

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL: PCS/SB 12 (821992)

INTRODUCER: Appropriations Committee (Recommended by Appropriations Subcommittee on Health and Human Services); Senator Garcia and others

SUBJECT: Mental Health and Substance Abuse

DATE: February 17, 2016

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	Favorable
2.	Brown	Pigott	AHS	Recommend: Fav/CS
3.	Brown	Kynoch	AP	Pre-meeting

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/SB 12 addresses Florida’s system for the delivery of behavioral health services. The bill provides for mental health services for children, parents, and others seeking custody of children involved in dependency court proceedings. The bill creates a coordinated system of care to be provided either by a community or a region for those suffering from mental illness or substance use disorder through a “No Wrong Door” system of single access points.

The Agency for Health Care Administration (AHCA) and the Department of Children and Families (DCF) are directed to modify licensure requirements to create an option for a single, consolidated license to provide both mental health and substance use disorder services. Additionally, the AHCA and the DCF are directed to develop a plan to increase federal funding for behavioral health care.

To the extent possible, the bill aligns the legal processes, timelines, and processes for assessment, evaluation, and receipt of available services of the Baker Act (mental illness) and Marchman Act (substance abuse) to assist individuals in recovery and reduce readmission to the system.

The duties and responsibilities of the DCF are revised to set performance measures and standards for managing entities¹ and to enter into contracts with the managing entities that support efficient and effective administration of the behavioral health system and ensure accountability for performance. The duties and responsibilities of managing entities are revised accordingly.

The bill has an indeterminate fiscal impact.

The bill has an effective date of July 1, 2016.

II. Present Situation:

Mental Health and Substance Abuse

Mental illness creates enormous social and economic costs.² Unemployment rates for persons with mental disorders are high relative to the overall population.³ People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent.⁴ Mental illness increases a person's risk of homelessness in America threefold.⁵ Studies show that approximately 33 percent of our nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are not receiving treatment.⁶ Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future re-offenses.⁷

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.⁸ NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.⁹ When mental health disorders are left untreated, substance abuse is likely to increase. When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.¹⁰

¹ See s. 394.9082, F.S. A managing entity is a not-for-profit corporation organized in Florida which is under contract with the DCF on a regional basis to manage the day-to-day operational delivery of behavioral health services through an organized system of care and a network of providers who are contracted with the managing entity to provide a comprehensive array of emergency, acute care, residential, outpatient, recovery support, and consumer support services related to behavioral health.

² Mental Illness: The Invisible Menace, *Economic Impact* <http://www.mentalmenace.com/economicimpact.php>

³ Mental Illness: The Invisible Menace, *More impacts and facts* <http://www.mentalmenace.com/impactsfacts.php>

⁴ *Id.*

⁵ Family Guidance Center, *How does Mental Illness Impact Rates of Homelessness?* (February 4, 2014) available at <http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/>

⁶ *Id.*

⁷ *Id.*

⁸ Donna M. White, LPCI, CACP, Psych Central.com, *Living with Co-Occurring Mental & Substance Abuse Disorders*, (October 2, 2013) available at <http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occurring-mental-substance-abuse-disorders/>

⁹ *Id.*

¹⁰ *Id.*

Behavioral Health Managing Entities

In 2008, the Legislature required the Department of Children and Families (DCF) to implement a system of behavioral health managing entities that would serve as regional agencies to manage and pay for mental health and substance abuse services.¹¹ Prior to this time, the DCF, through its regional offices, contracted directly with behavioral health service providers. The Legislature found that a management structure that places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level, would promote improved access to care, promote service continuity, and provide for more efficient and effective delivery of substance abuse and mental health services. There are currently seven managing entities across the state.¹²

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.¹³ The Baker Act authorizes treatment programs for mental, emotional, and behavioral disorders. The Baker Act requires programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery. Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Marchman Act

In 1993, the Legislature adopted the Hal S. Marchman Alcohol and Other Drug Services Act. The Marchman Act provides a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services. Services must be provided in the least restrictive environment to promote long-term recovery. The Marchman Act includes various protections and rights of patients served.

Transportation to a Facility

The Marchman Act authorizes an applicant seeking to have a person admitted to a facility, the person's spouse or guardian, a law enforcement officer, or a health officer to transport the individual for an emergency assessment and stabilization.¹⁴

The Baker Act requires each county to designate a single law enforcement agency to transfer the person in need of services. If the person is in custody based on noncriminal or minor criminal behavior, the law enforcement officer will transport the person to the nearest receiving facility. If, however, the person is arrested for a felony the person must first be processed in the same

¹¹ See s. 394.9082, F.S., as created by Chapter 2008-243, Laws of Fla.

¹² Department of Children and Families website, <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities>, (last visited Jan. 11, 2016).

¹³ Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.

¹⁴ Section 397.6795, F.S.

manner as any other criminal suspect. The law enforcement officer must then transport the person to the nearest facility, unless the facility is unable to provide adequate security.¹⁵

The Marchman Act allows law enforcement officers, however, to temporarily detain substance-impaired persons in a jail setting. An adult not charged with a crime may be detained for his or her own protection in a municipal or county jail or other appropriate detention facility. Detention in jail is not considered to be an arrest, is temporary, and requires the detention facility to provide if necessary transfer of the detainee to an appropriate licensed service provider with an available bed.¹⁶ However, the Baker Act prohibits the detention in jail of a mentally ill person if he or she has not been charged with a crime.¹⁷

Involuntary Admission to a Facility

Criteria for Involuntary Admission

The Marchman Act provides that a person meets the criteria for involuntary admission if a good-faith reason exists to believe that the person is substance-impaired and, because of the impairment:

- Has lost the power of self-control with respect to substance abuse; and either
 - Has inflicted, threatened to or attempted to inflict self-harm; or
 - Is in need of services and due to the impairment, judgment is so impaired that the person is incapable of appreciating the need for services.¹⁸

Protective Custody

A person who meets the criteria for involuntary admission under the Marchman Act may be taken into protective custody by a law enforcement officer.¹⁹ The person may consent to have the law enforcement officer transport the person to his or her home, a hospital, or a licensed detoxification or addictions receiving facility.²⁰ If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.²¹

Time Limits

A critical 72-hour period applies under both the Marchman Act and the Baker Act. Under the Marchman Act, a person may be held in protective custody for no more than 72 hours, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.²²

The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.²³ Within that 72-hour examination period, or, if the 72

¹⁵ Section 394.462(1)(f) and (g), F.S.

¹⁶ Section 397.6772(1), F.S.

¹⁷ Section 394.459(1), F.S.

¹⁸ Section 397.675, F.S.

¹⁹ Section 397.677, F.S.

²⁰ Section 397.6771, F.S.

²¹ Section 397.6772(1), F.S.

²² Section 397.6773(1) and (2), F.S.

²³ Section 394.463(2)(f), F.S.

hours ends on a weekend or holiday, no later than the next working 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 resume custody;
- The patient must be released into voluntary outpatient treatment;
- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or
- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.²⁴

Under the Marchman Act, if the court grants the petition for involuntary admission, the person may be admitted for a period of five days to a facility for involuntary assessment and stabilization.²⁵ If the facility needs more time, the facility may request a seven-day extension from the court.²⁶ Based on the involuntary assessment, the facility may retain the person pending a court decision on a petition for involuntary treatment.²⁷

Under the Baker Act, the court must hold a hearing on involuntary inpatient or outpatient placement within five working days after a petition for involuntary placement is filed.²⁸ The petitioner must show, by clear and convincing evidence, all available less-restrictive treatment alternatives are inappropriate and that the individual:

- Is mentally ill and because of the illness has refused voluntary placement for treatment or is unable to determine the need for placement; and
- Is manifestly incapable of surviving alone or with the help of willing and responsible family and friends, and without treatment is likely suffer neglect that poses a real and present threat of substantial harm to his or her well-being, or substantial likelihood exists that in the near future he or she will inflict serious bodily harm on himself or herself or another person.²⁹

III. Effect of Proposed Changes:

Section 1 amends s. 29.004, F.S., to allow courts to use state revenue to provide case management services such as service referral, monitoring, and tracking for mental health programs under s. 394, F.S.

Section 2 amends s. 39.001(6), F.S., to include mental health treatment in dependency court services and directs the state to contract with mental health service providers for such services.

Section 3 amends s. 39.507(10), F.S., to allow a dependency court to order a person requesting custody of a child to submit to a mental health or substance abuse disorder assessment or evaluation, require participation of such person in a mental health program or a treatment-based drug court program, and to oversee the progress and compliance with treatment by the person who has custody or is requesting custody of a child.

²⁴ Section 394.463(2)(i)4., F.S.

²⁵ Section 397.6811, F.S.

²⁶ Section 397.6821, F.S.

²⁷ Section 397.6822, F.S.

²⁸ Sections 394.4655(6) and 394.467(6), F.S.

²⁹ Section 394.467(1), F.S.

Section 4 amends s. 39.521(1)(b), F.S., to authorize a court, with jurisdiction of a child that has been adjudicated dependent, to require the person who has custody or is requesting custody of the child to submit to a mental illness or substance abuse disorder assessment or evaluation, to require the person to participate in and comply with the mental health program or drug court program, and to oversee the progress and compliance by the person who has custody or is requesting custody of a child.

Section 5 amends s. 394.455, F.S., to add, update, or revise definitions as appropriate.

Section 6 amends s. 394.4573, F.S., to create a coordinated system of care in the context of the No Wrong Door model which is defined as a delivery system of health care services to persons with mental health or substance abuse disorders, or both, which optimizes access to care, regardless of the entry point to the system.

The bill also defines a coordinated system of care to mean the full array of behavioral and related services in a region or community offered by all service providers, whether under contract with the managing entity or another method of community partnership or mutual agreement.

Additionally, the Department of Children and Families (DCF) is required to submit, on or before October 1 of each year, an annual assessment of the behavioral health services in the state to the Governor and the Legislature. The assessment must include comparison of the status and performance of behavioral health systems, the capacity of contracted services providers to meet estimated needs, the degree to which services are offered in the least restrictive and most appropriate therapeutic environment, and the scope of system-wide accountability activities used to monitor patient outcomes and measure continuous improvement of the behavioral health system.

The bill authorizes the DCF, subject to a specific appropriation, to award system improvement grants to managing entities based on the submission of detailed plans to enhance services, coordination of services, or a performance measurement in accordance with the No Wrong Door model. The grants must be awarded through a performance-based contract that links payments to documented and measurable system improvements.

The essential elements of a coordinated system of care under the bill must include community interventions, a designated receiving system that consists of one or more facilities serving a defined geographic area, transportation, crisis services, case management, including intensive case management, and various other services.

Section 7 amends s. 394.4597(2)(d) and (e), F.S., to specify the persons who are prohibited from being named as a patient's representative.

Section 8 amends s. 394.4598(2) through (7), F.S., to specify the persons who are prohibited from appointment as a patient's guardian advocate when a court has determined that a person is incompetent to consent to treatment but the person has not been adjudicated incapacitated. The bill also sets out the training requirements for persons appointed as guardian advocates.

Section 9 amends s. 394.462, F.S., to direct that a transportation plan must be developed and implemented in each county or, if applicable, counties that intend to share a transportation plan. The plan must specify methods of transport to a facility within the designated receiving system and may delegate responsibility for other transportation to a participating facility when necessary and agreed to by the facility. The plan must ensure that persons meeting the criteria for involuntary assessment and evaluation pursuant to s. 394.463 and 397.675 will be transported. For the transportation of a voluntary or involuntary patient to a treatment facility, the plan must specify how the hospitalized patient will be transported to, from, and between facilities.

Section 10 amends s. 394.463(2), F.S., to allow a circuit or county court to enter an ex parte order stating that a person appears to meet the criteria for involuntary examination. The ex parte order must be based on written or oral sworn testimony that includes specific facts supporting the findings. Facilities accepting patients based on ex parte orders must send a copy of the order to the managing entity in its region the next working day. A facility admitting a person for involuntary examination who is not accompanied by an ex parte order must notify the DCF and the managing entity the next working day.

The bill also adds language that a person may not be held for involuntary examination for more than 72 hours without specified actions being taken.

Section 11 amends s. 394.4655, F.S., to allow a court to order a person to involuntary outpatient services, upon a finding by clear and convincing evidence, that the person meets the criteria specified. The recommendation by the administrator of a facility of a person for involuntary outpatient services must be supported by two qualified professionals, both of whom have personally examined the person within the preceding 72 hours. A court may not order services in a proposed treatment plan which are not available. The service provider must notify the managing entity as to the availability of the requested services, and the managing entity must document its efforts to obtain the requested services.

Section 12 amends s. 394.467, F.S., to add to the criteria for involuntary inpatient placement for mental illness the present threat of substantial physical or mental harm to a person's well-being. The bill prohibits a court from ordering an individual with traumatic brain injury or dementia who lacks a co-occurring mental illness to be involuntarily placed in a treatment facility.

Section 13 amends s. 394.46715, F.S., to provide the DCF rulemaking authority.

Section 14 creates s. 394.761, F.S., to direct the DCF, in coordination with the managing entities, to compile detailed documentation of the cost and reimbursements for Medicaid-covered services provided to Medicaid-eligible individuals by providers of behavioral health services that are also funded through the DCF. The DCF's documentation, along with a report of general revenue funds supporting behavioral health services that are not spent as matching funds for federal programs or otherwise required under federal regulations, must be submitted to the Agency for Health Care Administration (AHCA) by December 31, 2016. Copies of the report must also be provided to the Governor, the President of the Senate, and the Speaker of the House of Representatives. If the report presents clear evidence that Medicaid reimbursements are less than the costs of providing the services, the AHCA and the DCF will prepare and submit any budget amendments necessary to use unmatched general revenue funds in the 2016-2017 fiscal

year to draw additional federal funding to increase Medicaid funding for behavioral health service providers receiving the unmatched general revenue. Such payments must be made to providers in accordance with federal law and regulations.

Section 15 amends s. 394.875, F.S., to direct the DCF and the AHCA, by January 1, 2017, to modify licensure rules and procedures to create an option for a single, consolidated license for a provider who offers multiple types of mental health and substance abuse services regulated under chs. 394 and 397, F.S.

Section 16 amends s. 394.9082, F.S., to revise and update the duties and responsibilities of the managing entities and the DCF and to provide definitions, contracting requirements, and accountability measures.

The DCF's duties and responsibilities are revised to include the designation of facilities into the receiving system developed by one or more counties; contract with the managing entities; specify data reporting and use of shared data systems; develop strategies to divert persons with mental illness or substance abuse disorders from the criminal and juvenile justice system; support the development and implementation of a coordinated system of care to require providers receiving state funds through a direct contract with the DCF to work with the managing entity to coordinate the provision of behavioral health services; set performance measures and standards for managing entities; develop a unique identifier for clients receiving services; and coordinate procedures for referral and admission of patients to, and discharge from, state treatment facilities.

This section sets out the DCF's duties regarding its contracts with the managing entities. The contracts must support efficient and effective administration of the behavioral health system and ensure accountability for performance. The managing entities' contracts are subject to performance review beginning July 1, 2018. The review must include analysis of the managing entities' performance measures, the results of the DCF's contract monitoring, and related performance and compliance issues. Based on a satisfactory performance review, the DCF may negotiate with the managing entity for a four-year contract pursuant to s. 287.057(3)(e), F.S. If a managing entity does not meet the requirements of the performance review, the DCF must create a corrective action plan. If the corrective action plan is not satisfactorily completed by the managing entity, the DCF will terminate the contract at the end of the contract term and initiate a competitive procurement process to select a new managing entity.

The revised and updated duties and responsibilities of the managing entities under the bill include conducting an assessment of community behavioral health care needs in each managing entity's geographic area. The assessment must be updated annually and include, at a minimum, information the DCF needs for its annual report to the Governor and Legislature. Managing entities must also develop local resources by pursuing third-party payments for services, applying for grants, and other methods to ensure services are available and accessible; provide assistance to counties to develop a designated receiving system and a transportation plan; enter into cooperative agreements with local homeless councils and organizations to address the homelessness of persons suffering from a behavioral health crisis; provide or contract for case management; and collaborate with local criminal and juvenile justice systems to divert persons

with mental illness or substance abuse disorders, or both, from the criminal and juvenile justice systems.

Section 17 amends s. 397.311, F.S., to create a definition for involuntary services and revise the definition of qualified professional.

Section 18 amends s. 397.675, F.S., to revise the criteria for assessment, stabilization, and involuntary treatment for persons with a substance abuse or co-occurring mental health disorder to include that without care or treatment, the person is likely to suffer from neglect or to refuse to care for himself or herself and that neglect or refusal poses a real and present threat of substantial harm to his or her well-being and that 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 substantial likelihood that the person has inflicted, or threatened to or attempted to inflict, or is likely to inflict, physical harm on himself or herself, or another.

Section 19 amends s. 397.679, F.S., to expand the types of professionals who may execute a certificate for application for emergency admission of a person to a hospital or licensed detoxification facility to include a physician, an advanced registered nurse practitioner, a clinical psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed mental health counselor, a physician assistant working under the scope of practice of the supervising physician, or a master's level certified addictions professional if the certification is specific to substance abuse disorders.

Section 20 amends s. 397.6791, F.S., to expand the types of professionals who may initiate a certificate for emergency assessment or admission of a person who may meet the criteria for substance abuse disorder to include a physician, an advanced registered nurse practitioner, a clinical psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed mental health counselor, a physician assistant working under the scope of practice of the supervising physician, or a master's level certified addictions professional if the certification is specific to substance abuse disorders

Section 21 amends s. 397.6793, F.S., to revise the criteria for a person to be examined or assessed to include a reasonable belief that without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself and that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being. The professional's certificate authorizing the involuntary admission of a person is valid for seven days after issuance.

Section 22 amends s. 397.6795, F.S., to allow a person's spouse or guardian, or a law enforcement officer, to deliver a person named in a professional's certificate for emergency admission to a hospital or licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization.

Section 23 amends s. 397.681, F.S., to specify that a court clerk may not charge a filing fee for the filing of a petition for involuntary assessment and stabilization.

Section 24 amends s. 397.6811(1), F.S., to allow a petition for assessment and stabilization to be filed by a person who has direct personal knowledge of a person's substance abuse disorder.

Section 25 amends s. 397.6814, F.S., to remove the requirement that a petition for involuntary assessment and stabilization contain a statement regarding the person's ability to afford an attorney. This section also directs that a fee may not be charged for the filing of a petition pursuant to this section.

Section 26 amends s. 397.6819, F.S., to allow a licensed service provider to admit a person for a period not to exceed 5 days unless a petition for involuntary outpatient services has been initiated pending further order of the court.

Section 27 amends s. 397.695, F.S., to provide for the filing of a petition for involuntary outpatient services and the professionals that must support such a recommendation. If the person has been stabilized and no longer meets the criteria for involuntary assessment and stabilization, he or she must be released while waiting for the hearing. The service provider must prepare certain reports and a treatment plan, including certification to the court that the recommended services are available. If the services are unavailable, the petition may not be filed with the court.

Section 28 amends s. 397.6951, F.S., to amend the content requirements of the petition for involuntary outpatient services to include the person's history of failure to comply with treatment requirements, a factual allegation that the person is unlikely to voluntarily participate in the recommended services, and a factual allegation that the person is in need of the involuntary outpatient services.

Section 29 amends s. 397.6955, F.S., to update the duties of the court upon the filing of a petition for involuntary outpatient services by including the requirement to schedule a hearing within five days unless a continuance is granted.

Section 30 amends s. 397.6957, F.S., to update the requirements of the court to hear and review all relevant evidence at a hearing for involuntary outpatient services, including the requirement that the petitioner has the burden of proving by clear and convincing evidence that the respondent has a history of lack of compliance with treatment for substance abuse, is unlikely to voluntarily participate in the recommended treatment, and that, without services, is likely to suffer from neglect or to refuse to care for himself or herself. One of the qualified professionals that executed the involuntary outpatient services certificate must be a witness at the hearing.

Section 31 amends s. 397.697, F.S., to allow courts to order involuntary outpatient services when the court finds the conditions have been proven by clear and convincing evidence; however, the court cannot order involuntary outpatient services if the recommended services are not available.

Section 32 amends s. 397.6971, F.S., to reflect the change in terminology from involuntary outpatient treatment to involuntary outpatient services.

Section 33 amends s. 397.6975, F.S., to reflect the change in terminology from involuntary outpatient treatment to involuntary outpatient services.

Section 34 amends s. 397.6977, F.S., to reflect the change in terminology from involuntary outpatient treatment to involuntary outpatient services.

Section 35 creates s. 397.6978, F.S., to allow for the appointment of a guardian advocate for a person determined incompetent to consent to treatment. The bill lists the persons prohibited from being appointed the patient's guardian advocate.

Section 36 amends s. 39.407, F.S., to correct cross-references.

Section 37 amends s. 212.055, F.S., to correct cross-references.

Section 38 amends s. 394.4599, F.S., to correct cross-references.

Section 39 amends s. 394.495(3), F.S., to correct cross-references.

Section 40 amends s. 394.496(5), F.S., to correct cross-references.

Section 41 amends s. 394.9085(6), F.S., to correct cross-references.

Section 42 amends s. 397.405(8), F.S., to correct cross-references.

Section 43 amends s. 397.407(1) and (5), F.S., to correct cross-references.

Section 44 amends s. 397.416, F.S., to correct cross-references.

Section 45 amends s. 409.972(1)(b), F.S., to correct cross-references.

Section 46 amends s. 440.102(1)(d) and (g), F.S., to correct cross-references.

Section 47 amends s. 744.704(7), F.S., to correct cross-references.

Section 48 amends s. 790.065(2)(a), F.S., to correct cross-references.

Section 49 provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Since the bill requires a transportation plan to be developed and implemented in each county or, if applicable, in counties that intend to share a transportation plan, it falls within the purview of Section 18(a), Article VII, Florida Constitution, which provides that cities and counties are not bound by certain general laws that require the expenditure of funds unless certain exceptions or exemptions are met. None of the exceptions apply. However, subsection (d) provides an exemption from this prohibition for laws determined to have an "insignificant fiscal impact." The fiscal impact of this requirement is indeterminate because the number of rides needed by residents cannot be predicted. If the costs exceed the insignificant threshold, the bill will require a 2/3 vote of the membership of each house and a finding of an important state interest.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

PCS/SB 12 prohibits a filing fee being charged for Marchman Act petitions; however, this does not create a fiscal impact on the clerks of court or the state court system because no fees are currently assessed.³⁰

B. Private Sector Impact:

Persons appointed by the court as guardian advocates for individuals in need of behavioral health services will have increased training requirements under the bill.

Behavioral health managing entities that have satisfactory contract performance will benefit from the provisions that allow the DCF to negotiate a new four-year contract using the exemption provided in s. 287.057(3)(e), F.S.

C. Government Sector Impact:

State

To the extent that the bill encourages the use of involuntary outpatient services rather than inpatient placement, the state would experience a positive fiscal impact. The cost of care in state treatment facilities is more expensive than community based behavioral health care. The amount of this potential cost savings is indeterminate.

Under the bill, the DCF has revised duties to review local behavioral health care plans, write or revise rules, and award any grants for implementation of the No Wrong Door policy. Similar administrative duties are currently performed by the DCF so these revised duties are not expected to create a fiscal impact.

Local

Local governments must revise their transportation plans for acute behavioral health care under the Baker Act and Marchman Act. The bill requires that as part of the transportation plan for the No Wrong Door policy, transportation must be provided between the single point of entry for behavioral health care and other treatment providers

³⁰ E-mail received from Florida Court Clerks & Comptroller, Nov. 6, 2015, and on file in the Senate Committee on Children, Families & Elder Affairs.

or settings as appropriate. This may create an indeterminate fiscal impact as such services are not currently provided in all areas of the state.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 29.004, 39.001, 39.507, 39.521, 394.455, 394.4573, 394.4597, 394.4598, 394.462, 394.463, 394.4655, 394.467, 394.46715, 394.761, 394.875, 394.9082, 397.311, 397.675, 397.679, 397.6791, 397.6793, 397.6795, 397.681, 397.6811, 397.6814, 397.6819, 397.695, 397.6951, 397.6955, 397.6957, 397.697, 397.6971, 397.6975, 397.6977, 397.6978, 39.407, 212.055, 394.4599, 394.495, 394.496, 394.9085, 397.405, 397.407, 397.416, 409.972, 440.102, 744.704, and 790.065.

This bill creates the following sections of the Florida Statutes: 394.761 and 397.6978.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS by Appropriations Subcommittee on Health and Human Services on January 26, 2016:

The CS:

- Removes the provision in the original bill authorizing a service provider to petition a county court for continued involuntary outpatient services;
- Prohibits a court from ordering an individual with traumatic brain injury or dementia who lacks a co-occurring mental illness to be involuntarily placed in a treatment facility;
- Revises the bill's provisions for the Department of Children and Families and the Agency for Health Care Administration to seek to maximize the amount of federal Medicaid funds available in the state for behavioral health services; and
- Makes technical terminology revisions throughout the bill.

B. Amendments:

None.