HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 7097 PCB CFSS 16-01 Mental Health and Substance Abuse
SPONSOR(S): Health Care Appropriations Subcommittee; 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	10 Y, 0 N, As CS	Fontaine	Pridgeon
2) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 7079 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;
- Requiring managing entities to earn coordinated behavioral health system of care designation by 2019 and requiring the annual submission of plans for phased enhancement of the subsystems within their system of care, including specific information on recommendations for additional funding;
- Requiring managing entities to provide 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' governing boards, and requiring managed behavioral health organizations serving as managing entities to have advisory boards with that membership;
- Allowing managing entities 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 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 revises the Marchman Act, which provides for voluntary and involuntary treatment for substance abuse impairment, by:

- Requiring DCF to develop, adopt and publish standard forms for Marchman Act pleadings and reporting;
- Requiring DCF to create a statewide database for collecting utilization data for all Marchman Act initiated detoxification unit and addictions receiving facility services funded by DCF;
- Requiring law enforcement to execute a DCF-created Marchman Act form when initiating protective custody, unless the individual is being taken to jail;
- Prohibiting courts from charging a filing fee for petitions;
- Allowing the court to grant a continuance for the hearing on the petition for involuntary treatment; and
- Allowing the respondent, or an individual on the respondent's behalf, to pay for court ordered involuntary treatment.

The bill repeals a variety of obsolete statutes.

The bill provides a nonrecurring appropriation of $400,000 to DCF for the creation of the statewide Marchman Act database.

The bill provides an effective date of July 1, 2016, except as otherwise provided in the act.

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 January 4, 2016).
[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 January 4, 2016).
[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=dYMIVdrWOYmqgwTBIYDQDA&usg=AFQjCNEATQZ5TXJF063JkMNgg9ZnwZb_ZA&bvm=bv.88198703,d.eXY (last viewed on January 4, 2016).
[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 January 4, 2016).
[7] *Substance Abuse*, World Health Organization. http://www.who.int/topics/substance_abuse/en/ (last viewed on January 4, 2016).

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]

Florida's Substance Abuse and Mental Health Program

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[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 January 4, 2016).

[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 January 4, 2016).

[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 January 4, 2016).

[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 viewed on January 4, 2016).

[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 January 4, 2016).

[18] *Co-Occurring Disorders*, Psychology Today. https://www.psychologytoday.com/conditions/co-occurring-disorders (last viewed on January 4, 2016).

[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 January 4, 2016).

[20] Id.

[21] *Supra* footnote 18.

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.[22]

Behavioral Health Managing Entities

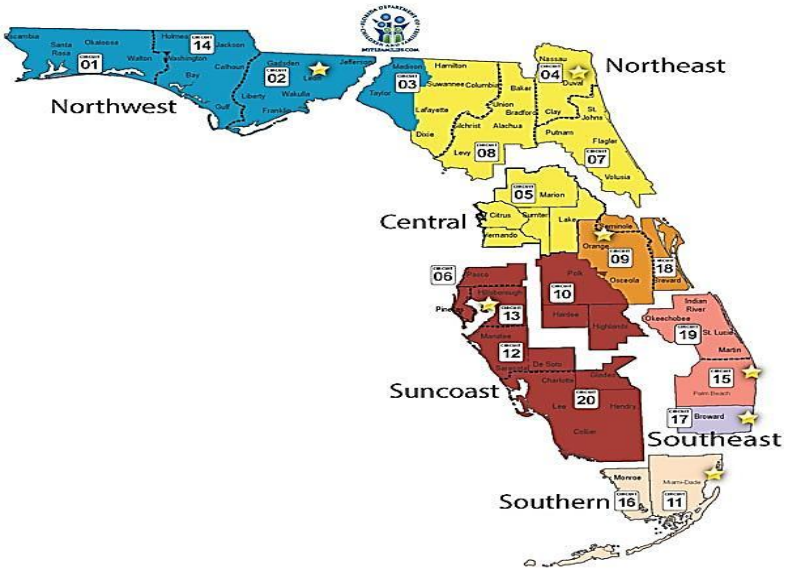
In 2001, the Legislature authorized DCF to implement behavioral health managing entities as the management structure for the delivery of local mental health and substance abuse services.[23] This was based upon the Legislature's decision that a management structure that places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level would:[24]

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

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.[25] Full implementation of the statewide managing entity system occurred in April 2013, with all geographic regions now served by a managing entity.[26] Implementation has allowed DCF to reduce the number of direct contracts for mental health and substance abuse services from several hundred to 7.[27] 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:[28]

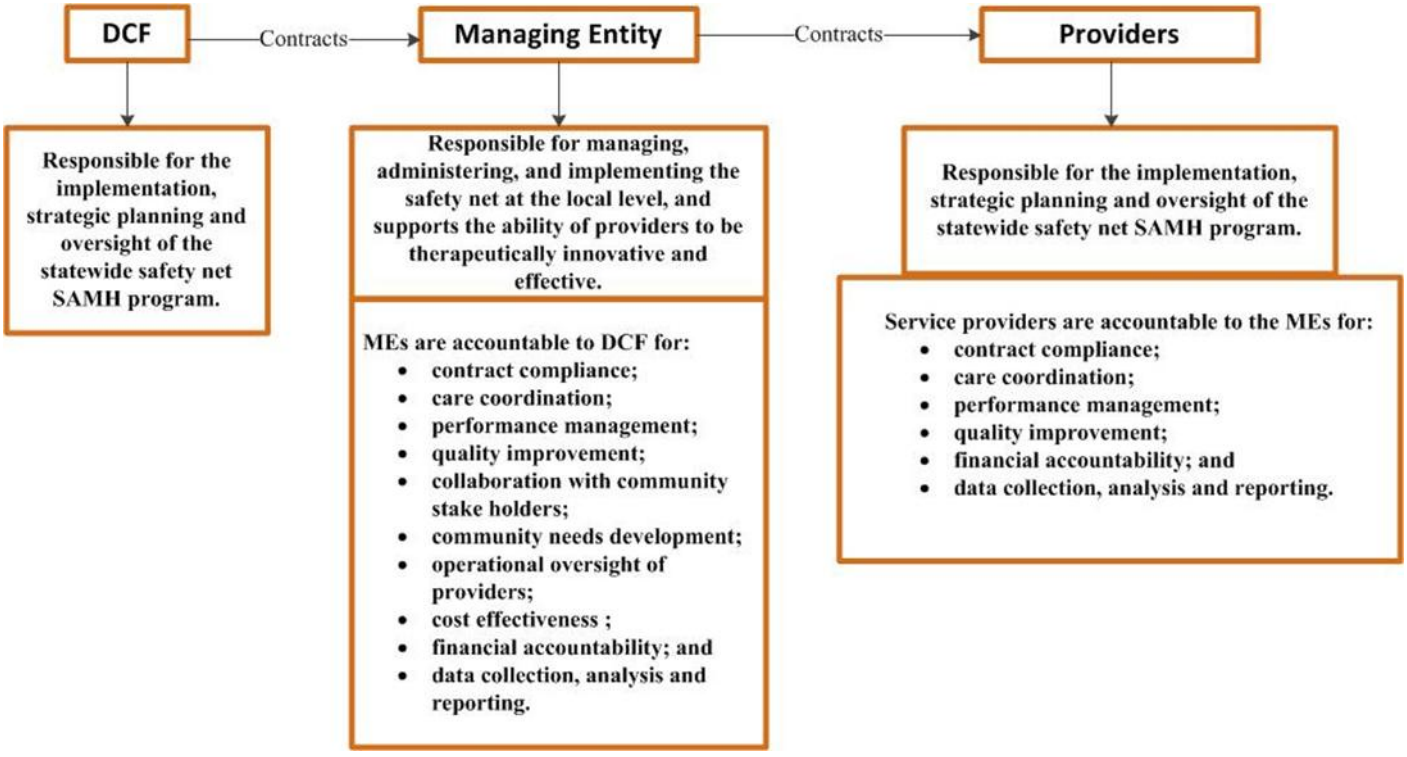
- Big Bend Community Based Care- April 1, 2013 (**blue**).
- Lutheran Services Florida- July 1, 2012 (**yellow**).
- Central Florida Cares Health System- July 1, 2012 (**orange**).
- Central Florida Behavioral Health Network, Inc.- July 1, 2012 (**red**).
- Southeast Florida Behavioral Health- October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

[22] 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.
[23] Ch. 2001-191, Laws.
[24] Section 394.9082, F.S.
[25] Chapter 2008-243, Laws.
[26] *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.
[27] *Department of Children and Families Service System Management Plan, Statewide Implementation of Managing Entities or Similar Model*, July 2009.
[28] *Managing Entities*, Department of Children and Families. http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities (last viewed on January 4, 2016).



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

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:[29]

- **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

[29] *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.

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.

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

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 health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.[30]

Currently, only a county or a consortium of counties who have established planning councils or committees may apply for a grant under the Program.[31] 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.[32] Applicants may seek a one-year planning grant or a three-year implementation or expansion grant.[33] 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.[34]

The Program's Statewide Grant Review Committee (Committee) is responsible for evaluating applications submitted to the Program. The Committee includes:[35]

- 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.[36] DCF may then transfer funds, if available, to any counties or consortium of counties awarded a grant.[37] 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.[38] For fiscally constrained counties, the available resources may be at 50 percent of the total amount of the grant.[39]

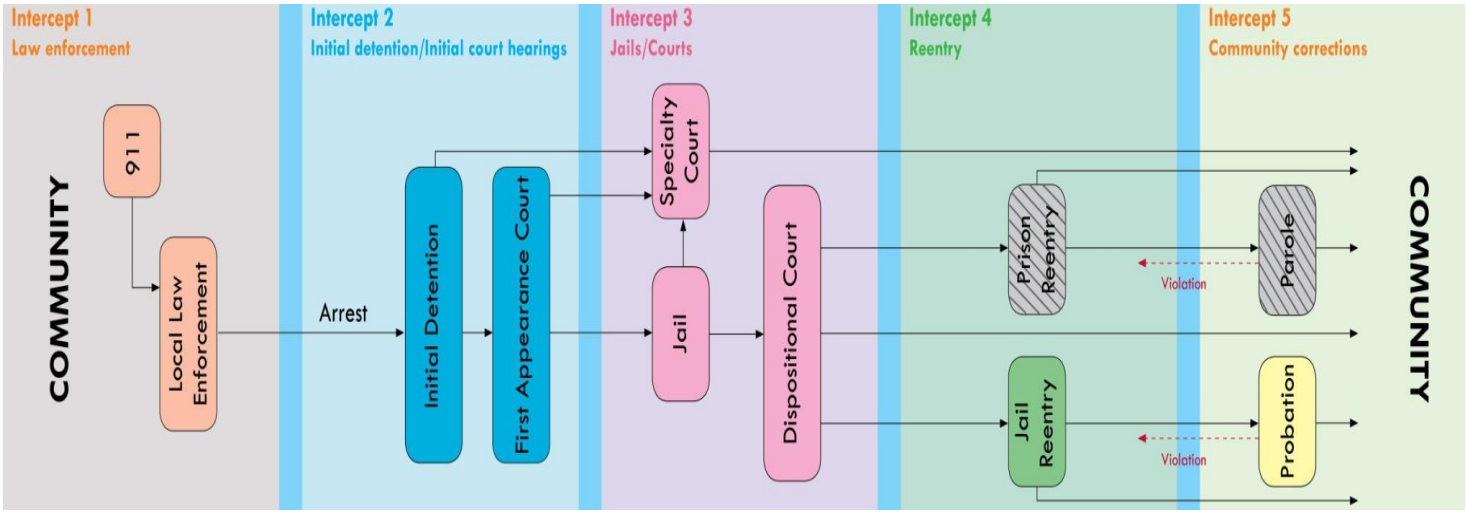
[30] Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant: Request for Applications, Department of Children and Families, May 2013.
[31] Section 394. 658(3), F.S.
[32] Id.
[33] Section 394. 656(3)(a), F.S.
[34] Section 394. 658(2)(b) and (c), F.S.
[35] Section 394. 656(2)(a-e), F.S.
[36] Section 394. 656(4), F.S.
[37] Id.
[38] Section 394. 658(2)(b) and (c), F.S.
[39] Id.

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.[40] 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.[41] The interception points are:[42]

- 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



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.[43]

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.[44] 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.[45]

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

[40] *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 January 4, 2016).
[41] Id.
[42] Id.
[43] Id.
[44] Sections 394.451-394.47891, F.S.
[45] Section 394.459, F.S.

voluntary or involuntary basis.[46] 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[47]:

- 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 a private facility that 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.[48] 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 such purpose.[49] 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.[50]

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.[51] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[52]

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.[53] Individuals often enter the public mental health system through CSUs.[54] 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.[55]

For FY 2014-15 there are 544 adult and 106 crisis stabilization beds funded by DCF.[56] There were 181,471 involuntary examinations initiated at hospitals and CSUs in calendar year 2014 (most recent report).[57]

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

[46] Sections 394.4625 and 394.463, F.S.
[47] Section 394.463(1), F.S.
[48] Section 394.455(26), F.S.
[49] Section 394.455(25), F.S
[50] Rule 65E-5.400(2), F.A.C.
[51] Section 394.875(1)(a), F.S.
[52] Id
[53] Id.
[54] Budget Subcommittee on Health and Human Services Appropriations, the Florida Senate, Crisis Stabilization Units, (Interim Report 2012-109) (Sept. 2011).
[55] Id. Sections 394.65-394.9085, F.S.
[56] Id.
[57] Christy, A. (2015). Report of 2014 *Baker Act Data*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.

incompetent to consent to treatment.[58] 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.[59] The court will appoint a qualified guardian advocate if it finds the patient incompetent.[60] The court may not appoint certain individuals as a guardian advocate:[61]

- 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.

The facility must provide a guardian advocate with sufficient information for a guardian advocate to make an informed decision.[62] 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.[63] 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.[64] 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.[65]

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.

The Marchman Act

In the early 1970s, the federal government enacted laws creating formula grants for states to develop continuums of care for individuals and families affected by substance abuse. [66] The laws resulted in separate funding streams and requirements for alcoholism and drug abuse; in response to the laws, the Florida Legislature enacted Chapters 396, F.S., (alcohol) and 397, F.S. (drug abuse).[67] Each of these laws governed different aspects of addiction, and thus had different rules promulgated by the state to fully implement the respective pieces of legislation.[68] However, because persons with substance abuse issues often do not restrict their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not adequately address the problems faced by Florida's citizens.[69] In 1993 legislation was adopted to combine Chapters 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act ("the Marchman Act").[70]

The Marchman Act program is designed to support the prevention and remediation of substance abuse through the provision of a comprehensive system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

Voluntary vs. Involuntary Admissions

[58] Section 394.4598(1), F.S.
[59] Id.
[60] Id .
[61] Id.
[62] Section 394.4598(2), F.S.
[63] Id.
[64] Id.
[65] Section 394.4598(7), F.S.
[66] Department of Children and Families, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5
[67] Id.
[68] Id.
[69] Id.
[70] Ch. 93-39, s. 2, Laws of Fla., codified in ch. 397, F.S.

An individual may receive services under the Marchman Act through either a voluntary or an involuntary admission. The Marchman Act encourages persons to seek treatment on a voluntary basis and to be actively involved in planning their own services with the assistance of a qualified professional. An individual who wishes to enter treatment may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service provider.[71] However, denial of addiction is a common symptom, raising a barrier to early intervention and treatment.[72] As a result, treatment often comes because of a third party making the intervention needed for substance abuse services.[73]

The Marchman Act establishes a variety of methods under which substance abuse assessment, stabilization and treatment can be obtained on an involuntary basis. There are five involuntary admission procedures that can be broken down into two categories depending upon whether the court is involved. Regardless of the nature of the proceedings, an individual meets the criteria for an involuntary admission under the Marchman Act when there is good faith reason to believe the individual is substance abuse impaired and, because of such impairment, has lost the power of self-control with respect to substance use; and either has inflicted, attempted or threatened to inflict, or unless admitted, is likely to inflict physical harm on himself/herself or another; or the person's judgment has been so impaired because of substance abuse that he/she is incapable of appreciating the need for substance abuse services and of making a rational decision in regard to substance abuse services.[74]

Non-Court Involved Involuntary Admissions

The three types of non-court procedures for involuntary admission for substance abuse treatment under the Marchman Act are:

- Protective Custody: Law enforcement officers use this when an individual is substance-impaired or intoxicated in public and is brought to the attention of the officer. The purpose of this procedure is to allow the person to be taken to a safe environment for observation and assessment to determine the need for treatment.[75] Law enforcement is not required to execute a written report for the initiation of protective custody.
- Emergency Admission: This permits an individual who appears to meet the criteria for involuntary admission to be admitted to a hospital, an addiction receiving facility or a detoxification facility for emergency assessment and stabilization. Individuals admitted for involuntary assessment and stabilization under this provision must have a physician's certificate for admission, demonstrating the need for this type of placement and recommending the least restrictive type of service that is appropriate to the needs of the individual.[76]
- Alternative Involuntary Assessment for Minors: This provides a way for a parent, legal guardian or legal custodian to have a minor admitted to an addiction receiving facility to assess the minor's need for treatment by a qualified professional.[77]

Court Involved Involuntary Admissions

The two court involved Marchman Act procedures are involuntary assessment and stabilization, which provides for short-term court-ordered substance abuse treatment, and involuntary treatment, which

[71] S. 397.601(1), F.S. Additionally, under s. 397.601(4)(a), F.S., a minor is authorized to consent to treatment for substance abuse.
[72] Darran Duchene and Patrick Lane, *Fundamentals of the Marchman Act*, RISK RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Program, http://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited December 16, 2015).
[73] Id.
[74] S. 397.675, F.S.
[75] S. 397.667, F.S. A law enforcement officer may take the individual to their residence, to a hospital, a detoxification center, or addiction receiving facility, or in certain circumstances, to jail. Minors, however, cannot be taken to jail.
[76] S. 397.679, F.S.
[77] S. 397.6822, F.S.

provides for long-term court-ordered substance abuse treatment. Both are initiated through the filing of a petition for which the court may charge a filing fee.

Involuntary Assessment and Stabilization

Involuntary assessment and stabilization involves filing a petition with the court. The petition for involuntary assessment and stabilization must contain:

- The name of the applicant or applicants (the individual(s) filing the petition with the court);
- The name of the respondent (the individual whom the applicant is seeking to have involuntarily assessed and stabilized);
- The relationship between the respondent and the applicant;
- The name of the respondent's attorney, if he or she has one, and whether the respondent is able to afford an attorney; and
- Facts to support the need for involuntary assessment and stabilization, including the reason for the applicant's belief that:
    - The respondent is substance abuse impaired; and
    - The respondent has lost the power of self-control with respect to substance abuse; and either that
    - The respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
    - The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.[78]

Once the petition is filed with the court, the court issues a summons to the respondent and the court must schedule a hearing to take place within 10 days, or can issue an ex parte order immediately.[79]

After hearing all relevant testimony, the court determines whether the respondent meets the criteria for involuntary assessment and stabilization and must immediately enter an order that either dismisses the petition or authorizes the involuntary assessment and stabilization of the respondent.

If the court determines the respondent meets the criteria, it may order him or her to be admitted for a period of 5 days[80] to a hospital, licensed detoxification facility, or addictions receiving facility, for involuntary assessment and stabilization.[81] During that time, an assessment is completed on the individual.[82] The written assessment is sent to the court. Once the written assessment is received, the court must either

- Release the individual and, if appropriate, refer the individual to another treatment facility or service provider, or to community services;
- Allow the individual to remain voluntarily at the licensed provider; or

[78] S. 397.6814, F.S.
[79] S. 397.6815, F.S. Under the ex parte order, the court may order a law enforcement officer or other designated agent of the court to take the respondent into custody and deliver him/her to the nearest appropriate licensed service provider
[80] If a licensed service provider is unable to complete the involuntary assessment and, if necessary, stabilization of an individual within 5 days after the court's order, it may, within the original time period, file a request for an extension of time to complete its assessment. The court may grant additional time, not to exceed 7 days after the date of the renewal order, for the completion of the involuntary assessment and stabilization of the individual. The original court order authorizing the involuntary assessment and stabilization, or a request for an extension of time to complete the assessment and stabilization that is timely filed pursuant to this section, constitutes legal authority to involuntarily hold the individual for a period not to exceed 10 days in the absence of a court order to the contrary. S. 397.6821, F.S.
[81] S. 397.6811, F.S. The individual may also be ordered to a less restrictive component of a licensed service provider for assessment only upon entry of a court order or upon receipt by the licensed service provider of a petition
[82] S. 397.6819, F.S., The licensed service provider must assess the individual without unnecessary delay using a qualified professional. If an assessment is performed by a qualified professional who is not a physician, the assessment must be reviewed by a physician before the end of the assessment period.

- Hold the individual if petition for involuntary treatment has been initiated.[83]

Involuntary Treatment

Involuntary treatment allows the court to require the individual to be admitted for treatment for a longer period only if the individual has previously been involved in at least one of the four other involuntary admissions procedures within a specified period.[84] Similar to a petition for involuntary assessment and stabilization, a petition for involuntary treatment must contain the same identifying information for all parties and attorneys and facts to support the need for involuntary treatment including the reason for the petitioner's belief that:

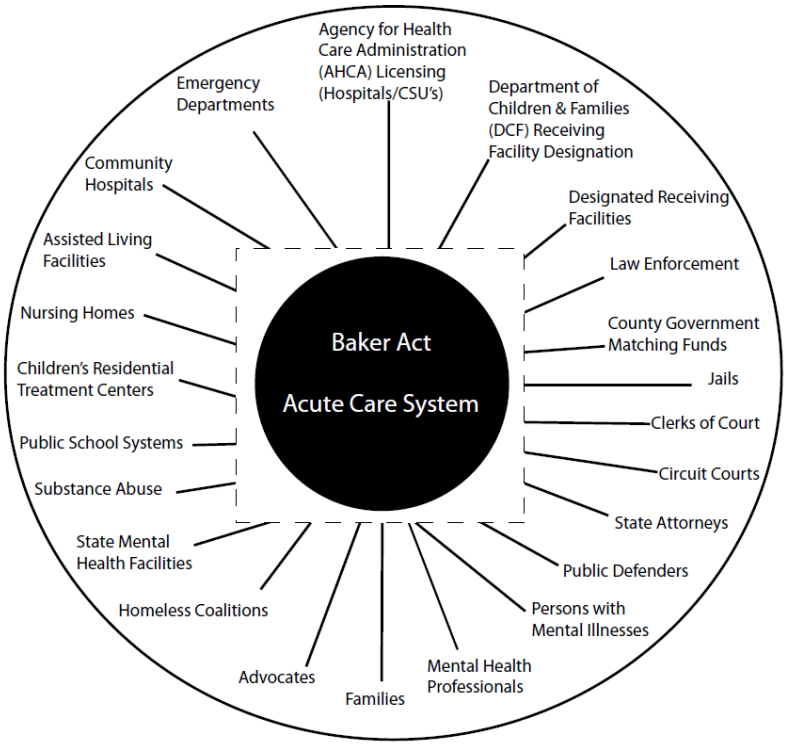
- The respondent is substance abuse impaired; and
- The respondent has lost the power of self-control with respect to substance abuse; and either that
    - The respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
    - The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.[85]

A treatment hearing must be scheduled within 10 days after the petition is filed. Under this provision if the court finds that the conditions for involuntary substance abuse treatment have been proven, it may order the respondent to undergo involuntary treatment with a licensed service provider for a period not to exceed 60 days.[86] The statute does not expressly state whether the individual must be sent to a publicly or privately funded service provider.

Behavioral Health Acute Care System

The behavioral health acute care system is extraordinarily complex. This graphic indicates the entities involved in the system regarding mental health specifically. Additional entities are involved regarding substance abuse, such as addictions receiving facilities and detoxification units.

[83] S. 397.6822, F.S. The timely of a Petition for Involuntary Treatment authorizes the service provider to retain physical custody of the individual pending further order of the court.
[84] S. 397.693, F.S.
[85] S. 397.6951, F.S.
[86] If the need for treatment is longer, renewal of the order may be petitioned prior to the expiration of the initial 60-day period.



Source: Florida Mental Health Institute, USF, 2014 Baker Act User Reference Guide.

Various state and federal laws and associated regulations govern the operation of and interaction between these entities in the performance of their duties relating to behavioral health acute care. Examples include:

- Federal:
  - Emergency Medical Treatment and Active Labor Act[87], which applies to all hospitals with emergency service capacity, including freestanding psychiatric hospitals. The law prohibits the delay or denial of emergency medical services, including psychiatric or substance abuse emergencies, due to inability to pay.[88]
- State:
  - Baker Act and other provisions of ch. 394, F.S., governing the operation of the mental health system, including those governing transportation of clients, local match for mental health services, and the managing entity system.
  - Marchman Act and other provisions of ch. 397, F.S., including those governing substance abuse facility licensure.
  - Access to emergency services and care, s. 396.1041, F.S., which also prohibits the delay or denial of emergency services by hospitals. It governs access to care and transfers from a hospital.
  - Guardianship, ch. 744, F.S., through which an individual is adjudicated incompetent and a guardian appointed.
  - Advance directives, ch. 765, F.S., which addresses advanced planning for incapcity and surrogate health care decisionmakers and proxies.
  - Medicaid, ch. 409, which governs the operation of the state's medical assistance program. For example, managed care plans must offer at a minimum mental health services and substance abuse treatment services.[89]

Other laws, such as federal law regarding the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants, which fund safety-net services, and confidentiality of client records govern behavioral health care generally and also affect the operation of the behavioral health acute care system.

[87] 42 U.S.C. 1395dd.
[88] *Florida Mental Health Institute, USF, 2014 Baker Act User Reference Guide.*
[89] s. 409.973(1)(q) and (bb), F.S.

Funding for services provided in this system comes from a variety of sources, including but not limited to local government funding[90], state general revenue, federal block grant funds, Medicaid, private insurance, and client fees[91].

Pursuant to s. 394.9082(6)(a), F.S., managing entities are tasked with demonstrating the ability of their networks of providers to comply with the pertinent provisions of both the Baker and Marchman Acts. However, managing entities are not specifically charged with overseeing planning for the effective operation of the behavioral health acute care system.

Provisions of ch. 394 and 397 govern transportation to and among facilities, though the Baker Act is more detailed than the Marchman Act. For instance, s. 394.462, F.S., specifies that law enforcement transports individuals for involuntary admission to the nearest receiving facility, except under very specific circumstances. In contrast, transportation to emergency assessment and stabilization under the Marchman Act may be provided by a variety of parties such as the applicant for the person's emergency admission, his or her spouse or guardian, law enforcement officer, or health officer.[92] Neither act requires formal planning for transportation to support the community's behavioral health acute care system, though the Baker Act allows for counties to exempt themselves from certain statutory transportation requirements under certain circumstances.[93]

Suitability Assessments for Children in the Child Welfare System

Section 39.407, F.S., provides a process for assessing a child in the legal custody of DCF for suitability for residential mental health treatment. This assessment must be conducted by a qualified evaluator and evaluates whether the child appears to have an emotional disturbance serious enough to require treatment, the child has had the treatment explained to him or her, and no less restrictive modalities are available. The Medicaid plan may be financially responsible for the child's residential treatment, if the child is served by one; however, statute does not require the plan to receive a copy of the assessment.

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

[90] s. 394.76, F.S.
[91] s. 394.674(3), F.S.
[92] s. 397.6795, F.S.
[93] s. 394.462(4), F.S.
[94] Rule 64B4-2.001, F.A.C.
[95] Section 491.005, F.S.

minimum coursework requirements, and possess the appropriate graduate degree. A provisional license is valid for 2 years.[96]

Effect of the Proposed Changes

Substance Abuse and Mental Health Program

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, 2016.

Behavioral Health Managing Entities

The bill revises definitions and creates new definitions, including:

- "Coordinated behavioral health system of care" to be a system of care that has earned designation by DCF as having achieved the standards required by subsection (8) of s. 394.9082, F.S.
- "Managed behavioral health organization" as a Medicaid managed care organization currently under contract with the Medicaid managed medical assistance program or a behavioral health specialty managed care organization established pursuant to part IV of chapter 409.
- "Managing entity" to be a corporation selected by DCF to execute the administrative duties defined in the section to facilitate the delivery of behavioral health services through a coordinated behavioral health system of care.
- "Subregion" as a distinct portion of a managing entity's geographic region defined by unifying service and provider utilization patterns.

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

The bill specifies the duties of the managing entity to include:

- serving as the leader in its geographic area in behavioral health services provision,
- encouraging collaboration and coordination among the many organizations and systems involving in meeting the geographic area's behavioral health care needs;
- assessing community needs;
- contracting with service providers;
- monitoring provider performance;
- collecting and reporting data;
- facilitating effective provider relationships;
- working to improve access to and effectiveness, quality, and outcomes of behavioral health services;
- assisting local providers with securing local matching funds; and
- administrative and fiscal management duties necessary to comply with federal grant reporting.

The bill amends s. 394.9082(6), F.S., to specify behavioral health system of care elements. These elements may be funded by the managing entity to the extent allowed by resources, or by other

[96] Section 491.0046, F.S. and Rule 64B-3.0075, F.A.C.

entities. Among elements the bill includes is consumer care coordination, specifying that managing entities, within available resources, shall provide 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 recovery support 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 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 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. Examples of such standards exclude 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 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 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 governing board. Managing entities must create a

transparent process for nomination. 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 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 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 creates a new subsection addressing coordinated behavioral health system of care designation and community planning. It provides for managing entities to earn the coordinated behavioral health system of care designation by developing and implementing plans in a collaborative manner that facilitate coordination between their network providers and other systems of care, such as the child welfare and Medicaid systems. The plans must specifically address coordination within and between the prevention and diversion subsystem, the coordinated receiving system, and the treatment and recovery support subsystem, and other major systems. The bill specifies deadlines for key steps in the process, including for managing entities under contract on July 1, 2016:

- DCF issues measurable minimum standards for earning the coordinated behavioral health system of care designation by November 30, 2016;
- Managing entities submit their plans for earning the designation by June 30, 2017;
- DCF approving plans by September 30, 2017;
- Managing entity reports on current status and progress during the previous fiscal year by September 30, 2018, and 2019, and
- DCF determines whether the managing entities have earned the designation by October 31, 2019.

DCF may renew the contracts of managing entities that earn the designation of having a coordinated behavioral health system of care for an additional term, provided other contract requirements and performance standards are met.

Managing entities initially contracted by the state after July 1, 2016, must earn the coordinated behavioral health system of care designation within three years of the contract execution date. DCF shall set deadlines for submitting plans and reports and may also renew the contracts of such managing entities that successfully earn the coordinated behavioral health coordinated system of care designation, provided other contract requirements and performance standards are met.

Annually by February 1, beginning in 2018, managing entities shall develop using an inclusive process and submit to DCF a plan for phased enhancement of the subsystems, by subregion, based on the assessed behavioral health needs of the subregion and system gaps. If the plan recommends additional funding, it must include specific information about those recommendations, including the needs to be met, services to be purchased, likely benefits of the services, projected costs, and number of individuals projected to benefit.

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.

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, 2016.

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;
- One representative of the Florida Prosecuting Attorneys Association;
- One representative of the Florida Public Defender Association; 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 or a managing entity to apply for a grant. A not-for-profit community provider or 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

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.

Transportation

The bill revises current law regarding exceptions to requirements for transportation to receiving facilities. The bill provides that counties may develop transportation exception plans, and groups of nearby counties may develop shared transportation plans. Counties' governing boards, managing entities, and DCF must approve plans before they are implemented. While such plans are optional, the

bill requires counties, during the process provided in the bill in s. 394.9082(8), F.S., for managing entities to plan for a coordinated behavioral health system of care, to evaluate whether use of a transportation exception plan would enhance the functioning of the coordinated receiving system.

The bill also clarifies that law enforcement may transport an individual to a receiving facility other than the nearest one pursuant to the county's transportation exception plan.

Marchman Act

DCF publishes limited forms for Marchman Act pleadings and reporting. The bill amends the Marchman Act to require DCF to develop and publish standard forms for pleadings and reporting. This includes forms for petition for involuntary admissions and forms for the initiation of protective custody by law enforcement. The bill also requires DCF to notify the courts, law enforcement and other state agencies of the existence and availability of these forms.

Currently, there are no express reporting requirements for the Marchman Act. Conversely, the Baker Act has robust reporting requirements. The bill amends the Marchman Act to require reporting requirements on par with those of the Baker Act. As such, the bill requires DCF to create a statewide database for collecting utilization data for detoxification unit and addiction receiving facilities services under the Marchman Act funded by DCF.

Section 397.6772, F.S. authorizes law enforcement to take an individual meeting involuntary admission criteria under the Marchman Act into protective custody. The statute does not require law enforcement to execute a report. The bill amends this section to require law enforcement to execute a DCF created form when initiating protective custody. The reporting requirement is only applicable if law enforcement is taking the individual to a hospital or a licensed detoxification or addictions receiving facility.

The bill makes various changes to court proceedings under the Marchman Act. The bill amends s. 397.681, F.S., to prohibit the court from charging a filing fee for petitions filed under the Marchman Act. The bill also amends s. 397.6955, F.S., to allow for a continuance of the hearing on the petition for involuntary treatment. Finally, the bill amends s. 397.697, F.S., to expressly authorize the court to order an individual into involuntary treatment with a private funder service provider if the respondent has the ability to pay for the treatment, or if any person on respondent's behalf, voluntarily demonstrates willingness and ability to pay for the treatment.

"Informed consent" is not defined in the Marchman Act. The bill amends s. 397.311, F.S., to define "informed consent" as consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. This is identical to the definition of "express and informed consent" in the Baker Act, which term is used in a similar manner to "informed consent" in the Marchman Act.

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.

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 397.331, F.S., which provides definitions and legislative intent related to state drug control.
- 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.
- Sections 397.6772, 397.697, and 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.
- Sections 397.97 and 397.98, F.S., relating to the Children's Network of Care Demonstration Models, authorizing their operation for four years. These were originally established in 1999.

B. SECTION DIRECTORY:

Section 1: Amends s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.
Section 2: Amends s. 394.4597, F.S., relating to persons to be notified; appointment of a patient's representative.
Section 3: Amends s. 394.462, F.S., relating to transportation.
Section 4: Amends s. 394.467, F.S., relating to involuntary inpatient placement
Section 5: Amends s. 394.656, F.S., relating to the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program.
Section 6: Creates s. 394.761, F.S., relating to revenue maximization.
Section 7: Amends s. 394.875, F.S., relating to crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.
Section 8: Amends s. 394.9082, F.S., relating to behavioral health managing entities.
Section 9: Amends s. 397.311, F.S., relating to definitions.
Section 10: Amends s. 397.321, F.S, relating to duties of the department.
Section 11: Creates s. 397.402, F.S., relating to single, consolidated licensure.
Section 12: Amends s. 397.6772, F.S, relating to protective custody without consent.
Section 13: Amends s. 397.681, F.S, relating to involuntary petitions; general provisions; court jurisdiction and right to counsel.
Section 14: Amends s. 397.6955, F.S, relating to duties of court upon filing a petition for involuntary treatment.
Section 15: Amends s. 397.697, F.S, relating to court determination and effect of court order for involuntary substance abuse treatment.
Section 16: Amends s. 409.967, F.S, relating to managed care plan accountability.

Section 17: Amends s. 409.973, F.S, relating to benefits.
Section 18: Amends s. 491.0045, F.S., relating to intern registration requirements.
Section 19: Repeals s. 394.4674, F.S., relating to plan and report.
Section 20: Repeals s. 394.4985, F.S., relating to districtwide information and referral network; implementation.
Section 21: Repeals s. 394.745, F.S., relating to annual report; compliance of providers under contract with department.
Section 22: Repeals s. 397.331, F.S., relating to definitions; legislative intent.
Section 23: Repeals s. 397.801, F.S., relating to substance abuse impairment coordination.
Section 24: Repeals s. 397.811, F.S., relating to juvenile substance abuse impairment coordination; legislative findings and intent.
Section 25: Repeals s. 397.821, F.S., relating to juvenile substance abuse impairment prevention and early intervention councils.
Section 26: Repeals s. 397.901, F.S., prototype juvenile addictions receiving facilities.
Section 27: Repeals s. 397.93, F.S., children's substance abuse services; target populations.
Section 28: Repeals s. 397.94, F.S., children's substance abuse services; information and referral network.
Section 29: Repeals s. 397.951, F.S., treatment and sanctions.
Section 30: Repeals s. 397.97, F.S., children's substance abuse services; demonstration models.
Section 31: Repeals s. 397.98, F.S., children's substance abuse services; utilization management.
Section 32: Amends s. 212.055, F.S., discretionary sales surtaxes; legislative intent; authorization and use of proceeds.
Section 33: Amends s. 394.657, F.S., relating to county planning councils or committees.
Section 34: Amends s. 394.658, F.S., relating to criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program requirements.
Section 35: Amends s. 394.9085, F.S., relating to behavioral provider liability.
Section 36: Amends s. 397.405, F.S., exemptions from licensure
Section 37: Amends s. 397.407, F.S., relating to licensure process; fees.
Section 38: Amends s. 397.416, F.S., relating to substance abuse treatment services; qualified professional.
Section 39: Amends s. 409.966, F.S, relating to eligible plans and selection.
Section 40: Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
Section 41: Provides an appropriation.
Section 42: Provides an effective date of July 1, 2016, except as otherwise provided in the act.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires DCF to create a statewide database for collecting utilization data for certain Marchman-Act initiated substance abuse services funded by the department. DCF estimates that it will cost $400,000 to implement these changes though modifications to the existing Crisis Stabilization Unit (CSU) database. [97]The bill provides a nonrecurring appropriation of $400,000 from state trust funds to DCF for these system upgrades.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

[97] Correspondence from DCF to the House of Representative's Children, Families and Seniors Subcommittee dated December 17, 2015, on file with the Children, Families and Seniors Subcommittee.

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The managing entities are required to submit plans to earn the coordinated behavioral health system of care designation and enhancement plans for the subsystems within their system of care. However, managing entities' current responsibilities include needs assessment and planning. Managing entities that earn the coordinated behavioral health system of care may have their contracts renewed even if a renewal is not authorized under the current terms of the contract, provided contract performance is satisfactory.

All entities licensed or funded by DCF or the AHCA, or funded or operated by the Department of Health, are required to cooperate with the development and implementation of coordinated behavioral health system of care designation plans. While this may be a workload impact, these entities may experience greater overall savings due to increased efficiency and effectiveness from enhanced coordination with other providers and systems.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 8, 2016, the Health Care Appropriations Subcommittee adopted one amendment that provides a nonrecurring appropriation of $400,000 to DCF for system modifications to the CSU database. These modifications will enable the collection of Marchman Act service data as prescribed by the bill. This analysis is drafted to the bill as amended.