The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Rules

BILL:	CS/CS/SB 1240
INTRODUCER:	Appropriations Committee on Health and Human Services; Children, Families, and Elder Affairs Committee and Senator Calatayud
SUBJECT:	Substance Abuse and Mental Health Care
DATE:	April 18, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kennedy	Tuszynski	CF	**Fav/CS**
2.	Sneed	McKnight	AHS	**Fav/CS**
3.	Kennedy	Yeatman	RC	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1240 integrates the 988 Suicide and Crisis Lifeline Call Center into the state mental health crisis response network and requires the Department of Children and Families (DCF) to authorize, regulate, and oversee Florida's 988 Lifeline program.

The bill removes the "needs assessment" requirement for licensure of medication-assisted treatment (MAT) programs for opioid addiction.

The bill establishes enhanced training standards for mental health professionals conducting forensic evaluations, emphasizing competency restoration, evidence-based practices, and placement alternatives to ensure consistent and effective forensic evaluations. The bill requires court-appointed mental health experts performing forensic evaluations to complete DCF-approved forensic training and ongoing education.

The bill increases the timeframe from 12 to 24 hours within which a receiving facility must take action after the attending physician of a patient undergoing involuntary examination documents that the patient's medical condition has stabilized or that no emergency medical condition exists to clarify that the patient must either be: (1) examined and released; or (2) accepted for transfer by a designated facility, not actually transferred to that designated facility as required under current law.

The bill requires the receiving facility to notify the designated facility of the transfer within 12 hours of the patient's stabilization, instead of the 2-hour requirement under current law.

The bill also requires mental health professionals to assess the availability of community-based treatment before recommending involuntary hospitalization.

The bill has an indeterminate fiscal impact on state expenditures. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

II. Present Situation:

The present situation for each issue is described below in Section III, Effect of Proposed Changes.

III. Effect of Proposed Changes:

The bill makes changes to Florida's mental health and substance abuse coordinated system of care by integrating crisis services, expanding treatment accessibility, and strengthening provider oversight. The bill improves response times for mental health emergencies, streamlines treatment, and enhances training for behavioral health professionals.

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

[1] World Health Organization, *Mental Health: Concepts in Mental Health*, available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited Mar. 7, 2025).
[2] Centers for Disease Control and Prevention, *Mental Health Basics*, available at: http://medbox.iiab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm (last visited Mar. 7, 2025).
[3] *Id.*

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 childhood and adolescence, almost half of children will experience a mental disorder, though the proportion experiencing severe impairment during childhood and adolescence is lower, at about 22 percent.[5]

Florida Mental Health and Substance Abuse Services Acts

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.[6] The DCF is charged with providing a coordinated system of care, to serve as a "no-wrong-door model" that provides a comprehensive array of behavioral health services from front end crisis intervention through long-term recovery services, including a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services.[7]

988 Suicide and Crisis Lifeline

Present Situation

The 988 Suicide and Crisis Lifeline is the national three-digit telephone number available for mental health crises, providing a 24/7 connection to free and confidential emotional support.[8] Launched on July 16, 2022, 988 was established by federal law as an easy-to-remember alternative to the 10-digit National Suicide Prevention Lifeline.[9] By dialing 988 (or texting 988, or using web chat), callers in distress are routed to one of over 200 local crisis centers nationwide, where trained crisis counselors provide immediate counseling, support, and referrals to resources.[10] By May 2024, nearly two years post-launch, the 988 Lifeline had fielded 10.8 million interactions nationwide, comprising roughly 6.4 million calls, 1.6 million chats, and 1.6 million texts.[11]

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[4] National Institute of Mental Health (NIHM), *Mental Illness*, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited Mar. 7, 2025).
[5] *Id.*
[6] *See generally*, Part I, Ch. 394, F.S., and Ch. 397, F.S.
[7] *See* s. 394.4573, F.S.
[8] 988 Suicide & Crisis Lifeline, *The Lifeline and 988*, available at: https://988lifeline.org/current-events/the-lifeline-and-988/#:~:text=On%20July%2016%2C%202022%2C%20the,Vibrant (last visited Mar. 7, 2025).
[9] KFF, *One Year After the Launch of 988, the National Suicide and Crisis Hotline Has Received Nearly 5 Million Combined Calls, Texts, and Chats*, Available at: https://www.kff.org/mental-health/press-release/one-year-after-the-launch-of-988-the-national-suicide-and-crisis-hotline-has-received-nearly-5-million-combined-calls-texts-and-chats/#:~:text=Overall%2C%20the%20988%20line%20steers,mental%20health%20crisis%20to%20recall (last visited Mar. 7, 2025).
[10] 988 Suicide & Crisis Lifeline, *The Lifeline and 988*, available at: https://988lifeline.org/current-events/the-lifeline-and-988/#:~:text=On%20July%2016%2C%202022%2C%20the,Vibrant (last visited Mar. 7, 2025).
[11] KFF, *988 Suicide & Crisis Lifeline: Two Years After Launch*, available at: https://www.kff.org/mental-health/issue-brief/988-suicide-crisis-lifeline-two-years-after-launch/#:~:text=Since%20launch%20in%20July%202022%2C,third%20of%20total%20contacts%2C%20accounting (last visited Mar. 7, 2025).

The federal government established the 988 Suicide and Crisis Lifeline with the intention of turning over its oversight and funding responsibilities to the states in 2026.

Since July 2022, the in-state 988 Lifeline program known as the Florida 988 Lifeline (988 Lifeline) has connected 95,672 individuals to mental health or related services and offered telephone-based support to 398,939 people across the state.[12] The 988 Lifeline network ensures individuals have immediate access to trained professionals through a centralized helpline which ultimately reduces dependence on 911 calls and law enforcement for mental health emergencies.

Effect of Proposed Changes

Section 1 amends s. 394.4573, F.S., to add the 988 Suicide and Crisis Lifeline Call Center as a statutorily required part of the state's crisis response as part of the behavioral health coordinated system of care. This change places the duties of regulation and assessment of the 988 Suicide Crisis Lifeline with the DCF.

Section 7 amends s. 394.67, F.S., to define "988 Suicide and Crisis Lifeline Call Center" to mean a call center that meets national accreditation and is recognized by the DCF to receive 988 calls, texts, or other forms of communication. The bill adds the 988 Suicide and Crisis Lifeline Call Center to the definition of "mental health crisis services." These changes integrate the role of 988 centers into the state's behavioral health system, specifically as a crisis response service.

Section 8 creates s. 394.9088, F.S., to require the DCF to authorize and provide oversight to the 988 network crisis call centers. The bill prohibits 988 services from being provided by non-authorized call centers. The bill allows the DCF to ensure compliance with state and federal crisis response standards, improving service quality, and establishing a framework for coordination between 988 and 911 emergency services.

Receiving Facilities and Involuntary Examination

Present Situation

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.[13] Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by the DCF as a receiving facility.

Receiving facilities are public or private facilities designated by the 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.[14] A public receiving facility is a facility that has contracted with an ME to provide mental health services to all persons, regardless of their ability to pay, and is receiving state

[12] Department of Children and Families, 2025 Agency Analysis, p. 2 (on file with the Children, Families, and Elder Affairs Committee).
[13] Sections 394.4625 and 394.463, F.S.
[14] Section 394.455(40), F.S. This term does not include a county jail.

funds for such purpose.[15] Currently, there are 120 DCF-designated receiving facilities, either public or private.[16]

Involuntary Examination

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 the 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.[17]

Involuntary patients must be taken to either a public or private facility that has been designated by DCF as a receiving facility. A receiving facility has up to 72 hours to examine an involuntary patient.[18] During those 72 hours, an involuntary patient must be examined by a physician, 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.[19] 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.[20]

Within that 72-hour examination period, one of the following must happen:[21]

- 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.

Specific actions must take place promptly once a patient's medical condition has been stabilized or it has been determined that no emergency medical condition exists.[22] Within 12 hours of this medical assessment being documented by the attending physician, one of two things must happen: either the patient must be examined and released by the facility, or the patient must be transferred to a designated facility equipped to provide the necessary medical treatment.[23]

[15] Section 394.455(38), F.S.
[16] Department of Children and Families, *SB 1620 Agency Bill Analysis* (2025) (on file with the Senate Children Families, and Elder Affairs Committee).
[17] Section 394.463(1), F.S.
[18] Section 394.463(2)(g), F.S.
[19] Section 394.463(2)(f), F.S.
[20] Section 394.463(2)(g), F.S.
[21] *Id.*
[22] Section 394.463(2)(i), F.S.
[23] *Id.*

Effect of Proposed Changes

Section 4 amends s. 394.463, F.S., to extend the timeframe within which a receiving facility must take action after the attending physician of a patient undergoing involuntary examination documents that the patient's medical condition has stabilized or that no emergency medical condition exists. The bill increases this timeframe from 12 hours to 24 hours and revises the required action of the receiving facility to clarify that the patient must either be:

- Examined and released; or
- *Accepted* for transfer by a designated facility rather than actually transferred as required under current law.

The bill also requires the receiving facility to notify the designated facility of the transfer within 12 hours of the patient's condition being documented as stabilized or a non-emergency medical condition, instead of the 2-hour requirement under current law.

Medication-Assisted Treatment (MAT) Needs Assessment

Present Situation

Medication-Assisted Treatment (MAT) for opioid use disorders is a service that uses methadone or other medication as authorized by state and federal law, in combination with medical, rehabilitative, supportive, and counseling services in the treatment of individuals who are dependent on opioid drugs.[24] This integrated approach aims to provide a whole-patient treatment strategy.[25] Medications commonly used in MAT include methadone, buprenorphine, and naltrexone, which work by reducing cravings, alleviating withdrawal symptoms, and blocking the euphoric effects of substances.[26]

Current law requires the DCF to determine the need for new MAT providers in the state.[27] This requirement does not allow opioid treatment programs (OTPs) or methadone clinics to open freely at will; instead, new clinics can only be established if the DCF finds there is an unmet need in a region for additional services.[28] This needs-based licensure process serves as a state-level control on the number and location of MAT clinics.

Florida currently has 72 operational MAT clinics, collectively assisting nearly 22,000 clients statewide.[29] However, under the current federal methodology, three needs assessments have been conducted since Fiscal Year 2018-2019, and none have identified a statewide need for additional facilities. The DCF lacks the flexibility to grant licenses outside of the annual needs-based

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[24] Section 397.311,7

[25] Department of Health – Palm Beach County, *Medication Assisted Treatment (MAT)*, https://palmbeach.floridahealth.gov/programs-and-services/OD2A/_documents/Fact-Sheet-Medication-Assisted-Treatment.pdf (last visited Mar. 17, 2025)

[26] Substance Abuse and Mental Health Services Administration, *Find Substance Use Disorder Treatment*, available at https://www.samhsa.gov/substance-use/treatment/find-treatment (last visited March 17, 2025); Addiction Group, *What is Medication-Assisted Treatment (MAT)*, available at https://www.addictiongroup.org/treatment/therapies/mat/ (last visited Mar. 17, 2025)

[27] Section 397.427, F.S.

[28] *Id.*

[29] Department of Children and Families, 2025 Agency Analysis, p. 2 (on file with the Children, Families, and Elder Affairs Committee).

determination process, even in urgent situations such as the closure of the only clinic in a given area.[30]

The federal algorithm presents additional challenges in addressing the needs of jail-based and rural populations. Current law does not exempt agencies that serve specific limited groups such as jails, prisons, and federally qualified health centers.[31] Providing these facilities with the flexibility to offer services as needed would improve access to care for those specialized populations.

Effect of Proposed Changes

Section 9 deletes s. 397.427(2) and amends s. 397.427(4), F.S., to remove the requirement that the DCF conduct Methadone MAT Needs Assessments annually. The proposed change will deregulate the process, allowing any interested provider to apply for an MAT maintenance license without the need for a certificate of need. This change will expedite the process to open a facility or operate a mobile MAT unit as they will not have to await an award of a certificate of need. This change will increase access to treatment, particularly in smaller, less populous counties. Additionally, removing the certificate of need requirement will provide greater flexibility for mobile MAT clinics, enabling providers to expand beyond their brick-and-mortar locations to better serve communities. The overall intended effect of repealing this requirement is a significant decrease in overdose deaths due to opioid use.

Forensic Evaluators

Present Situation

Chapter 916, F.S., establishes the Forensic Client Services Act detailing the framework for addressing mental health issues within the state's criminal justice system, specifically requiring the DCF to establish, locate, and maintain facilities and programs for the treatment or training of defendants who have been charged with a felony and who have been found to be incompetent to proceed in the legal system due to mental illness.[32] The law guides how courts appoint mental health experts, assess a defendant's competency to stand trial, and manage individuals found not guilty by reason of insanity.

Mental health evaluations ensure that defendants with mental health conditions receive proper assessment and treatment. Courts appoint licensed psychiatrists, psychologists, or physicians to determine a defendant's competency, sanity, or need for involuntary treatment.[33] These professionals have specific forensic training and a one-time class from the DCF. These evaluations conducted in jails, forensic centers, or medical facilities, help courts decide whether a defendant can stand trial or requires hospitalization. If deemed incompetent, individuals may be committed to a DCF facility for treatment until they can participate in legal proceedings or, if their behavior is non-threatening, may be released under supervision.[34]

[30] Department of Children and Families, 2025 Agency Analysis, p. 2 (on file with the Children, Families, and Elder Affairs Committee).
[31] *Id.*
[32] Chapter 916, F.S.
[33] Section 916.11, F.S.
[34] Section 916.12, F.S.

Defendants found not guilty by reason of insanity may be involuntarily committed if they pose a danger to themselves or others.[35] Placement in a State Mental Health Treatment Facility (SMHTF) ensures access to necessary treatment while maintaining public safety. Regular evaluations determine whether continued hospitalization is required or if a supervised release plan is appropriate. Mental health professionals conduct these assessments, provide expert testimony, and oversee treatment, helping courts balance the needs of individuals with mental illness against legal and public safety concerns.[36]

Florida faces growing challenges with increasing referrals to the SMHTFs from courts and forensic hospital bed occupancy rates above 97%. These challenges delay care and leave individuals in jail awaiting inpatient services. With 462 people on the waitlist and 333 waiting more than 15 days, the backlog continues to strain the system.[37] However, many of these individuals could be restored to competency through less restrictive alternatives, reducing the need for full hospitalization in a SMHTF. Court decisions on commitment orders are heavily influenced by evaluators' findings and recommendations, which help determine the most appropriate treatment setting.[38]

In 2023, changes to Chapter 916, F.S., introduced a requirement for expert evaluators and courts to assess alternative treatment options before committing a defendant to a SMHTF. Evaluators are expected to provide a comprehensive report on available alternatives, including a thorough justification if those options are deemed inadequate.[39] Evaluators must consider a list of minimum alternative treatment options before ordering a defendant to be placed in a treatment facility. Experts must also report on the appropriateness of the following community-based options for treating and supporting the recovery of a patient:[40]

- Mental health services;
- Treatment services;
- Rehabilitative services;
- Support services; and
- Case management services as those terms are defined in s. 394.67(16), F.S., which may be provided by or within:
  - Multidisciplinary community treatment teams;
  - Community treatment teams, such as Florida Assertive Community Treatment (FACT) teams;
  - Conditional release programs;
  - Outpatient services or intensive outpatient treatment programs; and
  - Supportive employment and supportive housing opportunities.[41]

[35] Section 916.15, F.S.
[36] *Id*.
[37] Department of Children and Families, 2025 Agency Analysis, p. 3 (on file with the Children, Families, and Elder Affairs Committee).
[38] *Id*.
[39] *Id.*
[40] Section 916.12, F.S.
[41] Section 394.67, F.S.

However, the implementation of this requirement has not been consistent statewide. Without a legal requirement for forensic evaluators to participate in ongoing training, evaluators lack critical updates on new or revised statutes, alternative placements, and least restrictive options.[42]

Effect of Proposed Changes

Section 10 amends s. 916.111, F.S., to update training requirements for mental health professionals conducting forensic evaluations. The bill requires training on statutes and rules related to competency restoration, evidence-based practices, and least restrictive treatment alternatives and placements. This change will require trainings to be more accurate, aligned with current law, and produce more standardized evaluations in legal proceedings.

Section 11 amends s. 916.115, F.S., to require court-appointed mental health experts to complete both an initial and ongoing DCF-approved forensic training. The bill requires those experts performing juvenile evaluations to complete annual juvenile forensic competency evaluation training and requires all current expert evaluators to complete the newly created DCF-provided continuing education for experts by July 1, 2026, to remain an active evaluator.

These increased training requirements for expert forensic evaluators is intended to improve the consistency of evaluations and ultimately, the judicial decision-making in criminal cases involving defendants with mental illness.

Section 12 amends s. 916.12, F.S., to require mental health evaluators to assess whether less restrictive treatment alternatives are available in the community and acceptable. The bill requires this assessment to involve the use of current resources and information, and include the ongoing DCF-approved training. This change is intended to ensure individuals receive care in the least restrictive setting possible to eliminate the need for unnecessary institutionalization.

Conforming Language and Cross-Reference Changes to Align with 2024 Legislation

Present Situation

A number of bills were introduced and passed during the 2024 legislative session. CS/SB 7016 was the flagship of the 2024 "Live Healthy" initiative. The bill revised preexisting health care programs, created new programs, revised licensure and regulatory requirements for health care practitioners and facilities, created new provisions within programs relating to health care practitioner education, amended the state Medicaid program, and appropriated both general revenue and trust fund dollars for the purpose of growing Florida's health care workforce and increasing access to health care services.

CS/CS/HB 7021 made substantive changes to both Florida's Baker and Marchman Acts by combining processes for courts to order individuals to involuntary outpatient services and involuntary inpatient placement in the Baker Act. This bill streamlined the process for obtaining involuntary services and provided more flexibility for courts to meet individuals' treatment needs. The bill also integrated existing provisions for court-ordered involuntary assessments and stabilization in the Marchman Act into a new consolidated involuntary treatment process.

[42] Section 394.67, F.S.

Effect of the Bill

The bill makes multiple conforming language changes to clarify and refine provisions and further align current law with the changes in the 2024 legislation.

Sections 2, 3, 5, and 6 amends multiple sections of ch. 394, F.S., to make conforming language and cross-reference changes to align current law with the substantive changes of HB 7021 (2024) and SB 7016 (2024). Specifically, the bill amends current law to:

- Clarify that a guardian advocate is to be discharged when a patient is discharged from an order for involuntary outpatient services, involuntary inpatient placement, or when the patient is transferred from involuntary to voluntary status.[43]
- Clarify that a clinical psychologist must have three years of clinical training in the practice of clinical psychology.[44]
- Require that petitioners prepare a services plan for patients prior to submitting an order for involuntary outpatient placement services.[45]
- Define the responsibilities of administrative law judges and courts regarding involuntary inpatient placement and involuntary outpatient services.[46]

Sections 13, 14, and 15 make conforming cross-reference changes.

The bill takes effect July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

[43] Section 394.4598, F.S.
[44] Section 394.4625, F.S.
[45] Section 394.4655, F.S.
[46] Section 394.467, F.S.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill has an indeterminate fiscal impact on state expenditures. Increasing the timeframe that a receiving facility has to discharge a patient could result in extended patient stays and additional room and board charges.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill amends the following sections of the Florida Statutes: 394.4573, 394.4598, 394.4625, 394.463, 394.4655, 394.467, 394.67, 397.427, 916.111, 916.115, 916.12, 394.674, 394.74 and 397.68141.

This bill creates section 394.9088 of the Florida Statutes.

IX. Additional Information:

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

CS/CS by Appropriations Committee on Health and Human Services on April 15, 2025:
The committee substitute:

- Increases the timeframe from 12 to 24 hours within which a receiving facility must take action after the attending physician of a patient undergoing involuntary examination documents that the patient's medical condition has stabilized or that no emergency medical condition exists to clarify that the patient must either be: (1) examined and released; or (2) accepted for transfer by a designated facility rather than actually transferred as required under current law.
- Requires the receiving facility to notify the designated facility of the transfer within 12 hours of the patient’s condition being documented as stabilized or a non-emergency medical condition, instead of the 2-hour requirement under current law.

CS by Children, Families, and Elder Affairs on March 19, 2025:
The CS makes the following changes:

- Clarifies that a guardian advocate is to be discharged of responsibility when a patient enters involuntary outpatient services.
- Requires a clinical psychologist to have three years of clinical training in the practice of clinical psychology.
- Allows the court to order involuntary outpatient placement based on expanded criteria.
- Mandates that petitioners prepare service plans for patients prior to submitting an order for involuntary outpatient placement services.
- Defines the responsibilities of administrative law judges and courts regarding involuntary inpatient placement and involuntary outpatient services.

B. Amendments:

None.