HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/HB 7097	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Health & Human Services Committee; Health Care Appropriations Subcommittee; Children, Families & Seniors Subcommittee; Harrell; Peters and others	118 **Y's**	1 **N's**
COMPANION BILLS:	CS/SB 12	**GOVERNOR'S ACTION:**	Approved

SUMMARY ANALYSIS

CS/CS/HB 7097 passed the House on March 7, 2016, as CS/SB 12 as amended. The Senate further amended and concurred with the House amendment on March 11, 2016. The House concurred with the Senate amendment and subsequently passed the bill as amended on March 11, 2016. The bill includes portions of CS/HB 373, CS/CS/CS/HB 439 and CS/HB 615.

The bill addresses 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). The bill enhances DCF oversight of managing entities (ME), ME performance and ME accountability. The bill:

- Requires MEs to accredit their networks by 2019 and annually submit strategies for enhancing services and addressing priority needs, including specific recommendations for additional funding.
- Requires DCF to develop performance standards that measure improvement in a community's behavioral health and in specified individuals' functioning or progress toward recovery;
- Specifies members for MEs' governing boards, and requires managed behavioral health organizations serving as MEs to have advisory boards with that membership;
- Allows MEs flexibility in shaping their provider networks while requiring processes for publicizing opportunities to join and evaluating providers for participation.
- Authorizes DCF to award system improvement grants to MEs if funded by the Legislature.

The bill requires counties and MEs to collaborate to create and implement designated receiving systems and transportation plans by July 1, 2017, to enhance the provision of acute behavioral health services to meet the needs of individuals with mental illness, substance abuse disorders, and co-occurring conditions. The bill encourages MEs to create "no-wrong-door" access models for the new designated receiving systems and requires DCF to designate the receiving systems.

The bill revises the Criminal Justice, Mental Health, and Substance Abuse Grant Program and expands the membership of the Statewide Grant Review Committee to include more non-state representatives and renames it the Policy Committee.

The bill revises the Baker and Marchman Acts to align some provisions, make the procedures more accessible, and enhance reporting on admissions pursuant to these acts. The bill:

- Expands the types of professionals who can admit clients involuntarily,
- Allows county court judges to issue ex parte orders for involuntary examinations under the Baker Act,
- Requires DCF to develop and publish standard forms for Marchman Act pleadings and reporting,
- Requires DCF to create a statewide database for collecting utilization data for all Marchman Act initiated detoxification and addictions receiving facility services funded by DCF, and
- Allows the respondent, or an individual on his or her behalf, to privately pay for court-ordered involuntary treatment.

The bill provides a nonrecurring appropriation of $400,000 to DCF for the Acute Care Services Utilization Database.

The bill was approved by the Governor on April 15, 2016, ch. 2016-241, L.O.F., and will become effective on July 1, 2016.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF 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]

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[1] *Mental Health Basics*, Centers for Disease Control and Prevention. http://www.cdc.gov/mentalhealth/basics.htm (last viewed on March 16, 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 March 16, 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=dYMIVdrWOYmqgwTBlYDQDA&usg=AFQjCNEATQZ5TXJF063JkMNgg9ZnwZb_ZA&bvm=bv.88198703,d.eXY (last viewed on March 16, 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 March 16, 2016).

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] 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

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[7] *Substance Abuse*, World Health Organization. http://www.who.int/topics/substance_abuse/en/ (last viewed on January 4, 2016).
[8] Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.samhsa.gov%2Fdata%2Fsites%2Fdefault%2Ffiles%2FNSDUHresultsPDFWHTML2013%2FWeb%2FNSDUHresults2013.pdf&ei=L74IVZydKO2SsQStroDQCg&usg=AFQjCNE8sNFxhZQfOgdkJvOgZR3fP5I0Uw (last viewed on March 16, 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 March 16, 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 March 16, 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 March 16, 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 March 16, 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 March 16, 2016).
[20] Id.

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

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).

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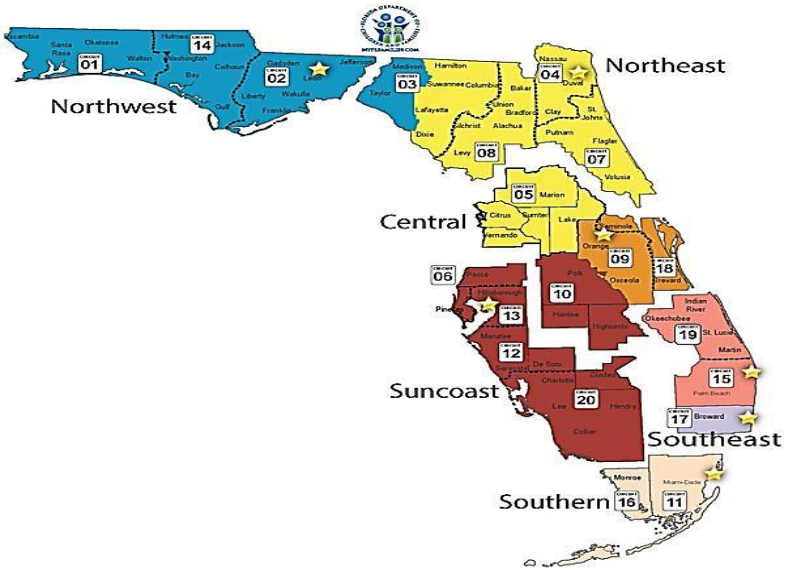
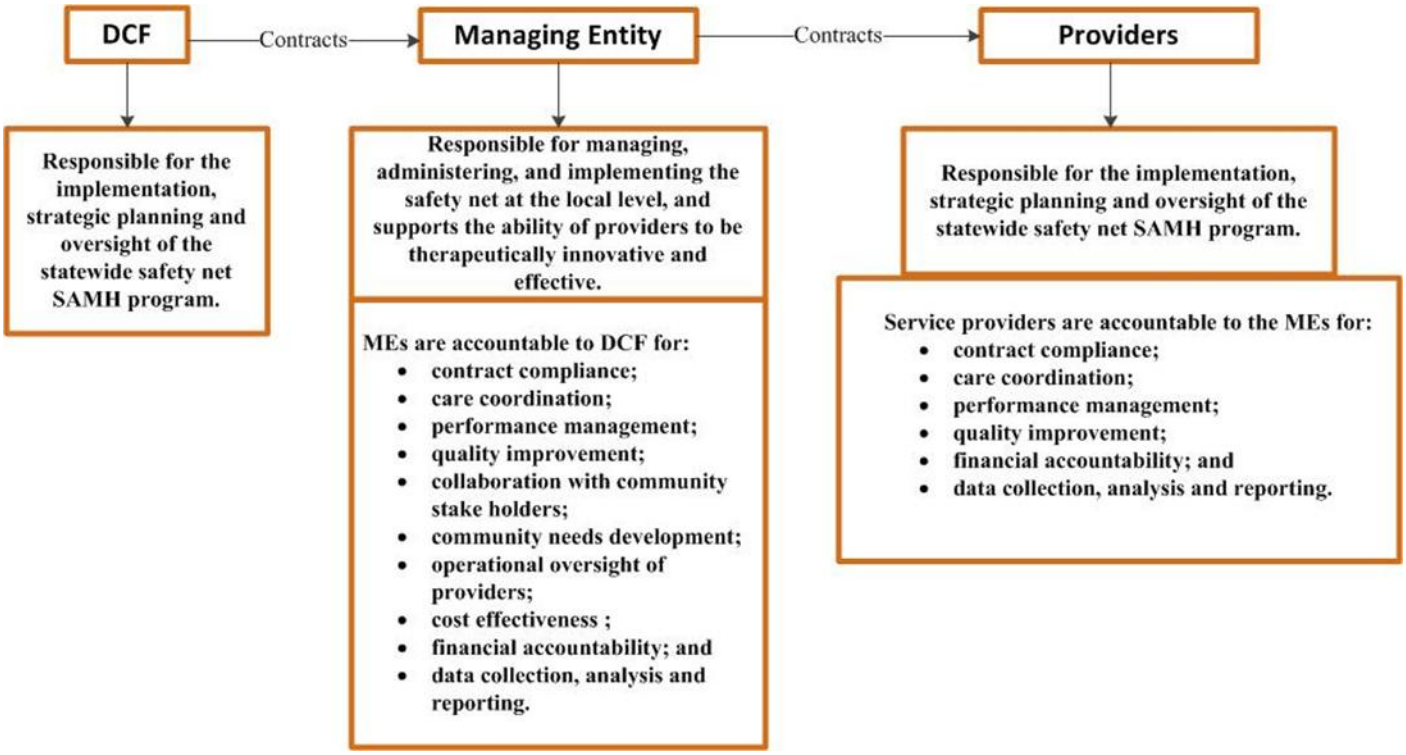
[21] *Supra* footnote 18.
[22] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance and children at risk for initiating drug use.
[23] Ch. 2001-191, L.O.F.
[24] S. 394.9082, F.S.
[25] Chapter 2008-243, L.O.F.
[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 March 16, 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 uses 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.

[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.

- **Network Service Provider Compliance** – A minimum of 95% of the managing entity's network service providers shall demonstrate annual compliance with a minimum of 85% of the applicable network service provider measures (i.e., client outcome measures) at the target levels for the network service provider established in the subcontract.
- **Block Grant Implementation** – The managing entity shall ensure 100% of the cumulative annual network service provider expenses comply with the block grant and maintenance of effort establish allocation standards.
- **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.

Apart from DCF's direct oversight of managing entities through evaluating adherence to contractual requirements and measuring performance, accreditation is a way of assuring the quality of a managing entity's services. Accreditation through an accrediting organization with published standards allows a managing entity to demonstrate achievement of those standards. One type of accreditation available to a managing entity is accreditation of its network. For instance, the Commission on Accreditation of Rehabilitation Facilities (also known as CARF International) offers a network accreditation that addresses domains such as integrated strategic planning, resource coordination, and technology.[30] Currently four of the seven managing entities have a network accreditation.[31]

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.[32]

Currently, only a county or a consortium of counties who have established planning councils or committees may apply for a grant under the Program.[33] 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.[34] Applicants may seek a one-year planning grant or a three-year implementation or expansion grant.[35] 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.[36]

The Program's Statewide Grant Review Committee (Committee) is responsible for evaluating applications submitted to the Program. The Committee includes:[37]

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[30] Why does accreditation matter? http://www.carf.org/Accreditation/ (last viewed March 16, 2016).
[31] Email from Linda McKinnon, re: possible ME network accreditation language, Feb. 15, 2016 (on file with the Children, Families, and Seniors Subcommittee).
[32] Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant: Request for Applications, Department of Children and Families, May 2013.
[33] Section 394. 658(3), F.S.
[34] Id.
[35] S. 394. 656(3)(a), F.S.
[36] S. 394. 658(2)(b) and (c), F.S.
[37] S. 394. 656(2)(a-e), F.S.

- 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.[38] DCF may then transfer funds, if available, to any counties or consortium of counties awarded a grant.[39] 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.[40] For fiscally constrained counties, the available resources may be at 50 percent of the total amount of the grant.[41]

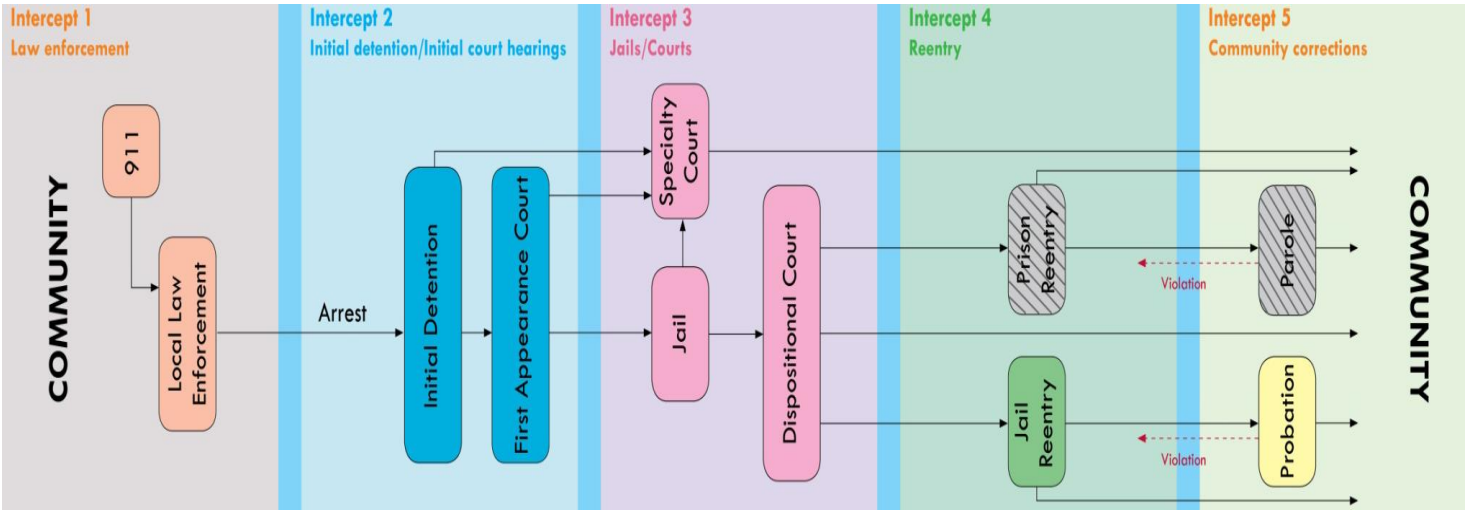
Sequential Intercept Model

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems.[42] 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.[43] The interception points are:[44]

- 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.

[38] S. 394. 656(4), F.S.
[39] Id.
[40] S. 394. 658(2)(b) and (c), F.S.
[41] Id.
[42] *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, Munetz MR and Griffin PA, Psychiatr. Serv., 2006 April; 57(4):544-9. http://www.ncbi.nlm.nih.gov/pubmed/16603751 (last viewed on March 16, 2016).
[43] Id.
[44] Id.

Sequential Intercept Model



Source: 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.[45]

Baker 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. [46] 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.[47]

Involuntary Examination and Receiving Facilities

Individuals in acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[48] 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[49]:

- 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.

[45] Id.
[46] Ss. 394.451-394.47891, F.S.
[47] S. 394.459, F.S.
[48] Ss. 394.4625 and 394.463, F.S.
[49] S. 394.463(1), F.S.

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.[50] 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.[51] 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.[52]

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.[53] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[54]

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.[55] Individuals often enter the public mental health system through CSUs.[56] 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.[57]

For FY 2014-15 there were 544 adult and 106 crisis stabilization beds funded by DCF.[58] There were 181,471 involuntary examinations initiated at hospitals and CSUs in calendar year 2014 (most recent report).[59]

Guardian Advocate

The Baker Act provides for the appointment of a guardian advocate for individuals who are incompetent to consent to treatment. The guardian advocate is responsible for making well-informed mental health treatment decisions for the patient. The administrator of a receiving or treatment facility may petition the court for the appointment of advocate guardian if a psychiatrist has determined that a patient is incompetent to consent to treatment.[60] 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.[61] The court will appoint a qualified guardian advocate if it finds the patient incompetent.[62] The court may not appoint certain individuals as a guardian advocate:[63]

- 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.

[50] S. 394.455(26), F.S.
[51] S. 394.455(25), F.S
[52] Rule 65E-5.400(2), F.A.C.
[53] S. 394.875(1)(a), F.S.
[54] Id
[55] Id.
[56] Budget Subcommittee on Health and Human Services Appropriations, the Florida Senate, Crisis Stabilization Units, (Interim Report 2012-109) (Sept. 2011).
[57] Id. Sections 394.65-394.9085, F.S.
[58] Id.
[59] Christy, A. (2015). *Report of 2014 Baker Act Data*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.
[60] Section 394.4598(1), F.S.
[61] Id.
[62] Id.
[63] Id.

The facility must provide a guardian advocate with sufficient information for a guardian advocate to make an informed decision.[64] 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.[65] 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.[66] 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.[67]

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.

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. [68] 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).[69] 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.[70] 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.[71] 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").[72]

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 and Involuntary Admissions

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.[73] However, denial of addiction is a common symptom, raising a barrier to early intervention

[64] Section 394.4598(2), F.S.
[65] Id.
[66] Id.
[67] Section 394.4598(7), F.S.
[68] Department of Children and Families, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5.
[69] Id.
[70] Id.
[71] Id.
[72] Ch. 93-39, s. 2, Laws of Fla., codified in ch. 397, F.S.
[73] 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.

and treatment.[74] As a result, treatment often comes because of a third party making the intervention needed for substance abuse services.[75]

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.[76]

Involuntary Admissions

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

- **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.[77] 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.[78]
- **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.[79]

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 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);

[74] 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 March 16, 2015).
[75] Id.
[76] S. 397.675, F.S.
[77] 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.
[78] S. 397.679, F.S.
[79] S. 397.6822, F.S.

- 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.[80]

Once the petition is filed with the court, the court issues a summons to a respondent and the court must schedule a hearing to take place within 10 days, or can issue an ex parte order immediately.[81]

After hearing all relevant testimony, the court determines whether a 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 a respondent meets the criteria, it may order him or her to be admitted for a period of 5 days[82] to a hospital, licensed detoxification facility, or addictions receiving facility, for involuntary assessment and stabilization.[83] During that time, an assessment is completed on the individual.[84] 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
- Hold the individual if petition for involuntary treatment has been initiated.[85]

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

[80] S. 397.6814, F.S.
[81] 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.
[82] 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.
[83] 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.
[84] 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.
[85] 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.

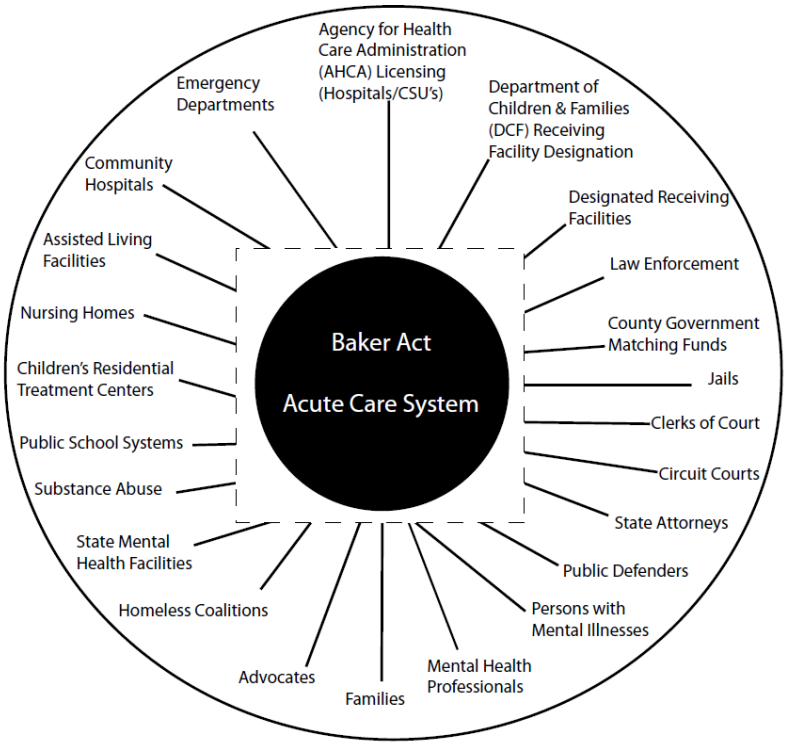
admissions procedures within a specified period.[86] Similar to a petition for involuntary assessment and stabilization, a petition for involuntary treatment must contain the same identifying information for all parties and attorneys and facts to support the need for involuntary treatment including the 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
  - 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.[87]

A treatment hearing must be scheduled within 10 days after the petition is filed. 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.[88] 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.



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

[86] S. 397.693, F.S.
[87] S. 397.6951, F.S.
[88] If the need for treatment is longer, renewal of the order may be petitioned prior to the expiration of the initial 60-day period.

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. For example, the federal Emergency Medical Treatment and Active Labor Act[89] 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.[90] Examples of state laws include:

- 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 incapacity 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.[91]

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.

Funding for services provided in this system comes from a variety of sources, including but not limited to local government funding[92], state general revenue, federal block grant funds, Medicaid, private insurance, and client fees[93].

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 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, a law enforcement officer, or a health officer.[94] 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.[95]

[89] 42 U.S.C. 1395dd.
[90] *Florida Mental Health Institute, USF, 2014 Baker Act User Reference Guide.*
[91] S. 409.973(1)(q) and (bb), F.S.
[92] S. 394.76, F.S.
[93] S. 394.674(3), F.S.
[94] S. 397.6795, F.S.
[95] S. 394.462(4), F.S.

Advance Directives

Competent adults may formulate, in advance, preferences regarding a course of treatment in the event that injury or illness causes severe impairment or loss of decision-making capacity. An advance directive is a written document or oral statement designed to control certain future health care when a person becomes unable to make decisions and choices on his or her own.[96]

All 50 states permit an individual to use an advance directive to express his or her wishes as to medical treatment in the event the individual becomes terminally ill or has an injury or disease making the individual unable to communicate or make medical decisions.[97] However, the requirements to create a valid advance directive vary among the states.

Under Florida law, a health care advance directive is a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care.[98] Health care advance directives include, but are not limited to, the designation of a health care surrogate, a living will, or an anatomical gift.[99] No specific form is required, and an individual can provide direction for all health care issues, including life-prolonging procedures and mental health treatment.[100] Health care facilities are required to provide each patient with written information concerning the individual's rights relating to advance directives and the facility's policies respecting the implementation of such rights.[101]

Dementia

Dementia is not a disease but rather is an umbrella term used for a set of symptoms which commonly include impaired thinking and memory loss.[102] Based upon the individual's symptomology, dementia is classified as either a major or minor neurocognitive disorder. Examples of common causes of dementia include vascular dementia, frontotemporal lobar degeneration, Creutzfeldt-Jacob disease, and Alzheimer's disease.[103] An estimated 14% of individuals aged 71 years or older have some form of dementia.[104]

Most types of dementia cannot be cured, but the symptoms may be temporarily improved through non-pharmacological therapies and medication. Treatment can be complicated as dementia-related disorders can co-occur with other mental disorders such as depression, anxiety disorders, and psychotic conditions.[105] The symptoms of dementia-related disorders should initially be managed through the use of non-pharmacological therapies.[106] If non-pharmacological therapies do not prove

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[96] *Advance Directives*, American Cancer Society. http://www.cancer.org/treatment/findingandpayingfortreatment/understandingfinancialandlegalmatters/advancedirectives/advance-directives-types-of-advance-health-care-directives (last viewed on March 16, 2016). Living Wills may also contain a durable power of attorney, DNR and health care advance directives.

[97] American Bar Association, "Living Wills, Health Care Proxies, & Advance Health Care Directives," *available at* http://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/living_wills_health_care_proxies_advance_health_care_directives.html (last visited on March 16, 2016).

[98] S. 765.101(1), F.S.

[99] Id.

[100] S. 765.101(5)(a), F.S.

[101] S. 765.110(1), F.S.

[102] *Difference Between Alzheimer's and Dementia*. http://www.alzheimers.net/difference-between-alzheimers-and-dementia/ (last visited March 16, 2016).

[103] *2015 Alzheimer's Disease Fact and Figures*, Alzheimer's Association, http://www.alz.org/alzheimers_disease_facts_and_figures.asp (last visited March 16, 2016).

[104] Id.

[105] *Cognitive Camouflage — How Alzheimer's Can Mask Mental Illness*, Michael B. Friedman, LMSW; Gary J. Kennedy, MD; and Kimberly A. Williams, LMSW, Aging Well, Vol. 2 No. 2 P. 16, January/February 2009. http://www.todaysgeriatricmedicine.com/archive/030209p16.shtml (last visited March 16, 2016).

[106] *A Systematic Evidence Review of Non-pharmacological Interventions for Behavioral Symptoms of Dementia*, Department of Veterans Affairs, March 2011. http://www.ncbi.nlm.nih.gov/books/NBK54971/ (last visited February 19, 2016).

effective the next step is to employ various medications. These include antidepressants, anxiolytics and antipsychotic medications.[107]

No drugs have been specifically approved by the U.S. Food and Drug Administration (FDA) to treat behavioral and psychiatric dementia symptoms.[108] Further, the FDA issued a warning notifying healthcare professionals that antipsychotics are associated with an increased risk of mortality in elderly patients treated for dementia-related psychosis.[109]

Effect of the Proposed Changes

Behavioral Health Managing Entities

The bill substantially revises s. 394.9082, F.S., governing managing entities, which the bill defines as corporations selected by and under contract with DCF to manage the daily operational delivery of behavioral health services through a coordinated system of care. The bill also defines "behavioral health services" as mental health and substance abuse services as defined in ch. 394 and 397. The bill states Legislative findings that untreated behavioral health disorders are major health problems for Florida residents and increase demands on the state's criminal justice systems, child welfare system, and health care systems. However, these disorders respond to treatment, which may be facilitated through a regional management structure.

The bill also includes Legislative intent that managing entities work to create linkages among services and systems. The bill states that the purpose of managing entities is to plan, coordinate, and contract for the delivery of community mental health and substance abuse services, improve access to care, promote service continuity, purchase services, and support efficient and effective delivery of services. The bill deletes current language regarding the transition to the managing entity system and reorganizes provisions to specifically address managing entity functions, including contracting, DCF and managing entity responsibilities, performance management and accountability, network accreditation and systems coordination agreements, enhancement plans, and the acute care services utilization database.

Managing Entity Contracts

The bill requires DCF to contract with organizations to serve as managing entities. The bill allows entities other than non-profit organizations to serve as managing entities under specific circumstances. Using an invitation to negotiate, DCF must first attempt to contract with nonprofit organizations for the delivery of these services, using at a minimum the following criteria to evaluate bidders:

- Experience serving persons with mental health and substance use disorders;
- Established community partnerships with behavioral health providers;
- Demonstrated organizational capabilities for network management functions;
- Capability to coordinate behavioral health care services with primary care services; and
- Willingness to provide recovery-oriented services and systems of care and work collaboratively with persons with mental health and substance use disorders and their families in designing such systems and delivering such services.

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[107] *Treatments for Behavior*, Alzheimer's Association. http://www.alz.org/alzheimers_disease_treatments_for_behavior.asp#medications (last visited March 16, 2016).
[108] Id.
[109] *Information for Healthcare Professionals: Conventional Antipsychotics,* U.S. Food and Drug Administration, June 16, 2008. http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm124830.htm (last visited March 16, 2016).

However, if DCF receives fewer than two responsive bids, DCF must reissue the solicitation, and managed behavioral health organizations[110] will also be eligible to bid and be awarded a contract. The bill requires all for-profit and nonprofit contractors serving as managing entities to operate under the same contractual requirements. Each managing entity must have a board of directors or, if a managed behavioral health organization, an advisory board that is representative of the community. In the contracts, DCF must specify the geographic areas[111] served by managing entities and require managing entities to cooperate with the transition to a new managing entity if necessary. DCF must also perform a readiness review before a managing entity may begin performing its duties.

The bill also addresses funding for managing entities, requiring a fixed-price contract with a two-month advance payment at the beginning of the fiscal year and equal monthly payments thereafter. The bill allows managing entities to carry forward unexpended state funds not to exceed 8% of the annual contract amount under certain conditions.

[110] The bill defines a "managed behavioral health organization" as a Medicaid managed care organization currently under contract with the statewide Medicaid managed medical assistance program or a behavioral health specialty managed care organization established pursuant to part IV of chapter 409.
[111] The bill defines "geographic area" as one or more contiguous counties, circuits, or regions as described in s. 409.966, F.S.

DCF Oversight of Managing Entities

The bill imposes specific duties for managing entity oversight. DCF must:

- Specify data reporting requirements and the use of shared data systems;
- Provide technical assistance to the managing entities;
- Facilitate coordination between the managing entity and other payors of behavioral health care and between providers contracting directly with DCF and the managing entity;
- Develop and provide a unique identifier for clients receiving services through the managing entity;
- Coordinate procedures for the referral and admission of patients to, and the discharge of patients from, treatment facilities, and their return to the community;
- Ensure that managing entities comply with state and federal laws, rules, regulations and grant requirements; and
- Develop rules for the operations of, and the requirements that shall be met by, the managing entity, if necessary.

DCF must also define the priority populations that will benefit from receiving care coordination, considering the availability of resources and:

- The number and duration of involuntary admissions within a specified time.
- The degree of involvement with the criminal justice system and risk to public safety posed by the individual;
- Whether the individual has recently resided in or is currently awaiting admission to or discharge from a treatment facility as defined in s. 394.455.
- The degree of utilization of behavioral health services.
- Whether the individual is a parent or caregiver who is involved with the child welfare system.

Additionally, DCF is to promote the coordination of behavioral health care and primary care, support the development and implementation of a coordinated system of care by requiring providers directly contracting with DCF to coordinate with managing entities, and periodically review contract and reporting requirements and reduce costly, duplicative, and unnecessary administrative requirements.

Managing Entity Responsibilities

The bill also details requirements for managing entities regarding needs assessment and service planning, network management, and governance and stakeholder relations. Managing entities must promote the development and effective implementation of a coordinated system of care. Specifically, the bill requires managing entities to conduct a community behavioral health care needs assessment every three years in the geographic area served by the managing entity; the needs assessment must be developed through a process including public participation, specify needs by subregion[112], include certain information needed by DCF for its annual report, and be provided to DCF. Based on this assessment, managing entities must determine the optimal array of services to meet the community's identified needs, manage and allocate funds for services to meet the requirements of law or rule, and expand the scope of services as resources become available, including promoting and supporting care coordination activities.

They also are to develop comprehensive networks of qualified providers to deliver behavioral health services. The bill defines a managing entity "provider network" as the group of direct service providers, facilities, and organizations under contract with a managing entity to provide a comprehensive array of emergency, acute care, residential, outpatient, recovery support, and consumer support services, including prevention services. 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

[112] The bill defines "subregion" as a distinct portion of a managing entity's geographic region defined by unifying service and provider utilization patterns.

network and evaluating to determine whether a provider may be part of its network. The bill requires managing entities to develop resources and monitor network providers' performance and their compliance with contract requirements and federal and state laws, rules, regulations, and grant requirements and implement shared data systems.

To facilitate the broader operation of the behavioral health system, the bill requires managing entities to provide assistance to counties to develop designated receiving systems and transportation plans. Managing entities must also promote coordination of behavioral health with primary care.

The bill requires managing entities to work with local homeless councils and organizations to share information about clients, available resources, and other data or information for addressing the homelessness of persons suffering from a behavioral health crisis and work collaboratively with public receiving facilities, homeless services providers, and housing providers to create or find placements for individuals served by the managing entity to prevent or reduce readmissions. Managing entities must also work collaboratively with public receiving facilities and licensed housing providers to establish a network of licensed housing resources for mental health consumers that will prevent and reduce readmissions to public receiving facilities.

Managing entities must operate in a transparent manner and work independently and in collaboration with stakeholders to improve coordination among, access to, and effectiveness, quality, and outcomes of behavioral health services. The bill specifically requires managing entities to coordinate with local criminal and juvenile justice systems to enhance diversion from those systems, local court systems to maximize the use of involuntary outpatient services, and the child welfare system to provide effective and timely services to parents and caregivers involved in both systems.

Managing Entity Network Accreditation and Systems Coordination

The bill requires managing entities to earn accreditation within three years of either the bill's effective date (for managing entities under contract as of that date) or of the contract execution date. DCF must identify acceptable accreditations that at a minimum address coordination within the managing entity's network. The bill requires DCF to consider whether the accreditation facilitates such actions as integrated strategic planning, resource coordination, and technology integration when identifying acceptable accreditations. If a managing entity under contract as of July 1, 2016, earns accreditation within the three-year timeframe and meets other contract requirements and performance standards, the bill permits DCF to continue the managing entity's contract for an additional five years.

If the accreditation does not also address coordination between the network and other major systems and programs such as the child welfare system, courts system, and Medicaid program, managing entities must execute memoranda of understanding regarding communication and coordination with such systems and programs within one year of either the bill's effective date or the managing entity's contract execution date.

Managing Entity Performance Measurement and Accountability

The bill allows DCF to determine the data which the managing entities must collect and submit, to include at a minimum persons served, outcomes of persons served, and the costs of services provided through DCF's contract. DCF, to the extent possible, must use applicable measures based on nationally recognized standards which are to be used to measure managing entity performance and the results of their joint efforts with other systems in meeting the community's behavioral health needs. Examples of such standards include the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's National Outcome Measures and those developed by the National Quality Forum or the National Committee for Quality Assurance. The bill requires DCF to work with managing entities to establish additional performance measures related to, at a minimum:

- The extent to which individuals in the community receive services, including, but not limited to, parents or caregivers involved in the child welfare system who need behavioral health services;
- The improvement in the overall behavioral health of a community;
- The improvement in functioning or progress in recovery of individuals served by the managing entity;
- Success of strategies to divert admissions from acute levels of care, jails, prisons, and forensic facilities; integrate behavioral health services with the child welfare system; and address the housing needs of individuals being released from public receiving facilities who are homeless;
- Consumer and family satisfaction; and
- Level of engagement of key community constituencies such as law enforcement agencies, community-based care lead agencies, school districts, and the courts.

Managing Entity Enhancement Plans

Annually by September 1, beginning in 2017, managing entities must develop using an inclusive process and submit to DCF a description of strategies for enhancing services and addressing three to five priority needs in the service area. Strategies must be described in detail, including an implementation plan specifying action steps, services that would be purchased, likely benefits of the services, projected costs, and number of individuals projected to be served. DCF may include all or part of the enhancement plans in its legislative budget request.

Baker Act

Involuntary Examination

Currently, law enforcement must execute a written report when delivering a person in custody to a receiving facility and if the receiving facility accepts the patient it must send a copy of the report to AHCA by the next work day. The bill requires the receiving facility to send the report to DCF instead of AHCA.

The bill specifies that either a circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination. The bill defines involuntary examination as an examination performed pursuant to the Baker Act or an involuntary assessment and stabilization pursuant under the Marchman Act to determine if the person needs involuntary services. Involuntary services however is defined as court ordered outpatient services or inpatient placement under the Baker Act.

Involuntary Inpatient Placement

The bill expresses legislative intent that licensed, qualified health professionals should be authorized to practice to the full extent of their education and training in the performance of professional functions necessary to carry out the intent of the act. Consistent with that intent, the bill adds psychiatrists and psychiatric nurses to the list of professionals who can recommend continued involuntary inpatient placement.

The bill specifies that the hearing on involuntary inpatient placement must be within five “court working” days.

Currently, the court must order a patient that meets the criteria to receive treatment from a treatment facility, on an involuntary basis, for a period of up to 6 months. The bill expands the venues where treatment may be ordered to include facilities, defined as any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training or hospitalization of persons who appear to have or have been diagnosed as having a mental illness or a substance abuse impairment. However, the bill limits the duration of the court order for treatment at those locations to a maximum of 90 days. The bill also 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.

Involuntary Outpatient Services

The bill replaces the term “involuntary outpatient placement” with “involuntary outpatient services” in an effort to modernize the terminology and more accurately describe the treatment being provided.

Under current law only circuit courts are authorized to order an individual into involuntary outpatient services. The bill defines “court” as either a circuit court or a criminal county court, allowing a criminal county court to order an individual into involuntary outpatient services and aligning the bill’s provisions with CS/CS/CS/HB 439. The bill requires that a copy of this order be sent to appropriate managing entity rather than to AHCA as required by current law.

The bill expresses legislative intent that licensed, qualified health professionals should be authorized to practice to the full extent of their education and training in the performance of professional functions necessary to carry out the intent of the act. Consistent with that intent, the bill allows physicians with experience in the treatment of mental illness and psychiatric nurses to provide the second opinions required by current law for recommendations for involuntary outpatient services in all counties in the state, rather than just allowing them to do so in counties with populations under 50,000. The bill also expands the professionals who can render this second opinion to include clinical social workers and physician assistants who have at least 3 years’ experience and are supervised by such licensed physicians or a psychiatrists.

The bill revises the content of the treatment plan that must be prepared by the service provider for submission to the court for inclusion in the involuntary outpatient services order. The treatment plan must address the nature and extent of the mental illness and any co-occurring substance use disorders that necessitate involuntary outpatient services. It must also specify the likely level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient services. The bill removes the requirement that a copy of the treatment plan be provided to the patient and the administrator of the receiving facility.

Additionally, the bill requires the service provider to notify the managing entity if the requested involuntary outpatient services are not available and requires the managing entity to document efforts to obtain those services.

The bill reduces the maximum duration of court ordered involuntary outpatient services from six months to 90 days. If the patient continues to meet the criteria for involuntary outpatient services, the bill requires the service provider to petition the court at least 10 days before the expiration of the treatment period for the extension. The bill requires the court to immediately schedule a hearing on the petition to be held within 15 days of the filing of the petition.

The bill also strikes current intent language regarding least restrictive interventions.

Patient Representative

The bill expands the number of individuals who are prohibited from serving as the patient’s representative when a patient is admitted to a facility for involuntary examination or placement, or when a petition for involuntary placement is filed. The following individuals are prohibited from serving as the patient’s representative by the bill:

- A professional providing clinical services to the patient under the Baker Act;

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

Guardian Advocate

The bill amends s. 394.4598, F.S., to prohibit the following persons from serving as the patient's guardian advocate:

- A professional providing clinical services to the individual under the Marchman Act;
- The qualified professional who initiated the involuntary examination of the individual, if the examination was initiated by a qualified professional's certificate;
- An employee, an administrator, or a board member of the facility providing the examination of the individual;
- An employee, an administrator, or a board member of the treatment facility providing treatment of the individual;
- A person providing any substantial professional services to the individual, including clinical services;
- A creditor of the individual;
- A person subject to an injunction for protection against domestic violence and for which the individual was the petitioner; and
- A person subject to an injunction for protection against repeat violence, sexual violence, or dating violence and for which the individual was the petitioner.

The bill also provides for training requirements for guardian advocates. Guardian advocates may either complete the training for guardians appointed pursuant to ch. 744, F.S., or attend at least a four-hour training course approved by the court. Current law allows the court discretion to waive some or all of the training requirements or to impose additional requirements on the guardian advocate on a case-by-case basis.

Rulemaking Authority

Currently, under s. 394.46715, F.S., DCF has rulemaking authority to implement the provisions of ss. 394.455, 394.4598, 394.4615, 394.463, 394.4655, and 394.467, F.S. The bill grants DCF rule-making authority for all sections of the Baker Act.

Marchman Act

Court Proceedings

The bill makes various changes to court proceedings under the Marchman Act. The bill prohibits the court from charging a filing fee for petitions filed under the Marchman Act. The bill limits the time for which an order for involuntary admission is valid to seven days, unless otherwise specified in the order.

DCF currently publishes a limited number of forms for Marchman Act pleadings. The bill amends the Marchman Act to require DCF to develop and publish standard forms for pleadings, including forms for petitions for involuntary admissions. The bill requires DCF to notify the courts and other state agencies of the existence and availability of these forms.

Involuntary Admission

The bill revises the criteria for an involuntary admission under the Marchman Act. Under the bill, a person meets the criteria for involuntary admission if there is good faith reason to believe he or she is substance abuse impaired or has a co-occurring mental health disorder and, because of this impairment or disorder has lost the power of self-control with respect to substance abuse use and:

- Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision in that regard; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services; or
- Without care or treatment, is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that 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 substantial likelihood that the person has inflicted, or threatened to or attempted to inflict, or, unless admitted, is likely to inflict, physical harm on himself, herself, or another.

The bill expresses legislative intent that licensed, qualified health professionals should be authorized to practice to the full extent of their education and training in the performance of professional functions necessary to carry out the intent of the act. Consistent with that intent, the bill expands the professionals who may execute a certificate for emergency admission under the Marchman Act from solely a physician to also allow a clinical psychologist, physician assistant, psychiatric nurse, advanced registered nurse practitioner, mental health counselor, marriage and family therapist, master's level certified addiction professional for substance abuse services, or clinical social worker to do so. The professional must have examined the person within the five days prior to executing the certificate.

Involuntary Assessment and Stabilization

The bill reduces the number of adults with direct personal knowledge of a person's substance abuse impairment necessary to file a petition for involuntary assessment and stabilization from three to one. The bill also revises the standards for involuntary assessment and stabilization to reflect the new criteria for involuntary admission.

Involuntary Services

The bill makes changes throughout the Marchman Act to rename "involuntary treatment" as "involuntary services". The bill also extends the length of the initial order for involuntary services from 60 to 90 days and also extends the length of an order for renewal of those services from 60 to 90 days. When involuntary services are ordered, the court must send a copy of the order to the managing entity.

The bill requires the court to appoint regional conflict counsel to represent the respondent in petitions for involuntary services and continued involuntary services if the individual does not have an attorney. Additionally, the bill sets forth procedures for the court to follow regarding petitions for continued involuntary services and allows the respondent to agree to continued services without a hearing.

The bill allows for a continuance of the hearing on the petition for involuntary services and reduces the time within which the court must hear the petition, absent a continuance, from ten to five days, to align

with the Baker Act. Finally, the bill expressly authorizes the court to order an individual into involuntary services with a publicly funded service provider or privately funded service provider if the respondent has the ability to pay for the services, or if any person on the respondent's behalf voluntarily demonstrates willingness and ability to pay for the services.

The bill also revises the standards for involuntary services to reflect the new criteria for involuntary admission.

Informed Consent

The bill defines "informed consent," which is not currently defined in the Marchman Act, 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.

Guardian Advocate

Currently, the Marchman Act does not authorize the courts to appoint guardian advocates for patients who are incompetent to consent to treatment under the Marchman Act. The bill creates s. 397.6978, F.S., which allows the court to appoint a guardian advocate for the patient, based on a petition by the administrator of a receiving facility, if it finds that a patient is incompetent to consent to treatment, has not been adjudicated incapacitated, and that a guardian with the authority to consent to mental health treatment has not been appointed. In order for a guardian advocate to be appointed, the court must hold a hearing, at which the patient has the right to be represented by counsel, to testify, to cross-examine witnesses, and present witnesses.

Additionally, the bill requires information to be provided to a prospective guardian advocate. It also requires the guardian advocate to either complete the training for guardians appointed pursuant to ch. 744, F.S., or attend at least a four-hour training course approved by the court. However, the bill provides the court discretion to waive some or all of the training requirements or to impose additional requirements on the guardian advocate on a case-by-case basis.

The bill prohibits the following persons from serving as the patient's guardian advocate:

- A professional providing clinical services to the individual under the Marchman Act;
- The qualified professional who initiated the involuntary examination of the individual, if the examination was initiated by a qualified professional's certificate;
- An employee, an administrator, or a board member of the facility providing the examination of the individual;
- An employee, an administrator, or a board member of the treatment facility providing treatment of the individual;
- A person providing any substantial professional services to the individual, excluding public and professional guardians;
- A creditor of the individual;
- A person subject to an injunction for protection against domestic violence and for which the individual was the petitioner; and
- A person subject to an injunction for protection against repeat violence, stalking, sexual violence, or dating violence and for which the individual was the petitioner.

When selecting the guardian advocate, the bill requires the court to give preference to the patient's health care surrogate, if one has already been designated by the patient. If the patient has not previously designated a health care surrogate, the selection shall be made, except for good cause, from among the following persons, listed in order of priority:

- The patient's spouse;
- An adult child of the patient;
- A parent of the patient;
- The adult next of kin of the patient;
- An adult friend of the patient; then
- An adult trained and willing to serve as the guardian advocate for the patient.

Prior to appointment, the facility requesting appointment of a guardian advocate shall, before the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including information about the ethics of medical decision making. Additionally, prior to requesting the guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment. The bill permits the court to authorize the guardian advocate to consent to medical treatment as well as substance abuse disorder treatment; however, absent specific court approval, the guardian advocate may not consent to:

- Abortion;
- Sterilization;
- Electroshock therapy;
- Psychosurgery; or
- Experimental treatments that have not been approved by a federally approved institutional review board.

The bill requires the guardian advocate to be discharged when the patient is discharged from an order for involuntary outpatient services, involuntary inpatient placement, or when the patient is transferred from involuntary to voluntary status.

Reporting

The Baker Act has robust reporting requirements. For example, pursuant to s. 394.463(2)(a)2, F.S., law enforcement officers must execute a written report detailing the circumstances under which the person was taken into custody and delivered to a receiving facility. If the receiving facility accepts the patient it must send a copy of the report to AHCA by the next work day.[113]

The Marchman Act authorizes law enforcement to take an individual meeting involuntary admission criteria into protective custody; however, it does not require law enforcement to execute a report. The bill requires law enforcement to execute a written report on a DCF-created form when initiating protective custody.[114] The reporting requirement is only applicable if law enforcement is taking the individual to a hospital or a licensed detoxification or addictions receiving facility.

Behavioral Health System of Care

Essential Elements

The bill amends s. 394.4573, F.S., to establish essential elements of a coordinated system of care:

[113] S. 394.463(2)(a)2, F.S.
[114] S. 397.6772, F.S., currently requires law enforcement to take an individual meeting involuntary admission criteria into protective custody; however, it does not require law enforcement to execute a report.

- Community interventions, such as prevention, primary care for behavioral health needs, therapeutic and supportive services, crisis response services, and diversion programs;
- A designated receiving system (further described below);
- Transportation in accordance with a plan developed under s. 394.462, F.S.;
- Crisis services, including mobile response teams, crisis stabilization units, addiction receiving facilities, and detoxification facilities;
- Case management, defined as direct services to clients for assessing needs; planning; arranging services; coordinating service providers; linking the service system to a client; monitoring service delivery; and evaluating patient outcomes to ensure the client is receiving the appropriate services;
- Care coordination, defined as the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support, such as supportive housing, supported employment, family support and education, independent living skill development, wellness management, and self-care.

The bill requires that all case managers and their direct supervisors hold a valid certification issued by a DCF-approved credentialing entity by July 1, 2017, and within six months of hire thereafter.

The bill repeals s. 394.675, F.S., requiring that a community-based system of comprehensive substance abuse and mental health services shall be established and providing for its components, and replaces cross-references to that statute with cross-references to s. 394.4573, F.S., which provides the essential elements of a coordinated system of care.

The bill also expresses legislative intent that services should use coordination-of-care principles and include social support services. It strikes current intent language regarding least restrictive interventions and collaboration by state agencies and service systems.

Designated Receiving Systems

The bill describes the requirements for designated receiving systems in detail in s. 394.4573, F.S. A designated receiving system consists of one or more facilities serving a defined geographic area and responsible for assessment and evaluation, both voluntary and involuntary, and treatment or triage of patients who have a mental health or substance use disorder, or co-occurring disorders. The bill requires counties, individually or in coordination with other counties, and managing entities to plan and implement a designated receiving system by July 1, 2017, and review and update the designated receiving system at least once every three years. The counties and managing entities must use an inclusive process in planning the designated receiving system and document it through written memoranda of agreement or other binding arrangements.

The bill allows counties and managing entities flexibility in designing their designated receiving systems as long as a county's model, to the extent allowed by available resources, is a "no-wrong-door model," that responds to individual needs and integrates services among various providers. The bill defines a "no wrong door model" as a model for the delivery of acute care services to persons who have mental health or substance use disorders, or both, which optimizes access to care, regardless of the entry

point to the behavioral health care system[115].The bill describes three examples of designated receiving systems, including:

- A central receiving system, involving a designated central receiving facility which is a single point of access for individuals with mental illness, substance use disorder, or co-occurring disorders providing assessment, evaluation, and triage or treatment.
- A coordinated receiving system, involving multiple designated receiving facilities that are linked by shared data systems, formal referral agreements, and cooperative agreements for care coordination and case management.
- A tiered receiving system, involving designated receiving facilities and at least one other type of provider offering specialized or limited services, such as a triage center[116] or access center[117]. These facilities, within existing resources, must be linked by methods to share data, formal referral agreements, and cooperative agreements for care coordination and case management.

The bill requires maintenance of an inventory of participating service providers, including their capabilities, limitations, and ability to accept patients, which shall be available at all times to first responders.

The bill amends s. 394.461, F.S., regarding designation of receiving and treatment facilities to address designation of receiving systems. The bill authorizes DCF to designate receiving systems developed pursuant to s. 394.4573, F.S., and allows DCF to adopt rules with procedures and criteria for such designation.

Transportation

The bill amends s. 394.462, F.S., to require that a county or group of counties working through a memorandum of understanding collaborate with the managing entity to develop and implement a transportation plan by July 1, 2017. The plan must describe methods for transporting individuals for involuntary examination under the Baker Act and involuntary admission under the Marchman Act. Additionally, the plans may address transportation under other circumstances. The bill allows the plans to rely on emergency medical transport services or private transport companies. The plans must comply with the transportation requirements in ss. 394.462, 397.6772, 397.697, 397.6795, 397.6822, and s. 397.697, F.S.

The bill allows for transportation to the appropriate facility within the designated receiving system pursuant to a transportation plan or an exception granted by DCF, or to the nearest receiving facility if neither apply. The bill prohibits DCF from granting exceptions after June 30, 2017, and requires all exceptions to expire on that date.

The bill requires facilities to provide a basic screening or triage sufficient to refer the person to the appropriate services.

DCF Assessment of Behavioral Health Services and Systems Improvement Grants

[115] The bill adds or revises various definitions within s. 394.455, F.S, to incorporate substance abuse disorders within the Baker Act. These changes are necessary to effectuate the no wrong door system. These include “designated receiving facility”, “detoxification facility”, “qualified professional”, “physician assistant” and “substance abuse impairment”. Revised definitions include “receiving facility”, “private facility”, “facility”, “mobile crisis response service, “patient”, “service provider”, and “incompetent to consent to treatment”.
[116] The bill defines a “triage center” as a facility that has medical, mental health, and substance abuse professionals present or on call to provide emergency screening and evaluation for mental health or substance abuse disorders for individuals transported to the center by a law enforcement officer.
[117] The bill defines an ‘access center” as a facility that has medical, mental health, and substance abuse professionals to provide emergency screening and evaluation for mental health or substance abuse disorders and may provide transportation to an appropriate facility if an individual is in need of more intensive services.

The bill amends s. 394.4573, F.S., to require DCF to submit an assessment of behavioral health services in the state annually by December 1 to the Governor and Legislature. The bill provides minimum criteria for DCF to use in its assessment, including the extent to which designated receiving systems function as no-wrong-door models, the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches, the availability of less-restrictive services, and the use of evidence-informed practices. Beginning in 2017, DCF must include the managing entities' enhancement plans submitted pursuant to s. 394.9082(8), F.S., and its evaluation of each plan.

If funding is provided by the Legislature, DCF may award system improvement grants to managing entities. Managing entities must submit detailed plans to enhance services based on the no-wrong-door model or to meet needs identified in DCF's assessment. DCF must use performance-based contracts to award grants.

Medicaid Managed Care Program

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program. The SMMC program requires AHCA to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care through a Managed Medical Assistance (MMA) program. Behavioral health care is covered by Medicaid managed care plans for MMA program enrollees.

The bill amends s. 409.967, F.S., relating to Medicaid managed care plans. The bill requires managed care plans to provide or contract for care coordination of behavioral health care. The aim of such care coordination is to provide services in the least restrictive environment. The bill requires behavioral health care services delivered by Medicaid managed care plans to be integrated with primary care. Plans are to meet specific outcome standards developed by AHCA in consultation with the DCF. The bill also amends s. 409.973, F.S., to require MMA plans to work with behavioral health managing entities to establish specific organizational supports and protocols to enhance the integration and coordination of primary care and behavioral health services for Medicaid recipients.

The MMA program includes s. 409.975(6), F.S., which contains requirements for managed care plans participating in MMA relating to the rates, methods, and terms of payment negotiated between the plans and hospitals, including minimum and maximum rates of payments. Managed care plans must negotiate with hospitals for rates of payment that are no lower than the rate the AHCA would have paid the hospital on the first day that the contract between the plan and the hospital takes effect. Additionally, payments to contracted hospitals must not exceed 120 percent of the initial contract rate unless specifically approved by the AHCA.

HB 5101, passed on March 11, 2016, deletes the provision establishing the minimum rates a plan may pay a Medicaid managed care hospital from s. 409.975(6), F.S. The bill reenacts the minimum payment rate provision, notwithstanding changes to that subsection in HB 5101, to preserve the minimum Medicaid managed care hospital payment rates in current law.

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.

The bill requires DCF to provide information to AHCA regarding the costs and reimbursements for Medicaid covered services provided to Medicaid eligible individuals by providers of behavioral health services that are also funded for programs authorized by chapters 394 and 397. If the report presents clear evidence that Medicaid reimbursements are less than the costs of providing the services, the agency and the department shall request such additional trust fund authority as is necessary to draw

federal Medicaid funds as a match for the documented general revenue expenditures supporting covered services delivered to eligible individuals. Payment of the federal funds is to be made to providers in such a manner as is allowed by federal law and regulations.

AHCA and DCF must submit the written plan and report to the President of the Senate and the Speaker of the House of Representatives no later than December 31, 2016.

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

The bill converts the Statewide Grant Review Committee to the Statewide Grant Policy Committee. Under the bill, 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 National Alliance on Mental Illness;
- 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.

Facility Requirements

Section 394.879, F.S., preempts regulation of the design, construction, erection, alteration, modification, repair, or demolition of crisis stabilization units to the Florida Building Commission and the State Fire Marshal through adoption and maintenance of the Florida Building Code and the Florida Fire Prevention Code. The Florida Building Code contains provisions governing crisis stabilization units and short-term residential treatment facilities, including a requirement that a crisis stabilization unit or short-term treatment facility structure be a single-story ground level facility.[118] The bill allows a crisis

[118] 457.1.4.2.1, Florida Building Code, 5th edition (2014)—Building. http://codes.iccsafe.org/app/book/content/2014_Florida/Building%20Code/Chapter%204.html (accessed March 17, 2016).

stabilization unit, a short-term residential treatment facility, or an integrated adult mental health crisis stabilization and addictions receiving facility that is collocated with a centralized receiving facility to be in a multi-story building and be authorized on floors other than the ground floor.

The bill also moves from the current s. 394.9082, F.S., to s. 394.4685, F.S., requirements for a public receiving facility initiating a patient transfer to a private hospital for acute care mental health to notify the hospital of such transfer and send the hospital all records relating to the patient's emergency psychiatric or medical condition.

The bill revises s. 394.879, F.S., to require DCF and AHCA to develop a plan for the Governor and Legislature by November 1, 2016, presenting 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 statutory revisions that are required to allow consolidation. The bill directs the department and agency to accomplish licensure consolidation administratively and by rule to the extent possible.

Acute Care Services Utilization Database

Currently, pursuant to s. 394.9082, F.S., DCF has a statewide database to analyze payments for and use of state-funded crisis stabilization services. The law requires DCF to develop, implement, and maintain standards under which a behavioral health managing entity must collect utilization data from public receiving facilities located within its geographic service area. DCF must also develop standards and protocols for managing entities and public receiving facilities to use to collect, store, transmit, and analyze data.

Public receiving facilities must submit specified utilization data to managing entities in real time or at least daily. Managing entities must perform reconciliations monthly and annually to ensure data accuracy and must submit data to DCF on a monthly and annual basis.

The bill renames the Crisis Stabilization Services Utilization database established under s. 394.9082, F.S., as the Acute Care Services Utilization Database. It revises the data collected to also include:

- All admissions and discharges of clients receiving substance abuse services in an addictions receiving facility or detoxification facility pursuant to parts IV and V of chapter 397 who qualify as indigent; and
- The current active census of total licensed and utilized beds, the number of beds purchased by the department, the number of clients qualifying as indigent who occupy any of those beds, the total number of unoccupied licensed beds, regardless of funding, and the number in excess of licensed capacity. Crisis units licensed for both adult and child use must report as a single unit.

The bill provides a nonrecurring appropriation of $400,000 from state trust funds to DCF for these system upgrades.

Child Welfare

To advance the goal of combating substance abuse in families, ss. 39.507 and 39.512, F.S., authorize dependency courts to order an individual to undergo a substance abuse disorder assessment. The statutes additionally authorize a dependency court to order an individual to participate in and comply with a treatment-based drug court program.[119] Treatment-based drug court is an alternative to

[119] Ss. 39.507, F.S., and 39.512, F.S.

incarceration for defendants who enter the judicial system because of addiction and consists of an intensive, judicially monitored treatment program. [120]

The bill authorizes courts in the child welfare system to order a child, parent or legal custodian to participate in a mental health court program and to undergo a mental health assessment or treatment. The bill amends s. 39.001, F.S., to define the term "qualified professional",[121] which is used in the amended sections to specify the professionals who may conduct such assessments.

Section 39.407, F.S., provides a process for assessing the suitability of a child in the child welfare system who is in the legal custody of DCF 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.

Children receiving foster care assistance through federal Title IV-E funding are a mandatory eligibility group under Medicaid.[122] Thus for many foster children, a Medicaid managed care plan may be responsible for the cost of their residential mental health treatment; however, statute does not require the plan to receive a copy of the assessment. The bill requires a written copy of the suitability assessment performed pursuant to s. 39.407, F.S., to be provided to any Medicaid managed care plan financially responsible for the child's care in residential treatment.

Advance Directives

The bill requires DCF to appoint a workgroup to consider the feasibility of individuals using advance directives to express treatment wishes for substance abuse disorders. The workgroup will serve without compensation and must review the use of advance directives in mental health, the use of advance directives for substance use disorders in other states, and the use of similar legal instruments to express the treatment wishes of individuals suffering from substance use disorders. The workgroup must provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2017/ The section of law creating the workgroup expires May 6, 2017.

Parenting Plans

A parenting plan is a document established in a divorce or support proceeding under ch. 61, F.S., which details the legal rights and responsibilities of separated parents with regard to timesharing and parenting of their minor child. The parenting plan must be developed and agreed to by the parents and approved by a court; or established by the court, if the parents cannot agree.[123]

The parenting plan may address the child's education, health care, and physical, social, and emotional well-being, but at a minimum must:[124]

- Describe in adequate detail how the parents will share and be responsible for the daily tasks associated with the upbringing of the child;
- Include a time-sharing schedule which specifies the time that the minor child will spend with each parent;

[120] *Drug Court*, First Judicial Circuit Court of Florida. http://www.firstjudicialcircuit.org/programs-and-services/drug-court (last viewed on March 16, 2016).
[121] The bill defines "qualified professional" as physician, physician assistant, or a psychiatrist licensed under ch. 458 or ch. 459; psychologist; clinical social worker; marriage and family therapist; or mental health counselor; or a psychiatric nurse.
[122] S. 409.903(4), F.S.
[123] Section 61.046(14), F.S.
[124] Section 61.13(2)(b), F.S.; A rebuttable presumption exists that shared parenting is detrimental to the child in cases in which a parent has been convicted of domestic violence or is incarcerated.

- Designate the parent(s) responsible for health care, school-related matters (including the address to be used for school-boundary determination and registration) and other activities; and
- Address the methods and technologies that the parents will use to communicate with the child.

The bill requires that if a court orders shared parental responsibility for health care decisions, the parenting plan must provide that either parent may consent to mental health treatment for the child.

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.[125] An applicant seeking registration as an intern must:[126]

- 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 an individual to practice, under the supervision of a licensed mental health professional, while not meeting all of the clinical experience requirements. Individuals must have met minimum coursework requirements, and possess the appropriate graduate degree. A provisional license is valid for 2 years.[127]

The bill amends s. 491.0045, F.S., limiting 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 also prohibits a person with provisional licensure from applying for intern registration in the same profession.

Repeals

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

- Section 394.4674, F.S., which requires DCF to complete a deinstitutionalization plan. This section was enacted in 1980 and is obsolete following further developments in federal law.
- Section 394.4985, F.S., which requires DCF's regions to develop and maintain an information and referral network. This duplicates other requirements.
- Section 394.745, F.S., which requires an annual report to the Legislature of compliance of substance abuse and mental health treatment providers under contract with DCF.
- Section 397.331, F.S., which established the Statewide Drug Policy Advisory Council.
- Section 397.801, F.S., which requires DCF, the Department of Education, the Department of Corrections, and the Department of Law Enforcement to appoint a policy level staff person to

[125] Rule 64B4-2.001, F.A.C.
[126] Section 491.005, F.S.
[127] S. 491.0046, F.S. and Rule 64B-3.0075, F.A.C.

serve as the agency substance abuse impairment coordinator and also requires DCF to designate a substance abuse impairment coordinator 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.

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

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. 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:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The managing entities are required to earn network accreditation and submit enhancement plans for their behavioral health systems of care. However, managing entities' current responsibilities include needs assessment and planning.

Network accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF International) costs $9,000 every three years. Managing entities that initially earn network accreditation may have their contracts renewed even if a renewal is not authorized under the current terms of the contract, provided contract performance is satisfactory and other contract terms are met.

D. FISCAL COMMENTS:

The bill requires AHCA and DCF to submit a plan regarding maximizing revenue. Implementation of such a plan could increase the revenue available for mental health and substance abuse services.