The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 1678
INTRODUCER:	Children, Families, and Elder Affairs and Senator Montford
SUBJECT:	Substance Abuse and Mental Health
DATE:	February 13, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon	CF	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1678 adds dementia and traumatic brain injury to the listed conditions excluded in the definition of "mental illness" as it relates to involuntary commitments under the Baker Act. The bill adds mandatory community action team (CAT) coverage to include Charlotte and Leon counties. The bill revises the eligibility criteria for receiving Department of Children and Families (DCF) funded substance abuse and mental health services to modify eligibility determinations. The bill also revises membership in, and the scope of, the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Statewide Grant Review Committee.

The bill also makes several changes to both the Baker Act and the Marchman Act. The bill broadens the criteria to serve additional individuals under both the Baker Act and Marchman Act. The bill makes significant changes to court procedures, filing deadlines, and responsibilities for Marchman Act petitioners.

The bill repeals the requirement for DCF to develop a certification process for community substance abuse prevention coalitions. The bill also revises training requirements for court-appointed forensic evaluators, requiring refresher training every three years.

The bill will have an indeterminate fiscal impact on DCF and the state court system and has an effective date of July 1, 2020.

II. Present Situation:

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

Behavioral Health Managing Entities

In 2001, the Legislature authorized DCF to implement behavioral health managing entities as the management structure for the delivery of local mental health and substance abuse services.[1] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[2] Full implementation of the statewide managing entity system occurred in April 2013; all geographic regions are now served by a managing entity.[3]

DCF contracts with seven MEs - Big Bend Community Based Care, Lutheran Services Florida, Central Florida Cares Health System, Central Florida Behavioral Health Network, Inc., Southeast Florida Behavioral Health, Broward Behavioral Health Network, Inc., and South Florida Behavioral Health Network, Inc., that in turn contract with local service providers[4] for the delivery of mental health and substance abuse services:[5]

Baker Act

In 1971, the Legislature passed the Florida Mental Health Act (also known as "The Baker Act") to address the mental health needs of individuals in the state. The Baker Act allows for voluntary and, under certain circumstances, involuntary, examinations of individuals suspected of having a mental illness and presenting a threat of harm to themselves or others. The Baker Act also establishes procedures for courts, law enforcement, and certain health care practitioners to initiate such examinations and then act in response to the findings.

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.[6] 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:[7]

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[1] Ch. 2001-191, Laws of Fla.
[2] Ch. 2008-243, Laws of Fla.
[3] *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.
[4] Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
[5] Department of Children and Families, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited February 9, 2020).
[6] SS. 394.4625 and 394.463, F.S.
[7] S. 394.463(1), F.S.

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

Marchman Act

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

Individual Bill of Rights

Both the Marchman Act and the Baker Act provide an individual bill of rights.[8] Rights in common include the right to dignity, right to quality of treatment, right to not be refused treatment at a state-funded facility due to an inability to pay, right to communicate with others, right to care and custody of personal effects, and the right to petition the court on a writ of habeus corpus. The individual bill of rights also imposes liability for damages on persons who violate individual rights.[9] The Marchman Act bill of rights includes the right to confidentiality of clinical records. The individual is the only person who may consent to disclosure.[10] The Baker Act addresses confidentiality in a separate section of law and permits limited disclosure by the individual, a guardian, or a guardian advocate.[11] The Marchman Act ensures the right to habeus corpus, which means that a petition for release may be filed with the court by an individual involuntarily retained or his or her parent or representative.[12] In addition to the petitioners authorized in the Marchman Act, the Baker Act permits the DCF to file a writ for habeus corpus on behalf of the individual.[13]

Transportation to a Facility

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

[8] Section 397.501, F.S., provides "Rights of Individuals" for individuals served through the Marchman Act; s. 394.459, F.S., provides "Rights of Individuals" for individuals served through the Baker Act.
[9] Sections 397.501(10)(a) and 394.459(10), F.S.
[10] Section 397.501(7), F.S.
[11] Section 394.4615(1) and (2), F.S.
[12] Section 397.501(9), F.S.
[13] Section 394.459(8)(a), F.S.
[14] Section 397.6795, F.S.

The Baker Act requires each county to designate a single law enforcement agency to transfer the person in need of services. If the person is in custody based on noncriminal or minor criminal behavior, the law enforcement officer will transport the person to the nearest receiving facility. If, however, the person is arrested for a felony the person must first be processed in the same manner as any other criminal suspect. The law enforcement officer must then transport the person to the nearest facility, unless the facility is unable to provide adequate security.[15]

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

Voluntary Admission to a Facility

The Marchman Act authorizes persons who wish to enter treatment for substance abuse to apply to a service provider for voluntary admission. A minor is authorized to consent to treatment for substance abuse.[18] Under the Baker Act, a guardian of a minor must give consent for mental health treatment under a voluntary admission.[19]

When a person is voluntarily admitted to a facility, the emergency contact for the person must be recorded in the individual record.[20] When a person is involuntarily admitted, contact information for the individual's guardian, guardian advocate, or representative, and the individual's attorney must be entered into the individual record.[21] The Marchman Act does not address emergency contacts.

The Baker Act requires an individualized treatment plan to be provided to the individual within five days after admission to a facility.[22] The Marchman Act does not address individualized treatment plans.

Involuntary Admission to a Facility

Criteria for Involuntary Admission

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

- Has lost the power of self-control with respect to substance abuse; and either

[15] Section 394.462(1)(f) and (g), F.S.
[16] Section 397.6772(1), F.S.
[17] Section 394.459(1), F.S.
[18] Section 397.601(1) and (4)(a), F.S.
[19] Section 394.4625(1)(a), F.S.
[20] Section 394.4597(1), F.S.
[21] Section 394.4597(2), F.S.
[22] Section 394.459(2)(e), F.S.

- Has inflicted, threatened to or attempted to inflict self-harm; or
- Is in need of services and due to the impairment, judgment is so impaired that the person is incapable of appreciating the need for services.[23]

Protective Custody

A person who meets the criteria for involuntary admission under the Marchman Act may be taken into protective custody by a law enforcement officer.[24] The person may consent to have the law enforcement officer transport the person to his or her home, a hospital, or a licensed detoxification or addictions receiving facility.[25] If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.[26]

Time Limits

A critical 72-hour period applies under both the Marchman and the Baker Act. Under the Marchman Act, a person may only be held in protective custody for a 72-hour period, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.[27] The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.[28] Within that 72-hour examination period, or, if the 72 hours ends on a weekend or holiday, no later than the next working day, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will resume custody;
- The patient must be released into voluntary outpatient treatment;
- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or
- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.[29]

Under the Marchman Act, if the court grants the petition for involuntary admission, the person may be admitted for a period of five days to a facility for involuntary assessment and stabilization.[30] If the facility needs more time, the facility may request a seven-day extension from the court.[31] Based on the involuntary assessment, the facility may retain the person pending a court decision on a petition for involuntary treatment.[32]

Under the Baker Act, the court must hold a hearing on involuntary inpatient or outpatient placement within five working days after a petition for involuntary placement is filed.[33] The

[23] Section 397.675, F.S.
[24] Section 397.677, F.S.
[25] Section 397.6771, F.S.
[26] Section 397.6772(1), F.S.
[27] Section 397.6773(1) and (2), F.S.
[28] Section 394.463(2)(f), F.S.
[29] Section 394.463(2)(i)4., F.S.
[30] Section 397.6811, F.S.
[31] Section 397.6821, F.S.
[32] Section 397.6822, F.S.
[33] Sections 394.4655(6) and 394.467(6), F.S.

petitioner must show, by clear and convincing evidence all available less restrictive treatment alternatives are inappropriate and that the individual:

- Is mentally ill and because of the illness has refused voluntary placement for treatment or is unable to determine the need for placement; and
- Is manifestly incapable of surviving alone or with the help of willing and responsible family and friends, and without treatment is likely suffer neglect to such an extent that it poses a real and present threat of substantial harm to his or her well-being, or substantial likelihood exists that in the near future he or she will inflict serious bodily harm on himself or herself or another person.[34]

Notice Requirements

The Marchman Act requires the nearest relative of a minor to be notified if the minor is taken into protective custody.[35] No time requirement is provided in law. Under the Baker Act, receiving facilities are required to promptly notify a patient's guardian, guardian advocate, attorney, and representative within 24 hours after the patient arrives at the facility on an involuntary basis, unless the patient requests otherwise.[36] In requiring notice on behalf of a patient, current law does not distinguish between adult and minor patients. The facility must provide notice to the Florida local advocacy council no later than the next working day after the patient is admitted.

Mental Illness and Substance Abuse

According to the National Alliance on Mental Illness (NAMI), about 50 percent of persons with severe mental health disorders are affected by substance abuse.[37] NAMI also estimates that 29 percent of people diagnosed as mentally ill abuse alcohol or other drugs.[38] When mental health disorders are left untreated, substance abuse likely increases. When substance abuse increases, mental health symptoms often escalate as well or new symptoms are triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[39]

Advance Directive for Mental Health or Substance Abuse Treatment

Florida law currently allows an individual to create an advance directive which designates a surrogate to make health care decisions for the individual and provides a process for the execution of the directive.[40] Current law also allows an individual to designate a separate surrogate to consent to mental health treatment for the individual if the individual is determined by a court to be incompetent to consent to treatment.[41] A mental health or substance abuse

[34] Section 394.467(1), F.S.
[35] Section 397.6772(2), F.S.
[36] Section 394.4599(2)(a) and (b), F.S.
[37] Donna M. White, OPCI, CACP, *Living with Co-Occurring Mental & Substance Abuse Disorders, available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occuring-mental-substance (last visited on February 12, 2020).
[38] *Id.*
[39] *Id.*
[40] Section 765.202, F.S.
[41] Section 765.202(5), F.S.

treatment advance directive is much like a living will for health care; acute episodes of mental illness temporarily destroy the capacity required to give informed consent and often prevent people from realizing they are sick, causing them to refuse intervention.[42] Even in the midst of acute episodes, many people do not meet commitment criteria because they are not likely to injure themselves or others and are still able to care for their basic needs.[43] If left untreated, acute episodes may spiral out of control before the person meets commitment criteria.[44]

Mental Health Courts

Mental health courts are a type of problem-solving court that combines judicial supervision with community mental health treatment and other support services in order to reduce criminal activity and improve the quality of life of participants. Mental health court programs are not established or defined in Florida Statutes. A key objective of mental health courts is to prevent the jailing of offenders with mental illness by diverting them to appropriate community services or to significantly reduce time spent incarcerated.

Crisis Stabilization Units

Individuals experiencing severe emotional or behavioral problems often require emergency treatment to stabilize their situations before referral for outpatient services or inpatient services can occur. Emergency mental health stabilization services may be provided to individuals on a voluntary or involuntary basis. Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by DCF as a "receiving facility" as defined in Part I of ch. 394, F.S.[45]

Receiving facilities, often referred to as Baker Act Receiving Facilities, are public or private facilities designated by DCF for the purposes of receiving and examining individuals on an involuntary basis under emergency conditions and to provide short-term treatment. Receiving facilities that receive public funds from one of the managing entities to provide mental health services to all persons regardless of their ability to pay are considered public receiving facilities.[46]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding and provide a less intensive and less costly alternative to inpatient psychiatric hospitalization for individuals presenting as acutely mentally ill. CSUs screen, assess, and admit individuals brought to the unit under the Baker Act, as well as those individuals who voluntarily present themselves, for short-term services.[47] CSUs provide services 24 hours a day, seven days a week, through a team of mental health professionals. The purpose of the CSU is to examine, stabilize, and redirect people to the most appropriate and least restrictive treatment settings, consistent with their mental health needs. Individuals often enter the public mental health system through

[42] Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute*, 14 YALE J. HEALTH POL'Y, L. & ETHICS 1, (Winter 2014).
[43] *Id* at 17.
[44] *Id.*
[45] Section 394.455(26), F.S.
[46] Section 394.455(25), F.S.
[47] Section 394.875, F.S.

CSUs. Managing entities must follow current statutes and rules that require CSUs to be paid for bed availability rather than utilization.

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 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.[48]

A county, non-profit community provider or managing entity designated by a county planning council or committee may apply for a one-year planning grant or a three-year implementation expansion grant under the Program.[49] The purpose of the grants is to demonstrate that investment in treatment efforts related to mental illness, substance abuse disorders, or co-occurring mental health and substance abuse disorders results in a reduced demand on the resources of the judicial, corrections, juvenile detention, and health and social services systems.[50] Currently, there are 24 grant agreements for county programs.[51] Total funding for the 24 grant agreements over their lifetimes is $28,174,388.[52]

Certification of Community Substance Abuse Prevention Coalitions

Section 397.321, F.S., requires DCF to license and regulate all substance abuse providers in the state. It also requires DCF to develop a certification process by rule for community substance abuse prevention coalitions (prevention coalitions) process.[53]

Prevention coalitions are local partnerships between multiple sectors of the community that respond to community conditions by developing and implementing comprehensive plans that lead to measurable, population-level reductions in drug use and related problems.[54] They do not provide substance abuse treatment services, and certification is not a requirement for eligibility to receive federal or state substance abuse prevention funding. However, to receive funding from DCF, a coalition must follow a comprehensive process that includes a detailed needs assessment and plan for capacity building, development, implementation, and sustainability to ensure that data-driven, evidence–based practices are employed for addressing substance misuse for state-funded coalitions.[55]

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[48] S. 394.656(1), F.S.
[49] S. 394.656(5), F.S.
[50] Id.
[51] *Florida Substance Abuse and Mental Health Plan – Triennial State and Regional Master Plan Fiscal Years 2019-2022*, Florida Department of Children and Families, p. 28, (May 2019), https://www.myflfamilies.com/service-programs/samh/publications/docs/SAMH%20Services%20Plan%202019-2022.pdf (last visited February 12, 2020).
[52] Id. at 71-72.
[53] Department of Children and Families, Agency Bill Analysis for 2020 SB 1678, January 14, 2020. On file with the Senate Children, Families, and Elder Affairs Committee.
[54] Id.
[55] Id.

Some prevention coalitions choose to apply for certification from nationally-recognized credentialing entities. Additionally, the Florida Certification Board, a non-profit professional credentialing entity, offers certifications for Certified Prevention Specialists and Certified Prevention Professionals, for those individuals who desire professional credentialing.[56] However, Florida is the only state that requires prevention coalitions to be certified. Only one other state, Ohio, has established a certification program for prevention coalitions, and it is voluntary.[57]

Community Action Treatment Teams

According to the National Institute of Mental Health (NIMH), half of all lifetime cases of mental health disorders have begun by age 14 and three quarters have begun by age 24.[58] Successful transition between the children and adult systems is critical; many individuals with mental health disorders fall through the gaps between the children and adult mental health systems during a critical time in their lives.[59] In 2003, the New Freedom Commission on Mental Health released a report that identified further gaps in the mental health system and recommended transforming the mental health system through community-based services to help individuals with mental illnesses live successfully in their communities.[60] The CAT team model is an example of a comprehensive service approach that allows young people with mental illnesses who are at risk or out-of-home placements to receive services and remain in their communities with their caregivers.[61]

To be eligible for services through a CAT team, the individual must be a child or young adult, up to 21 years old, with a mental health or co-occurring substance abuse diagnosis and specified accompanying characteristics, the requirements for which vary by age.[62] If the child is less than 11 years old he or she must meet two of the following accompanying characteristics; however, individuals aged 11-21 must only meet one of the following accompanying characteristics:[63]
The individual is at-risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care;
The individual has had two or more hospitalizations or repeated failures;
The individual has had involvement with DJJ or multiple episodes involving law enforcement; or

[56] Id.
[57] Id.
[58] Kessler, Berglund, Demler, Jin, Merikangas, and Walters, *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication*, Archives of General Psychiatry. June 2005, https://www.ncbi.nlm.nih.gov/pubmed/15939837 (last visited February 12, 2020).
[59] Maryann Davis and Bethany Hunt, *State efforts to expand transition supports for young adults receiving adult public mental health services*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2005, https://pdfs.semanticscholar.org/40ae/063ae28b3273f498eb7c7b609677b1e5be92.pdf?_ga=2.44077420.995818869.1579903552-877004500.1579903552 (last visited February 12, 2020).
[60] Letter from The President's New Freedom Commission on Mental Health to President George W. Bush, July 22, 2002, http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf (last visited February 12, 2020).
[61] Department of Children and Families, *Community Action Team Evaluation Report*, February 1, 2014, p. 6, https://www.myflfamilies.com/service-programs/samh/publications/docs/CAT_Team_Evaluation_January_31_2014.pdf (last visited February 12 2020).
[62] Id. at 2.
[63] Id.

The individual has poor academic performance and/or suspensions.

The CAT model is an integrated service delivery approach that utilizes a team of individuals to comprehensively address the needs of the young person, and his or her family.[64] The CAT team includes a full-time team leader, mental health clinicians, a psychiatrist or advanced registered nurse practitioner (ARNP), a registered or licensed practical nurse, a case manager, therapeutic mentors, and support staff.[65] They work collaboratively to deliver the majority of behavioral health services, coordinate with other service providers when necessary, and assist the family in developing or strengthening its natural support system.[66]

One of the differences between CAT teams and traditional mental health services is that services are provided or coordinated by the multidisciplinary team; these services are individualized and often do not fit into the standard of medical necessity, and are typically not reimbursed by Medicaid or private insurance.[67] The number of sessions and the frequency at which they are provided is set through collaboration rather than service limits.[68] In addition, the family is treated as a unit, and the CAT team addresses all family members' needs.[69]

CAT teams provide services in the family's home or in other community locations that are convenient for the family being served. The mix of services and supports the CAT team provides to the individual and his or her family should be developmentally appropriate for the young person and serve to strengthen him or her and his or her family.[70] Examples of services provided by the CAT team are [71]
Crisis Intervention and 24/7 On-call Coverage: Assists the family with crisis intervention, referrals, or supportive counseling;
Family Education: Families are educated on topics related to their treatment goals, including effective parenting skills and behavior management; and
Therapy: Provides and coordinates individual, group, and family therapy services. The type, frequency and location of therapy provided are based on their individual needs.

In addition to the services the CAT team provides, it also encourages the young person and his or her family to develop connections to natural supports[72] within their own network of associates, such as friends and neighbors; through connections with the community; through service and religious organizations; and through participation in clubs and other civic activities.

Eligibility for SAMH Services

Section 394.674, F.S., establishes eligibility requirements for receiving Department-funded substance abuse and mental health services by identifying a set of priority populations. As a

[64] Id.
[65] Id.
[66] Id.
[67] Id.
[68] Id.
[69] Id. at 9.
[70] *Supra* at note 61
[71] *Supra* at note 61.
[72] Natural supports ease the transition from formal services and provide ongoing support after discharge.

result, only individuals who are members of one of the priority populations are eligible to receive substance abuse and mental health services funded by the Department.

DCF states that as currently written, it is difficult to determine if a person meets eligibility requirements.[73] Additionally, the current eligibility criteria for substance abuse treatment for adults does not include adults with a substance use disorder unless they have history of intravenous drug use.

Forensic Evaluators

Forensic mental health evaluation is a form of evaluation performed by a mental health professional to provide relevant clinical and scientific data during civil or criminal proceedings. Florida's circuit courts are responsible for appointing mental health experts to conduct forensic evaluations of individuals with mental illnesses who are adjudicated incompetent to proceed of a felony offense or acquitted of a felony offense by reason of insanity. DCF is required to provide one time training for psychiatrists, psychologists, and other mental health professionals on how to conduct evaluations for criminal courts.[74] The training program is a three day program offered through a course provided by the Louis de la Parte Florida Mental Health Institute at the University of South Florida which focuses on competence to stand trial and sanity evaluations.[75] Participants learn Florida laws and rules of criminal procedure relevant to forensic evaluation, general legal principles relevant to forensic evaluation, and assessment techniques and procedures used in competency to proceed and mental state at the time of the offense evaluations,[76] though no specific topics are required to be covered.

Because training for forensic evaluators is only a one time requirement, mental health professionals who have completed the training can remain on the list of DCF approved evaluators for years without receiving continuing education, meaning that their initial training becomes outdated as statutes and practices change over time.[77]

III. Effect of Proposed Changes:

Section 1 amends s. 394.455, F.S., defining "neglect or refuse to care for himself or herself" to include evidence that a person is unable to provide adequate food or shelter for themselves, is substantially unable to make an informed treatment choice, or needs care or treatment to prevent deterioration. The bill also adds criteria for a "real and present threat of substantial harm" to include evidence that an untreated person will lack, refuse, or not receive health services or will suffer severe harm leading to an inability to function cognitively or in their community generally.

[73] *Supra* at note 53.
[74] S. 916.111, F.S.
[75] Department of Children and Families, *Forensic Evaluator Training and the Importance of Appointing Approved Forensic Evaluators as Experts,* https://www.myflfamilies.com/service-programs/samh/adult-forensic-mental-health/forensic-evaluator-training-and-importance-appointing-approved-forensic-evaluators-experts.shtml (last visited February 12, 2020).
[76] Id.
[77] *Supra* at note 75.

The bill revises the definition of 'mental illness' to specifically exclude dementia and traumatic brain injury.

Section 2 amends s. 394.459, F.S., relating to rights of patients, to require that a patient with a serious mental illness who has been released after being Baker Acted must be provided with information regarding the essential elements of recovery and provided with accessing a continuum of care regimen. DCF is provided with rulemaking authority to determine what services may-be available in such regimens and which serious mental illnesses will entitle an individual to services. Current law only requires the state to provide involuntary treatment at a state hospital.

Section 3 amends s. 394.4598, F.S., relating to guardian advocates to correct a cross reference.

Section 4 amends s. 394.4599, F.S., relating to involuntary admission, to correct a cross-reference.

Section 5 amends s. 394.461, F.S., to allow civil patients to be admitted to designated receiving facilities under the Baker Act without undergoing a transfer evaluation. The bill also provides that before the close of the State's case in a Baker Act hearing for involuntary placement, the state may establish that a transfer evaluation was performed and the document properly executed by providing the court with a copy of the transfer evaluation. The bill also prohibits the court from considering the substantive information in the transfer evaluation unless the evaluator (typically a health care practitioner) testifies at the hearing.

Section 6 amends s. 394.4615, F.S., to eliminate provisions referring to s. 394.4655, F.S., relating to involuntary outpatient services, rendered inapplicable by the bill.

Section 7 amends s. 394.462, F.S., relating to transportation, to eliminate cross references to ss. 397.6811 and 397.6822, F.S.

Section 8 amends s. 394.4625, F.S., relating to voluntary admissions, requiring a person to show evidence of mental illness in order to be admitted to a facility on a voluntary basis. Adults must consent in writing, and minors may only be admitted on a voluntary basis if both the minor and their parent or guardian give express and informed consent. The minor's assent is considered an affirmative agreement to remain at the facility for examination. A minor's assent must be verified through a clinical assessment performed within 12 hours of arrival at the facility. The examining professional must provide the minor with an explanation as to why they are at the facility, what to expect, and when they can expect to be released, using language that is appropriate to the minor's age, experience, maturity, and condition. The professional must document that the minor can understand this information. The facility administrator must file notice with the court of the minor's voluntary placement within 1 day of admission.
A public defender shall be appointed by the court to review the voluntariness of the minor's admission and verify assent. The public defender can interview and represent the minor and shall have access to all relevant witnesses and records. If the public defender does not review their assent, the clinical record shall serve as verification of assent. If assent is not verified, a petition for involuntary placement must be filed or the minor must be released to their parent or guardian within 24 hours of arrival at the facility.

Section 9 amends s. 394.463, F.S., relating to involuntary examinations, providing that a person is subject to an involuntary examination if there is a substantial likelihood that without care or treatment the person will cause serious harm to themselves or others in the near future, as evidenced by his or her recent behavior, actions, or omissions, to include property damage.

The bill also adds criminal penalties for unlawful activities relating to examination and treatment. The unlawful activities detailed in the bill are: (a) knowingly furnishing false information for the purpose of obtaining emergency or other involuntary admission for any person; (b) causing or conspiring with another to cause, any involuntary mental health procedure for the person without a reason for believing a person is impaired; or, (c) causing, or conspiring to cause, any person to be denied their rights under the mental health statutes unlawful acts would be a misdemeanor of the first degree, punishable as provided by a fine up to $5,000. The bill provides law enforcement with discretion in transporting those who appear to meet Baker Act criteria to receiving facilities. It also requires receiving facilities to inform DCF of any person who has been Baker Acted 3 or more times within a 12 month period.

Section 10 amends s. 394.4655, F.S., relating to involuntary outpatient services, to provide that in lieu of inpatient treatment, a court may order a respondent in a Baker Act case into outpatient treatment for up to six months if it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment at least twice during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician certifies that the respondent can be more appropriately treated on an outpatient basis, and can follow a treatment plan. Without private insurance or Medicaid, DCF would presumably be required to pay for such treatment.

The bill also requires that for the duration of their treatment, the respondent must have a willing, able, and responsible supervisor who will inform the court of any failure to comply with the treatment plan. The bill requires the court to retain jurisdiction over the parties for entry of further orders after a hearing, and the court may order inpatient treatment to stabilize a respondent who decompensates during their period of court-ordered treatment if they continue to meet the other statutorily required criteria for commitment. The bill eliminates all other existing procedures in this section pertaining to criteria and procedures for involuntary examination.

Section 11 amends s. 394.467, F.S., relating to involuntary inpatient placement, to add a likelihood of committing property damage to the criteria for involuntary inpatient placement. The bill provides that with respect to a hearing on involuntary inpatient placement, both the patient and the state are independently entitled to at least one continuance of the hearing. The patient's continuance may be for a period of up to 4 weeks and requires concurrence of the patient's counsel. The state's continuance may be for a period of up to 7 court working days and requires a showing of good cause and due diligence by the state before it can be requested. The state's failure to timely review and readily available document or failure to attempt to contact a known witness does not merit a continuance. The bill requires the court to increase the number of court working days in which the hearing may be held from 5 to 7. The bill allows for all witnesses to a hearing to appear telephonically or by other remote means. The bill also allows the state attorney to access the patient, any witnesses, and any records needed to prepare its case. The bill prohibits the court from ordering an individual with a developmental disability as

defined under s. 393.063, TBI or dementia who lacks a co-occurring mental illness into a state treatment facility. Such individuals must be referred to the Agency for Persons with Disabilities or the Department of Elder Affairs for further evaluation and the provision of appropriate services for their individual needs. In addition, if it reasonably appears that the individual would be found incapacitated under chapter 744 and the individual does not already have a legal guardian, the receiving facility must inform any known next of kin and initiate guardianship proceedings. The receiving facility may hold the individual until the petition to appoint a guardian is heard by the court and placement is secured.

Section 12 amends s. 394.495, F.S., relating to programs and services for child and adolescent mental health systems of care, explicitly requiring that for assessments of children and adolescents under the Baker Act, a clinical psychologist, clinical social worker, physician, psychiatric nurse, psychiatrist, or a person working under the direct supervision of one of these professionals may perform an assessment. This is current law, however currently this statute refers to these professionals in a cross-reference rather than listing them in this section of statute.

The bill also revises counties that must be served by a community action team to include Charlotte and Leon County. The Senate proposed budget contains funding for these new CAT teams.

Section 13 amends s. 394.496, F.S., relating to service planning, requiring that for assessments of children and adolescents under the Baker Act, a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist must be among the persons included in developing a services plan for the child or adolescent. This is current law, however currently this statute refers to these professionals in a cross-reference rather than listing them in this section of statute.

Section 14 amends s. 394.499, F.S., relating to integrated children's CSU/juvenile addiction receiving facility services, adding the terms "parent or legal" in front of guardian to state: a person under 18 years of age for whom voluntary application is made by his or her parent or legal guardian. Also, the bill adds a statutory reference to the voluntary admissions section in statute (s. 394.4625, F.S.).

Section 15 amends s. 394.656, F.S., revising the duties of and renaming the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Review Committee to the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Advisory Committee. The bill revises the membership of the committee to remove the administrator of an assisted living facility that holds a limited mental health license; add the Florida Behavioral Health Association, to reflect the merger of the Florida Alcohol and Drug Abuse Association with the Florida Council for Community Mental Health.

The bill allows county consortiums to apply for a 1-year planning or 3-year implementation or expansion grant. The bill allows a county planning council or committee to designate the county sheriff or local law enforcement agency to apply for a grant on behalf of the county.

The bill removes the ability of the committee to participate in the development of criteria used to review grants and in the selection of grant recipients. Instead, DCF, in collaboration with the Department of Corrections, the Department of Juvenile Justice, the Department of Elder Affairs,

the Office of the State Courts Administrator, and the Department of Veterans' Affairs must establish criteria used to review applications and select the county that will be awarded a 1-year planning grant or a 3-year implementation or expansion grant.

Section 16 amends s. 394.657, F.S., conforming changes to the name of the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Review Committee to changes made by the bill.

Section 17 amends s. 394.658, F.S., to align with the changes made in s. 394.656, F.S., which limits the grant review and selection responsibilities to the six state agencies. Specifically, this section is revised to require the Department, in collaboration with the Department of Corrections, the Department of Juvenile Justice, the Department of Elder Affairs, the Office of the State Courts Administrator, and the Department of Veterans' Affairs to establish criteria to be used to review grant applications and select grant recipients.

Section 18 amends s. 394.674, F.S., modifying the determination of eligibility for individuals with serious behavioral health conditions who do not have the financial means to access services. Specifically, the revisions to this section modify eligibility for DCF-funded mental health and substance abuse services by setting forth a definition for eligibility based on diagnoses, level of functioning, and financial need, rather than one based on priority populations.

The bill also amends s. 394.908, F.S., to replace the term "priority population" with "individuals who meet eligibility requirements."

Section 19 amends s. 394.908, F.S., to conform with the changes to terminology made to s. 394.674, F.S., by the bill.

Section 20 amends s. 394.9085, F.S., relating to behavioral provider liability, adding a cross reference to s. 394.455(41), F.S.

Section 21 amends s. 397.305, F.S., revising legislative intent related to the Marchman Act to include that patients be placed in the most appropriate and least restrictive environment conducive to long-term recovery while protecting individual rights.

Section 23 amends s. 397.321, F.S., by removing the requirement that DCF develop a certification process by rule for prevention coalitions. As a result, prevention coalitions would no longer be subject to a certification process.

Section 17 amends s. 397.311, F.S., relating to definition under the Marchman Act, to make the same changes to definitions in statute to the Marchman Act as the bill makes to the Baker Act.

Section 24 amends s. 397.416, F.S., to change a cross reference.

Section 25 amends s. 397.501, F.S., relating to rights of individuals, requiring that a patient with a serious substance abuse addiction who has been released after being Marchman Acted must be provided with information on the elements of a coordinated system of care. DCF is provided with rulemaking authority to determine what services may be provided to patients.

Section 26 amends s. 397.675, F.S., relating to criteria for involuntary admissions, to make the same changes to involuntary treatment criteria to the Marchman Act as the bill makes to the Baker Act, and to add history of noncompliance with substance abuse treatment and continued substance use as additional criterion.

Section 27 amends s. 397.6751, F.S., relating to service provider responsibilities regarding involuntary admissions, requiring that all patients admitted under the Marchman Act be placed in the most appropriate and least restrictive environment conducive to the patient's treatment needs.

Section 28 amends s. 397.681, F.S., relating to involuntary petitions, making the state attorney the real party of interest in all Marchman Act proceedings.

Section 29 repeals s. 397. 6811, F.S., relating to involuntary assessment and stabilization.

Section 30 repeals s. 397. 6814, F.S., relating to contents of a petition in an involuntary assessment and stabilization matter.

Section 31 repeals s. 397. 6815, F.S., relating to procedure in an involuntary assessment and stabilization matter.

Section 32 repeals s. 397. 6818, F.S., relating to court determination.

Section 33 repeals s. 397. 6819, F.S., relating to responsibility of a licensed service in an involuntary assessment and stabilization matter.

Section 34 repeals s. 397. 6821, F.S., relating to an extension of time for completion of an involuntary assessment and stabilization.

Section 35 repeals s. 397. 6822, F.S., relating to disposition of an individual after an involuntary assessment.

Section 36 amends s, 397.693, F.S., relating to involuntary treatment, providing that a person may be involuntary admitted under the Marchman Act if they reasonably appear to meet the relevant statutory critera.

Section 37 amends s. 397.695, F.S., relating to involuntary treatment, changing instances of 'treatment' to 'treatment services' throughout the section and allowing the court to waive or prohibit service of process fees for indigent respondents.

Section 38 amends 397.6951, F.S., relating to contents for a petition for involuntary treatment, changing instances of 'treatment' to 'treatment services' throughout the section and removing the requirement that a petition for involuntary treatment contain findings and recommendations of an assessment by a qualified professional.

The bill requires a petition for involuntary treatment to demonstrate that the petitioner believes that without treatment the respondent is likely to either:

- suffer from neglect or refuse to care for themselves which poses a real and substantial threat of harm and is unavoidable without the help of others or provisions of services; or
- inflict serious harm to themselves or others, including property damage.

The bill provides that a petition may be accompanied by a certificate or report of a qualified professional or licensed physician who has examined the respondent within the past 30 days. The certificate must contain the professional's findings and if the respondent refuses to submit to an examination must document the refusal.

The bill provides that in the event of an emergency requiring an expedited hearing, the petition must contain documented reasons for expediting the hearing.

Section 39 amends s. 397.6955, F.S., relating to the duties of the court upon the filing of a petition for involuntary treatment revising the duties of the court upon the filing of a Marchman Act petition for involuntary treatment. The bill requires the clerk of court to notify the state attorney upon the filing of such a petition if the petition does not indicate that the petitioner has retained private counsel, notify the respondent's counsel if any has been retained, and schedule a hearing on the petition within 10 court working days unless a continuance is granted.

In the case of an emergency, the bill allows the court to rely solely on the contents of a petition to enter an ex parte order authorizing the involuntary assessment and stabilization of the respondent. The bill allows the court to order a law enforcement officer to take the respondent into custody and deliver them to the nearest service provider while the full hearing is conducted.

Section 40 amends s. 397.6957, F.S., requires a respondent to be present during a hearing on an involuntary treatment petition unless the respondent has knowingly and willingly waived their right to appear. Testimony from family members familiar with the respondent's history and how it relates to their current condition is permissible. The bill allows witnesses to testify remotely via the most appropriate and convenient technological method of communication available to the court, including but not limited to teleconference, and allows any witnesses intending to remotely to attend and testify at the hearing as long as they provide the parties with all relevant documents in advance of the hearing.

The bill provides that if the respondent has not previously been assessed by a qualified professional, the court must allow 10 days for the respondent to undergo such evaluation, unless the court suspects that the respondent will not appear at a rescheduled hearing or refuses to submit to an evaluation, the court may enter a preliminary order committing the respondent to an appropriate treatment facility until the rescheduled hearing date. The court may also order the respondent to undergo drug screenings as part of the evaluation. The respondent's evaluation must occur within 72 hours of arrival at the treatment facility. If the facility cannot have the evaluation completed in this time period, they must petition the court for an extension of time not to extend beyond a period of 3 days before the reschedule hearing. If the period of time is extended and ends on a weekend or holiday, the court may only hold the respondent until the next court working day. Copies of the evaluation report must be provided to all parties and their counsel, and the respondent may be held and treatment initiated until the rescheduled hearing. The court may order law enforcement to transport the respondent as needed to and from a treatment facility to the court for the rescheduled hearing.

If the respondent is a minor, assessment must occur within 12 hours of admission. The service provider may petition the court for a 72-hour extension of time if the provider furnishes copies of the motion for extension of time to all parties. The court may expedite or grant additional time for the involuntary treatment hearing, but only if there is agreement among the parties on the hearing date or if there is statutorily appropriate notice and proof of service. If the period is extended and ends on a weekend or holiday, the court can only hold the respondent until the next court working day.

The bill requires the petitioner to prove, through clear and convincing evidence that the respondent is substance abuse impaired, has lost the power of self-control with respect to substance abuse, has a history of lack of compliance with treatment, and has demonstrated continued substance use. The bill requires the petitioner to also prove that it is likely that the respondent poses a threat of substantial harm to their own well-being and it is apparent that such harm may not be avoided through the help of willing, able, and responsible family member or friends or the provision of services, or that there is a substantial likelihood that, unless admitted, the respondent will cause harm to themselves or others, which may include property damage.

The bill allows the court to initiate involuntary proceedings at any point during the hearing if it reasonably believes that the respondent is likely to injure themselves if allowed to remain free. Any treatment order entered by the court at the conclusion of the hearing must contain findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

Section 41 amends s, 397.697, F.S., relating to court determinations and the effect of a court order for involuntary services, providing that in order to qualify for involuntary outpatient treatment an individual must be accompanied by a willing, able, and responsible advocate, or a social worker or case manager of a licensed service provider, who will inform the court if the individual fails to comply with their outpatient program. The bill also requires that if outpatient treatment is offered in lieu of inpatient treatment, it must be available in the county where the respondent resides and it may be offered for up to six months if it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment at least twice during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician certifies that the respondent can be more appropriately treated on an outpatient basis and can follow a treatment plan.

The bill requires the court to retain jurisdiction in all cases resulting in involuntary inpatient treatment so that it may monitor compliance with treatment, change treatment modalities, or initiate contempt of court proceedings as needed.

The bill also provides that in cases involving minors who violate an involuntary treatment order, the court may hold the minor in contempt for the same amount of time as their court-ordered treatment, so long as the court informs the minor that the contempt can be immediately ended by compliance with the treatment plan. If a contempt order results in incarceration, status conference hearings must be held every 2 to 4 weeks to assess the minor's well-being and inquire whether the minor will enter treatment. If the minor agrees to enter treatment, service providers are required to prioritize their entry into treatment.

Finally the bill clarifies that while subject to the court's oversight, a service provider's authority is separate and distinct from the court's continuing jurisdiction.

Section 42 amends s. 397.6971, related to early release from involuntary services, to change all instances of the word 'services' to the word 'treatment.'

Section 43 amends s. 397.6975, F.S., related to extension of involuntary services periods, allowing a service provider to petition the court for an extension of an involuntary treatment period if an individual in treatment is nearing the end of their court-ordered time period in treatment and it appears that they will require additional care. The bill provides that such a petition will preferably be filed at least 10 days before the expiration of the current scheduled treatment period. The bill requires the court to immediately schedule a hearing to be held not more than 10 court working days after the filing of the petition. The bill allows the court to order additional treatment if the original time period will expire before the hearing is concluded and it appears likely to the court that additional treatment will be required.

Section 44 amends s. 397.6977, F.S., relating to disposition of individual completion of involuntary treatment services, to change all instances of the word 'services' to the word 'treatment.'

Section 45 repeals s. 397.6978, F.S., relating to guardian advocates; patients incompetent consent; and substance abuse disorder.

Section 46 amends s. 397.99, F.S., allowing managing entities, rather than DCF, to use a competitive solicitation process to review grant applications for the school substance abuse prevention partnership grant program.

Section 47 amends s. 916.111, F.S., requiring court-appointed forensic evaluators to take a refresher training on conducting forensic evaluations. The refresher training would include forensic statutory requirements, recent changes to statute, Florida trends and concerns related to forensic commitments, alternatives to maximum security treatment facilities, community forensic treatment providers, evaluation requirements, and forensic service array updates.

Section 48 amends s. 916.115, F.S., requiring the refresher training required by the bill to be completed every three years.

Section 49 amends s. 409.972, F.S., relating to mandatory and voluntary enrollment in Medicaid programs, to change a cross reference.

Section 50 amends s. 464.012, F.S., relating to the scope of practice for advanced registered nurse practitioners to correct a cross reference.

Section 51 amends s. 744.2007, F.S., relating to powers and duties of guardians, to correct a cross-reference.

Section 52 amends s. 790.065, relating to the sale and delivery of firearms, to eliminate cross references.

Section 53 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

DCF estimates that the refresher training required for court-appointed forensic evaluators will create a positive fiscal impact for providers of the training and will negatively impact the evaluators required to take the training. The fiscal impact to providers and evaluators is indeterminate.

The bill may impact private service providers who will be required to update forms to accommodate new requirements and to train service provider staff and administrators on the new requirements.

C. Government Sector Impact:

DCF estimates that recurring General Revenue needed to fund the addition of CAT teams in Charlotte and Leon counties is $1.5 million. [78] The Senate proposed budget contains funding for these new CAT teams.

Section 394.674, F.S. currently defines DCF's priority populations, stating that individuals with serious mental illness are eligible to receive substance abuse and mental health services funded by DCF when the individual does not have some type of insurance or other way to pay for services. DCF estimates that it is likely that some individuals impacted by this provision will not be eligible for Department funded services. DCF is unable to estimate the increase in the number of individuals who would be receiving services through a community mental health center under the bill. Managing Entities negotiate rates with community mental health providers for various behavioral health services. For the increase in the number of individuals eligible for these services through DCF, the funding available to pay for those services will need to be increased.

The Office of the State Court Administrator (OCSA) predicts that the number of experts appointed would not change because of the bill; although the bill could reduce the list of available experts due to some experts not completing the newly required refresher training every three years, it is not anticipated that any such reduction would be significant.[79]

OCSA predicts that clarifying and expanding involuntary admissions criteria for the Marchman Act could result in an increase in petitions filed and granted, however this impact is indeterminate. Similarly, making the state attorney the real party in interest in Marchman Act cases may impact workloads, however it may also result in more efficient processing of cases, and any fiscal impact resulting from this provision is indeterminate.

There will be a fiscal impact to the state as a result of the broadened Baker Act and Marchman Act criteria under the bill. More individuals will be subject to involuntary commitment under both statutes, leading to an impact on courts and state receiving facilities. The requirement that patients be provided assistance with accessing services comprising a post-discharge continuum of care will create an additional, indeterminate fiscal impact. DCF must establish what services may be provided through rulemaking and it is unclear what individuals will qualify for these services.

VI. Technical Deficiencies:

None.

[78] *Supra* at note 53.
[79] Office of the State Courts Administrator, Agency Analysis of SB 1678. On file with the Children, Families, and Elder Affairs Committee.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 394.455, 394.459, 394.4598, 394.4599, 394.461, 394.4615, 394.462, 394.4625, 394.463, 394.4655, 394.467, 394.495, 394.496, 394.499, 394.656, 394.657, 394.658, 394.674, 394.908, 394.9085, 397.321, 397.305, 397.311, 397.416, 397.501, 397.675, 397.6751, 397.681, 397.693, 397.695, 397.6951, 397.6955, 397.6957, 397.697, 397.6971, 397.6975, 397.6977, 397.99, 409.972, 464.012, 744.2007, 790.065, 916.111, and 916.115 of the Florida Statutes.

This bill repeals sections 397.6811, 397.6814, 397.6815, 397.6818, 397.6819, 397.6821, 397.6822, and 397.6978 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on February 11, 2020:

- Defines "neglect or refuse to care for himself or herself" to include evidence that a person is unable to provide adequate food or shelter for themselves, is substantially unable to make an informed treatment choice, or needs care or treatment to prevent deterioration.
- Adds criteria for a "real and present threat of substantial harm" to include evidence that an untreated person will lack, refuse, or not receive health services or will suffer severe harm leading to an inability to function cognitively or in their community generally.
- Requires a patient with a serious mental illness who has been released after being Baker Acted be provided with information regarding the essential elements of recovery and provided with accessing a continuum of care regimen. DCF is provided with rulemaking authority to determine what services may-be available in such regimens and which serious mental illnesses will entitle an individual to services. Current law only requires the state to provide involuntary treatment at a state hospital.
- Allows civil patients to be admitted to designated receiving facilities under the Baker Act without undergoing a transfer evaluation.
- Provides that before the close of the State's case in a Baker Act hearing for involuntary placement, the state may establish that a transfer evaluation was performed and the document properly executed by providing the court with a copy of the transfer evaluation.
- Prohibits the court from considering the substantive information in the transfer evaluation unless the evaluator (typically a health care practitioner) testifies at the hearing.

- Eliminates provisions referring to s. 394.4655, F.S., relating to involuntary outpatient services, rendered inapplicable by the CS.
- Requires a person to show evidence of mental illness in order to be admitted to a facility on a voluntary basis. Adults must consent in writing, and minors may only be admitted on a voluntary basis if both the minor and their parent or guardian give express and informed consent. The minor's assent is considered an affirmative agreement to remain at the facility for examination. A minor's assent must be verified through a clinical assessment performed within 12 hours of arrival at the facility. The examining professional must provide the minor with an explanation as to why they are at the facility, what to expect, and when they can expect to be released, using language that is appropriate to the minor's age, experience, maturity, and condition. The professional must document that the minor can understand this information. The facility administrator must file notice with the court of the minor's voluntary placement within 1 day of admission.
- A public defender shall be appointed by the court to review the voluntariness of the minor's admission and verify assent. The public defender can interview and represent the minor and shall have access to all relevant witnesses and records. If the public defender does not review their assent, the clinical record shall serve as verification of assent. If assent is not verified, a petition for involuntary placement must be filed or the minor must be released to their parent or guardian within 24 hours of arrival at the facility.
- Provides that a person is subject to an involuntary examination if there is a substantial likelihood that without care or treatment the person will cause serious harm to themselves or others in the near future, as evidenced by his or her recent behavior, actions, or omissions, to include property damage.
- Adds criminal penalties for unlawful activities relating to examination and treatment. The unlawful activities detailed in the CS are: (a) knowingly furnishing false information for the purpose of obtaining emergency or other involuntary admission for any person; (b) causing or conspiring with another to cause, any involuntary mental health procedure for the person without a reason for believing a person is impaired; or, (c) causing, or conspiring to cause, any person to be denied their rights under the mental health statutes unlawful acts would be a misdemeanor of the first degree, punishable as provided by a fine up to $5,000. The CS provides law enforcement with discretion in transporting those who appear to meet Baker Act criteria to receiving facilities. It also requires receiving facilities to inform DCF of any person who has been Baker Acted 3 or more times within a 12 month period.
- Provides that in lieu of inpatient treatment, a court may order a respondent in a Baker Act case into outpatient treatment for up to six months if it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment at least twice during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician certifies that the respondent can be more appropriately treated on an outpatient basis, and can follow a treatment plan.
- Requires that for the duration of their treatment, the respondent must have a willing, able, and responsible supervisor who will inform the court of any failure to comply with the treatment plan. The CS requires the court to retain jurisdiction over the

parties for entry of further orders after a hearing, and the court may order inpatient treatment to stabilize a respondent who decompensates during their period of court-ordered treatment if they continue to meet the other statutorily required criteria for commitment.

- Requires that for assessments of children and adolescents under the Baker Act, a clinical psychologist, clinical social worker, physician, psychiatric nurse, psychiatrist, or a person working under the direct supervision of one of these professionals may perform an assessment. This is current law, however currently this statute refers to these professionals in a cross-reference rather than listing them in this section of statute.
- Requires that for assessments of children and adolescents under the Baker Act, a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist must be among the persons included in developing a services plan for the child or adolescent. This is current law, however currently this statute refers to these professionals in a cross-reference rather than listing them in this section of statute.
- Requires that a patient with a serious substance abuse addiction who has been released after being Marchman Acted must be provided with information on the elements of a coordinated system of care. DCF is provided with rulemaking authority to determine what services may be provided to patients.
- Makes the same changes to involuntary treatment criteria to the Marchman Act as the CS makes to the Baker Act, and to add history of noncompliance with substance abuse treatment and continued substance use as additional criterion.
- Requires that all patients admitted under the Marchman Act be placed in the most appropriate and least restrictive environment conducive to the patient's treatment needs.
- Makes the state attorney the real party of interest in all Marchman Act proceedings.
- Repeals sections 397.6811, 397.6814, 397.6815, 397.6818, 397.6819, 397.6821 and 397.6822, and 397.6978 of the Florida Statutes.
- Provides that a person may be involuntary admitted under the Marchman Act if they reasonably appear to meet the relevant statutory criteria.
- Requires a petition for involuntary treatment to demonstrate that the petitioner believes that without treatment the respondent is likely to either:
  - Suffer from neglect or refuse to care for themselves which poses a real and substantial threat of harm and is unavoidable without the help of others or provisions of services; or
  - Inflict serious harm to themselves or others, including property damage.
- Provides that a petition may be accompanied by a certificate or report of a qualified professional or licensed physician who has examined the respondent within the past 30 days. The certificate must contain the professional's findings and if the respondent refuses to submit to an examination must document the refusal.
- Requires the clerk of court to notify the state attorney upon the filing of a Marchman Act petition if the petition does not indicate that the petitioner has retained private counsel, notify the respondent's counsel if any has been retained, and schedule a hearing on the petition within 10 court working days unless a continuance is granted.
- In the case of an emergency, the CS allows the court to rely solely on the contents of a petition to enter an ex parte order authorizing the involuntary assessment and

stabilization of the respondent. The CS allows the court to order a law enforcement officer to take the respondent into custody and deliver them to the nearest service provider while the full hearing is conducted.

- Requires a respondent to be present during a hearing on an involuntary treatment petition unless the respondent has knowingly and willingly waived their right to appear. Testimony from family members familiar with the respondent's history and how it relates to their current condition is permissible. The CS allows witnesses to testify remotely via the most appropriate and convenient technological method of communication available to the court, including but not limited to teleconference, and allows any witnesses intending to remotely to attend and testify at the hearing as long as they provide the parties with all relevant documents in advance of the hearing.
- if the respondent has not previously been assessed by a qualified professional, the court must allow 10 days for the respondent to undergo such evaluation, unless the court suspects that the respondent will not appear at a rescheduled hearing or refuses to submit to an evaluation, the court may enter a preliminary order committing the respondent to an appropriate treatment facility until the rescheduled hearing date. The court may also order the respondent to undergo drug screenings as part of the evaluation. The respondent's evaluation must occur within 72 hours of arrival at the treatment facility. If the facility cannot have the evaluation completed in this time period, they must petition the court for an extension of time not to extend beyond a period of 3 days before the reschedule hearing. If the period of time is extended and ends on a weekend or holiday, the court may only hold the respondent until the next court working day. Copies of the evaluation report must be provided to all parties and their counsel, and the respondent may be held and treatment initiated until the rescheduled hearing. The court may order law enforcement to transport the respondent as needed to and from a treatment facility to the court for the rescheduled hearing.
- If the respondent is a minor, assessment must occur within 12 hours of admission. The service provider may petition the court for a 72-hour extension of time if the provider furnishes copies of the motion for extension of time to all parties. The court may expedite or grant additional time for the involuntary treatment hearing, but only if there is agreement among the parties on the hearing date or if there is statutorily appropriate notice and proof of service. If the period is extended and ends on a weekend or holiday, the court can only hold the respondent until the next court working day.
- Requires the petitioner to prove, through clear and convincing evidence that the respondent is substance abuse impaired, has lost the power of self-control with respect to substance abuse, has a history of lack of compliance with treatment, and has demonstrated continued substance use. The CS requires the petitioner to also prove that it is likely that the respondent poses a threat of substantial harm to their own well-being and it is apparent that such harm may not be avoided through the help of willing, able, and responsible family member or friends or the provision of services, or that there is a substantial likelihood that, unless admitted, the respondent will cause harm to themselves or others, which may include property damage.
- Allows the court to initiate involuntary proceedings at any point during the hearing if it reasonably believes that the respondent is likely to injure themselves if allowed to remain free. Any treatment order entered by the court at the conclusion of the hearing

must contain findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

- Provides that in order to qualify for involuntary outpatient treatment an individual must be accompanied by a willing, able, and responsible advocate, or a social worker or case manager of a licensed service provider, who will inform the court if the individual fails to comply with their outpatient program. The CS also requires that if outpatient treatment is offered in lieu of inpatient treatment, it must be available in the county where the respondent resides and it may be offered for up to six months if it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment at least twice during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician certifies that the respondent can be more appropriately treated on an outpatient basis and can follow a treatment plan.
- Requires the court to retain jurisdiction in all cases resulting in involuntary inpatient treatment so that it may monitor compliance with treatment, change treatment modalities, or initiate contempt of court proceedings as needed.
- Provides that in cases involving minors who violate an involuntary treatment order, the court may hold the minor in contempt for the same amount of time as their court-ordered treatment, so long as the court informs the minor that the contempt can be immediately ended by compliance with the treatment plan. If a contempt order results in incarceration, status conference hearings must be held every 2 to 4 weeks to assess the minor's well-being and inquire whether the minor will enter treatment. If the minor agrees to enter treatment, service providers are required to prioritize their entry into treatment.
- Allows a service provider to petition the court for an extension of an involuntary treatment period if an individual in treatment is nearing the end of their court-ordered time period in treatment and it appears that they will require additional care. The CS provides that such a petition will preferably be filed at least 10 days before the expiration of the current scheduled treatment period. The CS requires the court to immediately schedule a hearing to be held not more than 10 court working days after the filing of the petition. The CS allows the court to order additional treatment if the original time period will expire before the hearing is concluded and it appears likely to the court that additional treatment will be required.

B. Amendments:

None.