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TASK FORCE REPORT ON INVOLUNTARY EXAMINATION OF MINORS

Department of Children and Families

Office of Substance Abuse and Mental Health

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Secretary

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I. Executive Summary

The Florida Legislature passed House Bill 1121 (HB 1121) during the 2017 Session, which was signed into law by Governor Rick Scott on June 23, 2017 as Chapter 2017-151, Laws of Florida. This law created a task force within the Department of Children and Families (Department) to address the issue of involuntary examination of minors age 17 years and younger. The statute requires 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 Department convened the Task Force on Involuntary Examination of Minors (Task Force) on July 20, 2017. The Task Force includes stakeholders and other individuals with expertise in various aspects of part I of Chapter 394, the Florida Mental Health Act, commonly referred to as the Baker Act. Task force membership includes representatives of the law enforcement, mental health, legal, and education fields, along with community stakeholders and family members of individuals who were involuntarily examined as minors (See Appendix A). The Florida Guardian ad Litem Program also provided invaluable assistance toward this effort.

The Task Force also held meetings on August 18, September 28, October 4, and October 11, 2017. Meeting materials are available at:

http://www.myflfamilies.com/service-programs/mental-health/involuntary-examination-minors

Task Force efforts began with an analysis of data from the Baker Act Reporting Center at the Louis de la Parte Florida Mental Health Institute at the University of South Florida (Reporting Center), which shows that 32,475 involuntary examinations were initiated under the Baker Act for individuals under the age of 18 between July 1, 2015, and June 30, 2016.[1] This capped a five-year period in which the number of minors who were involuntarily examined increased by 49.3 percent, compared with a 5.53 percent rise in the state's population.[2]

The Task Force was charged with scrutinizing the data behind the increase in involuntary Baker Act examinations and making recommendations aimed at reducing the number and duration of these proceedings.

This report summarizes the major findings of the Task Force. First among them is that further data are needed, as there are significant gaps in data reporting requirements and many of the statutorily

[1] http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf
[2] http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

required forms that accompany individuals who are transported to Baker Act receiving facilities are incomplete.[3]

To address this barrier in the short term, Task Force members and staff developed survey instruments that were tailored to key constituencies such as law enforcement officers, district school superintendents, public defenders, mental health providers, mobile crisis teams, school resource officers, and parents and guardians.

A total of 309 key stakeholders responded to the survey. Common responses or themes from each respondent type are summarized in the Key Stakeholder Survey, which is available at the following link. Responses were used in development of several Task Force recommendations.

http://www.myflfamilies.com/service-programs/mental-health/involuntary-examination-minors

The Task Force carefully considered each of the statutory responsibilities assigned in HB 1121 as it identified strategies to fulfill the mandate. By unanimous decision, the members agreed to the following general themes in its approach to performing the assigned duties:

- The increase in Baker Act examinations is a complex, multi-faceted issue that is symptomatic of a number of societal challenges;
- Access to prevention and early intervention services is critical to reducing the number of minors having a Baker Act initiated;
- There are areas across the state where options short of a Baker Act are limited or nonexistent;
- The statutory standard for initiating a Baker Act is the individual "appears to meet" criteria;
- The fact that the clinical examination determines the individual does not meet Baker Act criteria does not necessarily mean the initiation of the Baker Act was inappropriate. There is not always a direct correlation between the earlier crisis that led to the decision to initiate the Baker Act and the clinician's final determination after a full examination ; and
- Analysis of an increase in Baker Act examinations must take into account a myriad of factors that impact involuntary examinations. Examples include prevalence of mental health disorders, significant increase in major depressive episodes and suicide attempts among youth, social media and cyber bullying, school and workplace violence, shortage of services and supports in some areas, family dynamics and dysfunction, parental and student substance use, and the increase in mental health training and awareness.

II. Background

Statutes governing the treatment of mental illness in Florida date back to 1874. Below are significant revisions that have taken place since that time:

- The 1971 Legislature created the Florida Mental Health Act, commonly referred to as the Baker Act. This law substantially strengthened the due process and civil rights of individuals receiving services and treatment in the state's public mental health system.
- The 1996 Legislature further amended the Baker Act to offer greater protections to individuals seeking voluntary admission, to strengthen guardian advocacy provisions, to expand notice

[3] http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

requirements, and to specify provisions relating to suspension and withdrawal of receiving and treatment facility designations.

- The 2016 Legislature enacted Senate Bill 12 (SB 12), Chapter 2016-241, Laws of Florida. This law made significant changes to the Baker Act to focus on the provision of behavioral health services for individuals experiencing co-occurring disorders, including:
  - Promoting a coordinated, comprehensive system of care for behavioral health disorders and establishing the essential elements of the system;
  - Creating behavioral health receiving systems that function as no-wrong-door models for the delivery of acute care services to individuals who have mental health or substance use disorders, or both, which optimizes access to care, regardless of the entry point into the system;
  - Requiring the use of coordination of care principles that are characteristic of recovery-oriented support services necessary for individuals with mental health disorders to live successfully in their communities. Examples of these support services include housing assistance, life skills and vocational training, peer support services, and employment assistance; and
  - Revising the duties and responsibilities of the Department to set performance standards and enter into contracts with managing entities (MEs) that support efficient and effective administration of the behavioral health system and ensure accountability for performance. The duties and responsibilities of MEs are revised accordingly.

As the designated Mental Health Authority of Florida, the Department is responsible for:

- Developing and designing programs to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders;
- Planning, evaluating, and implementing a comprehensive statewide program, including community services, receiving and treatment facilities, and research;
- Establishing standards, providing technical assistance, and exercising supervision of mental health programs;
- Establishing minimum standards of education and experience for professional and technical personnel employed in mental health programs; and
- Publishing and distributing appropriate materials for the education and training of persons actively engaged in implementing the Baker Act provisions that relate to the involuntary examination and placement of individuals who are believed to have a mental illness.

To operationalize its duties as the state mental health authority, the Department contracts with MEs to plan, coordinate, and deliver public community mental health and substance abuse services; to improve access to care; to promote service continuity; to purchase services; and to support efficient and effective delivery of services.

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

fund sources. Expansion of these teams within existing resources will further reduce efforts to adequately fund the network of prevention, early intervention, and treatment services.

E. Florida Kids Count at Florida Mental Health Institute, University of South Florida

Florida Kid's Count presented data from the Annie E. Casey 2017 Kids Count Data Book, which showed Florida ranked number 40 on a 2017 state-to-state comparison of overall child well-being for the second year in a row.[8] This information can be found at the following link:

http://www.floridakidscount.org/

Florida's rankings in the four domains are:

- Number 45 in economic well-being, number 31 in education, number 44 in health, and number 35 in family and community.
- Florida Kid's Count also looked at data from Florida sources and found that where you live matters. There are a growing number of children living in areas of concentrated poverty; these neighborhoods lack access to quality food and have overburdened schools with lack of resources.

F. Service Utilization/Diagnostic Information

The Agency was unable to provide data within the time frame needed by the Task Force. Data for services/encounters are reported by the Medicaid Health Plans, but there is no field to identify that an encounter claim was for a Baker Act examination. An encounter claim may be for inpatient psychiatric services, but whether the services were provided as a result of a Baker Act commitment cannot be determined. As with the utilization data provided by the Department, Medicaid data are only part of the larger picture. It is important to note that many children are covered by Medicaid and are enrolled in a health plan. For example, almost all children in foster care have Medicaid.

G. National Trends

Anxiety and depression have been on the rise since 2012.

- A 2016 study published in *Pediatrics*,[9] the journal of the American Academy of Pediatrics, showed that the number[10] of teens and young adults experiencing a major depressive episode increased by 37% between 2005 and 2014, with no "corresponding increase in mental health treatment for this population during this time."[11]

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[8] The Kids County data used to create the well-being rankings is usually two years prior to the year in which it is published. For example, the 2017 rankings used 2015 data, the 2016 rankings used 2014 data, and so forth. Florida was ranked as follows in Kids Count Data Books published in 2010 (35), 2011 (36), 2012 (38), 2013 (38), 2014 (38), 2015 (37) and 2016 (40). The Florida Kids County data are compiled by the Annie E. Casey Foundation in collaboration with more than 50 Kids Count State Organizations (http://datacenter.kidscount.org/about). Overall child well-being rankings for all states are available at http://www.aecf.org/m/databook/2017KC_databook_rankings.pdf

[9] http://pediatrics.aappublications.org/content/early/2016/11/10/peds.2016-1878

[10] "Number" in the context of this study was the 12-month prevalence of major depressive disorders. "Prevalence" is "the proportion of a population who have (or had) a specific characteristic in a given time period."

[11] *The Brown University Children & Adolescent Psychopharmacology Update* (January, 2017), p. 5.

- Anxiety disorders were found to be the most common condition (31.9%) among youth ages 13-18, followed by behavior disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%).[12]

H. Baker Act Reporting Center

The Baker Act contains several data reporting provisions, including requiring the Department to receive and maintain copies of:

- Documents to initiate involuntary examinations that are submitted by receiving facilities[13]
    - Ex parte orders for involuntary examination,
    - Professional certificates, and
    - Law enforcement officers' reports
- Documents related to involuntary outpatient services/placement submitted by Clerk of Court
    - Involuntary outpatient services petitions/orders, and
    - Involuntary inpatient placement petitions/orders

The Department contracts with the Reporting Center to obtain Baker Act forms from receiving facilities, enter data from these forms, analyze data and prepare the legislatively mandated Annual Baker Act Report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The FY 2015/2016 Annual Report[1] indicated:[14]

- There were 194,354 total involuntary examinations during this period
- One in six (16.71%) of these involuntary examinations were for children under 18 years of age
- Almost one-quarter (22.03%) of involuntary examinations were for children who were at school at the time the examination was initiated. By comparison, 4.07% were in the Department's custody and 1.52% were in the custody of DJJ.

1. Limitations of the Data

Certain limitations to the data should be noted. The data analyzed for this report are from initiation forms received by the Reporting Center. Involuntary examination forms for people with a Baker Act examination initiated who never reach a receiving facility are not sent to the Reporting Center and are not included in the data in the annual report. This includes people who spend all or most of their 72-hour involuntary examination period at emergency rooms subsequent to being medically cleared but are not transferred to a receiving facility. Other data limitations include the following:

a. Some individuals for whom forms were received were never admitted to the receiving facility because the clinical examination performed prior to admission determined they did not meet criteria;
b. The data do not indicate whether the clinical examination resulted in an admission;
c. The data do not include information on what occurred after the clinical examination;

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[12] 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. doi:10.1016/j.jaac.2010.05.017

[13] http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

[14] http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

d. The data do not reveal how long individuals stayed at the facility and whether they remained on an involuntary status or were transferred by express and informed consent to voluntary status;
e. The data do not indicate when a Baker Act initiation was converted to a Marchman Act assessment;
f. The data do not include when a Marchman Act assessment was converted to a Baker Act examination;
g. The data do not indicate if a person was admitted on a voluntary status and converted to an involuntary status at a receiving facility; and
h. Some forms are incomplete for date of birth, social security number, and other data elements.

This area requires further study by the Department.

2. Changes Over Time in Involuntary Examinations for Children

Involuntary examinations for children have increased over time (see Figure 1). From FY 2000/2001 to FY 2015/2016, there was an 86% increase in involuntary examinations for children. By comparison, the population increase for children from 2000 to 2015 was 11%.[15] Increases in involuntary examinations for age groups are as follows:

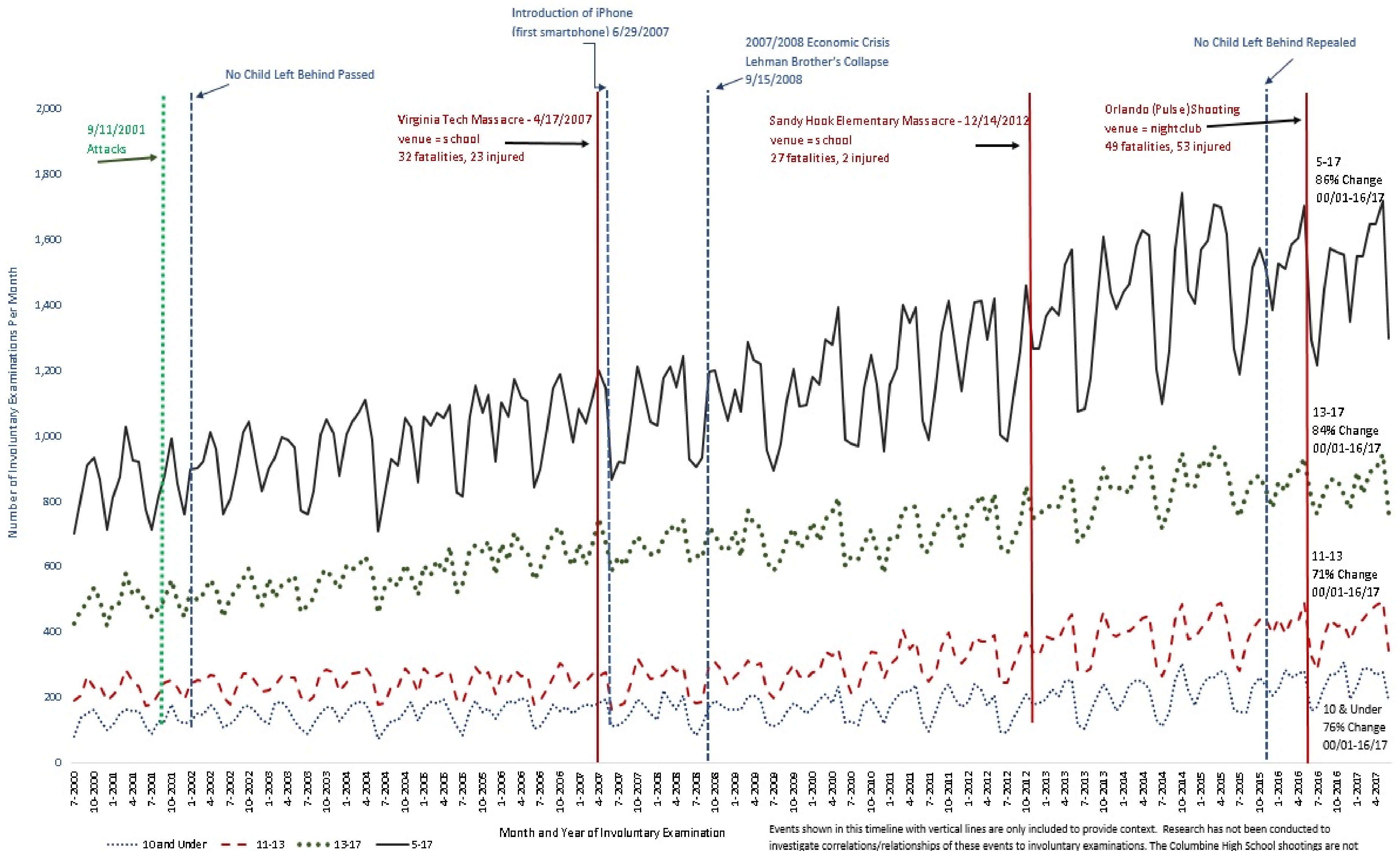
- ages 14-17: 84%;
- ages 11-13: 71%;
- ages 5-10: 76%.

A seasonal pattern is seen in the data, with decreases of involuntary examinations for children when school is not in session (summer and over winter break). This seasonality accounts for the wave-like pattern in Figure 1.

Certain key events are shown in Figure 1 with vertical lines. These events are shown in the timeline in order to provide context to events that occurred in relation to the volume of involuntary examinations. Analyses were not conducted to investigate the possible correlation of these events to counts of involuntary examinations. **Therefore, the events on the timeline should not be construed as causes for the increase in involuntary examinations. These events do provide important context, however.** Note the Columbine High School shootings that occurred in April 1999 pre-date the availability of involuntary examination data, which is why this event is not shown in Figure 1.

[15] Percent change in population computed using population estimates from http://www.flhealthcharts.com

Figure 1: Timeline of Involuntary Examinations for Children with Key Events



3. *Risk Factors for Increases in Mental Health Concerns for Children: Contextual Data*

The Task Force was presented with and discussed a variety of data related to involuntary examinations of minors. Table 1 includes:

- Poverty is both a cause and a consequence of mental illness.[16] The data show that the percentage of individuals, including children, below poverty level increased from 2009 to 2015, comprising nearly one quarter of children in Florida. (Data for 2016 were not available.)
- The number of deaths by suicide per year for Florida's children/youth from 2004 to 2016.
- An increasing number of adults and youth have been trained in Mental Health First Aid, an eight-hour course that teaches people to identify, understand, and respond to signs of mental illness and substance use disorders.
- Florida has consistently ranked between 48 and 50 out of 52 states and territories in per capita federal funding for mental health.

Table 1: Metrics to Consider as Related to Involuntary Examination of Minors

Metric	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Percent of individuals below level[17]						13.2%	13.8%	14.7%	15.6%	16.3%	16.7%	16.5%	
Percent of children below poverty level[18]						18.3%	19.5%	20.9%	22.5%	23.6%	24.1%	24.1%	
Suicide Count of Children ages 0-18[19]	55	76	55	53	54	64	53	66	86	73	85	81	89
Suicide Count of Children 10-14	16	19	4	6	7	10	14	14	13	13	21	20	21
Suicide Count of Children 15-18	39	56	51	47	45	54	39	52	73	59	64	61	67
Adult/Youth Trained in Mental Health First Aid					16	133	54	228	523	1,381	4,334	9,028	12,967
Funds for State Mental Health Entity[20]	49th	48th	49th	48th	49th	50th	48th	48th	50th				

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[16] Elliott, I. (June 2016) Poverty and Mental Health: A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy. London: Mental Health Foundation. https://www.mentalhealth.org.uk/publications/poverty-and-mental-health, http://www.who.int/mental_health/policy/development/1_Breakingviciouscycle_Infosheet.pdf, and https://psychcentral.com/blog/archives/2011/11/02/the-vicious-cycle-of-poverty-and-mental-health/

[17] Source: http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0545

[18] Source for poverty data: http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndGrpDataViewer.aspx?cid=0294

[19] Source for suicide data: http://www.flhealthcharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116
Mental Health First Aid training numbers were obtained by contacting Mental Health First Aid USA, which is operated by the National Council for Behavioral Health

[20] Source: https://www.kff.org/other/state-indicator/smha-expenditures-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, rankings are out of 52 because Puerto Rico and the District of Columbia are included in the rankings. The statistics reported by the Kaiser Family Foundation come from the National Association of State Mental Health Program Directors (NASMHPD) NRI. A NASMHPD report, *Too Significant to Fail: the Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, Their Families and Their Communities* provides helpful context to the statistics of per capita rates of funding. The NASMHPD report describes why state mental health entity funding matters - https://www.nasmhpd.org/sites/default/files/Too%20Signficant%20To%20Fail%20Overview%283%29.pdf

4. Rates of Baker Act Examination of Minors

Purpose of Analysis: To understand the rate of involuntary examination by county of residence and age groups.

Findings: The percentages with an involuntary examination of youth overall (under 18) and by age groups are reported below in Table 2. These percentages were computed by dividing the number of involuntary examinations by the number of children estimated in the population from Florida Health Charts. Some children have more than one involuntary examination, although the majority of children have only one involuntary examination in a given year.

Table 2: Percentages of Baker Act Examination by Age Groups for FY 2015/2016

County of Residence	Age Groups			
	5-10	11-13	14-17	Under 18
State Total	0.23	1.18	2.22	1.08
Alachua	0.40	1.83	3.14	1.60
Baker	0.09	1.13	1.15	0.66
Bay	0.24	1.49	2.37	1.17
Bradford	0.10	3.32	2.13	1.44
Brevard	0.26	1.48	3.05	1.45
Broward	0.10	0.57	1.62	0.70
Calhoun	0.00	1.21	2.12	0.92
Charlotte	0.52	1.64	4.25	2.02
Citrus	0.34	2.60	3.61	1.92
Clay	0.10	0.99	2.18	0.97
Collier	0.13	0.82	2.15	0.92
Columbia	0.24	1.77	4.06	1.79
Desoto	0.24	1.08	3.44	1.41
Dixie	0.48	0.19	2.18	0.94
Duval	0.29	1.14	1.90	0.98
Escambia	0.32	1.92	3.40	1.59
Flagler	0.17	0.94	1.96	0.91
Franklin	0.00	0.00	2.40	0.69
Gadsden	0.05	1.10	1.92	0.84

County of Residence	Age Groups			
	5-10	11-13	14-17	Under 18
Gilchrist	0.17	1.35	1.85	1.01
Glades	0.00	0.90	1.17	0.57
Gulf	0.00	1.42	2.28	1.05
Hamilton	0.20	1.42	1.81	1.02
Hardee	0.11	1.29	0.93	0.63
Hendry	0.18	2.04	2.12	1.19
Hernando	0.30	1.35	2.66	1.30
Highlands	0.11	1.24	2.51	1.10
Hillsborough	0.33	1.51	2.46	1.27
Holmes	0.07	1.48	3.42	1.45
Indian River	0.20	1.00	1.71	0.86
Jackson	0.12	0.73	2.09	0.89
Jefferson	0.22	1.11	2.63	1.14
Lafayette	0.00	0.30	1.66	0.57
Lake	0.27	1.57	2.73	1.33
Lee	0.22	1.27	2.47	1.16
Leon	0.13	0.92	2.49	1.04
Levy	0.40	1.14	2.56	1.27
Liberty	0.16	2.21	2.63	1.45
Madison	0.14	1.82	2.76	1.36
Manatee	0.27	1.20	1.86	0.97
Marion	0.45	2.19	3.38	1.76
Martin	0.17	0.69	1.20	0.63
Miami-Dade	0.14	0.58	1.33	0.62
Monroe	0.08	0.40	0.69	0.34
Nassau	0.09	0.80	1.50	0.72
Okaloosa	0.33	1.10	2.12	1.05

County of Residence	Age Groups			
	5-10	11-13	14-17	Under 18
Okeechobee	0.35	1.61	2.58	1.35
Orange	0.17	0.71	1.42	0.69
Osceola	0.28	1.38	1.84	1.03
Palm Beach	0.10	0.82	1.72	0.78
Pasco	0.33	1.96	3.32	1.64
Pinellas	0.48	1.80	3.47	1.74
Polk	0.36	1.98	3.17	1.59
Putnam	0.28	0.97	2.59	1.12
Saint Johns	0.04	0.48	1.20	0.51
Saint Lucie	0.22	1.16	1.85	0.94
Santa Rosa	0.13	0.73	2.11	0.91
Sarasota	0.28	1.62	3.03	1.49
Seminole	0.28	1.20	2.02	1.07
Sumter	0.36	2.02	2.06	1.27
Suwannee	0.66	2.56	4.19	2.18
Taylor	0.07	0.42	3.16	1.08
Union	0.10	1.45	2.08	1.08
Volusia	0.41	1.58	2.30	1.05
Wakulla	0.18	1.87	4.43	1.28
Walton	0.07	0.82	1.28	1.93
Washington	0.23	2.42	1.21	0.59

Table 3 compares the percent of Baker Act examinations from Table 2 with the percent change in Baker Act examinations from FY 2011/2012 to FY 2015/2016. In the middle column, the top ten counties in terms of increase in involuntary examinations are shown in red. In the right hand column, the top ten counties in rate of involuntary examination initiation are shown in red. With the exception of Charlotte County, the counties with a high rate and a high percentage increase are not the same. Note that counties with smaller counts of involuntary examinations are not reported for this example because of the disproportionate impact of changes over time on small numbers. Data on the top 30 counties in volume makes the point about focusing on increases and/or per capita rates.

Table 3: Percentage of Involuntary Examinations for Children Compared to Percent Change: Top 30 Counties in Volume

County of Residence	% Change FY11/12 – 15/16	% of Baker Act Examinations for 5-17 Age Group FY15/16 (from Table 2)
Alachua	56.25	**1.60**
Bay	**111.76**	1.17
Brevard	37.20	**1.45**
Broward	26.26	0.70
Charlotte	**96.57**	**2.02**
Citrus	63.02	**1.92**
Clay	44.36	0.97
Collier	**170.00**	0.92
Duval	12.50	0.98
Escambia	22.02	**1.59**
Hernando	14.14	1.30
Hillsborough	**142.16**	1.27
Lake	**92.17**	1.33
Lee	**135.77**	1.16
Leon	**116.15**	1.04
Manatee	27.29	0.97
Marion	23.89	**1.76**
Miami-Dade	48.21	0.62
Okaloosa	47.35	1.05
Orange	19.61	0.69
Osceola	**65.95**	1.03
Palm Beach	**80.16**	0.78
Pasco	42.73	**1.64**
Pinellas	28.92	**1.74**
Polk	**137.00**	**1.59**
Saint Lucie	23.66	0.94
Santa Rosa	47.40	0.91
Sarasota	42.53	**1.49**
Seminole	35.33	1.07
Volusia	11.26	1.05

5. Initiator Type and Evidence Type

Purpose of Analysis: To understand variability in the type of initiator, evidence type, and type of harm when harm is the evidence type for involuntary examinations for children.

- Evidence type is the reason for the initiation – harm, neglect, harm and neglect.
- Type of harm – harm to self, harm to others, harm to self and others.

Findings: The findings are presented in Figure 2 (See Appendix B for Figure 2).

- The majority of involuntary examinations for children are initiated by law enforcement, followed by mental health professionals. Less than one percent of involuntary examinations of children are initiated by a court order.
- The majority were based on evidence of harm with harm and neglect second. Some forms were incomplete for these data.
- When the evidence type is harm, the form asks for the harm type. Harm to self was the most common harm type. Harm to self and others was the second highest with less than 10% having only harm to others as the harm type.

The percentages of involuntary examinations of children in FY 2015/2016 according to professional type of initiator show that of the nearly 31% of total involuntary examinations initiated by a professional, more than 50% were initiated by a physician who is not a psychiatrist (see Figure 3 in Appendix B). Data on how the physician came to interact with the child to initiate the involuntary examination are not available.

6. Repeated Baker Act Examinations

Purpose of Analysis: To understand the patterns of repeated involuntary examination.

Findings: Counts of repeated Baker Act examinations for five years and one year are presented in Table 4. Social security numbers are necessary to count individuals (children), however, the percentage of forms missing social security numbers means the count of children with repeated involuntary examinations initiated is an undercount (missing SSNs: 5 years = 43%, 1 year 49%). Even with the limitation the missing social security numbers poses for this analysis, data show that a meaningful number of children have repeated involuntary examinations.

Table 4: Repeated Involuntary Examinations of Children (Under 18) for 5 Years and 1 Year

# of Baker Act Examinations	5 Years: FY11/12 – FY15/16				1 Year: FY15/16			
	People		Examinations		People		Examinations	
	#	%	#	%	#	%	#	%
1	35,217	70.47	35,217	40.79	9,055	76.71	9,055	53.16
2	7,722	15.45	15,444	17.89	1,675	14.19	3,350	19.67
3	2,935	5.87	8,805	10.20	528	4.47	1,584	9.30
4	1,491	2.98	5,964	6.91	233	1.97	932	5.47
5	815	1.63	4,075	4.72	121	1.03	605	3.55
6	487	0.97	2,922	3.38	69	0.58	414	2.43
7	311	0.62	2,177	2.52	50	0.42	350	2.05
8	241	0.48	1,928	2.23	25	0.21	200	1.17
9	190	0.38	1,710	1.98	14	0.12	126	0.74
10	112	0.22	1,120	1.30	11	0.09	110	0.65
11-15	298	0.60	3,708	4.29	19	0.16	233	1.37
16-20	86	0.17	1,521	0.25				
21-25	44	0.09	999	0.23				
26-30	14	0.03	390	0.07				
31+	10	0.02	361	0.42				

7. Analysis of Involuntary Examination Data Combined with DJJ Data

a. DJJ Arrests in Context with Baker Act Examinations

Purpose of Analysis: To show decline in juvenile arrest rates and to put them in relation to involuntary examination counts over time.

Findings: There is more than a decade long, national trend of decreasing juvenile arrests, with a steady decline since 2006, and an historic low as of 2012 (OJJDP, 2017).[21] This includes Florida. County level DJJ data were obtained from the DJJ website. Between FY 2011/2012 and FY 2015/2016, there was an increase in involuntary examinations for children and a decrease in juvenile arrests as well as school arrests (See Table 5 in Appendix B).

The total number of involuntary examinations and arrests that occurred annually between FY 2011/2012 and FY 2015/2016 are negatively correlated, which means that the variables are moving in different directions – as one decreases the other increases. For example, as juvenile arrests decreased, Baker Act examinations increased (See Figure 4 in Appendix B). It is important to note that these correlations do not imply causation.

b. Juvenile Arrests, Civil Citations and Involuntary Examinations

Purpose of Analysis: To compare trends in juvenile arrests, civil citations, and involuntary examinations for children/youth.

Findings: Civil citation is one kind of diversion of youth from the criminal justice system. Such diversions involve "providing the youth with a caution or warning, which may be delivered informally or more formally in the form of a civil citation. The warning is issued by the police and may involve no further action, whereas in other cases, the civil citation involves referral to a diversion program. When a referral to diversion occurs by civil citation, other steps are followed as part of the diversion actions. These steps may involve an accountability action (e.g., letter of apology and community services) and a treatment intervention. They will generally include a community-based service relevant to the needs of youth (e.g., substance abuse, anger management, and education). Failure to complete the accountability and treatment requirements may entail referral back to the system for further processing".[22]

DJJ oversees civil citations[23] that have been implemented over time by all but six Florida counties. By the end of FY 2011/2012, 32 counties had implemented the process. Currently, 61 of the 67 counties have implemented civil citation. Details on implementation by counties is available on the DJJ website: http://www.djj.state.fl.us/partners/our-approach/florida-civil-citation

Florida Kids Count faculty and staff conducted an analysis to compare juvenile arrests when the youth was eligible for a civil citation and involuntary examinations over time (See Figure 5 in Appendix B).[24] There was an increase in civil citations and a decrease in arrests when the youth was eligible for a civil citation. For FY 2016/2017, data show there were more civil citations than arrests.

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[21] OJJDP Statistical Briefing Book. Online. Available: http://www.ojjdp.gov/ojstatbb/crime/JAR_Display.asp?ID=qa05201.
[22] Hoge, R. D. (2016). Application of Precharge Diversion Programs. *Criminology & Public Policy*, *15*(3), 991-999.
[23] http://www.djj.state.fl.us/partners/our-approach/florida-civil-citation
[24] The figure and some text in this section were provided by Florida Kids Count.

I. Findings and Considerations

The available data regarding involuntary examinations of minors show:

- Involuntary examinations for children occur in varying degrees across counties.
- There is an increasing trend statewide and in certain counties.
- The seasonal pattern shows that involuntary examinations are more common when school is in session.
- Some children have multiple involuntary examinations, although most children who have an involuntary examination have only one.
- Decreases in juvenile arrests are correlated to increases of involuntary examinations of children, although it is important to note that the analyses presented in this report do not show a causal link and there has been a long pattern of decreases in juvenile crime over more than a decade.
- While recent increases in involuntary examinations in certain counties are deserving of focus, a more important focus needs to be on counties that have high rates of involuntary examination. Counties with high rates are, for the most part, not the same counties with the recent increases.
- The most common involuntary examination for children is initiated by law enforcement based on evidence of harm to self.
- The majority of involuntary examinations initiated for children by mental health professionals are initiated by physicians, followed by licensed mental health counselors, and clinical social workers, with many fewer initiated by psychologists, psychiatric nurses, marriage and family therapists, and physicians' assistants.

Additional areas for research:

- The relationship between metrics related to health, education, poverty, state funding, and insurance mechanisms to the use of involuntary examinations, and how funding impacts the availability of alternatives to involuntary examination – especially less restrictive alternatives.
- The relationship of a variety of initiatives – such as those involving SEDNET and specific to school districts – to the use of involuntary examination.

VI. Root Causes of Trends in Involuntary Examination of Minors

The Task Force concentrated much of its research efforts on the root causes of trends in the increased involuntary examination of minors in Florida and nationally. The members reviewed and discussed many sources of information in researching root causes, which include but are not limited to the following:

- National and Florida specific trends related to involuntary examinations;
- The prevalence of and factors contributing to emotional and behavioral challenges and wellbeing among children and teens;
- Meeting presentations and public comment; and
- Input from the key stakeholder survey.

The consensus of the Task Force is that, based on data and information currently available and the complexity of this issue, it is not possible to identify specific root causes directly linked to the trend of increased Baker Act initiations. There is a confluence of individual, family, community, and societal factors at play, which may vary by community. However, the Task Force identified the following areas as potential root causes or contributing factors to the increase in Baker Act initiations among children in Florida.

A. Social Stressors and Risk Factors

There are multiple risk factors and stressors that impact child wellbeing. Informed by the key stakeholder survey and relevant presentations, the Task Force identified and discussed many stressors and risk factors, to include but not limited to the following (in alphabetical order):

1. Impact of child abuse and trauma;
2. Lack of coping skills among children;
3. Lack of parental knowledge on how to assist their child and limited family support;
4. Parental/caretaker substance use disorders and mental health conditions impacting parental capability;
5. Poverty/economic insecurity;
6. School/public shootings; and
7. Social media and cyber bullying;

Additional consideration was given to the status of children, families and communities, based on the Florida Kids Count Data Book - 2017.[25] Florida's relatively low ranking in the major domains of Economic Well-Being, Education, Health, and Family and Community were discussed as relevant risk factors that impact child wellbeing.

B. Mental Health Conditions Among Children and Teens

Another possible root cause for the trend in involuntary examination of minors is the prevalence of behavioral health disorders. This is particularly relevant because a Baker Act initiation requires a suspected mental illness.

According to the National Conference of State Legislatures, "studies estimate that one in five children and adolescents have a diagnosable mental health disorder, two-thirds of whom are not receiving necessary treatment.[26] According to the March 2017 report, *Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers*, nearly one in seven children age two to eight years in the United States has a mental, behavioral, or developmental disorder. Among children and adolescents age nine to 17 years, as many as one in five may have a diagnosable psychiatric disorder."[27]

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[25] http://www.floridakidscount.org/index.php/publications/108-2017-kids-count-data-book

[26] National Conference of State Legislatures, State Mental Health Lawmakers' Digest. Vol 6, No. 2. Spring 2009

[27] Elizabeth Tobin Tyler, JD, MA, Rachel L. Hulkower, JD, MSPH, and Jennifer W. Kaminski, PhD. Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers. Milbank Memorial Fund March 2017

The report found that data collected from FY 2005/2006 to FY 2011/2012 indicated the most common mental disorders diagnosed among children age three through 17 were attention-deficit/hyperactivity disorder, behavioral or conduct problems, anxiety, depression, autism spectrum disorder, and Tourette syndrome, all of which are amenable to behavior therapy approaches. Timely and adequate treatment can promote lifelong health and development, whereas a lack of appropriate treatment could lead to worsening and compounding of the child's difficulties in home, academic, and community settings. It is estimated that 70 percent of children in the juvenile justice system have a mental health condition, and children with mental health issues have significantly lower family incomes as adults."[28]

Some children and teens for which a Baker Act examination is initiated do not have an identified mental health condition; however, they may be at higher risk for developing one. Research shows that half of all lifetime cases of mental illness begin by age 14 and scientists are discovering that changes in the body leading to mental illness may start much earlier, before any symptoms appear. [29]

The Task Force discussed the prevalence of mental health conditions among children and youth, specifically an increase in anxiety and depression among teens in recent years. A study published in *Pediatrics* stated that prevalence of youth ages 12 to 20 experiencing a major depressive episode increased 37 percent from 2005 to 2014.[30] This trend was more prominent among girls than boys and among non-Hispanic whites than minorities.

Additionally, the prevalence of anxiety among children and teens was researched and discussed. The lifetime prevalence of anxiety disorders among children is 25.1% of 13 to 18 year olds. The lifetime prevalence of severe anxiety disorder is 5.9% of 13 to 18 year olds. [31] Anxiety and depression frequently co-occur both concurrently and sequentially in children and adolescents, and one often increases the risk for another. [32] The prevalence and early development of these and other mental health conditions speak to the critical need for the availability of and access to a full continuum of services and supports, including prevention and diversion services for children at risk of developing them.

C. Limited Availability of and Access to a Continuum of Services and Supports

The availability of and access to effective services and supports was identified as a root cause by respondents to the key stakeholder survey and discussed at length by the Task Force. Relevant issues identified include, but are not limited to the following:

- Need for more child psychiatrists – 59% of active psychiatrists are over the age of 55;[33]
- Variation in the availability of services and supports within local communities, to include prevention and diversion services;
  - Limited access to and availability of school-based mental health services and supports;

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[28] Ibid

[29] National Institute of Mental Health: Treatment of Children with Mental Illness https://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml

[30]http://pediatrics.aappublications.org/content/pediatrics/early/2016/11/10/peds.2016-1878.full.pdf

[31]National Institute of Mental Health: https://www.nimh.nih.gov/health/statistics/prevalence/any-anxiety-disorder-among-children.shtml

[32]National Institute of Health: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074295/

[33]National Institute of Health: https://www.staffcare.com/uploadedFiles/StaffCare/Content/Resources/Blogs/white-paper-behavioral-health-silent-shortage.pdfhttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074295/

- Limited community-based services available between the most restrictive residential mental health treatment level of care and the lowest level of outpatient treatment; and
- Challenges in accessing services and supports, including denials and limitations by third-party payers and transportation.

Since 1993, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has funded Children's Mental Health Initiative grants, for which Florida has been a recipient, with the goal of transforming the children's mental health system. These grants support the implementation and expansion of the Systems of Care (SOC) approach to serving children and youth with or who are at risk of developing mental health conditions or other challenges. In their 2015 Report to Congress, SAMHSA reported SOC outcomes to include, but not limited to: an improvement in overall functioning of children and youth in the areas of home, school and in the community, in symptoms of anxiety and depression, and other areas related to child and family functioning. [34]

A core value of the SOC approach is a broad and comprehensive array of services and supports, such as prevention and early intervention services, an array of outpatient services, intensive home-based services, 24-hour emergency services available seven days a week. continuum of mental health treatment placements, respite and peer support services, and recovery support services such as supported employment. The SOC comprehensive array of services and supports serves as a benchmark for an effective children's mental health system of care.

An additional point of discussion was the correlation between the reduction in juvenile arrests and commitment to facilities and the increase in Baker Act initiations. Although there is no clear causal relationship between these factors, the Task Force discussed the fact that an increase in Baker Act initiations or arrests and commitments are not good options for children. The initiation of a Baker Act itself will cause additional stress for a child and their family. Services and supports should reduce the need for these interventions.

The availability of access to services and supports varies across the state, with some communities having a wide array of services, supports, and providers. However, other communities, especially rural ones, have less services and supports available.

D. Investment in the Lives of Children, Youth, and Families

Given the identified potential root causes contributing to an increase in Baker Act initiations, there is a clear need to ensure children, youth and families have access to effective services and supports when they are needed, rather than allowing behavioral health conditions to deteriorate to a point where crisis services are required. Waiting lists for services, limitations on coverage or approval, limited or no funding for prevention and diversion services, and a shortage of psychiatrists and other professionals were discussed by the Task Force related to this root cause.

[34] https://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

When families are stressed, children can be negatively impacted. The Task Force concluded that Florida is not adequately investing in its children, youth, and families.

E. Impact of Positive Initiatives on Increase in Involuntary Examination of Minors

It is important to consider how the increased use of involuntary examinations could be the positive result of years of systemic changes to increase awareness and action when a minor is experiencing a crisis. Historically, mental health organizations such as the National Alliance on Mental Illness have emphasized strong support for initiatives that serve to decriminalize mental illness, including:

- Youth Mental Health First Aid training;
- Use of alternatives to expulsion or referral to law enforcement agencies; and
- Crisis Intervention Team (CIT) training for law enforcement officers and other first responders to individuals in crisis;

Youth Mental Health First Aid training has increased in recent years throughout the state. This training is specific to youth and is designed to teach parents, caregivers, teachers, neighbors and other caring citizens on how to help youth (age 12 – 18) who are experiencing mental health or additional challenges or are in crisis.[35] Providers and other agencies that serve children have increased this training within communities and schools in an attempt to build community capacity to assist youth in need and reduce crisis and suicide.

The impact of this training was mentioned in the key stakeholder survey and discussed by the Task Force, as many individuals believe this training increased awareness and perhaps increased Baker Act initiations. Others think the training decreased the need for and occurrences of Baker Act initiations.

Another example of a possible unintended consequence of a positive initiative is the 2009 Legislature's amendment to s. 1006.13(3), F.S. This statutory revision encourages schools to use alternatives to expulsion or referral to law enforcement agencies by addressing disruptive behavior through restitution, civil citation, teen court, neighborhood restorative justice, or similar programs. A reduction in children involved in the criminal justice system (as evidenced by decreased juvenile arrests and increased use of civil citations), could mean that children who would have been located in the DJJ facilities are now in the community. These youth are likely to have behavioral health needs, and may experience crises and have involuntary examinations.

CIT training is a third example of a possible positive correlation. Law enforcement officers and other first responders are being trained to recognize the symptoms of mental illness and initiate Baker Act examinations rather than arresting minors.

These positive initiatives are supported by research, mental health advocates and other stakeholders. However, an adequate network of prevention, early intervention, and treatment programs needs to be in place to properly respond to the anticipated increase in Baker Act examinations.

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[35] US Mental Health First Aid: https://www.mentalhealthfirstaid.org/take-a-course/course-types/youth/

Some key stakeholder survey respondents stated a decrease in the initiation of Baker Act examinations could be attributed to the following:

- CIT training
- Mobile crisis teams
- School suicide risk assessment protocols and procedures
- Increased parental involvement
- Ability to better diffuse, assess, and explain the situation to the parent, who is more willing to assist in a crisis situation if they are consulted and included in the process

There are no data available to support an increase or decrease in Baker Act initiations resulting from these initiatives.

VII. Options for Expediting Involuntary Examination of Minors

1. **Expand the list of mental health professionals who can conduct the clinical examination.** With passage of HB 1121, the 2017 Legislature implemented a requirement to expedite the involuntary examination of minors. While the examination period remains 72 hours, the clinical examination to determine if criteria for involuntary services are met must be initiated for minors within the first 12 hours after their arrival at the facility. This reduces the amount of time before the clinical examination is typically initiated.

   The 12-hour limitation on initiation of the clinical examination for minors could be further reduced by expanding the list of licensed mental health professionals who are authorized to conduct the exam.

   Current law limits the clinicians who can conduct the involuntary examination to a physician, clinical psychologist, or a psychiatric nurse performing within the framework of an established protocol with a psychiatrist. Amending section 394.463(2)(f), F.S., would expand this list of professionals to include the physician assistant, licensed clinical social worker, licensed mental health counselor, and the licensed marriage and family therapist. Except for the physician assistant, the other professional categories currently have the authority to initiate a Baker Act. Physician assistants currently initiate Baker Act examinations by authority of a 2008 Attorney General's Opinion.

2. **Increase funding for mobile crisis teams. These funds would be used to establish additional teams to provide statewide coverage.** Mobile crisis teams are deployed prior to the individual's arrival at a receiving facility or emergency room to provide immediate assessment, intervention, recommendations, referral, and support services. They also link individuals to appropriate community resources, typically on a 24-hours per day, 7-days a week basis.

   They are designed to be accessible to anyone in the community at any time. Families and friends of an individual experiencing a mental health crisis can call a mobile crisis team to assist and support their loved one. Many of the families who use the crisis teams are parents of children and adolescents. Crisis teams are available to anyone, regardless of their ability to pay, and must be ready to respond to any mental health emergency.

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him/her. Loved ones and caregivers are often ill-equipped to handle these situations and need the advice and support of professionals. Frequently, law enforcement or emergency medical technicians are called to respond to mental health crises and they often lack the training and experience to effectively handle the situation. Mobile crisis teams have the training and know-how to help resolve mental health crises.

By intervening early, mobile crisis teams can help prevent costly and unnecessary stays in hospitals and jails. They are also effective in connecting people with the community mental health system who had not accessed treatment and services before.

VIII. Recommendations for Encouraging Alternatives to and Eliminating Inappropriate Initiation of Involuntary Examination of Minors

The Task Force cautions against assuming the increase in Baker Act examinations is due to inappropriate practices. A myriad of other factors that impact involuntary examinations, which are discussed throughout this report, must be taken into account to avoid reducing options for dealing with minors in crisis. The Task Force concentrated on strategies to reduce the need to rely on Baker Act provisions by ensuring an adequate network of services is available to assist the individual during a mental health crisis. These services would offer court officials, law enforcement, and clinicians effective alternatives to initiating a Baker Act.

Section 394.463, F.S., authorizes use of the Baker Act only if there is no other less restrictive means and it is not clear that the threat of substantial harm to self or others could be avoided through the help of willing family members or friends, or the provision of other services.

Research confirms that in communities where appropriate prevention services and supports are available and accessible, crises are avoided and there is less reliance on Baker Act provisions. When a crisis situation does occur, availability of and access to intervention services reduces reliance on the Baker Act as a means of addressing the incident.

The Task Force offers the following recommendations for encouraging alternatives to the Baker Act:

1. Fund an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis. These services include, but are not limited to, community action teams, mobile crisis/response teams, wraparound services and intervention teams, case management, community-based services, crisis intervention with providers, child welfare safety management or diversion services, parenting classes and support, more intensive in-home services and supports, and age-related peer support groups, additional residential mental health treatment beds, and community education for parents, school resource officers and personnel.

2. Expand access to outpatient crisis intervention services and treatment. Section 394.4784, F.S., specifies that when a minor age 13 years and older experiences an emotional crisis to such degree that he or she perceives the need for professional assistance they have the right to request, consent to, and receive outpatient diagnostic and evaluation services and outpatient crisis intervention, therapy and

counseling services provided by a licensed mental health professional or in a mental health facility. The following two suggestions support this recommendation:

- Require MEs to identify the outpatient services that are available in their regions, advertise these services on their website, and educate parents and the community about their availability; and
- Revise s. 394.4784, F.S., to make outpatient crisis intervention services and treatment available to minors under age 13.

3. 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. This program would be structured similar to the Department's Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program and would provide matching state funds for planning and implementation grants that encourage counties, MEs, local behavioral health systems, and community partners, including law enforcement, school districts, courts, etc. to develop evidence-informed strategies to reduce reliance on Baker Act initiations within their regions.

4. Encourage school districts, through legislative intent language, to adopt a standardized suicide risk assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination. Data support the conclusion that implementation of risk assessment protocols significantly reduced the number of children and youth who received Baker Act initiations in school districts across the state. It is recommended that all school districts to develop and implement risk assessment procedures. This initiative is an example of how the "Invest in the Mental Health of our Children" grant program funds could be used.

5. Revise s. 394.463(2)(a)3, F.S., to include school psychologists licensed under Chapter 490 to the list of mental health professionals who are qualified to initiate a Baker Act. School psychologists are uniquely trained and qualified to provide crisis prevention and intervention services to children and youth in educational settings. The inclusion of licensed school psychologists to the list of mental health professionals with authority to initiate involuntary examinations will:

- Help reduce involuntary examinations by utilizing professionals trained to conduct risk assessments and differentiate the level of risk to inform the Baker Act consideration;
- Lessen the trauma of the experience by having trained professionals who are familiar with the students and the school setting;
- Encourage the routine practice of increasing parent/family involvement;
- Increase availability of school-based mental health professionals;
- Provide for better continuity of follow-up services and supports; and
- Decrease dependence on law enforcement to initiate Baker Act examinations from school settings.

6. <u>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</u>. Youth Mental Health First Aid training teaches parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. This program is listed in the SAMHSA's National Registry of Evidence-based Programs and Practices.[36]

CIT training is an effective law enforcement response program designed for first responders who handle crisis situations involving individuals with mental illness or co-occurring disorders. It emphasizes a partnership between law enforcement, the mental health and substance abuse treatment system, mental health advocacy groups, and consumers of mental health services and their families.

This training offers evidence-informed techniques designed to calm the individual in crisis down, reduces reliance on the Baker Act as a means of handling the crisis, and informs individuals of local resources that are available to people in need of mental health services and supports.

IX. Other General Process Improvement Recommendations

1. <u>The Agency should continue to work with Medicaid health plans to promote access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children, including behavioral health assessments and treatment. The Agency should be required to post quarterly Medicaid health plans' EPSDT compliance reports on its website</u>. The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under the age of 21 years who are enrolled in Medicaid, as specified in Section 1905(a)(4)(B) of the Social Security Act (the Act) and defined in 42 U.S.C. § 1396dl(5) and 42 CFR 441.50 or its successive regulation.[37]

The EPSDT benefit is more expansive than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

Accordingly, service limits that state Medicaid programs may impose on adults, such as a limit on therapy sessions, or a maximum number of prescriptions per month, cannot be applied to children, provided those services are deemed "medically necessary".

Health plans are required to comply with all EPSDT requirements for their Medicaid enrollees under the age of 21 years. EPSDT services include, but are not limited to:

- Behavioral Health Overlay Services
- Child Health Check-Up Services
- Early Intervention Services
- Hospital Services, including Psychiatric Services

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[36] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=1229#hide1
[37] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/EPSDT_Overview_FAQs_2016-06-06.pdf

- 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.

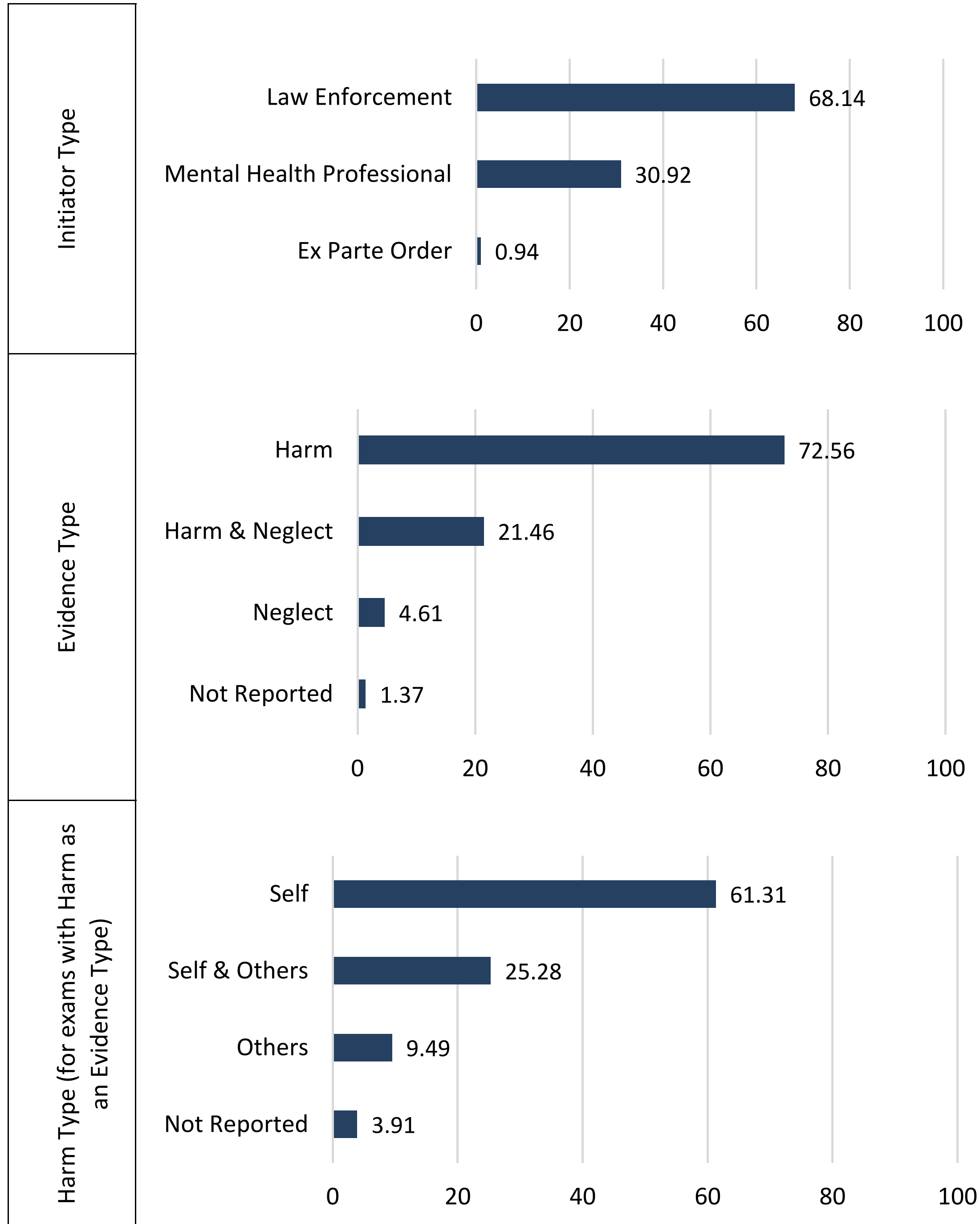
Appendix A

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

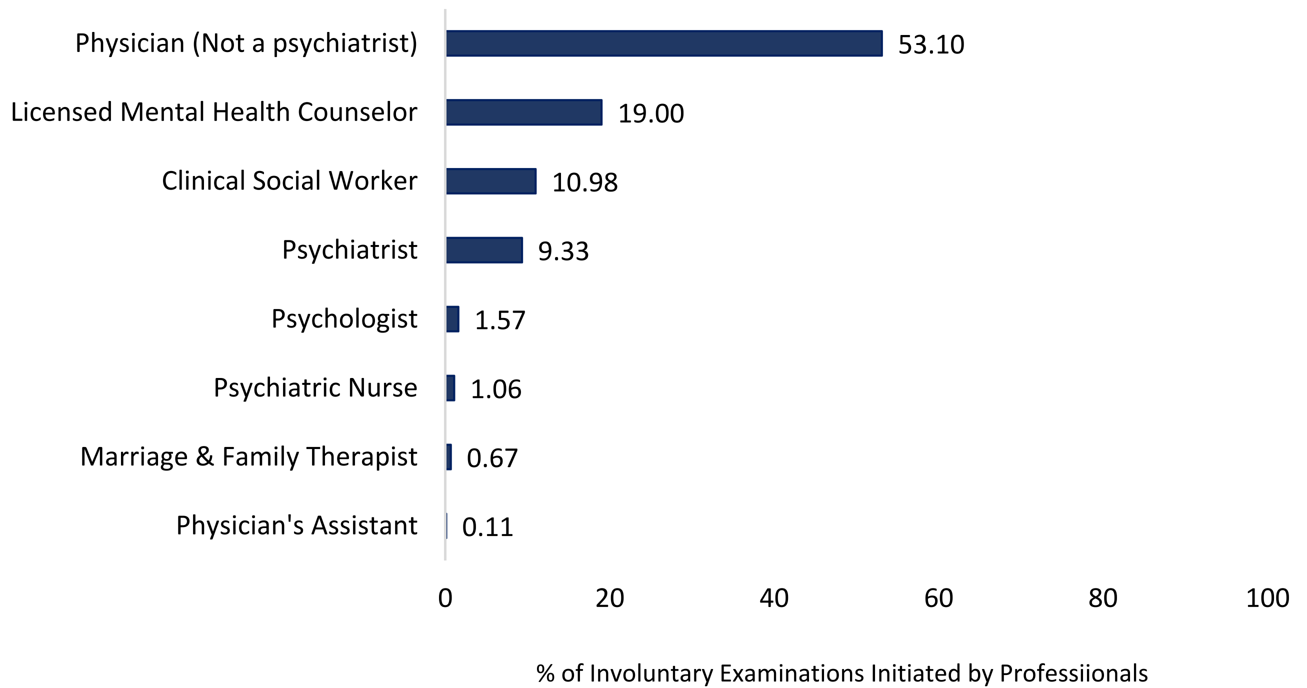
Appendix B

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



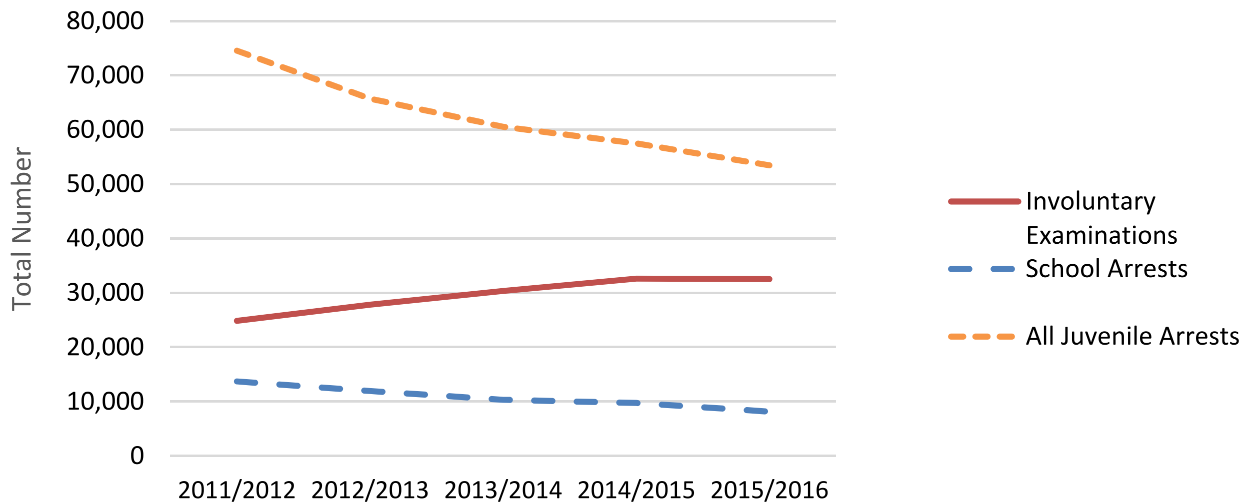
Source: http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf

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

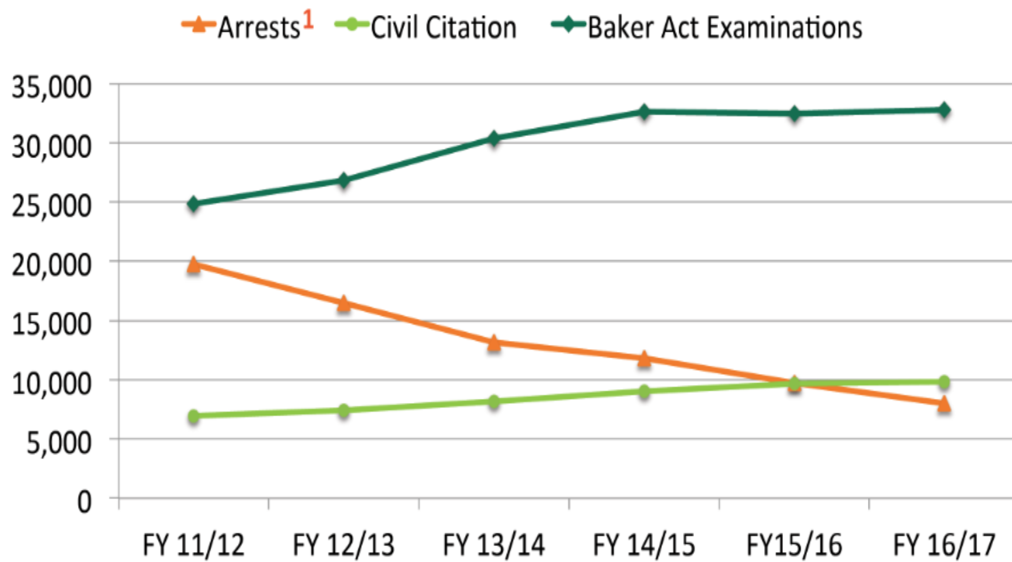
Figure 4: Involuntary Examinations, School Arrests and All Juvenile Arrests from FY11/12-FY15/16



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