HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 361 Behavioral Health of Minors
SPONSOR(S): Children, Families & Seniors Subcommittee, Silvers and others
TIED BILLS: HB 363 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N	Gilani	Brazzell
2) Appropriations Committee	29 Y, 0 N	Potvin	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In 1971, the Legislature passed the Florida Mental Health Act (also known as “The Baker Act”) to address the mental health needs of individuals in the state. The Baker Act allows for voluntary and, under certain circumstances, involuntary, examinations of individuals suspected of having a mental illness and presenting a threat of harm to themselves or others. An individual may be held for an involuntary examination for up to 72 hours. When the patient is a minor, the examination must be initiated within 12 hours after the minor patient arrives at the facility.

In 2017, the Legislature created a task force within the Department of Children and Families (DCF) to address the issue of involuntary examination of minors. The task force reported its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives on November 15, 2017. Among them were recommendations to:

- Encourage school districts to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of an involuntary examination; and
- Increase the number of days, from the next working day to five working days that the receiving facility has to submit forms to DCF, to allow DCF to capture data on whether the minor was admitted, released, or a petition filed with the court.

The CS/HB 361 implements these two task force recommendations.

The bill may have a fiscal impact on school districts but the impact is indeterminate. See Fiscal Comments.

The bill provides an effective date of July 1, 2019.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

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. One in five adults experiences mental illness in a given year, [4] and one in five children ages 13-18 have or will have a serious debilitating mental illness at some point during their life.[5] Half of all lifetime cases of mental illness begin by age 14, and scientists are discovering that changes in the body leading to mental illness may start much younger, before any symptoms appear.[6] Suicide is the third leading cause of death in youth age 10 to 24 and research indicates that 90 percent of people who die by suicide have an underlying mental illness.[7]

Baker Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[8] 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.[9]

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[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 Mar. 15, 2019).
[2] CENTERS FOR DISEASE CONTROL AND PREVENTION, *Learn About Mental Health*, http://www.cdc.gov/mentalhealth/basics.htm (last visited Mar. 15, 2019).
[3] Id.
[4] NATIONAL ALLIANCE ON MENTAL ILLNESS, *Mental Health Facts in America,* http://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf (last visited Mar. 15, 2019).
[5] NATIONAL ALLIANCE ON MENTAL ILLNESS *Mental Health Facts: Children & Teens*, http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf (last visited Mar. 15, 2019).
[6] NATIONAL INSTITUTE OF MENTAL HEALTH, *Children and Mental Health*, https://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml (last visited Mar. 15, 2019).
[7] *Supra* note 5.
[8] Ss. 394.451-394.47892, F.S.
[9] S. 394.459, F.S.

Involuntary Examination and 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.[10] 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:[11]

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

Involuntary patients must be taken to either a public or a private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. The purpose of receiving facilities is 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.[12] 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.[13] 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.[14]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[15] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[16] The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[17] Individuals often enter the public mental health system through CSUs.[18] For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by Legislature in the 1970s to ensure continuity of care for individuals.[19]

As of March 2019, there are 121 Baker Act receiving facilities in this state, including 53 public receiving facilities and 68 private receiving facilities.[20] Of the 53 public receiving facilities, 40 are also contracted to provide CSU services.[21]

[10] Ss. 394.4625 and 394.463, F.S.
[11] S. 394.463(1), F.S.
[12] S. 394.455(39), F.S. This term does not include a county jail.
[13] S. 394.455(37), F.S
[14] Rule 65E-5.400(2), F.A.C.
[15] S. 394.875(1)(a), F.S.
[16] Id
[17] Id.
[18] FLORIDA SENATE, Budget Subcommittee on Health and Human Services Appropriations, *Crisis Stabilization Units*, (Interim Report 2012-109) (Sept. 2011), available at https://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-109bha.pdf (last visited Mar. 15, 2019).
[19] Id. Sections 394.65-394.9085, F.S.
[20] DEPARTMENT OF CHILDREN AND FAMILIES, *Designated Baker Act Receiving Facilities*, (Mar. 7, 2019), available at http://www.dcf.state.fl.us/service-programs/samh/crisis-services/docs/baker/Baker%20Act%20Receiving%20Faciliites.pdf (last visited Mar. 15, 2019).
[21] Id.

