**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

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| BILL: | CS/SB 1340 |
| INTRODUCER: | Children, Families, and Elder Affairs Committee and Senator Latvala |
| SUBJECT: | Mental Health and Substance Abuse |
| DATE: | March 19, 2015 |
| REVISED: | |

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

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 1340 creates the Substance Abuse Assistance Pilot Program within the Department of Children and Families (DCF or department). The department will determine the number of participants subject to available funding, be required to develop safe and cost efficient treatment alternatives, contract with specified entities to serve as program managers in the selected regions and provide an annual report to the Governor, the President of the Senate and the Speaker of the House of Representatives by October 1, of each year.

The legislation also creates a process for an adult with capacity to execute a mental health or substance abuse treatment advance directive to guide their treatment should they become incapacitated. The bill provides for the revocation or expiration of the advance directive and the terms for revoking the advance directive. Specifically, for participants in the pilot program, the bill allows an individual to create a self-binding arrangement which specifies the conditions the individual may be admitted for inpatient mental health or substance abuse treatment for up to 14 days. Additionally, the bill prohibits the criminal prosecution of a health care facility, provider or surrogate who acts in accordance with a mental health or substance abuse treatment advance directive.

The bill provides an effective date of July 1, 2015. The fiscal impact of the bill on DCF is indeterminate.

## II. Present Situation:

### Mental Health, Homelessness and Substance Abuse

According to the Substance Abuse and Mental Health Administration, 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness.[1] Poor mental health may also affect physical health.[2] In addition, half of the mentally ill homeless population in the United States also suffers from substance abuse and dependence.[3] Some mentally ill people self-medicate using street drugs, which not only can lead to addictions but to disease transmission.[4] This combination of mental illness, substance abuse and poor physical health makes it very difficult for people to obtain employment and residential stability.[5] Better mental health services would combat not only mental illness, but homelessness as well.[6] However, even if homeless individuals with mental illness are provided with housing, they are unlikely to achieve residential stability and remain off the streets unless they have access to continued treatment and services.[7] Research has shown that supported housing is effective for people with mental illnesses and supported housing programs offer services such as mental health treatment, physical health care, education and employment opportunities, peer support, and daily living and money management skills training.[8]

Mental illness creates enormous social and economic costs.[9] Unemployment rates for people with all mental disorders are high.[10] People with severe mental illness have exceptionally high rates of unemployment between 60-100%.[11] While mental illness increases a person's risk of homelessness in America threefold, there is now a new victim – children and young adults of parents who are having difficulty making ends meet.[12] Studies show that approximately 33 percent of our nation's homelessness live with a serious mental disorder such as schizophrenia for which they are not receiving treatment.[13] Often the combination of homelessness and mental illness creates the perfect storm for incarceration which further decreases a person's chance of receiving proper treatment and lead to future re-offenses.[14]

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.[15] NAMI also

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[1] National Coalition for the Homeless, *Mental Illness and Homelessness,* July 2009.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Mental Illness: The Invisible Menace; Economic Impact, available at* http://www.mentalmenace.com/economicimpact.php
[10] *Mental Illness: The Invisible Menace: More impacts and facts, available at* http://www.mentalmenace.com/impactsfacts.php
[11] *Id.*
[12] *How does Mental Illness Impact Rates of Homelessness? Available at* http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/
[13] *Id.*
[14] *Id.*
[15] Donna M. White, OPCI, CACP, *Living with Co-Occurring Mental & Substance Abuse Disorders, available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occuring-mental-substance

estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.[16] When mental health disorders are left untreated, substance abuse is likely to increase. One may try to self-medicate with substances to reduce mental health symptoms. One may also increase substance use as a result of stress and inability to cope with issues or situations.[17] When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[18]

The best treatment for co-occurring disorders is commonly referred to as an integrated approach. This method of treatment simultaneously combines the treatment of both mental health and substance abuse disorders.[19] Treatment often includes education regarding both substance abuse and mental health diagnoses; however, these individual may require longer treatment than those with a single disorder.[20]

**Advance Directive for Mental Health or Substance Abuse Treatment**

Florida law currently allows an individual to create an advance directive which designates a surrogate to make health care decisions and provides a process for the execution of the directive.[21] Currently law also allows an individual to designate a separate surrogate to consent to mental health treatment if the individual is determined by a court to be incompetent to consent to mental health treatment[22] A mental health or substance abuse treatment advance directive is much like a living will for health care.[23] Acute episodes of mental illness temporarily destroy the capacity required to give informed consent and often prevent people from realizing they are sick, causing them to refuse intervention.[24] Even in the midst of acute episodes, many people do not meet commitment criteria because they are not likely to injure themselves or others and are still able to care for their basic needs.[25] Left untreated, the episode will likely spiral out of control and by the time the person meets the commitment criteria, devastation has already occurred.[26]

The Uniform Law Commissioners enacted the Uniform Health-Care Decisions Act as a model statute to address all types of advance health care planning, including planning for mental illness; however, the Act focuses on end-of-life care and fails to address many issues faced by people with mental illness.[27] A key failure of the Uniform Act is that it does not empower patients to

[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] Section 765.202, F.S.
[22] Section 765.202(5), F.S.
[23] Washington State Hospital Association, *Mental Health Advance Directives,* copy on file with the Senate Committee on Children, Families and Elder Affairs.
[24] Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute,* 14 Yale Journal of Health Policy, Law & Ethics, Winter 2014 on file with the Senate Committee on Children, Families and Elder Affairs.
[25] *Id.*
[26] *Id.*
[27] *Id.*

form self-binding arrangements for care.[28] These self-binding arrangements are known as Ulysses arrangement. A Ulysses arrangement is a type of mental health advance directive that serves as a preventative measure for a patient to obtain treatment during an episode because the patient has learned that episodes cause him or her to refuse needed intervention.[29] The arrangement is entered into when the individual has capacity. A Ulysses arrangement authorizes doctors to treat the patient during a future episode when the he or she lacks capacity even if the episode causes the individual to refuse treatment at that time. Without a Ulysses arrangement, an individual whose illness causes him to revoke his mental health advance directive and refuse treatment has no mechanism to secure intervention unless he meets involuntary commitment criteria.[30] Ulysses arrangements are superior to involuntary commitment because involuntary commitment comes too late and is often traumatic; the proceedings can be dehumanizing; and police intervention and apprehension can be dangerous.[31] Additionally, the Ulysses arrangement allows the individual to secure treatment from the individual's regular mental health treatment provider who understands the patient's illness and history, in a facility the individual chooses.[32]

## III. Effect of Proposed Changes:

**Section 1** amends s. 394.455, F.S., to add the definition of "interested person" to the definitions used in this part of the statutes.

**Section 2** amends s. 394.4598, F.S., to allow a family member of the patient, or interested party, in addition to the administrator of a receiving or treatment facility, to petition the court for the appointment of a guardian advocate for a patient incompetent to consent to treatment but not adjudicated incapacitated. The bill adds mental health care or substance abuse treatment surrogates to the list of people the court should give preference to when selecting a guardian advocate.

**Section 3** creates s. 397.803, F.S., to create the Substance Abuse Assistance Pilot Program within the Department of Children and Families. The pilot program is created to determine whether the provision of comprehensive services through a coordinated system of case management offering a range of recovery support services leads to increased employment, stability in housing, and decreased involvement in the criminal justice system for substance abuse impaired adults. The pilot program in selected regions will develop safe and cost efficient treatment alternatives and provide comprehensive case management and continuum of care services to participants. Participation in the pilot program may be designated as an alternative to criminal imprisonment for participants.

To be eligible to participate in the pilot program a person must:

- Be 18 years of age or older with a history of chronic substance abuse or addiction.

[28] *Id.*
[29] *Id at 2.*
[30] *Id at 6.*
[31] *Id.*
[32] Judy Ann Clausen, *Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients,* article to be published in Marquette University's Elder's Advisor Law Review. Copy on file with the Senate Committee on Children, Families and Elder Affairs.

- Execute a mental health advance directive which must include a self-binding arrangement. If the participant does not have a family member or other adult available to serve as a surrogate, the entity under contract with the Statewide Public Guardianship Office shall be appointed to serve as the surrogate.
- Share the responsibility for the costs of the pilot program according to their ability to pay, based on a sliding scale.

The bill directs DCF to contract with the Medicaid managed care organization or behavioral health managing entity in the selected region to serve as program manager and it shall be responsible for the following functions:

- Recruitment, retention and management of a network of qualified service providers to ensure accessibility and quality of care.
- Development and implementation of an organizational structure and operational policies to ensure the provision of coordination of care, continuity of care and the avoidance of duplication of services.
- Comprehensive case management including direct interaction with participants and other activities to assess, plan, implement, and monitor the needed services.
- Administrative functions for the network, including, but not limited to, data management, financial management and contract compliance.

The department is responsible for establishing criteria to ensure an adequate number of qualified providers are included in the network. For the duration of the pilot program, each selected region is limited to one network. The provider network shall:

- Offer a comprehensive range of services for substance abuse impaired or drug addicted adults.
- Divert nonviolent offenders with histories of serious substance abuse or chronic addiction into intensive treatment, comprehensive case management and rehabilitation services through agreements with law enforcement agencies and the criminal justice system.
- Enter into an agreement with the appropriate neighborhood housing services program to provide housing assistance to eligible participants.
- Provide guardians to act as surrogates for eligible participants who do not have family or other adults to perform such duties through an agreement with the public guardianship entity under contract with the Statewide Public Guardianship Office in each selected region.
- In each selected region, enter into an agreement with the local legal services organization to provide legal assistance to participants in the pilot program.

The selected network in each region must be capable of providing, at a minimum, the following services to substance abuse impaired or drug addicted adults:

- Comprehensive case management and continuum of care coordination.
- Outpatient treatment services.
- Crisis care, including mobile response, and detoxification in short-term residential facilities.
- Step-down residential treatment services.
- Housing needs assessment and assistance.
- Employment assistance programs.

- Transportation needs assessment and assistance; and
- Legal services.

The bill provides that general revenue funds appropriated for the pilot program services only pay after an eligible participant's private pay or Medicaid insurance coverage has been exhausted. Eligible participants may share in the cost of provided services based on his or her ability to pay.

The bill directs the department to provide a written report by October 1 of each year to the Governor, the President of the Senate and the Speaker of the House of Representatives which describes the operation and effectiveness of the pilot program. The report must include a recommendation regarding the continuation, expansion, or termination of the pilot program.

**Section 4** transfers and renumbers s. 765.401, F.S. as s. 765.311, F.S.

**Section 5** transfers and renumbers s. 765.404, F.S. as s. 765.312, F.S.

**Section 6** directs the Division of Law Revision and Information to rename part IV of chapter 765, F.S., from "Absence of Advance Directive" to "Mental Health and Substance Abuse Advance Directives."

**Section 7** creates s. 765.4015, F.S., to be named the "Jennifer Act" and also creates and ss.765.402-765.411, F.S..

**Section 8** creates s. 765.402, F.S., to provide legislative findings that individuals with capacity have the ability to control decisions relating to his or her own mental health or substance abuse treatment. The Legislature further finds that substance abuse and mental illness cause individuals to fluctuate between capacity and incapacity; the individual may be unable to provide informed consent necessary to access needed treatment during a time when the individual's capacity is unclear; early treatment may prevent the individual from becoming so ill that involuntary treatment is necessary; and individuals with mental illness and substance abuse impairment need an established procedure to express their instructions and preferences for treatment and to provide advance consent to or refusal of treatment. This procedure should be less restrictive and less expensive than guardianship.

Mental health or substance abuse treatment advance directives must provide the individual with a full range of choices, including the right of revocation during periods of inability to consent to treatment or of incapacity, and allow the individual to choose how to apply their directives. Treatment providers must abide by the individual's treatment choices.

**Section 9** creates s. 765.403, F.S., to provide definitions for terms used in this section.

**Section 10** creates s. 765.405, F.S., to provide for the creation, execution and allowable provisions of mental health or substance abuse treatment advance directives. An adult with capacity may execute a mental health or substance abuse impairment advance directive. A directive executed in accordance with this part is presumed valid, however, the inability to honor one or more of the provisions of the advance directive does not invalidate the remaining provisions. The directive may include any provision related to mental health or substance abuse

treatment or the care of the principal or the principal's personal affairs. Without limitation, the directive may include:

- The individual's preferences and instructions for mental health or substance abuse treatment.
- Refusal to consent to specific types of mental health or substance abuse treatment.
- Consent to admission to and retention in a facility for mental health or substance abuse treatment for up to 14 days; however, such consent must be an affirmative statement contained in the directive and must clearly state whether the consent is revocable by the individual during a mental health or substance abuse crisis.
- Descriptions of situations that may cause the individual to experience a mental health or substance abuse crisis.
- Suggested alternative responses that may supplemental or be in lieu of direct mental health or substance abuse treatment, such as treatment approaches from other providers.
- Appointment of a surrogate to make mental health or substance abuse treatment decisions on the individual's behalf.
- The nomination of a guardian, limited guardian, or guardian advocate, by the individual.
- The directive may be independent of or combined with a nomination of a guardian or other durable power of attorney.

**Section 11** creates s. 765.406, F.S., to provide for the execution, effective date and expiration of a mental health or substance abuse advance directive. The bill provides that the advance directive must be in writing, clearly indicate that the individual intends to create a directive, clearly indicate whether the individual intends for the surrogate to have the authority to consent to the individual's voluntary admission to inpatient mental health or substance abuse treatment and if such consent is revocable, be dated and signed by the individual or at his or her direction if unable to sign. The directive must be witnessed by two adults, who must declare they were present when the individual dated and signed the directive, and that the individual did not appear to be incapacitated, acting under fraud, undue influence or duress. The surrogate named in the directive cannot act as a witness to the execution of the directive and at least one witness must not be the spouse or blood relative of the individual executing the directive.

The bill provides that the directive is valid upon execution but all or part may take effect at a later date as designated in the directive. It also provides that a directive may be revoked in whole or in part or expire under its own terms. A directive may not create an entitlement to mental health, substance abuse, or medical treatment or supersede a determination of medical necessity. The directive does not obligate any health care provider, professional person, or health care facility to pay the costs associated with requested treatment or to be responsible for the nontreatment or personal care of the individual or his or her affairs outside the facilities' scope of services. Additionally, the directive does not replace or supersede any will, testamentary document or the provision of intestate succession.

**Section 12** creates s. 765.407, F.S., to provide for the revocation or waiver of an advance directive. The bill provides that an individual may revoke his or her advance directive only if, at the time of execution, he or she elected to be able to revoke when incapacitated. A copy of the revocation of the advance directive must be provided by the individual, and is effective upon receipt by, his or her agent, each health care provider, professional person or health care facility

that received a copy of the individual's advance directive. The directive may be revoked in whole or in part, expressly or to the extent on any inconsistency by a subsequent directive or be superseded by a court order, including an order entered in a criminal matter. The directive may not be interpreted to interfere with incarceration or detention by the Department of Corrections or a municipal or county jail or the treatment of an individual subject to involuntary treatment pursuant to ch. 394.

The bill provides that a directive that would have otherwise expired but is effective because the individual is incapacitated remains effective until the individual is no longer incapacitated unless the individual elected to be able to revoke the directive while incapacitated and has revoked the directive.

**Section 13** creates s. 765.410, F.S., to provide that a surrogate, health care facility, provider or other person who acts under the direction of a health care facility or provider is not subject to criminal prosecution or civil liability or to have engaged in unprofessional conduct as a result of carrying out a mental health or substance abuse treatment decision contained in a directive.

**Section 14** creates s. 765.411, F.S., to provide for the recognition of a mental health advance directive executed in compliance with the law of another state is valid.

**Section 15** amends s. 395.495, F.S., to correct cross-references.

**Section 16** amends s. 395.496, F.S., to correct cross-references.

**Section 17** amends s. 394.9085, F.S., to correct cross-references.

**Section 18** amends s. 395.0197, F.S., to correct cross-references.

**Section 19** amends s. 395.1051, F.S., to correct cross-references.

**Section 20** amends s. 409.972, F.S., to correct cross-references.

**Section 21** amends s. 456.0575, F.S., to correct cross-references.

**Section 22** amends s. 744.704, F.S., to correct cross-references.

**Section 23** amends s. 765.101, F.S., to correct cross-references.

**Section 24** amends s. 765.104, F.S., to correct cross-references.

**Section 25** reenacts ss. 394.459(3)(b), 394.4598(6) and (7), 394.4655(6)(d) and (7)(f), 394.467(6)(d), 394.46715, and 765.202(5), for the purpose of incorporating the amendments made to s. 394.4598, F.S.

**Section 26** creates an effective date of July 1, 2015.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The pilot program created in the bill would create a fiscal impact on DCF.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.455, 394.4598, 394.495, 394.496, 394.9085, 395.0197, 395.1051, 409.972, 456.0575, 744.704, 765.101, and 765.104.

This bill creates the following sections of the Florida Statutes: 397.803, 765.4015, 765.402, 765.403, 765.405, 765.406, 765.407, 765.410, and 765.411.

The bill transfers and renumbers the following sections of the Florida Statutes: 765.401, 765.404,

The bill reenacts the following sections of the Florida Statutes: 394.459(3)(b), 394.4598(6),(7), 394.4655(6)(d), 394.4655(7)(f), 394.467(6)(d), 394.46715 and 765.202(5).

## IX. Additional Information:

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

**CS by Children, Families and Elder Affairs on March 19, 2015:**

The Committee Substitute:

- Adds a definition for "interested person" to the definitions in s. 394.455, F.S.
- Moves the process to execute and revoke a mental health advance directive that includes a self-binding arrangement from the general provisions of creating a mental health advance directive into the eligibility requirement for participation in the pilot program.

B. Amendments:

None.