Baker Act form are completed. Results will be monitored for compliance through the Medical Executive Council.

## Recommendation 3

The VA North Florida/South Georgia Health System Director verifies that a process is in place to provide patients who are admitted for an involuntary examination under the Baker Act with written information on their rights and monitors compliance.

__X__Concur in Principle

____Nonconcur

Target date for completion: September 2024

### Director Comments

Written information on patient rights will be displayed on a wall-mounted form in designated mental health evaluation rooms in the Emergency Department, and the Mental Health Units. This display will be in accordance with Mental Health Environment of Care (MEHOC) guidance. Interior Design will confirm that the wall-mounted information is installed and progress regarding the installation of the wall-mounted patient rights will be reported to the Health Operations Council for monitoring.

## Recommendation 4

The VA North Florida/South Georgia Health System Director confirms that mental health staff document offering evidence-based therapies during treatment planning with patients diagnosed with posttraumatic stress disorder, as required by Veterans Health Administration policy, and monitors compliance.

__X__Concur

____Nonconcur

Target date for completion: November 2024

### Director Comments

New mental health patients with the diagnosis of post-traumatic stress disorder (PTSD) will be offered evidence-based therapy options during their treatment plan development. This will be documented in the electronic health record. A periodic review of charts associated with new mental health patients with a diagnosis of PTSD, will be conducted to validate that evidence-based therapies have been offered and documented. Compliance will be monitored through the Medical Executive Council.

## Recommendation 5

The VA North Florida/South Georgia Health System Director ensures that all licensed mental health staff receive annual training on the Baker Act and tracks compliance.

__X__Concur

____Nonconcur

Target date for completion: September 2024

### Director Comments

All licensed Mental Health staff will receive annual training on the Baker Act. Completion of the training will be tracked for compliance. Training compliance will be monitored through the Medical Executive Council.

## Recommendation 6

The VA North Florida/South Georgia Health System Director determines if there is a need for non-mental health providers in the emergency department to complete Baker Act training and takes action as warranted.

__X__Concur

____Nonconcur

Target date for completion: September 2024

### Director Comments

The VA North Florida/South Georgia Health System Director determined that all licensed staff in the Emergency Medicine Service should receive annual training. Annual training on the Baker Act will be assigned to the identified staff and be tracked for compliance through the Medical Executive Council.

## Recommendation 7

The VA North Florida/South Georgia Health System Director, in consultation with Veterans Health Administration's Senior Security Officer, ensures system police, emergency department, and mental health staff follow VA policy specific to assisting staff in the prevention of patient elopements prior to an involuntary mental health evaluation and tracks compliance.

__X__Concur

____Nonconcur

Target date for completion: August 2024

### Director Comments

A Standard Operating Procedure will be developed in collaboration with the Office of the Senior Security Officer to ensure the healthcare system police, emergency department, and mental health staff follow VA policy specific to assisting staff in the prevention of patient elopements prior to an involuntary mental health admission. The newly developed policy and compliance will be monitored by the Healthcare Operation Council.

## Recommendation 8

The VA North Florida/South Georgia Health System Director develops a process to provide oversight of compliance with all elements required by state law for use of the Baker Act as permitted by federal law and Veterans Health Administration policy.

__X__Concur

____Nonconcur

Target date for completion: November 2024

### Director Comments

The VA North Florida/South Georgia Health System Director develops a process to provide oversight of compliance with all elements required by state law for use of the Baker Act as permitted by federal law.

## Recommendation 9

The VA North Florida/South Georgia Health System Director, in consultation with the Office of General Counsel, determines whether Baker Act reporting by the system is required and provides clear guidance for applicable reporting processes.

__X__Concur

____Nonconcur

Target date for completion: August 2024

### Director Comments

The VA North Florida/South Georgia Health System Director will consult with the Office of General Counsel, to determine whether Baker Act reporting by the system is required.

## Recommendation 10

The VA North Florida/South Georgia Health System Director develops a process to ensure system policies adhere to Veterans Health Administration Directive 0999(1), medical center policy standardized template as it pertains to assignment of oversight responsibilities.

__X__Concur

____Nonconcur

Target date for completion: November 2024

### Director Comments

The VA North Florida/South Georgia Health System will develop and implement a process to ensure system policies adhere to Veterans Health Administration Directive 0999(1), medical center policy standardized template as it pertains to the assignment of oversight responsibilities.

## Recommendation 11

The VA North Florida/South Georgia Health System Director directs a review of current patient advocate processes for follow-up and resolution with complainants, updates the process as warranted, and monitors compliance.

__X__Concur

____Nonconcur

Target date for completion: November 2024

### Director Comments

The VA North Florida/South Georgia Health System will conduct a review of current patient advocate processes for follow-up and resolution with complainants. The results of that review, if warranted, will inform any necessary updates to the patient advocate follow-up and resolution process. A critical review of outliers will be conducted by the Chief of Veteran's Experience Office for appropriate actions. Compliance with the process and requirements will be monitored through the Healthcare Operations Council.

## Recommendation 12

The VA North Florida/South Georgia Health System Director considers having the patient advocate process for tracking and monitoring trends capture complaints specific to involuntary admissions for leaders awareness and follow-up.

__X__Concur

____Nonconcur

Target date for completion: November 2024

### Director Comments

A review to determine the feasibility of including complaints specific to involuntary admissions will be conducted. Findings will be reported to the Healthcare Operations Council and if needed, appropriate follow-up actions will be implemented.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| **Inspection Team** | Susan Tostenrude, OT, MS, Director<br>Jennifer Caldwell, PhD<br>Ting Hang T. Cha, PharmD<br>Debbie Davis, JD<br>Michelle Loewy, PhD<br>Sarah Reading, MD<br>Ann Ver Linden, RN, MBA |
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# Report Distribution

## VA Distribution

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General Counsel
Director, VA Sunshine Healthcare Network 8 (10N8)
Director, VA North Florida/South Georgia Health Care System (573/00)

## Non-VA Distribution

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House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
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