HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 915 Outpatient Mental Health Service
SPONSOR(S): Children, Families & Seniors Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee		Curry	Brazzell

SUMMARY ANALYSIS

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community. In Florida, the Baker Act provides a legal procedure for voluntary and involuntary mental health examination and treatment. The Department of Children and Families (DCF) is responsible for the operation and administration of the Baker Act.

PCS for HB 915 modifies the Baker Act and makes changes to the statutory process for mental health examinations and treatment. The bill combines the process for courts to order individuals to involuntary outpatient services and involuntary inpatient placement in the Baker Act to streamline the process for obtaining involuntary services. This provides more flexibility for courts to meet the individuals' treatment needs.

The bill grants law enforcement officers discretion on initiating involuntary examinations. The bill also allows a psychiatric nurse to release a patient from a receiving facility if certain criteria are met.

The bill prohibits a receiving facility from releasing a patient from involuntary examination outside of the facility's ordinary business hours if the examination period ends on a weekend or holiday and specifies that the 72 hour examination period begins when a patient arrives at the facility.

The bill allows witnesses to appear and testify remotely under oath at a hearing for involuntary services. The bill requires DCF to publish certain specified reports on its website.

The bill makes technical and conforming changes and updates cross references.

The bill will have a significant negative fiscal impact on state government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Health and Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being. Mental illness affects millions of people in the United States each year. Nearly one in five adults lives with a mental illness.[4] During their childhood and adolescence, almost half of children will experience a mental disorder, though the proportion experiencing severe impairment during childhood and adolescence is much lower, at about 22%.[5]

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.[6] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[7] MEs were fully implemented statewide in 2013, serving all geographic regions.

[1] World Health Organization, *Mental Health: Strengthening Our Response,* https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited January 24, 2024).
[2] Centers for Disease Control and Prevention, *Mental Health Basics*, http://medbox.iiab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm (last visited January 24, 2024).
[3] *Id*.
[4] National Institute of Mental Health (NIH), *Mental Illness*, https://www.nimh.nih.gov/health/statistics/mental-illness (last visited January 24, 2024).
[5] *Id*.
[6] Ch. 2001-191, Laws of Fla.
[7] Ch. 2008-243, Laws of Fla.

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.[8]

Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.[9] 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.[10] 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.[11] 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.[12] DCF must use performance-based contracts to award grants.[13]

There are several essential elements which make up a coordinated system of care, including:[14]

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- 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:[15]

- 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.

[8] DCF, *Managing Entities,* available at https://www.myflfamilies.com/services/samh/prov/*d*ers/managing-entities, (last visited January 24, 2024).
[9] S. 394.9082(5)(d), F.S.
[10] S. 394.4573(1)(c), F.S.
[11] S. 394.4573(3), F.S. The Legislature has not funded system improvement grants.
[12] *Id.*
[13] *Id.*
[14] S. 394.4573(2), F.S.
[15] S. 394.495(4), F.S

DCF must define the priority populations which would benefit from receiving care coordination.[16] In defining priority populations, DCF must consider the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.[17] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[18]

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]

The Department of Children and Families (DCF) is responsible for the operation and administration of the Baker Act, including publishing an annual Baker Act report. According to the Fiscal Year (FY) 2021-2022 Baker Act annual report, over 170,000 individuals were involuntarily examined under the Baker Act; of those, just over 11,600 individuals were 65 years of age or older. This age group is the most likely to include individuals with Alzheimer's disease or related dementia.

Receiving Facilities and Involuntary Examination

Receiving Facilities

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[21] Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by Department of Children and Families (DCF) as a receiving facility.

Receiving facilities, often referred to as Baker Act receiving facilities, are public or private facilities designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[22] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.[23] Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[24]

Crisis Stabilization Units

[16] S. 394.9082(3)(c), F.S.
[17] S. 394.9082(5)(b), F.S.
[18] S. 394.75(3), 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. 394.455(40), F.S. This term does not include a county jail.
[23] S. 394.455(38), F.S
[24] R. 65E-5.400(2), F.A.C.

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding and provide a less intensive and less costly alternative to inpatient psychiatric hospitalization for individuals presenting as acutely mentally ill. CSUs screen, assess, and admit individuals brought to the unit under the Baker Act, as well as those individuals who voluntarily present themselves, for short-term services. CSUs provide services 24 hours a day, seven days a week, through a team of mental health professionals. The purpose of the CSU is to examine, stabilize, and redirect people to the most appropriate and least restrictive treatment settings, consistent with their mental health needs.[25] Individuals often enter the public mental health system through CSUs. Managing entities must follow current statutes and rules that require CSUs to be paid for bed availability rather than utilization.

Although involuntary examinations under the Baker Act have recently been decreasing statewide, the population of Florida continues to grow, and there are counties where the number of involuntary examinations remain the same or are slightly increasing, while some receiving facilities within communities are closing. There has been some demonstrated success with mobile response teams diverting individuals from the receiving facilities, resulting in those persons who are admitted to a receiving facility for an involuntary examination having higher acuity and longer lengths of stay.

Involuntary Examination

An involuntary examination is required if there is reason to believe that the person has a mental illness and, because of his or her mental illness, 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 help of willing family members or friends, or will cause serious bodily harm to him or herself or others in the near future based on recent behavior.[26]

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[27] 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.[28]

Unlike the discretion afforded courts and medical professionals, current law mandates that law enforcement officers must initiate an involuntary examination of a person who appears to meet the criteria by taking him or her into custody and delivering or having the person delivered to a receiving facility for examination.[29] When transporting, officers are currently required to restrain the person in the least restrictive manner available and appropriate under the circumstances.[30] 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. The report must also include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles.
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.[31] 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

[25] S. 394.875, F.S.
[26] S. 394.463(1), F.S.
[27] S. 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[28] S. 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.
[29] 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.
[30] *Id.*
[31] S. 394.463(2)(g), F.S.

are met.[32] Current law does not indicate when the examination period begins for an involuntary patient. However, if the patient is a minor, a receiving facility must initiate the examination within 12 hours of arrival.[33]

Within that 72-hour examination period, one of the following must happen:[34]

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to be placed and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

If the patient's 72-hour examination period ends on a weekend or holiday, and the receiving facility:[35]

- Intends to file a petition for involuntary services, the patient may be held at a receiving facility through the next working day and the petition for involuntary services must be filed no later than such date. If the receiving facility fails to file a petition at the close of the next working day, the patient must be released from the receiving facility upon documented approval from a psychiatrist or a clinical psychologist.
- Does not intend to file a petition for involuntary services, the receiving facility may postpone release of a patient until the next working day if a qualified professional documents that adequate discharge planning and procedures and approval from a psychiatrist or a clinical psychologist are not possible until the next working day.

The receiving facility may not release an involuntary examination patient without the documented approval of a psychiatrist or a clinical psychologist. However, if the receiving facility is owned or operated by a hospital or health system, or a nationally accredited community mental health center, a psychiatric nurse performing under the framework of an established protocol with a psychiatrist is permitted to release a Baker Act patient in specified community settings. However, a psychiatric nurse is prohibited from approving a patient's release if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. [36]

Baker Act Reporting Requirements

DCF is required to prepare and provide annual reports to the agency itself, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives. The annual reports analyze data obtained from ex parte orders, involuntary orders issued under the Baker Act, professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients.[37] Current law does not provide a due date for the report.

Involuntary Services

Involuntary services are defined as court-ordered outpatient services or inpatient placement for mental health treatment.[38]

Involuntary Outpatient Services

[32] S. 394.463(2)(f), F.S.
[33] S. 394.463(2)(g), F.S.
[34] *Id*.
[35] S. 394.463(2)(g)4., F.S.
[36] S. 394.463(2)(f), F.S.
[37] S. 394.463(2)(e). F.S.
[38] S. 394.455(23), F.S.

A person may be ordered to involuntary outpatient services upon a finding of the court that by clear and convincing evidence, all of the following factors are met:[39]

- The person is 18 years of age or older;
- The person has a mental illness;
- The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
- The person has a history of lack of compliance with treatment for mental illness;
- The person has, within the immediately preceding 36 months:
    - Been involuntarily admitted to a receiving or treatment facility, or has received mental health services in a forensic or correctional facility, at least twice; or
    - Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others;
- The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;
- The person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being;[40]
- It is likely that the person will benefit from involuntary outpatient services; and
- All available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.

A petition for involuntary outpatient services may be filed by the administrator of either a receiving facility or a treatment facility. [41] The petition must allege and sustain each of the criterion for involuntary outpatient services and be accompanied by a certificate recommending involuntary outpatient services by a qualified professional and a proposed treatment plan.[42]

The petition for involuntary outpatient services must be filed in the county where the patient is located. However, if the patient is being placed from a state treatment facility, the petition must be filed in the county where the patient will reside.[43] The petition must be based on the opinion of two professionals who have personally examined the individual within the preceding 72 hours.[44] When the petition has been filed, the clerk of the court must provide copies of the petition and the proposed treatment plan to DCF, the managing entity, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel.[45]

Once a petition for involuntary outpatient services has been filed with the court, the court must hold a hearing within five business days, unless a continuance is granted.[46] Under current law, the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[47] The court may waive a patient's presence from all or any portion of the hearing if it finds the patient's presence is not in the patient's best interests and the patient's counsel does not object.[48] Otherwise, the patient must be present. The state attorney for the circuit in which the patient is located represents the state, rather than the petitioner, as the real party in interest in the proceeding.[49] The court must appoint the public defender to represent the person who is the subject of the petition, unless that person is otherwise represented by counsel.[50]

---

[39] S. 394.4655(2), F.S.
[40] This factor is evaluated based on the person's treatment history and current behavior.
[41] S. 394.4655(4)(a), F.S.
[42] S. 394.4655(4)(b), F.S.
[43] S. 394.4655(4)(c), F.S.
[44] S. 394.4655(3)(a)1., F.S.
[45] *Id*.
[46] S. 394.4655(7)(a)1., F.S.
[47] S. 394.4655(7)(a)1., F.S.
[48] S. 394. 4655(7)(a)1, F.S.
[49] *Id*.
[50] S. 394.4655(5), F.S. This must be done within one court working day of filing of the petition.

At the hearing on involuntary outpatient services, the court must consider testimony and evidence regarding the patient's competence to consent to treatment; if the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate.[51] If the court concludes that the patient meets the criteria for involuntary outpatient services, it must issue an order for those services.[52] The order must specify the duration of involuntary outpatient services, which may be up to 90 days, and the nature and extent of the patient's mental illness.[53] The order of the court and the treatment plan are to be made part of the patient's clinical record.[54]

If, at any time before the conclusion of the initial hearing on involuntary outpatient services, it appears to the court that the person does not meet the criteria for involuntary outpatient services, but instead meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary inpatient examination.[55]

Involuntary Inpatient Placement

A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that: [56]

- He or she is mentally ill and because of his or her mental illness:
    - He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement or is unable to determine for himself or herself whether placement is necessary; and
    - He or she is 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 a substantial likelihood that in the near future he or she will inflict serious bodily harm 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.

The administrator of the receiving or treatment facility that is retaining a patient for involuntary inpatient treatment must file a petition for involuntary inpatient placement in the court in the county where the patient is located.[57] The petition must be based on the opinions of two professionals who have personally examined the individual within the past 72 hours.[58] Upon filing, the clerk of the court must provide copies to DCF, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located.[59] Unlike the procedures for involuntary outpatient services, current law does not require a proposed treatment plan to be filed with the petition for involuntary inpatient placement.

Involuntary Inpatient Placement Hearing

[51] S. 394.4655(7)(d), F.S.
[52] S. 394.4655(7)(b)1., F.S.
[53] *Id*.
[54] *Id*.
[55] S. 394.4655(7)(c), F.S. Additionally, if the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to the Marchman Act, the court may order the person to be admitted for involuntary assessment pursuant to the statutory requirements of the Marchman Act.
[56] S. 394.467(1), F.S.
[57] S. 394.467(2) and (3), F.S.
[58] S. 394.467(2), F.S.
[59] S. 394.467(3), F.S.

The court proceedings for involuntary inpatient placement closely mirror those for involuntary outpatient services.[60] However, the laws governing involuntary inpatient placement are silent regarding the court's order becoming part of the patient's clinical record. Once a petition for involuntary inpatient placement has been filed, the court must hold a hearing within five business days in the county or facility where the patient is located, unless a continuance is granted.[61] Presently, only the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[62] Similar to the procedures for involuntary outpatient services, the court may waive a patient's presence from all or any portion of the hearing if it finds the patient's presence is not in their best interests, and the patient's counsel does not object.[63] Otherwise, the patient must be present.

Current law permits the court to appoint a magistrate to preside at the hearing, in general.[64] At the hearing, the state attorney must represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding.[65] Although the state attorney has the evidentiary burden in Baker Act cases, current law does not require a facility to make the patient's clinical records available to the state attorney so that the state can evaluate and prepare its case before the hearing. Additionally, there is no requirement that the court allow testimony from family members regarding the patient's prior history and how it relates to their current condition.

If, at any time before the conclusion of the hearing, it appears to the court that the person does not meet the criteria for involuntary inpatient placement, but rather meets the criteria for involuntary outpatient services, the court may order the person evaluated for involuntary outpatient services.[66] If the court concludes that the patient meets the criteria for involuntary inpatient placement, it has discretion to issue an order for involuntary inpatient services at a receiving facility for up to 90 days or in a state treatment facility[67] for up to six months.[68]

Current law prohibits a state treatment facility from admitting a civil patient unless he or she has undergone a transfer evaluation, the process by which the patient is evaluated for appropriateness of placement in a treatment facility.[69] Current law also requires the court to receive and consider the transfer evaluation's documented information before the involuntary placement hearing is held, but it does not specify that the evaluator must testify at the hearing in order for the court to consider any substantive information within it.[70] Under Florida law, if a court were to consider substantive information in the transfer evaluation without the evaluator testifying at the hearing, it would be a violation of the hearsay rule contained in Florida's Evidence Code.[71]

Current law requires the court's order to specify the nature and extent of the patient's illness and prohibits the court from ordering individuals with traumatic brain injuries or dementia who lack a co-occurring mental illness to be involuntarily committed to a state treatment facility.[72] However, there is currently no prohibition against involuntarily committing individuals with developmental disabilities who also lack a co-occurring mental illness to these facilities.

Remote Hearings

[60] *See* s. 394.467(6) and (7), F.S.
[61] S. 394.467(6), F.S.
[62] S. 394.467(5), F.S.
[63] S. 394.467(6), F.S.
[64] *Id*.
[65] *Id*.
[66] S. 394.467(6)(c), F.S.
[67] A treatment facility is any state-owned, state-operated, or state-supported hospital, center, or clinic designated by DCF to provide mentally ill patients treatment and hospitalization that extends beyond that provided for by a receiving facility. Treatment facilities also include federal government facilities and any private facility designated by DCF. Only VA patients may be treated in federal facilities S. 394.455(48), F.S. A receiving facility is any public or private facility or hospital designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider. County jails are not considered receiving facilities. S. 394.455(40), F.S.
[68] S. 394.467(6)(b), F.S.
[69] S. 394.461(2), F.S.
[70] *Id*.
[71] S. 90.802, F.S. The basic hearsay rule states that courts cannot rely on out-of-court, unsworn statements (written or spoken) as proof of the matter asserted in the statement.
[72] S. 394.467(6), F.S.

In response to the COVID-19 pandemic, on March 21, 2020, the Chief Justice of the Florida Supreme Court issued Supreme Court of Florida Administrative Order AOSC20-23, Amendment 2, authorizing courts to conduct hearings remotely. However, on January 8, 2022, Supreme Court of Florida Administrative Order AOSC21-17 was issued, requiring in-person hearings unless the facility where the individual is located is closed to hearing participants due to the facility's COVID-19 protocols or the individual waives the right to physical presence at the hearing.

Effect of the Bill

Involuntary Examination

One of the criteria for involuntary examination requires that the person to be likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to their well-being and such harm is unavoidable through the help of "willing" family members or friends. PCS for HB 915 amends this criteria to add that such family members or friends being considered for offering help also be able and responsible.

The bill authorizes, rather than requires as in current law, law enforcement officers to transport those who appear to meet Baker Act criteria to receiving facilities. This gives law enforcement officers the same discretion that courts and medical professionals have to initiate an involuntary examination. By removing the legal mandate to initiate an involuntary examination, there could be a reduction in involuntary examinations, especially in cases involving minors and schools. This may lead to greater use of alternatives to involuntary examinations, such as mobile response teams.

The bill removes the restriction prohibiting a psychiatric nurse from approving a patient's release from involuntary examination when the examination was initiated by a psychiatrist.

Receiving Facilities

The bill specifies that the 72 hour Baker Act examination period begins when a patient arrives at the receiving facility. The bill prohibits a receiving facility from releasing a patient from involuntary examination outside of the facility's ordinary business hours, including the hours before the facility's ordinary business hours on the morning of the next working day, if the 72 hour examination period ends on a weekend or holiday.

The bill requires the court to dismiss a petition for involuntary services if the petitioner fails to file the petition within the 72 hour Baker Act examination period.

Baker Act Reports

The bill amends s. 394.463(2)(e), F.S., to require DCF to publish the annual reports analyzing ex parte, involuntary outpatient services, and involuntary inpatient placement orders, and the professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients on the agency's website by November 30 of each year and eliminates the current requirement for DCF to provide annual reports to the department itself.

