HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 7097 PCB CFSS 16-01 Mental Health and Substance Abuse
SPONSOR(S): Health & Human Services Committee; Health Care Appropriations Subcommittee; Children, Families & Seniors Subcommittee; Harrell
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	11 Y, 0 N	McElroy	Brazzell
1) Health Care Appropriations Subcommittee	10 Y, 0 N, As CS	Fontaine	Pridgeon
2) Health & Human Services Committee	17 Y, 0 N, As CS	McElroy	Calamas

SUMMARY ANALYSIS

CS/CS/HB 7097 addresses the statewide system of safety-net prevention, treatment, and recovery services for substance abuse and mental health (SAMH) administered by the Department of Children and Families (DCF). DCF currently contracts with seven managing entities that in turn contract with local service providers to deliver SAMH services. To enhance DCF oversight of managing entities, improve managing entity performance, and encourage greater managing entity accountability, the bill:

- Allows managed behavioral health organizations to bid for managing entity contracts when fewer than two bids from non-profit organizations are received;
- Requires managing entities to accredit their networks by 2018 and submit plans for phased enhancement of their systems of care, including specific recommendations for additional funding;
- Requires managing entities to provide care coordination for priority populations within available resources;
- Requires DCF to develop performance standards that measure improvement in a community's behavioral health and in specified individuals' functioning or progress toward recovery;
- Specifies members for managing entities' governing boards, and requires managed behavioral health organizations serving as managing entities to have advisory boards with that membership;
- Allows managing entities flexibility in shaping their provider networks while requiring processes for publicizing opportunities to join and evaluating providers for participation.

The bill requires counties and managing entities to collaborate to create designated receiving systems and transportation plans by October 31, 2017, to enhance the provision of acute behavioral health services to meet the needs of individuals with mental illness, substance abuse disorders, and co-occurring conditions.

The bill revises the Criminal Justice, Mental Health, and Substance Abuse Grant Program. The bill expands the membership of the Statewide Grant Review Committee to include more non-state representatives and renames it the Policy Committee. The bill creates a grant review and selection committee. It also streamlines the local process for applying for grants and allows DCF to require sequential intercept mapping of systems to identify where interventions may be effective.

The bill revises the Baker and Marchman Acts, which provide for voluntary and involuntary treatment for mental illness and substance abuse impairment respectively, to align some provisions, make the procedures more accessible, and enhance reporting on admissions pursuant to these acts, such as by:

- Expanding the types of professionals who can admit clients involuntarily,
- Allowing county court judges to issue ex parte orders for involuntary examinations under the Baker Act,
- Requiring DCF to develop and publish standard forms for Marchman Act pleadings and reporting,
- Requiring DCF to create a statewide database for collecting utilization data for all Marchman Act initiated detoxification and addictions receiving facility services funded by DCF, and
- Allowing the respondent, or an individual on his or her behalf, to privately pay for court-ordered involuntary treatment.

The bill repeals a variety of obsolete statutes.

The bill provides a nonrecurring appropriation of $400,000 to DCF for the creation of the statewide Marchman Act database.

The bill provides an effective date of July 1, 2016, except as otherwise provided in the act.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Mental Illness and Substance Abuse

Mental health and mental illness are not synonymous. Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

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

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. Only about 17% of adults in the United States are considered to be in a state of optimal mental health.[4] This leaves the majority of the population with less than optimal mental health, for example: [5]

- One in four adults (61.5 million people) experiences mental illness in a given year;
- Approximately 6.7 percent (14.8 million people) live with major depression; and
- Approximately 18.1 percent (42 million people) live with anxiety disorders, such as panic disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder and phobias.

Many people are diagnosed with more than one mental illness. For example, people who suffer from a depressive illness (major depression, bipolar disorder, or dysthymia) often have a co-occurring mental illness such as anxiety.[6]

Substance abuse also affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[7]

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[1] *Mental Health Basics*, Centers for Disease Control and Prevention. http://www.cdc.gov/mentalhealth/basics.htm (last viewed on January 4, 2016).
[2] Id.
[3] Id.
[4] Id. Mental illness can range in severity from no or mild impairment to significantly disabling impairment. Serious mental illness is a mental disorder that has resulted in a functional impairment which substantially interferes with or limits one or more major life activities. *Any Mental Illness (AMI) Among Adults*, National Institute of Mental Health. http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml (last viewed on January 4, 2016).
[5] *Mental Illness Facts and Numbers,* National Alliance on Mental Illness. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&sqi=2&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.nami.org%2Ffactsheets%2Fmentalillness_factsheet.pdf&ei=dYMIVdrWOYmqgwTBIYDQDA&usg=AFQjCNEATQZ5TXJF063JkMNgg9ZnwZb_ZA&bvm=bv.88198703,d.eXY (last viewed on January 4, 2016).
[6] *Mental Health Disorder Statistics,* John Hopkins Medicine. http://www.hopkinsmedicine.org/healthlibrary/conditions/mental_health_disorders/mental_health_disorder_statistics_85,P00753/ (last viewed on January 4, 2016).
[7] *Substance Abuse*, World Health Organization. http://www.who.int/topics/substance_abuse/en/ (last viewed on January 4, 2016).

In 2013, an estimated 21.6 million persons aged 12 or older were classified with having substance dependence or abuse issues.[8] Of these, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs, 4.3 million had dependence or abuse of illicit drugs but not alcohol, and 14.7 million had dependence or abuse of alcohol but not illicit drugs.[9]

Significant social and economic costs are associated with mental illness. Persons diagnosed with a serious mental illness experience significantly higher rates of unemployment compared with the general population.[10] This results in substantial loss of earnings each year[11] and can lead to homelessness. Homelessness is especially high for people with untreated serious mental illness, who comprise approximately one-third of the total homeless population.[12] Both adults and youth with mental illness frequently interact with the criminal justice system, which can lead to incarceration. For example, seventy percent of youth in juvenile justice systems have at least one mental health condition and at least twenty percent live with a severe mental illness.[13]

Substance abuse likewise has substantial economic and societal costs. In 2004, the total estimated costs of drug abuse and addiction due to use of tobacco, alcohol and illegal drugs was estimated at $524 billion a year.[14] This consists of $181 billion/year related to illegal drugs, $185 billion/year related to alcohol and $193 billion/year related to tobacco use.[15] These figures assume costs related to health care expenditures, lost earnings, law enforcement and incarceration.[16]

Mental illness and substance abuse commonly co-occur. Approximately 8.9 million adults have co-occurring disorders.[17] In fact, more than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs). [18] Drug abuse can cause individuals to experience one or more symptoms of another mental illness.[19] Additionally, individuals with mental illness may abuse drugs as a form of self-medication.[20] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.[21]

Florida's Substance Abuse and Mental Health Program

[8] Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.samhsa.gov%2Fdata%2Fsites%2Fdefault%2Ffiles%2FNSDUHresultsPDFWHTML2013%2FWeb%2FNSDUHresults2013.pdf&ei=L74IVZydKO2SsQStroDQCg&usg=AFQjCNE8sNFxhZQfOgdkJvOgZR3fP5I0Uw (last viewed on January 4, 2016).
[9] Id.
[10] *Accounting for Unemployment Among People with Mental Illness*, Baron RC, Salzer MS, Behav. Sci. Law., 2002;20(6):585-99. http://www.ncbi.nlm.nih.gov/pubmed/12465129 (last viewed on January 4, 2016).
[11] *Supra* footnote 5.
[12] *How Many Individuals with A Serious Mental Illness are Homeless?* Treatment Advocacy Center, Backgrounder, November 2014. http://www.treatmentadvocacycenter.org/problem/consequences-of-non-treatment/2058 (last viewed on January 4, 2016).
[13] *Supra* footnote 5.
[14] Drug Abuse Costs The United States Economy Hundreds of billions of Dollars in Increased Health Care Costs, Crime and Lost Productivity, National Institute on Drug Abuse, July 2008. http://www.drugabuse.gov/publications/addiction-science-molecules-to-managed-care/introduction/drug-abuse-costs-united-states-economy-hundreds-billions-dollars-in-increased-health (last viewed on January 4, 2016).
[15] Id.
[16] Id.
[17] *About Co-Occurring*, Substance Abuse and Mental Health Services Administration. http://media.samhsa.gov/co-occurring/default.aspx (last viewed on January 4, 2016).
[18] *Co-Occurring Disorders*, Psychology Today. https://www.psychologytoday.com/conditions/co-occurring-disorders (last viewed on January 4, 2016).
[19] *Comorbidity: Addiction and Other Mental Illnesses*, U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCMQFjAA&url=http%3A%2F%2Fwww.drugabuse.gov%2Fsites%2Fdefault%2Ffiles%2Frrcomorbidity.pdf&ei=6q8NVf-iMsibNo7gg4AO&usg=AFQjCNFujSP7SHxxqB3FI7961yGQNQ56YA&bvm=bv.88528373,d.eXY (last viewed on January 4, 2016).
[20] Id.
[21] *Supra* footnote 18.

The Florida Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[22]

Behavioral Health Managing Entities

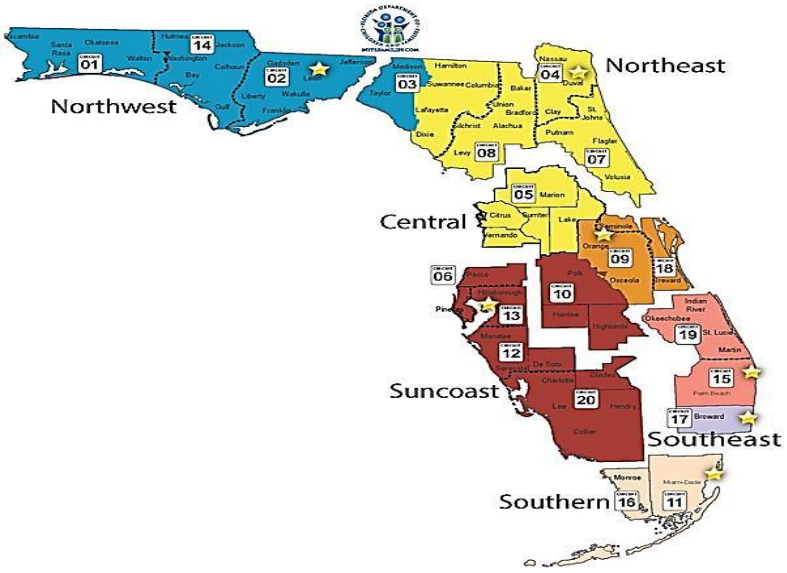
In 2001, the Legislature authorized DCF to implement behavioral health managing entities as the management structure for the delivery of local mental health and substance abuse services.[23] This was based upon the Legislature's decision that a management structure that places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level would:[24]

- Promote improved access to care;
- Promote service continuity; and
- Provide for more efficient and effective delivery of substance abuse and mental health services.

The implementation of the managing entity system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement managing entities statewide.[25] Full implementation of the statewide managing entity system occurred in April 2013, with all geographic regions now served by a managing entity.[26] Implementation has allowed DCF to reduce the number of direct contracts for mental health and substance abuse services from several hundred to 7.[27] DCF currently contracts with 7 managing entities that in turn contract with local service providers for the delivery of mental health and substance abuse services:[28]

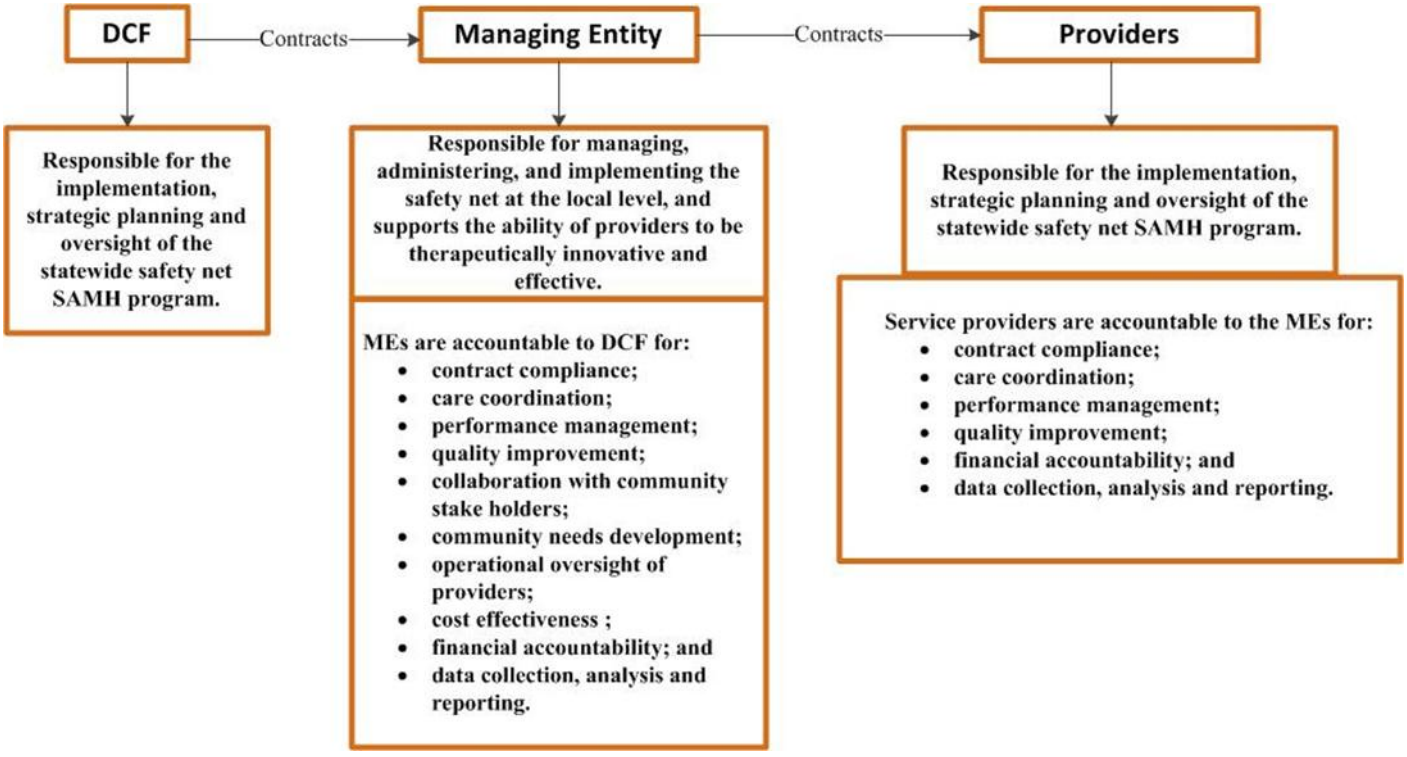
- Big Bend Community Based Care- April 1, 2013 (**blue**).
- Lutheran Services Florida- July 1, 2012 (**yellow**).
- Central Florida Cares Health System- July 1, 2012 (**orange**).
- Central Florida Behavioral Health Network, Inc.- July 1, 2012 (**red**).
- Southeast Florida Behavioral Health- October 1, 2012 (**pink**).
- Broward Behavioral Health Network, Inc.- November 6, 2012 (**purple**).
- South Florida Behavioral Health Network, Inc.- October 1, 2012 (**beige**).

[22] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance and children at risk for initiating drug use.
[23] Ch. 2001-191, Laws.
[24] Section 394.9082, F.S.
[25] Chapter 2008-243, Laws.
[26] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.
[27] *Department of Children and Families Service System Management Plan, Statewide Implementation of Managing Entities or Similar Model*, July 2009.
[28] *Managing Entities*, Department of Children and Families. http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities (last viewed on January 4, 2016).



Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.

DCF, managing entities and service providers have specific responsibilities in the SAMH program.



DCF uses four performance measures to evaluate the performance of the managing entities:[29]

- **Systemic Monitoring** – The managing entity shall complete on-site monitoring of no less than 20% of all network service providers each fiscal year;
- **Network Service Provider Compliance** – A minimum of 95% of the managing entity's network service providers shall demonstrate annual compliance with a minimum of 85% of the

[29] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis & Government Accountability, July 18, 2014.

applicable network service provider measures (i.e., client outcome measures) at the target levels for the network service provider established in the subcontract;

- **Block Grant Implementation** – The managing entity shall ensure 100% of the cumulative annual network service provider expenses comply with the block grant and maintenance of effort establish allocation standards; and
- **Implementation of the General Appropriations Act**: The managing entity shall meet 100% of the following requirements:
    - Implementation of specific appropriations, demonstrated by contracts with network services providers; and
    - Submission of all required plans for federal substance abuse and mental health block grants.

Apart from DCF's direct oversight of managing entities through evaluating adherence to contractual requirements and measuring performance, accreditation is a way of assuring the quality of a managing entity's services. Accreditation through an accrediting organization with published standards allows a managing entity to demonstrate achievement of those standards. One type of accreditation available to a managing entity is accreditation of its network. For instance, the Commission on Accreditation of Rehabilitation Facilities (also known as CARF International) offers a network accreditation that addresses domains such as integrated strategic planning, resource coordination, and technology.[30] Currently four of the seven managing entities have a network accreditation.[31]

Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program

In 2007, the Legislature created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program (Program). The purpose of the Program is to provide funding to counties to plan, implement, or expand initiatives that increase public safety, avert increased spending on criminal and juvenile justice, and improve the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance abuse disorder, or co-occurring mental health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.[32]

Currently, only a county or a consortium of counties who have established planning councils or committees may apply for a grant under the Program.[33] The county may designate an agency, including a non-county agency, as "lead agency;" however, the application must be submitted under the authority of the county.[34] Applicants may seek a one-year planning grant or a three-year implementation or expansion grant.[35] An applicant must have previously received a planning grant to be eligible for an implementation or expansion grant. A grant may not be awarded unless the applicant county, or a consortium of counties, makes available resources in an amount equal to the total amount of the grant.[36]

The Program's Statewide Grant Review Committee (Committee) is responsible for evaluating applications submitted to the Program. The Committee includes:[37]

- One representative of DCF;
- One representative of the Department of Corrections;
- One representative of the Department of Juvenile Justice;
- One representative of the Department of Elderly Affairs; and

[30] Why does accreditation matter? http://www.carf.org/Accreditation/ (last accessed Feb. 21, 2016).
[31] Email from Linda McKinnon, re: possible ME network accreditation language, Feb. 15, 2016 (on file with the Children, Families, and Seniors Subcommittee).
[32] Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant: Request for Applications, Department of Children and Families, May 2013.
[33] Section 394. 658(3), F.S.
[34] Id.
[35] Section 394. 656(3)(a), F.S.
[36] Section 394. 658(2)(b) and (c), F.S.
[37] Section 394. 656(2)(a-e), F.S.

- One representative of the Office of the State Courts Administrator.

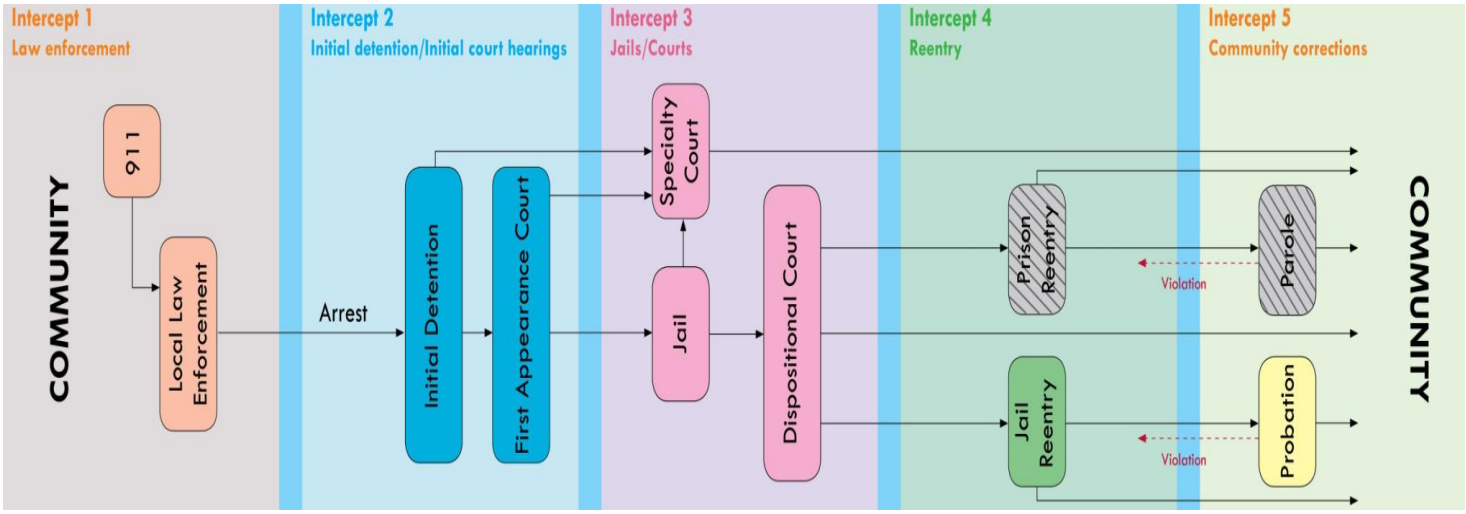
The Committee provides written notification to DCF of the names of the applicants who have been selected to receive a grant.[38] DCF may then transfer funds, if available, to any counties or consortium of counties awarded a grant.[39] A grant may not be awarded unless the applicant county, or a consortium of counties, makes available resources in an amount equal to the total amount of the grant.[40] For fiscally constrained counties, the available resources may be at 50 percent of the total amount of the grant.[41]

Sequential Intercept Model

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems.[42] The model seeks to identify points of interception where an intervention can occur to prevent an individual from entering or penetrating deeper into the criminal justice system.[43] The interception points are:[44]

- Law enforcement and emergency services;
- Initial detention and initial hearings;
- Jail, courts, forensic evaluations, and forensic commitments;
- Reentry from jails, state prisons, and forensic hospitalization; and
- Community corrections and community support.

Sequential Intercept Model



SAMHSA Gain Center for Behavioral Health and Justice Transformation.

A community can use the model to develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment.[45]

Florida Mental Health Act

[38] Section 394. 656(4), F.S.
[39] Id.
[40] Section 394. 658(2)(b) and (c), F.S.
[41] Id.
[42] *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, Munetz MR and Griffin PA, Psychiatr. Serv., 2006 April; 57(4):544-9. http://www.ncbi.nlm.nih.gov/pubmed/16603751 (last viewed on January 4, 2016).
[43] Id.
[44] Id.
[45] Id.

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. [46] The Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[47]

Involuntary Examination and Receiving Facilities

Individuals in acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[48] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness[49]:

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

Involuntary patients must be taken to either a public or a private facility that has been designated by DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment.[50] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.[51] Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[52]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[53] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[54]

The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[55] Individuals often enter the public mental health system through CSUs.[56] For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by Legislature in the 1970s to ensure continuity of care for individuals.[57]

[46] Sections 394.451-394.47891, F.S.
[47] Section 394.459, F.S.
[48] Sections 394.4625 and 394.463, F.S.
[49] Section 394.463(1), F.S.
[50] Section 394.455(26), F.S.
[51] Section 394.455(25), F.S
[52] Rule 65E-5.400(2), F.A.C.
[53] Section 394.875(1)(a), F.S.
[54] Id
[55] Id.
[56] Budget Subcommittee on Health and Human Services Appropriations, the Florida Senate, Crisis Stabilization Units, (Interim Report 2012-109) (Sept. 2011).
[57] Id. Sections 394.65-394.9085, F.S.

For FY 2014-15 there are 544 adult and 106 crisis stabilization beds funded by DCF.[58] There were 181,471 involuntary examinations initiated at hospitals and CSUs in calendar year 2014 (most recent report).[59]

Guardian Advocate

The Baker Act provides for the appointment of a guardian advocate for individuals who are incompetent to consent to treatment. The guardian advocate is responsible for making well-informed mental health treatment decisions for the patient. The administrator of a receiving or treatment facility may petition the court for the appointment of advocate guardian if a psychiatrist has determined that a patient is incompetent to consent to treatment.[60] The court will conduct a hearing on the petition during which a patient will have the right to testify, cross-examine witnesses, and present witnesses.[61] The court will appoint a qualified guardian advocate if it finds the patient incompetent.[62] The court may not appoint certain individuals as a guardian advocate:[63]

- An employee of the facility providing direct mental health services to the patient;
- A DCF employee;
- An administrator of a treatment or receiving facility; or
- A member of the Florida local advocacy council.

The facility must provide a guardian advocate with sufficient information for a guardian advocate to make an informed decision.[64] This includes information related to whether the proposed treatment is essential to the care of the patient and whether the proposed treatment presents an unreasonable risk of serious, hazardous, or irreversible side effects.[65] A guardian advocate must meet and talk with the patient and the patient's physician in person (if at all possible) before giving consent to treatment.[66] The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.[67]

Guardian advocates may only provide consent for mental health treatment if the patient is incompetent. The appointment of a guardian advocate will be terminated if a patient is:

- Discharged from an order for involuntary outpatient placement or involuntary inpatient placement;
- Transferred from involuntary to voluntary status; or
- Determined by the court to be competent.

<u>The Marchman Act</u>

In the early 1970s, the federal government enacted laws creating formula grants for states to develop continuums of care for individuals and families affected by substance abuse. [68] The laws resulted in separate funding streams and requirements for alcoholism and drug abuse; in response to the laws, the Florida Legislature enacted Chapters 396, F.S., (alcohol) and 397, F.S. (drug abuse).[69] Each of these laws governed different aspects of addiction, and thus had different rules promulgated by the state to

[58] Id.
[59] Christy, A. (2015). Report of 2014 *Baker Act Data*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.
[60] Section 394.4598(1), F.S.
[61] Id.
[62] Id .
[63] Id.
[64] Section 394.4598(2), F.S.
[65] Id.
[66] Id.
[67] Section 394.4598(7), F.S.
[68] Department of Children and Families, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5
[69] Id.

fully implement the respective pieces of legislation.[70] However, because persons with substance abuse issues often do not restrict their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not adequately address the problems faced by Florida's citizens.[71] In 1993 legislation was adopted to combine Chapters 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act ("the Marchman Act").[72]

The Marchman Act program is designed to support the prevention and remediation of substance abuse through the provision of a comprehensive system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

Voluntary vs. Involuntary Admissions

An individual may receive services under the Marchman Act through either a voluntary or an involuntary admission. The Marchman Act encourages persons to seek treatment on a voluntary basis and to be actively involved in planning their own services with the assistance of a qualified professional. An individual who wishes to enter treatment may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service provider.[73] However, denial of addiction is a common symptom, raising a barrier to early intervention and treatment.[74] As a result, treatment often comes because of a third party making the intervention needed for substance abuse services.[75]

The Marchman Act establishes a variety of methods under which substance abuse assessment, stabilization and treatment can be obtained on an involuntary basis. There are five involuntary admission procedures that can be broken down into two categories depending upon whether the court is involved. Regardless of the nature of the proceedings, an individual meets the criteria for an involuntary admission under the Marchman Act when there is good faith reason to believe the individual is substance abuse impaired and, because of such impairment, has lost the power of self-control with respect to substance use; and either has inflicted, attempted or threatened to inflict, or unless admitted, is likely to inflict physical harm on himself/herself or another; or the person's judgment has been so impaired because of substance abuse that he/she is incapable of appreciating the need for substance abuse services and of making a rational decision in regard to substance abuse services.[76]

Non-Court Involved Involuntary Admissions

The three types of non-court procedures for involuntary admission for substance abuse treatment under the Marchman Act are:

- **Protective Custody**: Law enforcement officers use this when an individual is substance-impaired or intoxicated in public and is brought to the attention of the officer. The purpose of this procedure is to allow the person to be taken to a safe environment for observation and

[70] Id.
[71] Id.
[72] Ch. 93-39, s. 2, Laws of Fla., codified in ch. 397, F.S.
[73] S. 397.601(1), F.S. Additionally, under s. 397.601(4)(a), F.S., a minor is authorized to consent to treatment for substance abuse.
[74] Darran Duchene and Patrick Lane, *Fundamentals of the Marchman Act*, RISK RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Program, http://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited December 16, 2015).
[75] Id.
[76] S. 397.675, F.S.

assessment to determine the need for treatment.[77] Law enforcement is not required to execute a written report for the initiation of protective custody.

- **Emergency Admission**: This permits an individual who appears to meet the criteria for involuntary admission to be admitted to a hospital, an addiction receiving facility or a detoxification facility for emergency assessment and stabilization. Individuals admitted for involuntary assessment and stabilization under this provision must have a physician's certificate for admission, demonstrating the need for this type of placement and recommending the least restrictive type of service that is appropriate to the needs of the individual.[78]
- **Alternative Involuntary Assessment for Minors**: This provides a way for a parent, legal guardian or legal custodian to have a minor admitted to an addiction receiving facility to assess the minor's need for treatment by a qualified professional.[79]

Court Involved Involuntary Admissions

The two court involved Marchman Act procedures are involuntary assessment and stabilization, which provides for short-term court-ordered substance abuse treatment, and involuntary treatment, which provides for long-term court-ordered substance abuse treatment. Both are initiated through the filing of a petition for which the court may charge a filing fee.

Involuntary Assessment and Stabilization

Involuntary assessment and stabilization involves filing a petition with the court. The petition for involuntary assessment and stabilization must contain:

- The name of the applicant or applicants (the individual(s) filing the petition with the court);
- The name of the respondent (the individual whom the applicant is seeking to have involuntarily assessed and stabilized);
- The relationship between the respondent and the applicant;
- The name of the respondent's attorney, if he or she has one, and whether the respondent is able to afford an attorney; and
- Facts to support the need for involuntary assessment and stabilization, including the reason for the applicant's belief that:
    - The respondent is substance abuse impaired; and
    - The respondent has lost the power of self-control with respect to substance abuse; and either that
    - The respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
    - The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.[80]

Once the petition is filed with the court, the court issues a summons to a respondent and the court must schedule a hearing to take place within 10 days, or can issue an ex parte order immediately.[81]

After hearing all relevant testimony, the court determines whether a respondent meets the criteria for involuntary assessment and stabilization and must immediately enter an order that either dismisses the petition or authorizes the involuntary assessment and stabilization of the respondent.

If the court determines a respondent meets the criteria, it may order him or her to be admitted for a period of 5 days[82] to a hospital, licensed detoxification facility, or addictions receiving facility, for

[77] S. 397.667, F.S. A law enforcement officer may take the individual to their residence, to a hospital, a detoxification center, or addiction receiving facility, or in certain circumstances, to jail. Minors, however, cannot be taken to jail.
[78] S. 397.679, F.S.
[79] S. 397.6822, F.S.
[80] S. 397.6814, F.S.
[81] S. 397.6815, F.S. Under the ex parte order, the court may order a law enforcement officer or other designated agent of the court to take the respondent into custody and deliver him/her to the nearest appropriate licensed service provider

involuntary assessment and stabilization.[83] During that time, an assessment is completed on the individual.[84] The written assessment is sent to the court. Once the written assessment is received, the court must either

- Release the individual and, if appropriate, refer the individual to another treatment facility or service provider, or to community services;
- Allow the individual to remain voluntarily at the licensed provider; or
- Hold the individual if petition for involuntary treatment has been initiated.[85]

Involuntary Treatment

Involuntary treatment allows the court to require the individual to be admitted for treatment for a longer period only if the individual has previously been involved in at least one of the four other involuntary admissions procedures within a specified period.[86] Similar to a petition for involuntary assessment and stabilization, a petition for involuntary treatment must contain the same identifying information for all parties and attorneys and facts to support the need for involuntary treatment including the reason for the petitioner's belief that:

- The respondent is substance abuse impaired; and
- The respondent has lost the power of self-control with respect to substance abuse; and either that
    - The respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
    - The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.[87]

A treatment hearing must be scheduled within 10 days after the petition is filed. If the court finds that the conditions for involuntary substance abuse treatment have been proven, it may order the respondent to undergo involuntary treatment with a licensed service provider for a period not to exceed 60 days.[88] The statute does not expressly state whether the individual must be sent to a publicly or privately funded service provider.

Behavioral Health Acute Care System

The behavioral health acute care system is extraordinarily complex. This graphic indicates the entities involved in the system regarding mental health specifically. Additional entities are involved regarding substance abuse, such as addictions receiving facilities and detoxification units.

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[82] If a licensed service provider is unable to complete the involuntary assessment and, if necessary, stabilization of an individual within 5 days after the court's order, it may, within the original time period, file a request for an extension of time to complete its assessment. The court may grant additional time, not to exceed 7 days after the date of the renewal order, for the completion of the involuntary assessment and stabilization of the individual. The original court order authorizing the involuntary assessment and stabilization, or a request for an extension of time to complete the assessment and stabilization that is timely filed pursuant to this section, constitutes legal authority to involuntarily hold the individual for a period not to exceed 10 days in the absence of a court order to the contrary. S. 397.6821, F.S.

[83] S. 397.6811, F.S. The individual may also be ordered to a less restrictive component of a licensed service provider for assessment only upon entry of a court order or upon receipt by the licensed service provider of a petition

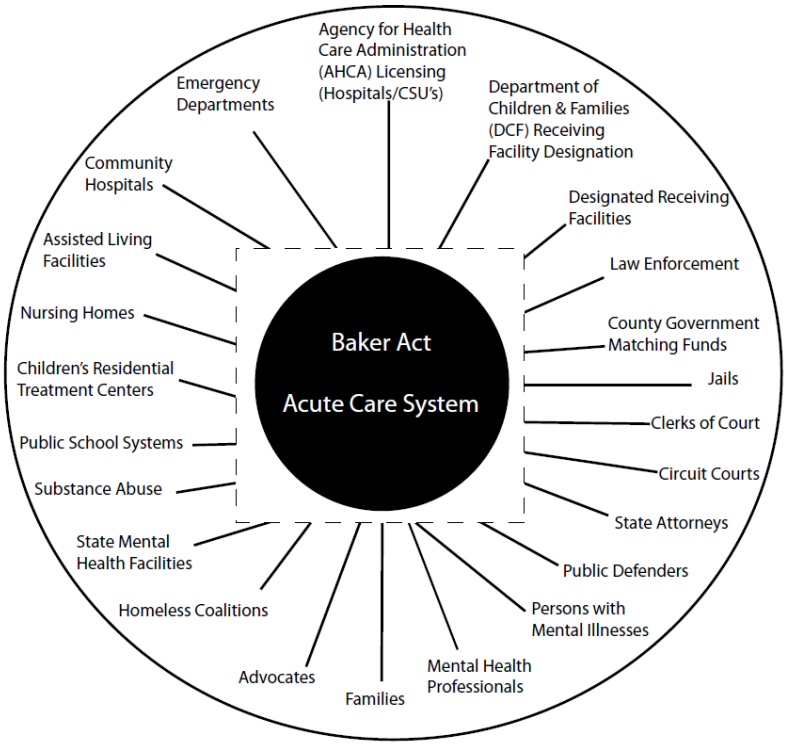
[84] S. 397.6819, F.S., The licensed service provider must assess the individual without unnecessary delay using a qualified professional. If an assessment is performed by a qualified professional who is not a physician, the assessment must be reviewed by a physician before the end of the assessment period.

[85] S. 397.6822, F.S. The timely of a Petition for Involuntary Treatment authorizes the service provider to retain physical custody of the individual pending further order of the court.

[86] S. 397.693, F.S.

[87] S. 397.6951, F.S.

[88] If the need for treatment is longer, renewal of the order may be petitioned prior to the expiration of the initial 60-day period.



Source: Florida Mental Health Institute, USF, 2014 Baker Act User Reference Guide.

Various state and federal laws and associated regulations govern the operation of and interaction between these entities in the performance of their duties relating to behavioral health acute care. Examples include:

- Federal:
  - Emergency Medical Treatment and Active Labor Act[89], which applies to all hospitals with emergency service capacity, including freestanding psychiatric hospitals. The law prohibits the delay or denial of emergency medical services, including psychiatric or substance abuse emergencies, due to inability to pay.[90]
- State:
  - Baker Act and other provisions of ch. 394, F.S., governing the operation of the mental health system, including those governing transportation of clients, local match for mental health services, and the managing entity system.
  - Marchman Act and other provisions of ch. 397, F.S., including those governing substance abuse facility licensure.
  - Access to emergency services and care, s. 396.1041, F.S., which also prohibits the delay or denial of emergency services by hospitals. It governs access to care and transfers from a hospital.
  - Guardianship, ch. 744, F.S., through which an individual is adjudicated incompetent and a guardian appointed.
  - Advance directives, ch. 765, F.S., which addresses advanced planning for incapacity and surrogate health care decisionmakers and proxies.
  - Medicaid, ch. 409, which governs the operation of the state's medical assistance program. For example, managed care plans must offer at a minimum mental health services and substance abuse treatment services.[91]

Other laws, such as federal law regarding the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants, which fund safety-net services, and confidentiality of

[89] 42 U.S.C. 1395dd.
[90] *Florida Mental Health Institute, USF, 2014 Baker Act User Reference Guide.*
[91] S. 409.973(1)(q) and (bb), F.S.

client records govern behavioral health care generally and also affect the operation of the behavioral health acute care system.

Funding for services provided in this system comes from a variety of sources, including but not limited to local government funding[92], state general revenue, federal block grant funds, Medicaid, private insurance, and client fees[93].

Pursuant to s. 394.9082(6)(a), F.S., managing entities are tasked with demonstrating the ability of their networks of providers to comply with the pertinent provisions of both the Baker and Marchman Acts. However, managing entities are not specifically charged with planning for the effective operation of the behavioral health acute care system.

Provisions of ch. 394 and 397 govern transportation to and among facilities, though the Baker Act is more detailed than the Marchman Act. For instance, s. 394.462, F.S., specifies that law enforcement transports individuals for involuntary admission to the nearest receiving facility, except under very specific circumstances. In contrast, transportation to emergency assessment and stabilization under the Marchman Act may be provided by a variety of parties such as the applicant for the person's emergency admission, his or her spouse or guardian, law enforcement officer, or health officer.[94] Neither act requires formal planning for transportation to support the community's behavioral health acute care system, though the Baker Act allows for counties to exempt themselves from certain statutory transportation requirements under certain circumstances.[95]

Suitability Assessments for Children in the Child Welfare System

Section 39.407, F.S., provides a process for assessing the suitability of a child in the child welfare system who is in the legal custody of DCF for residential mental health treatment. This assessment must be conducted by a qualified evaluator and evaluates whether the child appears to have an emotional disturbance serious enough to require treatment, the child has had the treatment explained to him or her, and no less restrictive modalities are available.

Children receiving foster care assistance through federal Title IV-E funding are a mandatory eligibility group under Medicaid.[96] Thus for many foster children, a Medicaid plan may be responsible for the cost of their residential mental health treatment; however, statute does not require the plan to receive a copy of the assessment.

Social Work, Therapy and Counseling Interns

In Florida, an individual may register as an intern in clinical social work, marriage and family therapy, or mental health counseling. Registering as an intern enables an individual to gain the required postgraduate or postmaster's clinical experience that is required for full licensure. Currently, 1,500 hours of face-to-face psychotherapy is required, which may not be accrued in fewer than 100 weeks.[97]

An applicant seeking registration as an intern must:[98]

- Submit the application form and the nonrefundable fee;
- Complete the education requirements;
- Submit an acceptable supervision plan for meeting the practicum, internship, or field work required for licensure that was not satisfied by graduate studies; and
- Identify a qualified supervisor.

[92] S. 394.76, F.S.
[93] S. 394.674(3), F.S.
[94] S. 397.6795, F.S.
[95] S. 394.462(4), F.S.
[96] S. 409.903(4), F.S.
[97] Rule 64B4-2.001, F.A.C.
[98] Section 491.005, F.S.

Currently, an intern may renew his or her registration every biennium, with no limit on the number of times a registration may be renewed.

A provisional license allows individual practice, under supervision a licensed mental health professional, while not meeting all of the clinical experience requirements. Individuals must met minimum coursework requirements, and possess the appropriate graduate degree. A provisional license is valid for 2 years.[99]

Dementia and Alzheimer's disease

Dementia is not a disease but rather is an umbrella term used for a set of symptoms which commonly include impaired thinking and memory loss.[100] Based upon the individual's symptomology, dementia is classified as either a major or minor neurocognitive disorder. Examples of common causes of dementia include vascular dementia, frontotemporal lobar degeneration, Creutzfeldt-Jacob disease, and Alzheimer's disease. [101] An estimated 14% of individuals aged 71 years or older have some form of dementia.[102]

Alzheimer's is a chronic disease with symptoms progressively worsening over time. Alzheimer's typically begins with mild memory loss; however, as the disease worsens the individual encounters greater difficulty in performing everyday tasks. Some symptoms of AD include memory loss that disrupts daily life; challenges in planning or solving problems; difficulty completing familiar tasks at home, at work or at leisure; and confusion with time or place. [103]

Similar to other chronic diseases, there is no single cause for Alzheimer's. Instead, it develops as a result of multiple factors, which include, but are not limited to age, family history, cardiovascular disease, mild cognitive impairment, education, social and cognitive engagement, and traumatic brain injury.

Alzheimer's disease is the most common cause of dementia.[104] There are an estimated 5.3 million people in the United States who have been diagnosed with Alzheimer's disease.[105] This number is projected to increase to 7.1 million people in 2025, and 13.8 million people by 2050.[106] In 2015, there were an estimated 500,000 Floridians with Alzheimer's disease with a projection of 580,000 people by 2020.[107]

Most types of dementia, including Alzheimer's, cannot be cured, but the symptoms may be temporarily improved through non-pharmacological therapies and medication. Treatment can be complicated as Alzheimer's and dementia-related disorders can co-occur with other mental disorders such as depression, anxiety disorders, and psychotic conditions.[108] The symptoms of Alzheimer's and dementia-related disorders should initially be managed through the use of non-pharmacological therapies.[109] If non-pharmacological therapies do not prove effective the next step is to employ various medications. These include antidepressants, anxiolytics and antipsychotic medications.[110]

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[99] Section 491.0046, F.S. and Rule 64B-3.0075, F.A.C.
[100] *Difference Between Alzheimer's and Dementia*. http://www.alzheimers.net/difference-between-alzheimers-and-dementia/ (last visited February 19, 2016).
[101] *2015 Alzheimer's Disease Fact and Figures*, Alzheimer's Association, http://www.alz.org/alzheimers_disease_facts_and_figures.asp (last visited February 19, 2016).
[102] Id.
[103] Id.
[104] Types of dementia. http://www.alz.org/dementia/types-of-dementia.asp (last visited February 22, 2016).
[105] Id.
[106] Id.
[107] *Alzheimer's Disease Initiative*, Florida Department of Elder Affairs. http://elderaffairs.state.fl.us/doea/alz.php (last visited February 19, 2016).
[108] *Cognitive Camouflage — How Alzheimer's Can Mask Mental Illness*, Michael B. Friedman, LMSW; Gary J. Kennedy, MD; and Kimberly A. Williams, LMSW, Aging Well, Vol. 2 No. 2 P. 16, January/February 2009. http://www.todaysgeriatricmedicine.com/archive/030209p16.shtml (last visited February 19, 2016).
[109] *A Systematic Evidence Review of Non-pharmacological Interventions for Behavioral Symptoms of Dementia*, Department of Veterans Affairs, March 2011. http://www.ncbi.nlm.nih.gov/books/NBK54971/ (last visited February 19, 2016).
[110] *Treatments for Behavior*, Alzheimer's Association. http://www.alz.org/alzheimers_disease_treatments_for_behavior.asp#medications (last visited February 19, 2016).

No drugs have been specifically approved by the U.S. Food and Drug Administration (FDA) to treat behavioral and psychiatric dementia symptoms.[111] Further, the FDA issued a warning notifying healthcare professionals that antipsychotics are associated with an increased risk of mortality in elderly patients treated for dementia-related psychosis.[112]

Effect of the Proposed Changes

Legislative Findings and Intent

CS/CS/HB 7097 adds legislative findings and intent to both the Baker (amending s. 394.453, F.S.) and Marchman (amending s. 397.305, F.S.) Acts to provide:

- Services should use coordination-of-care principles and include social support services;
- Policy and funding decisions should be data-driven; and
- Licensed, qualified health professionals should be authorized to practice to the full extent of their education and training in the performance of professional functions necessary to carry out the intent of the act.

The bill strikes current intent language regarding least restrictive interventions and collaboration by state agencies and service systems.

The bill also adds a legislative finding with respect to the managing entities in s. 394.9082, F.S., that discharge of consumers from public receiving facilities into homelessness is inappropriate and detrimental to their recovery, and managing entities, public receiving facilities, homeless services providers, and housing providers shall work together cooperatively to identify placements that meet consumers' needs and facilitate their recovery.

[111] Id.
[112] *Information for Healthcare Professionals: Conventional Antipsychotics,* U.S. Food and Drug Administration, June 16, 2008. http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm124830.htm (last visited February 19, 2016).

Substance Abuse and Mental Health Program

Behavioral Health System of Care

The bill revises the definitions in s. 394.67, F.S., for "mental health services" and "substance abuse services" to remove detail about specific types of services. This detail is instead placed in s. 394.675, F.S., which the bill amends to require the establishment of a behavioral health system of care as resources permit, to include mental health services, substance abuse services, and services for co-occurring disorders for prevention, assessment, intervention, treatment, rehabilitation, and support, such as:

- Crisis services provided through a designated receiving system;
- Case management, which includes direct services and may include assessment of individual needs, intervention planning, linking to services, monitoring service delivery, evaluating the effect of services, and advocating on behalf of the individual;
- Transportation in accordance with a plan developed under s. 394.4602, F.S.;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication Assisted Treatment and medication management;
- Recovery support, such as supportive housing; supported employment; family support and education; independent living skill development; and wellness management and self-care;
- Medical services which promote improved access to primary care by individuals with behavioral health conditions;
- Behavioral health services provided in a primary health care setting; and
- Prevention and outreach services.

CS/CS/HB 7097 requires that all case managers and their direct supervisors hold a valid certification issued by a DCF-approved credentialing entity.

The bill also requires care coordination to address the recovery support needs of certain consumers to the extent allowed by available resources. This includes coordination with other local systems and entities, public and private, that are involved with the consumer, such as primary health care, child welfare, behavioral health care, and criminal and juvenile justice. The bill defines priority groups for receiving care coordination to include:

- Individuals with serious mental illness or substance abuse disorders who have been admitted multiple times to acute levels of care, state mental health treatment facilities, jails, or prison;
- Individuals in receiving facilities or crisis stabilization units who are on the waitlist to a state treatment facility; and
- Individuals in state treatment facilities who are on the waitlist for community-based care.

Behavioral Health Managing Entities

The bill adds the definition of "managing entity" to s. 394.67, F.S., defining it as a corporation that is selected by DCF to execute administrative duties to facilitate the delivery of behavioral health services through a coordinated behavioral health system of care.

CS/CS/HB 7097 substantially revises s. 394.9082, F.S., governing managing entities. The revised section deletes current language regarding the transition to the managing entity system and reorganizes provisions to specifically address DCF responsibilities, contracting, managing entity responsibilities, performance management and accountability, network accreditation and systems coordination agreements, funding, and the crisis stabilization services utilization database.

Definitions

The bill revises current definitions and creates new definitions, to define:

- "Behavioral health services" as mental health and substance abuse services as defined in ch. 394 and 397 which are provided using local match and state and federal funds.
- "Behavioral health system of care" as the array of mental health and substance abuse services described in s. 394.675, F.S.
- "Geographic area" as one or more contiguous counties, circuits, or regions as described in s. 409.966, F.S.
- "Managed behavioral health organization" as a Medicaid managed care organization currently under contract with the Medicaid managed medical assistance program or a behavioral health specialty managed care organization established pursuant to part IV of chapter 409.
- "Provider network" as the direct service agencies under contract with a managing entity to provide behavioral health services.
- "Subregion" as a distinct portion of a managing entity's geographic region defined by unifying service and provider utilization patterns.

Contracts

The bill requires DCF to contract with organizations to serve as managing entities. The bill allows entities other than non-profit organizations to serve as managing entities under specific circumstances. Using an invitation to negotiate, DCF must first attempt to contract with nonprofit organizations for the delivery of these services, using at a minimum the following criteria to evaluate bidders:

- Experience serving persons with mental health and substance use disorders;
- Established community partnerships with behavioral health providers;
- Demonstrated organizational capabilities for network management functions;
- Capability to coordinate behavioral health care services with primary care services; and
- Willingness to provide recovery-oriented services and systems of care and work collaboratively with persons with mental health and substance use disorders and their families in designing such systems and delivering such services.

However, if fewer than two responsive bids are received to a solicitation, DCF must reissue the solicitation, and managed behavioral health organizations will be eligible to bid in addition to nonprofit organizations. CS/CS/HB 7097 requires all for-profit and nonprofit contractors serving as managing entities to operate under the same contractual requirements. DCF must perform a readiness review before a managing entity may begin performing its duties.

DCF Oversight of Managing Entities

In overseeing the operation of the managing entities, the bill requires DCF to:

- Specify data reporting requirements and the use of shared data systems;
- Provide technical assistance to the managing entities;
- Facilitate coordination between the managing entity and other payors of behavioral health care;
- Develop and provide a unique identifier for clients receiving services through the managing entity;
- Coordinate procedures for the referral and admission of patients to, and the discharge of patients from, treatment facilities and their return to the community;
- Ensure that managing entities comply with state and federal laws, rules, regulations and grant requirements; and
- Develop rules for the operations of, and the requirements that shall be met by, the managing entity, if necessary.

Additionally, DCF is to promote the coordination of behavioral health care and primary care, develop strategies to divert persons with mental illness or substance abuse disorders from the criminal and juvenile justice systems and to integrate services with the child welfare system, support the

development and implementation of a coordinated system of care, and designate a receiving systems developed under s. 394.4602(2), F.S.

Managing Entity Responsibilities

The bill also details requirements for managing entities regarding needs assessment and service planning, network management, and governance and stakeholder relations. Managing entities must promote the development and effective implementation of a coordinated system of care. Specifically, CS/CS/HB 7097 requires managing entities to conduct a community behavioral health care needs assessment every three years in the geographic area served by the managing entity; the needs assessment must specify needs by subregion and be provided to DCF. Based on this assessment, managing entities must determine the optimal array of services to meet the community's identified needs, manage and allocate funds for services to meet the requirements of law or rule, and expand the scope of services as resources become available. CS/CS/HB 7097 specifies that managing entities must provide directly or contract for case management.

In managing their networks, managing entities must submit network management plans and other documents as required by DCF. They also are to develop comprehensive networks of qualified providers to deliver behavioral health services. The bill provides managing entities flexibility to determine their network participants but requires them to have a process for publicizing opportunities for providers to join the network and evaluating to determine whether a provider may be part of its network. The bill requires managing entities to assist local providers in developing local resources by pursuing third-party payments for services, applying for grants, securing local matching funds and in-kind services, and obtaining other resources needed to ensure services are available and accessible. Additionally, managing entities are to monitor network providers' performance and their compliance with contract requirements and federal and state laws, rules, regulations, and grant requirements and implement shared data systems.

To facilitate the broader operation of the behavioral health system, CS/CS/HB 7097 requires managing entities to provide assistance to counties to develop a designated receiving system and a transportation plan. Managing entities must also promote coordination of behavioral health with primary care.

The bill requires managing entities to work with local homeless councils and organizations to share information about clients, available resources, and other data or information for addressing the homelessness of persons suffering from a behavioral health crisis and work collaboratively with public receiving facilities, homeless services providers, and housing providers to create or find placements for individuals served by the managing entity to prevent or reduce readmissions.

Each managing entity must have a board of directors or, if a managed behavioral health organization, an advisory board that is representative of the community, and must operate in a transparent manner. Managing entities must work independently and in collaboration with stakeholders to improve coordination among, access to, and effectiveness, quality, and outcomes of behavioral health services. CS/CS/HB 7097 specifically requires managing entities to coordinate with local criminal and juvenile justice systems to enhance diversion from those systems, local court systems to maximize the use of involuntary outpatient services, and the child welfare system to provide effective and timely services to parents and caregivers involved in both systems.

Data Collection and Performance Measurement

CS/CS/HB 7097 allows DCF to determine data which the managing entities must collect and submit, to include at a minimum persons served, outcomes of persons served, and the costs of services provided through DCF's contract. DCF, to the extent possible, must use applicable measures based on nationally recognized standards, if possible, which are to be used to measure managing entity performance and the results of their joint efforts with other systems in meeting the community's behavioral health needs. Examples of such standards include the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's National Outcome Measures and those developed by the National Quality Forum or the National Committee for Quality

Assurance. The bill requires DCF to work with managing entities to establish additional performance measures related to, at a minimum:

- The extent to which individuals in the community receive services;
- The improvement in the overall behavioral health of a community;
- The improvement in functioning or progress in recovery of individuals served by the managing entity;
- Success of strategies to divert admissions to acute levels of care, jails, prisons, and forensic facilities;
- Consumer and family satisfaction; and
- Satisfaction of key community constituencies such as law enforcement agencies, school districts, and the courts.

Network Accreditation and Systems Coordination

CS/CS/HB 7097 requires managing entities to earn accreditation within three years of either the bill's effective date (for managing entities under contract as of that date) or of the contract execution date. DCF must identify acceptable accreditations that at a minimum address coordination within the managing entity's network. The bill requires DCF to consider whether the accreditation facilitates such actions as integrated strategic planning, resource coordination, and technology integration when identifying acceptable accreditations. If a managing entity initially earns accreditation within the three-year timeframe and meets other contract requirements and performance standards, the bill permits DCF to renew the managing entity's contract for one additional five-year term.

If the accreditation does not also address coordination between the network and other major systems and programs such as the child welfare system, courts system, and Medicaid program, managing entities must execute memoranda of understanding regarding communication and coordination with such systems and programs within one year of either the bill's effective date or the managing entity's contract execution date. The bill requires entities comprising these systems and programs to cooperate with these memoranda.

Annually by February 1, beginning in 2018, managing entities shall develop using an inclusive process and submit to DCF a plan for phased enhancement of the behavioral health system of care by subregion, based on the assessed behavioral health needs of each subregion and system gaps. If the plan recommends additional funding, it must include specific information such as the needs to be met, services to be purchased, likely benefits of the services, projected costs, and number of individuals projected to benefit.

The bill also addresses funding for managing entities, requiring a fixed-price contract with a two-month advance payment at the beginning of the fiscal year and equal monthly payments thereafter. The bill allows managing entities to carry forward unexpended state funds not to exceed 8% of the annual contract amount.

Consolidated Licensure

The bill creates s. 397.402, F.S., which requires DCF and the Agency for Health Care Administration (AHCA) to develop a plan for modifying licensure statutes and rules to provide options for a single, consolidated license for a provider that offers multiple types of mental health and substance abuse services regulated under chapters 394 and 397. The plan must identify options for license consolidation within DCF and AHCA, as well as identify inter-agency license consolidation options. The bill requires DCF and AHCA to submit the plan to the Governor, President of the Senate, and Speaker of the House of Representatives by November 1, 2016.

Revenue Maximization

The bill creates s. 394.761, F.S., which requires AHCA and DCF to develop a plan to obtain federal approval for increasing the availability of federal Medicaid funding for behavioral health care. The plan

must identify the amount of general revenue funding appropriated for mental health and substance abuse services which is eligible to be used as state Medicaid match. The plan must also evaluate alternative uses of increased Medicaid funding and identify the advantages and disadvantages of each alternative. AHCA and DCF must submit the written plan to the President of the Senate and the Speaker of the House of Representatives no later than November 1, 2016.

Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program

The bill converts the Statewide Grant Review Committee to the Statewide Grant Policy Committee. Under the bill, the Policy Committee will consist of the existing members of the Review Committee and the following representatives:

- One representative of the Department of Veterans' Affairs;
- One representative of the National Alliance on Mental Illness;
- One representative of the Florida Sheriffs Association;
- One representative of the Florida Police Chiefs Association;
- One representative of the Florida Association of Counties;
- One representative of the Florida Alcohol and Drug Abuse Association;
- One representative of the Florida Association of Managing Entities;
- One representative of the Florida Council for Community Mental Health;
- One representative of the Florida Prosecuting Attorneys Association;
- One representative of the Florida Public Defender Association; and
- One administrator of a state-licensed limited mental health assisted living facility.

The Policy Committee will serve as the advisory body to review policy and funding issues that help reduce the impact of persons with mental illnesses and substance use disorders on communities, criminal justice agencies, and the court system. The bill requires DCF to create a grant review and selection committee which will be responsible for evaluating grant applications and selecting recipients. The grant review and selection committee will notify DCF of its selections.

Currently under s. 394.656, F.S., only a county or a consortium of counties may apply for a grant under the Program. The bill amends this section to additionally allow a county planning council or committee to designate a not-for-profit community provider or a managing entity to apply for a grant. A not-for-profit community provider or a managing entity must have express, written authorization from the county to apply for a grant to ensure local matching funds are available.

The bill amends s. 394.656, F.S., to authorize DCF to require, at its discretion, an applicant to conduct sequential intercept mapping for a project. The bill defines sequential intercept mapping as a process for reviewing a local community's mental health, substance abuse, criminal justice, and related systems and identifying points of interceptions where interventions may be made to prevent an individual with a substance use disorder or mental illness from penetrating further into the criminal justice system.

Florida Mental Health Act

Designated Receiving System

The bill creates s. 394.4602, F.S., to require counties and managing entities to designate one or more facilities as designated receiving systems by October 31, 2017, and review and update the designated receiving system every three years thereafter. A designated receiving system's facilities must serve a defined geographic area and perform assessment and evaluation, and either treatment or triage, on both a voluntary and involuntary basis for individuals in behavioral health crises. The counties and managing entities must use an inclusive process in planning the designated receiving system and document it through written memoranda of agreement or other binding arrangements. The bill allows counties and managing entities flexibility in designing their designated receiving systems as long as the county's model, to the extent allowed by available resources, is a "no-wrong-door model," defined as one which optimizes access to care regardless of an individual's entry point. The bill describes three examples of designated receiving systems, including:

- A central receiving system, involving a designated central receiving facility which is a single point of access providing assessment, evaluation, and triage or treatment.
- A coordinated receiving system, involving multiple designated receiving facilities that are linked by shared data systems, formal referral agreements, and cooperative agreements for care coordination and case management.
- A tiered receiving system, involving designated receiving facilities and at least one other type of provider offering specialized or limited services. These facilities must be linked by methods to share data, formal referral agreements, and cooperative agreements for care coordination and case management.

The bill requires maintenance of an inventory of participating service providers, including their capabilities, limitations, and ability to accept patients; the inventory shall be available at all times to first responders.

Transportation

The bill strikes current law allowing DCF to grant counties exceptions to the transportation requirements of s. 394.462, F.S. The new provisions of s. 394.4602, F.S., require that a county or groups of counties develop transportation plans that support the designated receiving system. These plans must describe methods for transporting individuals for involuntary examination under the Baker Act and involuntary assessment and stabilization under the Marchman Act. Additionally, the plans may address transportation for other purposes. The bill allows the plans to rely on emergency medical transport services or private transport companies as appropriate. The plans must comply with the transportation requirements in ss. 394.462, 397.6771, 397.6772, 397.697, 397.6795, and 397.6822, F.S.

Once the county has a transportation plan, the bill allows law enforcement to transport an individual to a receiving facility other than the nearest one pursuant to that plan.

When initiating transport of an individual with Alzheimer's disease or a dementia-related disorder, a law enforcement officer must collect any information regarding his or her condition, medications, and needs and provide that information to the receiving facility immediately upon arrival. As soon as practicable, such person shall be temporarily placed in a secure private area within the receiving facility, if available, and clinically indicated, where the person shall be permitted to be accompanied by a family member or caregiver provided it is safe for him or her to do so.

Patient Representative

The bill expands the number of individuals who are prohibited from serving as the patient's representative when a patient is admitted to a facility for involuntary examination or placement, or when a petition for involuntary placement is filed. The following individuals are prohibited from serving as the patient's representative by the bill:

- A professional providing clinical services to the patient under the Baker Act;
- The licensed professional who initiated the involuntary examination of the patient, if the examination was initiated by professional certificate;
- An employee, administrator, or board member of the facility providing the examination of the patient;
- An employee, administrator, or board member of a treatment facility providing treatment to the patient;
- A person providing any substantial professional services for the patient, including clinical and nonclinical services;
- A creditor of the patient;
- A person subject to an injunction for protection against domestic violence for which the patient was the petitioner; and
- A person subject to an injunction for protection against repeat violence, stalking, sexual violence, or dating violence for which the patient was the petitioner.

The bill also specifies the rights delegated to the patient's representative, whether selected by the patient or designated by the receiving facility. The patient's representative has the right to:

- Receive notice of the patient's admission;
- Receive notice of proceedings affecting the patient;
- Have access to the patient within reasonable timeframes in accordance with the provider's publicized visitation policy, unless such access is documented to be detrimental to the patient;
- Receive notice of any restriction of the patient's right to communicate or receive visitors;
- Receive a copy of the inventory of personal effects upon the patient's admission and request an amendment to the inventory at any time;
- Receive disposition of the patient's clothing and personal effects, if not returned to the patient, or approve an alternate plan for disposition of such clothing and personal effects;
- Petition on behalf of the patient for a writ of habeas corpus to question the cause and legality of the patient's detention or to allege that the patient is being unjustly denied a right or privilege granted under this part, or that a procedure authorized under this part is being abused;
- Apply for a change of venue for the patient's involuntary placement hearing for the convenience of the parties or witnesses or because of the patient's condition;
- Receive written notice of any restriction of the patient's right to inspect his or her clinical record;
- Receive notice of the release of the patient from a receiving facility at which an involuntary examination was performed;
- Receive a copy of any petition for the patient's involuntary placement filed with the court; and
- Be informed by the court of the patient's right to an independent expert evaluation pursuant to involuntary placement procedures.

Involuntary Examination

The bill specifies that either a circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination. If a person has been diagnosed with Alzheimer's disease or a dementia-related disorder, this condition must be indicated in the ex parte order, written report, or certificate.

Involuntary Inpatient Placement

The bill adds psychiatric nurses to the list of professionals who may make a recommendation for initial or continued involuntary inpatient placement. It also adds the patient's psychiatrist to those who can recommend continued involuntary placement.

The bill requires a facility filing a petition for involuntary inpatient placement to send a copy of the petition to the managing entity in its area.

The bill designates the state attorney as the real party in interest, on behalf of the state, in a petition for involuntary outpatient services. The bill gives the state attorney access to the patient's clinical records and the authority to evaluate the sufficiency and appropriateness of the petition for involuntary services.

The bill specifies that the hearing on involuntary inpatient placement must be within five "court working" days.

Currently, the court must order a patient that meets the criteria to receive treatment from a treatment facility, on an involuntary basis, for a period of up to 6 months. The bill expands the venues where treatment may be ordered to include a crisis stabilization unit or a short-term residential treatment facility, but limits the duration of the court order for treatment at those locations to a maximum of 90 days. The bill also amends this section to prohibit courts from ordering an individual with traumatic brain injury or dementia who lacks a co-occurring mental illness to be involuntarily placed in a state treatment facility.

Involuntary Outpatient Services

The bill defines a "qualified professional" for purposes of Part I, ch. 394 (the Baker Act) as a physician or a physician assistant licensed under chapter 458 or chapter 459; a professional licensed under chapter 490.003(7) or chapter 491, which include a psychologist, clinical social worker, a marriage and family therapist, and a mental health counselor; a psychiatrist licensed under chapter 458 or chapter 459; or a psychiatric nurse. The bill permits any two qualified professionals to support the recommendation for involuntary outpatient services, in contrast to the law's current provisions that the two opinions must include one from a psychiatrist and the second from either another psychiatrist or a clinical psychologist.

The bill revises the content of the treatment plan that must be prepared by the service provider for submission to the court for inclusion in the involuntary outpatient services order. The treatment plan must address the nature and extent of the mental illness and any co-occurring substance use disorders that necessitate involuntary outpatient services. It must also specify the likely level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient services. CS/CS/HB 7097 bill removes the requirement that a copy of the treatment plan be provided to the patient and the administrator of the receiving facility.

Additionally, the bill requires the service provider to notify the managing entity as to the availability of requested involuntary outpatient services and requires the managing entity to document efforts to obtain those services.

The bill designates the state attorney as the real party in interest, on behalf of the state, in a petition for involuntary outpatient services. The bill gives the state attorney access to the patient's clinical records and the authority to evaluate the sufficiency and appropriateness of the petition for involuntary services.

CS/CS/HB 7097 reduces the maximum duration of court ordered involuntary outpatient services from six months to 90 days. If the patient continues to meet the criteria for involuntary outpatient placement, the bill requires the service provider to petition the court at least 10 days before the expiration of the treatment period for the extension. The bill requires the court to immediately schedule a hearing on the petition to be held within 15 days of the filing of the petition. The order for involuntary services may be sent to AHCA by electronic means.

<u>Marchman Act</u>

Similar to the expansion of the types professionals who may be involved in involuntary admissions under the Baker Act, CS/CS/HB 7097 expands the professionals who may execute a certificate for emergency admission under the Marchman Act from solely a physician to also allow clinical psychologist, physician assistant, psychiatric nurse, advanced registered nurse practitioner, mental

health counselor, marriage and family therapist, master's level certified addiction professional for substance abuse services, or clinical social worker to do so. The professional must have examined the person within the five days prior to executing the certificate.

Court Proceedings

The bill makes various changes to court proceedings under the Marchman Act. The bill prohibits the court from charging a filing fee for petitions filed under the Marchman Act. The bill limits the time for which an order for involuntary admission is valid to seven days, unless otherwise specified in the order.

Involuntary Admission

The bill revises the criteria for an involuntary admission under the Marchman Act; under the bill, a person meets the criteria for involuntary admission if there is good faith reason to believe he or she is substance abuse impaired and, because of this condition, has refused services or is unable to determine whether services are necessary. However, refusal of services alone is insufficient evidence of an inability to determine whether services are necessary unless, without care or treatment one of the following criteria is also met:

- The person is likely to neglect or refuse care for himself or herself to the extent that the neglect or refusal poses a real and present threat of substantial harm to his or her well-being;
- The person is at risk of the deterioration of his or her physical or mental health which may not be avoided despite assistance from willing family members, friends, or other services; or
- There is a substantial likelihood that the person will cause serious bodily harm to himself or herself or others, as shown by the person's recent behavior.

The bill also revises the standards for involuntary assessment and stabilization and involuntary services to reflect the new criteria for involuntary admission.

Involuntary Assessment and Stabilization

The bill reduces the number of adults with personal knowledge of a person’s substance abuse impairment necessary to file a petition for involuntary assessment and stabilization from three to one. The bill also requires the service provider to notify the managing entity of a recommendation for involuntary services, so that it may assist in locating and providing the requested services. The managing entity must document its efforts to obtain the requested services.

Involuntary Services

The bill makes changes throughout the Marchman Act to rename “involuntary treatment” as “involuntary services”. The bill also extends the length of the initial order for involuntary services from 60 to 90 days and also extends the length of an order for renewal of those services from 60 to 90 days. When involuntary services are ordered, the court must send a copy of the order to the managing entity.

The bill requires the court to appoint regional conflict counsel to represent the respondent in petitions for involuntary services and continued involuntary services. Additionally, the bill sets forth procedures for the court to follow regarding petitions for continued involuntary services and allows the respondent to agree to continued services without a hearing.

The bill allows for a continuance of the hearing on the petition for involuntary services and reduces the time within which the court must hear the petition, absent a continuance, from ten to five days, to align with the Baker Act. Finally, the bill expressly authorizes the court to order an individual into involuntary services with a privately funded service provider if the respondent has the ability to pay for the services, or if any person on respondent’s behalf voluntarily demonstrates willingness and ability to pay for the services.

Informed Consent

The bill defines “informed consent,” which is not currently defined in the Marchman Act, as consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. This is identical to the definition of “express and informed consent” in the Baker Act, which term is used in a similar manner to “informed consent” in the Marchman Act.

Guardian Advocate

The bill creates s. 397.6878, F.S., which provides for the appointment of a guardian advocate for patients who are incompetent to consent to treatment under the Marchman Act. The bill allows the court to appoint a guardian advocate for the patient, based on a petition by the administrator of a receiving facility, if it finds that a patient is incompetent to consent to treatment, has not been adjudicated incapacitated, and that a guardian with the authority to consent to mental health treatment has not been appointed. In order for a guardian advocate to be appointed, the court must hold a hearing, at which the patient has the right to be represented by counsel, to testify, to cross-examine witnesses, and present witnesses.

Additionally, the bill provides for training requirements for guardian advocates. They may either complete the training for guardians appointed pursuant to ch. 744, F.S., or attend at least a four-hour training course approved by the court. However, the bill provides the court discretion to waive some or all of the training requirements or to impose additional requirements on the guardian advocate on a case-by-case basis.

The bill prohibits the following persons from serving as the patient’s guardian advocate:

- A professional providing clinical services to the individual under the Marchman Act;
- The qualified professional who initiated the involuntary examination of the individual, if the examination was initiated by a qualified professional's certificate;
- An employee, an administrator, or a board member of the facility providing the examination of the individual;
- An employee, an administrator, or a board member of the treatment facility providing treatment of the individual;
- A person providing any substantial professional services to the individual, including clinical services;
- A creditor of the individual;
- A person subject to an injunction for protection against domestic violence and for which the individual was the petitioner; and
- A person subject to an injunction for protection against repeat violence, sexual violence, or dating violence and for which the individual was the petitioner.

When selecting the guardian advocate, the bill requires the court to give preference to the patient's health care surrogate, if one has already been designated by the patient. If the patient has not previously designated a health care surrogate, the selection shall be made, except for good cause, from among the following persons, listed in order of priority:

- The patient's spouse;
- An adult child of the patient;
- A parent of the patient;
- The adult next of kin of the patient;
- An adult friend of the patient; then
- An adult trained and willing to serve as the guardian advocate for the patient.

Prior to appointment, the facility requesting appointment of a guardian advocate shall, before the appointment, provide the prospective guardian advocate with information about the duties and

responsibilities of guardian advocates, including information about the ethics of medical decision making. Additionally, prior to requesting the guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment. The bill permits the court to authorize the guardian advocate to consent to medical treatment as well as substance abuse disorder treatment; however, absent specific court approval, the guardian advocate may not consent to:

- Abortion;
- Sterilization;
- Electroshock therapy;
- Psychosurgery; or
- Experimental treatments that have not been approved by a federally approved institutional review board.

The bill requires the guardian advocate to be discharged when the patient is discharged from an order for involuntary outpatient services, involuntary inpatient placement, or when the patient is transferred from involuntary to voluntary status.

Form Submission and Data Collection

Currently, there are no express reporting requirements for the Marchman Act. Conversely, the Baker Act has robust reporting requirements. Such Baker Act reporting requirements include submission of documents regarding involuntary examinations and collection of data through the Crisis Stabilization Services Utilization Database under s. 394.9082(10), F.S.

DCF currently publishes a limited number of forms for Marchman Act pleadings and reporting. The bill amends the Marchman Act to require DCF to develop and publish standard forms for pleadings and reporting. This includes forms for petition for involuntary admissions, the related pleading forms, and forms for the initiation of protective custody by law enforcement. The bill also requires DCF to notify the courts, law enforcement, and other state agencies of the existence and availability of these forms.

The Marchman Act authorizes law enforcement to take an individual meeting involuntary admission criteria into protective custody; however, it does not require law enforcement to execute a report. The bill amends s. 397.6772, F.S., to require law enforcement to execute a written report on a DCF created form when initiating protective custody. The reporting requirement is only applicable if law enforcement is taking the individual to a hospital or a licensed detoxification or addictions receiving facility.

CS/CS/HB 7097 also amends s. 394.9082, F.S., to require managing entities to collect and submit to DCF utilization data for DCF-funded detoxification and addiction receiving facilities services provided under the Marchman Act.

Social Work, Therapy and Counseling Interns

Currently s. 491.0045, F.S., does not limit the number of times a social work, therapy, or counseling intern may renew his or her intern registration. The bill amends this section and limits the validity of an intern registration to five years. The bill also prohibits renewal of an intern registration unless the individual has passed the theory and practice examination for clinical social work, marriage and family therapy, or mental health counseling. The bill also prohibits a person with provisional licensure from applying for intern registration in the same profession.

Repeals

The bill repeals a number of obsolete and duplicative sections of statute, as follows.

- Section 394.4674, F.S., which requires DCF to complete a deinstitutionalization plan. This section was enacted in 1980 and is obsolete following further developments in federal law.
- Section 394.4985, F.S., which requires DCF's regions to develop and maintain an information and referral network. This duplicates other requirements.
- Section 394.745, F.S., which requires an annual report to the Legislature of compliance of substance abuse and mental health treatment providers under contract with DCF.
- Sections 397.6772, 397.697, and 397.801, F.S., requiring the Departments of Education, Corrections, Law Enforcement and Children and Families to each designate substance abuse impairment coordinators, and for DCF to also designate full-time substance abuse impairment coordinators in each of its regions.
- Section 397.811, F.S., which expresses the Legislature's intent that substance abuse prevention and early intervention programs be funded.
- Section 397.821, F.S., authorizing each judicial circuit to establish juvenile substance abuse impairment prevention and early intervention councils to identify needs. The managing entity now performs these duties.
- Section 397.901, F.S., authorizing DCF to establish prototype juvenile addiction receiving facilities. This section was enacted in 1993, and these projects are completed.
- Section 397.93, F.S., specifying target populations for children's substance abuse services, which duplicates other statutory requirements. This duplicates other provisions of law.
- Section 397.94, F.S., requiring the DCF's regions to plan and provide for information and referral services regarding children's substance abuse services.
- Section 397.951, F.S., requiring DCF to ensure that treatment providers use sanctions provided elsewhere in law to keep children in substance abuse treatment.
- Sections 397.97 and 397.98, F.S., relating to the Children's Network of Care Demonstration Models, authorizing their operation for four years. These were originally established in 1999.

B. SECTION DIRECTORY:

Section 1: Amends s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.
Section 2: Amends s. 394.453, F.S., relating to legislative intent.
Section 3: Amends s. 394.455, relating to definitions.
Section 4: Amends s. 394.4597, F.S., relating to persons to be notified; appointment of a patient's representative.
Section 5: Creates s. 394.4602, F.S., relating to designated receiving system; transportation plans.
Section 6: Amends s. 394.462, F.S., relating to transportation.
Section 7: Amends s. 394.463, F.S., relating to involuntary examination.
Section 8: Amends s. 394.4655, F.S., relating to involuntary outpatient placement.
Section 9: Amends s. 394.467, F.S., relating to involuntary inpatient placement.
Section 10: Amends s. 394.46715, F.S., relating to rulemaking authority.
Section 11: Amends s. 394.656, F.S., relating to the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program.
Section 12: Amends s. 394.67, F.S., relating to definitions.
Section 13: Amends s. 394.674, F.S., relating to eligibility for publicly funded substance abuse and mental health services; fee collection requirements.
Section 14: Amends s. 394.675, F.S., substance abuse and mental health service system.
Section 15: Creates s. 394.761, F.S., relating to revenue maximization.
Section 16: Amends s. 394.875, F.S., relating to crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.
Section 17: Amends s. 394.9082, F.S., relating to behavioral health managing entities.
Section 18: Amends s. 397.305, F.S., relating to legislative findings, intent, and purpose.
Section 19: Amends s. 397.311, F.S., relating to definitions.
Section 20: Amends s. 397.321, F.S, relating to duties of the department.

Section 21: Creates s. 397.402, F.S., relating to single, consolidated licensure.
Section 22: Amends s. 397.675, F.S., relating to criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.
Section 23: Amends s. 397.6772, F.S, relating to protective custody without consent.
Section 24: Amends s. 397.6773, F.S., relating to dispositional alternatives after protective custody.
Section 25: Amends s. 397.679, F.S., relating to emergency admission; circumstances justifying.
Section 26: Amends s. 397.6791, F.S., relating to emergency admission; persons who may initiate.
Section 27: Amends s. 397.6793, F.S., relating to physician's certificate for emergency admission.
Section 28: Amends s. 397.6795, F.S., relating to transportation-assisted delivery of persons for emergency assessment.
Section 29: Amends s. 397.681, F.S, relating to involuntary petitions; general provisions; court jurisdiction and right to counsel.
Section 30: Amends s. 397.6811, F.S., relating to involuntary assessment and stabilization.
Section 31: Amends s. 397.6814, F.S., relating to involuntary assessment and stabilization; contents of petition.
Section 32: Amends s. 397.6818. F.S., relating to court determination.
Section 33: Amends s. 397.6819. F.S., relating to involuntary assessment and stabilization; responsibility of licensed service provider.
Section 34: Repeals s. 397.6821, F.S., relating to extension of time for completion of involuntary assessment and stabilization.
Section 35: Amends s. 397.695, F.S., relating to involuntary treatment.
Section 36: Amends s. 397.6951, F.S., relating to contents of petition for involuntary treatment.
Section 37: Amends s. 397.6955, F.S, relating to duties of court upon filing a petition for involuntary treatment.
Section 38: Amends s. 397.697, F.S, relating to court determination; effect of court order for involuntary substance abuse treatment period.
Section 39: Amends s. 397.6971, F.S., relating to early release from involuntary substance abuse treatment.
Section 40: Amends s. 397.6975, F.S., relating to extension of involuntary substance abuse treatment.
Section 41: Amends s. 397.6977, F.S., relating to disposition of individual upon completion of involuntary substance abuse treatment.
Section 42: Creates s. 397.6978, F.S., relating to guardian advocate; patient incompetent to consent; substance use disorder.
Section 43: Amends s. 491.0045, F.S., relating to intern registration requirements.
Section 44: Repeals s. 394.4674, F.S., relating to plan and report.
Section 45: Repeals s. 394.4985, F.S., relating to districtwide information and referral network; implementation.
Section 46: Repeals s. 394.745, F.S., relating to annual report; compliance of providers under contract with department.
Section 47: Repeals s. 397.331, F.S., relating to definitions; legislative intent.
Section 48: Repeals s. 397.801, F.S., relating to substance abuse impairment coordination.
Section 49: Repeals s. 397.811, F.S., relating to juvenile substance abuse impairment coordination; legislative findings and intent.
Section 50: Repeals s. 397.821, F.S., relating to juvenile substance abuse impairment prevention and early intervention councils.
Section 51: Repeals s. 397.901, F.S., relating to prototype juvenile addictions receiving facilities.
Section 52: Repeals s. 397.93, F.S., relating to children's substance abuse services; target populations.
Section 53: Repeals s. 397.94, F.S., relating to children's substance abuse services; information and referral network.
Section 54: Repeals s. 397.951, F.S., relating to treatment and sanctions.
Section 55: Repeals s. 397.97, F.S., relating to children's substance abuse services; demonstration models.
Section 56: Repeals s. 397.98, F.S., relating to children's substance abuse services; utilization management.

Section 57: Amends s. 212.055, F.S., relating to discretionary sales surtaxes; legislative intent; authorization and use of proceeds.
Section 58: Amends s. 394.4598, F.S., relating to guardian advocate.
Section 59: Amends s. 394.4615, F.S., relating to clinical records; confidentiality.
Section 60: Amends s. 394.657, F.S., relating to county planning councils or committees.
Section 61: Amends s. 394.658, F.S., relating to criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program requirements.
Section 62: Amends s. 394.9085, F.S., relating to behavioral provider liability.
Section 63: Amends s. 397.405, F.S., exemptions from licensure
Section 64: Amends s. 397.407, F.S., relating to licensure process; fees.
Section 65: Amends s. 397.416, F.S., relating to substance abuse treatment services; qualified professional.
Section 66: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 67: Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
Section 68: Amends s. 744.704, F.S., relating to powers and duties.
Section 69: Amends s. 790.065, F.S., relating to sale and delivery of firearms.
Section 70: Provides an appropriation.
Section 71: Provides an effective date of July 1, 2016, except as otherwise provided in the act.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires DCF to create a statewide database for collecting utilization data for certain Marchman-Act initiated substance abuse services funded by the department. DCF estimates that it will cost $400,000 to implement these changes though modifications to the existing Crisis Stabilization Unit (CSU) database. [113]The bill provides a nonrecurring appropriation of $400,000 from state trust funds to DCF for these system upgrades.

[113] Correspondence from DCF to the House of Representatives Children, Families and Seniors Subcommittee dated December 17, 2015, on file with the Children, Families, and Seniors Subcommittee.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The managing entities are required to earn network accreditation and submit enhancement plans for their behavioral health systems of care. However, managing entities' current responsibilities include needs assessment and planning.

Network accreditation through CARF costs $9,000 every three years.[114] Managing entities that initially earn network accreditation may have their contracts renewed even if a renewal is not authorized under the current terms of the contract, provided contract performance is satisfactory and other contract terms are met.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill broadens DCF's rulemaking authority to include implementing the entirety of Part I rather than selected statutes within it. This will allow DCF rulemaking authority to implement, among other provisions, the newly-created section (s. 394.4062, F.S.) regarding designated receiving systems and transportation plans.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 8, 2016, the Health Care Appropriations Subcommittee adopted one amendment that provides a nonrecurring appropriation of $400,000 to DCF for system modifications to the CSU database. These modifications will enable the collection of Marchman Act service data as prescribed by the bill. This analysis is drafted to the bill as amended.

[114] *Supra,* 31.

On February 17, 2016, the Health and Human Services Committee adopted two amendments. The amendments:

- Revised the Baker and Marchman Acts to align some processes and timeframes.
- Required counties to create designated receiving systems that function as no-wrong-door models and transportation plans to support their operation.
- Specified a behavioral health continuum of care.
- Revised statutes governing the managing entity system to enhance accountability and encourage greater coordination among providers and related systems, including requiring managing entities to accredit their networks within three years.
- Expanded the membership of the policy committee for the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant program and permitted non-profit organizations and managing entities to apply for grants.
- Eliminated the term “involuntary treatment” from the Marchman Act and replaced it with “involuntary services” to demonstrate there is a greater array of substance abuse services available beyond treatment.
- Expanded the types of professionals who could initiate involuntary treatment under the Baker and Marchman Acts.
- Required a diagnosis of Alzheimer’s disease or dementia to be noted on documents initiating involuntary examination under the Baker Act, and allowed caregivers to provide additional information about the individual's needs for law enforcement to give to the facility, and required facilities to temporarily place such patients, accompanied by caregivers, in a secure private area in the facility, if clinically indicated.

The bill analysis is drafted to the bill as amended.