HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 979 Behavioral Health Care Services
SPONSOR(S): Children, Families & Seniors Subcommittee, Peters and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	12 Y, 0 N, As CS	Brazzell	Brazzell
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

CS/HB 979 makes a variety of changes to the state's laws governing the provision of acute behavioral health care. The bill implements several recommendations from the Department of Children and Families (DCF) Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-17 intended to improve access to the acute behavioral health care system, including:

- Amending various mental health and substance abuse statutes' intent language regarding the importance of data-based decisionmaking, behavioral health practitioners' authority to practice to the full extent of their education and training, and the use of recovery oriented services.
- Expanding the types of professionals authorized to initiate an emergency admission under the Marchman Act to align more closely with the Baker Act.
- Providing for orders for involuntary treatment or placement under the Marchman Act and Baker Act to be for 90-day increments, unless placement is in a state treatment facility under the Baker Act.
- Prohibiting circuit courts from charging a fee for filing Marchman Act petitions.
- Requiring a hearing to be held within five days on any petition for discharge, unless a continuance is granted.
- Providing that a court order for Marchman Act involuntary assessment and stabilization is valid only for the period specified in the order, unless no time limit is specified, in which case it is valid for 7 days after the date it was signed.

The bill also revises the criteria for involuntary admissions under the Marchman Act. The bill deletes current criteria and substitutes instead that the individual:

- Is likely to self-neglect or refuse to care such that there is a real and present threat of substantial harm to his or her well-being,
- Is at risk of deterioration of physical and mental health which can't be avoided even with the help of willing family members or friends or other services, or
- Is substantially likely to cause serious bodily harm to him- or herself or others, as shown by recent behavior.

CS/HB 979 also requires the sharing of copies of Baker Act petitions by the Agency for Health Care Administration with DCF.

The bill has an indeterminate fiscal impact. See Fiscal Analysis.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Mental Illness and Substance Abuse

Mental health and mental illness are not synonymous. Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

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

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

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

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

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[1] *Mental Health Basics*, Centers for Disease Control and Prevention. http://www.cdc.gov/mentalhealth/basics.htm (last viewed on January 4, 2016).
[2] Id.
[3] Id.
[4] Id. Mental illness can range in severity from no or mild impairment to significantly disabling impairment. Serious mental illness is a mental disorder that has resulted in a functional impairment which substantially interferes with or limits one or more major life activities. *Any Mental Illness (AMI) Among Adults*, National Institute of Mental Health. http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml (last viewed on January 4, 2016).
[5] *Mental Illness Facts and Numbers,* National Alliance on Mental Illness. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&sqi=2&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.nami.org%2Ffactsheets%2Fmentalillness_factsheet.pdf&ei=dYMIVdrWOYmqgwTBlYDQDA&usg=AFQjCNEATQZ5TXJF063JkMNgg9ZnwZb_ZA&bvm=bv.88198703,d.eXY (last viewed on January 4, 2016).
[6] *Mental Health Disorder Statistics,* John Hopkins Medicine. http://www.hopkinsmedicine.org/healthlibrary/conditions/mental_health_disorders/mental_health_disorder_statistics_85,P00753/ (last viewed on January 4, 2016).

