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 Children, Families, and Elder Affairs Committee

BILL:	SB 2678
INTRODUCER:	Senator Storms
SUBJECT:	Mental Health
DATE:	April 6, 2010
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hansson	Walsh	CF	**Pre-meeting**
2.			JU	
3.			HA	
4.				
5.				
6.				

I. Summary:

This bill revises part I of ch. 394, F.S., also known as the Baker Act, substituting the term "individual" for the terms "person," "patient," and "client" throughout the Baker Act. The bill also conforms terms by redefining and deleting obsolete or duplicate definitions and adding and defining new terms throughout the Baker Act.

The bill amends background screening requirements for mental health personnel to require level 2 background screening for all "mental health personnel." The bill removes the fingerprinting and screening exemption of mental health personnel working in a facility licensed under Chapter 395[1] who have less than 15 hours per week of direct contact with patients or who are health care professionals licensed by the Agency for Health Care Administration (AHCA or Agency).

The bill requires physical examinations and psychiatric evaluations to be documented in the clinical record and requires facilities to provide certain information and procedures. The bill specifies the rights, authority, and responsibilities of a representative and requires a guardian advocate to make every effort to make the same decision the individual would make. The bill specifies that only governmental facilities and others designated by the Department of Children and Families (DCF or Department) may hold or treat individuals on an involuntary basis. The bill provides that a law enforcement office acting in good faith may not be held liable for false imprisonment.

[1] A hospital, ambulatory, surgical center, or mobile surgical facility.

The bill significantly changes the requirements for voluntary admission of a minor. The bill requires a clinical assessment process for minors to verify assent to voluntary admissions. The bill defines assent and requires that the licensed professional provide the minor with certain information. According to the bill, if the minor's assent is not verified, a petition for involuntary inpatient placement must be filed with the court or the minor must be released.

The bill requires that an *ex parte* order for involuntary examination be based on specific facts and have occurred within the last 14 days. The bill specifies requirements for certificates for involuntary examination executed by examining professionals. The bill provides notification requirements to guardians of minors who are involuntarily examined. The bill revises the procedures for holding a person for involuntary examination and for emergency situations.

The bill requires a receiving or treatment facility filing for petition for involuntary inpatient placement to send a copy of the petition to AHCA by the next working day. The bill redefines the roles of attorneys with respect to involuntary placement proceedings. The bill prohibits continuance requests from parties other than the individual. The court is required to conduct a hearing on capacity to consent to treatment. The bill provides for the appointment of a guardian advocate if an individual is found incompetent. The bill requires the court to allow certain testimony at hearings on involuntary placement and requires the Division of Administrative Hearings to inform an individual of his or her right to an independent expert examination. The bill authorizes a public facility to request the transfer of an individual to a private facility.

The bill provides an effective date of July 1, 2010.

This bill substantially amends the following sections of the Florida Statutes: 394.453, 394.455, 394.457, 394.4572, 394.4573, 394.4574, 394.458, 394.459, 394.4593, 394.4595, 394.4597, 394.4598, 394.4599, 394.460, 394.461, 394.4615, 394.462, 394.4625, 394.463, 394.4655, 394.467, 394.46715, 394.4672, 394.4674, 394.4685, 394.469, 394.473, 394.475, 394.4785, 394.4786, 394.47865, 394.4787, 394.4788, 394.4789, 39.407, and 394.495.

II. Present Situation:

The Baker Act

It is estimated that one in four Americans ages eighteen and older suffers from a diagnosable mental illness, including substance abuse, in any given year,[2] while one out of every seventeen lives with a serious mental illness (e.g. schizophrenia, major depression, or bipolar disorder).[3] When applied to the most recent U.S. Census residential population estimates for people ages eighteen and older, the following data are obtained:

- 57 million Americans (3.5 million Floridians) suffer from a diagnosable mental illness; and

[2] National Institute of Mental Health, *Statistics*, http://www.nimh.nih.gov/health/topics/statistics/index.shtml, (last visited April 5, 2010).
[3] National Institute of Mental Health, *The Numbers County: Mental Disorders in America*, http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml, (last visited April 5, 2010).

- 12.6 million Americans (827,720 Floridians) suffer from a serious mental illness.

Part I of Chapter 394, F.S., the "Florida Mental Health Act," also known as the "Baker Act," is a civil commitment law which provides a process for the involuntary examination and subsequent involuntary placement (admission) of a person for either inpatient or outpatient treatment of a mental, emotional, or behavioral disorder. It is designed to use the least restrictive means of intervention, while preserving a person's dignity and human rights.[4]

The Baker Act encourages the voluntary evaluation and, in some cases, admission to a psychiatric facility,[5] of persons who have a mental illness,[6] when they are able to give express and informed consent to admission and treatment and are able to independently exercise their rights. When voluntary treatment is not possible due to the severity of a person's illness, the law ensures that the person's due process rights are protected.[7]

Express and Informed Consent
The issue of competence to provide express and informed consent to mental health treatment is separate from the issue of placement for mental health treatment, and is applicable in both voluntary and involuntary contexts.

The Baker Act provides the following definitions:

> "Express and informed consent" means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.[8]
>
> "Incompetent to consent to treatment" means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.[9]

The admitting physician of each receiving or treatment facility must determine and document whether a person being admitted pursuant to the Baker Act is competent to provide express and informed consent to treatment.[10] If the physician determines that an individual is incompetent to

[4] Section 394.453, F.S.
[5] Section 394.455(10), F.S., defines the term "facility" as a hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness.
[6] Section 394.455(18), F.S., defines "mental illness" an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology.
[7] Department of Children and Families (Mental Health Program Office), in collaboration with Department of Mental Health Law and Policy, Louis de la Parte Mental Health Institute, Univ. S. Fla., *2008 Baker Act User Reference Guide*, Appendix F-1(2008) (hereinafter "*Baker Act Guide*").
[8] Section 394.455(9), F.S.
[9] Section 394.455(15), F.S.
[10] *See* Section 394.459(3) and 394.4625(1)(f), F.S.; Chapter 65E-5.170; 65E-5.270, F.A.C.; Baker Act Form CF-MH 3104. *See also* s. 765.204, F.S. A person who has been adjudicated incapacitated will have a court-appointed guardian who, in most

consent to treatment, treatment may not be administered[11] until a guardian advocate[12] is appointed, unless the criteria for an emergency treatment order are met. An emergency treatment order supersedes a person's right to refuse treatment if a physician determines that the person is not capable of exercising voluntary control over his or her behaviors and these behaviors, if left uncontrolled, are an imminent danger to that person or to others within the facility.[13]

Involuntary Examination

Criteria

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 whether examination is necessary.

In addition, it must be determined that, without care or treatment, the person is either likely to suffer from neglect[14] resulting in a real and present threat of substantial harm that can't be avoided with the help of others, or is likely to cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.[15]

Initiation

Section 394.463(2), F.S., provides that an involuntary examination may be initiated in one of the following three ways:

1. A **court** may enter an ex parte order, based on sworn testimony by the petitioner, directing a law enforcement officer or other designated agent of the court to take the person to the nearest receiving facility. The order is only valid until executed, or if it is not executed, the order is valid only for the period specified in the order itself.[16] If no time limit is specified, the order is valid for seven days after the date it is signed. This method is most frequently used by relatives.

2. A **medical professional**[17] may execute 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 and stating the observations upon which that conclusion is based. A

cases, will have the power to give express and informed consent to mental health treatment. The guardian of a minor must provide express and informed consent to mental health treatment of the minor.

[11] The constitutionality of the forcible medication of civilly committed individuals has not been explicitly addressed by the United State Supreme Court. The Court has held, however, that both prisoners and pretrial detainees retain a fundamental right to refuse psychotropic medication, and that forcing antipsychotic drugs on a convicted prisoner or a pretrial detainee is "impermissible absent a finding of overriding justification and a determination of medical appropriateness." *Riggins v. Nevada*, 540 U.S. 127, 135 (1992).

[12] An guardian advocate is a person appointed by the court to make decision regarding the mental health treatment of an individual who has been found to be incompetent to consent to treatment under the Baker Act. Section 394.455(12), F.S.

[13] Chapter 65E-5.1703, F.A.C.

