TASK FORCE REPORT ON INVOLUNTARY EXAMINATION OF MINORS

Department of Children and Families

Office of Substance Abuse and Mental Health

November 15, 2017

Mike Carroll
Secretary

Rick Scott
Governor

III. Involuntary Examination Process

Section 394.463(1), F.S., establishes the criteria an individual must meet to be taken to a receiving facility for involuntary examination. This process includes the three key steps outlined below.

1. Determine if the Individual Appears to Meet Baker Act Criteria

An individual may be taken to a receiving facility for involuntary examination under the Baker Act if there is reason to believe he/she has a mental illness and because of the mental illness:

- The individual has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination, or he/she is unable to determine whether examination is necessary.

- Without care or treatment, the individual is likely to suffer from neglect or refuse to care for self, such neglect or refusal poses a real and present threat of substantial harm to their well-being, and it is not apparent that the harm may be avoided through the help of willing family members, friends, or the provision of other services.

- There is a substantial likelihood that without treatment the individual will cause serious bodily harm to self or others in the near future, as evidenced by recent behavior.

2. If so, Initiate the Baker Act

Upon a determination that an individual appears to meet Baker Act criteria, the involuntary examination process may be initiated by the court, law enforcement, or a qualified mental health professional.

A circuit or county court may enter an ex parte order specifying the findings on which that conclusion is based.

Law Enforcement must take an individual who appears to meet Baker Act criteria into custody and deliver, or have him or her delivered to an appropriate, or the nearest, facility in accordance with the approved county transportation plan.

A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating he or she has examined an individual within the preceding 48 hours and finds that they appear to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based.

3. Conduct a Clinical Examination

The Baker Act defines “involuntary examination” as an examination performed under sections 394.463, 397.6772, 397.679, 397.6798, or 397.6811, Florida Statutes (F.S.) to determine whether an individual qualifies for involuntary services. “Involuntary services” means court-ordered outpatient services or inpatient placement for mental health treatment pursuant to sections 394.4655 or 394.467, F.S.

Once a Baker Act has been initiated, the individual must be examined by one of the following mental health professionals to determine if the criteria for involuntary services are met and to determine the appropriate course of action:

- Physician
- Clinical psychologist
- Psychiatric nurse (within the framework of an established protocol with a psychiatrist)[4]

The statutorily established examination period is for up to 72 hours. For minors, however, once a Baker Act determination is made, the clinical examination to determine if the criteria for involuntary services are met must be initiated within the first 12 hours of their arrival at the facility. This means the mental health professional must have begun the clinical examination no later than 12 hours after the minor is received. If the examination period ends on a weekend or a holiday, no later than the next working day thereafter, one of the following four actions must be taken:

- The individual must be released, unless charged with a crime, in which case they are returned to the custody of law enforcement;
- The individual must be released, unless charged with a crime, for voluntary outpatient services, subject to the status of pending charges;
- The individual must be released, unless charged with a crime, and asked to give express and informed consent to voluntary admission; or
- A petition for involuntary services must be filed with the clerk of the circuit or county criminal court, as applicable, if inpatient admission is deemed necessary.[5]

IV. Baker Act Receiving Facilities

Involuntary examinations occur in public and private Baker Act receiving facilities that are designated by the Department and licensed by the Agency for Health Care Administration (Agency). Some receiving facilities are also called Crisis Stabilization Units (CSUs), which are usually inpatient units of community mental health centers. CSUs designated and licensed to serve children are referred to as Children's Crisis Stabilization Units (CCSUs). The purpose of a CSU/CCSU is to stabilize and redirect individuals to the most appropriate and least restrictive setting available, consistent with their needs. In these environments, individuals are generally offered services such as screening and assessment, and if necessary, they can be admitted for stabilization or observation. All CSUs/CCSUs are public receiving facilities that receive funds from the Department and must provide services, regardless of an individual's ability to pay.

Not all Baker Act receiving facilities are CSUs/CCSUs. Some receiving facilities are private and do not receive funds from the Department. Whether public or private, all designated and licensed receiving facilities are subject to the statutory provisions of the Baker Act and must submit certain information to the Department, unless otherwise exempted. To facilitate receipt of this information the Department developed mandatory forms that accompany individuals when transferred to a receiving facility under the

[4] § 394.463(2)(f), F.S.
[5] § 394.463(2)(g), F.S.

