HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 945 Children's Mental Health
SPONSOR(S): Children, Families & Seniors Subcommittee, Silvers
TIED BILLS: **IDEN./SIM. BILLS:** SB 1440

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	Morris	Brazzell
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Fontaine	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Overall, depressive episodes and serious thoughts of suicide are increasing among Florida's children. This may contribute to the over 36,000 involuntary examinations that were initiated under the Baker Act for individuals under the age of 18 between July 1, 2017 and June 30, 2018. Additionally, 22.61% of minors who had involuntary examinations had multiple such examinations in FY 2017-2018, ranging from 2 to 19 instances. The Department of Children and Families (DCF) identified 21 minors who had more than 10 involuntary examinations in FY 2017-2018 with a combined total of 285 initiations.

HB 945 creates a coordinated system of care, the development of which is facilitated by each behavioral health managing entity (ME), which integrates services provided through providers funded by the state's child-serving systems, as well as other systems for which children and adolescents would qualify, and facilitates access by children and adolescents to needed mental health treatment and services at any point of entry.

The bill includes crisis response services provided through mobile response teams (MRT) in the array of services available to children and adolescents who are members of certain target populations and specifies the elements of that service.

The bill revises the required provisions of the plans required for school district funding under the Mental Health Assistance allocation, such as to require a memorandum of understanding with the local managing entity and policies and procedures for referrals for other household members to services available through other delivery systems and payors under certain circumstances. It requires the development and use of a model protocol regarding use of MRTs in schools.

The bill requires DCF and the Agency for Health Care Administration (AHCA) to identify children and adolescents 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 2020-2021 and 2021-2022 to the Legislature. The bill also 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 requires the AHCA to continually test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

The bill has an insignificant fiscal impact on state government, which can be absorbed within existing resources, and an indeterminate fiscal impact on local governments. See fiscal comments section.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Mental Health and Mental Illness

Mental health and mental illness are not synonymous. 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 make a contribution to his or her community.[1]

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 and/or impaired functioning.[2] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental disorders among children are described as serious changes in the way children typically learn, behave, or handle their emotions, causing distress and problems getting through the day.[3] The most commonly diagnosed mental disorders in children are attention deficit hyperactivity disorder (ADHD), behavior problems, anxiety, and depression.[4] In 2016-2017, 21% of parents responding to a survey reported that a doctor has told them their child has autism, developmental delays, depression or anxiety, attention deficit disorder/ADHD, or behavioral/conduct problems.[5]

The most recently published data from the National Survey on Drug Use and Health shows 12.5% of children in Florida age 12 to 17 experienced a major depressive episode.[6] Approximately 37.7% of those children received depression care.[7] The Florida Department of Health's 2019 Youth Risk Behavior Survey of Florida's public high school students shows 33.7% experienced periods of persistent feelings of sadness and hopelessness, 15.6% seriously considered attempting suicide and 7.9% attempted suicide.[8] Seventy-six children between the ages of 2 to 17 died by suicide in Florida in 2018.[9]

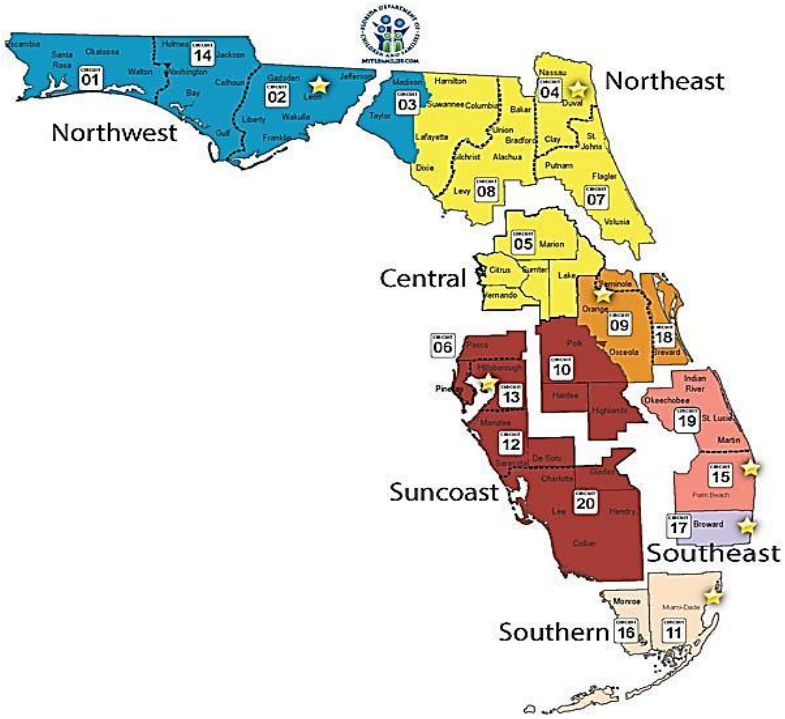
Mental Health Services in Florida

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

[1] Centers for Disease Control and Prevention, *Learn About Mental Health*, https://www.cdc.gov/mentalhealth/learn/ (last visited Jan. 6, 2020).
[2] Id.
[3] Centers for Disease Control and Prevention, *Data and Statistics on Children's Mental Health,* https://www.cdc.gov/childrensmentalhealth/data.html (last visited Jan. 6, 2020).
[4] Id.
[5] The Annie E. Casey Foundation Kids Count Data Center, *Children who have one or more emotional, behavioral, or developmental conditions in Florida,* (April 2019) https://datacenter.kidscount.org/data#FL/2/0/char/0 (last visited Jan. 13, 2020).
[6] Substance Abuse and Mental Health Services Administration, *Behavioral Health Barometer, Florida, Volume 5,* (2019), https://store.samhsa.gov/system/files/florida-bh-barometervolume5-sma19-baro-17-us.pdf (last visited Jan. 6, 2020).
[7] Id.
[8] Florida Department of Health, *2019 Florida Risk Behavior Survey Report,* (2019), http://www.floridahealth.gov/statistics-and-data/survey-data/florida-youth-survey/youth-risk-behavior-survey/index.html (last visited Jan. 6, 2020).
[9] Florida Department of Health FLHealthCHARTS, *Suicide Deaths,* http://www.flhealthcharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116 (last visited Jan. 13, 2020).

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.[10] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[11] Full implementation of the statewide managing entity system occurred in April 2013; all geographic regions are now served by a managing entity.[12]
DCF contracts with seven MEs - Big Bend Community Based Care (blue), Lutheran Services Florida (yellow), Central Florida Cares Health System (orange), Central Florida Behavioral Health Network, Inc. (red), Southeast Florida Behavioral Health (pink), Broward Behavioral Health Network, Inc. (purple), and South Florida Behavioral Health Network, Inc. (beige) that in turn contract with local service providers[13] for the delivery of mental health and substance abuse services:[14]



[10] Ch. 2001-191, Laws of Fla.
[11] Ch. 2008-243, Laws of Fla.
[12] *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.
[13] Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
[14] Department of Children and Families, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited Jan. 6, 2020).

In FY 2018-2019, the network service providers under contract with the MEs served 339,093 individuals:[15]

Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.[16] 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.[17] A community or region provides a coordinated system of care for those suffering from 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.[18] 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.[19] DCF must use performance-based contracts to award grants.[20]

There are several essential elements which make up a coordinated system of care, including:[21]

- Community interventions, such as prevention, primary care for behavioral health needs, therapeutic and supportive services, crisis response services, and diversion programs;
- A designated receiving system that consists of one or more facilities serving a defined geographic area and responsible for assessment and evaluation, both voluntary and involuntary, and treatment or triage of patients who have a mental health or substance use disorder, or co-occurring disorders;
- A transportation plan developed and implemented by each county in collaboration with the managing entity and in accordance with s. 394.462, F.S.;
- Crisis services, including mobile response teams, crisis stabilization units, addiction receiving facilities, and detoxification facilities;
- Case management, defined as direct services to clients for assessing needs; planning; arranging services; coordinating service providers; linking the service system to a client; monitoring service delivery; and evaluating patient outcomes to ensure the client is receiving the appropriate services;

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[15] Department of Children and Families, *Substance Abuse and Mental Health Triennial Plan Update for Fiscal Year,* (Dec. 6, 2019) https://www.myflfamilies.com/service-programs/samh/publications/docs/SAMH%20Services%20Plan%202018%20Update.pdf (last visited Jan. 14, 2020).
[16] S. 394.9082(5)(d), F.S.
[17] S. 394.4573(1)(c), F.S.
[18] S. 394.4573(3), F.S.. The Legislature has not funded system improvement grants.
[19] Id.
[20] Id.
[21] S. 394.4573(2), F.S.

- Care coordination, defined as the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support, such as supportive housing, supported employment, family support and education, independent living skill development, wellness management, and self-care.

A coordinated system of care must include, but is not limited to, the following array of services:

- 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.

DCF must define the priority populations which would benefit from receiving care coordination. Statute includes considerations for DCF in defining these to include:

- The number and duration of involuntary admissions within a specified time,
- The degree of involvement with the criminal justice system and the risk to public safety posed by the individual,
- Whether the individual has recently resided in or is currently awaiting admission to or discharge from a treatment facility as defined in s. 394.455,
- 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.[22]

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.[23] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[24]

[22] S. 394.9082(3)(c), F.S.
[23] S. 394.9082(5)(b), F.S.
[24] S. 394.75(3), F.S.

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.[25] 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.[26]

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.[27] 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:[28]

- 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.[29] 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.[30] 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.[31]

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.[32] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[33] 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.[34] Individuals often enter the public mental health system through CSUs.[35] For this reason, crisis services are a part of the comprehensive,

[25] Ss. 394.451-394.47892, F.S.
[26] S. 394.459, F.S.
[27] Ss. 394.4625 and 394.463, F.S.
[28] S. 394.463(1), F.S.
[29] S. 394.455(39), F.S. This term does not include a county jail.
[30] S. 394.455(37), F.S
[31] Rule 65E-5.400(2), F.A.C.
[32] S. 394.875(1)(a), F.S.
[33] Id
[34] Id.
[35] 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 6, 2020).

integrated, community mental health and substance abuse services established by the Legislature in the 1970s to ensure continuity of care for individuals.[36]

As of September 2019, there are 122 Baker Act receiving facilities in this state, including 54 public receiving facilities and 68 private receiving facilities.[37] Of the 54 public receiving facilities, 40 are CSU's.[38]

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[39] 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.[40] If the patient is a minor, the examination must be initiated within 12 hours.[41]

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:[42]

- 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.

[36] Id. Sections 394.65-394.9085, F.S.
[37] 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. 6, 2020). Hospitals can also be designated as public receiving facilities.
[38] Id.
[39] S. 394.463(2)(g), F.S.
[40] S. 394.463(2)(f), F.S.
[41] S. 394.463(2)(g), F.S.
[42] S. 394.463(2)(g), F.S.

Involuntary Examinations Fiscal Year 2001-2002 through Fiscal Year 2017-2018[43]

Fiscal Year	All Ages			Minors (< 18)		
	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000
2017-2018	205,781	N/A	1,005	36,078	N/A	1,186
2016-2017	199,944	2.92%	992	32,763	10.12%	1,092
2015-2016	194,354	5.88%	981	32,475	11.09%	1,097
2014-2015	187,999	9.46%	964	32,650	10.50%	1,102
2013-2014	177,006	16.26%	919	30,355	18.85%	1,030
2012-2013	163,850	25.59%	859	26,808	34.58%	914
2011-2012	154,655	33.06%	818	24,836	45.26%	848
2010-2011	145,290	41.63%	773	21,752	65.86%	743
2009-2010	141,284	45.65%	754	21,128	70.76%	702
2008-2009	133,644	53.98%	711	20,258	78.09%	664
2007-2008	127,983	60.79%	685	19,705	83.09%	643
2006-2007	120,082	71.37%	661	19,238	87.54%	652
2005-2006	118,722	73.33%	668	19,019	89.69%	651
2004-2005	114,700	79.41%	660	19,065	89.24%	664
2003-2004	107,705	91.06%	634	18,286	97.30%	648
2002-2003	103,079	99.63%	620	16,845	114.18%	606
2001-2002	95,574	115.31%	586	14,997	140.57%	547

Report on Involuntary Examinations of Minors

In 2017, the Legislature created a task force within DCF[44] to address the issue of involuntary examination of minors age 17 years or younger, specifically by:[45]

- 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:[46]

- 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.
  - 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.

[43] Florida Department of Children and Families, *Report on Involuntary Examination of Minors, 2019,* (Nov. 2019), p. 25, https://www.myflfamilies.com/service-programs/samh/publications/ (last visited Jan. 4, 2020).
[44] Ch. 2017-151, Laws of Florida.
[45] 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. 4, 2020).
[46] Id.

- 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.[47] 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.

The 2019 report found there were 205,781 involuntary examinations in FY 2017-2018, 36,078 of which were of minors.[48] From FY 2013-2014 to FY 2017-2018, statewide involuntary examinations increased 18.85% for children.[49] Children have a larger increase in examinations compared to young adults ages 18-24 (14.04%) and adults (12.49%).[50] Additionally, 22.61% of minors had multiple involuntary examinations in FY 2017-2018, ranging from 2 to 19.[51] DCF identified 21 minors who had more than ten involuntary examinations in FY 2017-2018, with a combined total of 285 initiations.[52] DCF's review of medical records found:[53]

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

[47] Ch. 2019-134, Laws of Florida.
[48] *Supra,* note 43.
[49] Id. at 2.
[50] Id.
[51] Id.
[52] Id.
[53] Id.

Recommendations

Among the 2017 task force report recommendations were to:[54]

- 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:[55]

- 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.

<u>Mental Health Services for Students</u>

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.[56] Student Services personnel,

[54] *Supra,* note 45.
[55] *Supra* note 43, at 17-18.
[56] S. 1003.42(2)(n), F.S.

which includes school psychologists, school social workers, and school counselors, are classified as instructional personnel responsible for advising students regarding personal and social adjustments, and provide direct and indirect services at the district and school level.[57]

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.[58] 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.[59]

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.[60] 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.[61]

DOE awards grants to district school boards for statewide planning and development of the multiagency Network for Students with Emotional or Behavioral Disabilities.[62] 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.[63] 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.[64]

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 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:

[57] S. 1012.01(2)(b), F.S.
[58] S. 1012.01(6), F.S.
[59] Id.
[60] See s. 1006.04(1)(a), F.S.
[61] S. 1006.04(1)(b), F.S.
[62] S. 1006.04(2), F.S.
[63] 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. 6, 2020).
[64] 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. 6, 2020).

- 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.

The Marjory Stoneman Douglas High School Public Safety Commission

The incident of mass violence at Marjory Stoneman Douglas High School in Parkland, Florida was preceded by multiple, repeated interactions between the shooter and law enforcement agencies, social services agencies, and schools, over many years. This history was characterized by a lack of communication and coordination, preventing these many entities from understanding the whole problem and taking action to prevent the mass violence incident.

In response to this problem, the Legislature created the Marjory Stoneman Douglas High School Public Safety Commission (Commission)[65] within the Florida Department of Law Enforcement (FDLE).[66] The Commission is composed of 16 voting members and four nonvoting members.[67] The Governor appoints five voting members to the Commission, including the chair; and President of the Senate and Speaker of the House of Representatives each appoint five voting members to the Commission. The Commissioner of FDLE serves as a member of the commission. The Secretary of DCF, the Secretary of DJJ, the Secretary of the Agency for Health Care Administration (AHCA) and the Commissioner of Education serve as ex officio, non-voting members of the Commission.

The Commission was tasked with investigating system failures in the Marjory Stoneman Douglas High School shooting and to develop recommendations for system improvements. Regarding children's behavioral health, the commission stated "serious consideration should be given to how children transition from child services into adult behavioral services, and Florida needs a better safety net for high-risk children."[68] The commission also expressed concern about uncoordinated care for children receiving services from multiple providers. It found that Florida's mental health system, specifically the Baker Act System, needs better discharge planning, master case management, and care coordination, and that no adequate or effective system exists for tracking or flagging high recidivist Baker Acts.[69]

Among the commission's recommendations are that:[70]

- The Legislature should require school districts to engage community health providers that receive state funding to participate in the coordination of student treatment plans.
- Programs such as Community Action Treatment teams should be enhanced and expanded, where necessary, to provide better continuity of behavioral health services to close the gap when high-risk children transition into adulthood.
- The Legislature should require DCF, DJJ and AHCA to develop an alert system to identify those individuals who are repeatedly Baker Acted. The responsible entity must develop a course of

[65] Commission is defined in s. 20.03, F.S. as a body created by specific statutory enactment within a department, the office of the Governor, or the Executive Office of the Governor and exercising limited quasi-legislative or quasi-judicial powers, or both, independently of the head of the department or the Governor.
[66] Ch. 2018-3, Laws of Florida.
[67] All members of the Commission must serve without compensation, but will be reimbursed for their per diem and travel expenses pursuant to s. 112.061, F.S.
[68] Marjory Stoneman Douglas High School Public Safety Commission, *Report Submitted to the Governor, Speaker of the House of Representatives, and Senate President* (Jan. 2, 2019) http://www.fdle.state.fl.us/MSDHS/CommissionReport.pdf (last visited Jan. 13, 2020).
[69] Id.
[70] Id.

action to address why the person is repeatedly Baker Acted.

Mobile Response Teams

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him or her. It can be caused by a variety of factors at any hour of the day.[71] Family members and caregivers of an individual experiencing a mental health crisis are often ill-equipped to handle these situations and need the advice and support of professionals.[72] All too frequently, law enforcement or EMTs are called to respond to mental health crises and they often lack the training and experience to effectively handle the situation.[73] Mobile response teams can be beneficial in such instances.

Mobile response teams 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.[74] 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.[75] 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.[76] Telehealth can be used to provide direct services to individuals via video-conferencing systems, mobile phones, and remote monitoring.[77] 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.[78]

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.[79] Recent MRT monthly reports showed an 80% statewide average of diverting individuals from involuntary examination.[80]

DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:[81]

- Be conducted with the collaboration of local Sherriff's Offices and public schools in the procurement planning, development, evaluation, and selection process;
- 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.

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[71] 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. 3, 2020).
[72] Id.
[73] Id.
[74] Id. at 2
[75] Supra note 71.
[76] Id.
[77] Supra note 71, at 7.
[78] Id.
[79] Supra note 48.
[80] Id.
[81] Supra note 71, at 2-3.

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by AHCA and financed by federal and state funds.

The Florida Medicaid program covers approximately 3.8 million low-income individuals.[82]

Medicaid Waivers

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[83]

The MMA program provides acute health care services through managed care plans contracted with AHCA in the 11 regions across the state. Coverage includes preventative care, acute care, behavioral health services, therapeutics, pharmacy, and transportation services.[84] Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans.

Most Medicaid recipients must be enrolled in the MMA program. Those individuals who are not required to enroll, but may choose to do so, are:

- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.[85]

Other Medicaid enrollees are exempt from the MMA program and receive Medicaid services on a fee-for-service basis. Exempt enrollees are:

- Women who are eligible for family planning services only;
- Women who are eligible only for breast and cervical cancer services; and
- Persons eligible for emergency Medicaid for aliens.

[82] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report,* December 2019, https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Jan. 16, 2020).
[83] S. 409.964, F.S.
[84] Agency for Health Care Administration, *A Snapshot of the Florida Statewide Medicaid Managed Care Program,* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf (last visited Jan. 16, 2020).
[85] S. 409.972, F.S.

The long-term care program provides coverage for individuals age 65 or older, or age 18 or older with a disability, who require nursing facility level of care or hospital level of care.[86] Long-term care coverage includes nursing facility care, assisted living, and home and community based services.[87]

Current law requires each managed care plan to have an accurate and complete online database of the providers in their networks, including information about their credentials, licensure, hours of operation, and location.[88]

Effect of Proposed Changes

Coordinated System of Care

HB 945 requires collaboration and planning between child-serving systems and other stakeholders to create a coordinated system of behavioral health care, facilitated by each managing entity, focused on services for children. The coordinated system of care is to integrate services provided through providers funded by the state's child-serving systems, as well as other systems for which children and adolescents would qualify, and facilitates access by children and adolescents to needed mental health treatment and services at any point of entry.

Within current resources, the ME and collaborating organizations must create integrated service delivery approaches that allow parents and caregivers to obtain services and support by making referrals to specialized treatment providers, should it be necessary, with follow up to ensure services are received. Each coordinated system of care for children and adolescents must be documented by the ME and collaborating organizations through a memorandum of understanding (MOU) or other binding arrangements.

Plans are required to be completed by the managing entity and submitted to DCF by July 1, 2021. The entities involved in the planning process must implement the coordinated system of care specified in each plan by July 1, 2022. The ME and collaborating organizations are required to review and update the plans, as necessary, at least once every three years after implementation. The ME is responsible for identifying any gaps in the arrays of services available under each plan and include that information in its annual needs assessment submitted to DCF.

The ME is required to lead the planning process, which includes input from at a minimum:

- Children and adolescents with behavioral health needs and their families;
- Behavioral health service providers;
- Law enforcement agencies;
- School districts or superintendents;
- SEDNET;
- DCF;
- Representatives of the child welfare and juvenile justice systems;
- Representatives of early learning coalitions;
- Representatives of Medicaid managed medical assistance plans; and
- Representatives of AHCA, APD, DJJ, and other community partners.

Organizations that receive state funding must participate in the planning process if requested by the managing entity.

When developing the plan, the ME and collaborating entities must take the geographical distribution of the population, needs, and resources into consideration and create separate plans on an individual county or multi-county basis in order to maximize collaboration and communication at the local level. The plan must integrate with the local plan for a designated receiving system.

[86] Supra note 84.
[87] Id.
[88] S. 409.967(2)(c)1., F.S.

Care Coordination

When defining the priority populations that will benefit from receiving care coordination, the bill requires DCF to also consider whether the individual is an adolescent who requires assistance in transitioning to services provided in the adult system of care.

Mobile Response Teams

The bill includes crisis response services provided through mobile response teams in the array of services available to children and adolescents who are members of certain target populations. It requires DCF to contract with MEs for MRTs to provide onsite behavioral health crisis services to children, adolescents, and young adults ages 18 to 25 who:

- Have an emotional disturbance;
- Are experiencing an acute mental or emotional crisis;
- Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function normally within their environment; or
- Are served by the child welfare system and are experiencing or are at high risk of placement instability.

At a minimum, the MRT must:

- Respond to new requests for services within 60 minutes;
- Respond to a crisis in the location where the crisis is occurring;
- Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family and enable them to deescalate and respond to behavioral health challenges through evidence-based practices;
- Provide screening, standardized assessments, early identification, and referrals to community services;
- Whenever possible, engage the child, adolescent, or young adult and their family as active participants in all phases of the treatment process;
- Develop a care plan for the child, adolescent, or young adult;
- Provide care coordination by facilitating the transition to ongoing services;
- Ensure a process for informed consent and confidentiality compliance measures is in place;
- Promote information sharing and the use of innovative technology; and
- Coordinate with the ME and other key entities providing services and supports to the child, adolescent, or young adult and their family.

At a minimum, when procuring a MRT, the managing entity must:

- Collaborate with local sheriff's offices and public schools in the planning, development, evaluation and selection processes;
- Require that services be made available 24 hours per day, 7 days per week, with a response time of 60 minutes;
- Require that the provider establish response protocols with local law enforcement agencies, CBC lead agencies, the child welfare system, and the DJJ;
- Require access to board-certified or board-eligible psychiatrists or psychiatric nurse practitioners; and
- Require MRTs to refer children, adolescents, or young adults and their families to an array of crisis response services that address their individual needs as necessary to address an immediate crisis event.

The bill requires the ME to promote the use of available crisis intervention services by requiring contracted providers to provide contact information for MRTs to parents and caregivers of children, adolescents, and young adults between the ages of 18 and 25, who receive safety-net behavioral health services.

The bill amends the preservice training requirements for licensure as a foster parent to include information about and contact information for the local MRT as a means for addressing a behavioral

health crisis or preventing placement disruption. It also requires CBC lead agencies to provide contact information for the local MRT to all individuals providing care for dependent children.

Mental Health Services for Students

The bill requires the Louis de la Parte Institute within the University of South Florida to develop a model response protocol by August 1, 2020, for schools to use MRTs. When developing the protocol the institute must, at a minimum, consult with:

- School districts that effectively use mobile response teams and those districts that use mobile response teams less often;
- Local law enforcement agencies;
- DCF;
- Managing entities; and
- Mobile response team providers.

Mental Health Assistance Allocation

The bill revises the requirements for plans that must be submitted by school districts in order to receive mental health assistance allocation funding to include an interagency agreement or MOU with the ME that facilitates referrals of students to community-based services and coordinates care for students served by school-based and community-based providers. The agreement or MOU must address the sharing of records and information, as provided by law, to coordinate care and increase access to appropriate services.

The plans for funding must also include policies and procedures, including contracts with service providers, which will ensure that:

- Parents are provided information about behavioral health services available through the students' school or local providers, including MRTs. The bill allows schools to meet this requirement by providing information about and website addresses for web-based directories or guides of local services as long as they are easily navigable and provide contact information for local providers;
- School districts use MRTs to the extent available and carry out the model response protocol; and
- Referrals to behavioral health services through other delivery systems or payors are available to individuals or students living in the same house as a student who is receiving services, if those services appear to be needed or would contribute to the improved well-being of the student who is receiving services.

Reporting Requirements

DCF and AHCA

The Department of Children and Families and the Agency for Health Care Administration are required to identify children and adolescents 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 to the Legislature in FY 2020-2021 through FY 2021-2022 on the actions taken by both agencies to better serve these children and adolescents.

The bill also requires DCF and AHCA to assess the quality of care provided in CSUs to children and adolescents who are high utilizers of such services. DCF and AHCA must:

- Review the current standards of care for settings applicable to licensure under chapters 394 and 408, Florida Statutes, and designation under s. 394.461, F.S.;
- Compare these standards to other states' and relevant national standards; and
- Make recommendations for improvements to standards.

At a minimum, the assessment and recommendations must address efforts by each CSU facility to:

- Gather and assess information regarding each child or adolescent;

- Coordinate with other providers treating the child or adolescent; and
- Create discharge plans that comprehensively and effectively address the needs of the child or adolescent in order to avoid or reduce his or her future use of CSU services.

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

Managing Entities

The bill requires managing entities to list and describe any gaps in the arrays of services for children or adolescents and recommendations for addressing such gaps in its annual needs assessment submitted to DCF.

Managed Care Plans

The bill requires the AHCA to continually test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.493, F.S., relating to target populations for child and adolescent mental health services funded through the department.
Section 2: Amends s. 394.495, F.S., relating to child and adolescent mental health systems of care; programs and services.
Section 3: Creates s. 394.4955, F.S., relating to coordinated system of care; child and adolescent mental health treatment and support.
Section 4: Amends s. 394.9082, F.S., relating to behavioral health managing entities.
Section 5: Amends s. 409.175, F.S., relating to licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.
Section 6: Amends s. 409.967, F.S., relating to managed care plan accountability.
Section 7: Amends s. 409.988, F.S., relating to lead agency duties; general provisions.
Section 8: Amends s. 985.601, F.S., relating to administering the juvenile justice continuum.
Section 9: Amends s. 1003.02, F.S., relating to district school board operation and control of public K-12 education within the school district.
Section 10: Amends s. 1004.44, F.S., relating to Louis de la Parte Florida Mental Health Institute.
Section 11: Amends s. 1006.04, F.S., relating to educational multiagency services for students with severe emotional disturbance.
Section 12: Amends s. 1011.62, F.S., relating to funds for operation of schools.
Section 13: Requires AHCA and DCF to submit a joint report to the Governor and Legislature.
Section 14: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

The bill requires DCF to collaborate with AHCA to assess the quality of care provided to children and adolescents who are high utilizers of crisis stabilization services. The agencies will be required to submit quarterly reports of their findings and recommendations through June 2022. Both agencies indicate there will be an increased workload associated with these requirements and that additional personnel resources will be needed to perform the collaborative analysis and subsequent reports. The reporting requirement is through Fiscal Year 2021-2022, and a review of DCF and AHCA's other personnel services (OPS) base budget shows a sufficient balance to cover two years.

The bill requires AHCA to test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems. AHCA has sufficient contracted services base budget to perform this requirement.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

School districts may incur expenses related to establishing policies and procedures to carry out the model response protocol, participating in the planning process for promoting a coordinated system of care for children and adolescents, and developing an interagency agreement or MOU with the managing entity. The impact cannot be determined at this time, but is likely insignificant and can be absorbed within each district's mental health assistance allocation.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Managing entities may experience an increase in workload within the scope of their current responsibilities associated with the proposed changes in HB 945, the extent of which cannot be determined but is likely insignificant.

D. FISCAL COMMENTS:

None.

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

On January 16, 2020, the Children, Families and Seniors Subcommittee adopted an amendment that requires the AHCA to continually test the managed care plan provider network databases to ensure that

behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems. The bill was reported the bill favorably as a committee substitute.

The analysis is drafted to the committee substitute as passed by the Children, Families and Seniors Subcommittee.