HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 7021 PCB CFS 24-01 Mental Health and Substance Abuse
SPONSOR(S): Health & Human Services Committee, Health Care Appropriations Subcommittee, Children, Families & Seniors Subcommittee, Maney and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1784

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	18 Y, 0 N	Curry	Brazzell
1) Health Care Appropriations Subcommittee	14 Y, 0 N, As CS	Fontaine	Clark
2) Health & Human Services Committee	16 Y, 0 N, As CS	Curry	Calamas

SUMMARY ANALYSIS

In Florida, the Baker Act provides a legal procedure for voluntary and involuntary mental health examination and treatment. The Marchman Act addresses substance abuse through a comprehensive system of prevention, detoxification, and treatment services. The Department of Children and Families (DCF) is the single state authority for substance abuse and mental health treatment services in Florida.

The bill modifies the Baker Act and makes significant changes to the Marchman Act, the statutory processes for mental health and substance abuse examinations and treatment, respectively.

The bill amends the Baker Act in that it:

- Combines processes for courts to order individuals to involuntary outpatient services and involuntary inpatient placement in the Baker Act, to streamline the process for obtaining involuntary services, and providing more flexibility for courts to meet individuals' treatment needs.
- Grants law enforcement officers discretion on initiating involuntary examinations.

The bill amends the Marchman Act in that it:

- Repeals existing provisions for court-ordered involuntary assessments and stabilization in the Marchman Act, and creates a new consolidated involuntary treatment process.
- Prohibits courts from ordering an individual with a developmental disability who lacks a co-occurring mental illness to a state mental health treatment facility for involuntary inpatient placement.
- Revises the voluntariness provision under the Baker Act to allow a minor's voluntary admission after a clinical review, rather than a hearing, has been conducted.
- Authorizes a witness to appear remotely upon a showing of good cause and with consent by all parties.
- Allows an individual to be admitted as a civil patient in a state mental health treatment facility without a transfer evaluation and prohibits a court, in a hearing for placement in a treatment facility, from considering substantive information in the transfer evaluation unless the evaluator testifies at the hearing.

The bill amends both acts in that it:

- Creates a more comprehensive and personalized discharge planning process.
- Requires the Louis de la Parte Florida Mental Health Institute to prepare and publish certain reports on its website.
- Removes the 30-bed cap for crisis stabilization units.

The bill appropriates $50,000,000 to the Department of Children and Families to implement its provisions, and has no fiscal impact on local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Health and Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

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

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being. Mental illness affects millions of people in the United States each year. Nearly one in five adults lives with a mental illness.[4] During their childhood and adolescence, almost half of children will experience a mental disorder, though the proportion experiencing severe impairment during childhood and adolescence is much lower, at about 22%.[5]

Mental Health Safety Net Services

The 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 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.

Current Situation - Behavioral Health Managing Entities

In 2001, the Legislature authorized DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.[6] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[7] MEs were fully implemented statewide in 2013, serving all geographic regions.

[1] World Health Organization, *Mental Health: Strengthening Our Response,* https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited January 3, 2024).
[2] Centers for Disease Control and Prevention, *Mental Health Basics*, http://medbox.iiab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm (last visited January 3, 2024).
[3] *Id*.
[4] National Institute of Mental Health (NIH), *Mental Illness*, https://www.nimh.nih.gov/health/statistics/mental-illness (last visited January 3, 2024).
[5] *Id*.
[6] Ch. 2001-191, Laws of Fla.
[7] Ch. 2008-243, Laws of Fla

DCF currently contracts with seven MEs for behavioral health services throughout the state. These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the state.[8]

Current Situation - Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.[9] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[10] A community or region provides a coordinated system of care for those with a mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.[11] MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.[12] DCF must use performance-based contracts to award grants.[13]

There are several essential elements which make up a coordinated system of care, including:[14]

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.

A coordinated system of care must include, but is not limited to, the following array of services:[15]

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and

[8] DCF, *Managing Entities,* available at https://www.myflfamilies.com/services/samh/prov/*d*ers/managing-entities, (last visited January 8, 2024).
[9] S. 394.9082(5)(d), F.S.
[10] S. 394.4573(1)(c), F.S.
[11] S. 394.4573(3), F.S. The Legislature has not funded system improvement grants.
[12] *Id.*
[13] *Id.*
[14] S. 394.4573(2), F.S.
[15] S. 394.495(4), F.S

- Trauma-informed services for children who have suffered sexual exploitation.

DCF must define the priority populations which would benefit from receiving care coordination.[16] In defining priority populations, DCF must consider the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.[17] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[18]

Effect of Bill - Coordinated System of Care

Office of Children's Behavioral Health Ombudsman

The bill creates the Office of Children's Behavioral Health Ombudsman (Office) within DCF for the purpose of being a central point to receive complaints on behalf of children and adolescents with behavioral health disorders receiving state-funded services and to use this information to improve the child and adolescent mental health treatment and support system. The bill requires the Office to:

- Receive and direct to the appropriate contact within the department, at the Agency for Health Care Administration, or the appropriate organizations providing behavioral health services complaints from children and adolescents and their families about the mental health treatment and support system.
- Maintain records of complaints received and the actions taken.
- Be a resource to identify and explain relevant polices or procedures to children, adolescents and their families about the child and adolescent mental health treatment and support system.
- Provide recommendations to the department to address systemic problems within the mental health treatment and support system that are leading to complaints. The department shall include an analysis of complaints and these recommendations in the report required under s. 394.4573, F.S.
- Engage in functions that may improve the child and adolescent mental health treatment and support system.

DCF and managing entities must place contact information for the Office prominently on a webpage related to children's behavioral health services on their websites.

Behavioral Health Interagency Collaboration

The bill creates the Behavioral Health Interagency Collaboration. The bill requires DCF and AHCA to work together to jointly establish regional behavioral health interagency collaboratives throughout the state. DCF is responsible for defining the region to be served by each collaborative and for facilitating meetings. The goal of the collaboratives are to identify and address ongoing challenges within the behavioral health system at the local level to improve the accessibility, availability, and quality of behavioral health services.

The regional collaborative membership shall, at a minimum, be composed of representatives from the following serving each region:

- Department of Children and Families;

[16] S. 394.9082(3)(c), F.S.
[17] S. 394.9082(5)(b), F.S.
[18] S. 394.75(3), F.S.

- Agency for Health Care Administration;
- Agency for Persons with Disabilities;
- Department of Elder Affairs;
- Department of Health;
- Department of Education;
- School districts;
- Area Agencies on Aging;
- Community-based care lead agencies;
- Managing entities, as defined;
- Behavioral health services providers;
- Hospitals;
- Medicaid Managed Medical Assistance Plans;
- Police departments; and
- Sheriffs' Offices.

All entities represented on the regional collaboratives must provide assistance as appropriate and reasonably necessary to fulfill the goals of the regional collaboratives.

The Baker Act

The Florida Mental Health Act, commonly referred to as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[19] The Act includes 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.[20]

DCF is responsible for the operation and administration of the Baker Act, including publishing an annual Baker Act report. According to the Fiscal Year (FY) 2021-2022 Baker Act annual report, over 170,000 individuals were involuntarily examined under the Baker Act; of those, just over 11,600 individuals were 65 years of age or older. This age group is the most likely to include individuals with Alzheimer's disease or related dementia. It is important to note the number of Baker Acts per year decreased during FY 2018-2019, FY 2019-2020, and FY 2020-2021, across all age groups.[21]

Rights of Patients

Current Situation

The Baker Act protects the rights of patients examined or treated for mental illness in Florida, including, but not limited to, the right to give express and informed consent for admission or treatment and the right to communicate freely and privately with persons outside a facility, unless the facility determines that such communication is likely to be harmful to the patient or others.[22]

Each patient entering treatment must be asked to give express and informed consent for admission or treatment.[23] If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment must be obtained from the patient's guardian or guardian advocate. If the patient is a minor, consent must be requested from the patient's guardian unless the minor is seeking outpatient crisis intervention services.[24] In situations where emergency medical treatment is needed and the patient or the patient's guardian or guardian advocate are unable

[19] The Baker Act is contained in Part I of ch. 394, F.S.
[20] S. 394.459, F.S.
[21] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.
[22] Ss.394.459(3), and 394.459(5), F.S. Other patient rights include the right to dignity; treatment regardless of ability to pay; express and informed consent for admission or treatment; quality treatment; possession of his or her clothing and personal effects; vote in elections, if eligible; petition the court for a writ of habeas corpus to question the cause and legality of their detention in a receiving or treatment facility; and participate in their treatment and discharge planning. See, s. 394.459 (1)-11), F.S. Current law imposes liability for damages on those who violate or abuse patient rights or privileges. See, s. 394.459 (10), F.S.
[23] S. 394.459(3).
[24] S. 394.4784, F.S.

to provide consent, the administrator of the facility may, upon the recommendation of the patient's attending physician, authorize treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient.[25]

Currently, a facility must provide immediate patient access to a patient's family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney, unless such access would be detrimental to the patient or the patient exercises their right not to communicate or visit with the person.[26] If a facility restricts a patient's right to communicate or receive visitors, the facility must provide written notice of the restriction and the reasons for it to the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative.[27] A qualified professional[28] must document the restriction within 24 hours, and a record of the restriction and the reasons thereof must be recorded in the patient's clinical record. Under current law, a facility must review patient communication restrictions at least every three days.[29]

Effect of Bill – Rights of Patients

If a facility restricts a patient's right to communicate, the bill requires a qualified professional to record the restriction and its underlying reasons in the patient's clinical file within 24 hours and to immediately serve the document of record to the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative.

Clinical Records

Current Situation

Clinical records maintained by mental health facilities, which can include medical records, progress notes, charts and admission and discharge data, and all other information recorded by facility staff pertaining to the patient's hospitalization or treatment,[30] are confidential and exempt from public disclosure by law.[31] A patient's clinical records and other information may be released if authorized by the patient or the patient's guardian. The patient's guardian or guardian advocate must be provided access to the appropriate information and clinical records of the patient and may authorize the release of such information and records to the appropriate persons to ensure the continuity of the patient's health care or mental health care.[32] Current law does not grant a patient's legal custodian access to the patient's information and clinical records or permit the legal custodian to authorize the release of a patient's clinical records and information.

Effect of Bill – Clinical Records

The bill grants the patient's legal custodian access to the appropriate information and clinical records of the patient and allows the legal custodian to authorize the release of the patient's clinical records.[33] This provision ensures that a patient's legal custodian may authorize the release of the patient's clinical records to the appropriate persons to ensure the continuity of care of the patient's health care or mental health care. For instance, when a child who is in the legal custody of the Department of Juvenile

[25] S. 394.459(3)(d), F.S.
[26] S. 394.459(5)(c), F.S.
[27] *S. 394.459(5)(d), F.S.*
[28] A qualified professional is a physician or a physician assistant, a psychiatrist licensed, a psychologist, or a psychiatric nurse. See s. 394.455(39), F.S.
[29] *Id*.
[30] S. 394.455(6), F.S.
[31] S. 394.4615, F.S.
[32] *Id.*
[33] Legal custody means the legal status created by a court which vests in a custodian of the person or guardian, whether an agency or an individual, the right to have physical custody of the child and the right and duty to protect, nurture, guide, and discipline the child and to provide him or her with food, shelter, education, and ordinary medical, dental, psychiatric, and psychological care. See s. 39.01, F.S.

Justice (DJJ) is released to DJJ from a mental health facility, some facilities may not provide DJJ with the child's discharge paperwork. In this case, DJJ's healthcare practitioners would have to contact the facility to get the information, or if the facility refused to release the information, the child's parent or guardian. If the child's parent or guardian is not responsive then DJJ would not have access to the child's discharge information for purposes of continuity of care. The addition of legal custodian ensures that DJJ can request and have access to the child's discharge information and other clinical records.

Receiving Facilities and Involuntary Examination

Current Situation – Receiving Facilities

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[34] Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by DCF as a receiving facility.

Receiving facilities, often referred to as Baker Act receiving facilities, are public or private facilities designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[35] 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.[36] 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.[37] Currently, there are 126 DCF designed receiving facilities.[38]

Crisis Stabilization Units

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. 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.[39] Individuals often enter the public mental health system through CSUs. Managing entities must follow current statutes and rules that require CSUs to be paid for bed availability rather than utilization.

Although involuntary examinations under the Baker Act have recently been decreasing statewide, the population of Florida continues to grow, and there are counties where the number of involuntary examinations remain the same or are slightly increasing, while some receiving facilities within communities are closing. There has been some demonstrated success with mobile response teams diverting individuals from the receiving facilities, resulting in those persons who are admitted to a receiving facility for an involuntary examination having higher acuity and longer lengths of stay.

In 2011, statute directed DCF to implement a demonstration project in circuit 18 to assess the impact of expanding the number of authorized CSU beds from 30 to 50. The facility in circuit 18 reported that by adding 20 additional beds, they were able to alleviate capacity issues within the county through 2021. The facility also reported that there are days that they exceed 100% capacity. Additionally, the facility

[34] Ss. 394.4625 and 394.463, F.S.
[35] S. 394.455(40), F.S. This term does not include a county jail.
[36] S. 394.455(38), F.S
[37] R. 65E-5.400(2), F.A.C.
[38] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.
[39] S. 394.875, F.S.

reported that the bed capacity expansion has allowed them to serve clients with complex needs (e.g., clients served by APD).[40]

Current Situation – Involuntary Examination

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[41] 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, has refused voluntary examination, is likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to that person's well-being, and such harm is unavoidable through help of willing family members or friends, or will cause serious bodily harm to him or herself or others in the near future based on recent behavior.[42]

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[43] or
- A physician, clinical psychologist, psychiatric nurse, an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion.[44]

Unlike the discretion afforded courts and medical professionals, current law mandates that law enforcement officers must initiate an involuntary examination of a person who appears to meet the criteria by taking him or her into custody and delivering or having the person delivered to a receiving facility for examination.[45] When transporting, officers are currently required to restrain the person in the least restrictive manner available and appropriate under the circumstances.[46] The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record. The report must also include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles.

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. Under the Baker Act, a receiving facility has up to 72 hours to examine an involuntary patient.[47] During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility, to determine if the criteria for involuntary services are met.[48] Current law does not indicate when the examination period begins for an involuntary patient. However, if the patient is a minor, a receiving facility must initiate the examination within 12 hours of arrival.[49]

Within that 72-hour examination period, one of the following must happen:[50]

[40] DCF, Agency Bill Analysis, (2023), on file with the House Children, Families, and Seniors Subcommittee.
[41] Ss. 394.4625 and 394.463, F.S.
[42] S. 394.463(1), F.S.
[43] S. 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[44] S. 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.
[45] S. 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.
[46] *Id.*
[47] S. 394.463(2)(g), F.S.
[48] S. 394.463(2)(f), F.S.
[49] S. 394.463(2)(g), F.S.
[50] *Id.*

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to be placed and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

If the patient's 72-hour examination period ends on a weekend or holiday, and the receiving facility:[51]

- Intends to file a petition for involuntary services, the patient may be held at a receiving facility through the next working day and the petition for involuntary services must be filed no later than such date. If the receiving facility fails to file a petition at the close of the next working day, the patient must be released from the receiving facility upon documented approval from a psychiatrist or a clinical psychologist.
- Does not intend to file a petition for involuntary services, the receiving facility may postpone release of a patient until the next working day if a qualified professional documents that adequate discharge planning and procedures and approval from a psychiatrist or a clinical psychologist are not possible until the next working day.

The receiving facility may not release an involuntary examination patient without the documented approval of a psychiatrist or a clinical psychologist. However, if the receiving facility is owned or operated by a hospital or health system, or a nationally accredited community mental health center, a psychiatric nurse performing under the framework of an established protocol with a psychiatrist is permitted to release a Baker Act patient in specified community settings. However, a psychiatric nurse is prohibited from approving a patient's release if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.[52]

Current Situation - Involuntary Examination of Minors

During fiscal year (FY) 2021-2022, 170,048 involuntary examinations were conducted for 115,239 individuals under the Baker Act;[53] of those examined, just over 36,000 were minors.[54] Individuals with multiple involuntary examinations accounted for a disproportionate number of examinations. Of the total involuntary examinations, there were 21.78 percent of individuals with two or more exams in FY 2021-2022. These individuals accounted for 46.99 percent of involuntary exams during the three-year period for FY 2019-2020 through FY 2021-2022.[55]

Approximately one in five (21.23 percent) of children with an involuntary examination in FY 2021-2022 had two or more involuntary exams. These children accounted for 44.93 percent of the of the involuntary examinations for the year.[56] According to the annual Baker Act Report, 12.40 percent of Baker Act examinations for children were initiated while at school.[57]

Current Situation - Transportation to a Receiving Facility

[51] S. 394.463(2)(g)4., F.S.
[52] S. 394.463(2)(f), F.S.
[53] DCF, *The Baker Act Florida Mental Health Act Fiscal Year 2021-2022 Report,* available at https://www.myflfamilies.com/sites/default/files/2023-07/FY%202021%202022%20Annual%20Report.pdf, (last visited February 16, 2024).
[54] DCF, *Report on Involuntary Examination of Minors,* available at https://www.usf.edu/cbcs/baker-act/documents/ba_minors_report_nov2023.pdf, (last visited February 16, 2024).
[55] *Id.*
[56] *Id.*
[57] DCF, *The Baker Act Florida Mental Health Act Fiscal Year 2021-2022 Report,* available at https://www.myflfamilies.com/sites/default/files/2023-07/FY%202021%202022%20Annual%20Report.pdf, (last visited February 16, 2024).

Each county is required to develop and implement a transportation plan in collaboration with the managing entities to transport individuals to designated receiving facilities for involuntary examination.[58] A county may enter into an agreement with the governing boards of nearby counties to establish a shared transportation plan. When multiple counties enter into an agreement for this purpose, the counties must notify the managing entity and provide the managing entity with a copy of the agreement.[59]

The transportation plan must describe the methods of transportation to a designated receiving facility and may identify responsibility for other transportation to a participating facility when necessary and agreed to by the facility. The plan may rely on emergency medical transport services or private transport companies, as appropriate.[60]

Each county is required to designate a single law enforcement agency within the county, or portions thereof, to take a person in need of services to a receiving facility for involuntary examination.[61] The designated law enforcement agency may decline to transport the person to a receiving facility only if:

- The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities at the sole cost of the county; and
- The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.[62]

Current Situation - Baker Act Reporting Requirements

Designated Receiving and Treatment Facilities

Facilities designated as public receiving or treatment facilities are required to report the following data to DCF on an annual basis:[63]

- Number of licensed beds;
- Number of contract days;
- Number of admissions by payor class and diagnoses;
- Number of bed days by payor class;
- Average length of stay by payor class; and
- Total revenues by payor class.

DCF must issue an annual report based on the data received from the facilities. The report must include individual facilities' data and statewide totals and be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Baker Act Report

DCF is required to receive and maintain copies of ex parte orders, involuntary orders issued under the Baker Act, professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients. These documents shall be used to prepare annual reports analyzing the data from the documents, without information identifying patients. Copies of the report must be provided DCF, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives.[64] Current law does specify the information that must be included in the annual reports or provide a due date for the reports.

Report on Involuntary Examination of Minors

[58] S. 394.462, F.S.
[59] *Id.*
[60] *Id.*
[61] S. 394.462(1)(a), F.S.
[62] S. 394.462(1)(b), F.S.
[63] S. 394.461(3), F.S.
[64] S. 394.463(2)(e). F.S.

DCF is required to submit reports detailing findings on repeated involuntary Baker Act examinations of minors using data collected from receiving facilities and school districts.[65] The reports must analyze data on both the initiation of involuntary examinations of children and the initiation of involuntary examinations of students who are removed from a school; identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child or student; study root causes for such patterns, trends, or repeated involuntary examinations; and make recommendations to encourage the use of alternatives to eliminate inappropriate initiations of such examinations. The report must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1 of each odd-numbered year.

Baker Act Reporting Center

The Baker Act Reporting Center (BARC) is located within the Louis de la Parte Florida Mental Health Institute at the University of South Florida.[66] BARC is operated on behalf of DCF and is contracted by the agency to analyze Baker Act data and produce the statutorily mandated Baker Act reports. Specifically, BARC is responsible for producing the annual Baker Act report and the Report on Involuntary Examinations of Minors.

Effect of Bill – Involuntary Examination

One of the criteria for involuntary examination requires that the person to be likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to their well-being and such harm is unavoidable through the help of "willing" family members or friends. The bill amends this criteria to add that such family members or friends being considered for offering help also be able and responsible.

The bill authorizes, rather than requires as in current law, law enforcement officers to transport those who appear to meet Baker Act criteria to receiving facilities. This gives law enforcement officers the same discretion that courts and medical professionals have to initiate an involuntary examination. By removing the legal mandate to initiate an involuntary examination, there could be a reduction in involuntary examinations, especially in cases involving minors and schools. This may lead to greater use of alternatives to involuntary examinations, such as mobile response teams.

Effect of Bill – Transportation to a Receiving Facility

When transporting a minor for involuntary examination, the bill requires law enforcement officers to provide the parent or legal guardian of the minor with the name, address, and contact information for the receiving facility to which the officer is transporting the minor to before departing, if the minor's parent or legal guardian is present, subject to any safety and welfare concerns for the minor.

The bill authorizes a county to include cost-sharing arrangements for transporting individuals to designated receiving facilities in the county's transportation plan. This will allow counties' to provide alternative transportation options to receiving facilities and share the cost with other entities.

Effect of Bill – Receiving Facilities

The bill:

- Specifies that the 72 hour Baker Act examination period begins when a patient arrives at the receiving facility.

[65] S. 394.463(4), F.S.

[66] The BARC is located within the Department of Mental Health Law & Policy, de la Parte Florida Mental Health Institute, College of Behavioral and Community Sciences at the University of South Florida. BARC, *College of Behavioral and Community Sciences*, available at https://www.usf.edu/cbcs/baker-act/, last visited February 15, 2024.

- Prohibits a receiving facility from releasing a patient from involuntary examination outside of the facility's ordinary business hours if the 72 hour examination period ends on a weekend or holiday.
- Removes facility bed caps for CSUs. This change will allow receiving facilities to expand to meet the need created by population growth, receiving facility closures, and longer lengths of stay.

The bill requires the court to dismiss a petition for involuntary services if the petitioner fails to file the petition within the 72 hour Baker Act examination period.

Effect of Bill - Baker Act Reporting Requirements

Designated Receiving and Treatment Facilities

The bill requires DCF to publish the report on designated public receiving and treatment facilities' data on the department's website and removes the requirement to submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Baker Act Report

The bill requires DCF to provide the data collected and used to prepare the annual Baker Act reports to the Louis de la Parte Florida Mental Health Institute (Institute). The bill requires the Institute to use the data to prepare the annual Baker Act reports. This provision will eliminate the need for DCF to contract with the BARC for the statutorily required reports. The bill requires the annual reports to include, but need not be limited to, the following information:

- A state level analysis of involuntary examinations;
- A description of demographic characteristics of individuals and the geographic locations of involuntary examinations;
- Counts of the number of involuntary examinations at each receiving facility; and
- Reporting and analysis of trends for involuntary examinations within the state.

The report shall also include counts of and provide demographic, geographic, and other relevant information about individuals with a developmental disability or a traumatic brain injury or dementia who were taken to a receiving facility for involuntary examination pursuant to and determined not to have a co-occurring mental illness.

The bill requires the Institute to post the annual reports on its website and provide copies of the reports to DCF, the President of the Senate, and the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives by November 30 of each year.

Report on Involuntary Examination of Minors

The bill requires DCF to provide data collected by the agency on the initiation of involuntary examinations of children and students who are removed from a school. The bill also requires DCF to provide child welfare data related to involuntary examinations and the Agency for Health Care Administration (AHCA) to provide Medicaid data, related to the involuntary examination of children enrolled in Medicaid, to the Institute. The bill authorizes DCF and AHCA to enter into any necessary agreements with the institute to provide the data. The bill requires the Institute to use the data to prepare reports analyzing the involuntary examination of minors.

The bill also requires the Institute to analyze service data collected on individuals who are high utilizers of crisis stabilization services provided in designated receiving facilities and identify patterns or trends and make recommendations to decrease avoidable admissions. The bill authorizes recommendations to be addressed in contracts with managing entities and in the contracts between AHCA for the Medicaid managed medical assistance plans. The Institute must publish the report on its website and

submit the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, DCF, and AHCA.

Involuntary Services

Involuntary services are defined as court-ordered outpatient services or inpatient placement for mental health treatment.[67]

Current Situation – Involuntary Outpatient Services

A person may be ordered to involuntary outpatient services upon a finding of the court that by clear and convincing evidence, all of the following factors are met:[68]

- The person is 18 years of age or older;
- The person has a mental illness;
- The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
- The person has a history of lack of compliance with treatment for mental illness;
- The person has, within the immediately preceding 36 months:
    - Been involuntarily admitted to a receiving or treatment facility, or has received mental health services in a forensic or correctional facility, at least twice; or
    - Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others;
- The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;
- The person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being;[69]
- It is likely that the person will benefit from involuntary outpatient services; and
- All available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.

A petition for involuntary outpatient services may be filed by the administrator of either a receiving facility or a treatment facility. [70] The petition must allege and sustain each of the criterion for involuntary outpatient services and be accompanied by a certificate recommending involuntary outpatient services by a qualified professional and a proposed treatment plan.[71]

The petition for involuntary outpatient services must be filed in the county where the patient is located. However, if the patient is being placed from a state treatment facility, the petition must be filed in the county where the patient will reside.[72] The petition must be based on the opinion of two professionals who have personally examined the individual within the preceding 72 hours.[73] When the petition has been filed, the clerk of the court must provide copies of the petition and the proposed treatment plan to DCF, the managing entity, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel.[74]

[67] S. 394.455(23), F. S.
[68] S. 394.4655(2), F.S.
[69] This factor is evaluated based on the person's treatment history and current behavior.
[70] S. 394.4655(4)(a), F.S.
[71] S. 394.4655(4)(b), F.S.
[72] S. 394.4655(4)(c), F.S.
[73] S. 394.4655(3)(a)1., F.S.
[74] *Id*.

Once a petition for involuntary outpatient services has been filed with the court, the court must hold a hearing within five business days, unless a continuance is granted.[75] Under current law, the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[76] The court may waive a patient's presence from all or any portion of the hearing if it finds the patient's presence is not in the patient's best interests and the patient's counsel does not object.[77] Otherwise, the patient must be present. The state attorney for the circuit in which the patient is located represents the state, rather than the petitioner, as the real party in interest in the proceeding.[78] The court must appoint the public defender to represent the person who is the subject of the petition, unless that person is otherwise represented by counsel.[79]

At the hearing on involuntary outpatient services, the court must consider testimony and evidence regarding the patient's competence to consent to treatment; if the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate.[80] If the court concludes that the patient meets the criteria for involuntary outpatient services, it must issue an order for those services.[81] The order must specify the duration of involuntary outpatient services, which may be up to 90 days, and the nature and extent of the patient's mental illness.[82] The order of the court and the treatment plan are to be made part of the patient's clinical record.[83]

If, at any time before the conclusion of the initial hearing on involuntary outpatient services, it appears to the court that the person does not meet the criteria for involuntary outpatient services, but instead meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary inpatient examination.[84]

Current Situation - Involuntary Inpatient Placement

A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that: [85]

- He or she is mentally ill and because of his or her mental illness:
    - He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement or is unable to determine for himself or herself whether placement is necessary; and
    - He or she is incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services; and
    - Without treatment, is likely to suffer from neglect or refuse to care for himself or herself; and
    - Such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
    - There is a substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
- All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

[75] S. 394.4655(7)(a)1., F.S.
[76] S. 394.4655(7)(a)1., F.S.
[77] S. 394. 4655(7)(a)1, F.S.
[78] *Id*.
[79] S. 394.4655(5), F.S. This must be done within one court working day of filing of the petition.
[80] S. 394.4655(7)(d), F.S.
[81] S. 394.4655(7)(b)1., F.S.
[82] *Id*.
[83] *Id*.
[84] S. 394.4655(7)(c), F.S. Additionally, if the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to the Marchman Act, the court may order the person to be admitted for involuntary assessment pursuant to the statutory requirements of the Marchman Act.
[85] S. 394.467(1), F.S.

The administrator of the receiving or treatment facility that is retaining a patient for involuntary inpatient treatment must file a petition for involuntary inpatient placement in the court in the county where the patient is located.[86] The petition must be based on the opinions of two professionals who have personally examined the individual within the past 72 hours.[87] Upon filing, the clerk of the court must provide copies to DCF, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located.[88] Unlike the procedures for involuntary outpatient services, current law does not require a proposed treatment plan to be filed with the petition for involuntary inpatient placement.

Current Situation - Involuntary Inpatient Placement Hearing

The court proceedings for involuntary inpatient placement closely mirror those for involuntary outpatient services.[89] However, the laws governing involuntary inpatient placement are silent regarding the court's order becoming part of the patient's clinical record. Once a petition for involuntary inpatient placement has been filed, the court must hold a hearing within five business days in the county or facility where the patient is located, unless a continuance is granted.[90] Presently, only the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[91] Similar to the procedures for involuntary outpatient services, the court may waive a patient's presence from all or any portion of the hearing if it finds the patient's presence is not in their best interests, and the patient's counsel does not object.[92] Otherwise, the patient must be present.

Current law permits the court to appoint a magistrate to preside at the hearing, in general.[93] At the hearing, the state attorney must represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding.[94] Although the state attorney has the evidentiary burden in Baker Act cases, current law does not require a facility to make the patient's clinical records available to the state attorney so that the state can evaluate and prepare its case before the hearing. Additionally, there is no requirement that the court allow testimony from family members regarding the patient's prior history and how it relates to their current condition.

If, at any time before the conclusion of the hearing, it appears to the court that the person does not meet the criteria for involuntary inpatient placement, but rather meets the criteria for involuntary outpatient services, the court may order the person evaluated for involuntary outpatient services.[95] If the court concludes that the patient meets the criteria for involuntary inpatient placement, it has discretion to issue an order for involuntary inpatient services at a receiving facility for up to 90 days or in a state treatment facility[96] for up to six months.[97]

Current law prohibits a state treatment facility from admitting a civil patient unless he or she has undergone a transfer evaluation, the process by which the patient is evaluated for appropriateness of placement in a treatment facility.[98] Current law also requires the court to receive and consider the transfer evaluation's documented information before the involuntary placement hearing is held, but it does not specify that the evaluator must testify at the hearing in order for the court to consider any

[86] S. 394.467(2) and (3), F.S.
[87] S. 394.467(2), F.S.
[88] S. 394.467(3), F.S.
[89] *See* s. 394.467(6) and (7), F.S.
[90] S. 394.467(6), F.S.
[91] S. 394.467(5), F.S.
[92] S. 394.467(6), F.S.
[93] *Id*.
[94] *Id*.
[95] S. 394.467(6)(c), F.S.
[96] A treatment facility is any state-owned, state-operated, or state-supported hospital, center, or clinic designated by DCF to provide mentally ill patients treatment and hospitalization that extends beyond that provided for by a receiving facility. Treatment facilities also include federal government facilities and any private facility designated by DCF. Only VA patients may be treated in federal facilities S. 394.455(48), F.S. A receiving facility is any public or private facility or hospital designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider. County jails are not considered receiving facilities. S. 394.455(40), F.S.
[97] S. 394.467(6)(b), F.S.
[98] S. 394.461(2), F.S.

substantive information within it.[99] Under Florida law, if a court were to consider substantive information in the transfer evaluation without the evaluator testifying at the hearing, it would be a violation of the hearsay rule contained in Florida's Evidence Code.[100]

Current law requires the court's order to specify the nature and extent of the patient's illness and prohibits the court from ordering individuals with traumatic brain injuries or dementia who lack a co-occurring mental illness to be involuntarily committed to a state treatment facility.[101] However, there is currently no prohibition against involuntarily committing individuals with developmental disabilities who also lack a co-occurring mental illness to these facilities.

Current Situation - Remote Hearings

In response to the COVID-19 pandemic, on March 21, 2020, the Chief Justice of the Florida Supreme Court issued Supreme Court of Florida Administrative Order AOSC20-23, Amendment 2, authorizing courts to conduct hearings remotely. However, on January 8, 2022, Supreme Court of Florida Administrative Order AOSC21-17 was issued, requiring in-person hearings unless the facility where the individual is located is closed to hearing participants due to the facility's COVID-19 protocols or the individual waives the right to physical presence at the hearing.

Current Situation - Discharge Planning

Under current law, before a patient is released from a receiving or treatment facility, certain discharge planning procedures must be followed. Each facility must have discharge planning and procedures that include and document consideration of, at a minimum:

- follow-up behavioral health appointments,
- information on how to obtain prescribed medications, and
- information pertaining to available living arrangements, transportation, and recovery support services.[102]

Additionally, for minors, information related to the Suicide and Crisis Lifeline must be provided.

Current Situation - Psychiatric Nurses Under the Baker Act

Psychiatric nurses are licensed as advanced practice registered nurses who have a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.[103] The Board of Nursing within DOH oversees the licensure and regulation of advanced practice registered nurses.

Effect of Bill - Involuntary Services

The process and criteria for involuntary outpatient services and involuntary inpatient placement are very similar. The bill combines these statutes and creates an "Involuntary Services" statute to remove duplicative functions, simplify procedures and to create a more streamlined and patient-tailored process for committing individuals to involuntary services. The new statute largely maintains current law for involuntary outpatient services and involuntary inpatient placement. However, the bill does make some substantive changes to the process, which are discussed below.

The bill allows those under age 18 access to all involuntary services. This will increase access to services, as current law required the individual be 18 or older for involuntary outpatient services.

[99] *Id*.
[100] S. 90.802, F.S. The basic hearsay rule states that courts cannot rely on out-of-court, unsworn statements (written or spoken) as proof of the matter asserted in the statement.
[101] S. 394.467(6), F.S.
[102] S. 394.468, F.S.
[103] Section 394.455, F.S.

The bill removes the involuntary outpatient services 36-month involuntary commitment criteria which required the person to have been committed to a receiving or treatment facility or received mental health services in a forensic or correctional facility within the preceding 36-month period.

The bill creates a single petition process for involuntary services. This gives the court more flexibility and authority to order a person to either involuntary outpatient services, involuntary inpatient placement, or a combination of both. The bill also creates a single certificate for petitioning for involuntary services and requires the court order for both involuntary outpatient services and involuntary inpatient placement be included in the patient's clinical record.

The bill replaces the term "treatment plan" with "services plan." This change helps ensure that the terminology aligns with the process. The bill authorizes a service provider to file a petition for involuntary services if the provider is treating the patient being petitioned. If a patient receiving involuntary outpatient services fails or refuses to comply with the court ordered services plan, the bill requires the service provider to report such noncompliance to the court. The bill requires a clinical psychologist or psychiatric nurse providing a second opinion to support a recommendation for involuntary outpatient services to have examined the patient within the preceding 30 days. The bill also requires the court to accept electronic signatures on petitions and other documentation attached to the petition.

The bill authorizes civil patients to be admitted to state treatment facilities without undergoing a transfer evaluation. This could result in a greater number of admissions to state treatment facilities. The bill also removes the requirement that the court receive and consider a transfer evaluation before a hearing for involuntary placement. Instead, it allows the state attorney to establish that a transfer evaluation was performed and that the document was properly executed by providing the court with a copy of the transfer evaluation before the close of the state's case. This change will likely improve court efficiencies as hearings will not need to be delayed because a transfer evaluation is unavailable before the hearing. The bill codifies current hearsay rules by specifying that the court may not consider substantive information in the transfer evaluation unless the evaluator testifies at the hearing.

The bill prohibits the court from ordering an individual with a developmental disability as defined under s. 393.063, F.S., who lacks a co-occurring mental illness, into a state treatment facility. This expands current law which prohibits such orders for persons with traumatic brain injury or dementia and ensures that limited state treatment facility beds remain for individuals who are appropriate for treatment. The bill makes technical and conforming changes and updates cross references.

Effect of Bill - Involuntary Services Hearing

The bill expands the grounds under which a patient's presence at the hearing may be waived. Specifically, the bill authorizes the court to waive a patient's presence if the patient knowingly, intelligently and voluntarily waives the right to be present. However, the bill maintains the requirement that the patient's counsel have no objections for the waiver to take effect.

The bill allows the state attorney to have access to records to litigate at the hearing. However, the bill requires that the records remain confidential and may not be used for criminal investigation or prosecution purposes or any purpose other than civil commitment. Additionally, the bill requires the court to allow testimony deemed relevant from family members regarding the patient's prior history and how it relates to their current condition and from other specified individuals, including medical professions, which aligns this provision with the Marchman Act.

Effect of Bill - Remote Hearing

The bill allows for all witnesses to appear and testify remotely under oath at a hearing via audio-video teleconference, upon a showing of good cause and if all parties consent. The bill further requires any witness appearing remotely to provide all parties with all relevant documents by the close of business the day prior to the hearing.

Effect of Bill - Discharge Planning

The bill amends the discharge procedures to require receiving and treatment facilities to include in their discharge planning and procedures documentation of the patient's needs and actions to address those needs. The bill requires the facilities to refer patients being discharged to care coordination services if the patient meets certain criteria and to recovery support opportunities through coordinated specialty care programs, including, but not limited to, connection to a peer specialist.

During the discharge transition process, the bill requires the receiving facility to coordinate face-to-face or through electronic means, while in the presence of the patient, discharge plans to a less restrictive community behavioral health provider, a peer specialist, a case manager, or a care coordination service.

To further enhance the discharge planning process, the bill requires receiving facilities to implement policies and procedures outlining strategies for how they will comprehensively address the needs of the individuals who demonstrate a high utilization of receiving facility services to avoid or reduce future use of crisis stabilization services. More specifically, the bill requires the provider to develop and include in discharge paperwork a personalized crisis prevention plan for the patient that identifies stressors, early warning signs of symptoms, and strategies to manage crisis.

The bill requires receiving facilities to have a staff member engage a family member, legal guardian, legal representative, or a natural support of the patient's in discharge planning and meet with them face to face or through other electronic means to review the discharge plan. Further, the bill provides direction to initiate a referral to an appropriate provider to continue care for instances where certain levels of care are not immediately available at discharge.

Effect of Bill – Psychiatric Nurses Under the Baker Act

The bill requires psychiatric nurses working within receiving and treatment facilities to work within the framework of an established protocol with a psychiatrist when performing certain tasks under the Baker Act. Specifically, a psychiatric nurse must work within the framework of an established protocol with a psychiatrist when:

- Providing an opinion to a court on the competence of an individual, in a facility, to consent to treatment in a proceeding to appoint a guardian advocate;
- Documenting in a patient's clinical records, who was voluntarily admitted into a treatment facility, that the patient is able to give express and informed consent for admission; and
- Providing a second opinion to support a recommendation that a patient receive involuntary services, after personally examining the patient to determine if he or she meets the criteria for such services.

Background Screening for Mental Health Care Personnel

Current Situation

Chapter 435, F.S., establishes standards procedures and requirements for criminal history background screening of prospective employees. There are two levels of background screening: level 1 and level 2. Level 1 screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE) and a check of the Dru Sjodin National Sex Offender Public Website,[104] and may include criminal records checks through local law enforcement agencies.[105] A level 2 background screening includes, but, is not limited to, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.[106]

[104] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. The website is available at https://www.nsopw.gov/ (last visited January 4, 2024).
[105] S. 435.03(1), F.S.
[106] S. 435.04, F.S.

Mental health personnel are required to complete level 2 background screening. Mental health personnel include all program directors, professional clinicians, staff members, and volunteers working in public or private mental health programs and facilities who have direct contact with individuals held for examination or admitted for mental health treatment.[107]

Section 456.0135, F.S., requires physicians, physician assistants, nurses, and other specified medical professionals to undergo a level 2 background screening as part of the licensure process.[108] The appropriate regulatory board reviews the background screening results to determine if the applicant or licensee has any offenses that would disqualify them from state licensure. A health care practitioner must also complete an additional level 2 background check as a condition of employment in mental health programs and facilities.

Effect of the Bill - Background Screening for Mental Health Care Personnel

The bill exempts physicians licensed under chapter 458 or 459 and nurses licensed under chapter 464 who were required to undergo background screening by the Department of Health as part of his or her initial licensure or licensure renewal, and who have an active and unencumbered license, from the background screening requirements for employment for mental health and substance use programs. Currently, these licensed medical professionals must undergo level 2 screening once for licensure and then again for employment purposes, which can cause delays for onboarding personnel. The bill will allow background screening for licensure of these medical professionals to satisfy employment screening when providing a service within their scope of practice.

Substance Abuse

Approximately, 48.7 million people in the U.S. aged 12 and older had a substance use disorder (SUD) in 2022.[109] It is estimated that 1.1 million Floridians have a substance use disorder.[110] Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[111] Abuse can result when a person uses a substance[112] in a way that is not intended or recommended, or because they are using more than prescribed. Drug abuse can cause individuals to experience one or more symptoms of another mental illness or even trigger new symptoms.[113] Additionally, individuals with mental illness may abuse drugs as a form of self-medication. Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance use disorder.[114]

A substance use disorder is determined by specified criteria included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). According to the DSM-5, a SUD diagnosis is based on evidence of impaired control, social impairment, risky use, and pharmacological indicators (tolerance and withdrawal). Substance use disorders occur when the chronic use of alcohol or drugs cause significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[115] Symptoms can range from moderate to severe, with addiction being the most

[107] S. 394.4572(1)(a), F.S.
[108] S. 456.0135, F.S.
[109] SAMHSA, *key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*, available at https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf, (last visited on January 5, 2024).
[110] Substance Abuse and Mental Health Administration, *Behavioral Health Barometer, Florida, Volume 6,* (2020), https://www.samhsa.gov/data/sites/default/files/reports/rpt32826/Florida-BH-Barometer_Volume6.pdf (last visited January 5, 2024).
[111] *World Health Organization, Substance Abuse*, https://www.afro.who.int/health-topics/substance-abuse (last visited January 5, 2024).
[112] Substances can include alcohol and other drugs (illegal or not), as well as substances that are not drugs at all, such as coffee and cigarettes.
[113] Robinson, L, Smith, M, and Segal, J, (October 2023). *Dual Diagnosis: Substance Abuse and Mental Health*, HealthGuide.org, available at https://www.helpguide.org/articles/addictions/substance-abuse-and-mental-health.htm#:~:text=Substance%20abuse%20may%20sharply%20increase,symptoms%20and%20delaying%20your%20recovery. (last visited January 5, 2024).
[114] National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited January 5, 2024).
[115] Substance Abuse and Mental Health Services Administration, *Mental Health and Substance Use Disorders,* http://www.samhsa.gov/disorders/substance-use (last visited January 5, 2024).

severe form of SUDs.[116] Brain imaging studies of persons with addiction show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[117] The most common substance use disorders in the U.S. are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[118]

According to the National Institute on Mental Health, a SUD is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications.[119] SUDs may co-occur with other mental disorders.[120] Approximately 19.4 million adults in the U.S. have co-occurring disorders.[121] 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.[122]

The Marchman Act

In the early 1970s, the federal government furnished grants for states "to develop continuums of care for individuals and families affected by substance abuse."[123] The grants provided separate funding streams and requirements for alcoholism and drug abuse.[124] In response, the Florida Legislature enacted ch. 396, F.S., (alcohol) and ch. 397, F.S. (drug abuse).[125] In 1993, legislation combined chapters 396 and 397, F.S., into a single law, entitled the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act).[126] The Marchman Act supports substance abuse prevention and remediation through a system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

An individual may receive services under the Marchman Act through either voluntary[127] or involuntary admission.[128] The Marchman Act establishes a variety of methods under which substance abuse assessment, stabilization, and treatment can be obtained on an involuntary basis. The Marchman Act encourages individuals to seek services on a voluntary basis within the existing financial and space capacities of a service provider.[129] However, denial of addiction is a prevalent symptom of a SUD, creating a barrier to timely intervention and effective treatment.[130] As a result, a third party must typically provide a person the intervention needed to receive SUD treatment.[131]

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[116] National Institute of Mental Health, *Substance Use and Co-Occurring Mental Disorders*, https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health (last visited January 5, 2024).
[117] National Institute on Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited January 5, 2024).
[118] The Rural Health Information Hub, *Defining Substance Abuse and Substance Use Disorders*, available at https://www.ruralhealthinfo.org/toolkits/substance-abuse/1/definition (last visited January 5, 2024).
[119] National Institute of Mental Health, Substance Use and Co-Occurring Mental Disorders, https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health (last visited January 5, 2024).
[120] *Id*.
[121] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2021 National Survey on Drug Use and Health,* (December 2022), https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf, (last visited January 5, 2024).
[122] *Id*.
[123] Darran Duchene & Patrick Lane, *Fundamentals of the Marchman Act,* Risk RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Program, *available at* http://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited January 5, 2024).
[124] *Id.*
[125] *Id*.
[126] Ch. 93-39, Laws of Fla., codified in Chapter 397, F.S. Reverend Hal S. Marchman was an advocate for persons who suffer from alcoholism and drug abuse.
[127] *See* s. 397.601, F.S.
[128] *See* ss. 397.675 – 397.6978, F.S.
[129] *See* s. 397.601(1) and (2), F.S. 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.
[130] SAMHSA, *key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*, available at https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf, (last visited on January 5, 2024).
[131] *Id*.

Rights of Individuals

Current Situation

The Marchman Act protects the rights of individuals receiving substance abuse services in Florida, including, but not limited to the right to receive quality treatment at a state-funded facility, regardless of ability to pay and the right to counsel.[132] Under the Marchman Act, an individual must be informed that he or she has the right to be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment and that he or she may apply immediately to the court to have an attorney appointed if he or she cannot afford one. If the individual is a minor, the minor's parent, legal guardian, or legal custodian may apply to the court to have an attorney appointed.[133]

Effect of Bill – Rights of Individuals

The bill amends s. 397.501, F.S., to require each individual receiving substance abuse services to be informed that the individual has the right to be represented by counsel in any judicial proceeding for involuntary substance abuse treatment.

Involuntary Admissions

Current Situation - Definitions

There are five involuntary admission procedures that can be broken down into two categories: non-court involved admissions and court involved admissions. 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: [134]

- Has lost the power of self-control with respect to substance use; and
- The person's judgment has been so impaired because of substance abuse that he or she is incapable of appreciating the need for substance abuse services and of making a rational decision in regard to substance abuse services; or
- Without care or treatment, is likely to suffer from neglect or refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to their well-being and such harm is unavoidable through help of willing family members or friends; or
- The person has either inflicted, attempted or threatened to inflict, or unless admitted, is likely to inflict physical harm on himself or herself or another.

Under the Marchman Act, to be "impaired" or "substance abuse impaired", a person must have a condition involving the use alcoholic beverages or any psychoactive or mood-altering substance, in a way that induces mental, emotional, or physical problems and causes socially dysfunctional behavior.[135] Examples of psychoactive or mood-altering substances include alcohol and illicit or prescription drugs, however, only alcohol is explicitly named under current law. Although having a substance use disorder often leads to being impaired or substance abuse impaired, it is not presently included in the "impaired" or "substance abuse impaired" definition.

Current Situation - Unlawful activities relating to assessment and treatment

[132] S. 397.501, F.S.
[133] *Id.*
[134] S. 397.675, F.S.
[135] S. 397.311, F.S.

It is unlawful to give false information for the purpose of obtaining emergency or other involuntary admission for assessment and treatment. It is also, unlawful to cause, conspire, or assist with conspiring: to have a person involuntarily admitted without a reason to believe the person is actually impaired; or to deny a person the right to treatment.[136]

Effect of Bill – Definitions

The bill updates and expands the definition of "impaired" or "substance abuse impaired" to include having a substance use disorder or a condition involving the use of illicit or prescription drugs. This change reflects current DSM-5 criteria and takes into consideration the use of drugs other than alcohol by substance abuse impaired individuals.

This change will likely grant courts more latitude in who may be ordered for involuntary treatment.

Effect of Bill - Unlawful activities relating to assessment and treatment

The bill amends s. 397.581, F.S., to make it unlawful for a person to *knowingly and willfully* (as opposed to just *willfully* under current law):

- Furnish false information for the purpose of obtaining emergency or other involuntary admission of another person;
- Cause or otherwise secure, or conspire with or assist another to cause or secure, any emergency or other involuntary procedure of another person under false pretenses; or
- Cause, or conspire with or assist another to cause, without lawful justification, the denial to any person of the right to involuntary procedures under chapter 397.

The bill expands the scope of law and makes it not only unlawful for an individual to knowingly and willfully provide false information, or to conspire or assist with conspiring, to obtain involuntary admission for his or herself, but also makes it unlawful for the individual to commit such acts against another person.

Current Situation - 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**: This procedure is used by law enforcement officers when an individual is substance-impaired or intoxicated in public and is brought to the attention of the officer.[137]
- **Emergency Admission**: This procedure 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.[138]
- **Alternative Involuntary Assessment for Minors**: This procedure 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.[139]

Court Involved Involuntary Admissions

Current Situation – General Provisions

[136] S. 397.581, F.S. Committing an unlawful activity relating to assessment and treatment is misdemeanor of the first degree, punishable by law and by a fine not exceeding $5,000.
[137] Ss. 397.6771 – 397.6772, F.S. A law enforcement officer may take the individual to his or her residence, to a hospital, a detoxification center, or addiction receiving facility, or in certain circumstances, to jail. Minors, however, cannot be taken to jail.
[138] S. 397.679, F.S.
[139] S. 397.6798, F.S.

Under current law, courts have jurisdiction over involuntary assessment and stabilization, which provides for short-term court-ordered substance abuse services to assess and stabilize an individual, and involuntary services,[140] which provides for long-term court-ordered substance abuse treatment. Both types of involuntary admissions involve filing a petition with the clerk of court in the county where the person is located, which may be different from where he or she resides. Current law permits the chief judge in Marchman Act cases to appoint a general or special magistrate to preside over all or part of the proceedings. Although this may include ancillary matters, such as writs of habeas corpus issued under the Marchman Act, this is not explicitly stated in current law.

Effect of Bill – Court Involved Involuntary Admissions

The bill revises language to specify that courts have jurisdiction over involuntary treatment petitions, rather than involuntary assessment and stabilization petitions. The bill also specifies that petitions may be filed with the clerk of court in the county where the subject of the petition resides instead of where he or she is located.

Current Situation - Involuntary Assessment and Stabilization

A petition for involuntary assessment and stabilization must contain identifying information for all parties and attorneys and facts necessary to support the petitioner's belief that the respondent is in need of involuntary assessment and stabilization.[141] Once the petition is filed, the court issues a summons to the respondent and the court must schedule a hearing to take place within 10 days, or can issue an ex parte order immediately.[142] The court may appoint a magistrate to preside over all or part of the proceedings.[143]

After hearing all relevant testimony, the court determines whether the 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.[144]

If the court determines the respondent meets the criteria, it may order him or her to be admitted for a period of 5 days[145] to a hospital, licensed detoxification facility, or addictions receiving facility, for involuntary assessment and stabilization.[146] During that time, an assessment is completed on the individual.[147] The written assessment is sent to the court. Once the written assessment is received, the court must either: [148]

- Release the individual and, if appropriate, refer the individual to another treatment facility or service provider, or to community services;

[140] The term "involuntary services" means "an array of behavioral health services that may be ordered by the court for a person with substance abuse impairment or co-occurring substance abuse impairment and mental health disorders." S. 397.311(23), F.S. SB 12 (2016), ch. 2016-241, Laws of Fla., renamed "involuntary treatment" as "involuntary services" in ss. 397.695 – 397.6987, F.S., however some sections of the Marchman Act continue to refer to "involuntary treatment." For consistency, this analysis will use the term involuntary services.

[141] S. 397.6951, F.S.

[142] 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 or her to the nearest appropriate licensed service provider.

[143] S. 397.681, F.S., F.S.

[144] S. 397.6818, F.S.

[145] 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, 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.

[146] 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.

[147] 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.

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

- Allow the individual to remain voluntarily at the licensed provider; or
- Hold the individual if a petition for involuntary services has been initiated.

Effect of the Bill - Involuntary Assessment and Stabilization

The bill repeals all provisions relating to court-ordered, involuntary assessments and stabilization under the Marchman Act and consolidates them into a new involuntary treatment process under ss. 397.6951-397.6975, F.S.

Current Situation - Involuntary Services

Involuntary services, synonymous with involuntary treatment, allows the court to require an individual to be admitted for treatment for a longer period if the individual meets the eligibility criteria for involuntary admission and has previously been involved in at least one of the four other involuntary admissions procedures within a specified period, including having been assessed by a qualified professional within five days.[149] Similar to a petition for involuntary assessment and stabilization, a petition for involuntary services must contain identifying information for all parties and attorneys and facts necessary to support the petitioner's belief that the respondent is in need of involuntary services.[150] Under current law, the petition must also contain the findings and recommendations of the qualified professional that performed the assessment.

An individual's spouse, legal guardian, any relative, or service provider, or any adult who has direct personal knowledge of the individual's substance abuse impairment or prior course of assessment and treatment may file a petition for involuntary services on behalf of the individual. If the individual is a minor, only a parent, legal guardian, or service provider may file such a petition.[151] Current law does not permit the court or clerk of court to waive or prohibit process service fees for indigent petitioners.

A hearing on a petition for involuntary services must be held within five days unless a continuance is granted.[152] A copy of the petition and notice of hearing must be provided to all parties and anyone else the court determines. Current law specifies that the court, not the clerk, must issue a summons to the person whose admission is sought.[153] However, typically the clerk of court, not the court, issues summons. Current law does not specify who must effectuate service (i.e., a law enforcement agency or private process servers). Current law requires the respondent to be present, unless the court finds appearance to be harmful, in which case the court must appoint a guardian advocate to appear on the respondent's behalf.[154]

In a hearing for involuntary services, the petitioner must prove by clear and convincing evidence that:[155]

- The individual is substance abuse impaired and has a history of lack of compliance with treatment for substance abuse; and
- Because of such impairment the person is unlikely to voluntarily participate in the recommended services or is unable to determine for himself or herself whether services are necessary and:
    - Without services the individual is likely to suffer from neglect or refuse to care for himself or herself and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that there is a substantial likelihood that without services the individual will cause serious bodily harm to himself, herself, or another in the near future, as evidenced by recent behavior; or

[149] S. 397.693, F.S.
[150] S. 397.6951, F.S.
[151] S. 397.695 (5), F.S.
[152] S. 397.6955, F.S.
[153] S. 397.6955(3), F.S.
[154] S. 397.6957(1), F.S.
[155] S. 397.6957(2), F.S.

- The individual'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.

At the hearing, the court must hear and review all relevant evidence, including the results of the involuntary assessment by a qualified professional, and either dismiss the petition or order the individual to receive involuntary services from his or her chosen licensed service provider, if possible and appropriate.[156]

If the court finds that the conditions for involuntary services have been proven, it may order the respondent to receive services from a publicly funded licensed service provider for up to 90 days.[157] If an individual continues to need involuntary services, at least 10 days before the 90-day period expires, the service provider can petition the court to extend services an additional 90 days.[158] A hearing must be then held within 15 days.[159] Unless an extension is requested, the individual is automatically released after 90 days.[160] Current law does not require facilities to offer discharge planning to assist the respondent with post-discharge care.

However, substance abuse treatment facilities other than addictions receiving facilities are not locked; therefore, individuals receiving treatment in such unlocked facilities under the Marchman Act may voluntarily leave treatment at any time, and the only legal recourse is for a judge to issue a contempt of court charge and impose brief jail time.[161] Current law does not permit courts to drug test respondents in Marchman Act cases.

Effect of the Bill - Involuntary Services

The bill amends the involuntary services criteria to allow the court to involuntarily admit an individual who *reasonably appears to meet*, rather than meets, the eligibility criteria and has previously been involved in at least one of the four other involuntary admissions procedures within a specified period. However, it amends the period for when the person has been assessed by a qualified professional to within the past 30 days, rather than five days.

The bill allows a petition to be accompanied by a certificate or report of a qualified professional or licensed physician who has examined the respondent within 30 days before the petition was filed. The certificate must contain the professional's findings and, if the respondent refuses to submit to an examination, must document the refusal. The bill specifies that in the event of an emergency requiring an expedited hearing, the petition must contain documented reasons for expediting the hearing.

The bill amends the time period in which the court is required to schedule a hearing on the petition to within 10 court working days, rather than five, unless a continuance is granted. With the elimination of the separate involuntary assessment and stabilization procedures, this means the total time for when a court would have to hear a petition for involuntary assessment and stabilization (within 10 days) and a petition for involuntary services (within 5 days) has been reduced from 15 to 10 court working days under the consolidated procedure.

The bill specifies that the clerk, rather than the court, must issue the summons to the respondent and requires a law enforcement agency to effectuate service for the initial hearing, unless the court authorizes disinterested private process servers to serve parties. The bill authorizes the court to waive or prohibit service of process fees for respondents deemed indigent under current law.

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[156] S. 397.6957(4), F.S.
[157] S. 397.697(1), F.S.
[158] S. 397.6975, F.S.
[159] *Id*.
[160] S. 397.6977, F.S.
[161] If the respondent leaves treatment, the facility will notify the court and a status conference hearing may be set. If the respondent does not appear at this hearing, a show cause hearing may be set. If the respondent does not appear for the show cause hearing, the court may find the respondent in contempt of court.

In light of the consolidation of the court involved involuntary admission procedures, the bill provides that, in the case of an emergency, or when upon review of the petition the court determines that an emergency exists, the court may rely exclusively upon the contents of the petition and, without an attorney being appointed, enter an ex parte order for the respondent's involuntary assessment and stabilization which must be executed during the period when the hearing on the petition for treatment is pending. The court may further order a law enforcement officer or other designated agent of the court to:

- Take the respondent into custody and deliver him or her to either the nearest appropriate licensed service provider or a licensed service provider designated by the court to be evaluated; and
- Serve the respondent with the notice of hearing and a copy of the petition.

In such instances, the bill requires a service provider to promptly inform the court and parties of the respondent's arrival and refrain from holding the respondent for longer than 72 hours of observation thereafter, unless:

- The service provider seeks additional time in accordance with the law and the court, after a hearing, grants that motion;
- The respondent shows signs of withdrawal, or a need to be either detoxified or treated for a medical condition, which will serve to extend the amount of time the respondent may be held for observation until the issue is resolved; or
- The original or extended observation period ends on a weekend or holiday, in which case the provider may hold the respondent until the next court working day.

Under the bill, if the ex parte order was not executed by the initial hearing date, it is deemed void. If the respondent does not appear at the hearing for any reason, including lack of service, and upon reviewing the petition, testimony, and evidence presented, the court reasonably believes the respondent meets the Marchman Act commitment criteria and that a substance abuse emergency exists, the bill allows the court to issue or reissue an ex parte assessment and stabilization order that is valid for 90 days. If the respondent's location is known at the time of the hearing, the court:

- Must continue the case for no more than 10 court working days; and
- May order a law enforcement officer or other designated agent of the court to:
    - Take the respondent into custody and deliver him or her to be evaluated either by the nearest appropriate licensed service provider or by a licensed service provider designated by the court; and
    - If a hearing date is set, serve the respondent with notice of the rescheduled hearing and a copy of the involuntary treatment petition if the respondent has not already been served.

The bill requires the petitioner and the service provider to promptly inform the court that the respondent has been assessed so that the court can schedule a hearing as soon as is reasonable. The bill requires the service provider to serve the respondent, before his or her discharge, with the notice of hearing and a copy of the petition. If the respondent has not been assessed within 90 days, the bill requires the court to dismiss the case.

The bill provides an exception to the requirement that a respondent be present at the hearing, allowing absence from the hearing if he or she knowingly, intelligently, and voluntarily waives their right to appear, or upon proof of service, the court finds that the respondent's presence is inconsistent with their best interests or will likely be harmful to the respondent.

To be consistent with the changes in the Baker Act, the bill allows for all witnesses to appear and testify remotely under oath at a hearing via audio-video teleconference, upon a showing of good cause and if all parties consent. The bill further requires any witness appearing remotely to provide all parties with all relevant documents by the close of business the day prior to the hearing. The bill requires the court

to hear and review all relevant evidence, including testimony from family members familiar with the respondent's history and how it relates to the respondent's current condition.

The bill prohibits a respondent from being involuntarily ordered into treatment if a clinical assessment is not performed, unless the respondent is present in court and expressly waives the assessment. Outside of emergency situations, if the respondent is not, or previously refused to be, assessed by a qualified professional and, based on the petition, testimony, and evidence presented, it appears that the respondent qualifies for involuntary treatment services, the bill requires the court to issue an involuntary assessment and stabilization order to determine the correct level of treatment for the respondent. In Marchman Act cases where an assessment was attached to the petition, the bill allows the respondent to request, or the court on its own motion to order, an independent assessment by a court-appointed physician or another physician agreed to by the court and the parties.

An assessment order issued in accordance with the bill is valid for 90 days, and if the respondent is present or there is either proof of service or the respondent's whereabouts are known, the bill provides that the involuntary treatment hearing may be continued for no more than 10 court working days. Otherwise, the petitioner and the service provider are required to promptly inform the court that the respondent has been assessed in order for the court to schedule a hearing as soon as practicable. The bill mandates that the service provider serve the respondent, before his or her discharge, with the notice of hearing and a copy of the petition. The bill requires the assessment to occur before the new hearing date. However, if there is evidence indicating that the respondent will not voluntarily appear at the hearing, or is a danger to self or others, the bill permits the court to enter a preliminary order committing the respondent to an appropriate treatment facility for further evaluation until the new hearing date. As stated above, the bill requires the court to dismiss the case if the respondent still has not been assessed after 90 days.

Assessments conducted by a qualified professional under the bill must occur within 72 hours after the respondent arrives at a licensed service provider unless the respondent displays signs of withdrawal or a need to be either detoxified or treated for a medical condition. In such cases, the amount of time the respondent may be held for observation is extended until that issue is resolved. If the assessment is conducted by someone other than a licensed physician, the bill requires review by a licensed physician within the 72-hour period.

If the respondent is a minor, the bill requires the assessment to begin within the first 12 hours after the respondent is admitted, in alignment with the Baker Act, and the service provider may file a motion to extend the 72 hours of observation by petitioning the court in writing for additional time. The bill requires a service provider to provide copies of the motion to all parties in accordance with applicable confidentiality requirements. After the hearing, the bill permits the court to grant additional time or expedite the respondent's involuntary treatment hearing. However, the involuntary treatment hearing can only be expedited by agreement of the parties on the hearing date or if there is notice and proof of service. If the court grants the service provider's petition, the service provider is permitted to hold the respondent until its extended assessment period expires or until the expedited hearing date. In cases where the original or extended observation period ends on a weekend or holiday, the provider is only permitted to hold the respondent until the next court working day.

The bill requires the qualified professional, in accordance with applicable confidentiality requirements, to provide copies of the completed report to the court and all relevant parties and counsel. The report is required to contain a recommendation on the level, if any, of substance abuse and any co-occurring mental health treatment the respondent may need. The qualified professional's failure to include a treatment recommendation results in the petition's dismissal.

The bill grants the court the authority to order a law enforcement officer or other designated agent of the court to take the respondent into custody and transport him or her to or from the treating or assessing service provider and the court for their hearing.

The bill provides that the court may initiate involuntary examination proceedings at any point during the hearing if it has reason to believe that the respondent, due to mental illness other than or in addition to

substance abuse impairment, is likely to neglect or injure himself, herself, or another if not committed, or otherwise meets the involuntary commitment provisions covered under the Baker Act. The bill requires any treatment order to include findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

The bill amends provisions relating to court determinations and the effect of a court order for involuntary services, providing that, 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 the 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 an outpatient care plan.

For cases resulting in an order for involuntary treatment services, the bill authorizes the court to retain jurisdiction over the case, including but not limited to, monitoring compliance with treatment, changing the treatment modality, or initiating contempt of court proceedings for violations of court orders. The authorizes hearings for involuntary services to be set by the motion of the parties or under the court's won authority. The motion of notice for such hearings must be served in accordance with relevant court procedural rules.

The bill permits the court to order drug tests for respondents in Marchman Act cases. The bill expands who may file a petition to extend treatment to include the person who filed the petition for the initial treatment order if the petition includes supporting documentation from the service provider. The bill removes the current requirement that the petition be filed at least 10 days before the expiration of the current court-ordered treatment period. The bill also reduces the court's requirement for scheduling a hearing from 15 days to within 10 court working days of the petition to extend being filed.

The bill requires the treatment facility to implement discharge planning and procedures for a respondent's release from involuntary treatment services. In alignment with the bill's new Baker Act requirements, discharge planning and procedures must include and document the respondent's needs, and actions to address those needs, for, at a minimum:

- follow-up behavioral health appointments,
- information on how to obtain prescribed medications, and
- information pertaining to available living arrangements, transportation, and referral to recovery support opportunities, including but not limited to, connection to a peer specialist.

The bill requires the Louis de la Parte Florida Mental Health Institute to publish a Marchman Act report on its website and provide copies of the report to DCF, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each year.

The bill makes technical and conforming changes, including changing instances of 'treatment' or 'services' to 'treatment services' in reference to involuntary petitions and admissions under the Marchman Act. This change ensures consistency in usage of the terms.

Substance Abuse Treatment in Florida

Current Situation

DCF provides treatment for substance abuse through a community-based provider system that offers detoxification, treatment and recovery support for adolescents and adults affected by substance misuse, abuse or dependence:[162]

- **Detoxification Services:** Detoxification focuses on the elimination of substance use. Detoxification services use medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.
- **Treatment Services:** Treatment services[163] include a wide array of assessment, counseling, case management, and support services that are designed to help individuals who have lost their abilities to control their substance use on their own and require formal, structured intervention and support. Some of these services may also be offered to the family members of the individual in treatment.
- **Recovery Support:** Recovery support services, including transitional housing, life skills training, parenting skills, and peer-based individual and group counseling, are offered during and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery.

Licensed Bed Capacity for Substance Abuse Service Providers

Current Situation

DCF regulates substance abuse treatment providers, establishing licensure requirements and licensing service providers and individual service components under ch. 397, F.S., and rule 65D-30, F.A.C. Currently, there are over 2,800 DCF licensed substance abuse providers.[164] Licensed service components include a continuum of substance abuse prevention,[165] intervention,[166] and clinical treatment services, including, but not limited to:[167]

- Addictions receiving facilities;
- Detoxification;
- Intensive inpatient treatment;
- Residential treatment;
- Day or night treatment, including, day or night treatment with host homes, and community housing;
- Intensive outpatient treatment;
- Outpatient treatment;
- Continuing care;
- Intervention;
- Prevention; and
- Medication-assisted treatment for opiate addiction.

For licenses issued to addictions receiving facilities, inpatient detoxification, intensive inpatient treatment, and residential treatment, DCF must certify and include on the service provider's license, the

[162] Department of Children and Families, *Treatment for Substance Abuse*, https://www.myflfamilies.com/services/samh/treatment, (last visited January 5, 2024).
[163] *Id*. Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child protective system, employment, increased earnings, and better health.
[164] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.
[165] S. 397.311(26)(c), F.S. Prevention is a process involving strategies that are aimed at the individual, family, community, or substance and that preclude, forestall, or impede the development of substance use problems and promote responsible lifestyles.
[166] S. 397.311(26)(b), F.S. Intervention is structured services directed toward individuals or groups at risk of substance abuse and focused on reducing or impeding those factors associated with the onset or the early stages of substance abuse and related problems.
[167] S. 397.311(26), F.S.

licensed bed capacity for each facility.[168] The licensed bed capacity is the total bed capacity, [169] or total number of operational beds, within the facility. The service provider must notify DCF of any change in the provider's licensed bed capacity equal to or greater than 10 percent, within 24 hours of the change.[170] Upon notification DCF must update the service provider's license to reflect the increased licensed bed capacity.[171]

Effect of Bill - Licensed Bed Capacity for Substance Abuse Service Providers

The bill prohibits a service provider operating an addictions receiving facility or providing detoxification on a non-hospital inpatient basis from exceeding its licensed capacity by more than 10 percent. A service provider also may not exceed its licensed capacity for more than three consecutive working days or for more than 7 days in a month. This is similar to the requirements for crisis stabilization units under the Baker Act.

State Forensic System

Criminal Defendants and Competency to Stand Trial

Current Situation

The Due Process Clause of the 14th Amendment to the United State Constitution prohibits the states from trying and convicting criminal defendants who are incompetent to stand trial.[172] The states must have procedures in place that adequately protect the defendant's right to a fair trial, which includes his or her participation in all material stages of the process.[173] Defendants must be able to appreciate the range and nature of the charges and penalties that may be imposed, understand the adversarial nature of the legal process, and disclose to counsel facts pertinent to the proceedings. Defendants also must manifest appropriate courtroom behavior and be able to testify relevantly.[174]

If a defendant is suspected of being mentally incompetent, the court, counsel for the defendant, or the state may file a motion for examination to have the defendant's cognitive state assessed.[175] If the motion is well-founded, the court will appoint experts to evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing.[176] If the defendant is found to be mentally competent, the criminal proceeding resumes.[177] If the defendant is found to be mentally incompetent to proceed, the proceeding may not resume unless competency is restored.[178]

Involuntary Commitment of a Defendant Adjudicated Incompetent

Current Situation

[168] *Id.*
[169] Bed capacity is total number of operational beds and the number of those beds purchased by DCF. DCF, *Substance Abuse and Mental Health Financial and Service Accountability Management System (FASAMS), Pamphlet 155-2 Chapter 8 Acute Care Data* (May 2021), available at https://www.myflfamilies.com/sites/default/files/2022-12/chapter_08_acute_care.pdf, (last visited January 8, 2024).
[170] *Id.*
[171] DCF, *Operating Procedures,* CF Operating Procedure No. 155-31 Mental Health/Substance Abuse, available at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-31_district_substance_abuse_licensing_and_regulatory_policies_and_procedures.pdf, (last visited January 8, 2024).
[172] *Pate v. Robinson*, 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed. 815 (1966); *Bishop v. U.S.*, 350 U.S.961, 76 S.Ct. 440, 100 L.Ed. 835 (1956); *Jones v. State*, 740 So.2d 520 (Fla. 1999).
[173] *Id*. See also Rule 3.210(a)(1), Fla.R.Crim.P.
[174] *Id*. See also s. 916.12, 916.3012, and 985.19, F.S.
[175] Rule 3.210, Fla.R.Crim.P.
[176] *Id*.
[177] Rule 3.212, Fla.R.Crim.P.
[178] *Id*.

Chapter 916, F.S., governs the state forensic system, which is a network of state facilities and community services for persons who have mental health issues, an intellectual disability, or autism, and who are involved with the criminal justice system. Offenders who are charged with a felony and adjudicated incompetent to proceed due to mental illness[179] and offenders who are adjudicated not guilty by reason of insanity may be involuntarily committed to state civil[180] and forensic[181] treatment facilities by the circuit court.[182] However, in lieu of such commitment, the offender may be released on conditional release[183] by the circuit court if the person is not serving a prison sentence.[184] The committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.[185]

A civil facility is, in part, a mental health facility established within DCF or by contract with DCF to serve individuals committed pursuant to ch. 394, F.S., and defendants pursuant to ch. 916, F.S., who do not require the security provided in a forensic facility.[186]

A forensic facility is a separate and secure facility established within DCF or the Agency for Persons with Disabilities (APD) to service forensic clients committed pursuant to ch. 916, F.S.[187] A separate and secure facility means a security-grade building for the purpose of separately housing individuals with mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed from non-forensic residents.[188]

A court may only involuntarily commit a defendant adjudicated incompetent to proceed for treatment upon finding, based on clear and convincing evidence, that:[189]

- The defendant has a mental illness and because of the mental illness:
    - The defendant is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, the defendant is likely to suffer from neglect or refuse to care for herself or himself and such neglect or refusal poses a real and present threat of substantial harm to the defendant's well-being; or
    - There is a substantial likelihood that in the near future the defendant will inflict serious bodily harm on herself or himself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm.
- All available, less restrictive treatment alternatives, including treatment in community residential facilities or community inpatient or outpatient settings, which would offer an opportunity for improvement of the defendant's condition have been judged to be inappropriate; and
- There is a substantial probability that the mental illness causing the defendant's incompetence will respond to treatment and the defendant will regain competency to proceed in the reasonably foreseeable future.

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[179] "Incompetent to proceed" means "the defendant does not have sufficient present ability to consult with her or his lawyer with a reasonable degree of rational understanding" or "the defendant has no rational, as well as factual, understanding of the proceedings against her or him." S. 916.12(1), F.S.

[180] A "civil facility" is a mental health facility established within the Department of Children and Families (DCF) or by contract with DCF to serve individuals committed pursuant to chapter 394, F.S., and defendants pursuant to chapter 916, F.S., who do not require the security provided in a forensic facility; or an intermediate care facility for the developmentally disabled, a foster care facility, a group home facility, or a supported living setting designated by the Agency for Persons with Disabilities (APD) to serve defendants who do not require the security provided in a forensic facility. Section 916.106(4), F.S. The DCF oversees two state-operated forensic facilities, Florida State Hospital and North Florida Evaluation and Treatment Center, and two privately-operated, maximum security forensic treatment facilities, South Florida Evaluation and Treatment Center and Treasure Coast Treatment Center.

[181] S. 916.106(10), F.S.

[182] S. 916.13, 916.15, and 916.302, F.S.

[183] Conditional release is release into the community accompanied by outpatient care and treatment. Section 916.17, F.S.

[184] S. 916.17(1), F.S.

[185] S. 916.16(1), F.S.

[186] S. 916.106(4), F.S.

[187] S. 916.106(10), F.S. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed pursuant to chapter 916, F.S., from non-forensic residents.

[188] *Id*.

[189] S. 916.13(1), F.S.

If a person is committed pursuant to chapter 916, F.S., the administrator at the commitment facility must submit a report to the court: [190]

- No later than 6 months after a defendant's admission date and at the end of any period of extended commitment; or
- At any time the administrator has determined that the defendant has regained competency or no longer meets the criteria for involuntary commitment.

Incompetent and Non-Restorable Defendants

If after being committed, the defendant does not respond to treatment and is deemed non-restorable, the administrator of the commitment facility must notify the court by filing a report in the criminal case.[191] Those who are found to be non-restorable must be civilly committed or released.[192]

Current Situation - Non-Restorable Competency

An individual's competency is considered non-restorable when it is not likely that he or she will regain competency in the foreseeable future.[193] DCF must make every effort to restore the competency of those committed pursuant to chapter 916, F.S., as incompetent to proceed. To ensure that all possible treatment options have been exhausted, all competency restoration attempts in less restrictive, step-down facilities should be considered prior to making a recommendation of non-restorability, particularly for individuals with violent charges.

Individuals who are found to be non-restorable in less than five years of involuntary commitment under section 916.13, F.S., require civil commitment proceedings or release. After an evaluator of competency has completed a competency evaluation and determined that there is not a substantial probability of competency restoration in the current environment in the foreseeable future, the evaluator must notify the appropriate recovery team[194] coordinator that the individual's competency does not appear to be restorable.

After notification, the recovery team's psychiatrist and clinical psychologist members must complete an independent evaluation to examine suitability for involuntary placement. Once the evaluation to examine suitability for involuntary placement is complete, the recovery team meets to consider the following:[195]

- Mental and emotional symptoms affecting competency to proceed;
- Medical conditions affecting competency to proceed;
- Current treatments and activities to restore competency to proceed;
- Whether relevant symptoms and conditions are likely to demonstrate substantive improvement;
- Whether relevant and feasible treatments remain that have not been attempted, including competency restoration training in a less restrictive, step-down facility; and
- Additional information as needed (including barriers to discharge, pending warrants and detainers, dangerousness, self-neglect).

[190] S. 916.13(2), F.S.
[191] S. 916.13(2)(b), F.S.
[192] *Mosher v. State*, 876 So.2d 1230 (Fla. 1st DCA 2004).
[193] DCF Operating Procedures No. 155-13, *Mental Health and Substance Abuse: Incompetent to Proceed and Non-Restorable Status*, September 2021, at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-13_incompetence_to_proceed_and_non-restorable_status.pdf (last visited March 13, 2023).
[194] A recovery team is an assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), community case manager, family member and other treatment professionals commensurate with the resident's needs, goals, and preferences. DCF Operating Procedures No. 155-16, *Recovery Planning and Implementation in Mental Health Treatment Facilities*, May 16, 2019, at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-16_recovery_planning_and_implementation_in_mental_health_treatment_facilities.pdf (last visited March 20, 2023).
[195] *Id*.

The recovery team must document the team meeting and considerations for review, and, if applicable, the extent to which the individual meets the criteria for involuntary examination pursuant to s. 394.463, F.S., or involuntary inpatient placement pursuant to s. 394.467(1), F.S. Each member of the recovery team must provide a recommendation for disposition. Individuals with competency reported as non-restorable may be considered, as appropriate, for recommendations of release without legal conditions or involuntary examination or inpatient placement.[196]

Current Situation - Competency Evaluation Report

Following the completion of the competency evaluation, the evaluation to examine suitability for involuntary placement, and consideration of restorability, the evaluator of competency must complete a competency evaluation report to the circuit court.[197] A competency evaluation report to the circuit court is a standardized mental health document that addresses relevant mental health issues and the individual's clinical status regarding competence to proceed. The report is completed, pursuant to s. 916.13(2), F.S., and DCF Operating Procedure 155-19 (Evaluation and Reporting of Competency to Proceed).[198] The operating procedures provide guidelines for the format and minimal content that must be included in the report. Evaluators may add other relevant and appropriate information as necessary to report on the individual's status and needs.[199] The report must include the following:

- A description of mental, emotional, and behavioral disturbances;
- An explanation to support the opinion of incompetence to proceed;
- The rationale to support why the individual is unlikely to gain competence to proceed in the foreseeable future;
- A clinical opinion that the individual no longer meets the criteria for involuntary forensic commitment pursuant to s. 916.13, F.S.; and
- A recommendation whether the individual meets the criteria for involuntary examination pursuant to s. 394.463, F.S.

In order for a criminal court to order an involuntary examination under the Baker Act, there must be sworn evidence that the defendant is believed to meet the Baker Act criteria. Reports from mental health treatment facilities, such as the competency evaluation report, provide the court with sufficient basis/evidence to enter an order for involuntary examination. These reports may be sworn upon request of the court.[200]

A competency evaluation report is used in the process of a forensic commitment becoming a civil commitment. However, to be considered in a criminal court proceeding as evidence that the defendant meets Baker Act criteria, the report must be sworn. Currently, competency evaluation reports are not sworn.

Current Situation - Civil Commitment after Determination of Non-Restorable Defendant

Civil commitment is initiated in accordance with Part I of Chapter 394, F.S. The procedures in that part ensure the due process rights of a person are protected and require examination of a person believed to meet Baker Act criteria at a designated receiving facility.

If a non-restorable defendant is returned to court in accordance with ch. 916, F.S., the criminal court has authority to enter an order for involuntary Baker Act examination, and the defendant is taken to the

[196] Chapter 394, F.S., or Mosher v. State, 876 So. 2d 1230 (Fla. 1st DCA 2004).
[197] DCF's Operating Procedure 155-19, *Evaluation and Reporting of Competency to Proceed*, February 15, 2019, at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-19_evaluation_and_reporting_of_competency_to_proceed.pdf (last visited March 20, 2023).
[198] *Id*.
[199] *Id*.
[200] DCF, *Agency Bill Analysis HB 201 (2023), p. 2 (on file with the House Children Families, & Seniors Subcommittee).*

nearest receiving facility. If found to meet criteria, a separate civil case is opened and the criminal case may be dismissed.[201]

Effect of Bill - Involuntary Commitment of a Defendant Adjudicated Incompetent

Current law requires DCF to conduct a competency evaluation and submit a report to the circuit court, upon determination that a defendant will not, or is unlikely to, regain competency to proceed. The bill requires DCF to submit this report within 30 days of the determination. The bill also requires the report to be sworn and provided to counsel in addition to the court. Further, the bill establishes the minimum information that must be included in the competency evaluation report. The minimum reporting requirements are current DCF procedures in which the bill codifies into law, except that the bill authorizes the defendant to be considered for involuntary services, rather than an involuntary examination.[202] The report must include, at a minimum, the following information regarding the defendant:

- A description of mental, emotional, and behavioral disturbances;
- An explanation to support the opinion of incompetency to proceed;
- The rationale to support why the defendant is unlikely to gain competence to proceed in the foreseeable future;
- A clinical opinion regarding whether the defendant no longer meets the criteria for involuntary forensic commitment; and
- A recommendation on whether the defendant meets the criteria for involuntary services pursuant to s. 394.467, F.S.

These provisions ensure that the appropriate report is submitted to the court to initiate the process of moving a forensic commitment to a civil commitment. They also ensure that all relevant information is received timely and that the court may respond to the information in a timely manner.

The bill authorizes a defendant, who meets the criteria for involuntary examination as determined by an independent clinical opinion, to appear remotely for the hearing. The bill also authorized the remote appearance of witnesses.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4572, relating to screening of mental health personnel.
Section 2: Amends s. 394.459, F.S., relating to rights of patients.
Section 3: Amends s. 394.4598, F.S., relating to guardian advocate.
Section 4: Amends s. 394.4599, F.S., relating to notice.
Section 5: Amends s. 394.461, F.S., relating to designation of receiving and treatment facilities and receiving systems.
Section 6: Amends s. 394, 4615, F.S., relating to clinical records; confidentiality.
Section 7: Amends s. 394.462, F.S., relating to transportation.
Section 8: Amends s. 394.4625, F.S., relating to voluntary admissions.
Section 9: Amends s. 394.463, F.S., relating to involuntary examination.
Section 10: Amends s. 394.4655, F.S., relating to involuntary outpatient services.
Section 11: Amends s. 394.467, F.S., relating to involuntary inpatient placement.
Section 12: Amends s. 394.468, F.S., relating to admission and discharge procedures.
Section 13: Creates s. 394.4915, F.S., relating to office of children's behavioral health ombudsman.
Section 14: Amends s. 394.495, F.S., relating to child and adolescent mental health system of care; programs and services.

[201] S.916.145, F.S.
[202] *Id*, note 26.

Section 15: Amends s. 394.496, F.S., relating to service planning.
Section 16: Amends s. 394.499, F.S., relating to integrated children's crisis stabilization unit/juvenile addictions receiving facility services.
Section 17: Amends s. 394.875, F.S., relating to crisis stabilization units.
Section 18: Creates s. 394.90826, relating to behavioral health interagency collaboration.
Section 19: Amends. S. 394.9085, F.S., relating to behavioral provider liability.
Section 20: Amends s. 397.305, F.S., relating to legislative findings, intent, and purpose.
Section 21: Amends s. 397.311, F.S., relating to definitions.
Section 22: Amends s. 397.401, F.S., relating to license required; penalty; injunction; rules waivers.
Section 23: Amends s. 397.4073, F.S., relating to personnel background checks; requirements and exceptions.
Section 24: Amends s. 397.501, F.S., relating to rights of individuals.
Section 25: Amends s. 397.581, F.S., relating to unlawful activities relating to assessment and treatment; penalties.
Section 26: Amends s. 397.675, F.S., relating to criteria for involuntary admissions.
Section 27: Amends s. 397.6751, F.S., relating to service provider responsibilities regarding involuntary admissions.
Section 28: Amends s. 397.681, F.S., relating to involuntary petitions; general provisions; court jurisdiction and right to counsel.
Section 29: Amends s. 397.693, F.S., relating to involuntary treatment.
Section 30: Amends s. 397.695, F.S., relating to involuntary services; persons who may petition.
Section 31: Amends s. 397.6951, F.S., relating to contents of petition for involuntary services.
Section 32: Amends s. 397.6955, F.S., relating to duties of court upon filing of petition for involuntary services.
Section 33: Amends s. 397.6818, F.S., relating to court determination.
Section 34: Amends s. 397.6957, F.S., relating to hearing on petition for involuntary services.
Section 35: Amends s. 397.697, F.S., relating to court determination; effect of court order for involuntary services.
Section 36: Amends s. 397.6971, F.S., relating to early release from involuntary services.
Section 37: Amends s. 397.6975, F.S., relating to extension of involuntary services period.
Section 38: Amends s. 397.6977, F.S., relating to disposition of individual upon completion of involuntary services.
Section 39: Repeals s. 397.6811, F.S., relating to involuntary assessment and stabilization.
Section 40: Repeals s. 397.6814, F.S., relating to involuntary assessment and stabilization; contents of petition.
Section 41: Repeals s. 397.6815, F.S., relating to involuntary assessment and stabilization; procedure.
Section 42: Repeals s. 397.6819, F.S., relating to involuntary assessment and stabilization; responsibility of licensed service provider.
Section 43: Repeals s. 397.6821, F.S., relating to extension of time for completion of involuntary assessment and stabilization.
Section 44: Repeals s. 397.6822, F.S., relating to disposition of individual after involuntary assessment.
Section 45: Repeals s. 397.6978, F.S., relating to guardian advocate; patient incompetent to consent; substance abuse disorder.
Section 46: Amends s. 916.13, F.S., relating to involuntary commitment of defendant adjudicated incompetent.
Section 47: Amends s. 40.29, F.S., relating to payment of due-process costs; reimbursement for petitions and orders.
Section 48: Amends s. 394.455, F.S., relating to definitions.
Section 49: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 50: Amends s. 464.012, F.S., relating to licensure of advanced practice registered nurses; fees; controlled substance prescribing.
Section 51: Amends s. 744.2007, F.S., relating to powers and duties.
Section 52: Amends s. 916.107, F.S., relating to rights of forensic clients.
Section 53: Provides an appropriation.
Section 54: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has a significant fiscal impact to DCF and the state court system as delineated below. The bill provides $50,000,000 to DCF with the flexibility to fund the various provisions of the bill as there is an impact to the department and among providers that offer different behavioral health services.

   - Reporting Requirements- DCF will be required to create and publish a report on Marchman Act services. The bill also requires DCF and the Agency for Health Care Administration to analyze the service data collected on individuals who are high users of crisis stabilization services. There is a resulting workload cost associated with these provisions.

   - Involuntary Services- The bill provides judges with greater flexibility regarding the type of involuntary services to which to order a person, rather than being required to order the specific services for which the petition was filed or no services at all. This is likely to increase demand for involuntary outpatient services, as these services have lower utilization rates.

   - Marchman Act Services- The bill makes it easier for family and friends of individuals with substance use disorder to successfully file pro se for Marchman Act services by streamlining the complicated two-petition process. This may result in increased demand for substance abuse treatment services as judges act on these petitions to order individuals into those services.

   - Discharge Planning- The bill modifies the discharge procedures for receiving facilities by requiring the referral of patients to follow-up supports and services; face-to-face or electronic interaction with the patient and persons in their support system to communicate about follow-up care; and development of a personalized crisis prevention plan for the patient in an effort to mitigate repeated utilization of receiving facility services. There is an expected workload increase to the facilities to implement these provisions.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   None.

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 does not provide rulemaking authority to implement the bill. However, the department has sufficient rulemaking authority to comply with the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 24, 2024, the Health Care Appropriations Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Revised discharge requirements by:
  - requiring a referral to care coordination only if the person needs the service,
  - removing the requirement for a masters' level or licensed staff member to handle the discharge meeting with the patient and family,
  - requiring facility staff to seek to engage the patient's family and friends, rather than requiring the staff member to engage them, and
  - removing the requirement for a receiving facility to coordinate ongoing treatment or make appointments.
- Appropriated the sum of $50,000,000 of recurring funds from the General Revenue Fund for the 2024-25 fiscal year to the Department of Children and Families to implement the bill.

On February 15, 2024, the Health and Human Services Committee adopted a strike-all amendment and reported the bill favorable as a committee substitute. The amendment makes the following changes regarding the Baker and Marchman Acts:

Baker Act:

- Amends practitioner responsibilities within receiving and treatment facilities;
- Restores a current law provision requiring a psychiatric nurse to get approval from the psychiatrist who initiated the Baker Act on a patient before releasing the patient;
- Makes changes to involuntary services criteria. Specifically:
  - Restores separate criteria for involuntary outpatient services and involuntary inpatient placement;
  - Requires the service provider to report to the court when a patient does not comply with an involuntary outpatient services order;
  - Allows a service provider to petition for involuntary services;
  - Replaces the term "treatment plan" with "services plan."
  - Removes language allowing for PAs and clinical social workers to provide a second opinion in certain cases.

- Requires the annual Baker Act report to include information on individuals with dementia, traumatic brain injuries, and developmental disabilities who were taken to a receiving facility for involuntary examination and determined not to have a co-occurring mental illness;
- Reorients the role and responsibilities of the Baker Act Reporting Center;
- Removes expansion of the magistrate's role;
- Requires courts to accept electronic signatures on petitions and other required attached documents;
- Permits a county transportation plan to allow for other jurisdictions to pay for alternate Baker Act transportation;
- Requires law enforcement officers transporting a minor to a designated Baker Act receiving facility to provide the parent or legal guardian with the name and contact information of the facility to which the officer is transporting the minor;
- Creates the Office of Children's Behavioral Health Ombudsman at DCF;
- Establishes regional collaboratives to facilitate enhanced interagency communication; and
- Allows a legal custodian to access a child's clinical records for behavioral health treatment.

Marchman Act:

- Allows a respondent to waive the right to representation if the court finds the waiver is made knowingly, intelligently, and voluntarily;
- To qualify for involuntary outpatient treatment, the bill requires an individual to be accompanied by a willing, able, and responsible advocate, social worker or a case manager of a licensed service provider, who will inform the court if the individual fails to comply with the outpatient program;
- For an individual ordered to outpatient services, requires the treatment to be available in the county where the individual resides;
- Authorizes the court to retain jurisdiction for involuntary treatment cases in certain instances; and
- Requires the Baker Act Reporting Center to prepare an annual Marchman Act report.

This analysis is drafted to the committee substitute as adopted by the Health and Human Services Committee.