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 Appropriations Subcommittee on Health and Human Services

BILL:	SB 1336
INTRODUCER:	Senator Latvala
SUBJECT:	Behavioral Health Care Services
DATE:	February 9, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	**Favorable**
2.	Brown	Pigott	AHS	**Pre-meeting**
3.			AP	

I. Summary:

SB 1336 addresses Florida's system for the delivery of behavioral health services when persons with complex, persistent, and co-occurring mental health and substance dependency disorders obtain services.

The bill directs behavioral health managing entities[1] (MEs) to develop a plan with each county or circuit in its geographic area to ensure all persons with mental health or substance use disorders subject to involuntary admission receive prompt assessment of their needs for evaluation and treatment. MEs are to develop a transportation plan for each county or circuit within its assigned region in consultation with county officials, law enforcement agencies, and local acute care providers.

The criteria for involuntary admission, stabilization, and treatment of persons with substance use or mental health disorders are revised. Additionally, the bill specifies certain professionals who are authorized to execute a certificate for emergency admission. The bill prohibits the courts from charging a filing fee for a petition for involuntary assessment and stabilization.

The bill creates the "Jennifer Act" which addresses the use of mental health and substance abuse treatment advance directives, which includes the allowable provisions, the process for the execution and revocation of such directives, and a suggested form to be used.

The bill's fiscal impact is indeterminate.

[1] *See* s. 394.9082, F.S. A managing entity is a not-for-profit corporation organized in Florida which is under contract with the Dept. of Children and Families on a regional basis to manage the day-to-day operational delivery of behavioral health services through an organized system of care and a network of providers who are contracted with the managing entity to provide a comprehensive array of emergency, acute care, residential, outpatient, recovery support, and consumer support services related to behavioral health.

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.[2] Unemployment rates for persons with mental disorders are high relative to the overall population.[3] People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent.[4] Mental illness increases a person's risk of homelessness in America threefold.[5] 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.[6] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future re-offenses.[7]

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.[8] NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.[9] 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 contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[10]

Behavioral Health Managing Entities

In 2008, the Legislature required the Department of Children and Families (DCF) 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.[11] Prior to this time, the DCF, 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

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[2] Mental Illness: The Invisible Menace, *Economic Impact* http://www.mentalmenace.com/economicimpact.php
[3] Mental Illness: The Invisible Menace, *More impacts and facts* http://www.mentalmenace.com/impactsfacts.php
[4] *Id.*
[5] 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/
[6] *Id.*
[7] *Id.*
[8] 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/
[9] *Id.*
[10] *Id.*
[11] *See* s. 394.9082, F.S., as created by Chapter 2008-243, Laws of Fla.

efficient and effective delivery of substance abuse and mental health services. There are currently seven managing entities across the state.[12]

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[13] The Baker Act authorizes treatment programs for mental, emotional, and behavioral disorders. The Baker Act requires 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.

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.[14]

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.[15]

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

[12] Department of Children and Families website, http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities, (last visited Jan. 11, 2016).
[13] Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.
[14] Section 397.6795, F.S.
[15] Section 394.462(1)(f) and (g), F.S.

available bed.[16] 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.[17]

Involuntary Admission to a Facility

Criteria for Involuntary Admission

The Marchman Act provides that a person meets the criteria for involuntary admission if a good-faith reason exists to believe that the person is substance-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.[18]

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.[19] 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.[20] If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.[21]

Time Limits

A critical 72-hour period applies under both the Marchman Act and the Baker Act. Under the Marchman Act, a person may be held in protective custody for no more than 72 hours, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.[22]

The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.[23] 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

[16] Section 397.6772(1), F.S.
[17] Section 394.459(1), F.S.
[18] Section 397.675, F.S.
[19] Section 397.677, F.S.
[20] Section 397.6771, F.S.
[21] Section 397.6772(1), F.S.
[22] Section 397.6773(1) and (2), F.S.
[23] Section 394.463(2)(f), F.S.

- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.[24]

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.[25] If the facility needs more time, the facility may request a seven-day extension from the court.[26] Based on the involuntary assessment, the facility may retain the person pending a court decision on a petition for involuntary treatment.[27]

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.[28] The petitioner must show, by clear and convincing evidence, all available less-restrictive treatment alternatives are inappropriate and that the individual:

- Is mentally ill and because of the illness has refused voluntary placement for treatment or is unable to determine the need for placement; and
- Is manifestly incapable of surviving alone or with the help of willing and responsible family and friends, and without treatment is likely suffer neglect that 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.[29]

Advance Directives for Mental Health or Substance Abuse Treatment

Florida law currently allows an individual to create an advance directive to designate a surrogate to make health care decisions and provide a process for the execution of the directive.[30] Currently law also allows an individual to designate a separate surrogate to consent to mental health treatment if the individual is determined by a court to be incompetent to consent to mental health treatment.[31]

A mental health or substance abuse treatment advance directive is much like a living will for health care.[32] Acute episodes of mental illness temporarily destroy the capacity required to give informed consent and often prevent people from realizing they are sick, causing them to refuse intervention.[33] Even in the midst of acute episodes, many people do not meet commitment criteria because they are not likely to injure themselves or others and are still able to care for

[24] Section 394.463(2)(i)4., F.S.
[25] Section 397.6811, F.S.
[26] Section 397.6821, F.S.
[27] Section 397.6822, F.S.
[28] Sections 394.4655(6) and 394.467(6), F.S.
[29] Section 394.467(1), F.S.
[30] Section 765.202, F.S.
[31] Section 765.202(5), F.S.
[32] Washington State Hospital Association, *Mental Health Advance Directives*, copy on file with the Senate Committee on Children, Families and Elder Affairs.
[33] Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute*, 14 Yale Journal of Health Policy, Law & Ethics, Winter 2014 on file with the Senate Committee on Children, Families and Elder Affairs.

their own basic needs.[34] If left untreated, acute episodes may spiral out of control before the person meets commitment criteria.[35]

The Uniform Law Commission[36] drafted the "Health-Care Decisions Act" (HCDA) in 1993 as a model statute to address all types of advance health care planning, including planning for mental illness. However, the HCDA focuses largely on end-of-life care and fails to address many issues faced by people with mental illness.[37] A key failure of the HCDA is that it does not empower patients to form self-binding arrangements for care.[38] Such a self-binding arrangement is known as a Ulysses arrangement. A Ulysses arrangement is a type of mental health advance directive that serves as a preventative measure for a patient to obtain treatment during an episode because the patient has learned that episodes cause him or her to refuse needed intervention.[39] A Ulysses arrangement is entered into while the individual has capacity.

A Ulysses arrangement authorizes doctors to treat the patient during a future episode when he or she lacks capacity, even if the episode causes the individual to refuse treatment at that time. Without a Ulysses arrangement, an individual whose illness causes him to revoke his mental health advance directive and refuse treatment, has no mechanism to secure intervention unless he or she meets involuntary commitment criteria.[40] Ulysses arrangements are sometimes viewed as superior to involuntary commitment because the latter often comes too late and is often traumatic; the proceedings can be dehumanizing; and police intervention and apprehension can be dangerous.[41] Additionally, a Ulysses arrangement allows an individual to secure treatment from the individual's regular mental health treatment provider who understands the patient's illness and history, and in a facility the individual chooses.[42]

III. Effect of Proposed Changes:

Section 1 amends s. 394.453, F.S., to include in the legislative findings that mental health and substance use disorders are diseases of the brain, are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are sub-specialties within the field of medical practice. The legislative intent is further amended to authorize licensed, qualified health professionals to exercise the full authority of their respective scopes of practice in the performance of professional functions necessary to carry out the intent of part 1 of ch. 394, L.O.F. Additionally, the intent to ensure that local systems of acute care services use a common

[34] *Id.*
[35] *Id.*
[36] The Uniform Law Commission (also known as the National Conference of Commissioners on Uniform State Laws) was established in 1892 and provides states with draft legislation that seeks to bring clarity and stability to critical areas of state statutory law. *See* "About the ULC," available at http://www.uniformlaws.org/Narrative.aspx?title=About%20the%20ULC (last visited Feb. 4, 2016)
[37] *Supra*, note 33.
[38] *Id.*
[39] *Id at 2.*
[40] *Id at 6.*
[41] *Id.*
[42] Judy Ann Clausen, *Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients*, article to be published in Marquette University's Elder's Advisor Law Review. Copy on file with the Senate Committee on Children, Families and Elder Affairs.

protocol and that services are provided using the coordination of care principles characteristic of recovery-oriented services, is added to the statute's legislative intent.

Section 2 amends s. 394.66, F.S., to provide that with respect to mental health and substance abuse services, it is the Legislature's intent to recognize that mental health and substance use disorders are diseases of the brain; are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are sub-specialties within the field of medical practice.

Section 3 amends s. 394.9082, F.S., to provide direction to managing entities (MEs) in their geographic regions to develop a plan to establish and maintain a behavioral health service system with sufficient capacity to ensure all persons with mental health or substance use disorders who are subject to involuntary admission receive prompt assessment of their need for evaluation and treatment. The bill requires that the plan must include components such as the designation of a receiving facility that must be used by law enforcement and may be used by other authorized persons and that without such designation, a facility may not hold or treat involuntary patients under chapter 394.

The bill also requires MEs to coordinate and develop a local plan that includes a county or circuit, establish specifications and minimum standards for access to care in each community, and develop a local transportation plan, including an option to procure nonmedical transportation of persons between facilities. The MEs must also conduct a needs assessment that incorporates community resources designated in such plans and coordinate the resources within their respective regions.

The transportation plan must:
- Address the designated public or private substance abuse receiving facility or residential detoxification facility to be used by local law enforcement as the primary receiving facility;
- Address the process for a person to be transported after law enforcement relinquishes physical custody; and
- Specify responsibility for and the means by which transportation to and between facilities will be implemented.

Section 4 amends s. 397.305, F.S., to provide that the Legislature finds that mental health and substance use disorders are diseases of the brain; are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are subspecialties within the field of medical practice. Under the bill, the Legislature recognizes that behavioral health disorders may temporarily or permanently affect a person's ability to reason, exercise good judgment, recognize the need for services, or sufficiently provide self-care, and that responsibility for such a person's care must be delegated to a third party and may be vested in an authorized, licensed, qualified health professional who can provide behavioral health services.

The bill provides that it is the intent of the Legislature:
- To authorize licensed, qualified health professionals to exercise the full authority of their respective scopes of practice in the performance of professional functions necessary to carry out the intent of ch. 397, F.S.;

- That state policy and funding decisions be driven by data that is representative of the populations served and the effectiveness of services provided; and
- To establish expectations that services provided to persons in this state use the coordination-of-care principles characteristic of recovery-oriented services and include social support services, such as housing support, life skills and vocational training, and employment assistance, necessary for persons with mental health and substance use disorders to live successfully in their communities.

The bill also repeals a provision in s. 397.505(2), F.S., which stated legislative intent "to require the collaboration of state agencies, service systems, and program offices to achieve the goals of [ch. 397, F.S.,] and address the needs of the public; to establish a comprehensive system of care for substance abuse; and to reduce duplicative requirements across state agencies."

Section 5 amends s. 397.675, F.S., to revise the criteria for involuntary admission for persons with substance use or a co-occurring mental health disorder to include the refusal or inability to determine whether examination is necessary and that without care or treatment, the person is likely to neglect or refuse care to the extent that:

- The neglect or refusal poses a real and present threat of substantial harm to his or her well-being;
- There is risk of deterioration of his or her physical or mental health; or
- There is substantial likelihood that the person will cause serious bodily harm to himself or herself or others.

Section 6 amends s. 397.6793, F.S., to expand the list of professionals who may initiate a certificate for emergency admission of a person to a hospital or licensed detoxification facility to include a physician, a clinical psychologist, physician's assistant working under the scope of practice of the supervising physician, psychiatric nurse, advanced registered nurse practitioner, licensed mental health counselor, licensed marriage and family therapist, master's level-certified addiction professional for substance abuse services, or a licensed clinical social worker. The professional executing the certificate must have examined the person within the preceding five days and state the observations upon which the conclusion is based that the person appears to meet the criteria for emergency admission.

Section 7 amends s. 397.681, F.S., to specify that a court may not charge a fee for the filing of a petition for involuntary assessment and stabilization.

Section 8 amends s. 397.6811, F.S., to allow a petition for involuntary assessment and stabilization to be filed by a person who has direct knowledge that the person is a threat to himself or herself or others.

Section 9 amends s. 397.6818, F.S., to provide that the court's order for involuntary admission is valid until executed or for the period specified in the order. If the order does not provide a time limit, the order is valid for seven days after the date the order is signed.

Section 10 amends s. 397.697, F.S., to increase the time a court may order a person to undergo involuntary treatment by a licensed service provider from 60 days to 90 days.

Section 11 amends s. 397.6971, F.S., to allow for early release from involuntary substance abuse treatment before the end of the 90 day treatment period if the individual no longer meets the criteria specified in s. 397.675, F.S.

Section 12 amends s. 397.6977, F.S., to reflect that the time frame that an individual may be ordered into involuntary substance abuse treatment is increased from 60 days to 90 days.

Section 13 amends s. 397.6955, F.S., to require the court to schedule a hearing on the petition for involuntary treatment within five days instead of 10 days unless a continuance is granted.

Section 14 creates an undesignated section of Florida law to provide that the Louis de la Parte Florida Mental Health Institute within the University of South Florida will provide the Department of Children and Families (DCF) copies of documents regarding involuntary examination and outpatient or inpatient placement orders on a monthly basis.

Section 15 amends s. 397.6773, F.S., to correct a cross-reference.

Section 16 redesignates Part V of chapter 765, F.S., as Part IV, and creates a new Part V of chapter 765, F.S., and entitles it as "Mental Health and Substance Abuse Treatment Advance Directives."

Section 17 creates s. 765.501, F.S., to provide that ss. 765.501-765.509, F.S., and this law may be cited as the "Jennifer Act".

Section 18 creates s. 765.502, F.S., to provide legislative findings that individuals with capacity have the ability to control decisions relating to his or her own mental health or substance abuse treatment. The Legislature further finds that substance abuse and mental illness cause individuals to fluctuate between capacity and incapacity; the individual may be unable to provide informed consent necessary to access needed treatment during a time when the individual's capacity is unclear; early treatment may prevent the individual from becoming so ill that involuntary treatment is necessary; and individuals with mental illness and substance abuse impairment need an established procedure to express their instructions and preferences for treatment and to provide advance consent to or refusal of treatment.

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

Section 19 creates s. 765.503, F.S., to provide definitions for terms used in this section.

Section 20 creates s. 765.504, F.S., to provide for the creation, execution and allowable provisions of mental health or substance abuse treatment advance directives. An adult with capacity may execute a mental health or substance abuse impairment advance directive. A directive executed in accordance with this part is presumed valid; however, the inability to honor one or more of the provisions of the advance directive does not invalidate the remaining provisions. The directive may include any provision related to mental health or substance abuse

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

- Preferences and instructions for mental health or substance abuse treatment;
- Refusal to consent to specific types of mental health or substance abuse treatment;
- Descriptions of situations that may cause the individual to experience a mental health or substance abuse crisis;
- Suggested alternative responses that may supplemental or be in lieu of direct mental health or substance abuse treatment, such as treatment approaches from other providers; and
- The nomination of a guardian, limited guardian, or guardian advocate.

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

Section 21 creates s. 765.505, F.S., to provide for the execution, effective date, and expiration of a mental health or substance abuse advance directive. The bill provides that the advance directive must be in writing and must clearly indicate that the individual intends to create a directive. The directive must be witnessed by two adults who must declare they were present when the individual dated and signed the directive and that the individual did not appear to be incapacitated, acting under fraud, or acting under undue influence or duress. A surrogate named in the directive cannot act as a witness to the execution of the directive and at least one witness must not be the spouse or blood relative of the individual executing the directive.

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

Section 22 creates s. 765.506, F.S., to provide for the revocation or waiver of an advance directive. A copy of the revocation of the advance directive must be provided by the individual, and is effective upon receipt by his or her agent, each health care provider, professional person, or health care facility that received a copy of the individual's advance directive. The bill provides that a directive that would have otherwise expired but is effective because the individual is incapacitated remains effective until the individual is no longer incapacitated, unless the individual elected to be able to revoke the directive while incapacitated and has revoked the directive.

Section 23 creates s. 765.507, F.S., to provide that a surrogate, health care facility, health care provider, or other person who acts under the direction of a health care facility or provider, is not subject to criminal prosecution or civil liability or to have engaged in unprofessional conduct as a result of carrying out a mental health or substance abuse treatment decision contained in a directive.

Section 24 creates s. 765.508, F.S., to provide for the recognition of mental health and substance abuse treatment, advance directives that are executed in another state in compliance with the laws of that state, are valid.

Section 25 creates s. 765.509, F.S., to provide that a service provider is to give information relating to mental health or substance abuse treatment advance directives to its patients and assist competent and willing patients in completing a directive. The service provider may not require patients to execute a mental health or substance abuse treatment advance directive; however, an executed mental health or substance abuse treatment advance directive shall be part of the patient's medical record. The DCF is directed to develop and publish on its website information on the creation, execution and purpose of mental health or substance abuse treatment advance directives, including a form for such document.

Section 26 amends s. 406.11, F.S., to correct cross-references.

Section 27 amends s. 408.802, F.S., to correct cross-references.

Section 28 amends s. 408.820, F.S., to correct cross-references.

Section 29 amends s. 765.101, F.S., to correct cross-references.

Section 30 amends s. 765.203, F.S., to create a suggested form for a mental health or substance abuse treatment advance directive and the designation of a health care surrogate.

Section 31 provides for 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:

SB 1336 prohibits a fee for filing a petition under the Marchman Act. No such fees are currently assessed; therefore, the bill will not reduce any fee revenue to the clerks of the circuit court and the state court system.

B. Private Sector Impact:

None

C. Government Sector Impact:

To the extent that the Department of Children and Families (DCF) must develop and publish information on the creation, execution, and purpose of mental health or substance abuse treatment advance directives, there may be an indeterminate fiscal impact.

VI. Technical Deficiencies:

In Section 3, the bill directs managing entities to *develop* a plan to establish and maintain a behavioral health service system. Subsequently, in the same section, managing entities are directed to *coordinate* the development of a local plan and provide technical assistance to counties or circuits for the development, receipt, and approval of such plans.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.453, 394.66, 394.9082, 397.305, 397.675, 397.6793, 397.681, 397.6811, 397.6818, 397.697, 397.6971, 397.6977, 397.6955, 397.6773, 406.11, 408.802, 408.820, 765.101, and 765.203.

This bill creates the following sections of the Florida Statutes: 765.501, 765.502, 765.503, 765.504, 765.505, 765.506, 765.507, 765.508, and 765.509.

The bill creates an undesignated section of Florida law.

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.