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[22] During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met.[23] If the patient is a minor, the examination must be initiated within 12 hours.[24]

Within that 72-hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next business day, one of the following must happen: [25]

- 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 a placement as a voluntary patient and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

There were 199,944 involuntary examinations in Fiscal Year 2016-2017, 32,763 of which were of minors.[26]

Involuntary Examinations FY 2001-2002 through FY 2016-2017[27]

Fiscal Year	All Ages		Children (< 18)	
	Involuntary Examinations	% Increase to FY 2016/2017	Involuntary Examinations	% Increase to FY 2016/2017
2016-2017	199,944		32,763	
2015-2016	194,354	2.88%	32,475	0.86%
2014-2015	187,999	6.35%	32,650	0.32%
2013-2014	177,006	12.96%	30,355	7.91%
2012-2013	163,850	22.03%	26,808	22.18%
2011-2012	154,655	29.28%	24,836	31.89%
2010-2011	145,290	37.62%	21,752	50.58%
2009-2010	141,284	41.52%	21,128	55.03%
2008-2009	133,644	49.61%	20,258	61.69%
2007-2008	127,983	56.23%	19,705	66.23%
2006-2007	120,082	66.51%	19,238	70.26%
2005-2006	118,722	68.41%	19,019	72.22%
2004-2005	114,700	74.32%	19,065	71.81%
2003-2004	107,705	85.64%	18,286	79.13%
2002-2003	103,079	93.97%	16,845	94.45%
2001-2002	95,574	111.42%	14,997	118.41%

Task Force Report on Involuntary Examination of Minors

During the 2017 Legislative session, the Legislature passed HB 1121, which the Governor signed as ch. 2017-151, Laws of Florida. One of its provisions created a task force within DCF to address the issue of involuntary examination of minors 17 years old and younger. The bill required the task force to:

[22] S. 394.463(2)(g), F.S.
[23] S. 394.463(2)(f), F.S.
[24] S. 394.463(2)(g), F.S.
[25] S. 394.463(2)(g), F.S.
[26] FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES, *The Baker Act Fiscal Year 2016/2017 Annual Report*, (June 2018), p. 5, available at: http://www.dcf.state.fl.us/service-programs/samh/publications/ (last visited Mar. 15, 2019).
[27] Id.

- Analyze data on the initiation of involuntary examinations of children;
- Research the root causes of trends in such examinations;
- Identify and evaluate options for expediting examinations for children; and
- Identify recommendations for encouraging alternatives to these examinations.

The task force was composed of stakeholders from the education, mental health, law enforcement, and legal fields. The task force was required to submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2017; the task force submitted its report on November 15, 2017.[28]

Data Analysis

Based on an analysis of available data regarding involuntary examinations of minors, the task force found that:[29]

- Involuntary examinations for children occur in varying degrees across counties.
- There is an increasing trend statewide and in certain counties to initiate involuntary examinations of minors.
- The seasonal pattern shows that involuntary examinations are more common when school is in session.
- Some children have multiple involuntary examinations, although most children who have an involuntary examination have only one.
- Decreases in juvenile arrests correlate with increases of involuntary examinations of children, although it is important to note that the analyses did not show a causal link and there has been a long pattern of decreases in juvenile crime over more than a decade.
- While recent increases in involuntary examinations in certain counties are deserving of focus, a more important focus needs to be on counties that have high rates of involuntary examination. Counties with high rates are, for the most part, not the same counties with the recent increases.
- The most common involuntary examination for children is initiated by law enforcement based on evidence of harm to self.
- The majority of involuntary examinations initiated for children by mental health professionals are initiated by physicians, followed by licensed mental health counselors, and clinical social workers, with many fewer initiated by psychologists, psychiatric nurses, marriage and family therapists, and physicians' assistants.

Root Causes of Increased Involuntary Examinations of Minors

Based on data, information currently available, and the complexity of this issue, the task force determined that it is not possible to identify specific root causes directly linked to the trend of increased Baker Act initiations. However, it identified the following areas as potential root causes or contributing factors to the increase in Baker Act initiations among children in Florida:[30]

- Social stressors and risk factors, including, but not limited to, child abuse and trauma; parents or caretakers with substance use disorders or mental illnesses affecting their parental capability; school and public shootings; and social media and cyber bullying.
- Prevalence of behavioral health disorders among children and teens.
- Limited availability of and access to a continuum of services and supports.

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[28] DEPARTMENT OF CHILDREN AND FAMILIES, Office of Substance Abuse and Mental Health, *Task Force Report on Involuntary Examination of Minors*, (Nov. 15, 2017), available at: http://www.dcf.state.fl.us/service-programs/samh/publications/ (last visited Mar. 15, 2019).
[29] Id. at 20.
[30] Id. at 21-25.

- Inadequate investment in the lives of children, youth, and families, including waiting lists for services, limitations on coverage or approval, a lack of funding for prevention and diversion services, and a shortage of psychiatrists.

It also noted that the increased use of involuntary examinations under the Baker Act for minors could be the positive result of years of systemic changes to increase awareness and action when a minor is experiencing a crisis.[31] For example, law enforcement and other first responders are being trained to recognize the symptoms of mental illness and initiate Baker Act examinations rather than arresting minors.[32]

Options for Expediting the Involuntary Examination of Minors

The task force identified two options for expediting the involuntary examination of minors. The first option is to expand the list of mental health professionals who can conduct the clinical examination.[33] The task force suggested expanding from physicians, clinical psychologists, and psychiatric nurses to also include physician assistants, licensed clinical social workers, licensed mental health counselors, and licensed marriage and family therapists.[34] It also suggested increasing funding for mobile crisis teams, which could be used to establish additional teams to provide statewide coverage.[35]

Recommendations

The task force made six recommendations for encouraging alternatives to and eliminating inappropriate initiations of involuntary examinations of minors under the Baker Act:[36]

- Fund an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis.
- Expand access to outpatient crisis intervention services and treatment.
- Create within DCF the “Invest in the Mental Health of our Children” grant program to provide matching funds to counties that can be used to plan, implement, or expand initiatives that increase public safety, avert increased mental health spending, and improve the accessibility and effectiveness of prevention and intervention services for children who have a diagnosed mental illness or co-occurring mental health and substance use disorder.
- Encourage school districts, through legislative intent language, to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination.[37]
- Revise s. 394.463(2)(a)3, F.S., to include school psychologists licensed under ch. 490, F.S. to the list of mental health professionals who are qualified to initiate a Baker Act.
- Require Youth Mental Health First Aid or Crisis Intervention Team (CIT) training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools.[38]

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[31] Id. at 24.
[32] Id.
[33] Id. at 25.
[34] Id.
[35] Id. Mobile crisis teams are deployed before someone in crisis arrives at a receiving facility or emergency room to provide immediate assessment, intervention, recommendations, referral, and support services. They also link individuals to appropriate community resources, typically on a 24-hours per day, 7-days a week basis.
[36] *Supra*, note 28 at 26-28.
[37] The Task Force found that data supports the conclusion that implementation of risk assessment protocols significantly reduced the number of children and youth who received Baker Act initiations in school districts across the state.
[38] CIT training is an effective law enforcement response program designed for first responders who handle crisis situations involving individuals with mental illness or co-occurring disorders. It emphasizes a partnership between law enforcement, the mental health and substance abuse treatment system, mental health advocacy groups, and consumers of mental health services and their families. Additionally, this training offers evidence-informed techniques designed to calm the individual in crisis down, reduces reliance on the Baker Act as a means of handling the crisis, and informs individuals of local resources that are available to people in need of mental health services and supports.

Additionally, the task force recommended amending s. 394.463(2)(a), F.S., to increase the number of days, from the next working day to five working days, that the receiving facility has to submit forms to DCF required by s. 394.463(2)(e), F.S.[39] The task force states that this change would allow DCF to capture data on whether the minor was admitted, released, or a petition filed with the court.[40]

In 2018, in response to the school shooting at Marjory Stoneman Douglas High School in Parkland, Florida, the Legislature passed sweeping legislation in SB 7026. Some elements of the bill addressed mental health challenges experienced by youth.[41] Among other things, it made and increased funding for the following changes recommended by the task force:

- School resource officers must complete mental health crisis intervention training using a curriculum developed by a national organization with expertise in mental health crisis intervention, including skills training to ensure student and officer safety during incidents involving students with emotional disturbance or mental illness.[42]
- Using a $9.3 million appropriation in the bill, DCF must contract with managing entities to establish additional community action treatment teams (CAT Teams) throughout the state to complement the services of the 26 teams then currently operating. These CAT Teams are required to:[43]
  - Provide community-based behavioral health and support services to children from 11 to 13 years of age, adolescents, and young adults from 18 to 21 years of age with serious behavioral health conditions who are at risk of out-of-home placement;
  - Use an integrated service delivery approach to comprehensively address the needs of the child, adolescent, or young adult and strengthen his or her family and support system, address therapeutic needs, assist in obtaining services and support, make referrals for specialist treatment providers if necessary, and follow up to ensure services are received;
  - Focus on engaging the child, adolescent, or young adult and his or her family as active participants in every phase of the treatment process; and
  - Coordinate with other key entities providing services and supports to the child, adolescent, or young adult and his or her family (i.e. through the school, child welfare system, and juvenile justice system).
- Using an $18.3 million appropriation in the bill, DCF must competitively procure proposals for additional mobile crisis teams to ensure reasonable access among all counties, taking into consideration the geographic location of existing mobile crisis teams, and select providers to serve areas of greatest need.

SB 7026 required that school personnel must engage behavioral health crisis resources if they suspect a student is in an immediate mental health or substance abuse crisis. Mobile crisis teams and school resource officers trained in crisis intervention must provide emergency intervention and assessment, make recommendations, and refer the student for appropriate services. SB 7026 also addressed information sharing between school personnel, the threat assessment team, any agencies involved with the student, and any known service providers.

SB 7026 also amended s. 1011.62, F.S., to create the mental health assistance allocation within the Florida Education Finance Program to provide funds for school-based mental health programs as annually provided in the General Appropriations Act (GAA).

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[39] *Supra*, note 28 at 30.
[40] Id.
[41] Ch. 2018-3, Laws of Fla.
[42] S. 1006.12(1)(c), F.S.
[43] S. 394.495(6), F.S.

Effect of Proposed Changes

The PCS for HB 361 implements two task force recommendations. It amends s. 394.463(2)(a), F.S., to increase the number of days that the receiving facility has to submit forms to DCF required by s. 394.463(2)(e), F.S., from the next working day to five working days, to allow DCF to capture data on whether the minor was admitted, released, or a petition was filed with the court. By extending the facilities' time to submit forms to DCF, DCF will now know whether the minor was admitted, released, or a petition was filed with the court.

The bill also requires the Department of Education (DOE), in consultation with the Statewide Office for Suicide Prevention and suicide prevention experts, to add suicide screening as part of its requirements for "Suicide Prevention Certified Schools." DOE must keep a list of "Suicide Prevention Certified Schools" on its website, and school districts must post on their websites a list of "Suicide Prevention Certified Schools" in their districts.

Additionally, the bill requires DOE to identify available standardized suicide screening instruments that are appropriate to use with a school-age population and have acceptable validity and reliability, and include information about obtaining instruction in their administration and use. The suicide screening will be used alongside awareness and prevention materials for training instructional personnel in elementary, middle, and high schools in youth suicide awareness, prevention, and screening.

The bill provides an effective date of July 1, 2019.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.463, F.S., relating to involuntary examination.

Section 2: Amends s. 1012.583, F.S., relating to continuing education and inservice training for youth suicide awareness and prevention.

Section 3: Provides an effective date of July 1, 2019.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   For a school to be considered a "Suicide Prevention Certified School", it must have two school-based staff members certified or otherwise deemed competent in the use of a suicide screening instrument pursuant to s. 1012.583, F.S. For those schools that do not already meet this requirement but want to obtain the "Suicide Prevention Certified" recognition, there may be a cost associated with the certification or training. The cost is indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

An elementary, middle, or high school that voluntarily elects to be a "Suicide Prevention Certified School" may incur indeterminate costs to train personnel on the suicide screening instrument.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES