HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 947 Involuntary Examination and Involuntary Admission of Minors
SPONSOR(S): Health & Human Services Committee; Children, Families & Seniors Subcommittee; Payne
TIED BILLS: **IDEN./SIM. BILLS:** SB 270

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	11 Y, 0 N, As CS	Langston	Brazzell
2) Health & Human Services Committee	20 Y, 0 N, As CS	Langston	Calamas

SUMMARY ANALYSIS

In 1971, the Legislature passed the Florida Mental Health Act (also known as "The Baker Act") to address the mental health needs of individuals in the state. The Baker Act allows for voluntary and, under certain circumstances, involuntary, examinations of individuals suspected of having a mental illness and presenting a threat of harm to themselves or others. An individual may be held for an involuntary examination for up to 72 hours. When the patient is a minor, the examination must be initiated within 12 hours after the minor patient arrives at the facility.

In 2017, the Legislature created a task force within the Department of Children and Families (DCF) to address the issue of involuntary examination of minors (Task Force). The Task Force reported its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives on November 15, 2017. Among them were recommendations to:

- Encourage school districts to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of an involuntary examination.
- Require Youth Mental Health First Aid or Crisis Intervention Team (CIT) training for school resource officers and other law enforcement officers who initiate involuntary examinations from schools.
- Increase the number of days, from the next working day to five working days that the receiving facility has to submit forms to DCF, to allow DCF to capture data on whether the minor was admitted, released, or a petition filed with the court.
- Require school administrators to notify a student's parent, guardian, or caregiver before an involuntary examination is initiated and the student is removed from school, school transportation, or a school-sponsored activity.

CS/CS/HB 947 implements these four Task Force recommendations. Additionally, it allows a facility the option of initiating either an assessment by a service provider or the examination within 12 hours for a minor held for an involuntary examination.

The bill will not have a fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2018.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

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. Only about 17% of adults in the United States are considered to be in a state of optimal mental health.[4] One in five adults (43.8 million people) experiences mental illness in a given year, [5] and one in five children ages 13-18 have or will have a serious mental illness.[6] 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 younger, before any symptoms appear.[7]

Baker Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. [8] The Act provides 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.[9]

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[1] Centers for Disease Control and Prevention, *Mental Health Basics*, (Oct. 4, 2013), available at http://www.cdc.gov/mentalhealth/basics.htm (last visited January 25, 2018).
[2] Id.
[3] Id.
[4] Id. Mental illness can range in severity from no or mild impairment to significantly disabling impairment. Serious mental illness is a mental disorder that has resulted in a functional impairment that substantially interferes with or limits one or more major life activities. National Institute of Mental Health, *Any Mental Illness (AMI) Among Adults*, available at http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml (last visited January 25, 2018).
[5] National Alliance on Mental Illness, *Mental Health Facts in America,* available at http://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf (last visited January 25, 2018).
[6] National Alliance on Mental Illness *Mental Health Facts: Children & Teens*, available at http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf (last visited January 25, 2018).
[7] National Institute of Mental Health, *Treatment of Children with Mental Illness*, (rev. 2009), available at https://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml (last visited January 25, 2018).
[8] Sections 394.451-394.47892, F.S.
[9] Section 394.459, F.S.

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.[10] 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[11]:

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; **and**
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **or**
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Involuntary patients must be taken to either a public or a private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[12] 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.[13] 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.[14]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[15] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[16] The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[17] Individuals often enter the public mental health system through CSUs.[18] For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by Legislature in the 1970s to ensure continuity of care for individuals.[19]

As of November 2015, there are 122 Baker Act receiving facilities in this state, including 53 public receiving facilities and 69 private receiving facilities.[20] Of the 53 public receiving facilities, 39 are also contracted to provide CSU services.[21]

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[10] Sections 394.4625 and 394.463, F.S.
[11] Section 394.463(1), F.S.
[12] Section 394.455(39), F.S. This term does not include a county jail.
[13] Section 394.455(37), F.S
[14] Rule 65E-5.400(2), F.A.C.
[15] Section 394.875(1)(a), F.S.
[16] Id
[17] Id.
[18] Florida Senate, Budget Subcommittee on Health and Human Services Appropriations, *Crisis Stabilization Units*, (Interim Report 2012-109) (Sept. 2011), available at https://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-109bha.pdf (last visited January 25, 2018).
[19] Id. Sections 394.65-394.9085, F.S.
[20] Department of Children and Families, *Crisis Stabilization Services Utilization Data Implementation Status Report*, (Feb. 29, 2016), available at http://www.dcf.state.fl.us/programs/samh/publications/CSSUReport.pdf (last January 25, 2018).
[21] Id.

