HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

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

FINAL HOUSE FLOOR ACTION: 110 **Y's** 0 **N's** **GOVERNOR'S ACTION:** Pending

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SUMMARY ANALYSIS

CS/CS/HB 945 passed the House on March 6, 2020, as amended, and subsequently passed the Senate on March 12, 2020.

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 minors in Fiscal Year 2017-2018, 22% of which had multiple examinations that year.

The bill requires a coordinated system of mental health care for children, the development of which is facilitated by each behavioral health managing entity. The system must 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 facilitate 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. It requires the Louis de la Parte Florida Mental Health Institute within the University of South Florida to develop a model protocol for school use of MRTs. The bill requires a principal or designee to verify that de-escalation strategies have been used with a student and outreach to a MRT has been initiated before contacting a law enforcement officer to initiate an involuntary examination of a student, unless a delay will increase the likelihood of harm to the student or others.

The bill requires the Department of Children and Families (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 jointly submit a quarterly report to the Legislature for two years. 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 jointly submit a report to the Governor and Legislature.

The bill requires AHCA to continually test the Medicaid 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, negative impact on DCF and AHCA which can be absorbed within existing resources. The bill has an indeterminate, negative fiscal impact on local governments.

Subject to the Governor's veto powers, the effective date of this bill is July 1, 2020.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Background

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] During the period 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 ages 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 (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

Behavioral Health Managing Entities

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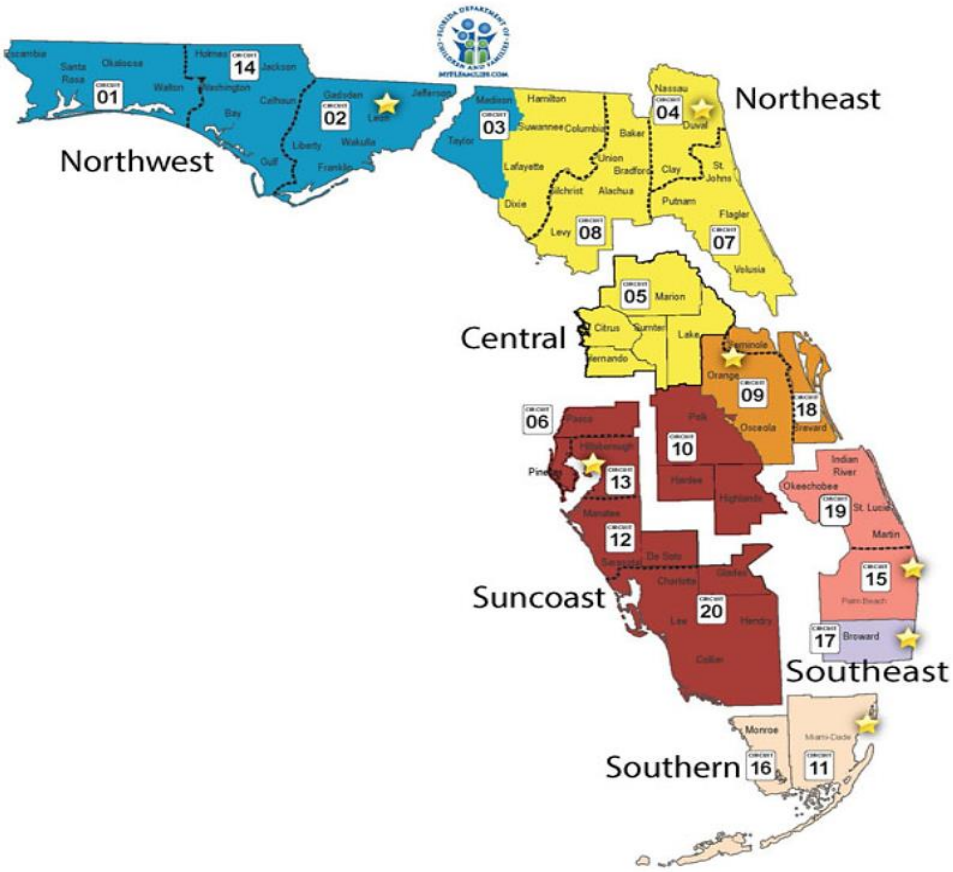
[1] Centers for Disease Control and Prevention, *Learn About Mental Health*, https://www.cdc.gov/mentalhealth/learn/ (last visited Feb. 21, 2020).
[2] Id.
[3] Centers for Disease Control and Prevention, *Data and Statistics on Children's Mental Health,* https://www.cdc.gov/childrensmentalhealth/data.html (last visited Feb. 21, 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/tables/9699-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=11&loct=2#detailed/2/11/false/1603/any/18942,18943 (last visited Feb. 21, 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 Feb. 21, 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 Feb. 21, 2020).
[9] Florida Department of Health FLHealthCHARTS, *Suicide Deaths,* http://www.flhealthcharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116 (last visited Feb. 21, 2020).

In 2001, the Legislature authorized DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.[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]



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

[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 Feb. 21, 2020).
[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 Feb. 21, 2020).

FY 2018-2019 Individuals Served by Managing Entities

Managing Entity	Total Served (unduplicated)	Adults: Mental Health	Children: Mental Health	Adults: Substance Abuse	Children: Substance Abuse
Big Bend CBC	37,874	22,074	7,248	9,493	2,608
Broward Behavioral Health Network, Inc.	25,630	14,084	2,560	9,177	2,004
Central Florida Behavioral Health Network, Inc.	116,557	71,225	17,564	31,031	8,349
Central Florida Cares Health System	31,586	14,714	2,254	14,523	4,058
Lutheran Services Florida	52,707	32,312	5,081	17,261	2,913
Southeast Florida Behavioral Health	30,390	16,170	5,661	7,542	2,837
South Florida Behavioral Health Network, Inc.	44,349	26,811	7,099	8,767	3,749

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;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.

[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.

A coordinated system of care must include, but is not limited to, the following array of services:[22]

- 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.

Current law requires DCF to define the priority populations which would benefit from receiving care coordination, including considerations when defining such population. [23] Considerations include the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.[24] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[25]

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.[26] 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.[27] 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.[28] 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.[29] 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.[30] Response teams are available to

[22] S. 394.495(4), F.S.
[23] S. 394.9082(3)(c), F.S.
[24] S. 394.9082(5)(b), F.S.
[25] S. 394.75(3), F.S.
[26] 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 Feb. 21, 2020).
[27] Id.
[28] Id.
[29] Id. at 2
[30] Supra note 26.

individuals 25 years of age and under, regardless of their ability to pay, and must be ready to respond to any mental health emergency.[31] Telehealth can be used to provide direct services to individuals via video-conferencing systems, mobile phones, and remote monitoring.[32] 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.[33]

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.[34] Recent MRT monthly reports showed an 80% statewide average of diverting individuals from involuntary examination.[35]

DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:[36]

- 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.

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.[37] 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.[38]

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.[39] An involuntary examination is required if there is reason to believe that the person has a mental illness and has, because of his or her mental illness, refused involuntary

[31] Id.
[32] Supra note 26, at 7.
[33] Id.
[34] 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/docs/Report%20on%20Involuntary%20Examination%20of%20Minors.pdf (last visited Feb. 21, 2020).
[35] Id.
[36] Supra note 26, at 2-3.
[37] Ss. 394.451-394.47892, F.S.
[38] S. 394.459, F.S.
[39] Ss. 394.4625 and 394.463, F.S.

examination, is likely to refuse to care for him or herself, or cause harm to him or herself or others in the near future.[40]

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.[41] 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.[42] 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.[43]

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.[44] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[45] 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.[46] Individuals often enter the public mental health system through CSUs.[47] 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.[48]

As of September 2019, there are 122 Baker Act receiving facilities in this state, including 54 public receiving facilities and 68 private receiving facilities.[49] Of the 54 public receiving facilities, 40 are CSU's.[50]

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[51] 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.[52] If the patient is a minor, the examination must be initiated within 12 hours.[53]

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:[54]

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;

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[40] S. 394.463(1), F.S.
[41] S. 394.455(39), F.S. This term does not include a county jail.
[42] S. 394.455(37), F.S
[43] Rule 65E-5.400(2), F.A.C.
[44] S. 394.875(1)(a), F.S.
[45] Id
[46] Id.
[47] 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 Feb. 21, 2020).
[48] Id. Sections 394.65-394.9085, F.S.
[49] 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 Feb. 21, 2020). Hospitals can also be designated as public receiving facilities.
[50] Id.
[51] S. 394.463(2)(g), F.S.
[52] S. 394.463(2)(f), F.S.
[53] S. 394.463(2)(g), F.S.
[54] S. 394.463(2)(g), F.S.

- 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.

Report on Involuntary Examinations of Minors

In 2017, the Legislature created a task force within DCF[55] to address the issue of involuntary examination of minors age 17 years or younger, specifically by:[56]

- 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 an increase in mental health concerns, social stressors, and a lack of availability of mental health services.[57]

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.[58] As part of the report (2019 report), DCF was required to:

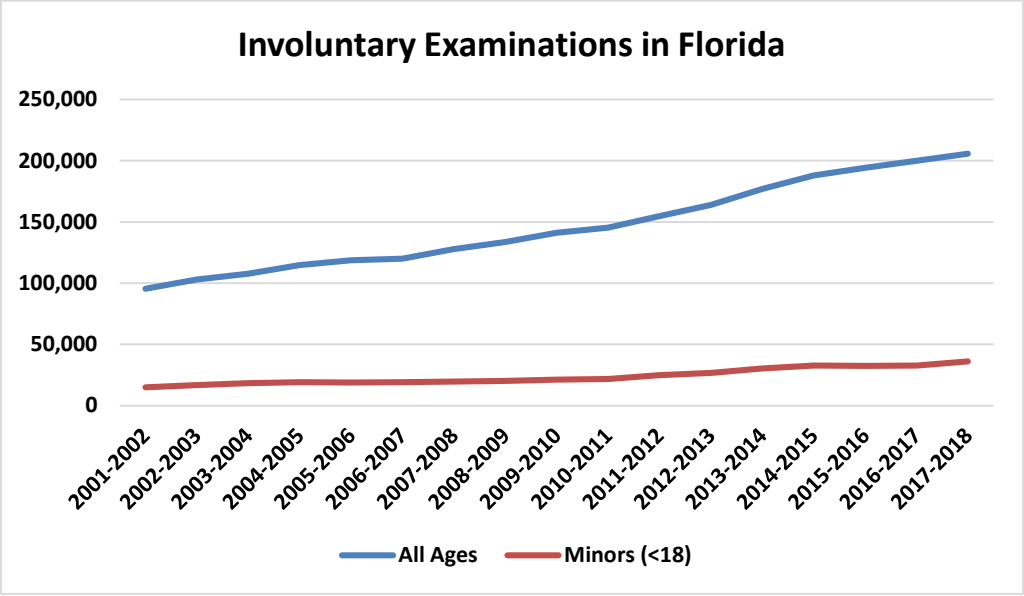
- Analyze data on the initiation of involuntary examinations of minors;
- Identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child;
- Study root causes for such patterns, trends, or repeated involuntary examinations; and
- Make recommendations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

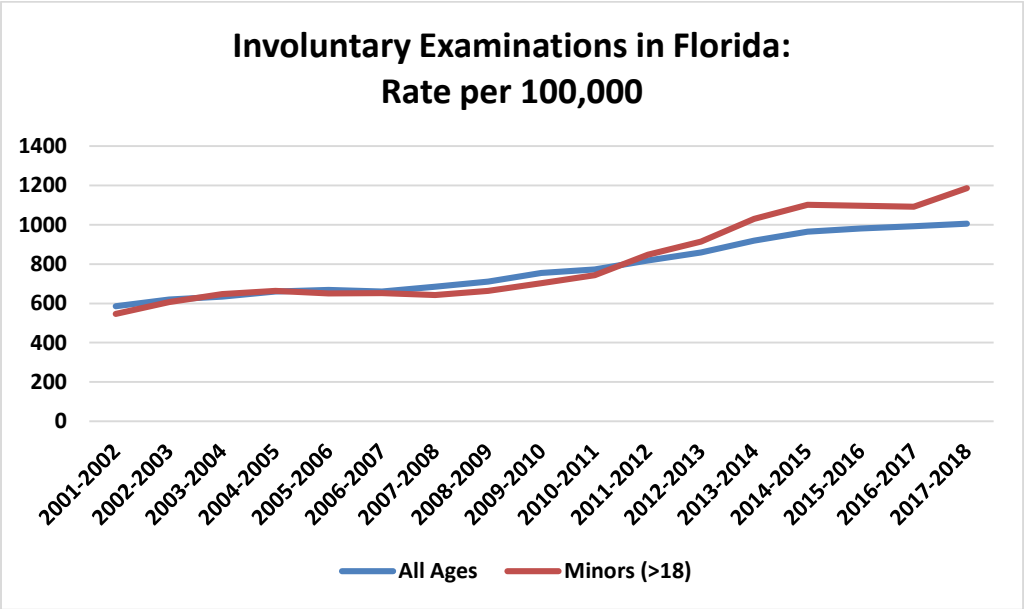
The 2019 report found there were 205,781 involuntary examinations in FY 2017-2018, 36,078 of which were of minors.[59] From FY 2013-2014 to FY 2017-2018, statewide involuntary examinations increased 18.85% for children.[60] Children have a larger increase in examinations compared to young adults ages 18-24 (14.04%) and adults (12.49%).[61]

Involuntary Examinations Fiscal Year 2001-2002 through Fiscal Year 2017-2018[62]

[55] Ch. 2017-151, Laws of Florida.
[56] Florida Department of Children and Families, *Task Force Report on Involuntary Examination of Minors,* (Nov. 2017), https://www.myflfamilies.com/service-programs/samh/publications/docs/S17-005766-TASK%20FORCE%20ON%20INVOLUNTARY%20EXAMINATION%20OF%20MINORS.pdf (last visited Feb. 21, 2020).
[57] Id.
[58] Ch. 2019-134, Laws of Florida.
[59] *Supra,* note 34.
[60] Id. at 2.
[61] Id.
[62] *Supra,* note 34.

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





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 involuntary examinations. Additionally, 22.61% of minors had multiple involuntary examinations in FY 2017-2018, ranging from 2 to 19.[63] DCF identified 21 minors who had more than ten involuntary examinations in FY 2017-2018, with a combined total of 285 initiations.[64] DCF's review of medical records found:[65]

- 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;

[63] Id.
[64] Id.
[65] Id.

- 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 to meet the child's needs.

Recommendations

The 2017 task force made a number of recommendations.[66] The task force recommended giving an receiving facilities more time to submit required data to DCF. It also recommended expediting involuntary exams by expanding the list of mental health professionals who can conduct the clinical exam. The task force recommended increasing funding for mobile crisis teams. Additionally, the task force recommended funding an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis. The task force also recommended expanded access to outpatient crisis intervention services and treatment especially for children under 13. Further, the task force recommended encouraging 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.

Several of these recommendations have been implemented through statutory change.[67]

The 2019 task force report recommended increasing care coordination, utilizing wraparound care coordination and existing local review teams, revising DCF rules to gather more information about actions taken after the initiation of exams, and ensuring that parents receive information about mobile crisis teams and other available community resources.[68]

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.[69] Student Services personnel, 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.[70]

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.[71] 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.[72]
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.[73] The program goals for each component of the multiagency network are to:

[66] *Supra,* note 56.
[67] *See,* chs. 2018-3, 2019-51, and 2019-22, L.O.F.
[68] *Supra,* note 34, at 17-18.
[69] S. 1003.42(2)(n), F.S.
[70] S. 1012.01(2)(b), F.S.
[71] S. 1012.01(6), F.S.
[72] Id.
[73] *See* s. 1006.04(1)(a), F.S.

- 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.[74]

DOE awards grants to district school boards for statewide planning and development of the multiagency Network for Students with Emotional or Behavioral Disabilities.[75] 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.[76] 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.[77]

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)[78] within the Florida Department of Law Enforcement (FDLE).[79] The Commission is composed of 16 voting members and four nonvoting members.[80] 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 the Department of Juvenile Justice (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

[74] S. 1006.04(1)(b), F.S.
[75] S. 1006.04(2), F.S.
[76] 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 Feb. 21, 2020).
[77] 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 Feb. 21, 2020).
[78] 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.
[79] Ch. 2018-3, Laws of Florida.
[80] 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.

high-risk children."[81] 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.[82]

The Commission recommended:[83]

- 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; and
- 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 action to address why the person is repeatedly Baker Acted.

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.[84]

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." Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

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) program.[85] Within the SMMC, the Managed Medical Assistance (MMA) program provides acute health care services through managed care plans contracted with AHCA in the 11 regions across the state. Coverage includes preventive care, acute care, therapeutics, pharmacy, transportation services, and behavioral health services.[86]

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.[87] Current law does not require AHCA to assess whether network providers are actively taking new Medicaid patients, or the ability to obtain timely care.

Parental Notification of Involuntary Examinations

When a student is removed from school grounds, school transportation, or a school-sponsored activity and transported to an involuntary examination receiving facility, current law requires principals of

[81] 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 Feb. 21, 2020).
[82] Id.
[83] Id.
[84] 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 Feb. 21, 2020).
[85] S. 409.964, F.S.
[86] 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 Feb. 21, 2020).
[87] S. 409.967(2)(c)1., F.S.

traditional K-12 public and charter schools to immediately notify the student's parent.[88] However, the principal may delay notification for up to 24 hours if the principal believes it is in the student's best interest and a report has been made to the central abuse hotline pursuant to s. 39.201, F.S.[89]

After the Marjory Stoneman Douglas High School shooting in 2018, school mental health services began focusing on training educators on how to de-escalate crisis situations.[90] De-escalation is "the reduction in the intensity of a conflict".[91] De-escalation training provides individuals with strategies to calmly deal with people who are experiencing mental crisis. De-escalation teaches individuals dealing with a person in crisis to use non-physical skills such as listening, distracting the person, re-focusing the person on something positive, changing the subject, and empathizing with the person to defuse a potentially dangerous situation.[92]

Effect of Proposed Changes

Coordinated System of Care

The bill 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.

The bill requires MEs to complete and submit plans to DCF by January 1, 2022. The entities involved in the planning process must implement the coordinated system of care specified in each plan by January 1, 2023. The ME and collaborating organizations must 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, with an option to request reasonable staff support from state agencies. MEs must obtain 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.

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[88] Sections 1002.20(3), F.S., and 1002.33(9)(q), F.S.
[89] *Id*.
[90] EducationDive, *De-escalation strategies effective in working with traumatized students*, https://www.educationdive.com/news/de-escalation-strategies-effective-in-working-with-traumatized-students/519911/ (last visited Feb. 9, 2020).
[91] Florida Department of Children and Families, Center for Child Welfare, *Verbal De-escalation Training Video*, Part 2, at 8:11, August 8, 2014, *available at* http://centervideo.forest.usf.edu/verbaldeescalation/start.html.
[92] Northeast Washington Education Service District 101, Risk Management Services, *Using Verbal De-Escalation*, *available at* https://personnel.ky.gov/KEAP/Verbal%20De-escalation%20presentation.pdf.

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.

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.

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.

The bill sets standards for MRTs. At a minimum, a MRT must:

- Triage and prioritize requests, then, to the extent permitted by available resources, respond in person within 60 minutes of prioritization;
- 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;
- 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.

When procuring a MRT, the managing entity must, at a minimum:

- 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.

The bill requires the Louis de la Parte Florida Mental Health Institute within the University of South Florida[93] 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.

[93] S. 394.659, F.S. The Louis de la Parte Florida Mental Health Institute's mission is to strengthen mental health and substance use services throughout Florida. The Institute serves as a bridge between university-based research and communities facing a variety of problems related to mental illness by blending elements of service, research, and training.

Involuntary Examination of Minors

The bill requires DCF and 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 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.

CSU Quality Analysis

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 mental health receiving and treatment facilities, hospitals, and CSUs;
- 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.

Parental Notification of Involuntary Examinations

Traditional public and charter school principals have a duty to notify a parent when a student is transported from school grounds, school transportation, or a school-sponsored activity and taken to a receiving facility for involuntary examination. The bill adds to this duty by requiring a principal to also verify that de-escalation strategies have been used with the student and outreach to a mobile response team has been initiated prior to the student's removal.

The bill provides an exemption from this verification when a principal reasonably believes that any delay in the student's removal will increase the likelihood of harm to the student or others.

Medicaid Behavioral Health Provider Network

The bill requires AHCA to continuously 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.

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 participating in the planning process for promoting a coordinated system of care for children and adolescents. The impact is indeterminate and insignificant, but can 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 the bill, the extent of which cannot be determined, but is likely insignificant.

D. FISCAL COMMENTS:

None.