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:	CS/SB 1418
INTRODUCER:	Children, Families, and Elder Affairs and Senator Powell
SUBJECT:	Admission to Mental Health Facilities
DATE:	April 2, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon	CF	**Fav/CS**
2.			GO	
3.			RC	

I. Summary:

CS/SB 1418 implements two recommendations of a Department of Children and Families (DCF) task force which has been studying the issue of Baker Act cases involving minors. The first of the specific recommendations contained in the CS encourages school districts to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of an involuntary examination. The second recommendation increases the number of days, from the next working day to five working days that the receiving facility has to submit forms to DCF, to allow DCF to capture data on whether the minor was admitted, released, or a petition filed with the court.

The CS also requires that when a patient communicates a specific threat against an identifiable individual to a mental health service provider, the provider must release information from the clinical record of the patient sufficient to inform the threatened individual. The provider must also inform law enforcement of the threat.

The CS will likely have a fiscal impact and takes effect on becoming a law.

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 must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice

[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.

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]

Task Force Report on Involuntary Examination of Minors

During the 2017 Legislative session, the Legislature passed HB 1121, which the Governor signed as ch. 2017-151, Laws of Florida. One of its provisions created a task force within DCF to address the issue of involuntary examination of minors 17 years old and younger.

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.[10]

Data Analysis

Based on an analysis of available data regarding involuntary examinations of minors, the task force found that:[11]

- 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.

[9] S. 394.4599(c), F.S.
[10] 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 April 2, 2019).
[11] Id. at 20.

- 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.

Recommendations

The task force made six recommendations for encouraging alternatives to and eliminating inappropriate initiations of involuntary examinations of minors under the Baker Act:

- Fund an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis.
- Expand access to outpatient crisis intervention services and treatment.
- Create within DCF the "Invest in the Mental Health of our Children" grant program to provide matching funds to counties that can be used to plan, implement, or expand initiatives that increase public safety, avert increased mental health spending, and improve the accessibility and effectiveness of prevention and intervention services for children who have a diagnosed mental illness or co-occurring mental health and substance use disorder.
- 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.[12]
- Revise s. 394.463, F.S., to include school psychologists licensed under ch. 490, F.S. to the list of mental health professionals who are qualified to initiate a Baker Act.
- Require Youth Mental Health First Aid or Crisis Intervention Team (CIT) training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools.[13]

Additionally, the task force recommended amending s. 394.463, 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, F.S. 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.[14]

Clinical Records and Confidentiality

Clinical records maintained by mental health facilities in Florida "include[] all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by facility staff which pertains to the patient's hospitalization or treatment[15]." Clinical records are

[12] 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.
[13] 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.
[14] Id.
[15] Section 394.4615, F.S.

confidential and exempt by statute.[16] Instances in which clinical records must be disclosed to certain individuals include:

- Authorization from patient or guardian
- Authorization from patient's attorney needed "for adequate representation"
- Court order
- The Department of Corrections, if the patient is committed to, or is to be returned to, the Department of Corrections from the Department of Children and Families.[17]

Therapist-Client Privilege

In 1996, the U.S. Supreme Court established a federal psychotherapist-patient privilege protecting a patient's confidential communication with a psychotherapist in the course of treatment or diagnosis.[18] The privilege protects a patient's confidential communication from compelled disclosure.[19] The majority of states have laws that either permit or require mental health professionals to disclose otherwise confidential information received from patients who the professional reasonably believes may become violent.[20]

Tarasoff and the Duty to Protect

In *Tarasoff v. Regents of the University of California*,[21] a University of California (UC) Berkeley student, Prosenjit Poddar, told his therapist of his plan to purchase a gun and murder another student, Tatiana Tarasoff.[22] The therapist informed the campus police of the threat but neither the police nor the therapist warned Tarasoff directly.[23] Poddar proceeded to carry out his plan and murder Tarasoff roughly two months later. Tarasoff's parents sued the UC Regents and the Supreme Court of California ultimately developed what is now known as a *Tarasoff* duty: "The general formulation is that a mental health worker is obligated promptly to notify either the potential victim or the police when a patient makes an explicit threat of serious physical harm against a readily identifiable third party . . . ."[24]

The *Tarasoff* duty has expanded into many different forms and requirements among the different states. There is no blanket federal duty to warn or protect; instead, there is substantial state-by-state variation in whether and how the duties are defined and codified. There are three general categories of states: those that mandate some duty to warn or protect (and that often specify whether law enforcement, the victim, or a combination should be "warned," generally considered 'mandatory' states); those that allow therapists to warn by protecting them from liability for breach of confidentiality if they do so, but do not require them to issue a warning (permissive states); and those that offer no statutory or case law guidance.[25]

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[16] *Id*.
[17] Section 394.4615(2), F.S.
[18] *See* Jaffee v. Redmond, 518 U.S. 1 (1996).
[19] *Id*.
[20] Edwards, Griffin Sims, Database of State Tarasoff Laws (February 11, 2010), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1551505 (last visited April 2, 2019).
[21] 551 P.2d 334 (Cal. 1976).
[22] *Id*.
[23] *Id*.
[24] Paul B. Herbert & Kathryn A. Young, Tarasoff at Twenty-Five, 30 J. Am. Acad. Psychiatry L. 275, 277 (2002).
[25] *Id*.

