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: SB 1440

INTRODUCER: Senator Powell

SUBJECT: Children's Mental Health

DATE: February 3, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon	CF	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 1440 requires the Department of Children and Families (DCF) and the Agency for Health Care Administration (AHCA) to identify individuals under age 18 who are the highest users of crisis stabilization services, collaboratively take action to meet the behavioral health needs of such children and submit a joint quarterly report during Fiscal Years 2020-2022 to the Legislature.

The bill also requires DCF to contract with managing entities for mobile response teams throughout the state to provide additional services minors. The bill requires the Department of Juvenile Justice (DJJ) to participate in the planning process for promoting a coordinated system of care to provide mental health services to minors.

The bill requires DCF and AHCA to assess the quality of care provided in crisis stabilization units to children and adolescents who are high utilizers of such services and submit a joint report to the Governor and Legislature.

The bill will have a fiscal impact on the state and has an effective date of July 1, 2020.

II. Present Situation:

The Department of Children and Families 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 as the management structure for the delivery of local mental health and substance abuse services.[1] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[2] Full implementation of the statewide managing entity system occurred in April 2013; all geographic regions are now served by a managing entity.[3]

DCF contracts with seven MEs - Big Bend Community Based Care, Lutheran Services Florida, Central Florida Cares Health System, Central Florida Behavioral Health Network, Inc., Southeast Florida Behavioral Health, Broward Behavioral Health Network, Inc., and South Florida Behavioral Health Network, Inc., that in turn contract with local service providers[4] for the delivery of mental health and substance abuse services:[5]

Baker Act

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. The Baker Act also establishes procedures for courts, law enforcement, and certain health care practitioners to initiate such examinations and then act in response to the findings.

Individuals in 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.[6] 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:[7]

- 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.

---

[1] Ch. 2001-191, Laws of Fla.
[2] Ch. 2008-243, Laws of Fla.
[3] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.
[4] Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
[5] Department of Children and Families, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited Jan. 30, 2020).
[6] SS. 394.4625 and 394.463, F.S.
[7] S. 394.463(1), F.S.

Involuntary Admissions

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.[8]

Within the 72-hour examination period, or if the 72 hours end on a weekend or holiday, no later than the next business day, one of the following must occur:

- 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 and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.[9]

Receiving facilities must give prompt notice[10] of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,[11] guardian advocate,[12] health care surrogate or proxy, attorney, and representative.[13] If the patient is a minor, the receiving facility must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice for an adult may be provided within 24 hours of arrival; however, notice for a minor must be provided immediately after the minor's arrival at the facility. The facility may delay the notification for a minor for up to 24 hours if it has submitted a report to the central abuse hotline. The receiving facility must attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until it receives confirmation that the notice has been received. Attempts must be repeated at least once every hour during the first 12 hours after the minor's arrival and then once every 24 hours thereafter until confirmation is received, the minor is released, or a petition for involuntary services is filed with the court.[14]

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.

[8] S. 394.455(39), F.S. This term does not include a county jail.
[9] S. 394.463(2)(g), F.S.
[10] Notice may be provided in person or by telephone; however, in the case of a minor, notice may also be provided by other electronic means. S. 394.455(2),F.S.
[11] "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. Section 394.455(17), F.S.
[12] "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment. Section 394.455(18), F.S.
[13] S. 394.4599(2)(b), F.S.
[14] S. 394.4599(c), F.S.

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.[15]

Data Analysis

Based on an analysis of available data regarding involuntary examinations of minors, the task force found that:[16]

- 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.

Recommendations

The task force made six recommendations for encouraging alternatives to and eliminating inappropriate initiations of involuntary examinations of minors under the Baker Act:[17]

- 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.

---

[15] 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 January 30, 2020).
[16] Id.
[17] Id.

- 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.[18]
- Revise s. 394.463, 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.[19]

Additionally, the task force recommended amending s. 394.463, 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, F.S. 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.[20]

DCF subsequently released an updated version of the report in 2019.[21] 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.

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

- 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;
- Most involuntary examinations were initiated at home or at a behavioral health provider; and

[18] 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.

[19] 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.

[20] Id.

[21] 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. 31, 2020).

- Discharge planning and care coordination by the receiving facilities was not adequate enough to meet the child's needs.

The 2019 report recommended:
- 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;
- 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.

Mobile Response Teams

Mobile response teams (MRTs) provide readily available crisis care in a community-based setting and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for jail or hospital/emergency department utilization.[22] Early intervention services are critical to reducing involuntary examinations in minors and there are areas across the state where options short of involuntary examination via the Baker Act are limited or nonexistent. Response teams are available to individuals 25 years of age and under, regardless of their ability to pay, and must be ready to respond to any mental health emergency.[23] Telehealth can be used to provide direct services to individuals via video-conferencing systems, mobile phones, and remote monitoring. It can also be used to provide assessments and follow-up consultation as well as initial triage to determine if an in-person visit is needed to respond to the crisis call.[24]

SB 7026 (2018) funded additional mobile response teams to serve areas of the state that were not being served by such teams at a total of $18.3 million. There are 40 MRTs serving all 67 counties in Florida, targeting services to individuals under the age of 25. Recent MRT monthly reports showed an 80% statewide average of diverting individuals from involuntary examination.[25]

DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:
- Be conducted with the collaboration of local Sherriff's Offices and public schools in the procurement planning, development, evaluation, and selection process;

[22] Department of Children and Families, *Mobile Response Teams Framework*, (August 29, 2018), p. 4, https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf (last visited Jan. 30, 2020).
[23] Id.
[24] Id.
[25] Id.

- Be designed to ensure reasonable access to services among all counties in the Managing Entity's service region, taking into consideration the geographic location of existing mobile crisis teams;
- Require services be available 24 hours per day, seven days per week with on-site response time to the location of referred crises within 60 minutes of the request for services;
- Require the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents;
- Require access to a board-certified or board-eligible Psychiatrist or Psychiatric Nurse Practitioner; and
- Provide for an array of crisis response services that are responsive to the individual and family needs, including screening, standardized assessments, early identification, or linkage to community services as necessary to address the immediate crisis event.

III. Effect of Proposed Changes:

Section 1 amends s. 394.493, F.S., requiring DCF and AHCA to identify children that are high utilizers of crisis stabilization services beginning in fiscal year 2020-2021 through 2021-2022. The bill requires both agencies to use this information to meet the behavioral health needs of these children within existing resources. The bill also requires DCF and AHCA to jointly submit quarterly reports to the Legislature listing the actions taken by both agencies.

Section 2 amends s. 394.495 F.S., requiring DCF to contract with the MEs for crisis response services provided through MRTs throughout the state to provide immediate, onsite behavioral health services to children and young adults through age 25. The bill provides that mobile response services must be available to children and young adults:

- With an emotional disturbance;
- Experiencing an acute mental health or emotional crisis;
- Experiencing escalating emotional or behavioral [health] symptoms that effect their ability to function within their community; or
- Children served by the child welfare system experiencing placement instability.

The bill requires mobile response services to respond to new requests for services within 60 minutes in the location where the crisis is occurring. Services must be responsive to the needs of the child, young adult, and their family. Services must be evidence-based, enabling the individuals served to independently and effectively deescalate, reducing the possibility for future crises. MRT services must include screening, standardized assessment, and referral to community services and engage children, young adults, and their families as active participants in the process when possible. The bill also requires that MRT providers develop a care plan, provide care coordination by facilitating referrals to community-based services, establish a process for obtaining informed consent, promote information sharing and the use of innovative technology, coordinate with the ME and other service providers and interested parties including schools, Multiagency Network for Students with Emotional/Behavioral Disabilities (SEDNET), the child welfare system, and DJJ.

When procuring MRT providers under the bill, MEs must:

- Collaborate with local law enforcement agencies and public schools in the planning, development, evaluation and selection processes;
- Require that services must be available 24 hours a day, seven days a week, with onsite response time to the location of the crisis within 60 minutes;
- Require the MRT provider to establish protocols with law enforcement agencies, community-based care lead agencies (CBCs), the child welfare system, DJJ, and school districts pursuant to s. 1004.44, F.S.;
- Require access to a board certified or board eligible psychiatrist or psychiatric nurse practitioner; and
- Require MRTs to develop referral processes for individuals served to an array of crisis response services that address individual and family needs, including screening, standardized assessments, early identification, and community services to address the immediate crisis.

Section 3 creates s. 394.4955, F.S., requiring each ME to develop a plan that promotes the development and effective implementation of a coordinated system of care to integrate services provided and funded through the state child serving systems to facilitate access to needed mental health services. The development of the plan must include a planning process led by the ME and must include DCF, individuals served and their families, behavioral health providers, law enforcement agencies, school districts or superintendents, SEDNET, representatives from the child welfare system, DJJ, early learning coalitions, AHCA, the Agency for Persons with Disabilities, Medicaid managed medical assistance plans, and other community partners. The bill requires that during the planning process, the ME and the collaborating organizations consider the geographical distribution of the population, needs, and resources, and create separate plans for each individual county or multi-county area to maximize collaboration and communication at the local level.

To the extent permitted by available resources, the local coordinated system of care must include the services listed in s. 394.495, F.S. The bill also requires each local plan to be integrated with the local designated receiving system plan developed under s. 394.4573, F.S., and shall document each coordinated system of care through written memoranda of understanding or other binding arrangements. The ME and collaborating organizations must also create integrated service delivery approaches within current resources that facilitate parents and caregivers obtaining services and supports by making referrals to specialized treatment providers, if necessary, with follow-up to ensure services are received as part of the plan. MEs must complete plans by July 1, 2021, for submission to DCF. The ME and collaborating organizations are required to implement the coordinated system of care as specified in the plan by July 1, 2022, and must review and update, as necessary, the plans every three years thereafter. When implementing the coordinated system of care. MEs must also identify gaps in the services arrays that are listed in s. 394.495, F.S., for each plan and include any relevant information in their needs assessment required by 394.9082, F.S.

Section 4 amends s. 394.9082, F.S., requiring DCF to consider adolescents who require assistance in transitioning to services provided by the adult system of care when defining the priority populations that will benefit receiving care coordination. The bill requires MEs to include a list and descriptions of gaps in the array of services for children and adolescents identified pursuant to s. 394.4955, F.S., and recommendations for addressing these gaps. The bill also requires MEs to promote the use of available crisis intervention services by requiring

contracted service providers to provide MRT contact information to parents and caregivers of children, adolescents, and young adults between ages 18 and 25, who receive safety-net behavioral health services.

Section 5 amends s. 409.175, F.S., requiring preservice training for foster parents to include information about the local MRT, including contact information, as a means for addressing any behavioral health crisis or to prevent placement disruption.

Section 6 amends s. 409.988, F.S., requiring that CBCs ensure that all individuals providing care for dependent children receive contact information for the local MRTs.

Section 7 amends s. 985.601, F.S., requiring DJJ to participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955, F.S.

Section 8 amends s. 1003.02, F.S., requiring district school boards to participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955, F.S.

Section 9 amends s. 1004.44, F.S., requiring the FMHI at the University of South Florida to develop a model response protocol for schools to utilize MRTs by August 1, 2020. The FMHI must consult with school districts that effectively work with MRTs, school districts that use MRTs less often, law enforcement agencies, DCF, MEs, and MRT providers.

Section 10 amends s. 1006.04, F.S., requiring SEDNET to participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955, F.S.

Section 11 amends s. 1011.62, F.S., to require school districts to enter into a Memorandum of Understanding (MOU) with MEs to facilitate referrals of students to community-based services and coordinate care for student services by school-based and community-based providers. The MOU must include a protocol to share information, coordinate care, and increase access to appropriate services.

The bill requires that school district policies, procedures, and contracts with service providers require that parents of students be provided with information about behavioral health services available through the school or local providers including MRT services. The school may provide this information through web-based directories or local guides if they are easy to understand and navigate by individuals who are unfamiliar with the behavioral health system. The bill also requires that school district policies, procedures, and contracts with service providers require the use MRT services to the extent that they are available. Each school district is required to establish policies and procedures to implement the model response protocol developed under s. 1004.44, F.S.

The bill also requires school districts to refer students or others living in the household of the student to behavioral health services available through other delivery systems or payers.

Section 12 requires DCF and AHCA to assess the quality of care provided in crisis stabilization units to children and adolescents who are high utilizers of services. The bill requires DCF and AHCA to review current laws regarding licensure and designation and compare standards to other states and relevant national standards to make recommendations for improvements. This assessment shall address efforts by facilities to gather and assess information regarding the child or adolescent, to create comprehensive discharge plans to effectively address the needs of the child to help avoid or reduce the need for future crisis stabilization services.

The bill requires DCF and AHCA to jointly submit a report of the findings and recommendations to the Governor, the Senate President, and the Speaker of the House of Representatives by November 15, 2020.

Section 13 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:

Private sector providers of behavioral health services for minors will need to generate new forms and hire additional staff to meet the increased need for services. The impact of these changes are indeterminate.

C. Government Sector Impact:

DCF estimates that one additional FTE will be required to accommodate the coordination of care for children that are high utilizers of crisis stabilization services, at a total cost for fiscal year 2020-2021 of $85,281 with an annualized cost of $80,833 in subsequent years.[26]

The additional responsibilities of MRTs under the bill will create a significant fiscal impact. Requiring services to be provided within 60 minutes of a request in the location where a request originates will be difficult to provide given the strained existing capacity of MRTs and the fact that MRTs often provide services remotely (via telehealth or other means of electronic communication). Additionally, there will be a significant fiscal impact to MRTs if the teams are responsible for on-going care. Currently, MRTs are responsible for the hand off and transition to on-going services; it is the responsibility of the agency who provides on-going services to ensure the active participation of parents and children and continued treatment.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 394.493, 394.495, 394.9082, 409.175, 409.988, 985.601, 1003.02, 1004.44, 1006.04, and 1011.62 of the Florida Statutes.
This bill creates section 394.4955 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

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

[26] Department of Children and Families Agency Analysis of HB 945, December 19, 2019. On file with the Senate Children, Families, and Elder Affairs Committee.