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 Health Policy

BILL:	CS/SB 690
INTRODUCER:	Health Policy Committee and Senator Diaz de la Portilla
SUBJECT:	Involuntary Examinations of Minors
DATE:	March 19, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Stovall	HP	**Fav/CS**
2.			ED	
3.			AED	
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 690 requires public and charter school principals or their designee to notify the parent or guardian of a minor child when the child is removed from school, school transportation, or a school-sponsored activity for involuntary examination under the Baker Act. The bill amends the Baker Act to distinguish between notice related to the whereabouts of an adult patient and notice related to the whereabouts of a minor patient. In both instances, notification may be by telephonic or electronic communication, or in person. Notification related to a minor child must be initiated immediately and continue hourly for the first 12 hours after the child's arrival and once every 24 hours thereafter until notification has been made. The bill also revises the definition of "emergency health services" in the school health services program to include mental illness.

II. Present Situation:

Involuntary Examination

In 1971, the Legislature created part I of ch. 394, F.S., the "Florida Mental Health Act," also known as the Baker Act, to address mental health needs in the state. The Baker Act is a civil commitment law which provides a process for the involuntary examination and subsequent involuntary placement (commitment) of a person for either inpatient or outpatient treatment of a mental, emotional, or behavioral disorder.

The Department of Children and Families (DCF) administers this law through receiving facilities, which are public or private facilities that are designated by the DCF to receive and hold involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment.[1] A patient who requires further treatment may be transported to a treatment facility. Treatment facilities designated by the DCF are state-owned, state-operated, or state-supported hospitals which provide extended treatment and hospitalization beyond what is provided in a receiving facility.[2]

Section 394.463(1), F.S., provides that a person may be taken to a receiving facility for involuntary examination if the person is believed to be mentally ill and because of that mental illness the person has refused voluntary examination or cannot determine for himself or herself whether examination is necessary; and, without care or treatment, the person is either likely to suffer from self-neglect, cause substantial harm to himself or herself, or be a danger to himself or herself or others.[3] An involuntary examination may be initiated in one of the following ways: [4]

- A court may enter an *ex parte* order stating a person appears to meet the criteria for involuntary examination. This order is based on sworn testimony, either written or oral.
- A law enforcement officer may take a person into custody who appears to meet the criteria for involuntary examination and transport him or her to a receiving facility for examination.
- A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she examined the person within the preceding 48 hours and the person appears to meet the criteria for involuntary examination.

A receiving facility is required to give prompt notice to the patient's guardian, guardian advocate, attorney, or representative by telephone or in person of the patient's whereabouts, unless the patient requests that no notification be made. Efforts to provide notice must be initiated as soon as reasonably possible after the patient's arrival and be documented in the patient's record and must occur within 24 hours.[5] In addition, the receiving facility must send a copy of the document initiating the examination to the Agency for Health Care Administration by the next working day.[6]

A person accepted by a receiving facility must receive an initial examination by a physician or clinical psychologist without unnecessary delay and may be given emergency treatment if ordered by a physician and necessary to protect the patient or others.[7] The examination must include:[8]

- A thorough review of any observations of the patient's recent behavior;
- A review of the document initiating the involuntary examination and the transportation form; and,

[1] Section 394.455(26), F.S.
[2] Section 394.455(32), F.S.
[3] Section 394.463(1), F.S.
[4] Section 394.463(2)(a), F.S.
[5] Section 394.4599(2), F.S.
[6] Section 394.463(2)(a), F.S.
[7] Section 394.463(2)(f), F.S.
[8] Rule 65E-5.2801(1), F.A.C.

- A face-to-face examination of the patient in a timely manner to determine if the patient meets criteria for release.

Within 72 hours of arriving at the receiving facility, one of the following must occur:[9]

- The patient is released, unless the person has committed a crime;
- The patient is offered the opportunity to consent to voluntary outpatient treatment and released for treatment, unless the person has committed a crime; or,
- A petition for involuntary placement must be filed with the circuit court.

The person cannot be released without the documented approval of a psychiatrist, clinical psychologist, or qualified hospital emergency department physician.[10] Notice of the discharge or transfer of a patient must be given to the patient's guardian, guardian advocate, attorney, or representative; the person who executed the certificate admitting the patient to the receiving facility; and any court that ordered the evaluation.[11]

In 2012, there were 157,352 involuntary examinations initiated in the state. Law enforcement initiated almost half of the involuntary examinations (49.75 percent), followed by mental health professionals (48.14 percent), and then *ex parte* orders by judges (2.10 percent). Overall, the number of involuntary examinations has been increasing annually in a number that exceeds Florida population growth. Between 2007 and 2012, the population of Florida increased by 2.93 percent, while the number of involuntary examinations increased by 28.50 percent.[12]

According to the DCF, of the approximately 150,000 involuntary examinations initiated in 2011, 18,000 were of children. Between 2002 and 2011, there was an overall increase of 50 percent in the number of involuntary examinations and a 35 percent increase in examinations of children.[13]

School Health Services Program

Section 381.0056, F.S., is the "School Health Services Act," which sets forth requirements related to school health. The Department of Health (DOH), in cooperation with the Department of Education, supervises the program and conducts periodic program reviews. However, implementation of program requirements occurs at the local level with the input of the local school health advisory committee.[14] A nonpublic school may request to participate in the school health services program.

