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 Judiciary

BILL:	CS/SB 7070
INTRODUCER:	Judiciary Committee and Appropriations Committee
SUBJECT:	Mental Health and Substance Abuse
DATE:	April 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	Brown/Crosier	Kynoch	AP	**AP Submitted as Committee Bill**
1.	Brown	Cibula	JU	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 7070 integrates the Marchman Act, which provides substance abuse intervention, clinical treatment, and recovery support services, into the Florida Mental Health Act, more commonly known as the Baker Act.

Marchman Act and Baker Act

Significant differences between current law and provisions in the bill are as follows:

Current law authorizes persons who are substance-abuse impaired to be held in protective custody for a 72-hour period. The bill extends the 72-hour period an additional 48 hours if a doctor determines that the individual would benefit from detoxification services.

Current law does not require parental or guardian notification if a minor is being held for an involuntary examination. This bill requires notice to be given immediately by the receiving facility, unless the facility has provided a report to the child abuse hotline, in which case notice may be delayed up to 24 hours. Public schools, including charter schools, must immediately notify a parent if a student is transferred from the school setting to a receiving facility for an involuntary examination.

Current law authorizes minors seeking voluntary admission to a facility to consent to substance abuse treatment themselves, while treatment for mental illness requires the consent of a guardian. The bill requires a guardian and a minor to jointly provide consent, unless the minor is to be

admitted to a substance abuse facility. At a treatment facility the minor may consent to treatment for substance abuse impairment upon documentation by a physician that the minor has a substance abuse impairment and that the physician established the ability of the minor to give consent.

The bill also addresses issues that are not addressed in current law. Specifically, the bill requires facilities to report the following to the DCF as soon as is reasonably possible:

- The death of an individual at the facility or that occurs within 72 hours after release;
- An injury sustained, or allegedly sustained by an individual at the facility if it requires medical treatment;
- The unauthorized departure or absence of an individual from a facility under an involuntary placement;
- A natural disaster or crisis situation that jeopardizes individual safety; or
- An allegation of sexual battery on an individual.

Additionally, the role of health care surrogates and proxies is recognized, and the bill provides them with the same ability to advocate as that granted to other representatives of an individual. The bill prohibits certain persons from serving as a representative or a guardian advocate of the individual, including if the person is a professional involved in assessment or treatment of the individual, or is the subject of an injunction in which the individual is the petitioner. Rights of representatives to advocate on behalf of an individual are specified.

Advance Directives

This bill establishes the "Mental Health and Substance Abuse Directives" Act, also known as the Jennifer Act. The purpose of the Jennifer Act is to enable persons at risk of need for future services based on mental illness or substance abuse impairment governed under ch. 394, F.S., to establish directives for care and treatment in advance of becoming incapacitated. The bill grants immunity to providers and facilities who act in good faith in providing treatment in accordance with an advance directive.

Forensic Hospital Diversion Pilot Program

This bill creates the Forensic Hospital Diversion Pilot Program, which replicates the model of the Miami-Dade Forensic Alternative Center into 4 additional counties. In addition to Miami-Dade, the DCF will implement the program in Alachua, Broward, Escambia, and Hillsborough Counties. The purpose of the program is to divert incarcerated defendants found mentally incompetent to proceed or not guilty by reason of insanity into a therapeutic setting which offers beds and community outpatient treatment.

Nonviolent Offender Reentry Program

This bill creates the Nonviolent Offender Reentry Program, a diversionary program available to qualifying nonviolent offenders who commit less serious felonies. The program is designed to reduce prison sentences, by replacing part of the sentence an offender would have spent incarcerated with a minimum stay of 6 months in a reentry program. Reentry programs will offer intensive substance abuse treatment and career education and testing.

II. Present Situation:

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[1] The Act authorized treatment programs for mental, emotional, and behavioral disorders. The Baker Act required programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery. Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Mental illness creates enormous social and economic costs.[2] Unemployment rates for persons having mental disorders are high relative to the overall population.[3] Rates of unemployment for people having a severe mental illness range between 60 percent and 100 percent.[4] Mental illness increases a person's risk of homelessness in America threefold.[5] Approximately 33 percent of the nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are untreated.[6] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future recidivism.[7]

Marchman Act

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

Comparison of the Marchman Act to the Baker Act

While the Baker Act is used to initiate approximately 136,000 involuntary examinations annually, the Marchman Act is used to initiate only an estimated 9,000 involuntary admissions per year.[8] This disparity is likely attributable to two factors:

- The Marchman Act is much more complex and difficult to apply. This leads law enforcement, mental health professionals, and the courts to prefer the Baker Act, even when substance abuse impairment may be the chief presenting problem; and

[1] Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.
[2] MentalMenace.com, *Mental Illness: The Invisible Menace; Economic Impact*, http://www.mentalmenace.com/economicimpact.php (last visited April 5, 2015).
[3] MentalMenace.com, *Mental Illness: The Invisible Menace: More impacts and facts*, http://www.mentalmenace.com/impactsfacts.php (last visited April 5, 2015).
[4] *Id.*
[5] Family Guidance Center for Behavioral Health Care, *How does Mental Illness Impact Rates of Homelessness?*, (February 4, 2014), http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/.
[6] *Id.*
[7] *Id.*
[8] Proposal to Streamline Baker Act and Marchman Act: Overview, pg. 1 (on file with the Senate Judiciary Committee).