[14] Neglect may take the form of refusing necessary prescription medications, refusing to eat or drink, inability to sleep, placing oneself in imminently dangerous situations, or other high risk behaviors. *Baker Act Guide*, Appendix F-4 (2008).

[15] Section 394.463(1)(b), F.S.

[16] An order may expire simply because the subject of that order cannot be located. Anecdotal evidence indicates that approximately 90 to 95 percent of *ex parte* orders are executed within two to three days.

[17] Section 394.463(2)(a)3, F.S., lists a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker as being able to execute a certificate.

law enforcement officer shall take the person into custody and deliver him or her to the nearest receiving facility. The officer must execute a written report detailing the circumstances under which the person was taken into custody.

3. A **law enforcement officer**[18]may take a person who appears to meet the criteria for involuntary examination into custody and deliver that person to the nearest receiving facility. The law enforcement officer must complete certain forms documenting the behavior and transportation of the individual.[19]

In 2007, there were 122,443 Baker Act involuntary examinations. Approximately 48 percent of these examinations were initiated by law enforcement officers; 49 percent by mental health professionals; and less than three percent by *ex parte* order.[20]

Once an involuntary examination has been initiated, the subject of the examination must receive an initial examination by a physician or clinical psychologist at a receiving facility within 24-hours[21] to rule out mock psychiatric symptoms caused by non-psychiatric medical illness, injury, metabolic disorders, and drug toxicity. This initial mandatory involuntary examination must include:[22]

- A thorough review of any observations of the person's recent behavior;
- A review of the document initiating the involuntary examination and transportation form;
- A brief psychiatric history; and
- A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

A person may not be held for involuntary examination longer than 72 hours and must be given the opportunity to notify others of his or her whereabouts. Within the 72-hour involuntary examination period, one of the following must take place:

- The person must be released unless charged with a crime;
- The person must be released for voluntary outpatient treatment;
- The person must be asked to give express and informed consent to voluntary placement; or
- A petition for involuntary placement must be filed with the circuit court by the facility administrator.[23]

The person cannot be released by the receiving facility without the documented approval of a psychiatrist, clinical psychologist, or physician in a hospital's emergency department.[24]

---

[18] The Baker Act defines "law enforcement officer" with reference to s. 943.10(1), F.S.
[19] Report of Law Enforcement Officer Initiating Involuntary Examination Form (Baker Act Form CF-MH 3052a) and Transportation to a Receiving Facility – Part 1 Form (Baker Act Form CF-MH 3100).
[20] Annette Christy, *Summary: Involuntary Examination Data and Key Research Finding,* pg. 7 (2008) (on file with the Children, Families and Elder Affairs Committee).
[21] Section 394.459(2)(c), F.S.
[22] Chapter 65E-5.2801, F.A.C.
[23] Section 394.463(2)(i), F.S.
[24] Section 394.463(2)(f), F.S.

If an individual is determined to require continued psychiatric care and does not give consent to voluntary placement, he or she may be the subject of a petition for involuntary placement filed by the facility administrator as indicated above. The Baker Act permits either involuntary inpatient[25] or involuntary outpatient[26] orders.

Involuntary Inpatient Placement

Criteria

The Baker Act provides that a person may be involuntarily placed for inpatient treatment if a court finds by clear and convincing evidence that the person has a mental illness, and because of the mental illness:[27]

- The person has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or is unable to determine for himself or herself whether placement is necessary; **and**

- He/she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and without treatment is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well being; **or**

  There is substantial likelihood that in the near future he or she will inflict serious bodily harm[28] on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; **and**

- All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

Initiation

While the administrator of a facility may file a petition for involuntary placement, the facility's recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or other psychiatrist,[29] both of whom have personally examined the subject of the recommendation within the preceding 72 hours.

