STATE OF FLORIDA

Best Practices Response Protocol for Schools to Use Mobile Response Teams

DEVELOPED BY: **Louis de la Parte Florida Mental Health Institute (FMHI)**

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Best Practices Response Protocol for Schools to Use Mobile Response Teams

Introduction

Florida's students now have access to additional resources and services to support their mental health needs with the passage of HB 945 (https://www.flsenate.gov/Session/Bill/2020/945/BillText/er/PDF). This Children's Mental Health bill was sponsored by State Representative David Silvers (D-District 87) and co-sponsored by State Representative Jennifer Webb (D-District 69). Schools will be better equipped to support students facing mental health challenges. The bill focuses on three key areas: (1) mobile response teams, (2) coordination of children's system of care, and (3) crisis stabilization services. Representative Silvers stated: "We have a responsibility to ensure our schools, teachers, administrators and others have access to the support and services needed for children and youth in our schools struggling with mental and behavioral health challenges." He also commented that: "The goal of this bill is to protect children from additional trauma while also providing a safe, caring environment for children as well as their classmates and teachers."

As part of the bill, the Louis de la Parte Florida Mental Health Institute (FMHI) was charged with developing a best practices response protocol for schools to use mobile response teams (MRT) when students are experiencing a behavioral health crisis and have been assessed to be at risk for harming themselves or others. This charge followed from the role that FMHI has played in the state. FMHI was established by the Florida legislature and is well versed in the field of children's mental health. For more than 45 years, FMHI has strived to contribute to a sustainable well-being within the community, particularly that of our children. The work that FMHI has done over the years has supported positive change around critical issues in children's mental health through local and statewide alliances.

The following page (page 2) displays an infographic that describes the best practices response protocol. This protocol has been developed for schools to use MRTs when students are experiencing a behavioral health crisis and have been assessed to be at risk for harming themselves or others. This protocol can also be used for e-learners in conjunction with school-based mental health personnel and MRTs. Also developed as part of HB 945 is a tool entitled School Crisis Response Implementation Protocol Tool (SCRIPT; page 6) to assist School Districts. In developing this best practices response protocol, FMHI consulted with key stakeholders who shared their insights and perceptions. In addition, several essential data sources were used to define best practice including, the successes and barriers of MRT implementation shared by key stakeholders, MRT data by county provided by the managing entities, MRT telehealth data from the Northeast region, involuntary examinations data for children in Florida provided by the Baker Act Reporting Center, state and national best practice resources, and relevant Florida bills and statutes (See Appendices A-F).

Best Practices Response Protocol for Schools to Use Mobile Response Teams (MRT)

MRT Protocol Goals

- Coordinated School and Community Crisis Intervention response
- De-escalation of crisis
- Least restrictive environment
- Reduce risk of trauma
- De-escalation, referral and follow-up
- Coordination of care with Schools, MRTs, and Law Enforcement

School-Based Mental Health Provider (SBMH)
A certified and/or licensed mental health services provider (i.e., certified school psychologist, school social worker, school counselor or licensed mental health provider).

Mobile Response Team (MRT)
MRT's are private/agency providers that are contracted through the Managing Entity to provide crisis response services. The team includes licensed mental health providers.

A K-12 student presents mental health crisis at school; without care, the student may cause harm to self, as evidenced by recent behavior.

PATH OF DE-ESCALATION

School de-escalation strategies begin (parent/guardian may be contacted)

A Certified or Licensed School-Based Mental Health Provider (SBMH) evaluates student using DOE approved Suicide Risk Assessment.

School de-escalation strategies continue

Principal or designee verifies school de-escalation strategies are implemented.

GOAL

Student returns to class

GOAL: Successful De-escalation

School de-escalation strategies continue

Mobile Response Team (MRT) is contacted by the School-Based Mental Health Provider and responds within 60 minutes either in person or telehealth.

GOAL

MRT de-escalation strategies (parent/guardian contacted as clinically indicated)

MRT initiates Baker Act when the student is at imminent risk of harm to self and arranges for transportation to a Baker Act receiving facility.

Principal or designee notifies student's parent or guardian as soon as possible but within 24 hours.

SBMH provider reports to school threat assessment team (STAT). The STAT contacts district re-entry or mental health teams and appropriate agencies to coordinate follow up.

Student returns to class

When to Call Law Enforcement or initiate a Baker Act immediately

- When it is believed that the student is at continued imminent risk of harming others after de-escalation strategies have been attempted.
- The MRT initiates involuntary examination requiring law enforcement transportation to a receiving facility.

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Best Practices Response Protocol for Schools

Mobile Response Teams (MRT) Protocol Goals

- To provide a best practices protocol for the coordination of care between schools, MRTs, and law enforcement for students experiencing a mental health crisis.
- To ensure timely coordinated school and community crisis intervention response.
- To ensure implementation of de-escalation strategies throughout the mental health crisis.
- To ensure students experiencing a mental health crisis are provided services in the least restrictive environment.
- To reduce the risk of trauma and re-traumatization.
- To ensure coordination of de-escalation, referral, and follow-up of schools, community interventions, and supports.

Instructions to Use Best Practices Response Protocol

Best Practices Response Protocol Steps

- K-12 student presents with mental health concerns at school indicating a risk of self-harm.
- School personnel engage in de-escalation strategies with the student throughout the response (parent/guardian may be contacted). At any point de-escalation strategies are successful, the student will return to class.
- Suicide Risk Assessment is completed by a certified and/or licensed School-Based Mental Health Provider (e.g., certified School Psychologist, School Social Worker, School Counselor or licensed Mental Health Provider). The evidence-based and Florida Department of Education (DOE) approved suicide risk assessments currently include:
  - Columbia-Suicide Severity Rating Scale (C-SSRS)
  - Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)
- Suicide Risk Assessment determines if a student is at imminent risk of self-harm.
- School principal or designee verifies school de-escalation strategies were implemented prior to contacting the MRT.
- School-Based Mental Health Provider (School Psychologists, Clinical Social Workers, and Mental Health Counselors) contacts the MRT (parent/guardian contacted as clinically indicated). See page 5 for more on parental consent and page 12 for more information regarding Memorandums of Understanding (MOUs) and school districts.
- De-escalation strategies are continued by School-Based Mental Health Provider while awaiting MRT response. If de-escalation strategies are successful, then the student should be connected to resources if ongoing behavioral health services are needed.
- MRT responds to the school request in person (when requested) or via telehealth within 60 minutes. Examples of Utilizing Telehealth include:
  - The school-based mental health provider indicates that crisis intervention and assessment is required immediately.
  - MRT telehealth video conferencing would assist with de-escalating the student.

- The MRT provider is not able to meet the requirement of responding in-person to the student's location within 60 minutes of the call to the MRT.
- If MRT professional is not licensed, utilize telehealth in order to contact licensed MRT professional.

- School principal or designee notifies student's parent or guardian of crisis intervention as soon as possible but within 24 hours after student is removed from school.
- School-Based Mental Health provider reports to School Threat Assessment Team (STAT). The STAT contacts district re-entry or mental health teams, MRT, and appropriate agencies within the local system of care based on the child's needs.
  - Information on MRT should be provided to parents as part of orientation as a resource to utilize in the community or during distance learning.
  - MRT can be used following a crisis episode/Baker Act as part of discharge and transition planning back to school.
- School Crisis Response Implementation Protocol Tool (SCRIPT) is completed by the school to document the crisis response process.

Additional Information

- The MRT provides:
  - Behavioral health crisis-oriented services
  - Evidence-based de-escalation strategies
  - Screening, assessment, and referrals to community-based providers
  - 72-hour short-term care coordination
- Provided below are some examples of ways that telehealth may be used:
  - School-Based Mental Health Provider indicates the immediate need for crisis intervention and assessment.
  - MRT telehealth video conferencing would assist with de-escalating the student.
  - MRT provider is not able to meet the requirement of responding in-person to the student's location within 60 minutes.
- When to call law enforcement or initiate a Baker Act immediately (HB945 does not supersede the authority of a law enforcement officer at act under s. 394.463
  - Student is at imminent risk of harming others.
  - Risk requires immediate law enforcement response to prevent harm to the student or others.
  - MRT initiates involuntary examination requiring law enforcement transportation to a Baker Act receiving facility.
- If necessary, involuntary examination may be initiated by:
  - A physician licensed under chapter 458 or chapter 459, a licensed clinical psychologist as defined in s. 490.003(7), an advanced practice registered nurse registered under s. 464.0123, a licensed mental health counselor under chapter 491, a licensed marriage and family therapist under chapter 491, or a licensed clinical social worker under chapter 491.
  - The qualified professional may execute a certificate stating that he or she has examined the student within the preceding 48 hours and finds that the student appears to meet the criteria for involuntary examination (s. 394.463, F.S.).

- Parental Consent
  - Currently, section 394.4784, F.S. allows minors age 13 years or older to request, consent to, and receive mental health diagnostic and evaluative services by a licensed mental health professional.
  - Parental consent must be obtained by the MRT or Principal/designee prior to the MRT assessing a student, when the MRT responding is not a licensed mental health provider, or is the youth is age 12 years or younger. This process should be outlined by the parties in an MOU. See page 12 for more information regarding MOUs.
  - Parental consent is not required for the initiation of a student Involuntary Examination as found in Florida Statutes section 394.463 (2020).
  - *Florida Statutes* 394.463 (2020) states: http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=involuntary+examination+of+a+minor&URL=0300-0399/0394/Sections/0394.463.html

    (1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:

    (a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

    2. The person is unable to determine for himself or herself whether examination is necessary; and

    (b)1. 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

    2. 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.

SCRIPT Florida School Crisis Response Implementation Protocol Tool

Student Information					
Student Name:		Age:		Date:	/ /
School Based Mental Health Provider Name:					
Name of School:					
Education Level:	☐ Elementary School	☐ Middle School	☐ High School		

De-escalation Strategies Utilized: (Please provide a detailed description of methods for de-escalation)	
De-escalation Verification by Principal or (Designee) Signature:	

Suicide Assessment Tools Utilized:	☐ Columbia Suicide Severity	☐ SAFE-T Suicide Assessment

Mobile Response Team (MRT) Information			
Assigned MRT Provider Name:			
Time of Call Initiation:		Time of Arrival:	
Type of Mobile Response Team Contact:	☐ In-person Contact	☐ Telehealth Meeting	

De-escalation Strategies Utilized by MRT: (Provide a detailed description of methods for de-escalation)			
Outcome:	☐ Baker Act	☐ Linked to Community Resources	☐ Return to Class

Please complete the following *(if Baker Act was initiated)*:					
Was Law Enforcement Officer (LEO) Contacted?	☐ Yes ☐ No	Who contacted LEO? (*include name/ position*)			
If yes: Time of Call:		Time of Arrival:		Time of Departure:	
Transporting Officer *(full name):*					
Parent/ Guardian Contacted by Principal (or Designee):	☐ Yes ☐ No				
Date of Parent/ Guardian Contact:		Time of Parent/Guardian Contact:			

Threat Assessment Team Alerted (Signature/Date):		/ /
School Safety Plan Created (Signature/Date):		/ /

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Instructions for the School Crisis Response Implementation Protocol Tool (SCRIPT)

The SCRIPT is a tool to assist School Districts and Stakeholders in reviewing the MRT and Schools protocol utilization data to help with HB 945 compliance and inform future decisions and directions. It is recommended that it be included in the MOU and that the school-based mental health professional complete the SCRIPT for all K-12 district students that present with a mental health crisis and a risk of self-harm. Given the confidential nature of the information, it is also recommended that completed forms be kept confidential in a locked filing cabinet within the school-based mental health professional's office or in another school location that can facilitate the storage of confidential information. If completed electronically, file folder should be password protected. Below is an outline of the information that is gathered for the SCRIPT.

- Student Information
  - Student Name
  - Age
  - Date
  - School Based Mental Health Provider Name
  - Name of School
  - Education Level
- De-escalation Strategies Utilized (provide detailed description of de-escalation methods)
  - De-escalation verification by Principal or (Designee) Signature
  - Suicide Assessment Tools Utilized (either Columbia Suicide Severity or SAFE-T Suicide Assessment)
  - MRT Information
  - Assigned MRT Provider Name
  - Time of Call Initiation
  - Time of Arrival
  - Type of Mobile Response Team Contact (either in-person contact or telehealth meeting)
- De-escalation Strategies Utilized by MRT (provide detailed description of de-escalation methods)
  - Outcome:
    - Baker Act
    - Linked to community resources
    - Return to class
- Complete Following if Baker Act Initiation
  - Was Law Enforcement Officer (LEO) contacted?
    - Who contacted LEO?
    - Time of Call
    - Time of Arrival
    - Time of Departure
  - Transporting Officer (full name)
  - Parent/ Guardian Contacted by Principal (or Designee)
  - Date of Parent/ Guardian Contact
  - Time of Parent/Guardian Contact
  - Threat Assessment Team Alerted (Signature/Date)
  - School Safety Plan Created (Signature/Date)

House Bill 945

The bill specifically added crisis response services, provided through mobile response teams, to the array of mental health services available to meet the individualized service and treatment needs of children and adolescents throughout the state. The bill further requires a principal or designee to verify that de-escalation strategies have been appropriately used with a student and outreach to a MRT has been initiated before contacting a law enforcement officer, unless a delay will increase the likelihood of harm to the student or others. The goals of the bill are as follows:

- Timely access to crisis intervention mental health services.
- Access to least intrusive mental health services necessary to prevent harm and meet student's mental health needs.
- Diversion from involuntary examination and placement, when possible, while providing de-escalation, referral, and follow up.
- Reduce law enforcement involvement unless a threatening situation arises.
- Reduce risk of trauma from a Baker Act.
- Increased coordination and collaboration between school mental health team, mobile crisis response providers, and law enforcement.

In Florida, Managing Entities are contracted by the Florida DCF for mobile response teams "to provide immediate, on-site behavioral health services to children and adolescents" who:

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

According to guidance requirement section 394.495(7), F.S., MRT services are provided by a team of licensed professionals, master's level professionals, and paraprofessionals trained in crisis intervention skills. In addition to helping resolve the crisis, MRTs work with individuals and families to identify resources, provide linkages, and develop strategies for effectively dealing with potential future crises. Supporting the "no wrong door" model, MRTs provide warm hand-offs and referrals to other services in the community to meet the ongoing needs of the individual and will follow-up to determine that the appropriate linkage is made. When the situation warrants, MRTs will assist with the individual being received by a designated receiving facility or a licensed substance abuse provider for further evaluation.

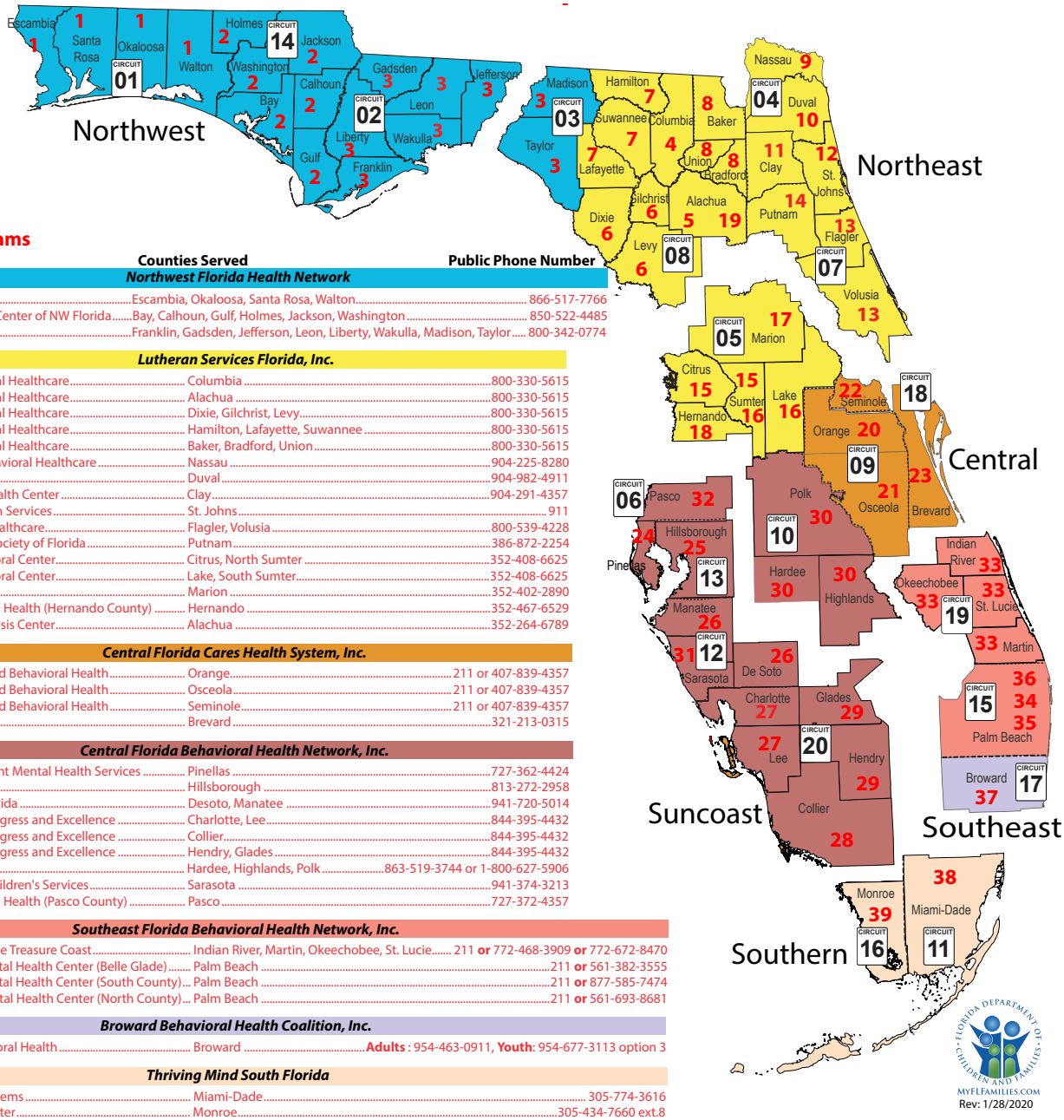
The 2017 Baker Act Task Force found that areas with MRTs serving children had lower rates of involuntary examinations via the Baker Act. In 2018, there was a total of 12 MRTs in 10 Florida Counties. During the 2018 Legislative session, the HB 7026 Marjory Stoneman Douglas High School Public Safety Act, (Ch. 2018-3, Laws of Florida) was passed. Section 48 of the law directed resources for the procurement of additional of mobile crisis teams, to ensure MRTs are available statewide. Therefore, funding was allocated to DCF for an additional 27 MRTs to ensure reasonable access among all counties (see Figure 1, page 9).

Figure 1

Florida Department of Children and Families, Substance Abuse and Mental Health

Managing Entity & Mobile Response Teams (MRTs)

https://www.myflfamilies.com/service-programs/samh/docs/maps/MRT.pdf



7-MES | 39-Teams

MRT Provider	Counties Served	Public Phone Number
Northwest Florida Health Network		
1. Lakeview Center	Escambia, Okaloosa, Santa Rosa, Walton	866-517-7766
2. Life Management Center of NW Florida	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	850-522-4485
3. Apalachee Center	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla, Madison, Taylor	800-342-0774
Lutheran Services Florida, Inc.		
4. Meridian Behavioral Healthcare	Columbia	800-330-5615
5. Meridian Behavioral Healthcare	Alachua	800-330-5615
6. Meridian Behavioral Healthcare	Dixie, Gilchrist, Levy	800-330-5615
7. Meridian Behavioral Healthcare	Hamilton, Lafayette, Suwannee	800-330-5615
8. Meridian Behavioral Healthcare	Baker, Bradford, Union	800-330-5615
9. Starting Point Behavioral Healthcare	Nassau	904-225-8280
10. Child Guidance	Duval	904-982-4911
11. Clay Behavioral Health Center	Clay	904-291-4357
12. St. Augustine Youth Services	St. Johns	911
13. SMA Behavioral Healthcare	Flagler, Volusia	800-539-4228
14. Children's Home Society of Florida	Putnam	386-872-2254
15. LifeStream Behavioral Center	Citrus, North Sumter	352-408-6625
16. LifeStream Behavioral Center	Lake, South Sumter	352-408-6625
17. The Centers	Marion	352-402-2890
18. BayCare Behavioral Health (Hernando County)	Hernando	352-467-6529
19. Alachua County Crisis Center	Alachua	352-264-6789
Central Florida Cares Health System, Inc.		
20. Devereux Advanced Behavioral Health	Orange	211 or 407-839-4357
21. Devereux Advanced Behavioral Health	Osceola	211 or 407-839-4357
22. Devereux Advanced Behavioral Health	Seminole	211 or 407-839-4357
23. Brevard C.A.R.E.S.	Brevard	321-213-0315
Central Florida Behavioral Health Network, Inc.		
24. Personal Enrichment Mental Health Services	Pinellas	727-362-4424
25. Gracepoint	Hillsborough	813-272-2958
26. Centerstone of Florida	Desoto, Manatee	941-720-5014
27. The Centers for Progress and Excellence	Charlotte, Lee	844-395-4432
28. The Centers for Progress and Excellence	Collier	844-395-4432
29. The Centers for Progress and Excellence	Hendry, Glades	844-395-4432
30. Peace River Center	Hardee, Highlands, Polk	863-519-3744 or 1-800-627-5906
31. Jewish Family & Children's Services	Sarasota	941-374-3213
32. BayCare Behavioral Health (Pasco County)	Pasco	727-372-4357
Southeast Florida Behavioral Health Network, Inc.		
33. New Horizons of the Treasure Coast	Indian River, Martin, Okeechobee, St. Lucie	211 **or** 772-468-3909 **or** 772-672-8470
34. South County Mental Health Center (Belle Glade)	Palm Beach	211 **or** 561-382-3555
35. South County Mental Health Center (South County)	Palm Beach	211 **or** 877-585-7474
36. South County Mental Health Center (North County)	Palm Beach	211 **or** 561-693-8681
Broward Behavioral Health Coalition, Inc.		
37. Henderson Behavioral Health	Broward	**Adults** : 954-463-0911, **Youth**: 954-677-3113 option 3
Thriving Mind South Florida		
38. Banyan Health Systems	Miami-Dade	305-774-3616
39. Guidance Care Center	Monroe	305-434-7660 ext.8

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Rev: 1/28/2020

Recommendations for Protocol Implementation

- MEs, MRTs, and the Florida Department of Children and Families (DCF) should conduct a current assessment of MRT capacity, accessibility, utilization, and need in each region specific to children and youth to determine if MRTs have the capacity to implement the best practices response protocol. The National Guidelines for Crisis Care – A Best Practice Toolkit advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts. It is intended to help mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems that meet community needs (https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf).
- MEs and MRT providers should ensure that each MRT consists of a licensed professional with the credentials specified in the Florida Mental Health Act to determine the need for and initiate, if necessary, an involuntary examination of a student experiencing a behavioral health crisis and is at risk of harming him or herself.
- Clarification of parental consent requirements for MRTs responding to a children's mental health crisis. According to DCF: MRTs are required to have policies and protocols for obtaining consent and to protect confidentiality (s. 394.495, F.S.). Outpatient crisis services may be provided by a licensed professional for children 13 and older, without parental consent (s. 394.4784, F.S.). For children 13 and younger, crisis services cannot be provided without parental consent unless provided for an Involuntary Examination.
- Telehealth can be used for increasing capacity of MRTs especially in rural areas, geographically large counties, very congested traffic areas or effective utilization of capacity when there are limited resources where it may be difficult responding in person within 60 minutes. The school-based mental health provider can contact the MRT via video-teleconferencing to provide initial assessments and collaborate with the MRT in responding to the behavioral health crisis.
- Each school district, ME, MRT provider, and law enforcement agency for the designated area should have a memorandum of understanding (MOU) that outlines mutually accepted expectations, shared tasks and responsibilities of each partner in providing mental health crisis intervention services and follow up for students K-12. The MOU should include specific limitations of services to students under the age of 13 based on Florida Statutes.
- Transportation other than law enforcement should be available to reduce trauma for youth and the stigma and criminalization of a mental health crisis. By statute, MRTs may transport an individual to a Baker Act Receiving Facility if they have the capability and determine that it is safe to do so. Refer to s. 394.462, F.S. for more information about transportation plans with MRTs (http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=minor+involuntary+examination&URL=0300-0399/0394/Sections/0394.462.html)

- Data collected should be reviewed collaboratively by the school districts, MEs, MRTs, and law enforcement on a quarterly basis in order to monitor outcome measures (e.g., numbers of diversions from Baker Act initiation, community referrals, Baker Act initiations, Baker Act evaluations, etc.) to identify and maximize strengths and minimize barriers to effective behavioral health crises response services for students. To ensure accountability and improve program practices, there should be developed continuous quality improvement plans. Ideally, this would be implemented via a collaborative process across key stakeholders. Linking of data across services and supports also allows ongoing monitoring of the impact of the service to divert crises and connect youth to needed services.
- Systemic work is necessary to ensure consistent and coordinated response to children in crisis at school. Regular meetings at both the state and local level should continue so that an open dialogue is possible about challenges, barriers and strengths involved in this best practices protocol. The different sectors should include but not limited to:
  - School-based personnel
  - Managing Entities
  - Mobile Response Team providers
  - State and local law enforcement
  - Department of Children and Families
- School-based mental health professionals and mobile response team professionals should receive training to complete and utilize the same suicide risk assessment protocols to reduce the burden of duplicative assessments and increase the ability to coordinate a crisis prevention response. Currently, the Florida Department of Education approved protocols are the following:
  - Columbia – Suicide Severity Rating Scale (C-SSRS): Lifetime-Recent
  - Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)
- Amend section 394.463(2)(a)3, F.S., to expand the list of professionals who can initiate the involuntary examination to include licensed School Psychologist.
- Consider establishing within FMHI a state data resource center to allow for the collection, analysis, and reporting of District and State SCRIPT data from Schools and MRTs to assist in the identification of trends in behavioral crisis diversions, baker act initiations, school safety plans and identification of the need for additional resources, barriers, and successes.

Memorandums of Understanding

Cooperation and coordination between agencies that may not have previously interacted are vital to safe and successful outcomes for students experiencing a mental/behavioral health crisis. No single agency can maintain all of the resources and supports needed to ensure the students in our schools will receive the interventions needed for all mental health crises. As a result, agreements between cooperating agencies are needed to address the coordination of services and data. Below are examples of steps that can be taken when establishing an MOU.

- Recommendations for establishing a Memorandum of Understanding (MOU) between Schools and MRTs.
  - MRT leadership and School District Leadership (Superintendent, School Board, or Director of Student Services) should engage in discussions regarding how the MRT can assist with identified student needs and develop a standard system for MRT response.
  - MRT should identify how they can assist the local School District in objective and measurable terms. School Districts should identify the process and expectations for the MRTs while on school property with clear objective goals and policies, to include confidentiality.
  - MRT leadership and School District Leadership should at least annually review successes and barriers and incorporate changes as needed. It is recommended that Stakeholders review data quarterly (page 11).
  - The MOU should be an official document signed by both the School District and the MRT.
  - Schools and MRTs should document and share information regarding the de-escalation strategies used and the result of the MRT response. It is recommended that School Districts utilize the SCRIPT for documentation.
- Recommendations for establishing an MOU between state and local agencies.
  - DCF, DOE, local law enforcement, and local school districts should consider developing an Interagency Agreement to establish guidelines and clarify roles and procedures for sharing data.
  - The Interagency Agreement should include the purpose and requirements of the agreement.
  - The Interagency Agreement should outline the activities procedures and timelines for data sharing.
  - The Interagency Agreement should document any limitations to data sharing due to Federal or State legislation or State Rule.
- It is strongly recommended that MOUs between School Districts and MRTs identify a process, provide specific steps on how and when parental consent will be obtained.
- For examples of State level MOUs between School Districts and MRTs visit: https://www.mobilecrisisempsct.org/moa/

Appendix A: MRT Data by Florida County

Table 2. MRT Data by Florida County (July 2019-June 2020)

This table displays mobile response team (MRT) data by Florida County from July 1, 2019 through June 30, 2020. The data is organized by managing entity and includes the following variables: (1) MRT total calls received, (2) MRT calls originated from school, (3) Overall % MRT calls from school, (4) MRT total calls that required an acute response, (5) Of those total calls requiring an acute response, how may resulted in an involuntary examination, (6) Of those MRT calls requiring an acute response, how many were diverted from an involuntary examination, (7) Overall % MRT calls diverted, (8) Average MRT response time for emergent situation, (9) Is the assigned MRT located in their county, and (10) Is the county type urban or rural.

County name	MRT Total calls received	MRT Calls originated from school	Overall % MRT calls from school	Total calls required emergent response	Total MRT calls requiring acute response		Overall % MRT calls diverted	Average response time for emergent situation	Is the assigned MRT located in their county?	Area Type* (Urban vs. Rural)
					# resulted in involuntary examination	# diverted from involuntary examination				
North West Florida Health Network										
Bay Calhoun Gulf Holmes Jackson Washington	684	464	68%	555	185	370	67%	24	Bay: Yes Calhoun: No Gulf: No Holmes: No Jackson: No Washing: No	Bay: Urban Calhoun: Rural Gulf: Rural Holmes: Rural Jackson: Rural Washington: Rural
Escambia Okaloosa Santa Rosa Walton	2,018	568	28%	1,191	300	891	75%	34	Escambia: Yes Okaloosa: No Santa Rosa: Yes Walton: No	Escambia: Urban Okaloosa: Urban Santa Rosa: Urban Walton: Rural
Franklin Gadsden Jefferson Leon Liberty Madison Taylor Wakulla	1,161	73	6%	590	68	522	88%	21	Franklin: No Gadsden: No Jefferson: No Leon: Yes Liberty: No Madison: No Taylor: No Wakulla: No	Franklin: Rural Gadsden: Rural Jefferson: Rural Leon: Urban Liberty: Rural Madison: Rural Taylor: Rural Wakulla: Rural
Broward Behavioral Health System										
Broward	1,671	639	38%	900	139	761	85%	32	Yes	Urban
Central Florida Behavioral Health Network										
Pasco	733	295	40%	564	108	456	81%	22	Yes	Urban
DeSoto Manatee	204	133	65%	67	3	64	96%	19	DeSoto: No Manatee: Yes	DeSoto: Rural Manatee: Urban
Collier	66	2	3%	10	9	1	10%	38	No	Urban
Glades Hendry	23	1	4%	2	0	2	100%	0	Glades: No Hendry: No	Rural
Charlotte Lee	412	87	21%	108	33	75	69%	33	Charlotte: No Lee: Yes	Urban
Hillsborough	479	1	0.2%	20	16	4	20%	32	Yes	Urban
Pinellas	663	11	2%	483	157	326	67%	27	Yes	Urban
Sarasota	148	79	53%	10	0	10	100%	27	Yes	Urban
Polk Hardee Highlands	487	204	42%	283	107	176	62%	34	Polk: Yes Hardee: No Highlands: No	Polk: Urban Hardee: Rural Highlands: Rural

* U.S. Census Bureau, 2010 Census of Population and Housing, Population and Housing Unit Counts, CPH-2-11, Florida U.S. Government Printing Office, Washington, DC, 2012.

Appendix A MRT Data by Florida County

County name	MRT Total calls received	MRT Calls originated from school	Overall % MRT calls from school	Total calls required emergent response	Total MRT calls requiring acute response		Overall % MRT calls diverted	Average response time for emergent situation	Is the assigned MRT located in their county?	Area Type* (Urban vs. Rural)
					# resulted in involuntary examination	# diverted from involuntary examination				
Central Florida Cares Health Systems										
Brevard	260	26	10%	203	10	193	95%	36	Yes	Urban
Orange	94	11	12%	87	4	83	95%	33	Yes	Urban
Osceola	195	36	18%	185	9	176	95%	46	No	Urban
Seminole	197	19	10%	194	7	187	96%	35	No	Urban
Lutheran Services Florida										
Alachua	157	35	22%	155	20	135	87%	27	Yes	Urban
Hernando	269	170	63%	269	40	229	85%	20	Yes	Urban
Duval	1,381	1,229	89%	1,120	200	920	82%	28	Yes	Urban
Putnam	136	74	54%	121	20	101	83%	26	Yes	Urban
Clay	115	94	82%	105	35	70	67%	37	Yes	Urban
Citrus North Sumter	189	114	60%	184	26	158	86%	27	Cirtus: No Sumter: No	Cirtus: Urban Sumter: Urban
Lake South Sumter	346	176	51%	322	38	284	88%	29	Lake: Yes Sumter: No	Lake: Urban Sumter: Rural
Dixie Gilchrist Levy Hamilton Suwannee Baker Bradford Union	433	201	46%	432	91	341	79%	34	Dixie: Yes Gilchrist: Yes Levy: Yes Hamilton: Yes Suwannee: Y es Baker: Yes Bradford: Yes Union: Yes	Dixie: Rural Gilchrist: Rural Levy: Rural Hamilton: Rural Suwannee: Rural Baker: Rural Bradford: Rural Union: Rural
St. Johns	359	284	79%	359	65	294	82%	28	Yes	Urban
Flagler Volusia	89	5	6%	87	38	49	56%	70	Flagler: No Volusia: Yes	Flagler: Urban Volusia: Urban
Nassau	230	60	26%	230	84	146	63%	35	Yes	Urban
Marion	201	76	38%	184	80	104	57%	15	Yes	Urban
Columbia	279	69	25%	278	80	198	71%	26	Yes	Rural
Thriving Mind South Florida										
Miami-Dade	1,094	51	5%	1,052	189	863	82%	69	Yes	Urban
Monroe	340	65	19%	291	35	256	88%	19	Yes	Rural
Southeast Florida Behavioral Health Network										
Indian River Martin Okeechobee St. Lucie	1,755	550	31%	1,603	217	1,386	86%	23	Indian River: No Martin: No Okeechobee: No St. Lucie: Yes	Indian River: Urban Martin: Urban Okeechobee: Rural St. Lucie: Urban
Palm Beach	1,244	150	12%	1,034	102	932	90%	30	Yes (2 MRTs)	Urban

* U.S. Census Bureau, 2010 Census of Population and Housing, Population and Housing Unit Counts, CPH-2-11, Florida U.S. Government Printing Office, Washington, DC, 2012.

Appendix B: Involuntary Examinations for Children (<18)

2010-2019 (July - June)

Data provided by the Baker Act Reporting Center displays involuntary examinations for children (under 18 years of age) by Florida County from July 1, 2010 through June 30, 2019. The data is organized alphabetically by County and includes total involuntary examinations for fiscal year 2010-2011 (July 1, 2010 - June 30, 2011) through 2018-2019 (July 1, 2018 - June 30, 2019). The most recent Baker Act report can be found at: https://www.usf.edu/cbcs/baker-act/documents/ba_usf_annual_report_2018_2019.pdf

County of Residence	Total 2010-11	Total 2011-12	Total 2012-13	Total 2013-14	Total 2014-15	Total 2015-16	Total 2016-17	Total 2017-18	Total 2018-19	Total 2010-19
Alachua	327	317	344	388	456	528	562	598	536	4,056
Baker	27	40	29	30	47	32	32	34	39	310
Bay	157	169	194	296	373	327	343	378	332	2,569
Bradford	32	25	46	55	64	58	61	66	70	477
Brevard	850	914	936	1,038	1,238	1,163	1,224	1,255	1,221	9,839
Broward	1,733	1,846	1,901	2,311	2,227	2,007	1,788	1,883	1,986	17,682
Calhoun	18	26	14	35	23	21	27	44	21	229
Charlotte	179	164	183	237	337	354	363	464	471	2,752
Citrus	196	240	208	270	275	316	340	346	332	2,523
Clay	258	269	284	307	297	377	409	428	511	3,140
Collier	173	192	268	320	398	462	435	437	680	3,365
Columbia	60	54	38	127	231	195	182	284	263	1,434
Desoto	30	33	44	68	93	88	103	110	113	682
Dixie	9	2	10	10	9	21	34	20	36	151
Duval	1,323	1,513	1,604	1,503	1,253	1,484	1,685	1,931	2,103	14,399
Escambia	625	604	661	604	726	763	796	777	728	6,284
Flagler	161	120	141	128	152	136	129	185	214	1,366
Franklin	2	5	4	10	8	10	12	12	9	72
Gadsden	28	32	26	51	57	71	55	106	79	505
Gilchrist	23	18	14	17	22	27	33	54	36	244
Glades	0	8	12	5	13	11	11	18	32	110
Gulf	9	17	22	27	11	20	26	14	12	158
Hamilton	4	7	3	13	9	23	21	20	23	123
Hardee	16	22	22	23	33	36	52	43	39	286
Hendry	11	11	25	52	64	96	43	51	60	413
Hernando	304	247	306	352	400	334	378	413	403	3,137
Highlands	78	109	147	134	114	154	133	169	147	1,185
Hillsborough	1,241	2,183	2,323	2,548	2,986	2,959	2,826	2,854	2,365	22,285
Holmes	25	36	21	45	37	43	34	33	44	318
Indian River	137	167	207	206	179	172	163	239	328	1,798
Jackson	45	49	52	56	55	63	49	58	47	474
Jefferson	15	21	7	24	25	22	27	43	54	238
Lafayette	6	1	1	8	6	8	7	9	16	62
Lake	334	397	444	459	486	652	620	682	730	4,804
Lee	489	765	1,011	1,022	1,124	1,146	1,225	1,325	1,488	9,595

Appendix B: Involuntary Examinations for Children (<18) Continued

County of Residence	Total 2010-11	Total 2011-12	Total 2012-13	Total 2013-14	Total 2014-15	Total 2015-16	Total 2016-17	Total 2017-18	Total 2018-19	Total 2010-19
Leon	194	228	246	375	428	427	455	648	671	3,672
Levy	47	36	60	64	95	77	51	73	82	585
Liberty	3	4	3	9	7	20	7	12	19	84
Madison	21	25	26	20	32	41	42	66	42	315
Manatee	418	353	337	472	542	529	529	561	600	4,341
Marion	684	620	734	777	854	849	794	1,155	1,196	7,663
Martin	75	98	109	115	155	125	143	218	257	1,295
Miami-Dade	1,707	1,972	2,178	2,637	2,667	2,555	2,539	2,359	3,137	21,751
Monroe	41	37	25	23	16	27	33	37	50	289
Nassau	57	80	84	76	63	86	119	121	94	780
Okaloosa	226	218	146	257	291	331	350	383	265	2,467
Okeechobee	72	65	58	104	75	102	112	138	189	915
Orange	1,278	1,344	1,483	1,543	1,611	1,531	1,615	1,736	1,868	14,009
Osceola	377	438	528	569	603	628	691	594	675	5,103
Palm Beach	922	1,370	1,432	1,437	1,612	1,598	1,621	1,743	2,046	13,781
Pasco	933	910	961	1,059	1,202	1,270	1,249	1,503	1,551	10,638
Pinellas	1,624	1,751	1,969	2,210	2,307	2,085	2,235	2,427	2,504	19,112
Polk	744	1,283	1,283	1,761	1,917	1,767	1,511	1,744	1,999	14,009
Putnam	85	73	73	94	140	135	133	147	113	993
Saint Johns	180	146	173	197	185	189	171	161	210	1,612
Saint Lucie	362	389	464	459	496	442	478	732	862	4,684
Santa Rosa	179	156	105	109	230	260	352	338	334	2,063
Sarasota	479	503	559	627	694	685	701	653	703	5,604
Seminole	586	629	632	741	802	792	778	646	670	6,276
Sumter	41	48	60	71	95	101	90	103	102	711
Suwannee	29	14	17	62	115	158	134	172	134	835
Taylor	18	13	15	25	19	34	43	45	34	246
Union	10	6	18	26	29	23	35	22	46	215
Volusia	819	780	737	812	864	919	902	1,026	1,192	8,051
Wakulla	34	33	23	62	113	98	81	153	147	744
Walton	55	45	40	46	55	56	70	77	58	502
Washington	27	19	37	36	41	40	41	60	46	347

Appendix C: Involuntary Examinations for Children (<18) by Age Group

July 2019 - June 2020

Data provided by the Baker Act Reporting Center displays involuntary examinations for children (under 18 years of age) divided by age group by Florida County from July 1, 2019 through June 30, 2020. The data is organized alphabetically by County and includes the following: (1) Ages <10 years, (2) Ages 11-13 years, (3) Ages 14-17 years, and (4) Total ages (<18 years).

County of Residence	Ages < 10 Total 2019-20	Ages 11-13 Total 2019-20	Ages 14-17 Total 2019-20	Ages <18 Total 2019-20
Alachua	59	116	281	456
Baker	3	8	22	33
Bay	36	145	242	423
Bradford	4	22	41	67
Brevard	126	273	696	1,095
Broward	140	408	1,255	1,803
Calhoun	1	3	7	11
Charlotte	54	137	255	446
Citrus	56	87	163	306
Clay	17	106	243	366
Collier	52	132	311	495
Columbia	26	63	109	198
Desoto	18	51	77	146
Dixie	2	7	10	19
Duval	264	629	1,055	1,948
Escambia	83	226	414	723
Flagler	17	53	131	201
Franklin	0	13	14	27
Gadsden	8	20	36	64
Gilchrist	5	4	17	26
Glades	1	8	21	30
Gulf	1	3	4	8
Hamilton	4	5	15	24
Hardee	1	15	14	30
Hendry	3	10	35	48
Hernando	48	108	296	452
Highlands	13	57	99	169
Hillsborough	242	805	1,614	2,661
Holmes	6	10	23	39
Indian River	24	65	174	263
Jackson	6	27	36	69
Jefferson	1	15	26	42
Lafayette	0	2	2	4
Lake	58	170	376	604

County of Residence	Ages < 10 Total 2019-20	Ages 11-13 Total 2019-20	Ages 14-17 Total 2019-20	Ages <18 Total 2019-20
Lee	149	299	749	1,197
Leon	63	189	321	573
Levy	2	21	32	55
Liberty	0	3	9	12
Madison	3	10	22	35
Manatee	67	174	368	609
Marion	156	303	500	959
Martin	20	66	148	234
Miami-Dade	225	837	2,128	3,190
Monroe	1	8	19	28
Nassau	5	24	50	79
Okaloosa	22	81	169	272
Okeechobee	14	55	106	175
Orange	132	498	1,190	1,820
Osceola	52	133	387	572
Palm Beach	175	499	1,230	1,904
Pasco	173	461	793	1,427
Pinellas	277	644	1,235	2,156
Polk	238	612	1,094	1,944
Putnam	10	55	79	144
Saint Johns	7	65	122	194
Saint Lucie	106	229	446	781
Santa Rosa	13	84	189	286
Sarasota	76	184	577	837
Seminole	38	191	414	643
Sumter	13	30	43	86
Suwannee	12	38	51	101
Taylor	4	7	24	35
Union	2	11	26	39
Volusia	135	309	609	1,053
Wakulla	3	54	40	97
Walton	2	10	34	46
Washington	2	11	35	48

Appendix D: List of Resources

American Foundation for Suicide Prevention, American School Counselor Association, the National Association of School Psychologists and the Trevor Project. (2019). Model School District Policy on Suicide Prevention, Model Language, Commentary and Resources. https://afsp.org/model-school-policy-on-suicide-prevention

This guide outlines model policies and best practices for K-12 schools and schools systems concerning a school prevention and intervention response to suicidal and high-risk behaviors including:

- Creation of a suicide prevention task force
- Timely assessment and referral by school-based mental health professionals
- Engaging law enforcement
- Parental involvement
- Follow up on re-entry to the school and class environment
- Considerations for LGBTQ and other high-risk youth
- Professional development

American Psychiatric Association and American Telemedicine Association. (2018). *Best practices in videoconferencing-based telemental health.* https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-and-ata-release-new-telemental-health-guide

This is a best-practices guide for mental health professionals providing videoconferencing-based telemental health representing a consolidation of the organizations' resources and guidance on clinical videoconferencing. It includes guidance on administrative, technical, and clinical considerations including legal and ethical concerns, cultural practices, and working with specific populations including children and adolescents.

Fendrich M, Ives M, Kurz B, Becker J, Vanderploeg J, Bory C, Lin HJ, & Plant R. (2019). Impact of mobile crisis services on emergency department use among youths with behavioral health service needs. *Psychiatric Services, 70(10),* 881-887. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201800450

This article describes an evaluation of a mobile crisis service intervention implemented in Connecticut with the goal of examining whether the intervention was associated with reduced behavioral health emergency department use among youth in need of services. The evaluation indicates that youth who received mobile crisis services had a significant reduction in the likelihood of an emergency department visit after crisis services compared with youth in the comparison sample. In the Connecticut model, the clinical crisis team provides screening and assessment; suicide assessment and prevention; brief, solution-focused interventions; and referral and linkage to services. The mobile crisis services can be accessed repeatedly with no set limitation.

Florida Department of Children and Families, Office of Substance Abuse and Mental Health. (2020). *Program guidance for Managing Entity contracts: Guidance 34, Mobile response team (MRT).* https://www.myflfamilies.com/service-programs/samh/managing-entities/2020/IncDocs/Guidance%2034%20MRT.pdf

The program guidance for Managing Entity contracts with mobile response teams was updated to include the amendments made by House Bill 945 to 394.495, F.S., to include MRTs in the child and adolescent array of services and programmatic requirements.

Florida Department of Children and Families, Office of Substance Abuse and Mental Health. (2018). ***Mobile Response Teams Framework.*** **https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf**

This framework was developed after the passing of the Marjory Stoneman Douglas High School Public Safety Act in 2018. The law includes a provision to create a statewide network of mobile response teams. The document outlines minimum requirements for competitive procurement, program goals, guiding principles, service components, roles and responsibilities, key partners, national best practice models, and programmatic outcome measures. The framework is not prescriptive and allows flexibility to implement a model within the recommendations of the framework that fits the needs of the local community.

Florida Department of Education, Office of Safe Schools. (2020). ***Model Behavioral Threat Assessment Policies and Best Practices for K-12 Schools.*** **http://www.fldoe.org/core/fileparse.php/18612/urlt/threat-assessment-model-policies.pdf**

This model approach disseminated by the Florida Department of Education outlines threat assessment policies and best practices pertaining to students or other individuals who have communicated or are exhibiting behaviors that suggest harm to others. The threat assessment process does not include a threat or intent of suicide or self-harm. A suicide risk assessment is a separate process. When a threat to others and a threat to self are present, threat assessment teams are instructed to involve mental and behavioral health experts to ensure the correct screenings and referrals are completed.

Gloff, N.E., LeNoue, S.R., Novins, D.K., & Myers, K. (2015). Telemental health for children and adolescents. International Review of Psychiatry, 27(6), 513–524. https://doi-org.ezproxy.lib.usf.edu/10.3109/09540261.2015.1086322

The review of literature indicates telemental health has outcomes comparable to in-person mental health services. The article emphasizes the use of telemental health to:

- Improve access to evidence-based mental health care especially in rural communities
- Expand availability of mental health services in schools
- Enhance coordination of care
- Reduce disparities
- Improve quality of child and adolescent mental health services

Shannahan, R. & Fields, S. (2016, May). Services in support of community living for youth with serious behavioral health challenges: Mobile crisis response and stabilization services. ***SAMHSA The TA Network Brief, National Technical Assistance Network for Children's Behavioral Health under contract with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.*** **https://theinstitute.umaryland.edu/media/ssw/institute/national-center-documents/Mobile-Crisis-Response-&-Stabilization-Services-May-2016.pdf**

This brief provides an overview of mobile crisis response and stabilization service models and best practices for children and youth based on a review of four model programs based in Milwaukee County, Wisconsin; King County, Washington; New Jersey; and Massachusetts. Specific to mobile crisis response services in schools the authors recommend several key strategies for mobile response providers including:

- Building relationships and establishing an MOU with school systems
- Marketing their services to schools as a viable alternative to law enforcement and emergency department visits
- Identifying at least one school official to serve as a liaison with their program
- Establishing coordinated cross-systems protocols with law enforcement, schools, emergency departments, and the mobile response provider

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). ***National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.*** **https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf**

This toolkit describes best practices and strategies for communities to create an effective crisis care system that includes core elements of crisis call centers, mobile crisis response teams, and crisis receiving and stabilization facilities. Concerning mobile crisis team services, it includes minimum service expectations and best practices. This toolkit by SAMHSA does not address the specific crisis service needs of children and adolescents nor the necessary interface and coordination with the school system to respond to children in crisis in a school setting.

Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS). (2019). ***Joint Informational Bulletin: Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools.*** **https://store.samhsa.gov/product/guidance-states-and-school-systems-addressing-mental-health-and-substance-use-issues**

This guidance includes examples of approaches for mental health and substance use disorder (SUD) related treatment services in schools, and describes some of the Medicaid state plan benefits and other Medicaid authorities that states may use to cover mental health and SUD related treatment services. Additionally, the guidance summarizes best practice models to facilitate implementation of quality, evidence-based comprehensive mental health and SUD related services for students.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). ***Preventing Suicide: A Toolkit for High Schools.*** **https://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669?referer=from_search_result**

This toolkit provides best practices and strategies for schools to develop and implement school-wide suicide prevention and intervention protocols and includes sample templates and forms related to:

- Suicide education
- Engaging community partners
- Parent involvement
- Development of a school-based crisis response team
- Implications of culture on suicide prevention
- Responding to suicide

Suicide Prevention Resource Center. (2104). ***Zero suicide toolkit.*** **Education Development Center. http://zerosuicide.edc.org/toolkit**

The Zero Suicide Toolkit provides a framework for system-wide implementation and transformation of suicide care best practices. The guiding belief is that suicide deaths of individuals receiving health and behavioral health care services are preventable. Zero Suicide is comprised of seven core elements: lead, train, identify, engage, treat, transition, and improve with each element comprised of specific implementation guidance and resources.

Appendix E: Relevant Florida Bills & Statutes

Marjory Stoneman Douglas High School Safety Act

Chapter 2018-3, Laws of Florida

http://laws.flrules.org/2018/3

Specific to mobile response teams the act states, "If an immediate mental health or substance abuse crisis is suspected, school personnel shall follow policies established by the threat assessment team to engage behavioral health crisis resources. Behavioral health crisis resources, including, but not limited to, mobile crisis teams and school resource officers trained in crisis intervention, shall provide emergency intervention and assessment, make recommendations, and refer the student for appropriate services. Onsite school personnel shall report all such situations and actions taken to the threat assessment team, which shall contact the other agencies involved with the student and any known service providers to share information and coordinate any necessary follow-up actions." In addition, the act appropriated $18,300,000 in recurring funds from the General Revenue Fund to the Department of Children and Families to competitively procure proposals for additional mobile crisis teams to ensure reasonable access among all counties. "The department shall consider the geographic location of existing mobile crisis teams and select providers to serve the areas of greatest need."

Florida Mental Health Act

Ch. 394, Part I, 394.451-394.47892. (2020)

https://www.flsenate.gov/Laws/Statutes/2018/0394.4784

Relevant to this model protocol, the Florida Mental Health Act, also referred to as The Baker Act specifies:

§ 394.463: Involuntary examination

- When a person who is believed to have a mental illness may be taken to a receiving facility for involuntary examination,
- Who can initiate an involuntary examination, and
- The process required for involuntary examination.

§ 394.459: Rights of patients

Express and informed consent for admission or treatment of a patient under 18 years of age shall be required from the patient's guardian, unless the minor is seeking outpatient crisis intervention services under s. 394.4784. Express and informed consent for admission or treatment given by a patient who is under 18 years of age shall not be a condition of admission when the patient's guardian gives express and informed consent for the patient's admission pursuant to s. 394.463 or s. 394.467.

§ 394.4784: Minors, access to outpatient crisis intervention services and treatment

The law allows a minor (age 13 or older) who is experiencing a behavioral health crisis a right to request, consent to, and receive mental health diagnostic, evaluative, and crisis intervention services within specified limitations. There is no stated requirement for a parent of a child to provide consent or refuse consent for a child's involuntary examination.

§ 394.462: Transportation

The law instructs each county in collaboration with the Managing Entity to develop a transportation plan that describes methods of transport to a facility for individuals subject to involuntary examination or involuntary admission including:

- Designation of a single law enforcement agency to transport individuals to the appropriate receiving facility.
- Optional use of emergency medical transport services or private transport companies, as appropriate.
- Allowance of transportation by a mental health overlay program or mobile crisis response service if a professional member of the service authorized to do so initiates an involuntary examination and determines that transportation to a receiving facility is needed.

Florida Statutes

§ 394.499. (2020). Integrated children's crisis stabilization unit/juvenile addictions receiving facility services

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.499.html

This statute specifies the eligibility criteria for children to receive integrated children's crisis stabilization unit/juvenile addictions receiving facility services. Specific to mental illness, this includes:

A person under 18 years of age who may be taken to a receiving facility for involuntary examination, if there is reason to believe that he or she is mentally ill and because of his or her mental illness, pursuant to section 394.463:

1. Has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or
2. Is unable to determine for himself or herself whether examination is necessary; and
    a. Without care or treatment 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
    b. There is a substantial likelihood that without care or treatment he or she will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

A person under 18 years of age who meets the criteria for examination or admission and has a coexisting mental health and substance abuse disorder.

House Bill 945

Chapter 2020-107, Laws of Florida

http://laws.flrules.org/2020/107

The bill instructs FMHI to develop a best practices response protocol for schools to use mobile response teams (MRT). The bill added crisis response services provided through mobile response teams to the array of mental health services available to meet the individualized service and treatment needs of children and adolescents throughout the state.

The bill also requires "before a principal or his or her designee contacts a law enforcement officer, he or she must verify that de-escalation strategies have been utilized and outreach to a mobile response team has been initiated unless the principal or the principal's designee reasonably believes that any delay in removing the student will increase the likelihood of harm to the student or others. This requirement does not supersede the authority of a law enforcement officer to act under s. 394.463.

The bill specifies notification of involuntary examinations by schools. It states, "the public school principal or the principal's designee shall immediately notify the parent of a student who is removed from school, school transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination pursuant to section 394.463. The principal or the principal's designee may delay notification for no more than 24 hours after the student is removed if the principal or the principal's designee deems the delay to be in the student's best interest and if a report has been submitted to the central abuse hotline, pursuant to section 39.201, based upon knowledge or suspicion of abuse, abandonment, or neglect.