- The Marchman Act allows facilities to turn clients away for a lack of capacity or lack of payor source, whereas Baker Act receiving facilities must accept any individual brought for involuntary examination.[9]

Individual Bill of Rights

Both the Marchman Act and the Baker Act provide an individual bill of rights.[10] Rights in common include the right to dignity, right to quality of treatment, right to not be refused treatment at a state-funded facility due to an inability to pay, right to communicate with others, right to care and custody of personal effects, and the right to petition the court on a writ of habeus corpus. The individual bill of rights also imposes liability for damages on persons who violate individual rights.[11] The Marchman Act bill of rights includes the right to confidentiality of clinical records. The individual is the only person who may consent to disclosure.[12] The Baker Act addresses confidentiality in a separate section of law and permits limited disclosure by the individual, a guardian, or a guardian advocate.[13] The Marchman Act ensures the right to habeus corpus, which means that a petition for release may be filed with the court by an individual involuntarily retained or his or her parent or representative.[14] In addition to the petitioners authorized in the Marchman Act, the Baker Act permits the DCF to file a writ for habeus corpus on behalf of the individual.[15]

Transportation to a Facility

The Marchman Act authorizes an applicant seeking to have a person admitted to a facility, the person's spouse or guardian, a law enforcement officer, or a health officer to transport the individual for an emergency assessment and stabilization.[16]

The Baker Act requires each county to designate a single law enforcement agency to transfer the person in need of services. If the person is in custody based on noncriminal or minor criminal behavior, the law enforcement officer will transport the person to the nearest receiving facility. If, however, the person is arrested for a felony the person must first be processed in the same manner as any other criminal suspect. The law enforcement officer must then transport the person to the nearest facility, unless the facility is unable to provide adequate security.[17]

The Marchman Act allows law enforcement officers, however, to temporarily detain substance-impaired persons in a jail setting. An adult not charged with a crime may be detained for his or her own protection in a municipal or county jail or other appropriate detention facility. Detention in jail is not considered to be an arrest, is temporary, and requires the detention facility to provide if necessary transfer of the detainee to an appropriate licensed service provider with an

[9] *Id.*
[10] Section 397.501, F.S., provides "Rights of Individuals" for individuals served through the Marchman Act; s. 394.459, F.S., provides "Rights of Individuals" for individuals served through the Baker Act.
[11] Sections 397.501(10)(a) and 394.459(10), F.S.
[12] Section 397.501(7), F.S.
[13] Section 394.4615(1) and (2), F.S.
[14] Section 397.501(9), F.S.
[15] Section 394.459(8)(a), F.S.
[16] Section 397.6795, F.S.
[17] Section 394.462(1)(f) and (g), F.S.

available bed.[18] However, the Baker Act prohibits the detention in jail of a mentally ill person if he or she has not been charged with a crime.[19]

Voluntary Admission to a Facility

The Marchman Act authorizes persons who wish to enter treatment for substance abuse to apply to a service provider for voluntary admission. A minor is authorized to consent to treatment for substance abuse.[20] Under the Baker Act, a guardian of a minor must give consent for mental health treatment under a voluntary admission.[21]

When a person is voluntarily admitted to a facility, the emergency contact for the person must be recorded in the individual record.[22] When a person is involuntarily admitted, contact information for the individual's guardian, guardian advocate, or representative, and the individual's attorney must be entered into the individual record.[23] The Marchman Act does not address emergency contacts.

The Baker Act requires an individualized treatment plan to be provided to the individual within 5 days after admission to a facility.[24] The Marchman Act does not address individualized treatment plans.

Involuntary Admission to a Facility

Criteria for Involuntary Admission

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

- Has lost the power of self-control with respect to substance abuse; and either
- Has inflicted, threatened to or attempted to inflict self-harm; or
- Is in need of services and due to the impairment, judgment is so impaired that the person is incapable of appreciating the need for services.[25]

Protective Custody

A person who meets the criteria for involuntary admission under the Marchman Act may be taken into protective custody by a law enforcement officer.[26] The person may consent to have the law enforcement officer transport the person to his or her home, a hospital, or a licensed detoxification or addictions receiving facility.[27] If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.[28]

[18] Section 397.6772(1), F.S.
[19] Section 394.459(1), F.S.
[20] Section 397.601(1) and (4)(a), F.S.
[21] Section 394.4625(1)(a), F.S.
[22] Section 394.4597(1), F.S.
[23] Section 394.4597(2), F.S.
[24] Section 394.459(2)(e), F.S.
[25] Section 397.675, F.S.
[26] Section 397.677, F.S.
[27] Section 397.6771, F.S.
[28] Section 397.6772(1), F.S.

Time Limits

A critical 72-hour period applies under both the Marchman and the Baker Act. Under the Marchman Act, a person may only be held in protective custody for a 72-hour period, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.[29] The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.[30] Within that 72-hour examination period, or, if the 72 hours ends on a weekend or holiday, no later than the next working day, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will resume custody;
- The patient must be released into voluntary outpatient treatment;
- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or
- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.[31]

Under the Marchman Act, if the court grants the petition for involuntary admission, the person may be admitted for a period of 5 days to a facility for involuntary assessment and stabilization.[32] If the facility needs more time, the facility may request a 7-day extension from the court.[33] Based on the involuntary assessment, the facility may retain the person pending a court decision on a petition for involuntary treatment.[34]

Under the Baker Act, the court must hold a hearing on involuntary inpatient or outpatient placement within 5 working days after a petition for involuntary placement is filed.[35] The petitioner must show, by clear and convincing evidence all available less restrictive treatment alternatives are inappropriate and that the individual:

- Is mentally ill and because of the illness has refused voluntary placement for treatment or is unable to determine the need for placement; and
- Is manifestly incapable of surviving alone or with the help of willing and responsible family and friends, and without treatment is likely suffer neglect to such an extent that it poses a real and present threat of substantial harm to his or her well-being, or substantial likelihood exists that in the near future he or she will inflict serious bodily harm on himself or herself or another person.[36]

Notice Requirements

The Marchman Act requires the nearest relative of a minor to be notified if the minor is taken into protective custody.[37] No time requirement is provided in law. Under the Baker Act,

[29] Section 397.6773(1) and (2), F.S.
[30] Section 394.463(2)(f), F.S.
[31] Section 394.463(2)(i)4., F.S.
[32] Section 397.6811, F.S.
[33] Section 397.6821, F.S.
[34] Section 397.6822, F.S.
[35] Sections 394.4655(6) and 394.467(6), F.S.
[36] Section 394.467(1), F.S.
[37] Section 397.6772(2), F.S.

receiving facilities are required to promptly notify a patient's guardian, guardian advocate, attorney, and representative within 24 hours after the patient arrives at the facility on an involuntary basis, unless the patient requests otherwise.[38] In requiring notice on behalf of a patient, current law does not distinguish between adult and minor patients. The facility must provide notice to the Florida local advocacy council no later than the next working day after the patient is admitted.

Mental Illness and Substance Abuse

According to the National Alliance on Mental Illness (NAMI), about 50 percent of persons with severe mental health disorders are affected by substance abuse.[39] NAMI also estimates that 29 percent of people diagnosed as mentally ill abuse alcohol or other drugs.[40] When mental health disorders are left untreated, substance abuse likely increases. When substance abuse increases, mental health symptoms often escalate as well or new symptoms are triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[41]

Advance Directive for Mental Health or Substance Abuse Treatment

Florida law currently allows an individual to create an advance directive which designates a surrogate to make health care decisions for the individual and provides a process for the execution of the directive.[42] Current law also allows an individual to designate a separate surrogate to consent to mental health treatment for the individual if the individual is determined by a court to be incompetent to consent to treatment.[43] A mental health or substance abuse treatment advance directive is much like a living will for health care.[44] 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.[45] 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.[46] If left untreated, acute episodes may spiral out of control before the person meets commitment criteria.[47]

Miami-Dade Forensic Alternative Center

The Miami-Dade Forensic Alternative Center (MDFAC) opened in 2009 as a community-based, forensic commitment program. The MDFAC serves adults:

- Aged 18 years old and older;

[38] Section 394.4599(2)(a) and (b), F.S.
[39] 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
[40] *Id.*
[41] *Id.*
[42] Section 765.202, F.S.
[43] Section 765.202(5), F.S.
[44] Washington State Hospital Association, *Mental Health Advance Directives* (on file with the Senate Judiciary Committee).
[45] Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute,* 14 YALE J. HEALTH POL'Y, L. & ETHICS 1, (Winter 2014).
[46] *Id* at 17.
[47] *Id.*

- Who have been found by a court to be incompetent to proceed at trial due to serious mental illness or not guilty by reason of insanity for a second or third degree felony; and
- Who do not have a significant history of violence.[48]

The MDFAC provides competency restoration and a continuum of care during commitment and after reentry into the community.[49]

Since the 2011-2012 Fiscal Year, all but two of the persons served in the program were adjudicated incompetent to proceed at trial. The Center currently operates a 16-bed facility at a daily cost of $284.81 per bed.[50]

Reentry Programs for Nonviolent Offenders

Inmates who enter prison often have shortcomings in one or more areas of education, employment skills, substance abuse-free living, and mental health that contributed to their current situation. For example, while 24.6 percent of the inmates admitted to prison during Fiscal Year 2011-2012 had been convicted of a drug crime,[51] almost two-thirds of inmates who enter prison for any crime also have a substance abuse problem.[52]

Unless addressed, these deficiencies are likely to contribute to re-offending and a return to prison. In the past decade the executive and legislative branches of state government have acknowledged the importance of reentry services and post-release planning and transition. In May 2007, the DOC revised its mission statement to include assisting offenders with reentry into society in order to reduce recidivism and to lower crime rates. The goal was to bring down the three-year post-release recidivism rate from 32 percent to 20 percent by 2012. The DOC reports that the three-year post-release recidivism rate for inmates released in 2009 was 27 percent.[53]

III. Effect of Proposed Changes:

Marchman Act and Baker Act

This bill adds concepts from the Marchman Act which relate to the commitment of a person having a substance abuse impairment into the Baker Act. As a conforming change, the bill repeals all provisions in current law which provide for the voluntary and involuntary civil commitment of a person for substance abuse impairment under the Marchman Act.

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[48] Department of Children and Families (DCF), *2015 Agency Legislative Bill Analysis* (March 4 2015) (on file with the Senate Judiciary Committee).
[49] Budget Subcommittee on Health and Human Services Appropriations, The Florida Senate, *Interim Report 2012-108, The Forensic Mental Health System* (September 2011).
[50] DCF, *supra* note 46, at 2.
[51] Fla. Dep't of Corrections, *Inmate Admissions*, http://www.dc.state.fl.us/pub/annual/1112/stats/im_admis.html (last visited April 8, 2015).
[52] Office of Program Policy Analysis and Governmental Accountability (OPPAGA), *Corrections Rehabilitative Programs Effective, But Serve Only a Portion of the Eligible Population*, Report No. 07-14 (February 2007), p. 6. http://www.oppaga.state.fl.us/Summary.aspx?reportNum=07-14
[53] Department of Corrections, *2012 Florida Prison Recidivism Study – Releases from 2004 to 2012*, p. 9, http://www.dc.state.fl.us/pub/recidivism/2012/ratesovertime.html (last visited on April 8, 2015).

Chapter 394, F.S., will now govern the commitment, treatment, and care of persons with mental illness and substance abuse impairment, as the conditions are presented separately or co-occurring.