Once a petition for involuntary placement is filed, the court must appoint the public defender to represent the subject of the petition within one court working day, unless he or she is otherwise represented.[30] The court is required to hold the hearing on involuntary commitment within five

[25] Section 394.467, F.S.
[26] Section 394.4655, F.S.
[27] Section 394.467(1), F.S.
[28] "Serious bodily harm" is interpreted to mean harm that requires medical treatment. *Craig v. State,* 804 So.2d 532, 534 (Fla. 3rd DCA 2002).
[29] Section 394.467(2), F.S., provides that in counties of less than 50,000 population, the second opinion may be provided by a licensed physician trained and experienced in mental and nervous disorder diagnosis and treatment or a psychiatric nurse.
[30] Section 394.467(4), F.S.

days of the filing of a petition, unless a continuance is granted.[31] The state attorney for the circuit where the patient is located is designated to represent the state.
If the court concludes that the subject of the petition meets the criteria for involuntary inpatient placement, it will order that the person be transferred to the proper facility and retained for treatment for up to six months. However, the facility is required to discharge a person any time he or she no longer meets the criteria for involuntary inpatient placement, unless the person has transferred to voluntary status.

If a person continues to meet the criteria for involuntary inpatient placement, the facility administrator must, prior to the expiration of the period during which the facility is authorized to retain the person, file a petition to request continued involuntary inpatient placement. Hearings on petitions for continued involuntary inpatient placement are administrative hearings conducted by an administrative law judge. The subject of the petition, unless otherwise represented, is represented by the public defender of the circuit in which the facility is located. If at these hearings it is shown that the patient continues to meet the criteria for involuntary inpatient placement, the judge must sign the order for continued involuntary placement for a period not to exceed six months.[32]

Background Screening

The majority of health care providers licensed by AHCA are required by law to conduct background screening for certain employment positions. Pursuant to section 408.809, F.S., all health care provider administrators, owners, directors and chief financial officers must undergo Level 2 screening. Currently, s. 394.4572, F.S., requires Level 2 background screening for all mental health personnel who have direct contact with unmarried patients under the age of 18 years. The provision, however, does not require a Level 2 background screening for staff that works with adults.

Additionally, the background screening must be facilitated through a State agency. Therefore, mental health providers must request Level 2 screening either through the Agency or through the Department. Mental health personnel working in a facility licensed under Chapter 395 who have less than 15 hours per week of direct contact with patients or who are health care professionals licensed by AHCA or a board thereunder are exempt from the fingerprinting and screening requirement.

According to AHCA, in 2009 the Agency processed 249 screening requests for mental health programs licensed by the Agency (crisis stabilization units, residential treatment facilities and residential treatment centers for adolescents). AHCA reports that this number is relatively low in proportion to the number of screenings processed for other health care providers during the same time period. This may be due in part to the limited number of staff working with unmarried minors and/or mental health providers choosing to conduct screening through the Department because of the reduced screening fees pursuant to section 943.053, F.S. The Agency does not

[31] Section 394.467(6)(a), F.S.
[32] Section 394.467(7), F.S.

have a reduced fee established through this provision of law; therefore health care providers must pay $43.25 per screening request.[33]

III. Effect of Proposed Changes:

Section 1
This section amends ch. 394, F.S., relating to the Baker Act, to conform provisions to changes made by the bill, largely by replacing the terms "person," "patient," and "client," with "individual," and to make technical amendments.

Section 2
The bill makes significant changes to the definition section of the Baker Act. The bill conforms terms by redefining and deleting obsolete or duplicate definitions and adding and defining the terms: adult; advance directive; government facility; minor; and physician assistant.

- The bill defines adult to mean an individual who is 18 years of age or older or who has had the disabilities of nonage removed pursuant to s. 743.01 or 743.015, F.S.

- The bill defines advance directive to have the same meaning as in s. 765.101, F.S., which defines advance directive as a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift.

- The bill defines government facility to mean a facility owned, operated, or administered by the Department of Corrections or the United States Department of Veteran Affairs.

- The bill defines a minor as an individual who is 17 years of age or younger and who has not had the disabilities of nonage removed pursuant to s. 743.01 or s. 743.015, F.S. This allows for emancipated or married minors to be treated as adults since they do not have a guardian to provide them with consent.[34]

- The bill defines a physician assistant to mean a person licensed as a physician assistant under chapters 458 or 459, F.S.

The phrase "regardless of etiology" is removed from the definition of mental illness as it relates to the Baker Act. Additionally, the bill excludes brain injuries and dementia from the definition of mental illness. DCF reports that individuals with these diagnoses could still receive mental health services if they have a co-occurring mental illness.[35] This would not prevent these individuals from being examined at a receiving facility to determine if they meet criteria for

[33] Agency for Health Care Administration 2010 Bill Analysis for SB 2678, on file with the Children, Families, and Elder Affairs Committee.
[34] Florida Department of Children, Families and Elder Affairs 2010 Bill Analysis for SB 2678, on file with the Children, Families, and Elder Affairs Committee.
[35] *Id.*

involuntary inpatient treatment; however, the intent is to avoid unnecessary Baker Act admissions for these populations.[36]

Section 3
This section amends ch. 394, F.S., relating to the Baker Act, to conform provisions to changes made by the bill, largely by replacing the terms "person," "patient," and "client," with "individual," and to make technical amendments.

Section 4
The bill provides that the department and AHCA shall require employment screening for mental health personnel using level 2 screening standards provided in s. 435.04. The bill amends the definition of "Mental Health Personnel" to include all program directors, professional clinicians, staff members, and volunteers working in public or private mental health programs and facilities that have direct contact with individuals held for examination or admitted for mental health treatment. Thus, the bill amends s. 394.4572, F.S., to require a Level 2 background screening for all personnel who work with individuals with mental illness, regardless of age, thereby expanding the current Level 2 background screening requirement, which applies to full-time staff who work with minors.

The bill removes the fingerprinting and screening exemption of mental health personnel working in a facility licensed under Chapter 395 who have less than 15 hours per week of direct contact with patients, or who are health care professionals licensed by AHCA or a board thereunder.

Section 5
The bill removes the requirement in s. 394.4573(4), F.S., that the department submit a report to the Legislature, prior to April 1 of each year, outlining departmental progress towards implementation of the minimum staffing patterns' standards in state mental health treatment facilities. DCF reports that this section was created in conjunction with implementation of the Unit Treatment and Rehabilitation Specialist (UTRS) model many years ago, and minimum staffing patterns have already been met. Therefore this section is obsolete.[37]

Section 6
This section amends s. 394.4574, F.S., by replacing the term "mental hospital" with the term "mental health treatment facility."

Section 7
The bill amends s. 394.458, F.S., to change the word "hospital" to "receiving or treatment facility." The bill also disallows firearms and other contraband from being carried into the unit unless authorized by the administrator of those facilities.

Section 8
Currently, s. 394.459(2), F.S., requires that a physical examination be conducted within 24 hours of arrival at a receiving or treatment facility. The bill amends s. 394.459(2), F.S., to require that a psychiatric evaluation occur within 24 hours of arrival if the person is not released. Florida

[36] *Id.*
[37] *Id.*

Administrative Code already requires that a public receiving facility conduct daily rounds and provide psychiatric coverage 24 hours a day, 7 days a week. A physician can provide back-up coverage as long as psychiatric consultation is available.[38] A psychiatrist or a physician can complete that evaluation.[39] The requirement in the bill will not change the allowance of 72 hours to complete the involuntary examination, but will serve to expedite the initiation of the examination. DCF reports that this may possibly result in the earlier release of a person being detained, and allow treatment to begin expeditiously.[40]

The bill amends s. 394.459(3), F.S., to clarify that consent is required by a minor's guardian for inpatient admission and treatment.

Currently, the Department can only require that public receiving and treatment facilities report adverse incidents to the Department. The bill adds s. 394.459(4)(b)4., F.S., to require that all facilities holding or treating an individual pursuant to Chapter 394, F.S., report adverse incidents to the Department. DCF reports that this will enable the Department to immediately investigate, provide technical assistance, and take action, as necessary, to protect the citizens of Florida.[41]

The bill updates the immunity clauses in the Baker Act[42] to mirror the language in the Marchman Act.[43] DCF reports that protecting law enforcement partners from liability for good faith efforts to implement the initiation of involuntary examinations (absent negligence) is good public policy.[44]

The bill adds s. 394.459(12), F.S., to require the Department to provide education about the benefits of advance directives.

Sections 9 through 10
These sections amend ch. 394, F.S., relating to the Baker Act, to conform provisions to changes made by the bill, largely by replacing the terms "person," "patient," and "client," with "individual," and to make technical amendments.

Section 11
The bill amends s. 394.4597(2)(e), F.S., to clarify the role and rights of representatives of persons held for involuntary examination or treatment. The list provided in this section does not reflect new tasks or rights, but consolidates them in the statute. According to the bill, the representative selected by the individual or designated by the facility has the right, authority, and responsibility to:

- Receive notice of the individual's admission;
- Receive notice of proceedings affecting the individual;

[38] *See* 65E-12.105(2)(a), F.A.C.
[39] *See* 65E-12.107(2)(c), F.A.C..
[40] Florida Department of Children, Families and Elder Affairs 2010 Bill Analysis for SB 2678, on file with the Children, Families, and Elder Affairs Committee.
[41] *Id.*
[42] Sections 394.459(10) and 394.462(1)(a), F.S.
[43] Chapter 397, F.S.
[44] Florida Department of Children, Families and Elder Affairs 2010 Bill Analysis for SB 2678, on file with the Children, Families, and Elder Affairs Committee.

- Have immediate access to the individual unless such access is documented to be detrimental to the individual;
- Receive notice of any restriction of the individual's right to communicate or receive visitors;
- Receive a copy of the inventory of personal effects upon the individual's admission and to request an amendment to the inventory at any time;
- Receive a disposition of the individual's clothing and personal effects if not returned to the individual, or to approve an alternate plan;
- Petition on behalf of the individual for a writ habeas corpus to question the cause and legality of the individual's detention or to allege that the individual is being unjustly denied a right or privilege granted herein, or that a procedure authorizing herein is being abused;
- Apply for a change of venue for the individual's involuntary placement hearing for the convenience of the parties or witnesses or because of the individual's condition;
- Receive written notice of any restriction of the individual's right to inspect his or her clinical record;
- Receive notice of the release of the individual from a receiving facility where an involuntary examination was performed;
- Receive a copy of any petition for the individual's involuntary placement filed with the court; and
- Be informed by the court of the individuals; right to an independent expert evaluation pursuant to involuntary placement procedures.

Section 12
The bill amends s. 394.4598(6), F.S., and clarifies that the role of a guardian advocate is to represent the interests of the individual for whom they have been appointed. The guardian advocate is to make every effort to make the mental health care decision he or she believes the individual would have made under the circumstances if the individual were capable of making such decision.

The bill amends s. 394.4598(4), F.S., to delete the requirement that the court approve organizations that can provide training to guardian advocates. However, the Department retains the authority to develop the curriculum that remains subject to approval by the chief judge of the circuit court. The Department is developing a free on-line training course that follows the current approved self-guided curriculum.[45]

The bill amends s. 394.4598(6), F.S., to permit the court to give the authority for a guardian advocate to consent for medical and other extraordinary procedures defined at the involuntary placement hearing instead of requiring a separate hearing.

Section 13
Subparagraph 394.4599(2)(a)2, F.S., clarifies that receiving facilities are required to notify legally-appointed representatives within 24 hours of the individual's arrival. This notification does not require the person's consent. This will serve to eliminate missing person reports in these

[45] *Id.*

situations. DCF notes that it will also eliminate the redundancy/cost of duplicated mailings of admission notices by allowing delivery by regular mail or registered/certified mail instead of requiring both.[46]

Section 14
The bill repeals section 394.460, F.S., which allows professionals at receiving and treatment facilities to refrain from providing services under the Baker Act. This section specifies that the participation of professionals in providing services under the Baker Act is voluntary. DCF notes that this section is redundant, because the Baker Act does not impose any obligations on professionals to provide services; it imposes obligations on facilities. Facilities in turn must hire or contract with willing professionals to provide the services. DCF further notes that this section may be confusing because it may be misunderstood to mean that a facility may refuse to provide services to an individual because the facility's professional staff refuses to provide the services. In fact, the facility is responsible for hiring or contracting with professionals who are qualified and willing to provide the appropriate services.[47]

Section 15
The bill provides that Governmental Facilities (previously defined as Veterans Administration and Department of Correction) have the authority to provide involuntary examination and treatment without being designated by the Department.

Section 16
Subsection 394.4615(4), F.S., adds that a researcher must follow all Departmental policies relating to access to files. The Department has extensive policy that follows Federal guidelines.[48]

Section 17
Current law permits receiving facilities to refuse admission to persons in police custody on felony charges, if the facility determines that the person cannot be held safely at the facility. In such cases, the facility must send a staff member to the jail to conduct the involuntary examination. Subsection 394.462(1)(h), F.S., is amended to limit this provision to adults, so that minors charged with felonies must be examined in a receiving facility.

Paragraph 394.462(3)(d), F.S., is created to authorize the Florida Department of Corrections to transport an individual who is being released from its custody to a receiving or treatment facility for involuntary examination or placement.

Section 18
The bill amends s. 394.4625 (1)(a)2., F.S., to require a clinical assessment process for minors to verify assent to voluntary admissions. This replaces the current requirement of a judicial hearing prior to admission. The bill defines the minor's assent to mean that the minor has affirmatively agreed to stay at the facility for examination or mental health treatment. Mere failure to object, absent affirmative agreement, does not constitute assent. Additionally, the assent must be

[46] *Id.*
[47] *Id.*
[48] *See* 45 C.F.R 46. *Id.*

verified through a clinical assessment that is documented in the clinical record and conducted within 12 hours after admission by a licensed professional.

The bill provides that the licensed professional is required to give the minor an explanation of why the minor will be examined and treated, what the minor can expect while in the facility, and when the minor may expect to be released. The licensed professional must use language that is appropriate to the minor's age, experience, maturity, and condition. The legal guardian's consent to the placement is also required. If the minor's assent is not verified as described above, a petition for involuntary inpatient placement must be filed with the court within one working day after admission, or the minor must be released to his or her guardian within 24 hours.

The bill amends s. 394.4625(1)(c) to ensure that a mental health professional who has any financial interest in the outcome of a voluntary examination cannot conduct the individual's competency examination.

This section also amends s. 394.4625(2) to require that a person on voluntary status who has been charged with a crime be released to law enforcement. This is consistent with the requirements for release of those involuntarily admitted.

Subsection 394.4625(4), F.S., is amended to clarify that a clinical assessment must be completed by a physician or licensed psychologist to establish competence of a person to consent to voluntary admission when being transferred from involuntary to voluntary status.

Section 19
The bill amends s. 394.463(2)(a) to clarify that an *ex parte* order for involuntary examination must be based upon sworn testimony which includes specific facts that support the finding that the criteria have been met. Additionally, any behavior relied on must have occurred within the preceding 14 days. No time frame is currently provided in law.

Subparagraph 394.463(2)(a)3., F.S., adds that a physician assistant can be one of the professionals who can initiate a professional certificate for involuntary examination and that a professional certificate for involuntary examination is valid for up to seven calendar days or until executed, whichever comes first.

Subsection 394.463(3), F.S., is amended to require immediate attempts to notify parents or guardians of a minor when an involuntary examination is initiated and when a person is accepted by a receiving facility.

Paragraph 394.463(2)(c), F.S., deletes language that currently permits a family member or guardian to transport a resident from a nursing home or assisted living facility to a receiving facility. This change is consistent with the rest of this section which requires law enforcement to transport individuals for involuntary examination. This change considers the safety issues that family members would face if they were able to, or asked to, transport their loved one.

The wording in ss. 394.463(2)(g)-(i), F.S., has been confusing for many people over the years. The entire section is being amended to promote clarity and improve organization. It also clarifies that the examination must be completed within 72 hours even if the petition cannot be filed the

next working day because of a holiday or weekend. The examination should not be delayed because of a holiday or weekend. It further specifies which professionals are allowed to release a person from an involuntary examination from an emergency department.

Section 20
Subsections 394.4655(2) & (3), F.S., are being amended to strike duplicative language concerning where to file the petition for involuntary placement found in s. 394.4655(3)(c), F.S.

Subparagraph 394.4655(2)(b)3., F.S., concerning the disallowance of filing a petition for involuntary outpatient placement if the services are not available is deleted due to duplication in revised s. 394.4655(6)(b), F.S.

