

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 12

INTRODUCER: Senator Garcia

SUBJECT: Mental Health and Substance Abuse

DATE: January 13, 2016

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	Pre-meeting
2.	_____	_____	AHS	_____
3.	_____	_____	AP	_____

I. SUMMARY:

SB 12 addresses the current system of behavioral health services which is fragmented and inefficient and makes it difficult for persons with complex, persistent and co-occurring disorders pertaining to mental illness and substance use disorder to obtain needed services.

The bill provides for mental health services for children, parents and others seeking custody of children involved in dependency court proceedings. The bill creates a coordinated system of care to be provided either by a community or a region for those suffering from mental illness or substance use disorder through a “No Wrong Door” system of single access points. The Agency for Health Care Administration (“the agency” or “AHCA”) and the Department of Children and Families (“the department” or “DCF”) are directed to modify licensure requirements to create an option for a single, consolidated license to provide both mental health and substance use disorder services. Additionally, the agency and the department are to develop a plan to increase federal funding for behavioral health care.

The bill directs that a transportation plan be developed and implemented in each county or group of counties. The plan must specify methods of transport to a facility within the designated receiving system and may delegate responsibility for other transportation to a participating facility when necessary and agreed to by the facility.

To the extent possible, the bill aligns the legal processes, timelines and processes for assessment, evaluation and receipt of available services of the Baker Act (Mental Illness) and Marchman Act (Substance Abuse) to assist individuals in recovery and reduce readmission to the system.

The duties and responsibilities of the department are revised and updated to include designation of facilities within the receiving system; specify data reporting and use of shared data systems within the system; set performance measures and standards for managing entities and enter into contracts with the managing entities that support efficient and effective administration of the behavioral health system and ensure accountability for performance.

The duties and responsibilities of the managing entities are revised and updated. Each managing entity is to conduct a community behavioral health care needs assessment in their geographic region which must include the information needed by the department for its annual report to the Governor and the Legislature. Additionally, the managing entities are to provide assistance to counties to develop a designated receiving system and transportation plan; enter into cooperative agreements with local homeless councils and organizations to share data and other information that is useful in addressing the homelessness of persons suffering from a behavioral health crisis; develop a comprehensive network of qualified providers to deliver behavioral health services; provide or contract for case management services; collaborate with local criminal and juvenile justice systems to divert persons with mental illness, substance use disorder, or both from the criminal justice system; collaborate with local court systems to develop procedures to maximize the use of involuntary outpatient services, reduce involuntary inpatient treatment and increase diversion from the criminal justice system; and promote integration of behavioral health with primary care.

The bill has an effective date of July 1, 2016.

II. Present Situation:

Mental Health and Substance Abuse

Mental illness creates enormous social and economic costs.¹ Unemployment rates for persons with mental disorders are high relative to the overall population.² People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent.³ Mental illness increases a person's risk of homelessness in America threefold.⁴ Studies show that approximately 33 percent of our nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are not receiving treatment.⁵ 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 re-offenses.⁶

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.⁷ NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.⁸ When mental health disorders are left untreated, substance abuse is likely to increase. When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the

¹ Mental Illness: The Invisible Menace, *Economic Impact* <http://www.mentalmenace.com/economicimpact.php>

² Mental Illness: The Invisible Menace, *More impacts and facts* <http://www.mentalmenace.com/impactsfacts.php>

³ *Id.*

⁴ Family Guidance Center, *How does Mental Illness Impact Rates of Homelessness?* (February 4, 2014) available at <http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/>

⁵ *Id.*

⁶ *Id.*

⁷ Donna M. White, LPCI, CACP, Psych Central.com, *Living with Co-Occurring Mental & Substance Abuse Disorders*, (October 2, 2013) available at <http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occurring-mental-substance-abuse-disorders/>

⁸ *Id.*

contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.⁹

Behavioral Health Managing Entities

In 2008, the Legislature required the department to implement a system of behavioral health managing entities that would serve as regional agencies to manage and pay for mental health and substance abuse services.¹⁰ Prior to this time, the department, through its regional offices, contracted directly with behavioral health service providers. The Legislature found that a management structure that places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level, would promote improved access to care, promote service continuity, and provide for more efficient and effective delivery of substance abuse and mental health services. There are currently seven managing entities across the state.¹¹

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.¹² 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.¹³ Unemployment rates for persons having mental disorders are high relative to the overall population.¹⁴ Rates of unemployment for people having a severe mental illness range between 60 percent and 100 percent.¹⁵ Mental illness increases a person's risk of homelessness in America threefold.¹⁶ Approximately 33 percent of the nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are untreated.¹⁷ 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.¹⁸

⁹ *Id.*

¹⁰ See s. 394.9082, F.S., as created by Chapter 2008-243, Laws of Fla.

