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 Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 1062
INTRODUCER:	Children, Families, and Elder Affairs and Senator Harrell
SUBJECT:	Involuntary Examinations of Minors
DATE:	February 5, 2020
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon	CF	**Fav/CS**
2.			ED	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1062 requires public and charter schools to contact the parents of a minor student before the student is removed from school, school transportation, or a school-sponsored activity for an involuntary mental health examination. The bill provides that a principal or their designee may delay notification if they believe it is necessary for the health and safety of the student or others. The bill requires schools to contact a mobile response service prior to initiating a student removal and requires all school safety officers to undergo crisis intervention training. The bill mandates the collection of data by school districts and the Department of Children and Families (DCF) relating to the number and frequency of involuntary examinations of minors initiated by schools.

The bill will have a fiscal impact on public and charter schools and has an effective date of July 1, 2020.

II. Present Situation:

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.[1] The Act includes legal procedures for mental health

[1] Ss. 394.451-394.47892, F.S.

examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[2]

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.[3] 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:[4]

- 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 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.[5] 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.[6] 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.[7]

Crisis Stabilization Units (CSUs) are specialized 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.[8] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[9] 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

[2] S. 394.459, F.S.
[3] Ss. 394.4625 and 394.463, F.S.
[4] S. 394.463(1), F.S.
[5] S. 394.455(39), F.S. This term does not include a county jail.
[6] S. 394.455(37), F.S
[7] Rule 65E-5.400(2), F.A.C.
[8] S. 394.875(1)(a), F.S.
[9] Id

client's needs.[10] Individuals often enter the public mental health system through CSUs.[11] For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by the Legislature in the 1970s to ensure continuity of care for individuals.[12]

As of September 2019, there are 122 Baker Act receiving facilities in this state, including 54 public receiving facilities and 68 private receiving facilities.[13] Of the 54 public receiving facilities, 40 are CSU's.[14]

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[15] 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.[16] If the patient is a minor, the examination must be initiated within 12 hours.[17]

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:[18]

- 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.

Mental Health Services for Students

The Florida Department of Education (DOE), through the Bureau of Exceptional Education and Student Services and the Office of Safe Schools, promotes a system of support, policies, and practices that focus on prevention and early intervention to improve student mental health and school safety. Florida law requires instructional personnel to teach comprehensive health education that addresses concepts of mental and emotional health as well as substance use and abuse.[19] Student Services personnel, which includes school psychologists, school social workers, and school counselors, are classified as instructional personnel responsible for advising students

[10] Id.
[11] 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 Jan 30, 2020).
[12] Id. Sections 394.65-394.9085, F.S.
[13] Department of Children and Families, *Designated Baker Act Receiving Facilities*, (Sept. 9, 2019), https://www.myflfamilies.com/service-programs/samh/crisis-services/docs/baker/Baker%20Act%20Receiving%20Faciliites.pdf (last visited Jan. 30, 2020). Hospitals can also be designated as public receiving facilities.
[14] Id.
[15] S. 394.463(2)(g), F.S.
[16] S. 394.463(2)(f), F.S.
[17] S. 394.463(2)(g), F.S.
[18] S. 394.463(2)(g), F.S.
[19] S. 1003.42(2)(n), F.S.

regarding personal and social adjustments, and provide direct and indirect services at the district and school level.[20]

State funding for school districts' mental health services is provided primarily by legislative appropriations, the majority of which is distributed through an allocation through the Florida Education Finance Program (FEFP) to each district. In addition to the basic amount for current operations for the FEFP, the Legislature may appropriate categorical funding for specified programs, activities or purposes.[21] Each district school board must include the amount of categorical funds as a part of the district annual financial report to DOE, and DOE must submit a report to the Legislature that identifies by district and by categorical fund the amount transferred and the specific academic classroom activity for which the funds were spent.[22]

The law allows district school boards and state agencies administering children's mental health funds to form a multiagency network to provide support for students with severe emotional disturbance.[23] The program goals for each component of the multiagency network are to:

- Enable students with severe emotional disturbance to learn appropriate behaviors, reduce dependency, and fully participate in all aspects of school and community living;
- Develop individual programs for students with severe emotional disturbance, including necessary educational, residential, and mental health treatment services;
- Provide programs and services as close as possible to the student's home in the least restrictive manner consistent with the student's needs; and
- Integrate a wide range of services necessary to support students with severe emotional disturbances and their families.[24]

DOE awards grants to district school boards for statewide planning and development of the multiagency Network for Students with Emotional or Behavioral Disabilities.[25] SEDNET is a network of 19 regional projects that are composed of major child-serving agencies, community-based service providers, and students and their families. Local school districts serve as fiscal agents for each local regional project.[26] SEDNET focuses on developing interagency collaboration and sustaining partnerships among professionals and families in the education, mental health, substance abuse, child welfare, and juvenile justice systems serving children and youth with and at risk of emotional and behavioral disabilities.[27]

Mental Health Assistance Allocation

Established in FY 2018-2019 in SB 7026, responding to the Parkland shooting, the mental health assistance allocation within the FEFP provides funds for school-based mental health programs as

[20] S. 1012.01(2)(b), F.S.
[21] S. 1012.01(6), F.S.
[22] Id.
[23] See s. 1006.04(1)(a), F.S.
[24] S. 1006.04(1)(b), F.S.
[25] S. 1006.04(2), F.S.
[26] Fiscal agents include the Brevard, Broward, Miami-Dade, Duval, Escambia, Hamilton, Highlands, Hillsborough, Lee, Leon, Marion, Orange, Palm Beach, Pinellas, Polk, Putnam, St. Lucie, Sarasota, and Washington school districts. Florida Department of Education, Bureau of Exceptional Education and Student Services, *BEESS Discretionary Projects*, January 2017, at p. 11, http://www.fldoe.org/core/fileparse.php/7567/urlt/projectslisting.pdf (last visited Jan. 30, 2020).
[27] Florida Department of Education, Bureau of Exceptional Education and Student Services, *BEESS Discretionary Projects*, January 2017, *available at* http://www.fldoe.org/core/fileparse.php/7567/urlt/projectslisting.pdf (last visited Jan. 30, 2020).

annually provided in the General Appropriations Act (GAA). The allocation provides each school district at least $100,000, with the remaining balance allocated based on each district's proportionate share of the state's total unweighted FTE student enrollment. Eligible charter schools are also entitled to a proportionate share of district funding.

At least 90 percent of a school district's allocation must be expended on:

- The provision of mental health assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and students at high risk of such diagnoses; and
- The coordination of such services with a student's primary care provider and with other mental health providers involved in the student's care.

In order to receive allocation funds, a school district must develop and submit a detailed plan outlining the local program and planned expenditures to the district school board for approval. In addition, a charter school must annually develop and submit a detailed plan outlining the local program and planned expenditures of the funds in the plan to its governing body for approval. Once the plan is approved by the governing body, it must be provided to its school district for submission to the Commissioner of Education.

Report on Involuntary Examinations of Minors

In 2017, the Legislature created a task force within DCF[28] to address the issue of involuntary examination of minors age 17 years or younger, specifically by:[29]

- Analyzing data on the initiation of involuntary examinations of minors;
- Researching the root causes of and trends in such involuntary examinations;
- Identifying and evaluating options for expediting the examination process; and
- Identifying recommendations for encouraging alternatives to or eliminating inappropriate initiations of such examinations.

The task force found that specific causes of increases in involuntary examinations of children are unknown. Possible factors cited in the task force report include:[30]

- Increase in mental health concerns:
- In 2017, 31.5% of high school students experienced periods of persistent feelings of sadness or hopelessness within the past year, an increase from 2007 (28.5%).
    - In 2017, 17.2% of high school students seriously considered attempting suicide in the past year, increasing from 14.5% in 2007.
- Social stressors such as parental substance use, poverty and economic insecurity, mass shootings, and social media and cyber bullying.
    - Lack of availability of mental health services, due to wait lists for services, limitations on coverage or approval, lack of funding for prevention and diversion, and shortage of psychiatrists and other mental health professionals.

[28] Ch. 2017-151, Laws of Florida.
[29] Florida Department of Children and Families, *Task Force Report on Involuntary Examination of Minors,* (Nov. 2017), https://www.myflfamilies.com/service-programs/samh/publications/ (last visited Jan. 30, 2020).
[30] Id.

  - Among children ages 12-17 in Florida, approximately 13.0% experienced a major depressive episode in the past year. Only about 33% of children experiencing a major depressive episode in the past year receive treatment.
- Emphasis on diversion and treatment, such as through increased Youth Mental Health First Aid, Crisis Intervention Team, and similar training on recognition of issues and appropriate referral; use of alternatives to expulsion or referral to law enforcement agencies.

As a follow up to the 2017 task force report, in 2019, the Legislature instructed DCF to prepare a report on the initiation of involuntary examinations of minors age 17 years and younger and submit it by November 1 of each odd numbered year.[31] As part of the report (2019 report), DCF was required to:

- Analyze data on the initiation of involuntary examinations of minors;
- Identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child;
- Study root causes for such patterns, trends, or repeated involuntary examinations; and
- Make recommendations for encouraging alternatives to and eliminating inappropriate initiations of such examinations.

Multiple Involuntary Examinations

The 2019 report revealed that some crisis stabilization units are not meeting the needs of children and adolescents with significant behavioral health needs, contributing to multiple exams.[32]

The 2019 report found there were 205,781 involuntary examinations in FY 2017-2018, 36,078 of which were of minors.[33] From FY 2013-2014 to FY 2017-2018, statewide involuntary examinations increased 18.85% for children.[34] Children have a larger increase in examinations compared to young adults ages 18-24 (14.04%) and adults (12.49%).[35] Additionally, 22.61% of minors had multiple involuntary examinations in FY 2017-2018, ranging from 2 to 19.[36] DCF identified 21 minors who had more than ten involuntary examinations in FY 2017-2018, with a combined total of 285 initiations.[37] DCF's review of medical records found:[38]

- Most initiations were a result of minors harming themselves and were predominately initiated by law enforcement (88%);
- Many minors were involved in the child welfare system and most experienced significant family dysfunction;
- Most had Medicaid health insurance;
- Most experienced multiple traumas such as abuse, bullying, exposure to violence, parental incarceration, and parental substance abuse and mental health issues;
- Most had behavioral disorders of childhood, such as ADHD or Oppositional Defiant Disorder, followed by mood disorders, followed by anxiety disorders;

[31] Ch. 2019-134, Laws of Florida.
[32] Florida Department of Children and Families, *Task Force Report on Involuntary Examination of Minors, 2019* (Nov. 2019), https://www.myflfamilies.com/service-programs/samh/publications/ (last visited Jan. 30, 2020).
[33] Id.
[34] Id.
[35] Id.
[36] Id.
[37] Id.
[38] Id.

- Most involuntary examinations were initiated at home or at a behavioral health provider; and
- Discharge planning and care coordination by the receiving facilities was not adequate enough to meet the child's needs.

Recommendations

Among the 2017 task force report recommendations were to:[39]

- Amend statute to increase the number of days that the receiving facility has to submit required forms to DCF to capture additional data;
- Expedite involuntary exams by expanding the list of mental health professionals who can conduct the clinical exam to include physician assistants, psychiatric advanced registered nurse practitioners, licensed clinical social workers, licensed mental health counselors, and licensed marriage and family therapist;
- Increase funding for mobile crisis teams;
- 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 especially for children under 13;
- Create the "Invest in the Mental Health of our Children" grant program to provide matching funds to counties to enhance their systems of care serving these children;
- Encourage school districts to adopt a standardized suicide risk assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination;
- Revise statutes to include school psychologists licensed under Chapter 490 to the list of mental health professionals who are qualified to initiate a Baker Act;
- Require Youth Mental Health First Aid and/or CIT training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools;
- Require AHCA to post quarterly Medicaid health plans' EPSDT compliance reports on its website; and
- Supporting Baker Act training and technical assistance by funding a position in DCF to train and provide technical assistance to providers, clinicians, and other professionals who are responsible for implementing the Baker Act.

Several of these recommendations have been implemented through statutory change or legislative appropriations.

The 2019 report recommended:[40]

- Increasing care coordination for minors with multiple involuntary examinations;
- Utilizing the wraparound care coordination approach for children with complex behavioral health needs and multi-system involvement to ensure one point of accountability and individualized care planning;
- Utilizing existing local review teams;

[39] *Supra*, note 29.
[40] *Supra* note 32.

- Revising administrative rules to gather more information about actions taken after the initiation of exams, require electronic submission of forms, and improve care coordination and discharge planning;
- Funding an additional FTE at DCF to provide technical assistance; and
- Ensuring that parents receive information about mobile crisis response teams and other community resources and supports upon child's discharge.

III. Effect of Proposed Changes:

Section 1 amends s. 381.0056, F.S., requiring school health services plans to mandate that a parent or guardian be notified before a student is removed from school or a school-sponsored activity for an involuntary examination except for when a principal or principal's designee believes that a delay in removal would jeopardize the health and safety of the student.

Section 2 amends s. 394.463, F.S., adding the initiation of involuntary examinations of students who are removed from school, school transportation, or a school-sponsored activity to the elements that must be included in data collected by DCF, and requiring DCF to submit a report on findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House by November 1 of each odd-numbered year.

Section 3 amends s. 1001.212, F.S., requiring that both the number of involuntary examinations initiated at each school or school-sponsored activity and the number of students for whom an involuntary examination was initiated be included in the data provided by the Office of Safe Schools to support the evaluation of mental health services.

Section 4 amends s. 1002.20, F.S., requiring the principal or principal's designee to notify a parent before a student is removed from school, school transportation, or a school-sponsored activity to be taken to a receiving facility for an involuntary examination. The bill allows the principal or principal's designee to delay notification, for no more than 24 hours, if the principal or designee believes that such a delay is necessary to avoid jeopardizing the health and safety of the student.

Section 5 amends s. 1002.33, F.S., requiring the charter school principal or the principal's designee to notify the parents before a student is removed from school, school transportation, or a school-sponsored activity to be taken to a receiving facility for an involuntary examination, and allowing the principal or principal's designee to delay notification, for no more than 24 hours, if the principal or designee believes that such a delay is necessary to avoid jeopardizing the health and safety of the student.

Section 6 amends s. 1006.07, F.S., requiring each district school board to adopt a policy requiring that the superintendent annually report to DOE the number of involuntary examinations initiated at a school, on school transportation, or at a school-sponsored activity.

Section 7 amends s. 1006.12, F.S., requiring that school safety officers complete mental health crisis intervention training using a curriculum developed by a national organization with expertise in mental health crisis intervention to improve skills in responding to students with emotional behavioral disability or mental illness, including de-escalation techniques.

Section 8 amends s. 1011.62, F.S., providing procedures to assist mental or behavioral health service providers, or school resource or school safety officers who have completed mental health crisis intervention training, in verbally de-escalating a crisis situation before initiating an involuntary examination. The bill specifically requires that the procedures include strategies to de-escalate a crisis situation for a student with a developmental disability.

The bill requires school districts to develop a memorandum of understanding with a local crisis response service and requires that school or law enforcement personnel contact in person or through telehealth, the mobile crisis response service, before initiating an involuntary examination. The bill requires school districts to provide all school resource officers and school safety officers training on protocols established in the memorandum of understanding.

Section 9 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

There will be an indeterminate impact to providers of crisis intervention training for school safety officers and school resource officers.

C. Government Sector Impact:

DOE estimates that the agency may incur costs relating to data collection and analyses of involuntary examinations, including costs relating to training school and district staff on data collection required by the bill. [41] The impact of these changes is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 381.0056, 394.463, 1001.212, 1002.20, 1002.33, 1006.07, 1006.12, and 1011.62 of the Florida Statutes.

IX. Additional Information:

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

CS by Children, Families, and Elder Affairs on February 4, 2020:
The CS corrects a reference to a definition from s. 394.463, F.S., to s. 394.455, F.S.

B. Amendments:

None.

[41] Florida Department of Education Agency Analysis of SB 1062, December 9, 2019. On file with the Senate Children, Families, and Elder Affairs Committee.