HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 361 Mental Health
SPONSOR(S): Health & Human Services Committee, Children, Families & Seniors Subcommittee, Silvers and others
TIED BILLS: HB 363 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	Gilani	Brazzell
2) Appropriations Committee	29 Y, 0 N	Potvin	Pridgeon
3) Health & Human Services Committee	18 Y, 0 N, As CS	Gilani	Calamas

SUMMARY ANALYSIS

Mental illness affects millions of people in the United States each year. One in five adults experiences mental illness in a given year, and one in five children ages 13-18 have or will have a serious debilitating mental illness at some point during their life. In 1971, the Legislature passed the Florida Mental Health Act (also known as "The Baker Act") to address the mental health needs of individuals in the state. The Baker Act allows voluntary and, under certain circumstances, involuntary, examinations of individuals suspected of having a mental illness and presenting a threat of harm to themselves or others. An individual may be held for an involuntary examination for up to 72 hours. When the patient is a minor, the examination must be initiated within 12 hours after the minor patient arrives at the facility.

CS/CS/HB 361 addresses mental health issues in various ways. Specifically, the bill:

- Addresses the increased risk of suicide in youth by enhancing the voluntary Suicide Prevention Certified Schools Program and encouraging school districts to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of an involuntary examination;
- Increases data gathering on involuntary examinations and requires the Department of Children and Families to report every two years on its findings and recommendations related to involuntary examinations initiated on minors; and
- Reduces the potential for violence by requiring certain mental health professionals and service providers at mental health facilities to report to law enforcement when a patient communicates a specific threat of serious bodily harm against an identifiable individual, and requires law enforcement to take appropriate action to protect the victim.

The bill has an indeterminate negative, but likely insignificant fiscal impact on DCF, DOE, and school districts.

The bill is effective July 1, 2019.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. One in five adults experiences mental illness in a given year, [4] and one in five children ages 13-18 have or will have a serious debilitating mental illness at some point during their life.[5] Half of all lifetime cases of mental illness begin by age 14, and scientists are discovering that changes in the body leading to mental illness may start much younger, before any symptoms appear.[6] Suicide is the third leading cause of death in youth age 10 to 24 and research indicates that 90 percent of people who die by suicide have an underlying mental illness.[7]

Baker Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[8] The Act includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[9]

---

[1] WORLD HEALTH ORGANIZATION, *Mental Health: Strengthening Our Response,* https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited Mar. 15, 2019).
[2] CENTERS FOR DISEASE CONTROL AND PREVENTION, *Learn about Mental Health*, http://www.cdc.gov/mentalhealth/basics.htm (last visited Mar. 15, 2019).
[3] Id.
[4] NATIONAL ALLIANCE ON MENTAL ILLNESS, *Mental Health Facts in America,* http://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf (last visited Mar. 15, 2019).
[5] NATIONAL ALLIANCE ON MENTAL ILLNESS *Mental Health Facts: Children & Teens*, http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf (last visited Mar. 15, 2019).
[6] NATIONAL INSTITUTE OF MENTAL HEALTH, *Children and Mental Health*, https://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml (last visited Mar. 15, 2019).
[7] *Supra* note 5.
[8] Ss. 394.451-394.47892, F.S.
[9] S. 394.459, F.S.

Involuntary Examination and Receiving Facilities

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[10] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:[11]

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; **and**
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or 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**
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Involuntary patients must be taken to either a public or a private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[12] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.[13] Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[14]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[15] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[16] The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[17] Individuals often enter the public mental health system through CSUs.[18] For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by Legislature in the 1970s to ensure continuity of care for individuals.[19]

As of March 2019, there are 121 Baker Act receiving facilities in this state, including 53 public receiving facilities and 68 private receiving facilities.[20] Of the 53 public receiving facilities, 40 are also contracted to provide CSU services.[21]

---

[10] Ss. 394.4625 and 394.463, F.S.
[11] S. 394.463(1), F.S.
[12] S. 394.455(39), F.S. This term does not include a county jail.
[13] S. 394.455(37), F.S
[14] Rule 65E-5.400(2), F.A.C.
[15] S. 394.875(1)(a), F.S.
[16] Id
[17] Id.
[18] FLORIDA SENATE, Budget Subcommittee on Health and Human Services Appropriations, *Crisis Stabilization Units*, (Interim Report 2012-109) (Sept. 2011), available at https://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-109bha.pdf (last visited Mar. 15, 2019).
[19] Id. Sections 394.65-394.9085, F.S.
[20] DEPARTMENT OF CHILDREN AND FAMILIES, *Designated Baker Act Receiving Facilities*, (Mar. 7, 2019), available at http://www.dcf.state.fl.us/service-programs/samh/crisis-services/docs/baker/Baker%20Act%20Receiving%20Faciliites.pdf (last visited Mar. 15, 2019).
[21] Id.

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[22] During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met.[23] If the patient is a minor, the examination must be initiated within 12 hours.[24]

Within that 72-hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next business day, one of the following must happen: [25]

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to a placement as a voluntary patient and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

There were 199,944 involuntary examinations in Fiscal Year 2016-2017, 32,763 of which were of minors.[26]

Involuntary Examinations FY 2001-2002 through FY 2016-2017[27]

Fiscal Year	All Ages		Children (< 18)	
	Involuntary Examinations	% Increase to FY 2016/2017	Involuntary Examinations	% Increase to FY 2016/2017
2016-2017	199,944		32,763	
2015-2016	194,354	2.88%	32,475	0.86%
2014-2015	187,999	6.35%	32,650	0.32%
2013-2014	177,006	12.96%	30,355	7.91%
2012-2013	163,850	22.03%	26,808	22.18%
2011-2012	154,655	29.28%	24,836	31.89%
2010-2011	145,290	37.62%	21,752	50.58%
2009-2010	141,284	41.52%	21,128	55.03%
2008-2009	133,644	49.61%	20,258	61.69%
2007-2008	127,983	56.23%	19,705	66.23%
2006-2007	120,082	66.51%	19,238	70.26%
2005-2006	118,722	68.41%	19,019	72.22%
2004-2005	114,700	74.32%	19,065	71.81%
2003-2004	107,705	85.64%	18,286	79.13%
2002-2003	103,079	93.97%	16,845	94.45%
2001-2002	95,574	111.42%	14,997	118.41%

Task Force Report on Involuntary Examination of Minors

In 2017, concerned with the dramatic increase in the number of involuntary examinations of minors since 2002, the Legislature created a task force within DCF to address the issue of involuntary examination of minors 17 years old and younger.[28] The bill required the task force to:

[22] S. 394.463(2)(g), F.S.
[23] S. 394.463(2)(f), F.S.
[24] S. 394.463(2)(g), F.S.
[25] S. 394.463(2)(g), F.S.
[26] FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES, *The Baker Act Fiscal Year 2016/2017 Annual Report*, (June 2018), p. 5, available at: http://www.dcf.state.fl.us/service-programs/samh/publications/ (last visited Mar. 15, 2019).
[27] Id.
[28] Ch. 2017-151, Laws of Fla.; HB 1121 (2017).

- Analyze data on the initiation of involuntary examinations of children;
- Research the root causes of trends in such examinations;
- Identify and evaluate options for expediting examinations for children; and
- Identify recommendations for encouraging alternatives to these examinations.

The task force was composed of stakeholders from the education, mental health, law enforcement, and legal fields. The task force was required to submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2017; the task force submitted its report on November 15, 2017.[29]

Data Analysis

Based on an analysis of available data regarding involuntary examinations of minors, the task force found that:[30]

- Involuntary examinations for children occur in varying degrees across counties.
- There is an increasing trend statewide and in certain counties to initiate involuntary examinations of minors.
- The seasonal pattern shows that involuntary examinations are more common when school is in session.
- Some children have multiple involuntary examinations, although most children who have an involuntary examination have only one.
- Decreases in juvenile arrests correlate with increases of involuntary examinations of children, although it is important to note that the analyses did not show a causal link and there has been a long pattern of decreases in juvenile crime over more than a decade.
- While recent increases in involuntary examinations in certain counties are deserving of focus, a more important focus needs to be on counties that have high rates of involuntary examination. Counties with high rates are, for the most part, not the same counties with the recent increases.
- The most common involuntary examination for children is initiated by law enforcement based on evidence of harm to self.
- The majority of involuntary examinations initiated for children by mental health professionals are initiated by physicians, followed by licensed mental health counselors, and clinical social workers, with many fewer initiated by psychologists, psychiatric nurses, marriage and family therapists, and physicians' assistants.

Root Causes of Increased Involuntary Examinations of Minors

The task force determined that it is not possible to identify specific root causes directly linked to the trend of increased Baker Act initiations because of the complexity of the issue and the limitations of the available data. However, it identified the following areas as potential root causes or contributing factors to the increase in Baker Act initiations among children in Florida:[31]

- Social stressors and risk factors, including, but not limited to, child abuse and trauma; parents or caretakers with substance use disorders or mental illnesses affecting their parental capability; school and public shootings; and social media and cyber bullying.
- Prevalence of behavioral health disorders among children and teens.
- Limited availability of and access to a continuum of services and supports.

[29] DEPARTMENT OF CHILDREN AND FAMILIES, Office of Substance Abuse and Mental Health, *Task Force Report on Involuntary Examination of Minors*, (Nov. 15, 2017), available at: http://www.dcf.state.fl.us/service-programs/samh/publications/ (last visited Mar. 15, 2019).
[30] Id. at 20.
[31] Id. at 21-25.

- Inadequate investment in the lives of children, youth, and families, including waiting lists for services, limitations on coverage or approval, a lack of funding for prevention and diversion services, and a shortage of psychiatrists.

It also noted that the increased use of involuntary examinations under the Baker Act for minors could be the positive result of years of systemic changes to increase awareness and action when a minor is experiencing a crisis.[32] For example, law enforcement and other first responders are being trained to recognize the symptoms of mental illness and initiate Baker Act examinations rather than arresting minors.[33]

Recommendations

The task force made six recommendations for encouraging alternatives to and eliminating inappropriate initiations of involuntary examinations of minors under the Baker Act.[34] In 2018, the Legislature adopted three of the task force's recommendations as part of its sweeping legislation in SB 7026, in response to the school shooting at Marjory Stoneman Douglas High School in Parkland, Florida.[35] This included increasing funding to support prevention and early intervention services to address mental health challenges prior to them becoming a crisis,[36] expanding access to outpatient crisis intervention services and treatment,[37] and requiring school resource officers to complete mental health crisis intervention training,[38] including skills training to ensure student and officer safety during incidents involving students with emotional disturbance or mental illness.[39]

The following task force recommendations have not yet been implemented by the Legislature:[40]

- Encourage school districts, through legislative intent language, to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination.[41]
- Amend s. 394.463(2)(a), F.S., to increase the number of days, from the next working day to five working days, that the receiving facility has to submit forms to DCF required by s. 394.463(2)(e), F.S.[42] The task force states that this change would allow DCF to capture data on whether the minor was admitted, released, or a petition filed with the court.[43]

---

[32] Id. at 24.
[33] Id.
[34] *Supra*, note 29 at 26-28.
[35] Ch. 2018-3, Laws of Fla.
[36] Using a $9.3 million appropriation in the bill, DCF was required to contract with managing entities to establish additional community action treatment teams (CAT Teams) throughout the state to complement the services of the 26 teams then currently operating. These CAT Teams are required to: Provide community-based behavioral health and support services to children from 11 to 13 years of age, adolescents, and young adults from 18 to 21 years of age with serious behavioral health conditions who are at risk of out-of-home placement; Use an integrated service delivery approach to comprehensively address the needs of the child, adolescent, or young adult and strengthen his or her family and support system, address therapeutic needs, assist in obtaining services and support, make referrals for specialist treatment providers if necessary, and follow up to ensure services are received; Focus on engaging the child, adolescent, or young adult and his or her family as active participants in every phase of the treatment process; and Coordinate with other key entities providing services and supports to the child, adolescent, or young adult and his or her family (i.e. through the school, child welfare system, and juvenile justice system). S. 394.495(6), F.S.
[37] Using an $18.3 million appropriation in the bill, DCF was required to competitively procure proposals for additional mobile crisis teams to ensure reasonable access among all counties, taking into consideration the geographic location of existing mobile crisis teams, and select providers to serve areas of greatest need.
[38] CIT training is an effective law enforcement response program designed for first responders who handle crisis situations involving individuals with mental illness or co-occurring disorders. It emphasizes a partnership between law enforcement, the mental health and substance abuse treatment system, mental health advocacy groups, and consumers of mental health services and their families. Additionally, this training offers evidence-informed techniques designed to calm the individual in crisis down, reduces reliance on the Baker Act as a means of handling the crisis, and informs individuals of local resources that are available to people in need of mental health services and supports.
[39] S. 1006.12(1)(c), F.S.
[40] *Supra*, note 29 at 26-28.
[41] Id. The Task Force found that data supports the conclusion that implementation of risk assessment protocols significantly reduced the number of children and youth who received Baker Act initiations in school districts across the state.
[42] *Supra*, note 29 at 30.
[43] Id.

Suicide Prevention Certified Schools

Section 1012.583, F.S., requires the Department of Education (DOE), in consultation with the Statewide Office for Suicide Prevention[44] and suicide prevention experts, to develop a list of approved youth suicide awareness and prevention training materials that may be used for training in youth suicide awareness and prevention for school instructional personnel. The approved list of materials:[45]

- Must include training on how to identify appropriate mental health services and how to refer youth and their families to those services;
- May include materials currently being used by a school district if such materials meet any criteria established by the department; and
- May include programs that instructional personnel can complete through a self-review of approved youth suicide awareness and prevention materials.

A school is considered a "Suicide Prevention Certified School" if it chooses to incorporate 2 hours of DOE-approved training materials and requires all of its instructional personnel to participate in the training. A school that chooses to participate must notify DOE of its participation. DOE must keep an updated record of all Suicide Prevention Certified Schools, but there is currently no requirement that DOE, school districts, or schools post this information on their websites.

Mental Health Professional Duty to Warn

Clinical records maintained by mental health facilities, which can include medical records, progress notes, charts, and admission and discharge data, and all other recorded information pertaining to the patient's hospitalization or treatment,[46] are confidential and exempt by statute.[47] Similarly, communications between a patient and a psychiatrist, psychologist, mental health counselor, marriage and family therapist, or clinical social worker are confidential.[48] Patients may always agree to the release of their clinical records or communications,[49] but the law also provides for certain exceptions where a mental health professional may breach this confidentiality without the patient's consent.

One instance where mental health professionals may breach confidentiality is when the patient has communicated an intent to physically harm an identifiable victim. In such instances, the mental health professional may release information from the clinical record or disclose a communication, but only to the extent necessary, to warn a potential victim or communicate the threat to a law enforcement agency.[50] While mental health professionals currently may breach patient confidentiality to communicate threats made against an identifiable person, there is no law that requires them to do so.

Approximately 30 states have adopted a mandatory duty to warn in some form.[51] These states' regulations and case law vary in which mental health professionals have a duty to warn, who they must report the threat to, and what actions they must take to either warn or protect the victim.[52] Florida is one of 16 states and Washington D.C. that currently has a permissive duty to warn.[53] Four states do not have any laws or case law addressing the issue.[54]

[44] The Statewide Office of Suicide Prevention, housed within the Department of Children and Families, coordinates education and training curricula in suicide prevention efforts for law enforcement personnel, first responders to emergency calls, health care providers, school employees, and other persons who may have contact with persons at risk of suicide. S. 14.2019, F.S.
[45] S. 1012.583(1), F.S.
[46] S. 394.455(6), F.S.
[47] S. 394.4615, F.S.
[48] Ss. 394.4615, 456.059, 490.0147, and 491.0147, F.S.
[49] Ss. 394.4615, 456.059, 490.0147, and 491.0147, F.S.
[50] Ss. 394.4615(3)(a), 456.059, 490.0147(3), and 491.0147(3), F.S.
[51] NATIONAL CONFERENCE OF STATE LEGISLATURES, *Mental Health Professionals' Duty to Warn,* (Rev. Oct. 2018), http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx#1 (last visited Apr. 10, 2019).
[52] Id.
[53] Id.
[54] Id. Those states are NV, NC, ND, and WI.

Sexually Violent Predator Program Criminal History Records Access

Federal Criminal History Record Information Databases

The Federal Bureau of Investigation administers the National Crime Information Center (NCIC) database, containing information on persons subject to civil protection orders and arrest warrants, and the Interstate Identification Index (III), containing criminal history record information (CRHI). Under federal regulation, CRHI from the NCIC/III-databases is made available to criminal justice agencies for criminal justice purposes.[55]

The National Crime Prevention and Privacy Compact defines "criminal justice agency" as a:[56]

- Court; or
- Governmental agency or any subunit thereof that:
    - Performs the administration of criminal justice pursuant to statute or executive order; and
    - Allocates a substantial part of its annual budget to the administration of criminal justice.

"Criminal justice" under the Compact includes activities relating to detection, apprehension, detention, pretrial release, post-trial release, prosecution, adjudication, correctional supervision, or rehabilitation of accused persons or criminal offenders.

The exchange of CRHI between the federal government and states is subject to cancellation if disseminated to unintended recipients.[57]

Sexually Violent Predator Program

A sexually violent predator is a person who has been convicted of a sexually violent offense[58] and has a mental abnormality or personality disorder that makes them likely to engage in future acts of sexual violence if not confined to a secure facility for long-term control, care, and treatment.[59] To address the treatment needs of these offenders, Legislature enacted the Involuntary Civil Commitment of Sexually Violent Predators Act,[60] also known as the Jimmy Ryce Act, in 1998. The Jimmy Ryce Act creates a civil commitment process for sexually violent predators that is similar to the Baker Act, used to involuntarily commit and treat mentally ill persons.[61] Under the Jimmy Ryce Act, offenders convicted of specified sex offenses who are nearing the end of their criminal sentence are referred to the DCF for a risk assessment by a multidisciplinary team as to whether the offender meets the clinical definition of a sexually violent predator. After the risk assessment, DCF provides a recommendation to the state attorney.[62]

Following receipt of DCF's recommendation and supporting information, the state attorney determines whether to file a petition with the circuit court alleging that the offender is a sexually violent predator.[63]

[55] 28 C.F.R. § 20.33(a)(1).
[56] 42 U.S.C. § 14616.
[57] 28 C.F.R. § 20.33(b); s. 943.054, F.S.
[58] S. 394.912(9), F.S., defines the term "sexually violent offense" as: Murder of a human being while engaged in sexual battery in violation of s. 782.04(1)(a)2., F.S.; Kidnapping or false imprisonment of a child under the age of 13 and, in the course of that offense, committing sexual battery; or a lewd, lascivious, or indecent assault or act upon or in the presence of the child; Sexual battery in violation of s. 794.011, F.S.; Lewd, lascivious, or indecent assault or act upon or in presence of the child in violation of ss. 800.04 or 847.0135(5), F.S.; An attempt, criminal solicitation, or conspiracy, in violation of s. 777.04, F.S., of a sexually violent offense; Any conviction for a felony offense in effect at any time before October 1, 1998, which is comparable to a sexually violent offense listed above or any federal conviction or conviction in another state for a felony offense that in this state would be a sexually violent offense; or any criminal act that, either at the time of sentencing for the offense or subsequently during civil commitment proceedings under this part, has been determined beyond a reasonable doubt to have been sexually motivated.
[59] S. 394.912(10), F.S.
[60] Ch. 394, Part V, F.S.
[61] Ch. 394, Part I, F.S.
[62] Id.
[63] S. 394.914, F.S.

At trial, a judge or jury must determine by clear and convincing evidence that an offender meets the definition of a sexually violent predator.[64] A sexually violent predator must be committed to DCF's custody for:[65]

- Control;
- Care; and
- Treatment.

To conduct its risk assessment and other functions, the DCF Sexually Violent Predator Program (SVPP) previously had access to the NCIC/III-databases, allowing it to review a person's full criminal history.[66] However, a recent FBI audit of a Florida sheriff's office concluded that SVPP's statutorily defined purpose did not meet the definition of a criminal justice agency and therefore was not entitled to access NCIC/III CHRI.[67] This determination prevents SVPP from accessing information about out-of-state convictions, which approximately 18 percent of committed sexually violent predators have.[68]

Effect of Proposed Changes

Involuntary Examinations

CS/CS/HB 361 implements two recommendations of the Task Force Report on Involuntary Examination of Minors. It amends s. 394.463(2)(a), F.S., to increase the number of days that the receiving facility has to submit forms to DCF required by s. 394.463(2)(e), F.S., from the next working day to five working days, and requires these forms to include information on whether the individual was ultimately admitted, released, or a petition was filed with the court. This will allow DCF to capture more meaningful data on the involuntary examinations initiated in the state.

The bill also require DCF to report to the Governor and Legislature every two years on its findings and recommendations related to involuntary examinations of minors. Specifically, DCF must use the additional data that it will be receiving under the bill to identify patterns and trends and cases where involuntary examinations are repeatedly initiated against the same child, study root causes for such patterns, trends, or repeated involuntary examinations, and make recommendations for encouraging alternatives to eliminating inappropriate initiations of such examinations.

The bill also requires DOE, in consultation with the Statewide Office for Suicide Prevention and suicide prevention experts, to add suicide screening as part of its requirements for Suicide Prevention Certified Schools under s. 1012.583, F.S. DOE must identify available standardized suicide screening instruments that are appropriate to use with a school-age population and have acceptable validity and reliability, and include information about obtaining instruction in their administration and use. The suicide screening will be used alongside awareness and prevention materials for training instructional personnel in elementary, middle, and high schools in youth suicide awareness, prevention, and screening.

Under the bill, to be considered a Suicide Prevention Certified School, the school must have at least two school-based staff members certified or otherwise deemed competent in the use of the DOE-approved suicide screening instrument, and must have a policy to use the suicide screening instrument to evaluate a student's suicide risk before requesting the initiation of, or initiating, an involuntary examination due to concerns about that student's suicide risk.

[64] S. 394.917, F.S.
[65] S. 394.917, F.S.
[66] Department of Children and Families, *Sexually Violent Predator Program (SVPP) NCIC Issue Summary* (Mar. 8, 2019)(on file with Health and Human Services Committee Staff).
[67] Id.
[68] Id.

The bill requires DOE to keep a list of Suicide Prevention Certified Schools on its website, requires each school to post on its website whether it is a Suicide Prevention Certified School, and requires school districts to post on their websites a list of Suicide Prevention Certified Schools in their districts.

Mental Health Professional Duty to Warn

The bill revises the requirements for mental health professionals and service providers at mental health facilities when a patient communicates a specific threat of harm to an identifiable person. Specifically, if a patient communicates a specific threat to cause serious bodily injury or death to an identified or a readily identifiable person, and the mental health professional makes a clinical judgment that the patient has the apparent intent and ability to carry out such threat, then the mental health professional:

- May disclose confidential communications to warn the potential victim; and
- Must disclose confidential communications to report the threat to a law enforcement agency.

Similarly, when a patient at a mental health facility communicates to a service provider a specific threat to cause serious bodily injury or death to an identified or a readily identifiable person, and the service provider reasonably believes, or should reasonably believe according to the standards of his or her profession, that the patient has the apparent intent and ability to carry out such threat, then the administrator at the facility:

- May authorize release of sufficient information from the clinical records to warn the potential victim; and
- Must authorize the release of sufficient information from the clinical records to report the threat to a law enforcement agency.

A law enforcement that receives such a report must take appropriate action to prevent the risk of harm, including, but not limited to, notifying the intended victim of the threat or initiating a risk protection order. A mental health professional that breaches patient confidentiality or a service provider who releases information from a clinical record to communicate such threat to the victim or law enforcement is immune from criminal or civil liability for doing so.

These provisions are mirrored in the respective sections of law relating to psychiatrists, psychologists, mental health counselors, marriage and family therapists, clinical social workers, and service providers at mental health facilities.

Sexually Violent Predator Program Criminal History Records Access

The bill revises the statutorily defined purpose of DCF's SVPP to include that it rehabilitates criminal offenders upon commitment of a sexually violent predator. This will allow SVPP to administer a criminal justice function pursuant to statute and therefore qualify as a criminal justice agency under federal law. As a criminal justice agency, SVPP will be able to access criminal history record information from the FBI's national and interstate criminal databases.

The bill provides an effective date of July 1, 2019.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4615, F.S., relating to clinical records; confidentiality.
Section 2: Amends s. 394.463, F.S., relating to involuntary examination.
Section 3: Amends s. 394.917, F.S., relating to determination; commitment procedure; mistrials; housing; counsel and costs in indigent appellate cases.
Section 4: Amends s. 456.059, F.S., relating to communications confidential; exceptions.
Section 5: Amends s. 490.0147, F.S., relating to confidentiality and privileged communications.
Section 6: Amends s. 491.0147, F.S., relating to confidentiality and privileged communications.

Section 7: Amends s. 1012.583, F.S., relating to continuing education and inservice training for youth suicide awareness and prevention.
Section 8: Reenacts s. 490.009, F.S., relating to discipline.
Section 9: Reenacts s. 491.009, F.S., relating to discipline.
Section 10: Provides an effective date of July 1, 2019.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

For a school to be considered a “Suicide Prevention Certified School”, it must have two school-based staff members certified or otherwise deemed competent in the use of a suicide screening instrument pursuant to s. 1012.583, F.S. For those schools that do not already meet this requirement but want to obtain the “Suicide Prevention Certified” recognition, there may be a cost associated with the certification or training. This cost is indeterminate.

DOE and school districts will be required to maintain websites listing Suicide Prevention Certified Schools, but will be able to absorb the associated costs within existing resources.

DCF will incur costs to prepare the report required under the bill, but will likely be able to absorb these costs within existing resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

DOE, DOH, and DCF have sufficient rulemaking authority in existing law to implement the changes in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On April 9, 2019, the Health and Human Services Committee adopted a strike-all amendment and an amendment to the strike-all amendment that:

- Requires receiving facilities to include information on the final disposition of an involuntary admission in reports to DCF.
- Requires DCF to analyze data collected on involuntary admissions of minors and report findings and recommendations to the Governor and Legislature every 2 years.
- Requires and provides immunity from liability for certain mental health professionals to report to law enforcement when a patient or client communicates a specific threat of harm to an identified person, and requires law enforcement to take appropriate action to protect the victim.
- Allows and provides immunity from liability for certain mental health professionals to warn an intended victim when a patient or client communicates a specific threat of harm to an identified person.
- Adds to the purpose of the DCF Sexually Violent Predator Program that it rehabilitates criminal offenders.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.