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[9] Section 394.463(2)(i), F.S.
[10] Section 394.463(2)(f), F.S.
[11] Section 394.463(3), F.S.
[12] University of South Florida, de la Parte Florida Mental Health Institute, *Annual Report of Baker Act Data, Summary of 2012 Data*, 3 (Feb. 2014) , *available at* http://bakeract.fmhi.usf.edu/document/BA_Annual_2012_Final.pdf (last visited March 13, 2014).
[13] Department of Children and Families, *Florida's Baker Act: 2013 Fact Sheet* (2013), *available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf (last visited March 13, 2014).
[14] The advisory committee must, at a minimum, represent the eight components of Coordinated School Health as defined by the Centers for Disease Control. These include: health education; healthy school nutrition; physical education; school health services, guidance, counseling, and social service; healthy school environment; staff wellness; and family and community support. (Florida Department of Health, *Coordinated School Health*, http://www.floridahealth.gov/healthy-people-and-families/childrens-health/school-health/coordinated-school-health/index.html (last visited March 13, 2014).

Each county health department must develop, jointly with the local school board and the school advisory committee, a school health services plan that includes, at a minimum, a plan for the delivery of school health services; accountability and outcome indicators; strategies for assessing and blending financial resources (both public and private); and establishment of a data system.[15] Section 381.0056, F.S., requires the plan to contain provisions addressing a wide range of services and health issues, including meeting emergency health needs[16] in each school.

The plan must be reviewed and updated annually and approved biennially by the school district superintendent, chair of the school board, county health department medical director or administrator, and the DOH district administrator.[17]

Student and Parental Rights and Educational Choices

Section 1002.20, F.S., sets forth the right of parents of public school students to receive accurate and timely information regarding their child's academic performance and ways parents can enhance their performance. The section assembles and restates rights afforded K-12 students and their parents in various locations throughout the Florida Statutes.

Section 1002.33, F.S., authorizes charter schools as part of the state's program of public education and establishes minimum standards for their operation.

III. Effect of Proposed Changes:

The bill amends the School Health Services Program by revising the definition of "emergency health needs." The definition is expanded to include evaluation for injury and illness, which is further described as both physical and mental illness, and release to law enforcement.

The bill revises the notification requirements under the Baker Act to distinguish between notice related to the whereabouts of an adult patient and notice related to the whereabouts of a minor patient. The notice related to a minor, which is created by the bill, must be by telephonic or electronic communication or in person and attempts at notification must be initiated immediately and documented in the patient record. If the facility cannot immediately locate the minor patient's guardian, it must repeat notification attempts hourly for the first 12 hours and once every 24 hours thereafter. A facility may request the assistance of law enforcement if notification is not made within the first 24 hours. Notification related to an adult patient is expanded to include notification made by electronic communication. The bill also removes obsolete language related to the local advocacy council.

Finally, the bill adds notification of involuntary examinations to the rights of parents of public school students. Specifically, the school principal or his or her designee must immediately notify a parent or guardian of a student who is removed from school, school transportation, or a school-

[15] Rule 64F-6.002(1), F.A.C.
[16] "Emergency health needs" means onsite management and aid for illness or injury pending the student's return to the classroom or release to a parent, guardian, designated friend, or designated health care provider (s. 381.0056(2)(a), F.S.).
[17] Rule 64F-6.002(3), F.A.C.

sponsored activity and taken to a receiving facility for involuntary examination. The school board must develop a policy and procedure for the required notification. The bill adds nearly identical language to the requirements in ch. 1002, F.S., applicable to charter schools. The language differs only in that it substitutes the term "charter school governing board" for "school board" in describing the entity responsible for developing the notification policy and procedure.

The bill has an effective date of July 1, 2014.

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:

Charter schools will incur an indeterminate cost to develop and adopt the required notification policy and procedure.

The requirement for hourly attempts at notification may require additional staff time at a privately owned receiving facility that does not already attempt repeated notification as a matter of policy and only in those cases when the receiving facility is unable to reach the minor patient's guardian immediately.

C. Government Sector Impact:

School districts will incur an indeterminate cost to develop and adopt the required notification policy and procedure.

The requirement for hourly attempts at notification may require additional staff time at a publicly-owned receiving facility that does not already attempt repeated notification as a matter of policy and only in those cases when the receiving facility is unable to reach the minor patient's guardian immediately.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.0056, 394.4599, 1002.20, and 1002.33.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 19, 2014:

The Committee Substitute:

- Changes the notification requirement for receiving facilities from hourly, to hourly for the first 12 hours after arrival and once per day thereafter.
- Authorizes receiving facilities to seek the assistance of law enforcement in trying to make contact with a child's guardian if notification does not occur within 24 hours.
- Removes the option for the receiving facility or the school principal to delay notification in cases of suspected child abuse, abandonment, and neglect.
- Removes the requirement for the school health services plan to address notification to parents and further revises the definition of "emergency health services," which are an element of the plan, to cover physical and mental illness.
- Conforms language related to a receiving facility's obligation to provide notification to terminology, including defined terms, elsewhere in the Baker Act.

B. Amendments:

None.