Baker Act. These forms are submitted by receiving facilities directly to the Reporting Center and are compiled into a database and analyzed.

V. Analysis of Data on the Initiation of Involuntary Examination of Minors

The Task Force collected and examined available data and information from various organizations and agencies, including The Department of Education and the Multiagency Network for Students with Emotional/Behavioral Disabilities (SEDNET), the Department of Juvenile Justice, the Department, Florida Kids Count, the Agency, national trends, and the Baker Act Reporting Center. The data are limited and the Task Force identified areas where data collection could be improved.

A. Department of Education

The Department of Education (DOE) presented the comprehensive system of supports used to address student academic, social, emotional, and behavioral needs. The primary mental health focus in schools is on prevention and early intervention within a multi-tiered framework. DOE noted:

- National prevalence data (Merikangas et al., 2011)[6] indicate that 20% of school-age children have a diagnosable mental health disorder; 10% with severe impairment in one or more areas of functioning (Williams et. al., 2017).[7]
- On the 2015 Florida Youth Risk Behavior Survey, 8% of high school students who completed the survey reported having attempted suicide within the past year.
- Florida AWARE (Advancing Wellness and Resiliency in Education), a Now is the Time grant, is DOE's primary mental health initiative. Florida AWARE is building state capacity to support districts in promoting mental wellness and ensuring that youth experiencing mental health problems have access to effective and coordinated supports and services. As part of Florida AWARE, Youth Mental Health First Aid (YMHFA) training is being provided at no cost to schools and communities statewide through Florida AWARE.
- DOE maintains a list of approved youth suicide awareness and prevention trainings that may be used with instructional staff.
- School-based mental health services and supports address barriers to learning that impact student engagement and achievement. Mental health services and supports are provided by school-based mental health services providers (DOE certified school psychologists, school social workers, and school counselors) and contracted mental health professionals. Following are student Services professional to student ratios in Florida public schools:
    - School Psychologists (1:2,032)
    - School Social Workers (1:2,469)

[6] Merikangas, K. R. et al. (2011, online first in 2010). Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Study – Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(10), 980-989.

[7] Williams, N. J., Scott, L., & Aarons, G. A. (2017, online first). Prevalence of serious emotional disturbance among U.S. Children: A meta-analysis. *Psychiatric Services.*

- School Counselors (1:488)

- The DOE does not track the number of Baker Act examinations initiated from school settings; however, data on school-initiated Baker Act examinations are reported by law enforcement or mental health professionals to the Reporting Center. Per the Reporting Center, 22% of the Baker Act initiations of minors in FY 2015/2016 occurred in school settings.

- Baker Act Policies and Procedures are addressed locally in the District Bylaws and Policies document and in suicide prevention protocols and procedures. Local school boards must have policies and procedures for providing immediate parental notice when a student is removed from school, school transportation, or a school-sponsored activity for an involuntary examination.

- Most districts have established protocols for responding when students indicate a serious threat to self or others. In many cases the protocol requires that a risk assessment be conducted by qualified school personnel (certified or licensed mental health services provider) who work for the district either in coordination with or prior to involving law enforcement. These protocols also provide for follow-up support when students return to school from a receiving facility.

Challenges noted include prevalence of mental health issues combined with difficulty of accessing mental health services in schools and communities, impact of mental health awareness training on referrals, limited options for students in a mental health crisis, and the risk of deciding not to Baker Act a minor who subsequently attempts suicide.

B. SEDNET Qualitative Data

SEDNET is a discretionary project funded by DOE and its work is reflective of the department's to address the mental health needs of children and youth. SEDNET representatives presented on local projects in areas of the state where percentage of increases for involuntary examinations of minors in FY 2015/2016 was low compared to other areas of the state. The following strategies were noted as factors that reduce reliance on the Baker Act to address crisis situations:

- Multi-agency collaborative Baker Act Review Teams meet monthly to examine data and ensure continuity of care and community access to needed services within the local system of care.
- School Resource Officers are trained in the Crisis Intervention Team (CIT) for Law Enforcement model.
- Mental Health Counselors are employed by the school district and/or a Memorandum of Understanding (MOU) is in place with community mental health providers and agencies to offer mental health services to youth in the school districts.
- School districts have established protocols for suicide risk assessment and re-entry of the student following a Baker Act hospitalization, to support access to needed services and service continuity.
- Team approach with linkage between school and community. An example is the Family Services Planning Team (FSPT) – monthly multi-agency team reviews services provided for the most

complex youth who have received multiple involuntary examinations and those with above average lengths of stay.

C. Department of Juvenile Justice

The Department of Juvenile Justice (DJJ) presented information on crisis intervention and intake/admission screening procedures in place at Juvenile Assessment Centers, detention centers, residential commitment programs, and day treatment programs.

- Initiation of an involuntary examination can result from any of the screenings conducted upon a youth's intake/admission to a DJJ facility or program or from a crisis event after admission. Certain mental health events are reported to the DJJ Central Communications Center; however, no data are readily available on the numbers transported to a receiving facility for an involuntary examination.
- All children/youth have an initial mental health and substance abuse screening at the Juvenile Assessment Center (JAC).
- Children/youth subsequently placed in a detention center receive mental health and substance abuse screening, which includes review of the screening conducted in the JAC and administration at the detention centers of the DJJ Suicide Risk Screening Instrument.
- Mental health and substance abuse screening is also completed at admission to a residential commitment program or day treatment program.
- The Baker Act forms sent to the Reporting Center to initiate involuntary examination include an item that indicates via checking yes or no if the child was at a DJJ facility prior to being transported to the receiving facility, but this item is not always completed.

D. Department of Children and Families

The Department designates crisis beds that are licensed by the Agency. Data were presented on CCSU beds, which show that utilization has decreased. It should be noted that these data are only for public facilities, however, and utilization data are only for Department funded admissions.

Private designated and licensed Baker Act receiving facilities provide involuntary examination and treatment services; however, they are exempt from certain reporting requirements, including data that captures utilization. This results in an incomplete picture of utilization. Although use of children's beds shows a decline, this does not mean the need has declined. It could mean children are occupying beds designated for adults or it could mean children are being served in private receiving facilities. This accounts for some of the gaps in data and was the subject of discussion by the Task Force.

The Department reported that there are 12 Mobile Crisis Teams in the state, which serve all or portions of the following counties; Brevard, Broward, Charlotte, Duval, Hillsborough, Indian River, Manatee, Martin, Miami-Dade, Okeechobee, Orange, Palm Beach, Polk, St. Lucie, and Volusia. These teams provide immediate assessment, intervention, referral, and support services. The Task Force believes that by making these services more accessible, involuntary examinations would be reduced.

The MEs purchase Crisis Support/Emergency covered services, including mobile crisis team services, with General Revenue, block grant, System of Care grants, Central Receiving System grants, and other

- Mental Health Targeted Case Management
- Nursing Facility Services
- Physician Services
- Prescribed Drug Services

Given the fact that the EPSDT benefit is a federal entitlement for children enrolled in Medicaid, behavioral health assessments, treatment and other behavioral health services are already available to all children in the program, including those enrolled in a Medicaid health plan.

Based on stakeholder and Task Force participant input, access to behavioral health services appears to be a contributing factor in the increase in involuntary examinations of children. For children in the Medicaid program, access to services could be increased through innovative funding mechanisms, changes to prior authorization processes, and education about the importance of improved access to these community based services. Further, Medicaid health plans can improve access to EPSDT services through improvements in care coordination, better partnerships with community resources, and development of robust provider networks with expertise in behavioral health treatment for children.

2. Support Baker Act training and technical assistance by funding a position in the Office of Substance Abuse and Mental Health within the Department to train and provide technical assistance to providers, clinicians, and other professionals who are responsible for implementing the Baker Act .
The lack of understanding of laws, rules, policies and procedures relating to the Baker Act results in widespread misunderstanding and misapplication of the law in communities across the state. In order to be more responsive to the needs of those charged with administering its provisions, a statewide training and technical assistance presence is critical. To fulfill its statutory responsibility to ensure these stakeholder groups are adequately trained to fully and properly implement Baker Act provisions and maximize services provided to individuals being served, the Department promulgates rules, creates guidance documents, and contracts for development and publication of online courses and user reference guides. However, due to limited funds for staff resources and training contracts, these efforts are not keeping pace with ongoing requests for technical assistance and in-person training.

Implementation of the Baker Act occurs within the framework of a complex, coordinated system of care, which includes the full array of behavioral and related services. Meaningful and lasting reform requires all stakeholder groups who are responsible for implementing Baker Act provisions to understand the system and the availability of services and supports that fall within the purview of the model.

The agencies, organizations, and professionals affected include:

- Department of Children and Families (State Mental Health Authority, State Substance Abuse Authority)
- Department of Juvenile Justice
- Department of Education
- Community-Based Care Lead Agencies
- Managing Entities and other contracted service providers
- Agency for Health Care Administration
- Medicaid health plans
- Law enforcement
- County government

- Circuit and criminal courts
- Public defenders
- State attorneys
- Individuals with mental illnesses or co-occurring mental and substance use disorders
- Mental health professionals
- Parents, guardians, and other family members
- Advocates and coalitions
- State mental health treatment facilities
- Public school systems
- Children's residential treatment centers
- Community hospitals
- Emergency departments

X. Summary of Recommendations

The Florida Legislature passed House Bill 1121 (HB 1121) during the 2017 Session, which was signed into law by the Governor on June 23, 2017, as Chapter 2017-151, Laws of Florida. This law created a task force within the Department to address the issue of involuntary examination of minors age 17 years and younger. The statute required the task force to:

- Analyze data on the initiation of involuntary examinations of minors;
- Research the root causes of any trends in such involuntary examinations;
- Identify and evaluate options for expediting the examination process; and
- Identify recommendations for encouraging alternatives to and eliminating inappropriate initiations of such examinations

The task force is also required to submit a report of its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 15, 2017.

The Task Force made several recommendations to address the overarching problem of increased Baker Act initiations of minors. Some of the recommendations and the accompanying details that support them are presented throughout the body of the report and in Section VII. Some of the recommendations can be addressed administratively within the Department. Those recommendations that require revisions to the statutes or legislative appropriation reproduced as follows:

A. Recommendations that Require Substantive Legislation

1. Amend s. 394.463(2)(a)1, 2, and 3, F.S., to increase the number of days, from the next working day to five working days, that the receiving facility has to submit forms required by s. 394.463(2)e, F.S., to the Department. This would allow the Department to capture data on whether the minor was admitted, released, or a petition filed with the court.

2. Amend s. 394.463(2)(a)3, F.S., to add physician assistants and licensed school psychologists to the list of professionals who can initiate a Baker Act.

3. Amend s. 394.463(2)(f), F.S., to add physician assistants, psychiatric advanced registered nurse practitioners, licensed clinical social workers, licensed mental health counselors, and

licensed marriage and family therapists to the list of mental health professionals who can conduct the clinical examination to determine if the criteria for involuntary services are met.

4. Amend s. 394.4784, F.S., to make outpatient intervention services and treatment available to children under age 13, to the extent funding allows.

5. Amend s. 381.0056(4)(a)19, F.S., to require school administrators to notify a student's parent, guardian, or caregiver before a Baker Act is initiated and the student is removed from school, school transportation, or a school-sponsored activity .

6. Encourage school districts, through legislative intent language, to adopt a standardized suicide risk assessment tool that school-based mental health professionals would be required to implement prior to initiating a Baker Act.

7. Require Crisis Intervention Training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools, to the extent funding allows.

8. Require the Agency to post quarterly Medicaid health plans' EPSDT compliance reports on its website.

B. Recommendation that Requires Substantive Legislation and Appropriation

1. Create within the Department the "Invest in the Mental Health of our Children" grant program to provide matching funds to counties that can be used to plan, implement, or expand initiatives that increase public safety, avert increased mental health spending, and improve the accessibility and effectiveness of prevention and intervention services for children who have a diagnosed mental illness or co-occurring mental health and substance use disorder.

C. Recommendations that Require Legislative Appropriations

1. Fund an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis.

2. Provide additional funds for the Department to contract for additional mobile crisis teams to expand coverage statewide.

3. Fund one FTE in the Department's Office of Substance Abuse and Mental Health to provide statewide training and technical assistance to organizations and agencies responsible for implementing Baker Act provisions.

XI. Conclusion

The Task Force was commissioned by the 2017 Legislature to analyze data on the initiation of involuntary examinations of children, research the root causes of any trends in such involuntary examinations, identify and evaluate options for expediting examinations for children, and identify recommendations for encouraging alternatives to and eliminating inappropriate initiations of such examinations.

The legislation creating the Task Force became effective July 1, 2017 and it expires on March 31, 2018. Task Force membership includes stakeholders and other individuals with expertise in various aspects of part I of Chapter 394, which creates the Florida Mental Health Act. Task Force membership includes representatives of the law enforcement, mental health, the courts, legal and education fields, along with community stakeholders and family members of individuals who were involuntarily examined as minors. The Florida Guardian ad Litem Program also provided invaluable assistance toward this effort.

The Task Force held five meetings. To assist with its research efforts, key constituencies such as law enforcement officers, district school superintendents, public defenders, mental health providers, mobile crisis teams, school resource officers, parents, and guardians were surveyed. The survey results were considered and many of the recommendations are included in the report.

The Task Force carefully considered each of the statutory responsibilities assigned in HB 1121 as it identified strategies to fulfill the legislative mandate. The members agreed to examine six general themes in its approach to performing the assigned duties.

The Task Force made several recommendations, including suggestions for administrative actions the Department can undertake to address data gaps and proposals for substantive legislative changes and appropriations.

Task Force members expressed appreciation for the opportunity to provide input to Florida leadership regarding a critical public policy issue that significantly impacts the lives of Florida's children.

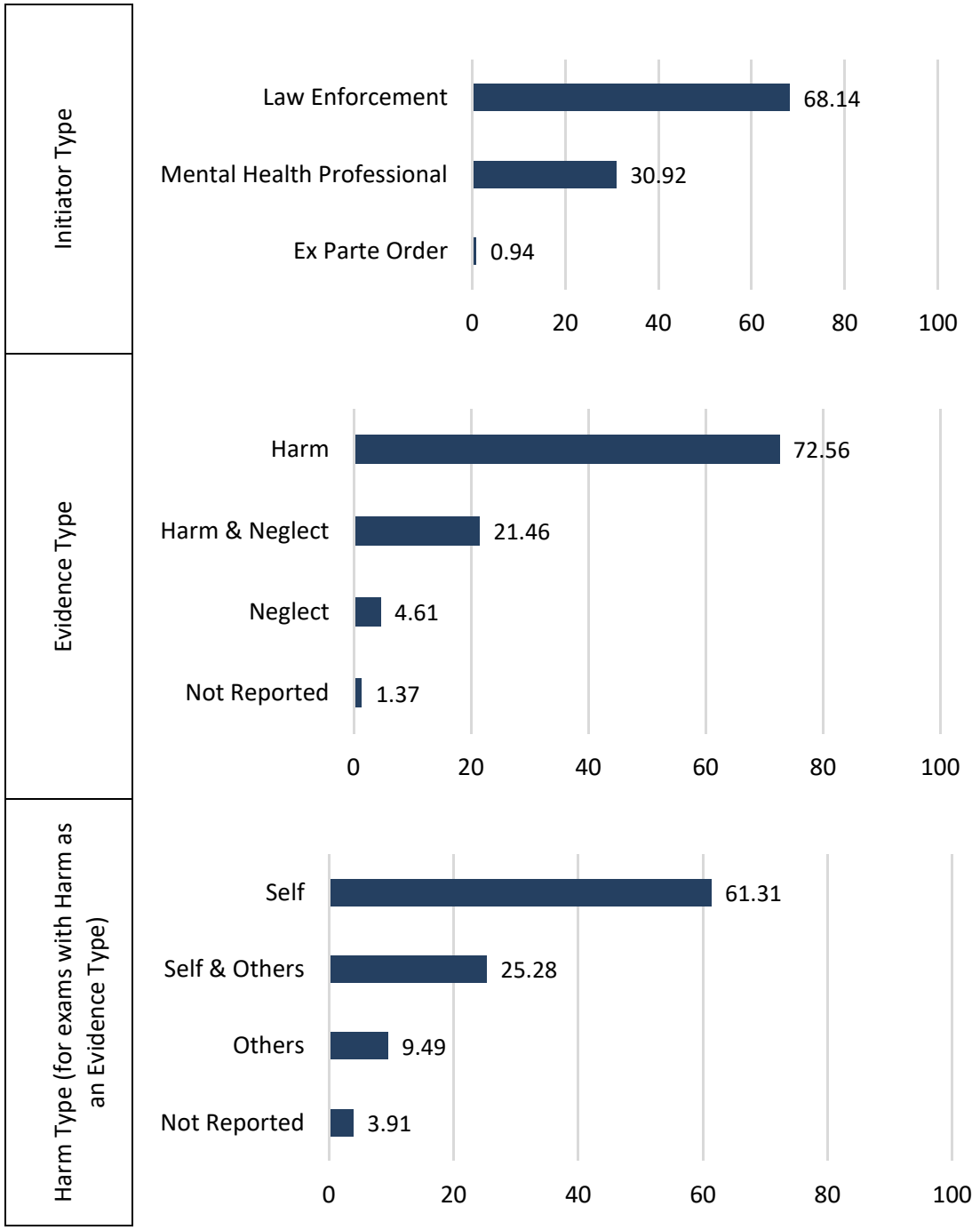
Appendix A

Task Force on Involuntary Examination of Minors	
Entity Represented	**Member**
Secretary of the Department of Children and Families or Designee (Task Force Chair)	John N. Bryant, Assistant Secretary Substance Abuse and Mental Health Department of Children and Families Tallahassee, FL
Commissioner of Education or Designee	Dr. David Wheeler Florida Department of Education Tallahassee, FL
Florida Public Defender Association	The Honorable Bob Dillinger Public Defender, 6th Judicial Circuit Clearwater, FL
Florida Association on District School Superintendents	Bob Bedford, Associate Executive Director Florida Association of District School Superintendents Tallahassee, FL
Florida Sheriff's Association	The Honorable Jerry L. Demings, Sheriff Orange County Orlando, FL
Florida Police Chiefs Association	John W. Mina, Chief of Police Orlando Police Department Orlando, FL
Florida Council for Community Mental Health	April Lott, President/CEO Directions for Living Clearwater FL 33764-2829
Florida Alcohol and Drug Abuse Association	Melissa Larkin-Skinner, CEO Centerstone of Florida Bradenton, FL
Behavioral Health Care Council of the Florida Hospital Association	Tammy L. Tucker, PSYD Memorial Healthcare System Hollywood, Florida
Florida Psychiatric Society	Mariam Rahmani, MD, FAPA Director, Child Psychiatry Residency Training University of Florida
National Alliance on Mental Illness	Dr. Rajiv Tandon Newberry, FL

Task Force on Involuntary Examination of Minors	
Entity Represented	**Member**
Family Member of a Minor	Nancy Daniels Tallahassee, FL
Family Member of a Minor	Erica Melvin Pensacola, FL
Florida Department of Juvenile Justice	Gayla Sumner, Director of Mental Health and Substance Abuse Services Florida Department of Juvenile Justice Tallahassee, FL
Florida State University College of Medicine	Dr. Patty Babcock Florida State University College of Medicine Tallahassee, Florida
Students with Emotional/Behavioral Disabilities Network (SEDNET)	Nickie Zenn, Statewide Director SEDNET Administration Project University of South Florida St. Petersburg, FL
DCF Substance Abuse & Mental Health Regional Office	April May, Regional Substance Abuse and Mental Health Director, Suncoast Region Department of Children and Families Tampa, FL
Office of State Courts Administrator	Sandy Neidert, MSW, Operations Manager Office of Court Improvement Office of the State Courts Administrator Tallahassee, FL
Florida Association of Managing Entities	Mike Watkins Big Bend Community Based Care Tallahassee, FL
Children's Crisis Stabilization Units	Derek McCarron, Director of Children's Inpatient Services Gracepoint Wellness and Behavioral Health Center Tampa, FL
Supreme Court Task Force on Mental Health and Substance Abuse	Kathleen (Kathy) A. Smith Public Defender, 20th Judicial Circuit Fort Myers, FL

Appendix B

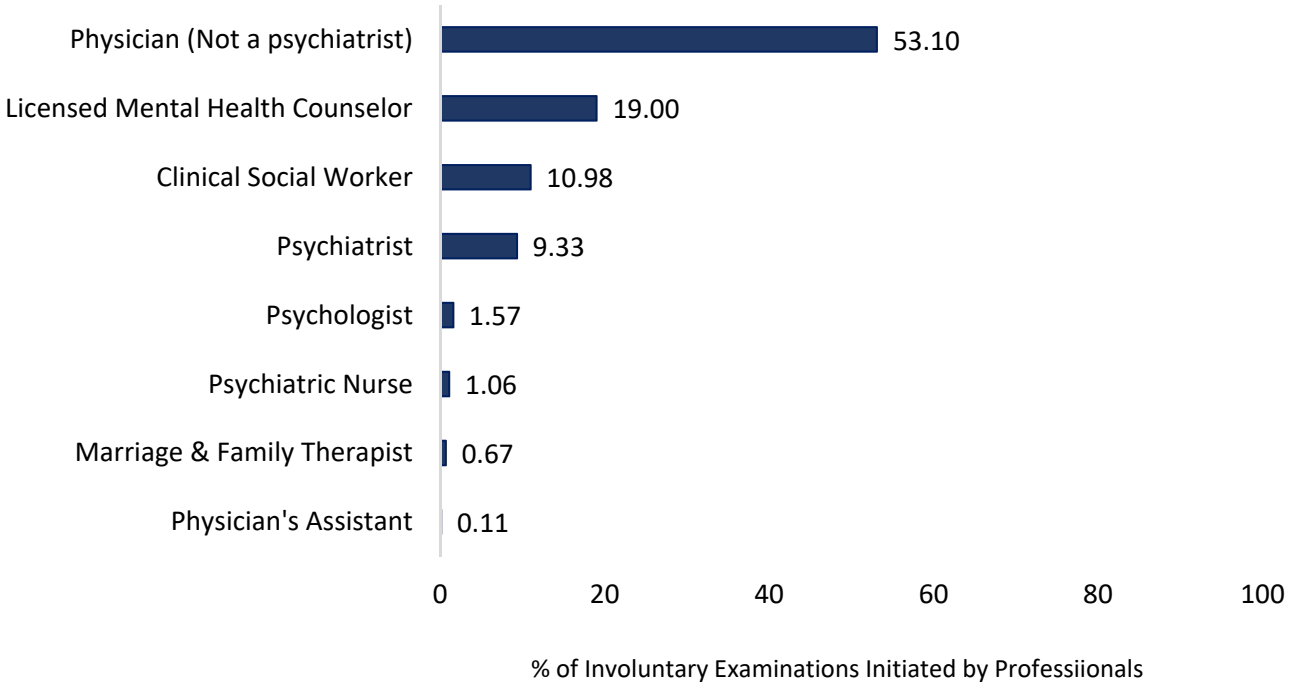
Figure 2: Initiator Type, Evidence Type & Harm Type for Involuntary Examinations of Minors – FY15/16



Source: http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

Figure 3: Professional Type of Initiations by Professionals (Using Form BA52b) Source: http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

Source: http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf



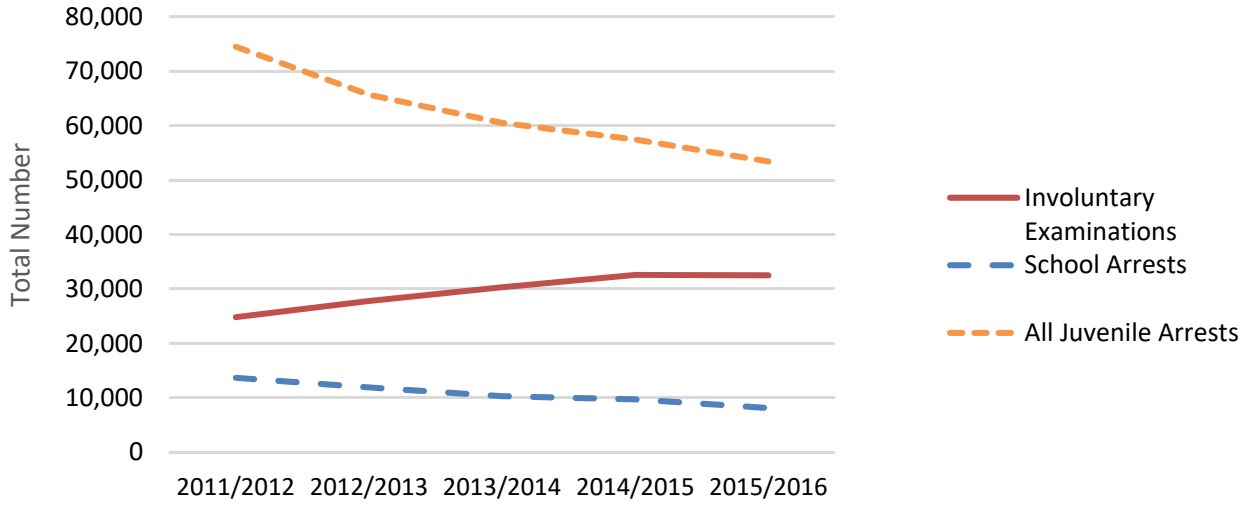
Source: http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

Table 5: Statewide Juvenile Arrest & Involuntary (Baker Act) Examinations

	Involuntary Examinations	School Based Arrests			All Juvenile Arrests		
		Misdemeanors	Felonies	Misdemeanor & Felonies	Misdemeanors	Felonies	Misdemeanor & Felonies
2011/2012	24,836	9,320	4,388	13,708	45,237	29,300	74,537
2015/2015	32521	4,875	3,274	8,149	27,162	26,293	53,455
Difference	7,685	-4445	-1,114	-5,559	-18,075	-3,007	-21,082
% Change	30.94%	-47.69%	-25.39%	-40.55%	-39.96%	-10.26%	-28.28%

Source: http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

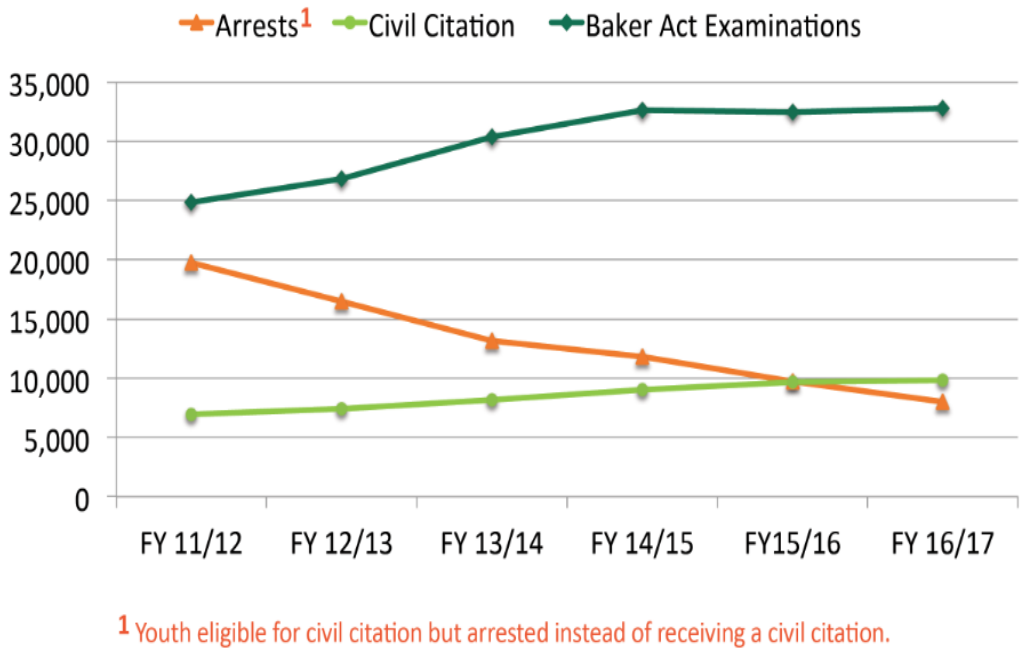
Figure 4: Involuntary Examinations, School Arrests and All Juvenile Arrests from FY11/12-FY15/16



Type of Arrest	Correlation * P < .01
School based juvenile arrests, misdemeanor & felonies	r = - .58*
School based juvenile arrests, misdemeanor	r = - .57*
School based juvenile arrests, felony	r = -.48*
All juvenile arrests, misdemeanor & felonies	r = -.39*
All juvenile arrests, misdemeanor	r = -.48*
All juvenile arrests, felony	r = +.02
All juvenile arrests "other" (usually lesser offenses)	r = -.62*

Source: http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

Figure 5: Involuntary Examinations, Civil Citations & Arrests for Florida Youth Under 18



Source: http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf