The Florida Senate

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Committee on Children and Families Senator Walter "Skip" Campbell, Jr., Chair

CLARIFYING THE BAKER ACT REQUIREMENTS AS THEY RELATE TO CHILDREN'S RECEIVING AND CRISIS STABILIZATION UNITS

SUMMARY

Part I of Chapter 394, F.S., The Florida Mental Health Act also known as "the Baker Act" governs the examination, admission, and treatment of persons for mental illnesses. Although for purposes of involuntary examination, the Baker Act does not differentiate between children and adults, several sections of Chapter 394, F.S., refer specifically to minors.

This interim project was generated because of concern about how the Baker Act is applied to children admitted to receiving facilities for involuntary examination. There is a perception that Baker Act involuntary examination procedures are being used inappropriately for children. Interest in this issue was fueled by anecdotal reports that children are being placed inappropriately in receiving facilities for extended periods without sufficient exploration of less intrusive alternatives.

A review of Chapter 394, F.S., and other relevant information reveals that unclear and sometimes conflicting interpretations of the Baker Act as it relates to children have evolved over time. Although some quantitative and qualitative information is available on actual practice, currently available data is insufficient to make broad policy recommendations or develop well conceived statutory amendments. A piecemeal approach to addressing the criteria or process for children who are in need of emergency evaluation or longer term mental health treatment will not resolve the current confusion. There are two courses of action that are recommended prior to any revisions to the current statute:

Data from reports generated for the Agency for Health Care Administration by the Baker Act Data Center and the special studies currently under way will provide critical information about examination and treatment of children in community facilities. At the end of 2006, additional data elements collected by the Center will provide the Legislature with reliable data on how the current law is being applied and whether changes are needed in statute or in the way the current statute is applied. This information is essential before any responsible policy recommendations can be made and it should be tracked by the Legislature.

The Legislature should direct an independent entity to conduct an interdisciplinary study on the legal rights of children under the Baker Act, as was recommended by the Supreme Court Commission on Fairness in 1999. The study should include:

- A comprehensive review of the legal rights of children in need of mental health treatment and subject to the Baker Act;
- A review of clinical research on current evidence-based practices in the treatment of children with serious emotional disorders;
- An analysis of available data on the admission, treatment, and discharge of children with serious emotional disorders pursuant to the Baker Act; and,
- Recommendations to the Legislature on amendments to current law and policy necessary to implement the recommended policies.

BACKGROUND

Part I of Chapter 394, F.S., The Florida Mental Health Act also known as "The Baker Act", as enacted by the Legislature in 1971, was considered landmark legislation at the time of its passage. The Baker Act, named for its primary author and sponsor, Representative Maxine Baker, provided due process to persons who were determined to be mentally ill and need of emergency evaluation or treatment. The statute provided for emergency admission for evaluation of

persons who because of a mental illness were likely to physically injure self or others. The Baker Act distinguished between admissions for emergency examination purposes and admission to a state mental health treatment facility (state hospital) and required the filing of a petition in circuit court before an individual could be involuntarily hospitalized. The statute provided that a person under 18 years of age could be admitted to a treatment facility on a voluntary basis if an application for admission was made by a parent or legal guardian. Additionally, it provided that "A facility may admit for evaluation, diagnosis, or treatment any individual fourteen years of age or older who makes application therefore,"[1] and provided that for children and youth under 18, a parent or guardian could apply for a child's discharge. As enacted, the Baker Act did not, nor does it today, distinguish between children and adults for purposes of involuntary examination.

The provisions in the Baker Act which govern the examination, admission, and treatment of persons for mental illnesses have evolved over time, as the mental health service delivery system has changed from one in which institutional placement was the primary treatment available to one in which such placements are rare and most treatment is provided in the home and community setting. This change has accelerated during the last decade because of advances in the diagnosis and treatment of serious mental illnesses. The knowledge base surrounding the treatment of children with serious emotional disturbances has focused on the development of a "system of care" approach, the use of home and community-based interventions, and the importance of addressing the child's needs within the context of the family. These approaches are based on research that has demonstrated their effectiveness.[2] Evolution of the system of care philosophy, availability of interventions that are less disruptive to a child's life, and the children's rights movement have all contributed to a better understanding of the importance of distinguishing the treatment of children from that of adults and in assuring timely access to appropriate services.

The final report of the President's New Freedom Commission on Mental Health issued in July 2003 noted the consequences of unidentified and untreated mental illnesses and emotional disorders in children. The Commission cited the growing body of research that supports the importance of early intervention and treatment of children with serious emotional disturbances.[3] Without appropriate intervention, these children have trouble at home, in social and peer relationships, and at school. Approximately 50 percent of students with severe emotional disturbance drop out of high school compared to 30 percent of students with other disabilities.[4]

Recently published research supported by the National Institute of Mental Health found evidence that half of all lifetime cases of mental illness begin by the age of 14.[5] Of equal concern were the findings that there are often long delays (sometimes decades) between the first onset of symptoms and subsequent treatment. A growing body of knowledge about the physiology of the brain suggests that favorable long term outcomes may hinge on the timeliness of intervention.[6] The long term consequences of untreated mental illness exact a cost on more than the affected child and his or her family. The World Health Organization reports that mental disorders are the leading cause of disability (lost years of productive life) in North America, Europe and, increasingly, in the world. By 2020, Major Depressive illness will be the leading cause of disability in the world for women and children.[7]

These reports reinforce the data on child mental illness cited in "Mental Health: A Report of the Surgeon General."[8] According to the Surgeon General's report, one in ten children in this country suffers from a mental illness serious enough to cause some level of impairment. Of these, it is estimated that just one in five of these children will receive treatment necessary to ameliorate his or her symptoms. Data presented to the President's Commission in 2003 cited prevalence of serious emotional disturbance and extreme functional impairment in children at 5 to 9 percent, serious emotional disturbance and substantial functional impairment at 9 to 13 percent, and any diagnosable disorder at 20 percent.[9] For children in the child welfare or juvenile justice system, estimates are that the prevalence of serious emotional disorders is as high as 75 percent.[10] [11]

Using these prevalence rates and 2004 population estimates,[12] there are approximately 570,601 Florida children and youth between ages 5 and 17 with a diagnosable emotional disorder. Of these, between 144,900 and 260,821 have severe emotional disturbance and extreme functional impairment. Accessing treatment for some of these children may require involuntary examination and placement in a mental health program, which is accomplished through the Baker Act.

Critical Developments in the Baker Act Relating to Children

Although for purposes of involuntary examination the Baker Act does not differentiate between children and adults, several sections of Chapter 394 are specific to children. The legislative history of some of these provisions illustrates the evolution of the current policy concerning involuntary examination and treatment of children. After its initial passage in 1971, the next major revision to the Baker Act occurred in 1979.[13] Substantial changes included establishing in statute two fundamental rights of persons being treated for mental illnesses, the right to treatment in the least restrictive environment and the requirement that express and informed consent be given by a person before beginning any treatment. The other significant change was replacing the term "hospitalization" with "placement," reflecting the increasing development of community-based treatment settings. A significant change was also made in provisions relating to voluntary treatment of minors. Before 1979, the statute allowed for any person subject to involuntary placement or continued involuntary placement to waive his or her right to a judicial hearing. This provision allowed a parent or guardian to waive the hearing on behalf of a child under 17. The law also provided that a child age 12 through 17 could be admitted as a voluntary patient by application of a parent or guardian, and any child over the age of 12 could admit him/herself by application.[14] The 1979 amendments revised the requirements relating to voluntary placement to provide that a person age 17 and under could make application for voluntary admission by informed consent but could be admitted only after a hearing to verify the voluntariness of consent. This revision occurred at approximately the same time that the United States Supreme Court was deciding a case relating to voluntary admission of a child to a state mental hospital in Georgia.[15] In deciding *Parham v. J.R.*, the Court held that "the risk of error inherent in the parental decision to have a child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a 'neutral fact finder' to determine whether the statutory requirements for admission are satisfied."[16] The Court held that three minimum due process requirements were necessary to protect a child's rights when he or she was admitted to a state mental health institution. These three requirements were a neutral fact finder, an inquiry into child's background and history that must include an interview with the child, and periodic review of the child's continued need for treatment.[17]The neutral fact finder in Florida was "the facility administrator or his designee."[18]

In 1982, the Legislature addressed two major issues relevant to the treatment and placement of children under the Baker Act.[19] First, it directed the Department of Health and Rehabilitative Services to stop commingling children and adults in state hospitals and to draft a plan for eliminating the need for placement of children in these facilities by developing appropriate community alternatives. At that time, two of the state hospitals had children and adolescents residing in special units within the facilities. The second significant amendment related to waiver of hearings on involuntary placement for persons under 18.[20] This legislation added language prohibiting waiver of this hearing for a person under the age of 18, which had the effect of providing an additional level of review for children and adolescents being admitted to or retained in psychiatric facilities involuntarily, to encourage thorough evaluation of their condition and exploration of other less intrusive treatment options.

The next major revision occurred in 1991 when the Baker Act provisions on express and informed consent for treatment were amended to create a new section of statute relating to minors and mental health services and treatment. [21] Language was added to the "rights of patients" requiring that in cases of admission or treatment of a person under 18 years of age, express and informed consent for treatment was required from the guardian, except in cases of outpatient crisis services. The legislation also specified that in cases of involuntary examination or involuntary placement, although consent of the minor was to be requested, it was not required as a condition of admission or treatment if consent had been obtained from the guardian.

The 1991 legislation also removed the disability of nonage for any minor 13 years of age or older for the purpose of seeking and receiving mental health crisis intervention services and treatment.[22] It provided any minor over the age of 13 with the right to request, consent to, and receive mental health diagnostic and evaluative services or outpatient crisis intervention services provided by a licensed provider or facility. Crisis intervention services were defined to include individual and group therapy, counseling, and other forms of verbal therapy. These crisis services were not to exceed two visits during any one week period; any additional interventions required parental consent.

In 1998, the Legislature created the Comprehensive Child and Adolescent Mental Health Services Act in Part III of Chapter 394, repealing obsolete language that related to admission of children to state operated residential and day treatment programs.[23] This legislation created a statutory framework for a publicly funded system of care for children and adolescents, providing legislative intent for a system that reflected the principles of the Child and Adolescent Service System Program as described by Public Law 99-660, the Comprehensive Mental Health Planning Act of 1986. These principles have been further defined through research at the federal, state, and local level over the last twenty years. The 1998 legislation integrated the concepts of "child-centered, family-focused, community-based"[24] service components into the law. For the purposes of Part III, a child was defined as a person from birth to the person's 13th birthday, and an adolescent was defined as a person at least 13 years of age but less than 18 years of age. This legislation provided definitions of the target populations to be served by state funded services. It further directed the Department of Children and Family Services to establish within available resources an array of services for children and adolescents in the target populations; crisis stabilization is included in the array of required services. The act provided no specific guidance about clinical or legal criteria for admission to these services but was significant in its expression of legislative intent regarding a system of care for children.

In 2000, an amendment to the Baker Act prohibited a child or adolescent from being admitted to a state owned or operated mental health treatment facility under any circumstance but authorized admission to a crisis stabilization unit, residential treatment facility, or licensed hospital pursuant to either an involuntary or voluntary admission process.[25] It required that these facilities must provide the least restrictive treatment appropriate to the child's needs and must adhere to the principles set forth in Part III. This conformed the Baker Act (Part I) with the language in Part III that stated that state facilities could not be part of the service array for children with serious emotional disturbances.

Public Mental Health Acute Care Services

In addition to procedural requirements for involuntary examination and voluntary and involuntary treatment, the Baker Act provides a framework for the public mental health service delivery system. The "front door" to that system is the public receiving facility. Receiving facilities admit persons for involuntary examination and are defined in the statute as "any public or private facility designated by the department to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment."[26] Public receiving facilities are those facilities which receive public funds specifically for Baker Act examinations. They are usually co-located with a community mental health provider agency or a public hospital. Private receiving facilities include community acute care hospitals, emergency rooms and private hospitals. There are currently 75 public receiving facilities and 53 private receiving facilities designated by the department. Among the public facilities, a total of 47 are licensed by the Agency for Health Care Administration and designated as Crisis Stabilization Units and, of these, 10 are Children's Crisis Stabilization Units. The agency may not issue a license to a crisis stabilization unit unless the unit receives state funds.

The definition of "crisis stabilization unit" and licensure requirements for these programs are found in Part IV of Chapter 394, F.S., the Community Substance Abuse and Mental Health Services Act. A crisis stabilization unit is defined as "a program that provides an alternative to inpatient hospitalization and that provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state."[27] Ten facilities are designated as children's units; they are located in the following counties: Brevard, Dade, Duval (2), Hillsborough, Lee, Orange, Pasco, Pinellas, and Sarasota. In areas where there are no children's crisis stabilization units, a child is taken to the nearest receiving facility.

The stated purpose of these units is to "stabilize and redirect the client to the most appropriate and least restrictive community setting available, consistent with the client's needs."[28] Services provided are screening, assessment, and admission of any person who requests admission or is brought to the unit for involuntary examination pursuant to s. 394.463, F.S. Crisis Stabilization Units were established in the mid-1980's as a less costly but equally intensive alternative to inpatient psychiatric units in general hospitals.

When a person is believed to be mentally ill and because of that illness to meet the Baker Act criteria, the law provides that the person must be taken to the nearest receiving facility. The criteria and process required to admit a person to a receiving facility for involuntary examination are found in s. 394.463 F.S., which provides that "A person may be taken to a receiving facility for involuntary examination if there is

reason to believe that the person has a mental illness and because of his or her mental illness:
(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or
2. The person is unable to determine for himself or herself whether examination is necessary; and
(b)1. 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
2. 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."

The involuntary examination process may be initiated by an ex parte court order, by a law enforcement officer, or by a certificate executed by a physician, clinical psychologist, psychiatric nurse, mental health counselor, or clinical social worker. Persons who are believed to meet the criteria for involuntary examination may be transported to the receiving facility in one of several ways, usually dependent on the method by which the examination was initiated. They may be brought to a facility by a law enforcement officer, a private ambulance service, a family member or friend, or may present themselves for examination.

A person brought to a receiving facility must be examined by a physician or clinical psychologist immediately and may be treated on an emergency basis if treatment is necessary for the safety of the person or others. If the individual is found to meet the criteria for involuntary examination, he or she may be held in a receiving facility for examination for no more than 72 hours. Based on the results of the examination, within the 72 hours one of following must occur:

- The person must be released unless he or she is charged with a crime, in which case he or she is to be returned to the custody of law enforcement;
- The person must be released for voluntary outpatient treatment;
- The person must be asked to give consent for voluntary placement (unless charged with a crime) and if consent is given, admitted as a voluntary patient; or,
- A petition for involuntary placement must be filed in the circuit court.[29]

Every receiving facility is required to submit copies of ex parte orders, law enforcement officers' reports, professional certificates, and beginning this year, involuntary placement orders to the Agency for Health Care Administration on the next working day after the subject of the examination was accepted at the facility.[30] This reporting requirement has been in place since 1996, and a report on the data collected has been submitted to the Legislature each year since 1997. The Agency contracts with the Louis de la Parte Florida Mental Health Institute to collect, analyze, and report on involuntary examination utilization pursuant to the requirements in the Baker Act. The Institute has established a Baker Act Reporting Center, and data from these reports has helped to illuminate some aspects of Baker Act utilization across the state.

Concern about how the Baker Act applies to children seems to center on two related issues. First, there is a perception that Baker Act involuntary examination procedures are being used inappropriately for children. There are anecdotal reports that children are being placed inappropriately in receiving facilities for extended periods of time without sufficient exploration of less intrusive alternatives. Second, there appear to be conflicting interpretations about the due process and informed consent requirements in the Baker Act as they relate to children. This is especially true for situations involving voluntary admission of a child by a parent and provision of express and informed consent to treatment. A minor is defined in Florida Statute as "any person who has not attained the age of 18 years."[31] Unless the disability of non-age is removed for a certain purpose, children are presumed to be legally incompetent to provide consent because of their age and emotional immaturity. Parents are the natural guardians of their children and usually provide consent for medical treatment. There is no definition for "minor" or "child" in the Baker Act, although disability of nonage is removed for outpatient treatment of children over the age of 13 in s. 394.4785, F.S., and the definitions of "child" and "adolescent" in Part III are cross-referenced in s.394.4785, F.S.

METHODOLOGY

The research methods used to prepare this report included a descriptive review of the relevant Florida Statutes and Laws of Florida, case law, historical documents produced by the Legislature and executive branch agencies, the Florida Administrative Code, and aggregate data from the Department of Children and Families, the Agency for Health Care Administration

and the University of South Florida - Florida Mental Health Institute. Relevant research in the area of mental health services, systems of care for children and adolescents with emotional disturbances and mental illnesses, child development, and legal rights of children was also reviewed.

Key informants stakeholders were interviewed including representatives from the Department of Children and Families, the University of South Florida – Louis de la Parte Florida Mental Health Institute, provider agency representatives, advocacy groups and consumer representatives.

FINDINGS

The 2004 Baker Act Handbook – User Reference Guide includes a section on "Consent for Admission and Treatment of Minors". At the beginning of this chapter, there is a cautionary note that reads, in part, "Certain issues involving the placement of minors including voluntariness hearings are currently in flux. This is a dynamic area of the law which may change after the publication of this Handbook." This statement reflects the current lack of clarity in how certain provisions in the Baker Act are applied in situations involving children. For those who are most involved in the day to day application of the law, this lack of clarity has created confusion over issues such as involuntary examination, consent to treatment by a child or parent, and voluntary admission. The Supreme Court Commission on Fairness in 1999 noted this lack of clarity when it recommended that the Legislature fund a comprehensive interdisciplinary study on the legal needs of children under the Baker Act. This study was not funded.

The Baker Act Reporting Center at the Louis de la Parte Florida Mental Health Institute developed a special report based on data collected on certificates for involuntary examinations initiated between January 2002 and November 2004. During that time, there were 302,083 certificates submitted; 49,284 (16 percent) were for children.[32] Since this is not an unduplicated count, the actual percentage of the total certificates that were for children may be less than 16 percent. The purpose of this study was to review the use of involuntary examinations across the state to determine the variation among Department of Children and Family service districts, with special focus on children with multiple examinations. The results of the study indicated that some districts with higher numbers of examinations and with more children with multiple examinations not only had a higher percent of children in the population but also had children's crisis stabilization units. This suggests that in certain communities, the presence of a children's crisis stabilization unit may increase Baker Act examinations as the unit is seen as a resource by schools, law enforcement, and mental health professionals. The author of the study cautions that this is not a perfect correlation but is significant enough to warrant continued tracking and examination.[33]

In another study, based on Baker Act examination forms submitted to the Center, involuntary examinations of children appear to decrease in the months of June and July and peak in September and October. This correlation with the school year may be an indication that the Baker Act and children's crisis stabilization units are over-utilized by some schools for children with behavior problems. This may be related to the "zero tolerance" policy, which has become standard practice and has resulted in schools being more likely to remove children who have behavior or emotional problems rather than attempt to address their problems in the school setting.

There are certain provisions in the Baker Act that over the course of time have become increasingly controversial in regard to the rights of minors. After examination at a receiving facility, a person who requires continued treatment "shall be asked to give express and informed consent for voluntary treatment."[34] Voluntary admission upon application of the guardian of a child under 18 requires a hearing to verify the voluntariness of the consent.[35] The nature of this hearing is not defined in statute or administrative rule. The references to "voluntariness hearings" being conducted at a facility by facility staff were removed from the Florida Administrative Code in 1997. It is the opinion of the Department of Children and Families that since "all other references to hearings in the Baker Act are judicial in nature", a judicial hearing of some type is required prior to admission of a minor on voluntary status."[36] In the *Parham* case, the Supreme Court required an impartial fact finder but left up to the state whether to require a formal hearing.[37] Some child advocates suggest that in all cases of admission of a child to an inpatient setting, regardless of the type of admission, the child should have an independent advocate to assure that his or her rights are protected. In the involuntary placement process, the statute no longer allows the hearing to be waived and requires the appointment of a public defender if the person is not represented by private counsel, but there is no similar provision for a child subject to a voluntariness hearing.

Whether involuntary examination is being used inappropriately and the extent of that use is difficult to determine given the current data. However, beginning in February 2005, forms submitted to the Agency for Health Care Administration and in turn to the Baker Act Reporting Center will provide more meaningful information on the circumstances surrounding the initiation of an examination. The forms have been modified to indicate if the law enforcement officer initiating an examination is a school resource officer and whether a child being examined is in the custody the Department of Children and Families or the Department of Juvenile Justice. The Center will also receive forms for each person who is placed by either involuntary outpatient or inpatient order which will provide more information on the disposition of persons who are examined. Faculty members at the Baker Act Data Center have also applied for a National Institute of Mental Health grant to investigate the use of the Baker Act for children.

The Florida Mental Health Institute is currently involved in a series of other activities to address the mental health acute care system in Florida. These activities include the development of a white paper on evidence-based practices in acute care, a statewide survey of Baker Act practices in receiving facilities, which will include specific elements focusing on children in crisis stabilization units, and a statewide "summit" on acute care.

There are several important data elements that are not available currently but are necessary to make responsible policy recommendations regarding the use of the Baker Act and children. Knowing the specific reasons for initiation of an examination, the legal status of children examined and if length of stay or disposition is different based on that status, and previous and subsequent treatment interventions for children who are examined is essential to understanding how the system is being used and to determining if it is functioning well as a gateway to a system of care for children with severe emotional disturbances.

RECOMMENDATIONS

Based on the information currently available, it would be premature to make specific recommendations on amending the Baker Act or other portions of Chapter 394, F.S., as it relates to children. A piecemeal approach to addressing the criteria or process for children who are in need of emergency evaluation or longer term mental health treatment will not resolve the current confusion. There are two courses of action that are recommended prior to any revisions to the current statute:

Data from reports generated for the Agency for Health Care Administration by the Baker Act Data Center and the special studies currently under way will provide critical information about examination and treatment of children in community facilities. At the end of 2006, additional data elements collected by the Center will provide the Legislature with reliable data on how the current law is being applied and whether changes are needed in statute or in the way the current statute is applied. This information is essential before any responsible policy recommendations can be realized and should be tracked by the Legislature.

The Legislature should direct an independent entity to conduct an interdisciplinary study on the legal rights of children under the Baker Act, as was recommended by the Supreme Court Commission on Fairness in 1999. The study should include:

- A comprehensive review of the legal rights of children in need of mental health treatment and subject to the Baker Act;
- A review of clinical research on current evidence-based practices in the treatment of children with serious emotional disorders;
- An analysis of available data on the admission, treatment, and discharge of children with serious emotional disorders pursuant to the Baker Act; and,
- Recommendations to the Legislature on amendments to current law and policy necessary to implement the recommended policies.

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[1] s. 394.465 (1) (b), F.S., 1971.

[2] K.Hoagwood, B. Burns, et al, "Evidence-Based Practice in Child and Adolescent Mental Health Services", Psychiatric Services, American Psychiatric Association, Arlington, VA, Vol. 52 No. 9, September 2001.

[3] New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America. Final Report, DHHS Pub. No. SMA-03-3832. Rockville, MD., 2003.

[4] Ibid. p. 58.

[5] R. Kessler, P. Berglund, et al, *"Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Co-Morbidity Survey Replication,"* Archives of

General Psychiatry, American Medical Association, Chicago, 2005, p.593-602.
[6] J. Shonkoff and D. Phillips, Editors; From Neurons to Neighborhoods: The Science of Early Childhood Development, National Academies Press, Washington, D.C., 2000 cited by The President's New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America. Final Report, DHHS Pub. No. SMA-03-3832. Rockville, MD. (2003), p.57.
[7] NAMI: The Nation's Voice on Mental Illness, About Mental Illness, 2005, http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm, October 12, 2005.
[8] U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Rockville, MD, 1999.
[9] R. Friedman, The Status of Children's Mental Health: A Need for Urgent Care, Presentation to the National Conference of State Legislatures, Salt Lake City, July 19, 2004.
[10] Child Welfare League of America, *"Best-Practice Framework for Addressing the Mental Health and Substance Abuse Needs of Children and their Families,"* January 21, 2003, http://www.cwla.org/programs/bhd/mhbestpracticeframework.htm, October 7, 2005.
[11] Coalition for Juvenile Justice, "Mental Health Needs of Youth and Young Offenders," 2000, http://www.juvjustice.org/resources/fs002.html, October 7, 2005.
[12] Office of Economic and Demographic Research, *Demographic Information for Members and Staff*, April 1, 2004 Population Estimate, The Florida Legislature, 2005.
[13] Chapter 79-298, L.O.F.
[14] s. 394.465 (1) (a), F.S., 1978.
[15] *Parham v. J.R.*, 442 U.S. 584, 99 S.Ct. 2493.
[16] *Parham* at 606.
[17] *Parham* at 607.
[18] Florida Department of Health and Rehabilitative Services, Alcohol, Drug Abuse and Mental Health Program Office, Baker Act Handbook, June 1985.
[19] Chapter 82-212, L.O.F.
[20] s. 394.67(2) (a) and s. 394.67 (4) (a), F.S., 1981.
[21] Chapter 91-170, L.O.F.
[22] s. 394.4784, F.S., 1991.
[23] Chapter 1998-5, L.O.F.
[24] B. Stroul and R. Friedman, A System of Care for Severely Emotionally Disturbed Children and Youth, Georgetown University Child Development Center, CASSP Technical Assistance Center, Washington, D.C., 1986.
[25] Chapter 2000-265, L.O.F.
[26] s. 394.455 (26), F.S.
[27] s. 394.67 (5), F.S.
[28] s. 394.875 (1) (a), F.S.
[29] s. 394.463 (2), F.S.
[30] Chapter 96-169, L.O.F.
[31] s. 1.01 (13), F.S.
[32] A. Christy, "*Special Report of Repeated Baker Act Examinations of Children with Special Emphasis on Department of Children and Families Districts*," Special Report, University of South Florida, Florida Mental Health Institute, Tampa, August 2005, p. 3.
[33] Ibid, p. 13.
[34] s. 394.463 (2) (i.) 3, F.S.
[35] s. 395.4625 (1) (a), F.S.
[36] Department of Children and Families, Baker Act: Frequently Asked Questions, Part I, p.37, www.dcf.state.fl.us/mentalhealth/laws/faq1.pdf .
[37] *Parham* at 607.