Subsection 394.4655(5), F.S., is being deleted and moved to s. 394.4655(5)(d), F.S., to improve the organization of the language. Paragraph 394.4655(5)(c), F.S, is created as a result of moving it from s. 394.4655(5)(d), F.S.

Paragraphs 394.4655(7)(c), F.S., and 394.467(7)(d), F.S., are created to require the notification of the right to request an independent expert examination regarding involuntary outpatient treatment and for the continued involuntary inpatient treatment orders.

Section 21
The bill amends s. 394.467(3), F.S., to require receiving and treatment facilities to submit copies of petitions for involuntary inpatient placement to AHCA (Baker Act Reporting Center), as they do for all involuntary examination initiations and involuntary placement orders. The copies must be sent to AHCA by the next working day. DCF reports that having this data would be beneficial to the AHCA and the Department for needs assessment and system oversight.[49]

The bill further clarifies the roles of the attorneys in Baker Act proceedings. An attorney representing an individual in involuntary placement proceedings shall represent the individual's expressed desires and must be present and actively participate in all hearings on involuntary placement. Also, the state is the real party in interest represented by the State Attorney.

Subsection 394.467(5), F.S., provides that an individual subject to a petition for involuntary inpatient placement has the right to at least one continuance of hearing and adds that the court may not grant a continuance of hearing based on the request of any party other than the individual or the individual's counsel.

Subsection 394.467(5), F.S., also requires the court to consider the issue of competency at the hearing on involuntary placement if there is a petition for adjudication of incompetence. In s. 394.467(6), F.S., language on the timing of the hearing is clarified (within 5 working days) and is consistent with involuntary outpatient placement. Subparagraph 394.467(6)(a)3, F.S., is created to allow family and others to provide relevant sworn testimony during hearings for involuntary inpatient placement.

[49] *Id.*

Sections 22 through 23
These sections amend ch. 394, F.S., relating to the Baker Act, to conform provisions to changes made by the bill, largely by replacing the terms "person," "patient," and "client," with "individual," and to make technical amendments.

Section 24
The bill removes s. 394.4674, F.S., which requires DCF to develop a comprehensive plan for deinstitutionalization of patients in a treatment facility who are over age 55 and do not meet the criteria for involuntary placement. The section also requires a semiannual report to the Legislature. This section was added to the statutes in 1980. DCF reports that the goals of this section have already been accomplished, and thus, it is now obsolete.[50]

Section 25
The bill provides that a public facility may request the transfer of an individual from the facility to a private facility, and the individual may be transferred upon acceptance of the individual by the private facility. This mirrors the way a private facility can request transfer of an individual to a public facility pursuant to s. 394.4685(3)(b), F.S.

Sections 26 through 40
These sections amend ch. 394, F.S., relating to the Baker Act, to conform provisions to changes made by the bill, largely by replacing the terms "person," "patient," and "client," with "individual," and to make technical amendments.

Section 41
The bill provides for an effective date of July 1, 2010.

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.

[50] *Id.*

B. Private Sector Impact:

The bill would require all facilities holding or treating an individual pursuant to Chapter 394, F.S., not just receiving and treatment facilities, to report adverse incidents to DCF.

The bill would also require receiving or treatment facilities filing for petition for involuntary inpatient placement to send a copy of the petition to AHCA by the next working day.

C. Government Sector Impact:

AHCA reports that the additional number of screenings for mental health staff proposed in this bill would require 2 FTEs[51] make eligibility determinations and process applications for exemptions from disqualification. The 2 FTEs would cost $114,696 the first year and a recurring $108,496 in subsequent years. If the bill included the requirement to submit fingerprints electronically, it would reduce the number of staff needed to one Health Services and Facilities Consultant[52] at a rate of $67,255 the first year and $64,155 in subsequent years.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

[51] It would require a Records Specialist (PG 15) to process screenings and fingerprint card rejections and a Health Services and Facilities Consultant (PG 24) to review criminal history reports. Agency for Health Care Administration 2010 Bill Analysis for SB 2678, on file with the Children, Families, and Elder Affairs Committee.
[52] It would require one PG 24. *Id.*