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[22] 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.[23] If the patient is a minor, the examination must be initiated within 12 hours.[24]

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:

- 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.[25]

There were 194,354 involuntary examinations in Fiscal Year 2015-2016, 32,475 of which were of minors.[26]

Involuntary Examinations FY 2001-2002 through FY 2015-2016[27]

Fiscal Year	All Ages		Children (< 18)	
	Involuntary Examinations	% Increase to FY 2015/2016	Involuntary Examinations	% Increase to FY 2015/2016
2015-2016	194,354	Not Applicable	32,475	Not Applicable
2014-2015	187,999	3.38%	32,650	-0.54%
2013-2014	177,006	9.8%	30,355	6.98%
2012-2013	163,850	18.62%	26,808	21.14%
2011-2012	154,655	25.67%	24,836	30.76%
2010-2011	145,290	33.77%	21,752	49.30%
2009-2010	141,284	37.56%	21,128	53.71%
2008-2009	133,644	45.43%	20,258	60.31%
2007-2008	127,983	51.86%	19,705	64.81%
2006-2007	120,082	61.85%	19,238	68.81%
2005-2006	118,722	63.71%	19,019	70.75%
2004-2005	114,700	69.45%	19,065	70.34%
2003-2004	107,705	80.45%	18,286	77.59%
2002-2003	103,079	88.55%	16,845	92.79%
2001-2002	94,574	105.50%	14,997	116.54%

Parental Notification for Involuntary Examination of Minors

Section 381.0056, F.S., requires a school health services plan to include immediate notification of a student's parent or guardian if the child is removed from school, school transportation, or a school-sponsored activity and taken for an involuntary examination. This plan must include the requirements in ss. 1002.20(3) and 1002.33(9), F.S., for parental notification when a minor is removed for an involuntary examination.[28] Sections 1002.20 and 1002.33 F.S., require a school's principal or the principal's designee to immediately notify the parent of a student who is removed from school, school

[22] Section 394.463(2)(g), F.S.
[23] Section 394.463(2)(f), F.S.
[24] Section 394.463(2)(g), F.S.
[25] *Supra* note 20.
[26] Id. at p. 5.
[27] Id.
[28] Section 381.0056(4)(a)19., F.S.

transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination.[29] However, immediate notification is not necessary and may be delayed up to 24 hours if the principal or the principal's designee deems the delay to be in the student's best interest and a report of abuse, abandonment, or neglect has been submitted to the DCF central abuse hotline.

Receiving facilities must give prompt notice[30] of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,[31] guardian advocate,[32] health care surrogate or proxy, attorney, or representative.[33] If the patient is a minor, the receiving facility must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice for an adult may be provided within 24 hours of arrival; however, notice for a minor must be provided immediately after the minor's arrival at the facility. The facility may delay the notification for a minor for up to 24 hours if it has submitted a report of abuse, abandonment, or neglect to the DCF central abuse hotline. The receiving facility must attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until it receives confirmation that the notice has been received. Attempts must be repeated at least once every hour during the first 12 hours after the minor's arrival and then once every 24 hours thereafter until confirmation is received, the minor is released, or a petition for involuntary services is filed with the court.[34]

Task Force Report on Involuntary Examination of Minors

During the 2017 Legislative session, the Legislature passed HB 1121, which the Governor signed as ch. 2017-151, Laws of Florida. One of the provisions of the bill created a task force within DCF to address the issue of involuntary examination of minors 17 years old and younger (the Task Force). The bill required the Task Force to:

- Analyze data on the initiation of involuntary examinations of children;
- Research the root causes of trends in such examinations;
- Identify and evaluate options for expediting examinations for children; and
- Identify recommendations for encouraging alternatives to these examinations.

The Task Force was comprised of stakeholders from the education, mental health, law enforcement, and legal fields. The Task Force was required to submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2017; the Task Force submitted its report on November 15, 2017.[35]

Data Analysis

Based on an analysis of available data regarding involuntary examinations of minors, the Task Force found that:[36]

- Involuntary examinations for children occur in varying degrees across counties.
- There is an increasing trend statewide and in certain counties to initiate involuntary examinations of minors.

[29] Sections 1002.20(3)(l) and 1002.33(9)(q), F.S.
[30] Notice may be provided in person or by telephone; however, in the case of a minor, notice may also be provided by other electronic means. Section 394.455(2), F.S.
[31] "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. Section 394.455(17), F.S.
[32] "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment. Section 394.455 (18), F.S.
[33] Section 394.4599(2)(b), F.S.
[34] Section 394.4599(c), F.S.
[35] Department of Children and Families, Office of Substance Abuse and Mental Health, *Task Force Report on Involuntary Examination of Minors*, (Nov. 15, 2017), *available at*, http://www.dcf.state.fl.us/programs/samh/publications/S17-005766-TASK%20FORCE%20ON%20INVOLUNTARY%20EXAMINATION%20OF%20MINORS.pdf (last visited January 24, 2018).
[36] Id. at p. 20.

- 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 correlate with increases of involuntary examinations of children, although it is important to note that the analyses did 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.

Root Causes of Increased Involuntary Examinations of Minors

Based on data, information currently available, and the complexity of this issue, the Task Force determined that it is not possible to identify specific root causes directly linked to the trend of increased Baker Act initiations. However, it identified the following areas as potential root causes or contributing factors to the increase in Baker Act initiations among children in Florida:[37]

- Social stressors and risk factors, including, but not limited to, child abuse and trauma; parents or caretakers with substance use disorders or mental illnesses affecting their parental capability; school and public shootings; and social media and cyber bullying.
- Prevalence of behavioral health disorders among children and teens.
- Limited availability of and access to a continuum of services and supports.
- Inadequate investment in the lives of children, youth, and families, including waiting lists for services, limitations on coverage or approval, a lack of funding for prevention and diversion services, and a shortage of psychiatrists.

It also noted that the increased use of involuntary examinations under the Baker Act for minors could be the positive result of years of systemic changes to increase awareness and action when minor is experience a crisis.[38] For example, law enforcement and other first responders are being trained to recognize the symptoms of mental illness and initiate Baker Act examinations rather than arresting minors.[39]

Options for Expediting the Involuntary Examination of Minors

The Task Force identified two options for expediting the involuntary examination of minors. The first option is to expand the list of mental health professionals who can conduct the clinical examination.[40] The Task Force suggested expanding from physicians, clinical psychologists, and psychiatric nurses to also include physician assistants, licensed clinical social workers, licensed mental health counselors, and licensed marriage and family therapists.[41] It also suggested increasing funds for mobile crisis teams, which could be used to establish additional teams to provide statewide coverage.[42]

[37] Id. at pp. 21-25.
[38] Id. at p. 24.
[39] Id.
[40] Id. at 25.
[41] Id.
[42] Id. Mobile crisis teams are deployed before someone in crisis arrives 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.

Recommendations

The Task Force made six recommendations for encouraging alternatives to and eliminating inappropriate initiations of involuntary examinations of minors under the Baker Act:[43]

- Fund an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis.
- Expand access to outpatient crisis intervention services and treatment.
- Create within DCF 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.
- Encourage school districts, through legislative intent language, to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination.[44]
- Revise s. 394.463(2)(a)3, F.S., to include school psychologists licensed under ch. 490, F.S. to the list of mental health professionals who are qualified to initiate a Baker Act.
- Require Youth Mental Health First Aid or Crisis Intervention Team (CIT) training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools.[45]

Additionally, the Task Force recommended amending s. 394.463(2)(a), 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 to DCF required by s. 394.463(2)(e), F.S.[46] The Task Force states that this change would allow DCF to capture data on whether the minor was admitted, released, or a petition filed with the court.[47]

The Task Force also recommended amending s. 381.0056(4)(a)19, F.S., to require school administrators to notify a student's parent, guardian, or caregiver before an involuntary examination is initiated and the student is removed from school, school transportation, or a school-sponsored activity.

Effect of Proposed Changes

CS/HB 947 implements four Task Force recommendations. It amends s. 394.463(2)(a), F.S., to increase the number of days that the receiving facility has to submit forms to DCF required by s. 394.463(2)(e), F.S., from the next working day to five working days, to allow DCF to capture data on whether the minor was admitted, released, or a petition was filed with the court. By extending the facilities' time to submit forms to DCF, DCF will now know whether the minor was admitted, released, or a petition was filed with the court.

The bill amends ss. 381.0056(4)(a)19., 1002.20(3)(l) and 1002.33(9)(q), F.S., to require a principal or a principal's designee to notify a student's parent, guardian, or caretaker prior to removing the student for an involuntary examination under s. 394.643, F.S., if such notification will not cause a delay that jeopardizes the student's or another individual's physical or mental health or safety.

[43] *Supra*, note 35 at pp. 26-28.
[44] The Task Force found that data supports 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.
[45] 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. Additionally, 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.
[46] *Supra*, note 35 at p. 30.
[47] Id.

The bill also requires employers to give school resource officers and school safety officers priority for enrollment in any crisis intervention training, Mental Health First Aid training, or similar training offered. The bill identifies other similar trainings as ones that identify students or other individuals who may have a mental illness, substance use disorder, or be in a behavioral health crisis and teach approaches and techniques for addressing their needs.

The bill also requires the Department of Education (DOE), in consultation with the Statewide Office for Suicide Prevention and suicide prevention experts, to add suicide screening as part of its requirements for "Suicide Prevention Certified Schools." DOE must keep a list of "Suicide Prevention Certified Schools" on its website, and school districts must post on their websites a list of "Suicide Prevention Certified Schools" in their districts.

Additionally, the bill requires DOE to identify available standardized suicide screening instruments that are appropriate to use with a school-age population and have acceptable validity and reliability, and include information about obtaining instruction in their administration and use. The suicide screening will be used alongside awareness and prevention materials for training instructional personnel in elementary, middle, and high schools in youth suicide awareness, prevention, and screening.

In addition to adopting recommendations from the Task Force, the bill allows a facility the option of initiating either an assessment by a service provider[48] or the examination within 12 hours for a minor held for an involuntary examination.

The bill provides an effective date of July 1, 2018.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.0056, F.S., relating to school health services program.
Section 2: Amends s. 394.463, F.S., relating to involuntary examination.
Section 3: Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
Section 4: Amends s. 1002.33, F.S., relating to charter schools.
Section 5: Amends s. 1006.12, F.S., relating to school resource officers and school safety officers.
Section 6: Amends s. 1012.583, F.S., relating to continuing education and inservice training for youth suicide awareness and prevention.
Section 7: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

[48] This includes a psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician, a psychiatrist, an advanced registered nurse practitioner, a psychiatric nurse, or a physician assistant. S. 394.455(44), F.S.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

An elementary, middle, or high school that voluntarily elects to be a “Suicide Prevention Certified School” may incur indeterminate, insignificant costs to train personnel on the suicide screening instrument. These costs could likely be absorbed within existing resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 30, 2018, the Children, Families, and Seniors Subcommittee adopted a proposed committee substitute and reported the bill favorably as a committee substitute. The committee substitute differs from the bill as filed by:

- Removing the provisions of the original bill that:
  - Authorized a parent or guardian, in lieu of a designated law enforcement agency, to transport a minor 14 years of age or younger to a designated receiving facility.
  - Required the consent of the parent or guardian before a designated law enforcement agency could transport a minor 14 years of age or younger to a receiving facility for involuntary examination.
  - Required an involuntary examination to be initiated within 8 hours after a minor 14 years of age or younger arrives at receiving facility.
  - Requiring a receiving facility to release a minor 14 years of age or younger without delay to their parent or guardian upon their request.
- Implementing recommendations from the task force within the Department of Children and Families that addressed the issue of involuntary examination of minors to:

- Encourage school districts to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of an involuntary examination.
- Require Youth Mental Health First Aid or CIT training for school resource officers and other law enforcement officers who initiate involuntary examinations from schools.
- Increase the number of days, from the next working day to five working days that the receiving facility has to submit forms to DCF, to allow DCF to capture additional data.

On February 7, 2018, the Health and Human Services Committee adopted an amendment that:

- Allowed a facility to initiate an assessment by a service provider within 12 hours for a minor held for an involuntary examination under s. 394.643, F.S., to satisfy the expedited time frame for minors.
- Required schools to notify a student's parent, guardian, or caretaker prior to removing the student for an involuntary examination under s. 394.643, F.S., if such notification will not cause a delay that jeopardizes the student's or another individual's physical or mental health or safety.

The bill was reported favorably as a committee substitute. This analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.