# FLORIDA HOUSE OF REPRESENTATIVES
# BILL ANALYSIS

*This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.*

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| **BILL #:** CS/HB 1013 | **COMPANION BILL:** CS/SB 886 (Leek) |
| **TITLE:** Crisis Care Coordination | **LINKED BILLS:** None |
| **SPONSOR(S):** Kincart Jonsson | **RELATED BILLS:** None |

**Committee References**

| Human Services | ➤ | Health Care Budget | ➤ | Health & Human Services |
|---|---|---|---|---|
| 17 Y, 0 N, As CS | | 13 Y, 0 N | | |

## SUMMARY


**Effect of the Bill:**

CS/HB 1013 requires the Department of Children and Families (DCF) to launch a crisis care coordination pilot program within Polk and Volusia counties. The bill requires nationally accredited community mental health centers to partner with local law enforcement agencies and providers of mental health and substance abuse services under written referral agreements, which will allow crisis counselors to help involuntarily examined individuals who experienced an acute mental health crisis to receive stabilizing and rehabilitative services through the local coordinated system of care network. The bill requires DCF to contract with an independent evaluator to report on the pilot program's efficacy and return-on-investment by January 15, 2029.

**Fiscal or Economic Impact:**

The bill will have an indeterminate, negative fiscal impact on state government.

Implementation of the bill is contingent upon the availability of funding provided in the General Appropriations Act.



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## ANALYSIS

### EFFECT OF THE BILL:

When individuals experience an acute mental health crisis, law enforcement officers are often the first point of contact. Without sufficient partnerships with professional crisis counselors, law enforcement officers initiate involuntary Baker Act examinations of these individuals, sometimes on multiple occasions because their mental health issues are not being appropriately addressed.

CS/HB 1013 requires the Department of Children and Families (DCF) to launch the Crisis Care Coordination Pilot Program in Polk and Volusia counties. The purpose of the pilot program is to reduce repeat involuntary examinations initiated by law enforcement, provide post-mental-health-crisis intervention services, and to alleviate the responsibility of law enforcement to handle acute mental health crisis events. (Section 1).

The bill creates local partnerships between nationally accredited community mental health centers, law enforcement, and providers of mental health and substance abuse services, local hospitals, non-profits, and other organizations that can assist individuals who have been in acute mental health crises to help law enforcement divert individuals involuntarily examined for an acute mental health crisis under the Baker Act to service providers within the local coordinated system of care network. The bill requires these partnerships to be memorialized in written referral agreements with information exchange procedures. The bill requires referral agreements to, at a minimum, facilitate a diverted individual's timely access to community-based behavioral health services and other local systems and entities as outlined in his or her discharge plan. (Section 1).

The bill requires crisis counselors to intervene on a Baker Act call to help law enforcement deescalate the emergency and help persons who experienced an acute mental health crisis to, on a voluntary basis, receive

ongoing, community-based, stabilizing and rehabilitative services. The pilot program service array for voluntary participants must include individualized assessment, safety planning, assistance in accessing recommended services, supportive counseling, and other necessary follow-up supports. (Section 1).

The bill requires DCF to contract for an independent evaluation of the pilot program which must, at a minimum, analyze the program's efficacy and return-on-investment. The evaluator must address, at a minimum, four research inquiries:

- The amount of time that law enforcement officers spent on Baker Act calls.
- Quantitative and qualitative observations about repeat Baker Act involuntary examinations initiated by law enforcement.
- Quantitative and qualitative observations about the voluntarily diverted participants in the pilot program, especially their engaged in post-crisis mental health and substance abuse services.
- The efficacy of the pilot program's service array.

In addition, the bill requires the evaluator to offer recommendations that address the topics of program enhancements, program continuation, and program expansion. The bill requires DCF to submit a final report of the independent evaluator's detailed assessment of the pilot program to the Governor, President of the Senate, and Speaker of the House by January 15, 2029. (Section 1).

The bill subjects the implementation of the pilot program to a specific appropriation and sunsets the pilot program on June 30, 2029. (Section 1).

The effective date of the bill is July 1, 2025. (Section 2).

**RULEMAKING:**

The bill modifies a provision of law that is already under the Department of Children and Families existing rulemaking authority, pursuant to s. 394.457(5), F.S.

***Lawmaking is a legislative power; however, the Legislature may delegate a portion of such power to executive branch agencies to create rules that have the force of law. To exercise this delegated power, an agency must have a grant of rulemaking authority and a law to implement.***

**FISCAL OR ECONOMIC IMPACT:**

STATE GOVERNMENT:

The bill will have an indeterminate, negative effect on state government.

Implementation of the bill is contingent upon the availability of funding provided in the General Appropriations Act.

## RELEVANT INFORMATION

**SUBJECT OVERVIEW:**

**Mental Health System**

Mental illness affects millions of people in the United States each year. It is estimated that more than one in five adults live with a mental illness.[1] In 2023, approximately 22.8 percent of adults experienced mental illness.[2]

[1] National Institute of Mental Health (NIH), *Mental Illness*, (last updated Sept. 2024) https://www.nimh.nih.gov/health/statistics/mental-illness (last visited Mar. 21, 2025).

Mental Health Safety Net Services

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

*Behavioral Health Managing Entities*

In 2001, the Legislature authorized DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.[3] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[4] MEs were fully implemented statewide in 2013, serving all geographic regions.

DCF currently contracts with seven MEs for behavioral health services throughout the state. These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the state.[5]

*Coordinated System of Care*

Managing entities are required to promote the development and implementation of a coordinated system of care.[6] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[7] A community or region provides a coordinated system of care for those with a mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.[8] MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.[9] DCF must use performance-based contracts to award grants.[10]

There are several essential elements which make up a coordinated system of care, including:[11]

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;

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[2] Substance Abuse and Mental Health Services Administration (SAMHSA), *Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health* (Jul. 30, 2024) https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report (last visited Mar. 21, 2025).
[3] Ch. 2001-191, Laws of Fla.
[4] Ch. 2008-243, Laws of Fla.
[5] DCF, *Managing Entities,* available at https://www.myflfamilies.com/services/samh/providers/managing-entities, (last visited Mar. 21, 2025).
[6] S. 394.9082(5)(d), F.S.
[7] S. 394.4573(1)(c), F.S.
[8] S. Legislature has not funded system improvement grants.
[9] *Id.*
[10] *Id.*
[11] S. 394.4573(2), F.S.

- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.

A coordinated system of care must include, but is not limited to, the following array of services:[12]

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

*Mobile Response Teams*

As of March 21, 2025, DCF has 55 Mobile Response Teams (MRTs) under contract, strategically stationed across the state, and ready to deploy 24/7 at a moment's notice to provide emergency on-site behavioral health crisis services to Floridians in need.[13] The MEs procure contracts with local mental health and behavioral health providers for MRT staffing and services.[14] These providers professionally staff MRTs with licensed mental health professionals, certified peer recovery specialists, on-call psychiatrists and psychiatric nurse practitioners, and support staff.[15] MRT services consist of brief crisis intervention services, which includes crisis screenings and assessment, crisis de-escalation and stabilization services, crisis counseling, safety planning, psychoeducation, and short-term targeted follow-up to help with the transition to ongoing care.[16]

Current law requires MRTs to serve, at a minimum, children, adolescents, and young adults ages 18 to 25 who manifest any of the following acute mental health crisis symptoms:[17]

- Have an emotional disturbance;
- Are experiencing an actual mental or emotional crisis;

[12] S. 394.495(4), F.S.
[13] S. 394.495(7), F.S.; Department of Children and Families, Mobile Response Teams, https://www.myflfamilies.com/services/samh/mobile-response-teams (last visited Mar. 21, 2025); Department of Children and Families, Specialty Treatment Team Maps, (last updated Feb. 18, 2025) https://www.myflfamilies.com/specialty-treatment-team-maps (last visited Mar. 21, 2025). Under the Map Selection menu on the left-hand side, select "Mobile Response Teams (MRT)".
[14] S. 394.495(7)(c), F.S.
[15] Department of Children and Families, Mobile Response Teams, https://www.myflfamilies.com/services/samh/mobile-response-teams (last visited Mar. 21, 2025).
[16] Department of Children and Families, Mobile Response Teams, https://www.myflfamilies.com/services/samh/mobile-response-teams (last visited Mar. 21, 2025).
[17] S. 394.495(7)(a), F.S., *see* s. 394.495(1), F.S., *see* s. 394.495(5)(q), F.S.

- Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function typically within the family, living situation, or community environment; or
- Are served by the child welfare system and are experiencing or are at high risk of placement instability.

Current law sets the minimum standards for MRTs. At a minimum, MRTs must: [18]

- Triage and prioritize requests, then, to the extent permitted by available resources, respond in person within 60 minutes of prioritization;
- Respond to a crisis in the location where the crisis is occurring;
- Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family and enable them to deescalate and respond to behavioral health challenges through evidence-based practices;
- Provide screening, standardized assessments, early identification, and referrals to community services;
- Provide care coordination by facilitating the transition to ongoing services;
- Ensure a process for informed consent and confidentiality compliance measures is in place;
- Promote information sharing and the use of innovative technology; and
- Coordinate with the managing entity and other key entities providing services and supports to the child, adolescent, or young adult and their family.

**The Baker Act**

The Florida Mental Health Act, commonly referred to as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. [19] 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.[20]

Involuntary Examination

Individuals in an acute mental 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.[21] Certain courts or authorized individuals may initiate an involuntary examination if there is reason to believe that the person of concern has a mental illness and, because of that mental illness:

- has refused voluntary examination,
- is likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to that person's well-being, and
- such harm is unavoidable through the help of willing, able, and responsible family members or friends, or will cause serious bodily harm to him or herself or others in the near future based on recent behavior.[22]

An involuntary examination may be initiated by:

- a circuit or county court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[23]

[18] S. 394.495(7)(b), F.S.
[19] The Baker Act is contained in Part I of ch. 394, F.S.
[20] S. 394.459, F.S.
[21] Ss. 394.4625 and 394.463, F.S.
[22] S. 394.463(1), F.S.
[23] S. 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.

- a law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;[24] or
- a physician, clinical psychologist, psychiatric nurse, an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion.[25]

Involuntary patients must be taken to either a public or a private facility that has been designated by DCF as a Baker Act receiving facility. Under the Baker Act, a receiving facility has up to 72 hours to examine an involuntary patient.[26] 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.[27] The 72-hour examination period begins when the patient arrives at the receiving facility. However, if the patient is a minor, a receiving facility must initiate the examination within 12 hours of arrival.[28]

Law Enforcement

Individuals in mental health crisis are more likely to encounter law enforcement than to receive a coordinated crisis care response.[29] The Florida Criminal Justice Executive Institute (FCJEI), the research and educational arm of the Florida Department of Law Enforcement,[30] published a commanding officer's independent research project to document law enforcement's response to community mental health crisis events. The literature review component emphasized the dangers associated with mental health crisis, the strain on police resources, criticism of police response, liability issues, and training challenges. The poll-based survey of 68 police departments across the state measured the amount of Baker Acts completed during the 2021 calendar year. Of the 33 police departments[31] that responded, 23 departments completed more than 90 Baker Act crisis calls during 2021. In addition, all 33 responding departments indicated they repeatedly respond to certain individuals experiencing recurring mental health crises.[32]

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[24] S. 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record. If transporting a minor and the parent or legal guardian of the minor is present, the law enforcement officer must provide the parent or legal guardian of the minor the name, address, and contact information of the receiving facility to which the minor is being transported.
[25] S. 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.
[26] S. 394.463(2)(g), F.S.
[27] S. 394.463(2)(f), F.S.
[28] S. 394.463(2)(g), F.S.
[29] Crisis Intervention and Community-Based Services, National Council of State Legislatures, (last updated Aug. 28, 2024) https://www.ncsl.org/civil-and-criminal-justice/crisis-intervention-and-community-based-services (last visited Mar. 21, 2025).
[30] Florida Criminal Justice Executive Institute, FCJEI History, Florida Department of Law Enforcement, https://www.fdle.state.fl.us/FCJEI/History/FCJEI-History-Home.aspx (last visited Mar. 21, 2025).
[31] The responding police departments were as follows: Apopka Police Department, Bradenton Police Department, Casselberry Police Department, Clermont Police Department, Coca Beach Police Department, Columbia County Sheriff's Office, Florida State University Police Department, Haines City Police Department, Homestead Police Department, Jacksonville Beach Police Department, Leesburg Police Department, Maitland Police Department, Nassau County Sheriff's Office, New Smyrna Beach Police Department, North Miami Beach Police Department, Ocoee Police Department, Oviedo Police Department, Palm Bay Police Department, Port Orange Police Department, Sanford Police Department, South Miami Police Department, St. Augustine Police Department, St. Cloud Police Department, Sunny Isles Beach Police Department, Suwannee County Sheriff's Office, Sweet Water Police Department, Tarpon Springs Police Department, Titusville Police Department, University of Florida Police Department, Wakulla County Sheriff's Office, Winter Garden Police Department, Winter Park Police Department, and Winter Springs Police Department. Marcos Ramirez, "Officer's Response to Community Mental Health Crisis," Florida Criminal Justice Executive Institute, pp. 14-15, (May 2022, SLP – 24) https://www.fdle.state.fl.us/FCJEI/Programs/SLP/SLP-Papers-by-Author.aspx (last visited Mar. 21, 2025). This independent research project was published as a part of FCJEI's Senior Leadership Program and the Executive Future Studies Program.
[32] Marcos Ramirez, "Officer's Response to Community Mental Health Crisis," Florida Criminal Justice Executive Institute, (May 2022, SLP – 24) https://www.fdle.state.fl.us/FCJEI/Programs/SLP/SLP-Papers-by-Author.aspx (last visited Mar. 21, 2025). This independent research project was published as a part of FCJEI's Senior Leadership Program and the Executive Future Studies Program.

The FCJEI survey also revealed that any partnership between law enforcement and mental health professionals in Florida is a discretionary decision made at the police department level. At the time of the report's publication:[33]

- Seven police departments were considering partnerships.
- Six police departments were not considering partnerships.
- Ten police departments entered partnerships.
- Three police departments offered nuanced answers.

*Co-Response Models*

The co-responder model pairs at least one law enforcement officer and one mental health or substance abuse professional together to coordinate a joint response in real-time to a possible behavioral health crisis event.[34] This model provides appropriate alternatives to arrest, officer use of force, hospitalizations and promotes the development of and access to quality mental health treatment and services. This model allows the mental health or substance abuse professional to follow-up with individuals and families after a crisis to decrease the probability of a future acute mental health crisis, a counterproductive diversion through the criminal justice system, and an unnecessary psychiatric hospitalization.[35]

Crisis Care Coordination Pilot

Crisis care coordination functions as a referral-based concierge of follow-up stabilization and rehabilitative services for individuals screened by law enforcement for a Baker Act involuntary examination. For this reason, crisis care coordination is distinguishable from both the MRT model of full-court press crisis intervention services and the co-response model where an interdisciplinary unit, consisting of one law enforcement officer and one crisis counselor, responds to calls involving acute mental health crises.

The purpose of the pilot program is to reduce the number of repetitive involuntary examinations initiated by law enforcement involving the same individuals in crisis. The crisis care coordination partnership model, which facilitates warm hand-offs of individuals involuntarily committed from local law enforcement to crisis counselors, is the means to accomplish the pilot program's purpose. This model, anchored by referral and information-sharing agreements between the MEs and the local service providers, connects individuals involuntarily committed with ongoing care, which can help these individuals avoid subsequent involuntary commitments and, simultaneously, relieve the time burden on law enforcement officers.

**RECENT LEGISLATION:**

| YEAR | BILL # | HOUSE SPONSOR(S) | SENATE SPONSOR | OTHER INFORMATION |
|---|---|---|---|---|
| 2024 | CS/CS/HB 7021 | Maney | Grall | Became law on July 1, 2024. |

[33] Marcos Ramirez, "Officer's Response to Community Mental Health Crisis," Florida Criminal Justice Executive Institute, (May 2022, SLP – 24) https://www.fdle.state.fl.us/FCJEI/Programs/SLP/SLP-Papers-by-Author.aspx (last visited Mar. 21, 2025).
[34] Ashley Krider, Regina Huerter, Kirby Gaherty, and Andrew Moore, "Responding to Individuals in Behavioral Health Crisis via Co-Responder Models: The Roles of Citeis, Counties, Law Enforcement, and Providers," Policy Research Inc. and The National League of Cities, pp. 4 (Jan. 2020) https://www.nlc.org/wp-content/uploads/2020/10/RespondingtoBHCrisisviaCRModels.pdf (last visited Mar. 21, 2025).
[35] University of Florida Police Department, Co-Responder Model, University of Florida, https://police.ufl.edu/divisions/behavioral-services/co-responder-team/co-responder-model/ (last visited Mar. 21, 2025).

## BILL HISTORY

| COMMITTEE REFERENCE | ACTION | DATE | STAFF DIRECTOR/ POLICY CHIEF | ANALYSIS PREPARED BY |
|---|---|---|---|---|
| Human Services Subcommittee | 17 Y, 0 N, As CS | 3/25/2025 | Mitz | DesRochers |
| THE CHANGES ADOPTED BY THE COMMITTEE: | • Creates a new section of law within Part IV of Chapter 394 for the Crisis Care Coordination Pilot Programs in Polk and Volusia counties to reduce repetitive, law enforcement-initiated, involuntary examinations of persons experiencing acute mental health crises.<br>• Creates local partnerships between nationally accredited community mental health centers and law enforcement to help law enforcement divert individuals previously involuntary examined under the Baker Act to crisis counselors so that persons who experienced an acute mental health crisis can, on a voluntary basis, receive ongoing, community-based, stabilizing and rehabilitative services.<br>• Requires that these partnerships be memorialized in written referral agreements.<br>• Requires DCF to submit a report of the independent evaluator's detailed assessment of the pilot programs efficacy and return-on-investment to the Governor, President of the Senate, and Speaker of the House by January 15, 2029. | | | |
| Health Care Budget Subcommittee | 13 Y, 0 N | 4/9/2025 | Clark | Smith |
| Health & Human Services Committee | | | | |

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**THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.**

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