Duties of Mental Health Professionals in Florida

Florida is considered a 'permissive' duty to warn/protect state: mental health providers are given discretion to breach confidentiality with patients and warn of a threat to a third party where a patient has "declared an intention to harm other persons."[26] The Legislature first added a dangerous patient exception to the confidentiality requirement for psychiatrists,[27] and later for psychologists[28] and for social workers and other mental health professionals.[29] Communications between a licensed or certified mental health worker and the patient or client are confidential, and may be waived, only when "there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society…" and the licensed professional communicates the information "only to the potential victim, appropriate family member, or …other appropriate authorities."[30]

III. Effect of Proposed Changes:

Section 1 amends section 394.4615, F.S., requiring the release of confidential information from a patient's clinical record sufficient to inform a third party of a specific threat to cause serious bodily injury or death to the individual. The threat must be communicated to both law enforcement and the threatened individual by the administrator of a mental health treatment facility or hospital once the patient has made the threat to a service provider at the facility or hospital.

Section 2 amends s. 394.463, F.S., to increase the number of days that a receiving facility has to submit forms to DCF from the next working day to five working days, to allow DCF to capture data on whether the minor was admitted, released, or a petition was filed with the court.

Section 3 amends section 456.059, F.S., requiring a psychiatrist to disclose patient communications to the extent necessary to warn law enforcement and a potential victim of a threat of serious bodily injury or death made by the patient of the threat. The CS provides that such disclosure of confidential communications may not be the basis of legal action or any civil or criminal liability against the psychiatrist.

Section 4 amends section 490.0147, F.S., requiring a psychologist to disclose patient communications to the extent necessary to warn law enforcement and a potential victim of a threat of serious bodily injury or death made by the patient of the threat. The CS provides that such disclosure of confidential communications may not be the basis of legal action or any civil or criminal liability against the psychologist.

Section 5 amends section 491.0147, F.S., requiring a health care professional licensed under Chapter 491, Florida Statutes, to disclose patient communications to the extent necessary to warn law enforcement and a potential victim of a threat of serious bodily injury or death made by the

[26] Section 394.4615, F.S.
[27] Section 456.059, F.S.
[28] Section 490.0147, F.S.
[29] Section 491.0147, F.S.
[30] *Id*.

patient of the threat. The CS provides that such disclosure of confidential communications may not be the basis of legal action or any civil or criminal liability against the health care professional.

Section 6 amends s. 1012.383, relating to youth suicide prevention training, to require the Department of Education (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." DOE must keep a list of "Suicide Prevention Certified Schools" on its website, and school districts must post on their websites a list of "Suicide Prevention Certified Schools" in their districts.

Additionally, the CS requires DOE to 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.

Section 7 reenacts paragraph (u) of section 490.009(1), F.S., for the purpose of incorporating changes made by the CS to s. 490.0147.

Section 8 reenacts paragraph (u) of section 491.009(1), F.S., for the purpose of incorporating changes made by the CS to s. 491.0147.

Section 9 provides that the bill will takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

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 an indeterminate fiscal impact due to the cost associated with the certification or training.

Additionally, an elementary, middle, or high school that voluntarily elects to be a "Suicide Prevention Certified School" may incur indeterminate costs to train personnel on the suicide screening instrument.

Local law enforcement offices may need additional training and/or to add personnel to handle what may be an increased threat response from mandatory reporting, however the impact of these potential needs cannot be determined.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The CS substantially amends sections 394.4615, 394.463, 456.059, 490.009, 490.0147, 491.009, 491.0147, and 1012.583 of the Florida Statutes.

IX. Additional Information:

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

CS by Children, Families, and Elder Affairs on April 1, 2019:

- The CS removes a provision requiring courts to appoint a public defender to represent minors being admitted to a receiving facility, a mental health treatment facility, or a

hospital under the Baker Act within one court working day of an involuntary placement petition being filed.

- The CS removes a provision requiring administrators of Baker Act receiving facilities to file a petition for a circuit court hearing within 24 hours of a minor patient applying for voluntary admission to the facility.
- The CS removes a provision requiring that courts hold a hearing within 5 days of receiving a completed application to determine whether the patient has voluntarily consented to be admitted to the facility.
- The CS provides Baker Act receiving facilities with five days, as opposed to one under current law, to submit paperwork on involuntary examinations to DCF.
- The CS encourages schools to use a standardized suicide screening instrument through the voluntary "Suicide Prevention Certified Schools" program.
- The CS requires various mental health service providers to warn potential victims and law enforcement of identifiable threats of serious bodily injury or death made by a patient.

B. Amendments:

None.