HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 7119 PCB CFSS 15-01 Mental Health and Substance Abuse
SPONSOR(S): Health & Human Services Committee; Children, Families & Seniors Subcommittee, Harrell
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	11 Y, 0 N	McElroy	Brazzell
1) Health Care Appropriations Subcommittee	13 Y, 0 N	Fontaine	Pridgeon
2) Health & Human Services Committee	16 Y, 0 N, As CS	McElroy	Calamas

SUMMARY ANALYSIS

CS/HB 7119 makes changes to the statewide system of safety-net prevention, treatment, and recovery services for substance abuse and mental health (SAMH) administered by the Department of Children and Families (DCF). DCF currently contracts with seven managing entities that in turn contract with local service providers to deliver SAMH services. The bill updates statutes that provided DCF initial authority and guidance for transitioning to the managing entity system. The bill makes changes regarding service provision and enhances operation of this outsourced approach by:

- Allowing managed behavioral health organizations to bid for managing entity contracts when fewer than two bids are received;
- Establishing essential elements for coordinated care organizations (CCO) and requiring managing entities to transition to coordinated care organizations by 2019;
- Requiring care coordination, specifying services that shall be provided within available resources, and prioritizing the populations served;
- Requiring DCF to develop performance standards that measure improvement in a community's behavioral health and in specified individuals' functioning or progress toward recovery;
- Specifying members for managing entities' and CCO's governing boards and technical advisory panels, and requiring managed behavioral health organizations serving as managing entities or CCOs to have advisory boards and technical advisory panels with that membership;
- Allowing managing entities and CCOs flexibility in shaping their provider network while requiring a system for publicizing opportunities to join and evaluating providers for participation; and
- Deleting obsolete statutes regarding the transition to the managing entity system.

The bill requires DCF to contract for a study of the safety-net system, with an interim and final report submitted on specified topics, and requires DCF and the Agency for Health Care Administration to report on options for increasing the availability of federal Medicaid SAMH services.

The bill revises the Criminal Justice, Mental Health, and Substance Abuse Grant Program. The bill expands the membership of the Statewide Grant Review Committee to include more non-state representatives and renames it the Policy Committee. The bill creates a grant review and selection committee. It also streamlines the local process for applying for grants and allows DCF to require sequential intercept mapping of systems to identify where interventions may be effective.

The bill adds family members and other interested parties as parties authorized to petition the court for the appointment of a guardian advocate to consent to treatment when the individual is not competent to do so. The bill requires specified health care facilities to provide written information on advance directives for mental health treatment to individuals. The bill also requires DCF to develop and publish on its website a mental health advance directive form.

The bill requires DCF to create the Crisis Stabilization Services Utilization database for collecting utilization data from all public receiving facilities.

The bill makes conforming changes to child welfare statutes to incorporate references to mental health treatment and mental health courts, subject to the passage of HB 7113, which authorizes the creation of mental health courts. The bill also repeals a variety of obsolete and duplicative statutes.

The bill has an indeterminate negative fiscal impact for the contract for the study; however, HB 5001 (the proposed General Appropriations Act) contains $200,000 for a systemic review of the state's mental health and substance abuse safety net system.

The bill provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Mental Illness and Substance Abuse

Mental health and mental illness are not synonymous. 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 make a contribution 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 and/or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. Only about 17% of adults in the United States are considered to be in a state of optimal mental health.[4] This leaves the majority of the population with less than optimal mental health, for example: [5]

- One in four adults (61.5 million people) experiences mental illness in a given year;
- Approximately 6.7 percent (14.8 million people) live with major depression; and
- Approximately 18.1 percent (42 million people) live with anxiety disorders, such as panic disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder and phobias.

Many people are diagnosed with more than one mental illness. For example, people who suffer from a depressive illness (major depression, bipolar disorder, or dysthymia) often have a co-occurring mental illness such as anxiety.[6]

Substance abuse also affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[7]

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[1] *Mental Health Basics*, Centers for Disease Control and Prevention. http://www.cdc.gov/mentalhealth/basics.htm (last viewed on March 17, 2015).
[2] Id.
[3] Id.
[4] Id. Mental illness can range in severity from no or mild impairment to significantly disabling impairment. Serious mental illness is a mental disorder that has resulted in a functional impairment which substantially interferes with or limits one or more major life activities. *Any Mental Illness (AMI) Among Adults*, National Institute of Mental Health. http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml (last viewed on March 17, 2015).
[5] *Mental Illness Facts and Numbers,* National Alliance on Mental Illness. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&sqi=2&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.nami.org%2Ffactsheets%2Fmentalillness_factsheet.pdf&ei=dYMIVdrWOYmqgwTBlYDQDA&usg=AFQjCNEATQZ5TXJF063JkMNgg9ZnwZb_ZA&bvm=bv.88198703,d.eXY
[6] *Mental Health Disorder Statistics,* John Hopkins Medicine. http://www.hopkinsmedicine.org/healthlibrary/conditions/mental_health_disorders/mental_health_disorder_statistics_85,P00753/ (last viewed on March 17, 2015).

In 2013, an estimated 21.6 million persons aged 12 or older were classified with having substance dependence or abuse issues.[8] Of these, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs, 4.3 million had dependence or abuse of illicit drugs but not alcohol, and 14.7 million had dependence or abuse of alcohol but not illicit drugs.[9]

Significant social and economic costs are associated with mental illness. Persons diagnosed with a serious mental illness experience significantly higher rates of unemployment compared with the general population.[10] This results in substantial loss of earnings each year[11] and can lead to homelessness. Homelessness is especially high for people with untreated serious mental illness, who comprise approximately one-third of the total homeless population.[12] Both adults and youth with mental illness frequently interact with the criminal justice system, which can lead to incarceration. For example, seventy percent of youth in juvenile justice systems have at least one mental health condition and at least twenty percent live with a severe mental illness.[13]

Substance abuse likewise has substantial economic and societal costs. In 2004, the total estimated costs of drug abuse and addiction due to use of tobacco, alcohol and illegal drugs was estimated at $524 billion a year.[14] This consists of $181 billion/year related to illegal drugs, $185 billion/year related to alcohol and $193 billion/year related to tobacco use.[15] These figures assume costs related to health care expenditures, lost earnings, law enforcement and incarceration.[16]

Mental illness and substance abuse commonly co-occur. Approximately 8.9 million adults have co-occurring disorders.[17] In fact, more than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs). [18] Drug abuse can cause individuals to experience one or more symptoms of another mental illness.[19] Additionally, individuals with mental illness may abuse drugs as a form of self-medication.[20] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.[21]

Coordinated Care Organizations

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[7] *Substance Abuse*, World Health Organization. http://www.who.int/topics/substance_abuse/en/ (last viewed on March 17, 2015).
[8] Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.samhsa.gov%2Fdata%2Fsites%2Fdefault%2Ffiles%2FNSDUHresultsPDFWHTML2013%2FWeb%2FNSDUHresults2013.pdf&ei=L74IVZydKO2SsQStroDQCg&usg=AFQjCNE8sNFxhZQfOgdkJvOgZR3fP5I0Uw (last viewed on March 17, 2015).
[9] Id.
[10] *Accounting for Unemployment Among People with Mental Illness*, Baron RC, Salzer MS, Behav. Sci. Law., 2002;20(6):585-99. http://www.ncbi.nlm.nih.gov/pubmed/12465129 (last viewed on March 17, 2015).
[11] *Supra* footnote 5.
[12] *How Many Individuals with A Serious Mental Illness are Homeless?* Treatment Advocacy Center, Backgrounder, November 2014. http://www.treatmentadvocacycenter.org/problem/consequences-of-non-treatment/2058 (last viewed on March 17, 2015).
[13] *Supra* footnote 5.
[14] Drug Abuse Costs The United States Economy Hundreds of Billions of Dollars in Increased Health Care Costs, Crime and Lost Productivity, National Institute on Drug Abuse, July 2008. http://www.drugabuse.gov/publications/addiction-science-molecules-to-managed-care/introduction/drug-abuse-costs-united-states-economy-hundreds-billions-dollars-in-increased-health (last visited on March 17, 2015).
[15] Id.
[16] Id.
[17] *About Co-Occurring*, Substance Abuse and Mental Health Services Administration. http://media.samhsa.gov/co-occurring/default.aspx (last viewed on March 17, 2015).
[18] *Co-Occurring Disorders*, Psychology Today. https://www.psychologytoday.com/conditions/co-occurring-disorders (last viewed on March 17, 2015).
[19] *Comorbidity: Addiction and Other Mental Illnesses*, U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCMQFjAA&url=http%3A%2F%2Fwww.drugabuse.gov%2Fsites%2Fdefault%2Ffiles%2Frrcomorbidity.pdf&ei=6q8NVf-iMsibNo7gg4AO&usg=AFQjCNFujSP7SHxxqB3FI7961yGQNQ56YA&bvm=bv.88528373,d.eXY (last viewed on March 21, 2015).
[20] Id.
[21] *Supra* footnote 18.

One approach to improving quality of care is to increase the coordination of care. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services.

One approach being tested through the federal Medicare program is the use of accountable care organizations (ACO's). ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.[22] When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

The state of Oregon has a Medicaid research and demonstration waiver allowing it to deliver comprehensive Medicaid services through coordinated care organizations (CCO's). CCOs are local organizations. They are paid a fixed sum that increases at a fixed rate to provide mental, physical and dental care to the covered population. Oregon has 16 CCO's. They are accountable for health outcomes of the population they serve and can receive bonus payments for meeting or exceeding required measures. They are governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.[23]

Florida's Substance Abuse and Mental Health Program

The Florida 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. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[24]

The Legislature appropriated $614,252,968 ($406,954,194 for mental health services and $207,298,774 for substance abuse services) to DCF for community behavioral health in FY 14-15.[25] This included $29,626,345 ($26,472,991 for mental health and $3,153,354 for substance abuse) in federal funds. In FY 2013-14, 377,519 individuals received behavioral health services through the SAMH program.

Behavioral Health Managing Entities

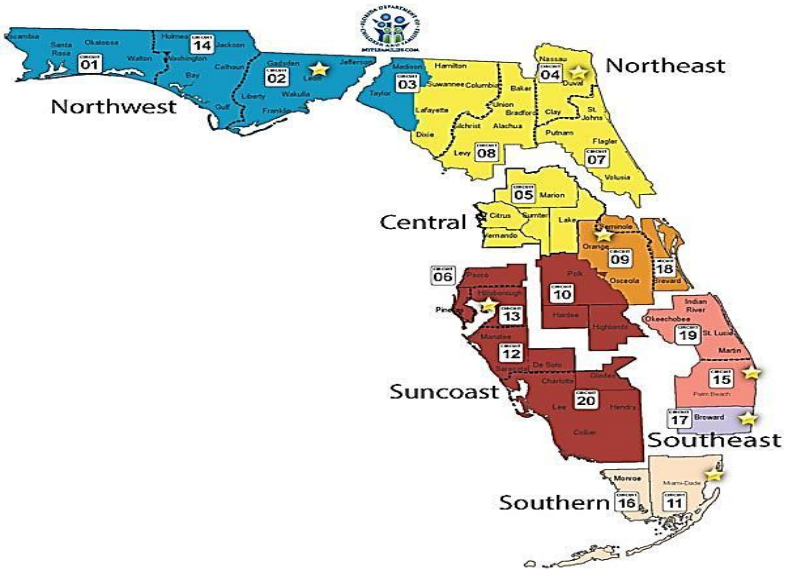
In 2001, the Legislature authorized DCF to implement behavioral health managing entities as the management structure for the delivery of local mental health and substance abuse services.[26] This was based upon the Legislature's decision that a management structure which places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level would:[27]

- Promote improved access to care;
- Promote service continuity; and
- Provide for more efficient and effective delivery of substance abuse and mental health services.

[22] "Accountable Care Organizations", Centers for Medicare and Medicaid Services, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco, (last accessed April 10, 2015).
[23] "Coordinated care: the Oregon difference", Oregon Health Policy Board, http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx (last accessed April 10, 2015).
[24] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance and children at risk for initiating drug use.
[25] *The Department of Children and Families Program Descriptions and Appropriation History Fiscal Year 2014-2015*.
[26] Ch. 2001-191, Laws.
[27] Section 394.9082, F.S.

The implementation of the managing entity system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement managing entities statewide.[28] Full implementation of the statewide managing entity system occurred in April 2013, with all geographic regions now served by a managing entity.[29] Implementation has allowed DCF to reduce the number of direct contracts for mental health and substance abuse services from several hundred to 7.[30] DCF currently contracts with 7 managing entities that in turn contract with local service providers for the delivery of mental health and substance abuse services:[31]

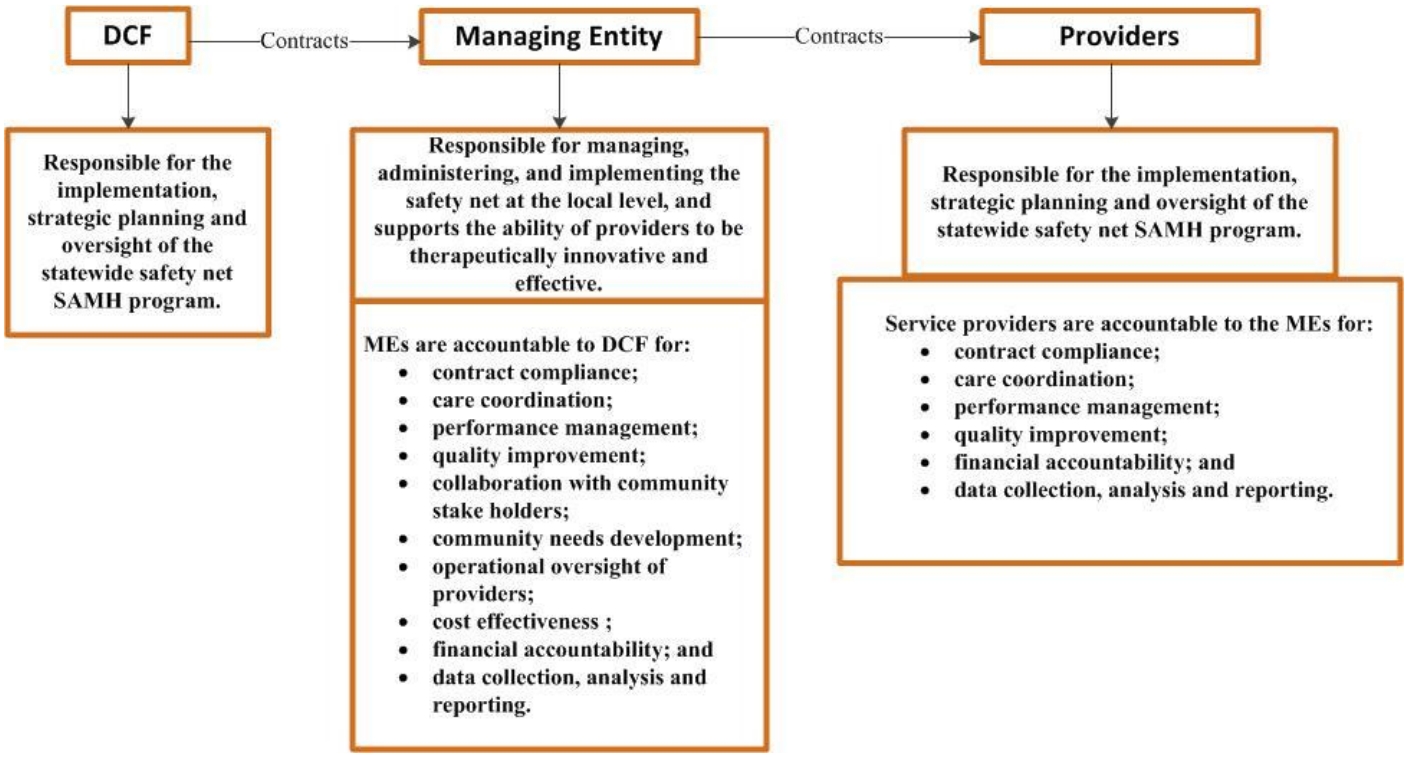
- Big Bend Community Based Care- April 1, 2013 (**blue**).
- Lutheran Services Florida- July 1, 2012 (**yellow**).
- Central Florida Cares Health System- July 1, 2012 (**orange**).
- Central Florida Behavioral Health Network, Inc.- July 1, 2012 (**red**).
- Southeast Florida Behavioral Health- October 1, 2012 (**pink**).
- Broward Behavioral Health Network, Inc.- November 6, 2012 (**purple**).
- South Florida Behavioral Health Network, Inc.- October 1, 2012 (**beige**).



Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.

[28] Chapter 2008-243, Laws.
[29] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.
[30] *Department of Children and Families Service System Management Plan, Statewide Implementation of Managing Entities or Similar Model*, July 2009.
[31] *Managing Entities*, Department of Children and Families. http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities (last visited on March 22, 2015).

DCF, managing entities and service providers have specific responsibilities in the SAMH program.



DCF utilizes four performance measures to evaluate the performance of the managing entities:[32]

- **Systemic Monitoring** – The managing entity shall complete on-site monitoring of no less than 20% of all network service providers each fiscal year;
- **Network Service Provider Compliance** – A minimum of 95% of the managing entity's network service providers shall demonstrate annual compliance with a minimum of 85% of the applicable network service provider measures (i.e., client outcome measures) at the target levels for the network service provider established in the subcontract;
- **Block Grant Implementation** – The managing entity shall ensure 100% of the cumulative annual network service provider expenses comply with the block grant and maintenance of effort establish allocation standards; and
- **Implementation of the General Appropriations Act**: The managing entity shall meet 100% of the following requirements:
    - Implementation of specific appropriations, demonstrated by contracts with network services providers; and
    - Submission of all required plans for federal substance abuse and mental health block grants.

<u>Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program</u>

In 2007, the Legislature created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program (Program). The purpose of the Program is to provide funding to counties to plan, implement, or expand initiatives that increase public safety, avert increased spending on criminal and juvenile justice, and improve the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance abuse disorder, or co-occurring mental

[32] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis & Government Accountability, July 18, 2014.

health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.[33]

Currently, only a county or a consortium of counties who have established planning councils or committees may apply for a grant under the Program.[34] The county may designate an agency, including a non-county agency, as "lead agency;" however, the application must be submitted under the authority of the county.[35] Applicants may seek a one-year planning grant or a three-year implementation or expansion grant.[36] An applicant must have previously received a planning grant to be eligible for an implementation or expansion grant. A grant may not be awarded unless the applicant county, or a consortium of counties, makes available resources in an amount equal to the total amount of the grant.[37]

The Program's Statewide Grant Review Committee (Committee) is responsible for evaluating applications submitted to the Program. The Committee includes:[38]

- One representative of DCF;
- One representative of the Department of Corrections;
- One representative of the Department of Juvenile Justice;
- One representative of the Department of Elderly Affairs; and
- One representative of the Office of the State Courts Administrator.

The Committee provides written notification to DCF of the names of the applicants who have been selected to receive a grant.[39] DCF may then transfer funds, if available, to any counties or consortium of counties awarded a grant.[40] A grant may not be awarded unless the applicant county, or a consortium of counties, makes available resources in an amount equal to the total amount of the grant.[41] For fiscally constrained counties, the available resources may be at 50 percent of the total amount of the grant.[42]

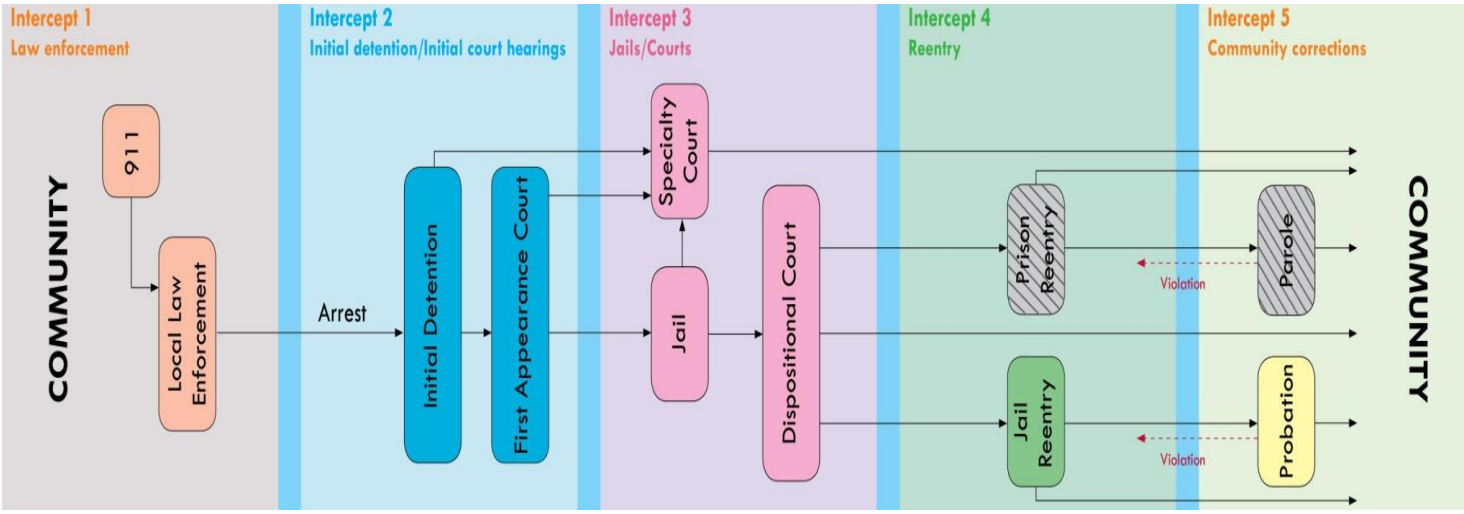
Sequential Intercept Model

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems.[43] The model seeks to identify points of interception where an intervention can occur to prevent an individual from entering or penetrating deeper into the criminal justice system.[44] The interception points are:[45]

- Law enforcement and emergency services;
- Initial detention and initial hearings;
- Jail, courts, forensic evaluations, and forensic commitments;
- Reentry from jails, state prisons, and forensic hospitalization; and
- Community corrections and community support.

Sequential Intercept Model

[33] Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant: Request for Applications, Department of Children and Families, May 2013.
[34] Section 394. 658(3), F.S.
[35] Id.
[36] Section 394. 656(3)(a), F.S.
[37] Section 394. 658(2)(b) and (c), F.S.
[38] Section 394. 656(2)(a-e), F.S.
[39] Section 394. 656(4), F.S.
[40] Id.
[41] Section 394. 658(2)(b) and (c), F.S.
[42] Id.
[43] *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, Munetz MR and Griffin PA, Psychiatr. Serv., 2006 April; 57(4):544-9. http://www.ncbi.nlm.nih.gov/pubmed/16603751 (last viewed on March 20, 2015).
[44] Id.
[45] Id.



SAMHSA Gain Center for Behavioral Health and Justice Transformation.

A community can use the model to develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment.[46]

Florida Mental Health Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[47] The Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[48]

Involuntary Examination and Receiving Facilities

Individuals in acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[49] 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[50]:

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

Involuntary patients must be taken to either a public or private facility which has been designated by DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment.[51] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for

[46] Id.
[47] Sections 394.451-394.47891, F.S.
[48] Section 394.459, F.S.
[49] Sections 394.4625 and 394.463, F.S.
[50] Section 394.463(1), F.S.
[51] Section 394.455(26), F.S.

such purpose.[52] Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially-eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[53]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[54] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[55]

The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[56] Individuals often enter the public mental health system through CSUs.[57] For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by Legislature in the 1970s to ensure continuity of care for individuals.[58]

DCF's expenditures during Fiscal Year 2014-2015 through December 2014 for adult CSU, Baker Act, and Inpatient Crisis Services were approximately $39.4 million.[59] Expenditures for the same services for children in the same time period were approximately $8.5 million.[60] As of February 2015, there were 63 public receiving facilities with 2,052 beds and 67 private receiving facilities with 3,371 beds.[61] For FY 2014-15 there are 544 adult and 106 crisis stabilization beds funded by DCF.[62] There were 171,744 involuntary examinations initiated at hospitals and CSUs in calendar year 2013 (most recent report).[63]

Guardian Advocate

The Baker Act provides for the appointment of a guardian advocate for individuals who are incompetent to consent to treatment. The guardian advocate is responsible for making well-informed mental health treatment decisions for the patient. The administrator of a receiving or treatment facility may petition the court for the appointment of advocate guardian if a psychiatrist has determined that a patient is incompetent to consent to treatment.[64] The court will conduct a hearing on the petition during which a patient will have the right to testify, cross-examine witnesses, and present witnesses.[65] The court will appoint a qualified guardian advocate if it finds the patient incompetent.[66] The court may not appoint certain individuals as a guardian advocate:[67]

- An employee of the facility providing direct mental health services to the patient;
- A DCF employee;
- An administrator of a treatment or receiving facility; or
- A member of the Florida local advocacy council.

[52] Section 394.455(25), F.S
[53] Rule 65E-5.400(2), F.A.C.
[54] Section 394.875(1)(a), F.S.
[55] Id
[56] Id.
[57] Budget Subcommittee on Health and Human Services Appropriations, the Florida Senate, Crisis Stabilization Units, (Interim Report 2012-109) (Sept. 2011).
[58] Id. Sections 394.65-394.9085, F.S.
[59] Correspondence from the Department of Children and Families to the House of Representatives' Children, Families & Seniors Subcommittee, dated February 9, 2015.
[60] Id.
[61] Id.
[62] Id.
[63] Christy, A. (2014). Report of 2013 *Baker Act Data*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.
[64] Section 394.4598(1), F.S.
[65] Id.
[66] Id .
[67] Id.

The facility must provide a guardian advocate with sufficient information for a guardian advocate to make an informed decision.[68] This includes information related to whether the proposed treatment is essential to the care of the patient and whether the proposed treatment presents an unreasonable risk of serious, hazardous, or irreversible side effects.[69] A guardian advocate must meet and talk with the patient and the patient's physician in person (if at all possible) before giving consent to treatment.[70] The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.[71]

Guardian advocates may only provide consent for mental health treatment if the patient is incompetent. The appointment of a guardian advocate will be terminated if a patient is:

- Discharged from an order for involuntary outpatient placement or involuntary inpatient placement;
- Transferred from involuntary to voluntary status; or
- Determined by the court to be competent.

Advance Directives

Competent adults may formulate, in advance, preferences regarding a course of treatment in the event that injury or illness causes severe impairment or loss of decision-making capacity. An advance directive is a written document or oral statement designed to control certain future health care when a person becomes unable to make decisions and choices on his or her own.[72] There are five common types of advance directives:[73]

- **Living Will**- Typically is self-directed planning for the type of medical treatment a person wants in situations where he or she has been determined to be terminally ill or in a persistent vegetative state. It also addresses under what conditions an attempt to prolong life should be started or stopped.[74]
- **Durable Power of Attorney for Health Care or Designation of Health Care Surrogate**- Identifies and authorizes a person to act as a proxy to make all health care decisions for the principal in the event the principal becomes incapacitated.[75]
- **Do Not Resuscitate (DNR) Order**- Directs health care providers to **not** to use CPR if breathing or heartbeat stops.[76]
- **Advance Health Care Directive**- Self-directed planning which establishes the health care treatment decisions an individual wants in the event he or she becomes incapacitated or incompetent. These address all health care decisions, including mental health care decisions.
- **Psychiatric or Mental Health Advance Directive**- Self-directed planning which establishes the mental health care treatment decisions an individual wants in the event he or she becomes incapacitated or incompetent.

All 50 states permit an individual to use an advance directive to express his or her wishes as to medical treatment in the event the individual becomes terminally ill or has an injury or disease making the

[68] Section 394.4598(2), F.S.
[69] Id.
[70] Id.
[71] Section 394.4598(7), F.S.
[72] *Advance Directives*, American Cancer Society. http://www.cancer.org/treatment/findingandpayingfortreatment/understandingfinancialandlegalmatters/advancedirectives/advance-directives-types-of-advance-health-care-directives (last viewed on March 20, 2015). Living Wills may also contain a durable power of attorney, DNR and health care advance directives.
[73] Each of the types of advance directives may be used independently but are commonly used in conjunction with each other.
[74] Id.
[75] Id.
[76] Id.

individual unable to communicate or make medical decisions.[77] However, the requirements to create a valid advance directive vary among the states.

Under Florida law, a health care advance directive is a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care.[78] Health care advance directives include, but are not limited to, the designation of a health care surrogate, a living will, or an anatomical gift.[79] No specific form is required, and an individual can provide direction for all health care issues, including life-prolonging procedures and mental health treatment.[80] Health care facilities are required to provide each patient with written information concerning the individual's rights relating to advance directives and the facility's policies respecting the implementation of such rights.[81]

Mental Health Courts

People with mental illness comprise a significant proportion of the incarcerated criminal justice population.[82] Between 25% and 40% of all individuals with mental illness in the United States will be involved with the criminal justice system.[83] There are a variety of issues that develop with incarcerating mentally ill persons:[84]

- Jail/prison overcrowding resulting from mentally ill prisoners remaining behind bars longer than other prisoners;
- Behavioral issues disturbing to other prisoners and correctional staff;
- Physical attacks on correctional staff and other prisoners;
- Victimization of prisoners with mental illness in disproportionate numbers;
- Deterioration in the psychiatric condition of inmates with mental illness as they go without treatment;
- Relegation in grossly disproportionate numbers to solitary confinement, which worsens symptoms of mental illness;
- Jail/prison suicides in disproportionate numbers;
- Increased taxpayer costs; and
- Disproportionate rates of recidivism.

To address this issue many jurisdictions developed mental health courts.

Mental health court is a type of problem-solving court which provides diversion from jail or prison for people with mental illness. Mental health courts vary widely among jurisdiction on several aspects, including target population, charge accepted (e.g., misdemeanor versus felony), plea arrangement,

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[77] American Bar Association, "Living Wills, Health Care Proxies, & Advance Health Care Directives," *available at* http://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/living_wills_health_care_proxies_advance_health_care_directives.html (last visited on March 20, 2015).
[78] Section 765.101(1), F.S.
[79] Id.
[80] Section 765.101(5)(a), F.S.
[81] Section 765.110(1), F.S.
[82] *Justice and Mental Health Collaboration Program: Fact Sheet*, Nathan James, Congressional Research Service, January 7, 2015. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=3&ved=0CC8QFjAC&url=http%3A%2F%2Ffas.org%2Fsgp%2Fcrs%2Fmisc%2FR43556.pdf&ei=M28LVY_HGcu5ggT3oIK4Dg&usg=AFQjCNHXlUzMTxFIRtesX1sN0fOMbET2NQ (last viewed on March 19, 2015).
[83] *Spending Money in All the Wrong Places: Jails & Prisons*, National Alliance on Mental Illness. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&ved=0CCQQFjAB&url=http%3A%2F%2Fwww.nami.org%2FContent%2FNavigationMenu%2FInform_Yourself%2FAbout_Public_Policy%2FPolicy_Research_Institute%2FPolicymakers_Toolkit%2FSpending_Money_in_all_the_Wrong_Places_Jails.pdf&ei=AUsLVbuFJYqwggSx4IL4BQ&usg=AFQjCNGyeFEsh0IjtQFmjOhUg2R5_keBEA (last viewed on March 19, 2015).
[84] *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, Treatment Advocacy Center, April 8, 2014. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&ved=0CCsQFjAB&url=http%3A%2F%2Ftacreports.org%2Fstorage%2Fdocuments%2Ftreatment-behind-bars%2Ftreatment-behind-bars.pdf&ei=k6QNVa_kDMyUNuPFgrgF&usg=AFQjCNEPJj-cXShX3wvNBRytFIKP2t0bFw (last viewed on March 21, 2015).

intensity of supervision, program duration, and type of treatment available.[85] Despite these differences, mental health courts typically share the following goals:[86]

- To improve public safety by reducing criminal recidivism;
- To improve the quality of life of people with mental illnesses and to increase their participation in effective treatment; and
- To reduce court- and corrections-related costs through administrative efficiencies and often by providing an alternative to incarceration.

Florida does not currently have a codified statewide mental health court program. Instead, each local jurisdiction has the authority to establish a mental health court. As a result, eligibility, program requirements, and other processes differ among the various mental health courts. For example, in order to be eligible to participate in Alachua County's Mental Health Court, a defendant must be diagnosed with a mental illness or developmental disability and be arrested for a misdemeanor or criminal traffic offense.[87] However, in order to be eligible to participate in Nassau County's Mental Health Court, the defendant must have an Axis I mental health diagnosis and have been charged with non-violent misdemeanors. Nassau County's Mental Health Court may also consider third degree felony convictions.[88] As of October 2014, there were 26 mental health courts operating in 16 counties.[89]

Child Welfare

DCF is responsible for the administration of Florida's child welfare program. The goals of the child welfare program are:[90]

- The prevention of separation of children from their families;
- The protection of children alleged to be dependent or dependent children including provision of emergency and long-term alternate living arrangements;
- The reunification of families who have had children placed in foster homes or institutions;
- The permanent placement of children who cannot be reunited with their families or when reunification would not be in the best interest of the child;
- The transition to self-sufficiency for older children who continue to be in foster care as adolescents;
- The preparation of young adults that exit foster care at age 18 to make the transition to self-sufficiency as adults; and
- The prevention and remediation of the consequences of substance abuse on families.[91]

To advance the goal of combating substance abuse in families, ss. 39.507, F.S., and 39.512, F.S., authorize dependency courts to order an individual undergo a substance abuse disorder assessment. The statutes additionally authorize a dependency court to order an individual to participate in and comply with a treatment-based drug court program.[92] Treatment-based drug court is an alternative to incarceration for defendants who enter the judicial system because of addiction and consists of an intensive, judicially monitored treatment program. [93]

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[85] *Supra*, footnote 80.
[86] FLORIDA COURTS, *Mental Health Courts*, http://www.flcourts.org/resources-and-services/court-improvement/problem-solving-courts/mental-health-courts.stml (last viewed Mar. 16, 2015).
[87] OFFICE OF THE STATE ATTORNEY EIGHTH JUDICIAL CIRCUIT, *Alachua County Mental Health Court*, http://sao8.org/Mental%20Health.htm (last viewed Mar. 16, 2015). Those charged with domestic violence, driving under the influence, and sexual offenses are excluded from the program. However, Alachua County does provide certain exemptions for defendants charged with certain crimes.
[88] NASSAU COUNTY MENTAL HEALTH COURT, Eligibility And Referral, http://www.ncmhc.org/default.cfm?page=eligibility (last viewed Mar. 16, 2015).
[89] FLORIDA COURTS, *Mental Health Courts*, http://www.flcourts.org/resources-and-services/court-improvement/problem-solving-courts/mental-health-courts.stml (last viewed Mar. 16, 2015).
[90] *Child Welfare*, Department of Children and Families. http://www.myflfamilies.com/service-programs/child-welfare (last visited on March 21, 2015).
[91] Section 39.001(6), F.S.
[92] Sections 39.507, F.S., and 39.512, F.S.
[93] *Drug Court*, First Judicial Circuit Court of Florida. http://www.firstjudicialcircuit.org/programs-and-services/drug-court (last viewed on March 21, 2015).

Social Work, Therapy and Counseling Interns

In Florida, an individual may register as an intern in clinical social work, marriage and family therapy, or mental health counseling. Registering as an intern enables an individual to gain the required postgraduate or postmaster's clinical experience that is required for full licensure. Currently, 1,500 hours of face-to-face psychotherapy is required, which may not be accrued in fewer than 100 weeks.[94]

An applicant seeking registration as an intern must:[95]

- Submit the application form and the nonrefundable fee;
- Complete the education requirements;
- Submit an acceptable supervision plan for meeting the practicum, internship, or field work required for licensure that was not satisfied by graduate studies; and
- Identify a qualified supervisor.

Currently, an intern may renew his or her registration every biennium, with no limit on the number of times a registration may be renewed.

A provisional license allows individual practice, under supervision a licensed mental health professional, while not meeting all of the clinical experience requirements. Individuals must met minimum coursework requirements, and possess the respective graduate degree. A provisional license is valid for 2 years.[96]

Effect of the Proposed Changes

Substance Abuse and Mental Health Program

Section 394.492 establishes the definitions to be used for the child and adolescent mental health system of care funded by DCF. Section 394.492 (1),(4) and (6) respectively define "adolescent", "child or adolescent at risk of emotional disturbance" and "child or adolescent who has a serious emotional disturbance or mental illness" as involving an individual under 18 years of age. The bill amends these subsections to extend the qualifying age from under 18 years of age to under 21 years of age. This aligns the definitions for the state program with Medicaid definitions and the age at which most individuals no longer qualify for extended foster care.

The bill creates section 397.402, F.S., which requires DCF and the Agency for Health Care Administration (AHCA) to develop a plan for modifying licensure statutes and rules to provide options for a single, consolidated license for a provider that offers multiple types of mental health and substance abuse services regulated under chapters 394 and 397. The plan must identify options for license consolidation within DCF and AHCA, as well as identify inter-agency license consolidation options. The bill requires DCF and AHCA to submit the plan to the Governor, President of the Senate, and Speaker of the House of Representatives by November 1, 2015.

Behavioral Health Managing Entities

The bill amends s. 394.9082(4)(a), F.S., to allow, in limited circumstances, entities other than nonprofit organizations to serve as managing entities and coordinated care organizations. DCF must first attempt to contract with nonprofit organizations for the delivery of these services. If fewer than two responsive bids are received to a solicitation, DCF must reissue the solicitation, and managed behavioral health organizations will be eligible to bid in addition to nonprofit organizations. However, the bill requires all

[94] Rule 64B4-2.001, F.A.C.
[95] Section 491.005, F.S.
[96] Section 491.0046, F.S. and Rule 64B-3.0075, F.A.C.

for-profit and not-for-profit contractors serving as managing entities and coordinated care organizations to operate under the same contractual requirements.

The bill defines “managed behavioral health organization” as a Medicaid managed care organization currently under contract with the Medicaid managed medical assistance program in this state pursuant to part IV of ch. 409 or a behavioral health specialty managed care organization established pursuant to part IV of chapter 409. The bill amends the definition of “managing entity” to include “managed behavioral health organization”, and nonprofit organizations which have not transitioned to being coordinated care organizations.

The bill requires improved coordination of behavioral health and primary care services through the development and effective implementation of coordinated care organizations. The bill establishes the essential services which a coordinated care organization must include or coordinate with other entities to provide. DCF is required to designate the regional network as a coordinated care organization after formal written agreements establishing common standards and protocols among the providers have been executed by the providers.

The bill requires DCF to negotiate a 5-year performance-based contract with each managing entity by July 1, 2016, requiring managing entities to transition to coordinated care organizations by 2019. DCF is authorized to levy penalties against managing entities that fail to timely plan and transition into a coordinated care organization or to meet other specific performance standards.
The bill amends s. 394.9082(6)(d), F.S., to require managing entities to provide certain core functions, which include, among others, consumer care coordination. The bill requires managing entities, within available resources, to contract for the provision of care coordination to facilitate the appropriate delivery of behavioral health care services for specific target populations:

- **Priority Population I**- Individuals with serious mental illness or substance abuse disorders who have been admitted multiple times to acute levels of care, state mental health treatment facilities, jails, or prison;
- **Priority Population II**-
    - Individuals in receiving facilities or crisis stabilization units who are on the waitlist to a state treatment facility;
    - Individuals in state treatment facilities who are on the wait list for community-based care;
    - Children who are involved in the child welfare system but are not in out-of-home care;
    - Parents or caretakers of children who are involved in the child welfare system; and
    - Individuals who account for a disproportionate amount of behavioral health expenditures; and
- **Priority Population III**- Other individuals eligible for services.

The care coordination must address the holistic needs of the consumer. This includes coordination with other local systems and entities, public and private, that are involved with the consumer, such as primary health care, child welfare, behavioral health care, and criminal and juvenile justice. To the extent allowable by available resources, support services provided through care coordination may include:

- Supportive housing;
- Supported employment;
- Family support and education;
- Independent living skill development;
- Peer support;
- Wellness management and self-care; and
- Case management.

The bill amends s. 394.9082(6)(e), F.S., to require managing entities and coordinated care organizations to work with the civil court system to develop procedures for the evaluation and use of involuntary outpatient placement for individuals as a strategy for diverting future admissions to acute levels of care, jails, prisons, and forensic facilities, subject to the availability of funding for services.

The bill amends s. 394.9082(6)(f), F.S., to allow DCF to develop additional data points which the managing entities and coordinated care organizations must collect and submit, in addition to the required data points of persons served, outcomes of persons served, and the costs of services provided through the department's contract. The managing entities and coordinated care organizations must report outcomes for all clients who have been served through the contract as long as they are clients of a network provider. DCF, to the extent possible, must use applicable measures based on nationally recognized standards such as the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's National Outcome Measures or those developed by the National Quality Forum, the National Committee for Quality Assurance, or similar credible sources.

The bill additionally amends s. 394.9082(6)(f), F.S., to require DCF to work with managing entities and coordinated care organizations to establish additional performance measures related to, at a minimum:

- The improvement in the overall behavioral health of a community;
- The improvement in functioning or progress in recovery of individuals served through care coordination;
- Success of strategies to divert admissions to acute levels of care.

The bill requires the method of paying managing entities and coordinated care organizations to include submission of complete and accurate data before they receive payment. It also requires consequences for performance failure.

The bill requires managing entities that are not managed behavioral health organizations to include representatives of law enforcement, the courts, and the community-based care lead agency, as well as individuals with business expertise, on its governance board. Managing entities and coordinated care organizations must create a transparent process for nomination and selection of board members with staggered term limits not exceeding 8 consecutive years. Managing entities and coordinated care organizations must also establish a technical advisory panel consisting of providers of mental health and substance abuse services under contract with the managing entity, of which one member will serve as a non-voting member of the managing entity board. If the managing entity is a managed behavioral health organization, it must have an advisory board that meets the requirements of s. 394.9082(7)(a), F.S. The bill requires the technical advisory panel and the advisory board of a managed behavioral health organization to make recommendations to DCF about the renewal of the managing entity's or coordinated care organization's contract or the award of a new contract to the managing entity or coordinated care organization.

The bill provides managing entities and coordinated care organizations flexibility to determine their network participants but requires them to have a process for publicizing opportunities for providers to join the network and evaluating to determine whether a provider may be part of its network.

The bill also deletes a variety of obsolete requirements, primarily those relating to the transition to the managing entity structure. Some examples are provisions addressing the initial funding for managing entities, the phase-in of their responsibilities, and reporting on the transition.

Study

The bill requires DCF to contract for a two-part study of the safety-net system with an entity with expertise in behavioral healthcare and health systems planning and administration. An interim report, due November 1, 2015, will review and provide recommendations about:

- The system's current operation and performance,
- Payment methodologies,
- Mechanisms for increased coordination between the safety-net system and other systems and funders providing mental health and substance abuse services ; and

- Performance measures.

A final report, due November 30, 2016, will also address:

- Populations that state law requires the safety-net system to serve,
- The sufficiency of the behavioral health workforce,
- Strategies to increase flexibility in providing services;
- Requirements for competency restoration;
- Involuntary commitment, including advantages and disadvantages of combining the Baker Act and Marchman Acts.

Revenue Maximization

The bill creates s. 394.761, F.S., which requires AHCA and DCF to develop a plan to obtain federal approval for increasing the availability of federal Medicaid funding for behavioral health care. The plan must identify the amount of general revenue funding appropriated for mental health and substance abuse services which is eligible to be used as state Medicaid match. The plan must also evaluate alternative uses of increased Medicaid funding and identify the advantages and disadvantages of each alternative. AHCA and DCF are required to submit the written plan to the President of the Senate and the Speaker of the House of Representatives no later than November 1, 2015.

Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program

The bill amends s. 394.656, F.S., and converts the Statewide Grant Review Committee to the Statewide Grant Policy Committee. The Policy Committee will consist of the existing members of the Review Committee and the following representatives:

- One representative of the Department of Veterans' Affairs;
- One representative of the Florida Sheriffs Association;
- One representative of the Florida Police Chiefs Association;
- One representative of the Florida Association of Counties;
- One representative of the Florida Alcohol and Drug Abuse Association;
- One representative of the Florida Association of Managing Entities;
- One representative of the Florida Council for Community Mental Health, and
- One administrator of a state-licensed limited mental health assisted living facility.

The Policy Committee will serve as the advisory body to review policy and funding issues that help reduce the impact of persons with mental illnesses and substance use disorders on communities, criminal justice agencies, and the court system. The bill requires DCF to create a grant review and selection committee which will be responsible for evaluating grant applications and selecting recipients. The grant review and selection committee will notify DCF of its selections.

Currently under s. 394.656, F.S., only a county or a consortium of counties may apply for a grant under the Program. The bill amends this section to additionally allow a county planning council or committee to designate a not-for-profit community provider, a managing entity or a coordinated care organization to apply for a grant. A not-for-profit community provider, coordinated care organization and a managing entity must have express, written authorization from the county to apply for a grant to ensure local matching funds are available.

The bill amends s. 394.656, F.S., to authorize DCF to require, at its discretion, an applicant to conduct sequential intercept mapping for a project. The bill defines sequential intercept mapping as a process for reviewing a local community's mental health, substance abuse, criminal justice, and related systems and identifying points of interceptions where interventions may be made to prevent an individual with a substance use disorder or mental illness from penetrating further into the criminal justice system.

Florida Mental Health Act

Guardian Advocate

Section 394.4598(1), F.S., of the Baker Act, permits only an administrator of a receiving or treatment facility may petition the court for the appointment of a guardian. The bill amends this section to allow a family member of the patient or an interested party, in addition to the administrator of a receiving or treatment facility, to petition the court for the appointment of a guardian advocate.

Involuntary Inpatient Placement

Section 394.467(6)(b) requires the court to order an individual to receive services from a receiving or treatment facility, on an involuntary basis, for a period of up to 6 months. The bill amends this section to prohibit courts from ordering an individual with traumatic brain injury or dementia, who lacks a co-occurring mental illness, to be involuntarily placed in a state treatment facility.

Receiving Facilities

The bill creates the Crisis Stabilization Services Utilization Database. The bill directs DCF to develop, implement, and maintain standards under which a behavioral health managing entity must collect utilization data from all public receiving facilities within its geographic service area. The bill defines "public receiving facility" as an entity that meets the licensure requirements of and is designated by DCF to operate as a public receiving facility under s. 394.875, F.S., and which is operating as a licensed crisis stabilization unit.

DCF must develop standards and protocols to be used by managing entities, coordinated care organizations and public receiving facilities for the collection, storage, transmittal, and analysis of data. The standards and protocols must allow for compatibility of data and data transmittal between public receiving facilities, managing entities, and DCF. Managing entities and coordinated care organizations must comply with these requirements by August 1, 2015.

A managing entity or coordinated care organization must require a public receiving facility within its provider network to submit data, in real time or at least daily, for:

- All admissions and discharges of clients receiving public receiving facility services who qualify as indigent as defined in s. 394.4787, F.S.; and
- Current active census of total licensed beds, the number of beds purchased by DCF, the number of clients qualifying as indigent occupying those beds, and the total number of unoccupied licensed beds regardless of funding.

A managing entity or coordinated care organization must require a public receiving facility within its provider network to submit data on a monthly basis which aggregates the daily data previously submitted. The managing entity or coordinated care organization must reconcile the data in the monthly submission to the daily data to check for consistency. If the monthly aggregate data is inconsistent with the daily data, the managing entity or coordinated care organization must consult with the public receiving facility to make corrections as necessary to ensure accurate data.

A managing entity or coordinated care organization must require a public receiving facility within its provider network to submit data on an annual basis which aggregates the monthly data previously submitted. The managing entity or coordinated care organization must reconcile the data in the annual submission to the monthly data to check for consistency. If the annual aggregate data is inconsistent with the monthly data, the managing entity or coordinated care organization must consult with the public receiving facility to make corrections as necessary to ensure accurate data.

After ensuring accurate data, the managing entity or coordinated care organization must submit the data to DCF on a monthly and annual basis. The bill requires DCF to use the reconciled data to develop a statewide database for the purpose of analyzing payments to and use of state-funded crisis stabilization services. The database must allow for analysis on both a statewide and individual public receiving facility basis.

The bill requires DCF to adopt rules and submit a report by January 31, 2016, and annually thereafter, to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report must contain details on the bill's implementation, including the status of the data collection process, and an analysis of the data collected.

Social Work, Therapy and Counseling Interns

Section 491.0045, F.S., does not limit the number of times an individual may renew his or her intern registration. The bill amends this section and limits the validity of an intern registration to five years. The bill also prohibits renewal of an intern registration unless the individual has passed the theory and practice examination for clinical social work, marriage and family therapy, or mental health counseling.

The bill provides that a person who holds a provisional license may not apply for intern registration in the same profession; which closes an avenue that may be utilized by some to lengthen the time period to practice in the field, once the intern registration expires in 5 years, without obtaining full licensure.

Advance Directives

Section 765.110, F.S., requires specified health care facilities to provide each patient written information concerning the patient's rights relating to advance directives. The bill amends this section to require the health care facilities to also provide written information relating to advance directives for mental health treatment. The bill requires DCF to develop and publish on its website a mental health advance directive form which may be used by an individual to direct future care.

Mental Health Courts

Chapter 39 sets forth the legal requirements for proceedings relating to children. Section 39.001, F.S., expressly states the goals for the state related to substance abuse treatment services in the dependency process. The bill amends this section to include mental illness treatment services as an element of the goals. Sections 39.507, F.S., and 39.512, F.S., authorize dependency courts to order an individual to undergo a substance abuse disorder assessment. These sections also authorize dependency courts to order an individual to participate in and comply with a treatment-based drug court program. The bill amends these sections to authorize dependency courts to order an individual to undergo a mental health disorder assessment and to participate in and comply with a treatment-based mental health court program established under s. 394.47892, F.S.

The bill makes these amendments contingent upon the passage of HB 7113 or similar legislation enacting s. 394.47892, F.S., authorizing the creation of treatment-based mental health court programs.

Repeals

The bill repeals a number of obsolete and duplicative sections of statute, as follows.

- Section 394.4674, F.S., which requires DCF to complete a deinstitutionalization plan. This section was enacted in 1980 and is obsolete following further developments in federal law.
- Section 394.4985, F.S., which requires DCF's regions to develop and maintain an information and referral network. This duplicates other requirements.
- Section 394.745, F.S., which requires an annual report to the Legislature of compliance of substance abuse and mental health treatment providers under contract with DCF.
- Section 397.331, F.S., providing definitions and legislative intent for the Drug Policy Advisory Council, which the bill also repeals.
- Section 397.333, F.S., establishing the Statewide Drug Policy Advisory Council at the Department of Health, which is duplicative of other statewide efforts.
- Section 397.801, F.S., requiring the Departments of Education, Corrections, Law Enforcement and Children and Families to each designate substance abuse impairment coordinators, and for DCF to also designate full-time substance abuse impairment coordinators in each of its regions.

- Section 397.811, F.S., which expresses the Legislature's intent that substance abuse prevention and early intervention programs be funded.
- Section 397.821, F.S., authorizing each judicial circuit to establish juvenile substance abuse impairment prevention and early intervention councils to identify needs. The managing entity now performs these duties.
- Section 397.901, F.S., authorizing DCF to establish prototype juvenile addiction receiving facilities. This section was enacted in 1993, and these projects are completed.
- Section 397.93, F.S., specifying target populations for children's substance abuse services, which duplicates other statutory requirements. This duplicates other provisions of law.
- Section 397.94, F.S., requiring the DCF's regions to plan and provide for information and referral services regarding children's substance abuse services.
- Section 397.951, F.S., requiring DCF to ensure that treatment providers use sanctions provided elsewhere in law to keep children in substance abuse treatment.
- Section 397.97, F.S., creating the Children's Network of Care Demonstration Models and authorizing their operation for four years. These were originally established in 1999.

B. SECTION DIRECTORY:

Section 1: Amends s. 39.001, F.S., relating to purposes and intent; personnel standards and screening for proceedings relating to children.
Section 2: Amends s. 39.507, F.S., relating to adjudicatory hearings and orders of adjudication for proceedings relating to children.
Section 3: Amends s. 39.521, F.S., relating to disposition hearings and powers of disposition for proceedings relating to children.
Section 4: Amends s. 394.4598, F.S., relating to guardian advocates.
Section 5: Amends s. 394.367, F.S., relating to involuntary inpatient treatment.
Section 6: Amends s. 394.492, F.S., relating to definitions for comprehensive child and adolescent mental health services.
Section 7: Amends s. 394.656, F.S., relating to the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program
Section 8: Creates s. 394.761, F.S., relating to revenue maximization.
Section 9: Amends s. 394.9082, F.S., relating to behavioral health managing entities
Section 10: Requires a study of the safety-net mental health and substance abuse system.
Section 11: Creates s. 397.402, F.S., relating to single, consolidated licensure.
Section 12: Amends s. 491.0045, F.S., relating to intern registration requirements.
Section 13: Amends s. 765.110, F.S., relating advance directives for mental health treatment.
Section 14: Repeals Sections 394.4674, 394.4985, 394.745, 394.9084, 397.331, 397.333, 397.801, 397.811, 397.821, 397.901, 397.93, 397.94, 397.951, 397.97, and 397.98, F.S.
Section 15: Amends s. 394.657, F.S., relating to county planning councils or committees.
Section 16: Amends 394.658, F.S. relating to the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant program.
Section 17: Amends s. 397.321, F.S, relating to duties of the department.
Section 18: Amends s. 343.031, F.S., relating to the Florida Violent Crime and Drug Control Council.
Section 19: Amends s. 343.042, F.S., relating to the Violent Crime Investigative Emergency and Drug Control Strategy Implementation Account.
Section 20: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

There will indeterminate costs to DCF for the study of the safety-net mental health and substance abuse system required by section 10 of the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

Infrastructure upgrades are required for five managing entities to comply with the expanded CSU reporting requirements contained within the bill. House Bill 79 includes identical provisions and provides a nonrecurring appropriation of $175,000 from the Alcohol, Drug Abuse, and Mental Health Trust Fund for these infrastructure upgrades.

The House proposed General Appropriations Act (GAA) includes a nonrecurring appropriation of $200,000 to DCF to contract with an university or research organization to review Florida's mental health and substance abuse prevention and treatment framework, and to make recommendations on topics such as payment methodologies, the integration of services provided in different provider settings or funded by multiple sources, and a review of existing or proposed performance measures. A report on such review and recommendations is due by November 30, 2015.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 24, 2015, the Children, Families & Seniors Subcommittee adopted four amendments to PCB CFSS 15-01. The amendments:

- Add the administrator of a state-licensed limited mental health assisted living facility to the membership of the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Policy Committee;
- Specify that managing entities may apply for Criminal Justice, Mental Health, and Substance Abuse Reinvestment grants in the same way as non-profit organizations;
- Amend the definition of “managed behavioral health organizations” to limit them to managed care organizations under contract with the Medicaid managed medical assistance program and to managed behavioral health organizations; and
- Add children involved in the child welfare system who are not in out-of-home care to the list of groups prioritized to receive care coordination.

On April 9, 2015, the Health & Human Services Committee adopted an amendment to HB 7119. The amendment:

- Deletes the exclusion of dementia and traumatic brain injury from the definition of "mental illness" and prohibits courts from ordering an individual with traumatic brain injury or dementia, who lacks a co-occurring mental illness, to be involuntarily placed in a state treatment facility.
- Adds a representative of the Florida Association of Managing Entities to the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program policy committee.
- Requires improved coordination of behavioral health and primary care services through the development and effective implementation of coordinated care organizations.
    - Requires all for-profit and not-for-profit contractors serving as managing entities or coordinated care organizations to operate under the same contractual requirements.
    - Requires DCF to negotiate a 5-year performance-based contract with each managing entity by July 1, 2016, requiring managing entities to transition to coordinated care organizations by 2019.
    - Authorizes penalties for managing entities that fail to timely plan and transition into a coordinated care organization or to meet other specific performance standards.
    - Requires DCF to designate the regional network as a coordinated care organization after formal written agreements establishing common standards and protocols among the providers have been executed by the providers.

    - Establishes the essential services which a coordinated care organization must include or coordinate with other entities to provide.
- Revises prioritization of populations for consumer care coordination.
- Requires managing entities and coordinated care organizations to create a transparent process for nomination and selection of board members with staggered term limits not exceeding 8 consecutive years on the governing board.
- Requires managing entities and coordinated care organizations to establish a technical advisory panel consisting of providers of mental health and substance abuse services under contract with the managing entity, of which one member will serve as a non-voting member of the managing entity board.
- Requires the technical advisory panel and the advisory board of a managed behavioral health organization to make recommendations to DCF about the renewal of the managing entity's contract or the award of a new contract to the managing entity.
- Requires ACHA and DCF to present a plan with options for streamlining licensure for those entities with multiple licensed components but does not require implementation.
- Limits an intern registration for a clinical social worker intern, marriage and family therapist intern, or mental health counselor intern to five years.
- Deletes the repeal of the Florida Self-Directed Care program.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.