Service Providers (Sections 3 and 16)

The bill recognizes that treatment may be provided not just by a state or local provider but also by a facility, mental health professional, or other health care provider affiliated with the United States Department of Veterans Affairs or the United States Department of Defense. The V.A. may:

- Initiate and conduct involuntary examinations for treatment;
- Provide voluntary treatment;
- Petition for involuntary inpatient placement; and
- Provide involuntary inpatient placement.

Advanced registered nurse practitioners are included in the list of service providers eligible to serve individuals under ch. 394, F.S.

Individual Bill of Rights (Section 6)

The bill modifies the individual bill of rights.

Right to Dignity

This bill allows persons detained for substance abuse treatment to be detained temporarily in a municipal or county jail. If a person is detained for purposes of protective custody and transfer, the detention facility must:

- Notify the nearest appropriate facility within 8 hours;
- Notify the nearest relative of a minor or of an adult, unless the adult requests otherwise; and
- Arrange for transport to the hospital or other receiving facility.

Right to Treatment

This bill clarifies that individuals must be provided the least restrictive appropriate available treatment.

In addition to a physical examination, individuals must be given a mental health or substance abuse evaluation by a psychiatrist, psychologist, psychiatric nurse, or qualified substance abuse professional within 24 hours after arrival if the person has not been released or discharged.

Right to Express and Informed Consent

Service providers are required to provide information and assist competent and willing individuals complete an advance directive.

The bill also expands the list of people who may be notified of an individual's admission to a facility to include a health care surrogate or proxy. Facilities providing services will be required to review any incidents resulting an injury or alleged injury, allegations of sexual battery, and

death, or unauthorized departure of an individual being held for involuntary examination or involuntary placement. Advance directives already in place must be honored, or the service provider must request a transfer of the individual to another facility.

Quality of Treatment

As soon as is reasonably possible, facilities must report to the DCF and the entity that manages the facility:

- The death of an individual which occurs while the person is at the facility or which occurs within 72 hours after release;
- An injury sustained, or allegedly sustained by an individual at the facility if it requires medical treatment, whether the injury is caused by an accident, self-inflicted, assault, abuse, neglect, or a suicide attempt;
- The unauthorized departure or absence of an individual from a facility in which he or she has been held involuntarily;
- A natural disaster or crisis situation that jeopardizes individual safety; or
- An allegation of sexual battery on an individual.

Communication, Abuse Reporting, and Visits

This bill adds to the list of persons authorized immediate access to the individual, unless access would be detrimental, a health care surrogate or proxy.

If access is restricted, the facility must document the reasons in the individual's record. Facility rules on communication must be the least restrictive possible.

Care and Custody of Personal Effects

Copies of an inventory of clothing and personal effects and the actual clothing and personal effects if appropriate, must be provided to the representative of the individual, including a health care surrogate or proxy.

Advance Directives

This bill includes advance directives in the individual bill of rights. A mental health or substance abuse treatment advance directive is a written document in which the principal provides instructions or preferences or appoints a surrogate to make decisions on behalf of the principal regarding mental health or substance abuse treatment, or both. The bill requires service providers to provide information on advance directives to individuals and to help competent and willing individuals complete an advance directive. Service providers must honor the advance directive.

Representatives and Notification (Sections 7 and 9)

A receiving facility must immediately notify a minor's parent, guardian, caregiver, or guardian advocate, in person, by phone, or by electronic communication, after the minor's arrival at the facility. In the event that a report has been provided to the child abuse hotline, notification may be delayed for up to 24 hours. If the facility is unable to successfully provide notification, the facility must repeat attempts to notify until confirmation is received.

Individuals voluntarily admitted to a facility must be asked to identify a person to be notified in case of emergency. If an individual is involuntarily admitted, a health care surrogate or proxy's contact information is required, if appropriate.

The bill prohibits from serving as a representative or guardian advocate:

- A professional providing clinical services to the individual;
- The licensed professional who initiated the involuntary examination of the individual, if initiated by professional certificate;
- An employee, administrator, or board member of the facility providing examination or treatment;
- A person providing any substantial professional services to the individual;
- A creditor of the individual; and
- A person subject to a repeat violence, sexual violence, dating violence, or domestic violence injunction in which the individual is the petitioner.

The bill specifies rights of representatives, including the right to receive certain notices, have immediate access to the individual, and petition on behalf of the individual for a writ of habeus corpus or change of venue.

Clinical Records (Section 9)

The bill maintains the confidentiality of clinical records and adds a health care surrogate or proxy to the list of representatives who have access to the records and who may waive consent to confidentiality. The bill adds as another basis for release of records that a petition for involuntary placement is filed and the state attorney needs access to the records, solely to evaluate the allegations in the petition or to prosecute the petition, not for a criminal investigation or prosecution.

Transportation to a Facility (Section 11)

This bill requires the nearest receiving facility to accept a person who has engaged in either noncriminal behavior of a felony other than a forcible felony.

If the person has been arrested for a forcible felony, the law enforcement officer must first process the person the same as any other person arrested. The nearest receiving facility may not accept the person if the facility does not have adequate security.

A person who meets the criteria for voluntary admission may request transport to a mental health receiving facility, addictions receiving facility, or a detoxification facility.

Voluntary and Involuntary Admissions, Examinations, and Placement (Sections 7, 9, and 13 through 17)

Admission and Transfer

To receive treatment, an adult must provide and be competent to provide express and informed consent.

Current law authorizes minors who seek voluntary admission for treatment under the Marchman Act to consent to treatment. Under the Baker Act, a guardian of a minor must provide consent for voluntary admission.

A minor may only be admitted for treatment if the minor's guardian gives express and informed consent along with the minor. A minor may, however, be admitted to an addictions receiving facility or detoxification facility by giving consent without consent of a guardian, if a physician documents in the record that the minor has a substance abuse impairment and that the minor is capable of giving consent. The bill establishes criteria for a clinician to establish consent of a minor. If a minor's consent is not verified, a petition for involuntary inpatient placement must be filed within the court within 1 court working day after arrival or the minor must be released to his or her guardian.

The bill also allows an individual on involuntary status in a facility who has been assessed and certified competent to provide express and informed consent to be transferred to voluntary status immediately. If the individual is on voluntary status and meets the criteria for involuntary placement, he or she must be transferred to a designated receiving facility.

A request for discharge by an individual on voluntary status must be conveyed to a physician, psychologist, or psychiatrist within 12 hours. If the individual meets the criteria for involuntary placement and is transferred to a receiving facility, the facility must file a petition with the court for involuntary placement within 2 court working days. Otherwise, the individual must be discharged.

Involuntary Examination

The bill directs the court to include specific facts in an ex parte order that support its findings that the required criteria for involuntary examination has been met and to designate the most appropriate type of facility for treatment. Any behavior that provides the basis for the order must have occurred within the preceding 7 calendar days. Additionally, specified medical personnel may execute a certificate that finds an individual meets the criteria for involuntary examination, and the certificate must specify the most appropriate facility.

Current law allows a person to be held for involuntary examination for 72 hours. The individual must be examined by a physician, clinical psychologist, or a psychiatric nurse operating within established protocol with a psychiatrist at a receiving facility. The bill extends the 72-hour period an additional 48 hours if a physician determines, under specific criteria, that the individual has ongoing symptoms of substance intoxication or substance withdrawal and would likely experience significant clinical benefit from detoxification services. One of the following actions must happen within the time period specified:

- The individual will be approved for release by an appropriate professional;
- The individual will be asked to consent to voluntary admission; or
- The receiving facility for involuntary inpatient or outpatient treatment will file a petition in circuit court.

Within 12 hours after a physician documents that an individual's emergency medical condition has stabilized or does not exist, the individual:

- Must be examined by a medical professional, and if found not to meet criteria for involuntary examination, must be released directly from the hospital providing the emergency medical services; or
- Must be transferred to a receiving facility if appropriate medical and mental health treatment is available, with 2-hours' notice provided to the receiving facility.

Crisis Stabilization Units

This bill lifts the cap in current law on the number of beds authorized in a crisis stabilization unit. A crisis stabilization unit provides emergency response regardless of ability to pay to persons are involuntarily placed or who voluntarily seek help in stabilizing themselves. Current law limits the number of beds per facility to 30 beds.

Involuntary Outpatient Placement

An individual in an involuntary outpatient placement proceeding has the right to counsel, appointed by the court within 1 court working day after the petition is filed. The attorney must advocate the individual's expressed desires or must advocate for liberty and if outpatient treatment is ordered, the least restrictive treatment possible. At a hearing on involuntary outpatient placement, the state attorney has access to the individual's clinical records and witnesses in order to determine the sufficiency of the allegations contained in the petition. The court must notify the individual or his or her representative of the right to an independent expert examination.

Involuntary Inpatient Placement

An individual may be retained or involuntarily placed in a mental health receiving facility, an addictions receiving facility, or a detoxification facility, upon recommendation of two psychiatrists or a psychiatrist and a psychologist. If a petition seeks placement for substance abuse impairment only and an addictions receiving facility or a detoxification facility conducts the examination, recommendation may be made by a physician and a substance abuse professional.

The individual has the same right to counsel and level of advocacy as that which apply to individuals facing a petition for involuntary outpatient placement. The court must hold a hearing after a petition is filed within 5 court working days. The individual may waive his or her presence if the court establishes that waiver if knowing, intelligent, and voluntary. The bill clarifies that the state attorney in the case represents the state and not the facility that initiated the petition. The bill grants the state attorney access to the individual's clinical record.

Also, when the petition is for inpatient placement for substance abuse impairment and the individual is examined by an addictions receiving facility or a detoxification facility, a physician may provide the first opinion and a substance abuse qualified professional the second opinion needed to support the petition.

The bill reduces from 6 months to 90 days the length of time an individual may be involuntarily placed without a court order granting a continuance. When a hearing is held on a petition to continue involuntary inpatient placement, the Division of Administrative Hearings must inform the individual of the right to an independent examination, provided by the court if the individual is unable to pay.

Jennifer Act (Sections 22 through 28)

Part IV of ch. 765, F.S. is redesignated from "Absence of Advance Directive" to "Mental Health and Substance Abuse Directives," also known as the Jennifer Act.

A mental health or substance abuse treatment advance directive is a written document in which the principal provides instructions or preferences or appoints a surrogate to make decisions on behalf of the principal regarding mental health or substance abuse treatment, or both.

The Act emphasizes the need to allow individuals with capacity to control decisions relating to his or her own treatment. The Act recognizes that substance abuse and mental illness cause individuals to fluctuate between capacity and incapacity. An individual in a crisis situation may be unable to provide informed consent in the midst of the crisis to prevent the need for involuntary treatment.

An adult who qualifies for advance directives is an individual who has reached majority or an emancipated minor.

A principal is a competent adult who executes a mental health or substance abuse treatment advance directive and on whose behalf treatment decisions are made.

A directive executed under the terms of the Act is presumed valid. However, an inability to honor one or more of the provisions of the advance directive does not invalidate the remaining provisions. The directive may address an 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, provided that consent is conveyed through an affirmative statement contained in the directive clearly stating whether the consent is revocable by the individual during a mental health or substance abuse crisis;
- Descriptions of situations which may cause the individual to experience a mental health or substance abuse crisis;
- Suggested alternative responses that may supplement 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; and
- Nomination of a guardian, limited guardian, or guardian advocate.

The directive may be independent of or combined with a nomination of a guardian or other durable power of attorney.

The bill addresses the execution, effective date, and expiration of a mental health or substance abuse advance directive.

Advance directives 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 whether consent is revocable;
- Be dated and signed by the individual or, if unable to sign, dated and signed at his or her direction;
- Be witnessed by two adults who declare they were present when the individual dated and signed the directive and that the individual did not appear incapacitated or acting under fraud, undue influence, or duress. The surrogate named in the directive cannot witness execution of the directive and at least 1 witness must not be the spouse or blood relative of the individual executing the directive.

The directive is valid upon execution, but all or part may take effect at a later date as designated in the directive. A directive may be revoked in whole or in part or expire under its own terms. But, an individual may revoke an advance directive only if, at the time of execution he or she elected to be able to revoke when incapacitated. A directive that would have otherwise expired but is effective because the individual is incapacitated remains effective until the individual is no longer incapacitated.

An advance directive executed properly in another state is considered valid in this state.

The bill imposes several restrictions on directives. A directive may not create an entitlement to mental health, substance abuse, or medical treatment or supersede a determination of medical necessity. A directive does not obligate a health care provider, professional person, or facility to incur costs associated with requested treatment or to be responsible for the non-treatment or personal care of the individual outside a facility's scope of services. Directives may not replace or supersede wills, testamentary documents, or the provision of intestate succession.

An individual's family, the health care facility, attending physician, or other interested person may seek expedited judicial intervention on a surrogate's decision if a surrogate has acted improperly or abused his or her powers or the individual has sufficient capacity to make his or her own health care decisions.

This bill provides immunity from civil and criminal liability to surrogates, health care facilities, and providers who execute mental health care or substance abuse treatment decisions pursuant to the Jennifer Act, on advance directives. Health care facilities and providers who comply with the Act are also deemed not to have engaged in unprofessional conduct. Immunity from liability applies unless a proponent can show by a preponderance of the evidence that the person or entity did not act in good faith.

Forensic Hospital Diversion Pilot Program (Section 29)

This bill creates the Forensic Hospital Diversion Pilot Program (Program). The purpose of the program is to divert incarcerated defendants who are found mentally incompetent to proceed at trial from state forensic mental health treatment facilities to locked residential treatment facilities, and eventually community outpatient treatment. Goals of treatment are restoration of competency and community reintegration.

Under the bill, the Department of Children and Families (DCF) is required to implement the Program in Alachua, Broward, Escambia, Hillsborough, and Miami-Dade counties, in conjunction with the court circuits in those counties. The model for the Program is the Miami-Dade Forensic Alternative Center, which is currently in operation.

In establishing the individual programs, the DCF must consider local needs and available local resources. The bill allows the DCF and the affected judicial circuits to implement these provisions within available resources. Additionally, the Legislature may provide a specific appropriation to support the Program.

Participation in the Program is limited to persons who:
- Are 18 years of age and older;
- Are charged with a second or third degree felony;
- Do not have a significant history of violent criminal offenses;
- Have been adjudicated either incompetent to proceed to trial or not guilty by reason of insanity;
- Meet safety and treatment criteria established by the DCF for placement in the community; and
- Would otherwise be admitted to a state mental health treatment facility.

The bill encourages the Florida Supreme Court, in conjunction with the Task Force on Substance Abuse and Mental Health Issues in the Courts, to develop educational training for judges in the pilot program counties on the community forensic system.

The DCF is authorized to adopt rules to facilitate to facilitate the provisions of the bill relating to the Program. The bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2016. The report must examine the efficiency and cost-effectiveness of the program, including its effect on public safety.

Nonviolent Offender Reentry Program (Section 30)

This bill creates the Nonviolent Offender Reentry Program, a diversionary program available to persons with substance abuse problems who have committed less serious felonies. The Program is designed to reduce prison sentences, by replacing part of the sentence an offender would have spent incarcerated with a minimum stay of 6 months in a reentry program. Reentry programs will offer intensive substance abuse treatment, GED training, and career education and testing.

Disqualifying Offenses

To qualify for participation, an offender must not be the subject of a pending domestic violence injunction or have committed as a primary offense, a crime more serious than a third-degree felony. Additionally, the Program excludes from participation offenders who have been convicted of:

- Forcible and other violent felonies, including assault or battery on a person 65 years old or older;
- Felonies involving firearms and other weapons;
- Child abuse or neglect or sexual offenses against children;
- Sexual offenses including computer pornography, obscenity, or a crime that requires the offender to register as a sex offender; or
- Assault or battery of certain public servants, including law enforcement officers, firefighters, emergency responders, code inspectors, or of juvenile detention or commitment facility staff.

Department of Corrections (DOC) Screening, Referral, and Reports

The DOC is required to implement the reentry program to the fullest extent using available resources. The DOC may locate reentry programs in a secure area in or next to correctional institutions. Although the DOC may enter into performance-based contracts to provide services under the program, only a court can release an offender from the jurisdiction of a court.

Screening

The DOC will screen offenders for eligibility in the program. At minimum, offenders must have served at least one-half of the original sentence and be in need of substance abuse treatment. Participation of offenders is voluntary and the program is dependent on available space. In addition to disqualifying offenses, the DOC must consider other factors designed to indicate suitability for reentry and the potential for success in the program.

Referral

The DOC will request in writing with supporting documentation that the court approve specific offenders' participation in the program. The DOC must provide notice and a copy of the request to the state attorney. The state attorney may file an objection with the court within 15 days after receipt of notice from the DOC.

The court must notify the DOC in writing of the decision to approve or disapprove placement in the program within 30 days after the court receives the request from the DOC.

Reports

At least 30 days before the offender is scheduled to complete the program, the DOC must provide a report to the court which certifies whether the offender satisfactorily completed the program. After the court reviews the report, holds a hearing if necessary, and determines that the offender successfully completed the program, the court will issue an order modifying the sentence imposed and ordering drug offender probation.

The DOC must also draft and provide an annual report on the program to the Governor, President of the Senate, and the Speaker of the House of Representatives on the success of the program, including recidivism rates. The deadline for the report is unspecified.

Consequences for Offenders who Fail to Cooperate in the Program

If an offender becomes unmanageable in the program, the DOC may revoke gain-time and place the offender in disciplinary confinement. After the offender completes the ordered discipline, the offender will be readmitted to the reentry program. The bill also provides grounds for the DOC to terminate an offender from the program for more serious behavior, or if the offender has a medical condition which precludes participation.

The bill takes effect July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

This bill does not appear to require counties or municipalities to spend funds or limit their authority to raise revenue or receive state-shared revenues as specified in Article VII, s. 10 of the Florida Constitution.

Although the Forensic Hospital Diversion Pilot Program envisions the availability of local resources as a type of support for the program, the bill does not require local funding.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Public Providers and Sovereign Immunity

Sovereign immunity originally referred to the English common law concept that the government may not be sued because "the King can do no wrong." Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents unless the public entity expressly waives immunity.

Article X, s. 13, of the Florida Constitution recognizes sovereign immunity and authorizes the Legislature to provide a waiver of immunity. Section 768.28(1), F.S., provides a broad waiver of sovereign immunity. But by law, liability to pay a claim or judgment is limited to $200,000 per plaintiff or $300,000 per incident.[54]

[54] Section 768.28(5), F.S.

This bill appears to provide absolute immunity to surrogates, health care facilities, and providers who execute in good faith mental health care or substance abuse treatment decisions pursuant to the law on advance directives. Accordingly, this bill creates an exception to the broad waiver of sovereign immunity under s. 768.28, F.S.

Private Providers and Access to Courts

The grant of immunity does not specify application to public providers or both public and private providers.

The Florida Supreme Court in *Kluger v. White* reviewed the constitutionality of a statute which abolished the traditional right of action for property vehicle damage in tort from the law unless a narrow exception applied.[55] In striking down the statute, the court held:

> where a right of action to the courts for redress for a particular injury has been provided by statutory law predating the adoption of the Declaration of Rights of the Constitution of the State of Florida, or where such right has become a part of the common law of the State…the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people…unless the Legislature can show an overpowering public necessity…and no alternative of meeting such public necessity can be shown.[56]

If this bill abolishes a cause of action that existed before the Declaration of Rights was adopted in 1968 by extending immunity to a private provider or facility, this bill may create an access to courts issue.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Marchman and Baker Act

The Department of Children and Families (DCF) indicates a potential fiscal impact from this bill. The bill modifies the timeframe for a hearing to determine whether continued involuntary retention is appropriate. The bill requires the court to hold a hearing every 90

[55] *Kluger v. White*, 281 So. 2d 1, 2 (Fla. 1973).
[56] *Id*. at 4.

days until the individual no longer meets criteria for commitment. The DCF anticipates the need for 12 FTE positions and an associated cost of $1.694 million.[57]

The bill expands the use of involuntary outpatient care. The state could experience cost savings for behavioral health care if services are diverted from inpatient settings to outpatient settings under the bill.

The Office of the State Courts Administrator (OSCA) indicates that the fiscal impact of the bill is indeterminate due to the unavailability of data needed to quantifiably establish the bill's impact on court and judicial workload. Merging the provisions of the Marchman and Baker Acts addressing voluntary and involuntary intervention may increase judicial workload. More ex-parte orders, appointments for guardian advocates, involuntary placement hearings, and writ of habeus corpus filings may increase workload. The bill authorizes an individual or his or her representative to request an independent expert examination for involuntary outpatient placement, which may also increase expert witness fees for the judicial branch. The addition of the advance directive language may result in fewer filings of guardianship petitions, which may reduce state courts revenues. However, an increase in revenues could result from an increase in the number of petitions for the determination of incompetency.[58]

Forensic Hospital Diversion Pilot Program

This bill replicates the Miami-Dade Forensic Alternative Center Program as a pilot program in 3 other counties.

The program's current contract with the DCF is $1.596 million. Funding this model for the five programs will require $7.98 million. The DCF anticipates that the redirection of $7.98 million from the department's budget for this program could impact or decrease the provision of services to other clients of the department.[59]

Cost savings may be realized, however, based on the success of the program. The program is able to keep individuals whose competency has been restored in the program rather than in jail while awaiting trial. Doing so may shorten the process, as defendants are less likely to decompensate, or lose competency again from the stress and the less-than-optimal treatment provided in a jail setting. Commitment bed and court cost savings are expected through this bill. Competency is restored more quickly through the program, which requires 103 days on average, than at state facilities, which requires 146 days on average.

[57] The Department of Children and Families, *2015 Legislative Bill Analysis* (March 30, 2015) (on file with the Senate Judiciary Committee).
[58] Office of the State Courts Administrator, *2015 Judicial Impact Statement* (April 5, 2015).
[59] Email correspondence from John Bryant, Assistant Secretary for Substance Abuse and Mental Health, DCF (April 2, 2015) (on file with the Senate Judiciary Committee).

In the 2011-12 Fiscal Year, the average cost for a secure forensic bed was $333 per day. A bed at the program cost much less, at $229 a day in 2011-12.[60] However, the current cost per bed per day at the program is $285 a day.[61]

The bill authorizes, rather than requires the pilot projects to be implemented based on available resources including local resources and resources the bill authorizes the DCF to reallocate from specified forensic programs. The extent to which local resources are available in the designated pilot areas and the amount of funding the DCF can reallocate is unknown.

Nonviolent Offender Reentry Program

The Department of Corrections (DOC) estimates that 760 inmates meet eligibility criteria for participation in the program. Of that number, potentially 611 inmates would qualify based on offense history, initial custody, and sentence length. An increase in workload would result for Classification Officers, Institutional Release Officers, and staff with the Bureau of Admission and Release. Additional correctional educators may be needed. The bill may increase the number of court-ordered referrals to DOC-funded community based residential and outpatient programs.

The DOC estimates technology costs at $5,000.

Due to variables requiring court approval, other fiscal impact is indeterminate.[62]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Nonviolent Offender Reentry Program

This bill creates the Nonviolent Offender Reentry Program. This language was the subject of House Bill 177 from 2012. The Governor vetoed House Bill 177 on the basis that:

> Justice to victims is not served when a criminal is permitted to be released early from a sentence imposed by the courts. Florida's sentencing laws have helped reduce Florida's crime rate to a 40-year low. This bill would permit criminals to be released after serving fifty percent of their sentences, thus creating an unwarranted exception to the rule that inmates serve [eighty-five] percent of their imposed sentences.[63]

[60] Budget Subcommittee on Health and Human Services Appropriations, *supra* note 47.
[61] Department of Children and Families (DCF), *2015 Agency Legislative Bill Analysis on SB 1452* (March 4, 2015) (on file with the Senate Judiciary Committee).
[62] Department of Corrections, *2015 Agency Legislative Bill Analysis* (April 8, 2015) (on file with the Senate Judiciary Committee).
[63] Executive Office of the Governor, *Veto Message* (April 6, 2012).

Independent Expert Examination

Section 14 of the bill provides, in instances of involuntary inpatient placement for an individual with mental illness or substance abuse impairment, that the Division of Administrative Hearings (DOAH) must inform the individual or his or her guardian, guardian advocate, health care surrogate or proxy, or representative, of the right to an independent expert examination, and, if the individual cannot afford the examination, the court must provide one. Which court is being referenced is unclear, as the case is being handled by the DOAH.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 39.407, 381.0056, 394.453, 394.455, 394.457, 394.4573, 394.459, 394.4597, 394.4598, 394.4599, 394.4612, 394.4615, 394.462, 394.4625, 394.463, 394.4655, 394.467, 394.4672, 394.875, 394.495, 394.496, 394.499, 394.67, 394.674, 394.9085, 395.0197, 395.1051, 397.311, 397.431, 397.702, 397.94, 402.3057, 409.1757, 409.972, 456.0575, 744.704, 765.101, 765.104, 790.065, 1002.20, and 1002.33.

This bill creates the following sections of the Florida Statutes: 765.4015, 765.402, 765.403, 765.405, 765.406, 765.407, 765.410, 765.411, 916.185, and 944.805.

This bill transfers and renumbers the following sections of the Florida Statutes: 765.401 and 765.404.

This bill repeals the following sections of the Florida Statutes: 397.601, 397.675, 397.6751, 397.6752, 397.6758, 397.6759, 397.677, 397.6771, 397.6772, 397.6773, 397.6774, 397.6775, 397.679, 397.6791, 397.6793, 397.6795, 397.6797, 397.6798, 397.6799, 397.681, 397.6811, 397.6814, 397.6815, 397.6818, 397.6819, 397.6821, 397.6822, 397.693, 397.695, 397.6951, 397.6955, 397.6957, 397.697, 397.6971, 397.6975, and 397.6977.

IX. Additional Information:

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

CS by Judiciary on April 7, 2015:
The CS:

- Reinstates current law to prohibit an individual with mental illness who has not been charged with a crime from being detained under the Baker Act in a jail setting;
- Creates the Nonviolent Offender Reentry Program to divert nonviolent offenders with substance abuse impairment from serving lengthy sentences through a partial service of sentence and referral to a reentry program;
- Adds the county of Broward County to the Forensic Hospital Diversion Pilot Program;
- Adds substance abuse evaluations to evaluations that may be performed by a receiving facility within 24 hours after arrival by the individual in need of intervention and adds substance abuse professionals to the list of professionals who may evaluate the individual;

- Requires a law enforcement officer to notify the nearest relative of a minor taken into protective custody that the minor has been taken into protective custody;
- Requires a public school principal or the principal's designee, including those at charter schools, to immediately notify a student's parent, guardian, guardian advocate, or caregiver if a student is transferred from the school environment to a receiving facility for an involuntary examination, unless a report has been provided to the child abuse hotline, in which case notification may be delayed for up to 24 hours;
- Requires a receiving facility to immediately notify, and repeatedly attempt to notify until contact is successful, a minor's parent, guardian, caregiver, or guardian advocate, in person, by phone, or by electronic communication, unless a report has been provided to the child abuse hotline, in which case notification may be delayed for up to 24 hours;
- Clarifies that a psychiatric nurse may examine an individual held for an involuntary examination at a receiving facility or approve the individual's release during the involuntary examination period, only in coordination with a psychiatrist and within the framework of an established protocol;
- Expands the definition of a psychiatric nurse to additionally require a national advance practice certification as a psychiatric-mental health advance practice nurse; and
- Authorizes an osteopathic physician, as a mental health professional, to provide care and treatment in accordance with an individual's advance directive.

B. Amendments:

None.