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

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

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

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

Florida's Substance Abuse and Mental Health Program

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[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 January 4, 2016).
[9] Id.
[10] *Accounting for Unemployment Among People with Mental Illness*, Baron RC, Salzer MS, Behav. Sci. Law., 2002;20(6):585-99. http://www.ncbi.nlm.nih.gov/pubmed/12465129 (last viewed on January 4, 2016).
[11] *Supra* footnote 5.
[12] *How Many Individuals with A Serious Mental Illness are Homeless?* Treatment Advocacy Center, Backgrounder, November 2014. http://www.treatmentadvocacycenter.org/problem/consequences-of-non-treatment/2058 (last viewed on January 4, 2016).
[13] *Supra* footnote 5.
[14] Drug Abuse Costs The United States Economy Hundreds of Billions of Dollars in Increased Health Care Costs, Crime and Lost Productivity, National Institute on Drug Abuse, July 2008. http://www.drugabuse.gov/publications/addiction-science-molecules-to-managed-care/introduction/drug-abuse-costs-united-states-economy-hundreds-billions-dollars-in-increased-health (last viewed on January 4, 2016).
[15] Id.
[16] Id.
[17] *About Co-Occurring*, Substance Abuse and Mental Health Services Administration. http://media.samhsa.gov/co-occurring/default.aspx (last viewed on January 4, 2016).
[18] *Co-Occurring Disorders*, Psychology Today. https://www.psychologytoday.com/conditions/co-occurring-disorders (last viewed on January 4, 2016).
[19] *Comorbidity: Addiction and Other Mental Illnesses*, U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCMQFjAA&url=http%3A%2F%2Fwww.drugabuse.gov%2Fsites%2Fdefault%2Ffiles%2Frrcomorbidity.pdf&ei=6q8NVf-iMsibNo7gg4AO&usg=AFQjCNFujSP7SHxxqB3FI7961yGQNQ56YA&bvm=bv.88528373,d.eXY (last viewed on January 4, 2016).
[20] Id.
[21] *Supra* footnote 18.

The Florida Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[22]

Behavioral Health Managing Entities

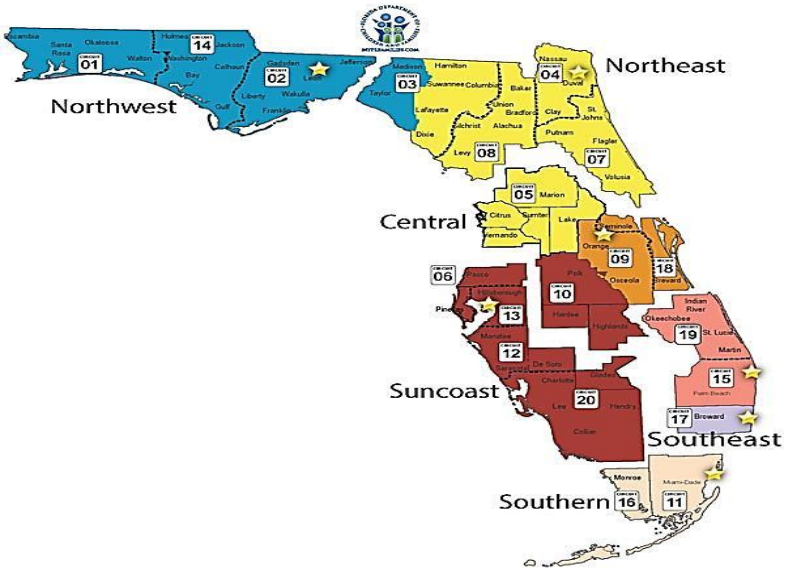
In 2001, the Legislature authorized DCF to implement behavioral health managing entities as the management structure for the delivery of local mental health and substance abuse services.[23] This was based upon the Legislature's decision that a management structure which places the responsibility for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

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

The implementation of the managing entity system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement managing entities statewide.[25] Full implementation of the statewide managing entity system occurred in April 2013, with all geographic regions now served by a managing entity.[26] Implementation has allowed DCF to reduce the number of direct contracts for mental health and substance abuse services from several hundred to 7.[27] DCF currently contracts with 7 managing entities that in turn contract with local service providers for the delivery of mental health and substance abuse services:[28]

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

[22] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance and children at risk for initiating drug use.
[23] Ch. 2001-191, Laws.
[24] Section 394.9082, F.S.
[25] Chapter 2008-243, Laws.
[26] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.
[27] *Department of Children and Families Service System Management Plan, Statewide Implementation of Managing Entities or Similar Model*, July 2009.
[28] *Managing Entities*, Department of Children and Families. http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities (last viewed on January 4, 2016).



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

Florida Mental Health Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[29] 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.[30]

Voluntary Examination

Statute provides for individuals age 18 or older to voluntarily be admitted to a facility, such as a receiving facility or hospital. Such individuals must be found competent to provide express and informed consent to the admission. Section 394.455(9), F.S., defines "express and informed consent" as consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. For an individual under age 17, his or her parent or guardian must make the application, and a hearing must be held to verify that the consent is voluntary.[31]

[29] Sections 394.451-394.47891, F.S.
[30] Section 394.459, F.S.
[31] s. 394.4625(1)(a), F.S.

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.[32] 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[33]:

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

Involuntary patients must be taken to either a public or private facility which has been designated by DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment.[34] 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.[35] 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.[36]

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.[37] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[38]

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.[39] Individuals often enter the public mental health system through CSUs.[40] 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.[41]

As of February 2015, there were 63 public receiving facilities with 2,052 beds and 67 private receiving facilities with 3,371 beds.[42] For FY 2014-15 there are 544 adult and 106 crisis stabilization beds funded by DCF.[43] There were 181,471 involuntary examinations initiated at hospitals and CSUs in calendar year 2014 (most recent report).[44]

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[32] Sections 394.4625 and 394.463, F.S.
[33] Section 394.463(1), F.S.
[34] Section 394.455(26), F.S.
[35] Section 394.455(25), F.S
[36] Rule 65E-5.400(2), F.A.C.
[37] Section 394.875(1)(a), F.S.
[38] Id
[39] Id.
[40] Budget Subcommittee on Health and Human Services Appropriations, the Florida Senate, Crisis Stabilization Units, (Interim Report 2012-109) (Sept. 2011).
[41] Id. Sections 394.65-394.9085, F.S.
[42] Correspondence from the Department of Children and Families to the House of Representatives' Children, Families & Seniors Subcommittee, dated February 9, 2015.
[43] Id.
[44] Christy, A. (2015). Report of 2013 *Baker Act Data*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.

Data Collection

Part I and Part IV of Ch. 394 provide for the submission, collection, and reporting of data for private and public receiving facilities. Requirements include:

- Daily reporting of CSU utilization through DCF's CSU Database. Managing entities collect data submitted by CSU's at least daily and then report to DCF on a monthly and annual basis regarding:
  - Number of indigent persons admitted and discharged,
  - Current active census of licensed beds,
  - Number of beds purchased by DCF, and
  - Number of unoccupied licensed beds.[45]
- Reporting on Baker Act petitions. Clerks of Court must submit copies of the following to DCF:
  - Petitions for involuntary outpatient treatment and individualized treatment plans,
  - Continued involuntary outpatient placement certificate and treatment plans, and
  - Petitions for involuntary inpatient placement.
- Copies of orders to the Agency for Health Care Administration (AHCA). Receiving facilities accepting a patient must provide AHCA copies of the following as appropriate:
  - Ex parte orders,
  - Involuntary outpatient placement orders,
  - Involuntary inpatient orders,
  - Professional certificates, and
  - Law enforcement officers' reports.[46]

The Baker Act Reporting Center at the Louis De La Parte Florida Mental Health Institute at the University of South Florida receives these copies of behalf of AHCA and enters information into a database. This information is used to create a statutorily-required annual report submitted by AHCA.[47]

Marchman Act

The Marchman Act provides for the voluntary and involuntary assessment, stabilization and treatment of individuals who are substance abuse impaired[48]. It was enacted in 1993 to consolidate the Treatment and Rehabilitation of Drug Dependents Act of 1970 and the Myers Act of 1971 which was the state's "Comprehensive Alcoholism Prevention, Control, and Treatment Act". A single, consolidated substance abuse statute was required because individuals with substance abuse issues often concurrently abuse alcohol and drugs and having two statutes to address a single issue was ineffective.

Voluntary Admission

Any person, including minors, who wishes to enter treatment for substance abuse may apply to a service provider for voluntary admission.[49] To be eligible for voluntary admission an individual must be substance abuse impaired and his or her medical and behavioral conditions must not be beyond the safe management capabilities of the service provider.[50] Additionally, the service provider must have the financial and space capabilities for the admission and must place the individual in the least restrictive setting appropriate for the individual's needs.[51]

Involuntary Admission

[45] s. 394.9082(10), F.S.
[46] s. 394.463(2), F.S.
[47] s. 394.463(2)(e), F.S.
[48] "Substance abuse impaired" is a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior. S. 397.311 (18), F.S.
[49] Section 397.601, F.S.
[50] Id.
[51] Id.

The Marchman Act establishes the criteria for involuntary assessment and admission. A person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:[52]

- Has lost the power of self-control with respect to substance use; **and either**
  - Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or
  - Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto.

The Marchman Act provides five approaches through which to involuntarily commit an individual for assessment or admission who is substance abuse impaired. These consist of two court involved and three non-court involved admissions.

- Non-Court Involved Assessment and Stabilization:
  - Protective Custody: Initiated by law enforcement;
  - Emergency: Initiated by a spouse, guardian, relative, adult or physician (requires physician's certificate of assessment and need); and
  - Alternative Involuntary Assessment for minors: Initiated by adult or guardian.
- Court Involved:
  - Involuntary Assessment and Stabilization, and
  - Involuntary Treatment.

Data Collection

Currently there are no statutory requirements for the collection, submission, or reporting of Marchman Act-related data to DCF.[53]

Comparison of Baker and Marchman Acts

Some similarities between the Baker and Marchman Acts include:

- Both address crisis stabilization AND longer-term treatment.
- Both govern voluntary AND involuntary admissions.
- Criteria for emergency assessment and involuntary treatment include potential injury to self and others.
- Both offer secure placements.

[52] Section 397.675, F.S.
[53] DCF, Baker Act and Marchman Act Project Team Report for FY 2016-17, Nov. 24, 2015.

However, there are many differences between the Baker and Marchman Acts. Some key differences include:

	Baker Act	Marchman Act
Petitioner/Counsel for involuntary (long-term) treatment	Petitioner-- Treatment facility; Counsel—state attorney	Petitioner--Family or other interested party Counsel—private or pro se
Client counsel for involuntary (longer-term) treatment	Public Defender	Regional Civil Counsel
Maximum initial period of examination/ assessment	Up to 72 hrs.	Up to 5 days unless court ordered, then up to 12 days.
Who may initiate admission	Law enforcement, practitioners including a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, court.	Law enforcement, physician, spouse, guardian, relative, practitioner, service provider, three adults with knowledge of impairment.
Transportation for crisis assessment/ examination	Law enforcement must transport examinees except under very specific conditions.	Does not mandate transportation.
Requirement to accept for crisis assessment/ examination	Crisis Stabilization Units (CSU) must accept individuals for examination.	Detox and Addiction Receiving Facilities (ARF) may only admit under certain conditions and cannot exceed licensed capacity.
Facilities and security	CSU – locked	Detox--unlocked; ARF—locked; jails—locked (adults only)
Length of stay for longer-term commitment	Initially up to 6 months with the ability to extend an additional 6 months	60 days with the ability to extend for an additional 90 days
Fees charged for related court filings	Clerks of Court may not charge fees for: • Habeus corpus (s. 394.459(8)(d), F.S.) • Ex parte order for involuntary examination (s. 394.463(2)(a)1., F.S.) • Petition for involuntary outpatient placement (s. 394.4655(3)(c), F.S.) • Petition for involuntary inpatient placement (s. 394.467(3), F.S.)	Statute silent
Data Collection	Statute requires specified data collection	No statutorily required data collection

DCF Baker Act and Marchman Act Project Team

Following the discussion during the 2015 Legislative session on the state's mental health and substance abuse safety-net system, DCF convened a team to develop recommendations to integrate access to the Baker Act and Marchman Act by defining a community system of behavioral health acute care services that:

1. Provides a single point of access to acute emergency care, intervention, and treatment services;
2. Ensures that individuals are determined to meet criteria for voluntary and involuntary examination and treatment for a mental illness or a substance use disorder have access to required services;
3. Ensures that each county or circuit has access to a designated receiving facility that, at a minimum, can screen, evaluate, and refer individuals to the appropriate level of care;
4. Ensures that individuals, their families, law enforcement agencies, judges and other court professionals, behavioral health professionals, and the public are aware of the locations of designated receiving facilities, access centers, or triage centers;
5. Determine the existing capacity for Addiction Receiving Facilities (ARF's), CSU's, and detoxification facilities;
6. Develops a standard or benchmark for determining the need for additional bed capacity over and above the capacity met through Medicaid, Medicare, and private insurance based on the number for beds per capita; and
7. Estimates the cost of the proposed recommendations based on several different models, or methods of calculation.

This team included representatives of state agencies, managing entities, community hospitals, provider organizations, professional trade organizations, court professionals, law enforcement, local government, Medicaid managed care organizations, consumers, and practitioners.[54] The team's report was dated November 24, 2015. The report contained a number of recommendations, including but not limited to:

- Amending various mental health and substance abuse statutes' intent language to include such provisions as shifting to a medical approach to behavioral health care, acknowledging that these are diseases of the brain; stating the importance of data collection; and authorizing certain behavioral health practitioners to have additional authority in acute behavioral health care.
- Requiring transportation plans that must address specific issues, such as how diversion will work in a community and how individuals will be transported once law enforcement has transferred their custody to a provider.
- Expanding the types of professionals authorized to initiate an emergency admission under the Marchman Act to align more closely with the Baker Act.
- Provide for orders for involuntary treatment under the Marchman Act to be for 90-day increments.
- Requiring reporting of Marchman Act data similar to that required for the Baker Act.[55]

Effect of the Proposed Changes

HB 979 implements several recommendations from the DCF Baker Act and Marchman Act Project Team Report in addition to making other changes.

Legislative Findings and Intent

The bill amends new legislative findings and intent into several different sections of both the Baker and Marchman Acts to provide:

[54] Id.
[55] Supra, note 53

- Authorizing licensed, qualified health professionals to practice to the full extent of their education and training in the performance of professional functions necessary to carry out the intent of this part (in ss. 394.453 and 397.305, F.S.).
- State policy and funding decisions should be data-driven (in ss. 394.453 and 397.305, F.S.), and
- Services should use coordination-of-care principles and include social support services (in ss. 394.453 and 397.305, F.S.).

The bill strikes current intent language that:

- The least restrictive means of intervention be used based on individual needs (from s. 394.453, F.S.), and
- That state agencies, service systems, and program offices collaborate to address the public's needs, establish a comprehensive system of care, and reduce duplicative requirements (from s. 397.305, F.S).

Baker Act

The bill amends s. 394.463(2)(e), F.S., to require the Agency for Health Care Administration to provide monthly to DCF copies of the orders that they receive from receiving facilities pursuant to s. 394.463(2), F.S. These include:

- Ex parte orders,
- Involuntary outpatient placement orders,
- Involuntary inpatient orders,
- Professional certificates, and
- Law enforcement officers' reports.

Marchman Act

The bill authorizes additional practitioners to execute a certificate finding that an individual appears to meet criteria for emergency admissions, including:

- Clinical psychologists,
- Physician's assistants working under the scope of practice of the supervising physician,
- Psychiatric nurses,
- Advanced registered nurse practitioners,
- Mental health counselors,
- Marriage and family therapists,
- Master's level certified addiction professionals for substance abuse services, and
- Clinical social workers.

This will increase the number of professionals in the state who will be able to initiate an emergency admission for purposes of involuntary substance abuse assessment and stabilization, aligning with the similar process in the Baker Act (except the certified addiction professional, who has no authority under the Baker Act).

The bill changes the criteria for involuntary admissions under the Marchman Act. The bill deletes current criteria and substitutes instead that the individual:

- Is likely to self-neglect or refuse to care such that there is a real and present threat of substantial harm to his or her well-being,
- Is at risk of deterioration of physical and mental health which can't be avoided even with the help of willing family members or friends or other services, or
- Is substantially likely to cause serious bodily harm to him or herself or others, as shown by recent behavior.

This aligns the criteria for involuntary admissions under the Marchman Act more closely to the criteria for similar admissions under the Baker Act. However, the new criteria contain a provision regarding the risk of deterioration of physical or mental health which is not currently a Baker Act criterion. It also appears to narrow the criteria compared to the current broad criteria in the Marchman Act.

The bill makes a number of other changes to the Marchman Act including:

- Changing the length of court-ordered treatment from 60 days to 90 days. This will eliminate the need for additional court filings if the individual is in need of treatment for 30 or fewer additional days.
- Prohibiting circuit courts from charging a fee for filing Marchman Act petitions. This aligns the Marchman Act with the Baker Act.
- Allowing for filing of a Marchman Act petition by any adult willing to testify about the person's actions.
- Providing that a court order for involuntary assessment and stabilization is valid until executed or for the period specified in the order, unless no time limit is specified, in which case it is valid for 7 days after the date it was signed.
- Specifying that assessments under the Marchman Act must be completed and reviewed by a physician within 72 hours, and that an individual must be released within five days unless a petition for involuntary treatment is filed with the court.
- Requires a hearing be held within five days on any petition for discharge, unless a continuance is granted.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 394.453, F.S.; relating to legislative findings and intent.
Section 2: Amends s. 394.63, F.S., relating to involuntary examination.
Section 3: Amends s. 394.4655, F.S., relating to hearing on involuntary outpatient placement.
Section 4: Amends s. 394.467, F.S., relating to involuntary inpatient placement.
Section 5: Amends s. 397.305, F.S., relating to legislative findings, intent, and purpose.
Section 6: Amends s. 397.675, F.S., relating to criteria for involuntary admissions.
Section 7: Amends s. 397.679, F.S., relating to emergency admission; circumstances justifying.
Section 8: Amends s. 397.6791, F.S., relating to emergency admission; persons who may initiate.
Section 9: Amends s. 397.6793, F.S., relating to professional certificate for emergency admission.
Section 10: Amends s. 397.6795, F.S., relating to transportation-assisted delivery of persons for emergency assessment.
Section 11: Amends s. 397.681, F.S., relating to involuntary petitions; general provisions; court jurisdiction and right to counsel.
Section 12: Amends s. 397.6811, F.S., relating to involuntary assessment and stabilization.
Section 13: Amends s. 397.6818, F.S., relating to court determination.
Section 14: Amends s. 397.6819, F.S., relating to involuntary assessment and stabilization; responsibility of licensed service provider.
Section 15: Repeals s. 397.6821, F.S.
Section 16: Amends s. 397.6955, F.S., relating to duties of court upon filing of petition for involuntary treatment.

Section 17: Amends s. 397.697, F.S., relating to court determination; effect of court order for involuntary substance abuse treatment.
Section 18: Amends s. 397.6971, F.S., relating to early release from involuntary substance abuse treatment.
Section 19: Amends s. 397.6977, F.S., relating to disposition of individual upon completion of involuntary substance abuse treatment.
Section 20: Amends s. 397.6773, F.S., relating to dispositional alternatives after protective custody.
Section 21: 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:

   Indeterminate. See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. See fiscal comments.

D. FICAL COMMENTS:

The bill's change to the length of court-ordered Marchman Act treatment from 60 days to 90 days will eliminate the need for additional court filings if the individual is in need of treatment for 30 or fewer additional days.

The bill appears to narrow the criteria for involuntary admissions under the Marchman Act from current law. It is currently unknown how this would affect the number of individuals qualifying for involuntary admissions under the Marchman Act who would receive state-funded services.

Allowing for filing of a Marchman Act petition for involuntary assessment and stabilization by any adult willing to testify about the person's actions, rather than requiring three adults with knowledge of the individual's substance abuse impairment, may increase the number of petitions filed that the court must process and then the number of individuals presenting for assessment and stabilization services. It is unknown how many additional petitions would be filed due to this change.

Expanding the number of professionals who may execute a certificate to permit the emergency admission of an individual may also increase the number of individuals presenting for assessment and stabilization services, though it is possible that these professionals may execute certificates in lieu of physicians doing so.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 26, 2016, the Children, Families, and Seniors Subcommittee adopted a strike-all amendment. The amendment made the following changes:

- Removes intent language that mental health and substance use disorders are diseases of the brain and that local systems of acute care services should operate effectively.
- Removes provisions regarding community planning for a behavioral health service system and transportation.
- Provides that orders under the Baker Act for involuntary outpatient placement and involuntary inpatient placement should be for up to 90 days rather than six months, unless commitment is to a state treatment facility.
- Requires that the Agency for Health Care Administration, rather than the Louis De La Parte Florida Mental Health Institute, share copies of Baker Act orders, certificates, and reports with DCF.
- Makes additional conforming changes regarding renaming the physician's certificate as the professional's certificate under the Marchman Act.
- Specifies that assessments under the Marchman Act must be completed and reviewed by a physician within 72 hours, and that an individual must be released within five days unless a petition for involuntary treatment is filed with the court.

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