¹¹ Department of Children and Families website, <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities>, (last visited Jan. 11, 2016).

¹² Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.

¹³ MentalMenace.com, *Mental Illness: The Invisible Menace; Economic Impact*, <http://www.mentalmenace.com/economicimpact.php> (last visited Jan. 11, 2016).

¹⁴ MentalMenace.com, *Mental Illness: The Invisible Menace: More impacts and facts*, <http://www.mentalmenace.com/impactsfacts.php> (last visited Jan. 11, 2016).

¹⁵ *Id.*

¹⁶ 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/>.

¹⁷ *Id.*

¹⁸ *Id.*

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.

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.¹⁹

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.²⁰

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 available bed.²¹ 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.²²

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.²³

¹⁹ Section 397.6795, F.S.

²⁰ Section 394.462(1)(f) and (g), F.S.

²¹ Section 397.6772(1), F.S.

²² Section 394.459(1), F.S.

²³ Section 397.675, F.S.

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.²⁴ 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.²⁵ If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.²⁶

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.²⁷ The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.²⁸ 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.²⁹

Under the Marchman Act, if the court grants the petition for involuntary admission, the person may be admitted for a period of five days to a facility for involuntary assessment and stabilization.³⁰ If the facility needs more time, the facility may request a seven-day extension from the court.³¹ Based on the involuntary assessment, the facility may retain the person pending a court decision on a petition for involuntary treatment.³²

Under the Baker Act, the court must hold a hearing on involuntary inpatient or outpatient placement within five working days after a petition for involuntary placement is filed.³³ 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

²⁴ Section 397.677, F.S.

²⁵ Section 397.6771, F.S.

²⁶ Section 397.6772(1), F.S.

²⁷ Section 397.6773(1) and (2), F.S.

²⁸ Section 394.463(2)(f), F.S.

²⁹ Section 394.463(2)(i)4., F.S.

³⁰ Section 397.6811, F.S.

³¹ Section 397.6821, F.S.

³² Section 397.6822, F.S.

³³ Sections 394.4655(6) and 394.467(6), F.S.

- 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.³⁴

III. Effect of Proposed Changes:

Section 1 amends s. 29.004, F.S., to allow courts to use state revenue to provide case management services such as service referral, monitoring and tracking for mental health programs under s. 394, F.S.

Section 2 amends s. 39.001(6), F.S., to include mental health treatment in dependency court services and directs the state to contract with mental health service providers to such services.

Section 3 amends s. 39.507(10), F.S., to allow the dependency court to order a person requesting custody of a child to submit to a mental health or substance abuse disorder assessment or evaluation, require participation of such person in a mental health program or a treatment-based drug court program and to oversee the progress and compliance with treatment by the person who has custody or is requesting custody of a child.

Section 4 amends s. 39.521(1)(b), F.S., to allow a court, with jurisdiction of a child that has been adjudicated dependent, to require the person who has custody or is requesting custody of the child to submit to a mental illness or substance abuse disorder assessment or evaluation, to require the person to participate in and comply with the mental health program or drug court program and to oversee the progress and compliance by the person who has custody or is requesting custody of a child.

Section 5 amends s. 394.455, F.S., to add, update or revise definitions as appropriate.

Section 6 amends s. 394.4573, F.S., to create a coordinated system of care in the context of the No Wrong Door model which is defined as a delivery system of health care services to persons with mental health or substance abuse disorders, or both, which optimizes access to care, regardless of the entry point to the system.

This section also defines a coordinated system of care to mean the full array of behavioral and related services in a region or community offered by all service providers whether under contract with the managing entity or another method of community partnership or mutual agreement.

Additionally, the department is required to submit, on or before October 1 of each year, an annual assessment of the behavioral health services in the state to the Governor and the Legislature. The assessment must include comparison of the status and performance of behavioral health systems, the capacity of contracted services providers to meet estimated needs, the degree to which services are offered in the least restrictive and most appropriate therapeutic

³⁴ Section 394.467(1), F.S.

environment; and the scope of systemwide accountability activities used to monitor patient outcomes and measure continuous improvement of the behavioral health system.

This section allows the department, subject to a specific appropriation by the Legislature, to award system improvement grants to managing entities based on the submission of detailed plans to enhance services, coordination, or performance measurement in accordance with the No Wrong Door model. The grants must be awarded through a performance-based contract that links payments to documented and measurable system improvements.

The essential elements of a coordinated system of care are in this section are to include community interventions, a designated receiving system that consists of one or more facilities serving a defined geographic area which may be organized in different ways to fit the needs of the geographic area so long as it functions as a No Wrong Door model, transportation, crisis services, case management, including intensive case management, and various other services including specific service for recovery support.

Section 7 amends s. 394.4597(2)(d) and (e), F.S., to specify those persons who are prohibited from being named as a patient's representative, when the receiving or treatment facility is selecting the representative.

Section 8 amends s. 394.4598(2) through (7), F.S., to specify those persons who are prohibited from appointment as a patient's guardian advocate when a court has determined that a person is incompetent to consent to treatment but the person has not been adjudicated incapacitated. This section also sets out the training requirements for persons appointed as guardian advocates.

Section 9 amends s. 394.462, F.S., to direct that a transportation plan must be developed and implemented in each county or, if applicable, counties that intend to share a transportation plan. The plan must specify methods of transport to a facility within the designated receiving system and may delegate responsibility for other transportation to a participating facility when necessary and agreed to by the facility. The plan must ensure that persons meeting the criteria for involuntary assessment and evaluation pursuant to s. 394.463 and 397.675 will be transported. For the transportation of a voluntary or involuntary patient to a treatment facility, the plan established by the county or counties must specify how the hospitalized patient will be transported to, from, and between facilities.

Section 10 amends s. 394.463(2), F.S., to allow a circuit or county court to enter an ex parte order stating that a person appears to meet the criteria for involuntary examination. The ex parte order must be based on written or oral sworn testimony that includes specific facts supporting the findings. Facilities accepting patients based on ex parte orders must send a copy of the order to the department and the managing entity in its region the next working day. A facility admitting a person for involuntary examination who is not accompanied by an ex parte order shall notify the department and the managing entity the next working day.

This section also adds language that a person may not be held for involuntary examination for more than 72 hours without specified actions being taken.

Section 11 amends s. 394.4655, F.S., to allow a court to order a person to involuntary outpatient services, upon a finding by clear and convincing evidence, that the person meets the criteria specified. The recommendation by the administrator of a facility of a person for involuntary outpatient services must be supported by two qualified professionals, both of whom have personally examined the person within the preceding 72 hours. A court may not order services in a proposed treatment plan which are not available. The service provider must document its inquiry with the department and the managing entity as to the availability of the requested services and the managing entity must document its efforts to obtain the requested services.

Section 12 amends s. 394.467, F.S., to add to the criteria for involuntary inpatient placement for mental illness the present threat of substantial physical or mental harm to a person's well-being.

Section 13 amends s. 394.46715, F.S., to provide the department rulemaking authority.

Section 14 creates s. 394.761, F.S., to direct the agency and the department to develop a plan to obtain federal approval for increasing availability of federal funding for behavioral health care. Increased funding is to be used to advance the goal of improved integration of behavioral health and primary care services. The plan is to be submitted to the President of the Senate and the Speaker of the House of Representatives by November 1, 2016.

Section 15 creates ss. (11) to s. 394.875, F.S., to direct the department, by January 1, 2017, to modify licensure rules and procedures to create an option for a single, consolidated license for a provider who offers multiple types of mental health and substance abuse services regulated under ch. 394 and ch. 397.

Section 16 amends s. 394.9082, F.S., to revise and update the duties and responsibilities of the managing entities and the department; to provide definitions; contracting requirements and accountability.

The department's duties and responsibilities are revised to include the designation of facilities into the receiving system developed by one or more counties; contract with the managing entities; specify data reporting and use of shared data systems; develop strategies to divert persons with mental illness or substance abuse disorders from the criminal and juvenile justice system; support the development and implementation of a coordinated system of care to require providers receiving state funds through a direct contract with the department to work with the managing entity to coordinate the provision of behavioral health services; set performance measures and standards for managing entities; to develop a unique identifier for clients receiving services; and to coordinate procedures for referral and admission of patients to, and discharge from, state treatment facilities.

This section sets out the department's duties regarding its contracts with the managing entities. The contracts must support efficient and effective administration of the behavioral health system and ensure accountability for performance. The managing entities' contracts are subject to performance review beginning July 1, 2018, which review must include, analysis of the managing entities' performance measures; the results of the department's contract monitoring and related performance and compliance issues. Based on a satisfactory performance review, the department may negotiate with the managing entity for a 4 year contract pursuant to s.

287.057(3)(e), F.S. If a managing entity does not meet the requirements of the performance review, the department must create a corrective action plan. If the corrective action plan is not satisfactorily completed by the managing entity, the department will terminate the contract at the end of the contract term and initiate a competitive procurement process to select a new managing entity.

The revised and updated duties and responsibilities of the managing entities are provided in this section which include conducting an assessment of community behavioral health care needs in its geographic area. The assessment must be updated annually and include, at a minimum, the information the department needs for its annual report to the Governor and Legislature. The managing entities must also develop local resources by pursuing third-party payments for services, applying for grants, and other methods to ensure services are available and accessible; provide assistance to counties to develop a designated receiving system and a transportation plan; enter into cooperative agreements with local homeless councils and organizations to address the homelessness of persons suffering from a behavioral health crisis; provide or contract for case management; collaborate with local criminal and juvenile justice systems to divert persons with mental illness or substance abuse disorders, or both, from the criminal and juvenile justice systems.

Section 17 amends s. 397.311, F.S., to create a definition for involuntary services, and revise the definition of qualified professional.

Section 18 amends s. 397.675, F.S., to revise the criteria for assessment, stabilization and involuntary treatment for persons with a substance abuse or co-occurring mental health disorder to include that without care or treatment, the person is likely to suffer from neglect or to refuse to care for himself or herself and that neglect or refusal poses a real and present threat of substantial harm to his or her well-being.

Section 19 amends s. 397.679, F.S., to expand the professionals who may execute a certificate for application for emergency admission of a person to a hospital or licensed detoxification facility to include a physician, an advanced registered nurse practitioner, a clinical psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed mental health counselor, a physician assistant working under the scope of practice of the supervising physician or a master's level certified addictions professional, if the certificate is specific to substance abuse disorders.

Section 20 amends s. 397.6791, F.S., to expand the professionals who may initiate a certificate for emergency assessment or admission of a person who may meet the criteria for substance abuse disorder to include a physician, an advanced registered nurse practitioner, a clinical psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed mental health counselor, a physician assistant working under the scope of practice of the supervising physician or a master's level certified addictions professional, if the certificate is specific to substance abuse disorders

Section 21 amends s. 397.6793, F.S., to revise the criteria for a person to be examined or assessed to include a reasonable belief that without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself and that such neglect or refusal poses a

real and present threat of substantial harm to his or her well-being. The professional's certificate authorizing the involuntary admission of a person is valid for 7 days after issuance.

Section 22 amends s. 397.6795, F.S., to allow a person's spouse or guardian, or a law enforcement officer to deliver a person named in a professional's certificate for emergency admission to a hospital or licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization.

Section 23 amends s. 397.681, F.S., to specify that a court may not charge a filing fee for the filing of a petition for involuntary assessment and stabilization.

Section 24 amends s. 397.6811(1), F.S., to allow a petition for assessment and stabilization to be filed by a person who has direct personal knowledge of a person's substance abuse disorder.

Section 25 amends s. 397.6814, F.S., to remove the requirement that a petition for involuntary assessment and stabilization contain a statement regarding the person's ability to afford an attorney. This section also directs that a fee may not be charged for the filing of a petition pursuant to this section.

Section 26 amends s. 397.6819, F.S., to allow a licensed service provider to admit a person for a period not to exceed 5 days unless a petition for involuntary outpatient services has been initiated pending further order of the court.

Section 27 amends s. 397.695, F.S., to provide for the filing of a petition for involuntary outpatient services and the professionals that must support the recommendation for such outpatient services. If the person has been stabilized and no longer meets the criteria for involuntary assessment and stabilization they must be released while waiting for the hearing. This section provides the service provider to prepare certain reports and a treatment plan, including certification to the court that the recommended services are available. If the services are unavailable, the petition may not be filed with the court.

Section 28 amends s. 397.6951, F.S., to amend the content requirements of the petition for involuntary outpatient services to include the person's history of failure to comply with treatment requirements, is unlikely to voluntarily participate in the recommended services and the person is in need of the involuntary outpatient services.

Section 29 amends s. 397.6955, F.S., updating the duties of the court upon the filing of a petition for involuntary outpatient services to include the requirement to schedule a hearing within 5 days unless a continuance is granted.

Section 30 amends s. 397.6957, F.S., to update the requirements of the court to hear and review all relevant evidence at a hearing for involuntary outpatient services, including the requirement that the petitioner has the burden of proving by clear and convincing evidence that the respondent has a history of lack of compliance with treatment for substance abuse, is unlikely to voluntarily participate in the recommended treatment and without services is likely to suffer from neglect or refuse to care for himself or herself. One of the qualified professionals that executed the involuntary outpatient services certificate must be a witness at the hearing.

Section 31 amends s. 397.697, F.S., to allow courts to order involuntary outpatient services when it finds the conditions have been proven by clear and convincing evidence; however, the court cannot order involuntary outpatient services if the recommended services are not available.

Section 32 amends s. 397.6971, F.S., to reflect the change in terminology from involuntary outpatient treatment to involuntary outpatient services.

Section 33 amends s. 397.6975, F.S., to reflect the change in terminology from involuntary outpatient treatment to involuntary outpatient services.

Section 34 amends s. 397.6977, F.S., to reflect the change in terminology from involuntary outpatient treatment to involuntary outpatient services.

Section 35 creates s. 397.6978, F.S., to allow for the appointment of a guardian advocate for a person determined incompetent to consent to treatment. This section lists the persons prohibited from being appointed the patient's guardian advocate.

Section 36 amends s. 39.407, F.S., to correct cross-references.

Section 37 amends s. 212.055, F.S., to correct cross-references.

Section 38 amends s. 394.4599, F.S., to correct cross-references.

Section 39 amends s. 394.495(3), F.S., to correct cross-references.

Section 40 amends s. 394.496(5), F.S., to correct cross-references.

Section 41 amends s. 394.9085(6), F.S., to correct cross-references.

Section 42 amends s. 397.405(8), F.S., to correct cross-references.

Section 43 amends s. 397.407(1) and (5), F.S., to correct cross-references.

Section 44 amends s. 397.416, F.S., to correct cross-references.

Section 45 amends s. 409.972(1)(b), F.S., to correct cross-references.

Section 46 amends s. 440.102(1)(d),(g), F.S., to correct cross-references.

Section 47 amends s. 744.704(7), F.S., to correct cross-references.

Section 48 amends s. 790.065(2)(a), F.S., to correct cross-references.

Section 49 provides an effective date of July 1, 2016.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

The bill prohibits a filing fee being charged for Marchman Act petitions; however, this does not create a fiscal impact on the clerks of court or the state court system, as no fees are currently assessed.³⁵

B. Private Sector Impact:

Persons appointed by the court as guardian advocates for individuals in need of behavioral health services will have increased training requirements under the bill.

Behavioral health managing entities that have satisfactory contract performance will benefit from the provisions that allow the department to negotiate a new 4 year contract using the exemption provided in s. 287.057(3)(e), F.S.

C. Government Sector Impact:**State**

To the extent that the bill encourages the use of involuntary outpatient services rather than inpatient placement, the state would experience a positive fiscal impact. The cost of care in state treatment facilities is more expensive than community based behavioral health care.

The department has revised duties to review local behavioral health care plans, write or revise rules, and award any grants for implementation of the No Wrong Door policy created in the bill. Similar administrative duties are currently performed by the department so these revised duties are not expected to create a fiscal impact.

³⁵ E-mail received from Florida Court Clerks & Comptroller, Nov. 6, 2015, and on file in the Senate Committee on Children, Families & Elder Affairs.

Local

Local governments must revise their transportation plans for acute behavioral health care under the Baker Act and Marchman Act. The bill requires that as part of the transportation plan for the No Wrong Door policy, transportation be provided between the single point of entry for behavioral health care and other treatment providers or settings as appropriate. This may create a fiscal impact as such services are not currently provided in all areas of the state.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 29.004, 39.001, 39.507, 39.521, 394.455, 394.4573, 394.4597, 394.4598, 394.462, 394.463, 394.4655, 394.467, 394.46715, 394.761, 394.875, 394.9082, 397.311, 397.675, 397.679, 397.6791, 397.6793, 397.6795, 397.681, 397.6811, 397.6814, 397.6819, 397.695, 397.6951, 397.6955, 397.6957, 397.697, 397.6971, 397.6975, 397.6977, 397.6978, 39.407, 212.055, 394.4599, 394.495, 394.496, 394.9085, 397.405, 397.407, 397.416, 409.972, 440.102, 744.704, 790.065

This bill creates the following sections of the Florida Statutes: 394.761, 394.875(11), 397.6978

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.