Involuntary Services

The process and criteria for involuntary outpatient services and involuntary inpatient placement are very similar. PCS for HB 915 combines these statutes and creates an "Involuntary Services" statute to remove duplicative functions, simplify procedures and to create a more streamlined and patient-tailored process for committing individuals to involuntary services. The new statute largely maintains current law for involuntary outpatient services and involuntary inpatient placement. However, the bill does make some substantive changes to the process, which are discussed below.

The bill allows those under age 18 access to all involuntary services. This will increase access to services, as current law required the individual be 18 or older for involuntary outpatient services.

The bill removes the involuntary outpatient services 36-month involuntary commitment criteria which required the person to have been committed to a receiving or treatment facility or received mental health services in a forensic or correctional facility within the preceding 36-month period.

PCS for HB 915 creates a single petition process for involuntary services. This gives the court more flexibility and authority to order a person to either involuntary outpatient services, involuntary inpatient placement, or a combination of both. The bill also creates a single certificate for petitioning for involuntary services. The bill requires a court order for both involuntary outpatient services and involuntary inpatient placement be included in the patient's clinical record.

The bill authorizes civil patients to be admitted to state treatment facilities without undergoing a transfer evaluation. This could result in a greater number of admissions to state treatment facilities. The bill also removes the requirement that the court receive and consider a transfer evaluation before a hearing for involuntary placement. Instead, it allows the state attorney to establish that a transfer evaluation was performed and that the document was properly executed by providing the court with a copy of the transfer evaluation before the close of the state's case. This change will likely improve court efficiencies as hearings will not need to be delayed because a transfer evaluation is unavailable before the hearing. The bill codifies current hearsay rules by specifying that the court may not consider substantive information in the transfer evaluation unless the evaluator testifies at the hearing.

The bill prohibits the court from ordering an individual with a developmental disability as defined under s. 393.063, F.S., who lacks a co-occurring mental illness, into a state treatment facility. This expands current law which prohibits such orders for persons with traumatic brain injury or dementia and ensures that limited state treatment facility beds remain for individuals who are appropriate for treatment.

The bill makes technical and conforming changes and updates cross references.

Involuntary Services Hearing

PCS for HB 915 expands the grounds under which a patient's presence at the hearing may be waived. Specifically, the bill authorizes the court to waive a patient's presence if the patient knowingly, intelligently and voluntarily waives the right to be present. However, the bill maintains the requirement that the patient's counsel have no objections for the waiver to take effect.

The bill states that magistrates may preside over hearings for the petition for involuntary inpatient placement and ancillary proceedings. The bill allows the state to have a continuance of hearing for a period of up to 5 days upon showing of good cause. The bill also allows the state attorney to have access to records to litigate at the hearing. However, the bill requires that the records remain confidential and may not be used for criminal investigation or prosecution purposes or any purpose other than civil commitment. Additionally, the bill requires the court to allow testimony deemed relevant from family members regarding the patient's prior history and how it relates to their current condition and from other specified individuals, including medical professions, which aligns this provision with the Marchman Act.

Remote Hearing

PCS for HB 915 allows for all witnesses to appear and testify remotely under oath at a hearing via audio-video teleconference, upon a showing of good cause and if all parties consent. The bill further requires any witness appearing remotely to provide all parties with all relevant documents by the close of business the day prior to the hearing.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4599, F.S., relating to notice.
Section 2: Amends s. 394, 4615, F.S., relating to clinical records; confidentiality.
Section 3: Amends s. 394.463, F.S., relating to involuntary examination.
Section 4: Amends s. 394.4655, F.S., relating to involuntary outpatient services.
Section 5: Amends s. 394.467, F.S., relating to involuntary inpatient placement.
Section 6: Amends s. 394.495, F.S., relating to child and adolescent mental health system of care; programs and services.
Section 7: Amends s. 394.496, F.S., relating to service planning.
Section 8: Amends. S. 394.9085, F.S., relating to behavioral provider liability.
Section 9: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 10: Amends s. 464.012, F.S., relating to licensure of advanced practice registered nurses; fees; controlled substance prescribing.
Section 11: Amends s. 744.2007, F.S., relating to powers and duties.
Section 12: Provides and effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has an indeterminate, yet significant, fiscal impact to DCF and the state court system. The bill provides judges with greater flexibility regarding the type of involuntary services to which to order a person, rather than being required to order the specific services for which the petition was filed or no services at all. This is likely to increase demand for involuntary outpatient services, as these services have lower utilization rates.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

   The bill does not provide rulemaking authority to implement the bill. However, the department has sufficient rulemaking authority to comply with the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

   None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES