

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1169 Coordinated Systems of Care for Children
SPONSOR(S): Children, Families & Seniors Subcommittee, Redondo and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1340

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	Curry	Brazzell
2) Appropriations Committee			
3) Education & Employment Committee			

SUMMARY ANALYSIS

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services.

DCF must establish a coordinated system of care that includes an array of services to meet the individual mental health service and treatment needs of children and adolescents who are members of the target population and experiencing an acute mental or emotional crisis, have a serious emotional disturbance or mental illness, have an emotional disturbance or are risk of an emotional disturbance.

PCS for HB 1169 establishes a mental health treatment and support system within school districts. The bill requires school districts providing certain mental health services to students diagnosed with, or at risk of being diagnosed with, one or more mental health issues or any co-occurring substance use disorder to adhere to the certain guiding principles and performance outcome requirements when implementing and developing a mental health treatment and support system within the school district. Adhering to these principles and guidelines will help to further promote effective implementation of a coordinated system of care.

The bill requires each school district to annually report to the Department of Education the general performance outcomes for the child and adolescent mental health treatment and support system and how funding for the support system is allocated and spent.

The bill has an indeterminate, negative fiscal impact on state and local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Health and Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.¹ The primary indicators used to evaluate an individual's mental health are:²

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.³ Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being. Mental illness affects millions of people in the United States each year. Nearly one in five adults lives with a mental illness.⁴ During their childhood and adolescence, almost half of children will experience a mental disorder, though the proportion experiencing severe impairment during childhood and adolescence is much lower, at about 22%.⁵

Mental Health Safety Net Services

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

Behavioral Health Managing Entities

In 2001, the Legislature authorized DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.⁶ The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.⁷ MEs were fully implemented statewide in 2013, serving all geographic regions.

¹ World Health Organization, *Mental Health: Strengthening Our Response*, <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response> (last visited January 21, 2024).

² Centers for Disease Control and Prevention, *Mental Health Basics*, <http://medbox.iab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm> (last visited January 21, 2024).

³ *Id.*

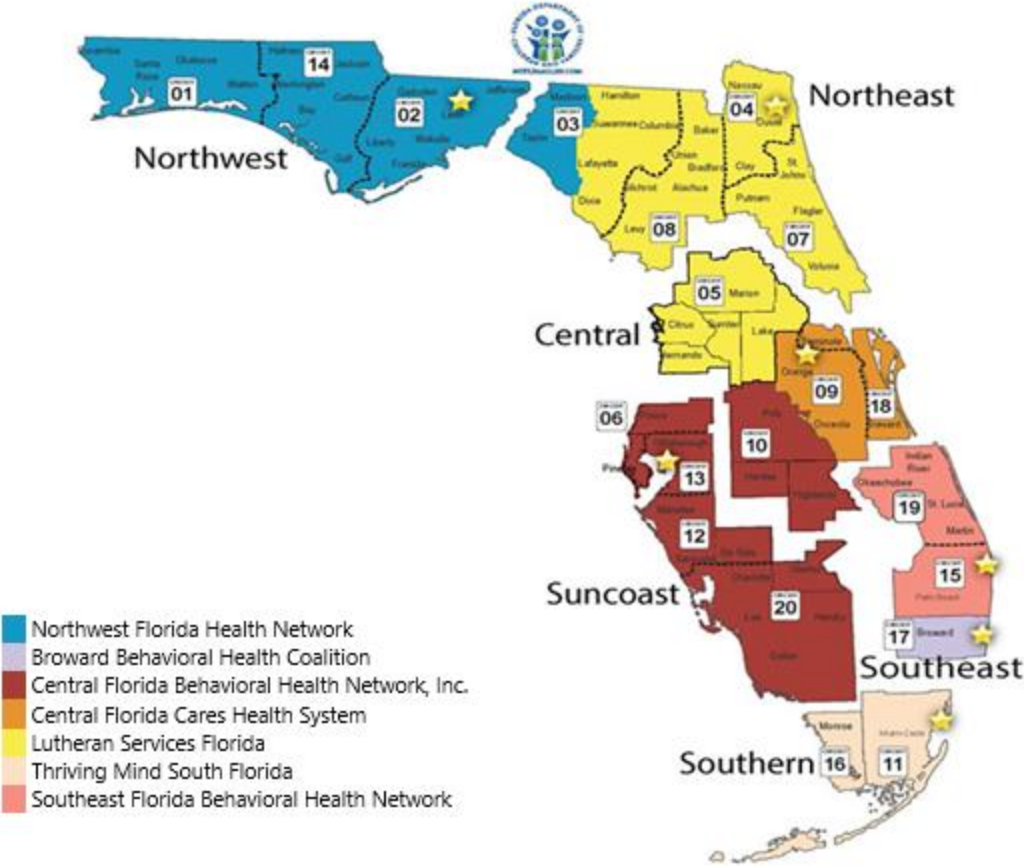
⁴ National Institute of Mental Health (NIH), *Mental Illness*, <https://www.nimh.nih.gov/health/statistics/mental-illness> (last visited January 21, 2024).

⁵ *Id.*

⁶ Ch. 2001-191, Laws of Fla.

⁷ Ch. 2008-243, Laws of Fla.

DCF currently contracts with seven MEs for behavioral health services throughout the state. These entities do not provide direct services; rather, they contract with local service providers⁸ for the delivery of mental health and substance abuse services.⁹ This allows the department’s funding to be tailored to the specific behavioral health needs in the various regions of the state.



Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.¹⁰ A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.¹¹ A community or region provides a coordinated system of care for those with a mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.¹² MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in DCF’s assessment of behavioral health services in this state.¹³ DCF must use performance-based contracts to award grants.¹⁴

There are several essential elements which make up a coordinated system of care, including:¹⁵

⁸ Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
⁹ DCF, *Managing Entities*, available at <https://www.myflfamilies.com/services/samh/providers/managing-entities>, (last visited January 21, 2024).
¹⁰ S. 394.9082(5)(d), F.S.
¹¹ S. 394.4573(1)(c), F.S.
¹² S. 394.4573(3), F.S. The Legislature has not funded system improvement grants.
¹³ *Id.*
¹⁴ *Id.*
¹⁵ S. 394.4573(2), F.S.
STORAGE NAME: h1169.CFS
DATE: 1/29/2024

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

A coordinated system of care must include, but is not limited to, the following array of services:¹⁶

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

DCF must define the priority populations which would benefit from receiving care coordination.¹⁷ In defining priority populations, DCF must consider the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.¹⁸ The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.¹⁹

Child and Adolescent Mental Health System of Care

Under current law, DCF must establish a system of care that includes an array of services to meet the individual mental health service and treatment needs of children and adolescents who reside with their parents or legal guardians or who are placed in state custody and:²⁰

- Are experiencing an acute mental or emotional crisis.
- Have a serious emotional disturbance or mental illness.
- Have an emotional disturbance.

¹⁶ S. 394.495(4), F.S.

¹⁷ S. 394.9082(3)(c), F.S.

¹⁸ S. 394.9082(5)(b), F.S.

¹⁹ S. 394.75(3), F.S.

²⁰ S. 394.495, F.S.

- Are at risk of emotional disturbance.

The services must include assessment services that provide a professional interpretation of the nature of the problems of the child or adolescent and his or her family; family issues that may impact the problems; additional factors that contribute to the problems; and the assets, strengths, and resources of the child or adolescent and his or her family. The assessment services to be provided must be determined by the clinical needs of each child or adolescent and include, but are not limited to, evaluation and screening in the following areas:²¹

- Physical and mental health for purposes of identifying medical and psychiatric problems;
- Psychological functioning, as determined through a battery of psychological tests;
- Intelligence and academic achievement;
- Social and behavioral functioning; and
- Family functioning.

The guiding principles of the system require that services be community-based, individualized, provide timely access to a comprehensive array of cost-effective mental health treatment and support services, be culturally competent, integrated, and coordinated. The goal is to provide a smooth transition, from children's mental health to the adult mental health system for continued age-appropriate services and supports. These services are designed to build resilience and to prevent, severity, duration and disabling aspects of children's mental and emotional disorders.²²

The system must achieve certain general performance outcomes for the children and adolescents who receive services through the system of care, which include the:²³

- Stabilization or improvement of the emotional condition or behavior of the child or adolescent, as evidenced by resolving the presented problems and symptoms of the serious emotional disturbance recorded in the initial assessment;
- Stabilization or improvement of the behavior or condition of the child or adolescent with respect to the family and school, so that the child or adolescent can function in the family and the school with minimum appropriate support; and
- Stabilization or improvement of the behavior or condition of the child or adolescent with respect to the way he or she interacts in the community, so that the child or adolescent can avoid behaviors that may be attributable to the emotional disturbance, such as substance abuse, unintended pregnancy, delinquency, sexually transmitted diseases, and other negative consequences.

Community Action Treatment Teams

Community Action Treatment (CAT) Teams are an important component of the child and adolescent mental health system of care. CAT teams are multi-disciplinary clinical teams that provide comprehensive, intensive community-based treatment to families with youth and young adults, ages 11 up to 21, who are at risk of out-of-home placement due to a mental health or co-occurring disorder and related complex issues for whom traditional services are not or have not been adequate.²⁴ CAT teams help these children and young adults recover at home safely and provide a safe and effective alternative to out-of-home treatment or residential care for children with serious behavioral health conditions. These teams also assist families in building and maintaining a support system within their community. CAT teams are available to:²⁵

²¹ *Id.*

²² *Id.*

²³ S. 394.494, F.S.

²⁴ Central Florida Cares Health System, *House Bill 945 Children's Coordinated System of Care Plan Central Region: Circuits 9 & 18 2022-2025*, available at https://centralfloridacares.org/wp-content/uploads/2022/01/CFCHS_Coordinated-Childrens-System-Plan_Rev-12.29.21.pdf, (last visited January 23, 2024)

²⁵ DCF, *Community Action Treatment Teams*, available at [https://www.myflfamilies.com/services/samh/community-action-treatment-teams#:~:text=Community%20Action%20Treatment%20\(CAT\)%20Teams.support%20system%20within%20their%20community,](https://www.myflfamilies.com/services/samh/community-action-treatment-teams#:~:text=Community%20Action%20Treatment%20(CAT)%20Teams.support%20system%20within%20their%20community,) (last visited January 23, 2024).

- Children and young adults with serious behavioral health conditions.
- Youth with complex needs that contribute to family disruption or increase the risk of family separation such as:
 - Multiple behavioral health hospitalizations;
 - Involvement with the Department of Juvenile Justice or law enforcement;
 - School challenges like poor academic performance or suspensions; and
 - Repeated failures at lower levels of care.

Mobile Response Teams

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him or her. It can be caused by a variety of factors and occur at any hour of the day.²⁶ Family members and caregivers of an individual experiencing a mental health crisis are often ill-equipped to handle these situations and need the advice and support of professionals.²⁷ Law enforcement or EMTs may be called to respond to mental health crises, and may lack the training and experience to effectively handle the situation.²⁸ Mobile response teams (MRT) can be beneficial in such instances.

MRTs support the child and adolescent mental health system of care and the behavioral health crisis response system as these teams travel to the acute situation or crisis to provide assistance. MRTs provide on-demand, community-based crisis intervention services 24 hours a day, seven days per week, in any setting in which a behavioral health crisis is occurring.²⁹ Mobile response services are typically provided by a team of crisis-intervention trained professionals and paraprofessionals who use face-to-face professional and peer intervention. MRTs are deployed in real time to the location of the person in crisis in order to achieve the best outcomes necessary for that individual, ensuring timely access to assessment, evaluation, support, and other services.³⁰ MRTs provide a warm handoff to other services, coordinate care, and ensure that the individual is engaged in services. MRTs are required to remain engaged for a minimum of 72 hours to ensure that the individual is actively connected to another service provider.³¹

In 2020, the Legislature required crisis response services be provided through MRTs under the Comprehensive Child and Adolescent Mental Health Services Act, which requires DCF to contract with the managing entities to procure mobile response teams throughout the state to provide immediate, onsite behavioral health crisis services to children, adolescents, and young adults ages 18-25, inclusive, who.³²

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

In Fiscal Year 2022-23, DCF received additional funding for MRTs allowing for the implementation of 12 new MRTs and the expansion of 30 existing teams. Currently there are 51 MRTs serving all 67 counties in Florida.³³ A recent review of MRT data from 2019 through 2022 shows that approximately

²⁶ Department of Children and Families, *Mobile Response Teams Framework*, (August 29, 2018), p. 4 <https://myflfamilies.com/sites/default/files/2022-12/Mobile%20Response%20Framework.pdf> (last visited December 18, 2023).

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ DCF correspondence to House Children, Families, & Seniors Subcommittee staff (Email dated December 4, 2023, on file with House Children, Families, & Seniors Subcommittee).

³² See Chapter 2020-107, L.O.F. and s. 394.495(7), F.S.

³³ DCF, Agency *Legislative Budget Request for Fiscal Year 2024-2025*, available at <http://floridafiscalportal.state.fl.us/Document.aspx?ID=26122&DocType=PDF>, (last visited January 22, 2024).

82 percent of MRT engagements resulted in community stabilization rather than involuntary admission or deeper penetration into the behavioral health system.³⁴

The Baker Act

The Florida Mental Health Act, commonly referred to as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.³⁵ The Act includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.³⁶

Involuntary Examination and Receiving Facilities

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.³⁷ Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by DCF as a receiving facility.

Receiving facilities, often referred to as Baker Act receiving facilities, are public or private facilities designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.³⁸ A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.³⁹ Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.⁴⁰

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding and provide a less intensive and less costly alternative to inpatient psychiatric hospitalization for individuals presenting as acutely mentally ill. CSUs screen, assess, and admit individuals brought to the unit under the Baker Act, as well as those individuals who voluntarily present themselves, for short-term services. CSUs provide services 24 hours a day, seven days a week, through a team of mental health professionals. The purpose of the CSU is to examine, stabilize, and redirect people to the most appropriate and least restrictive treatment settings, consistent with their mental health needs.⁴¹ Individuals often enter the public mental health system through CSUs. For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by the Legislature in the 1970s to ensure continuity of care for individuals.⁴²

An involuntary examination is required if there is reason to believe that the person has a mental illness and, because of his or her mental illness, has refused voluntary examination, is likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to that person's well-being, and such harm is unavoidable through help of willing family members or friends, or will cause serious bodily harm to him or herself or others in the near future based on recent behavior.⁴³

An involuntary examination may be initiated by:

³⁴ Department of Children and Families, *Triennial Plan for the Delivery of Mental Health and Substance Abuse Services: State Fiscal Years 2023-2024 and 2025-2026*, pg. 6, available at <https://www.google.com/url?client=internal-element-cse&cx=b5f7422ffe5734ed7&q=https://www.myflfamilies.com/sites/default/files/2023-06/Substance%2520Abuse%2520%2526%2520Mental%2520Health%2520Services%2520Triennial%2520State%2520and%2520Regional%2520Master%2520Plan%2520%25202023-2025.pdf> (last visited Nov. 28, 2023).

³⁵ The Baker Act is contained in Part I of ch. 394, F.S.

³⁶ S. 394.459, F.S.

³⁷ Ss. 394.4625 and 394.463, F.S.

³⁸ S. 394.455(40), F.S. This term does not include a county jail.

³⁹ S. 394.455(38), F.S.

⁴⁰ R. 65E-5.400(2), F.A.C.

⁴¹ S. 394.875, F.S.

⁴² Id. Ss 394.65-394.9085, F.S.

⁴³ S. 394.463(1), F.S.

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;⁴⁴
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination; or⁴⁵
- A qualified professional (physician, clinical psychologist, psychiatric nurse, an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker) executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion; or⁴⁶

Involuntary patients must be taken to either a public or a private facility that has been designated by DCF as a Baker Act receiving facility. Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.⁴⁷ During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met.⁴⁸ If the patient is a minor, the examination must be initiated within 12 hours.⁴⁹

Within that 72-hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next business day, one of the following must happen:⁵⁰

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to a placement as a voluntary patient and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

Involuntary Examination of Minors

During fiscal year (FY) 2021-2022, 170,048 involuntary examinations were conducted for 115,239 individuals under the Baker Act;⁵¹ of those examined, just over 36,000 were minors.⁵² Individuals with multiple involuntary examinations accounted for a disproportionate number of examinations. Of the total involuntary examinations, there were 21.78 percent of individuals with two or more exams in FY 2021-2022. These individuals accounted for 46.99 percent of involuntary exams during the three-year period for FY 2019-2020 through FY 2021-2022.⁵³

Approximately one in five (21.23 percent) of children with an involuntary examination in FY 2021-2022 had two or more involuntary exams. These children accounted for 44.93 percent of the of the

⁴⁴ S. 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.

⁴⁵ S. 394.463(2)(a)2., F.S.

⁴⁶ S. 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.

⁴⁷ S. 394.463(2)(g), F.S.

⁴⁸ S. 394.463(2)(f), F.S.

⁴⁹ S. 394.463(2)(g), F.S.

⁵⁰ S. 394.463(2)(g), F.S.

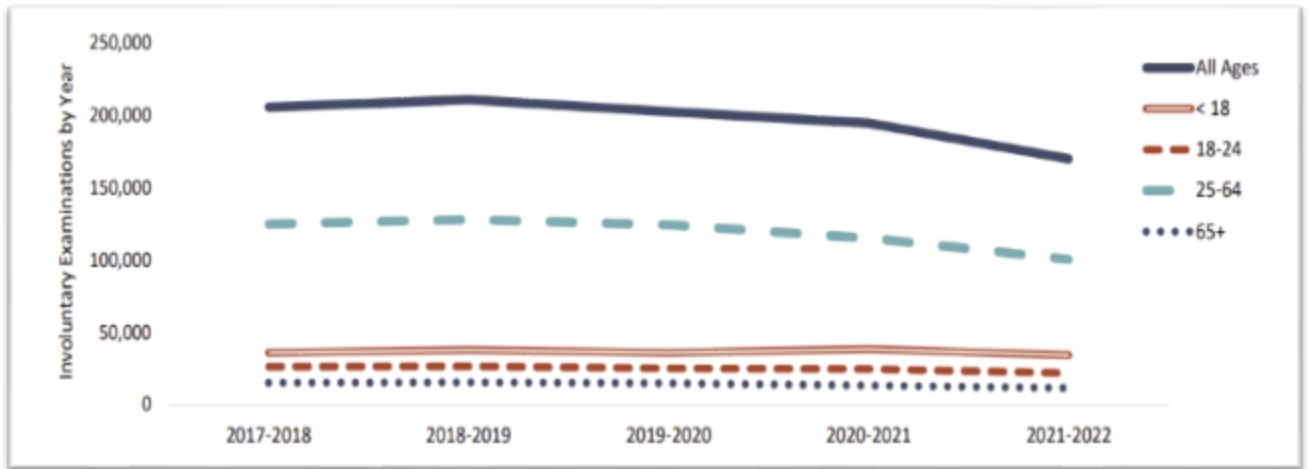
⁵¹ DCF, *The Baker Act Florida Mental Health Act Fiscal Year 2021-2022 Report*, available at <https://www.myflfamilies.com/sites/default/files/2023-07/FY%202021%202022%20Annual%20Report.pdf>, (last visited January 21, 2024).

⁵² DCF, *Report on Involuntary Examination of Minors*, available at https://www.usf.edu/cbcs/baker-act/documents/ba_minors_report_nov2023.pdf, (last visited January 21, 2024).

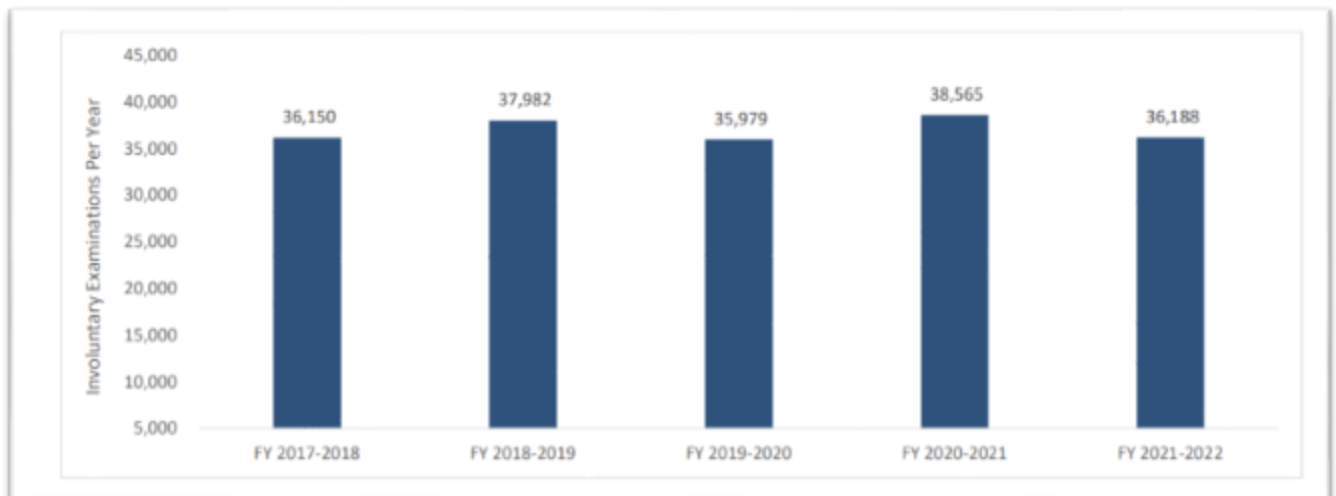
⁵³ *Id.*

involuntary examinations for the year.⁵⁴ According to the annual Baker Act Report, 12.40 percent of Baker Act examinations for children were initiated while at school.⁵⁵

Involuntary Examinations For 5 FY for All Ages⁵⁶



Involuntary Examinations for Children (< 18) for 5 FY Years⁵⁷



Involuntary Examinations for Children by Age Group for 5 FY Years⁵⁸

⁵⁴ *Id.*

⁵⁵ DCF, *The Baker Act Florida Mental Health Act Fiscal Year 2021-2022 Report*, available at <https://www.myflfamilies.com/sites/default/files/2023-07/FY%202021%202022%20Annual%20Report.pdf>, (last visited January 21, 2024).

⁵⁶ DCF, *Report on Involuntary Examination of Minors*, available at https://www.usf.edu/cbcs/baker-act/documents/ba_minors_report_nov2023.pdf, (last visited January 21, 2024).

⁵⁷ *Id.*

⁵⁸ *Id.*



Report on Involuntary Examinations of Minors

Under current law, DCF is required to prepare a report on the initiation of involuntary examinations of minors age 17 years and younger and submit the report by November 1 of each year.⁵⁹ The report must:⁶⁰

- Analyze data on both the initiation of involuntary examinations of children and the initiation of involuntary examinations of students who are removed from a school⁶¹;
- Identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child or student;
- Study root causes for such patterns, trends, or repeated involuntary examinations; and
- Make recommendations to encourage the use of alternatives to eliminate inappropriate initiations of such examinations.

Student Mental Health

In 2018, the Marjory Stoneman Douglas High School Public Safety Act⁶² created the Mental Health Assistance Allocation within the Florida Education Finance Program.⁶³ The allocation is intended to provide funding to assist school districts in establishing or expanding school-based mental health care, train educators and other school staff in detecting and responding to mental health issues, and connect children, youth, and families who may experience behavioral health issues with appropriate services.⁶⁴ For the 2023-2024 school year \$160,000,000 was appropriated for the allocation.⁶⁵ Each school district receives a minimum of \$100,000, and the remaining balance is allocated based on each district's proportionate share of the state's total unweighted full-time equivalent student enrollment.⁶⁶

To receive allocation funds, a school district must develop and submit to the district school board for approval a detailed plan outlining its local program and planned expenditures.⁶⁷ A school district's plan must include all district schools, including charter schools, unless a charter school elects to submit a

⁵⁹ S. 394.463(4), F.S. The report must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

⁶⁰ *Id.*

⁶¹ Each district school board is required to annually report to DCF the number of involuntary examinations that were initiated at school, on school transportation, or at a school-sponsored activity. S. 1006.07(10), F.S.

⁶² Chapter 2018-3, L.O.F.

⁶³ Section 1006.041, F.S.

⁶⁴ *Id.*

⁶⁵ Specific Appropriations 5 and 80, s. 2, ch. 2023-239, L.O.F.

⁶⁶ S. 1011.62(13), F.S.; See also Florida Department of Education, *Florida Education Finance Program 2023-24 Second Calculation*, p. 28, available at <https://www.fldoe.org/core/fileparse.php/7507/urlt/2324FEFP2ndCalc.pdf>, (last visited January 22, 2024).

⁶⁷ S. 1006.041(1), F.S.

plan independently from the school district.⁶⁸ Each approved plan must be submitted to the Commissioner of Education by August 1 each year.⁶⁹

The plan must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care.⁷⁰

Plans must include components such as:⁷¹

- Direct employment of school-based mental health service providers to expand and enhance school-based student services and reduce the ratio of students to staff to align with nationally recommended ratio models.
- Contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Team services to provide behavioral health staff presence and services at district schools.
- Policies and procedures which ensure:
 - Students who are referred to a school-based or community-based mental health service provider for mental health screening are assessed within 15 days of referral;
 - School-based mental health services are initiated within 15 days after identification and assessment and community-based mental health services are initiated within 30 days after school or district referral;
 - Parents and of a student receiving services are provided information about other behavioral services available through the student's school or local community-based behavioral health service providers; and
 - Individuals living in a household with a student receiving services are provided information about behavioral health services available through other delivery systems or payors for which the individuals may qualify, if such services appear to be needed or enhancement in such individual's behavioral health would contribute to the improve well-being of the student.
- Strategies or programs to reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems; depression; anxiety disorders; suicidal tendencies; or substance use disorders.
- Strategies to improve the early identification of social, emotional, or behavioral problems or substance use disorders; to improve the provision of early intervention services; and to assist students in dealing with trauma and violence.
- Procedures to assist a mental health services provider or a behavioral health provider, or a school resource officer or school safety officer who has completed mental health crisis intervention training with attempting to verbally de-escalate a student's crisis situation before initiating an involuntary examination.
- Policies requiring that school or law enforcement personnel, prior to initiating an involuntary examination, make a reasonable attempt to contact a mental health professional authorized to initiate an involuntary examination, unless the student in crisis poses an imminent danger to him- or herself or others.

School districts are also required to report program outcomes and expenditures for the previous fiscal year by September 30 each year.⁷² The report must, at a minimum, provide the number of each of the following:⁷³

- Students who receive screenings or assessments.

⁶⁸ *Id.*

⁶⁹ S. 1006.041(3), F.S.

⁷⁰ S. 1006.041(2), F.S.

⁷¹

⁷² Section 1006.041(4), F.S.

⁷³ *Id.*

- Students who are referred to either school-based or community-based providers for services.
- Students who receive either school-based or community-based interventions, or assistance.
- School-based and community-based mental health providers, including licensure type, that were paid out of the mental health assistance allocation.
- Contract-based or interagency agreement-based collaborative efforts or partnerships with community mental health programs, agencies, or providers.

Effect of the Bill

PCS for HB 1169 establishes a mental health treatment and support system within school districts. The bill requires school districts that provide mental health assessment, diagnosis, intervention, treatment, and recovery services to students diagnosed with, or at risk of being diagnosed with, one or more mental health issues or any co-occurring substance use disorder to adhere to the guiding principles and the performance outcomes requirements under DCF child and adolescent mental health treatment and support system when implementing and developing a mental health support system within the school district. Adhering to these principles and guidelines will help to further promote effective implementation of a coordinated system of care.

The bill requires each school district to report to the Department of Education, annually, the general performance outcomes for the child and adolescent mental health treatment and support system and how funding for the support system is allocated and spent.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 397.96, F.S., relating to care coordination.

Section 2: Creates s. 1006.041, F.S., relating to mental health coordinated system of care.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill may have an indeterminate negative fiscal impact on the Department of Education to accommodate the annual reporting requirement for school districts.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

School districts may incur additional expenses related to implementing the provisions of the bill and complying with the additional reporting requirements. The impact is indeterminate.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not provide rulemaking authority to implement the bill. However, the department has sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES