The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 1790
INTRODUCER:	Senator Powell
SUBJECT:	Baker Act
DATE:	January 26, 2018
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon	CF	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 1790 directs the Department of Children and Families (DCF) to create a work group to evaluate methods to improve the operational effectiveness of the Florida Mental Health Act (The Baker Act). The bill identifies the members of the workgroup and provides that a report be provided to the Secretary of DCF, the Secretary of the Agency for Health Care Administration, the President of the Senate, and the Speaker of the House of Representatives by November 1, 2018.

The bill also requires the administrators of Baker Act receiving facilities to file a petition for a circuit court hearing within 24 hours of a minor patient (a patient aged 17 years old or younger) applying for voluntary admission to the facility. The bill mandates that the circuit court hold a hearing within 5 days of receiving the completed application to determine whether the patient has voluntarily consented to be admitted to the facility.

The bill shall take effect upon becoming law and will likely have a fiscal impact.

II. Present Situation:

Baker Act

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 for 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. The Baker Act also establishes procedures for courts, law enforcement, and certain health care practitioners to initiate such examinations and then act in response to the findings.

Individuals in 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.[1] 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:[2]

- 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 Admissions

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.[3]

Within the 72-hour examination period, or if the 72 hours end on a weekend or holiday, no later than the next business day, one of the following must occur:

- 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 and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.[4]

Receiving facilities must give prompt notice[5] of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,[6] guardian advocate,[7] health care surrogate or proxy, attorney, and representative.[8] If the patient is a minor, the receiving facility

[1] SS. 394.4625 and 394.463, F.S.
[2] S. 394.463(1), F.S.
[3] S. 394.455(39), F.S. This term does not include a county jail.
[4] S. 394.463(2)(g), F.S.
[5] Notice may be provided in person or by telephone; however, in the case of a minor, notice may also be provided by other electronic means. S. 394.455(2),F.S.
[6] "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. Section 394.455(17), F.S.
[7] "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment. Section 394.455(18), F.S.
[8] S. 394.4599(2)(b), F.S.

must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice for an adult may be provided within 24 hours of arrival; however, notice for a minor must be provided immediately after the minor's arrival at the facility. The facility may delay the notification for a minor for up to 24 hours if it has submitted a report to the central abuse hotline. The receiving facility must attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until it receives confirmation that the notice has been received. Attempts must be repeated at least once every hour during the first 12 hours after the minor's arrival and then once every 24 hours thereafter until confirmation is received, the minor is released, or a petition for involuntary services is filed with the court.[9]

Voluntary Admissions and Transfer to Voluntary Status

Baker Act receiving facilities also admit any person 18 years of age or older making application by express and informed consent for admission or any person age 17 or under for whom such application is made by his or her guardian.[10] If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility.[11] Any person age 17 or under may be admitted only after a hearing to verify the voluntariness of their consent.[12] However, In 1997 a joint legislative committee determined that the "voluntariness hearing" described in the Baker Act Florida Administrative Rules at that time didn't conform to a "hearing" as intended in this section of the law because each other time that term was used in the law, it applied to a judicial hearing.[13] As a result, all reference to "voluntary hearings" were deleted from the rules. DCF stated that only a judicial hearing would suffice to meet this legal requirement and that it had to be conducted prior to the minor's voluntary admission, despite the consent of the parents or assent of the child to the admission.[14] Most patients age 17 or under are admitted under involuntary status and either discharged or later transferred to voluntary status, and it is unlikely that pre-admission court hearings for voluntary admission of minors are being conducted anywhere in the state.[15]

A patient admitted on an involuntary basis who applies to be transferred to voluntary status must be transferred to voluntary status immediately, unless the patient has been charged with a crime, or has been involuntarily placed for treatment by a court pursuant to s. 394.467, F.S., and continues to meet the criteria for involuntary placement.[16]

Crisis Stabilization Units

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

[9] S. 394.4599(c), F.S.
[10] S. 394.4625
[11] *Id*.
[12] *Id*.
[13] Department of Children and Families; Frequently Asked Questions, http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/Minors.pdf (last visited January 25, 2018).
[14] *Id*.
[15] *Id*.
[16] *Supra* at note 10.

individuals who are brought to the unit on an involuntary basis.[17] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[18] The purpose of a CSU is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[19] Individuals often enter the public mental health system through CSUs. For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by the Legislature in the 1970s to ensure continuity of care for individuals.[20]

Section 394.467, F.S., defines "residential treatment center for children and adolescents" as a 24-hour residential program, including a therapeutic group home, which provides mental health services to emotionally disturbed children or adolescents and which is a private for-profit or not-for-profit corporation licensed by the agency which offers a variety of treatment modalities in a more restrictive setting. Residential treatment centers provide longer-term treatment services. The purpose of a residential treatment center for children and adolescents is to provide mental health assessment and treatment services to children and adolescents who are experiencing an acute mental or emotional crisis, have a serious emotional disturbance or mental illness, or have an emotional disturbance. The treatment center must provide the least restrictive available treatment that is appropriate to the individual needs of the child or adolescent.[21]

Integrated Children's Crisis Stabilization Unit/Juvenile Addictions Receiving Facility Services

In 2001, the Legislature authorized DCF and the Agency for Health Care Administration (AHCA) to establish children's behavioral crisis unit (CBCU) demonstration models in Collier, Lee, and Sarasota Counties.[22] CBCUs integrate children's mental health crisis stabilization units with substance abuse juvenile addictions receiving facility services to provide emergency mental health and substance abuse services that are integrated within facilities licensed and designated by AHCA for eligible children under 18 years of age.[23] Like standard crisis stabilization units, patients are admitted on both a voluntary and involuntary basis, and patients admitted on an involuntary can apply for a transfer to voluntary status.

III. Effect of Proposed Changes:

Section 1 directs DCF to convene a workgroup to evaluate methods to improve the operational effectiveness of Part I of ch. 394, F.S., the Florida Mental Health Act, and recommend changes to existing laws, rules, and agency policies needed to implement the workgroup recommendations.

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[17] S. 394.875(1)(a), F.S.
[18] *Id.*
[19] *Id*.
[20] Florida Senate, Budget Subcommittee on Health and Human Services Appropriations, *Crisis Stabilization Units*, (Interim Report 2012-109) (Sept. 2011), *available at* http://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-109bha.pdf (last visited January 25, 2018).
[21] S. 394.4785(2), F.S.
[22] S. 394.499(1), F.S.
[23] *Id*. The integrated model of mental health crisis stabilization units and substance abuse addictions receiving facilities also exists for adult patients.

This section also provides that the workgroup consists of 20 members from various stakeholder groups. Members of the workgroup shall be appointed by June 1, 2018, and the first meeting of the workgroup shall take place before July 1, 2018. The draft of its recommendations shall be reviewed by the group by September 1, 2018. A final report shall be provided to the Secretary of the Department of Children and Families, the Secretary of the Agency for Health Care Administration, the President of the Senate and the Speaker of the House of Representatives by November 1, 2018. The report must include the workgroup's findings and recommended statutory and administrative rule changes.

Section 2 amends s. 394.4625, F.S., to require that in cases where a minor patient has either been admitted to a Baker Act receiving facility on a voluntary basis or has been involuntarily admitted and subsequently applied for a transfer to voluntary status, the administrator of a Baker Act receiving facility must, within 24 hours of admission or receiving the transfer request, petition the court where the patient is located for voluntary placement. The petition must include the application for voluntary admission/voluntary transfer status, documentation of express and informed consent to treatment by the patient or their legal guardian, certification that statutorily required disclosures regarding consent were made to the patient and their guardian, and pertinent demographic information about the patient and their guardian.

The bill requires the court, upon the filing of such petition, to provide copies to DCF, the patient, and their guardian. The court may not charge a fee for providing these copies. The bill also requires that within 5 working days after a minor patient is admitted, the court must hold a hearing to determine whether the consent to admission is voluntary. The court must similarly hold a hearing on the voluntariness of consent within 5 days of receiving a petition for transfer to voluntary status.

Section 3 amends s. 394.499, F.S., by imposing the same requirements of Section 2 of the bill to minor patients admitted to a CBCU on a voluntary basis. As such, a CBCU administrator must file a petition with the court upon application for voluntary admission and the court must hold a hearing within five days of the patient being admitted to determine the voluntariness of the patient's consent.

Section 4 provides that the bill shall take effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact

All voluntary packets (for voluntary admissions or conversions) will need to be filed with the court within 24 hours. Currently, such packets are not required to be filed, and incorporating this practice will likely result in additional costs to private receiving facilities. This impact is indeterminate.

C. Government Sector Impact:

The bill requires DCF to create the workgroup and the meetings of the workgroup to take place in Tallahassee; however, the bill does not address the issue of reimbursement of costs for members to travel in Tallahassee. If DCF is responsible for the reimbursements there will be an insignificant fiscal impact on the department.

The bill will also likely have an impact on courts, as they will have to schedule voluntariness hearings within 5 days, which may require hiring additional staff to handle the increased workload. Courts will also be required to provide copies of the petitions filed by receiving facilities without reimbursement. The impact of these changes is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill creates an undesignated section of the Florida Statutes.
The bill substantially amends the following sections of the Florida Statutes: 394.4625 and 394.499.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.