

**The Florida Senate**  
**BILL ANALYSIS AND FISCAL IMPACT STATEMENT**

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

---

Prepared By: The Professional Staff of the Committee on Appropriations

---

**BILL:** CS/SB 7012

**INTRODUCER:** Appropriations Committee (Recommended by Appropriations Subcommittee on Health and Human Services); Children, Families, and Elder Affairs Committee; and Senator Rouson

**SUBJECT:** Mental Health

**DATE:** March 2, 2020

**REVISED:** \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	<u>Delia</u>	<u>Hendon</u>		<b>CF Submitted as Committee Bill</b>
1.	<u>Sneed</u>	<u>Kidd</u>	<u>AHS</u>	<b>Recommend: Fav/CS</b>
2.	<u>Sneed</u>	<u>Kynoch</u>	<u>AP</u>	<b>Fav/CS</b>

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

---

**I. Summary:**

CS/SB 7012 makes several changes to laws relating to substance abuse and mental health services. Specifically, the bill:

- Redefines “mental illness” related to the Baker Act and post-adjudication commitment to exclude dementia and traumatic brain injury.
- Defines “coordinated specialty care programs” as an essential element of a coordinated system of care and requires the DCF to report annually on any gaps in availability or access in the state. Makes coordinated specialty care programs eligible for Criminal Justice, Mental Health, and Substance Abuse Reinvestment grants.
- Allows licensed health care professional and facilities to contract with the DCF and managing entities to provide mental health services without obtaining a separate license from the DCF.
- Broadens the scope and duties of the Statewide Office of Suicide Prevention (Statewide Office) in the Department of Children and Families (DCF) by requiring the Statewide Office to coordinate education and training curricula on suicide prevention efforts for veterans and services members.
- Creates the First Responders Suicide Deterrence Task Force within the Statewide Office to assist in the reduction of suicide rates of first responders.
- Broadens the scope and duties of the Suicide Prevention Coordinating Council by requiring the Council to make recommendations on the implementation of evidence-based mental

health programs and suicide risk identification training and adds five new members to the Council.

- Adds new training and staffing requirements for instructional personnel at public and charter schools.
- Adds new continuing education requirements related to suicide prevention for various health care practitioners.
- Requires Baker Act receiving facilities to provide suicide prevention information resources to minors being released from a facility.
- Provides civil immunity to persons who help or attempt to help others at imminent risk of suicide.
- Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to review other states' suicide prevention programs and submit a report of its findings and recommendations to the Legislature.
- Requires county jails to administer the psychotropic medications prescribed by the DCF when a forensic client is discharged and returned to the county jail, unless the jail physician documents the need to change or discontinue such medication.
- Requires the DCF treating physician to consult with the jail physician and consider prescribing medication included in the jail's drug formulary.
- Requires county jails to send to the DCF all medical information on individuals in their custody who will be admitted to a state mental health treatment facility. Requires the DCF to request this information immediately upon receipt of a completed commitment packet and requires the county jail to provide such information within three business days of the request.
- Removes the requirement for prevention coalitions to be certified by the DCF.

For Fiscal Year 2020-2021, the bill provides the DCF with two full-time equivalent (FTE) positions and appropriates \$418,036 in recurring funds and \$8,896 in nonrecurring funds from the General Revenue Funds for the Statewide Office of Suicide Prevention to meet the workload and information sharing requirements.

The bill takes effect July 1, 2020.

## II. Present Situation:

Suicide is a major public health issue and a leading cause of death nationally,<sup>1</sup> with complex causes such as mental health and substance use disorders, painful losses, exposure to violence, and social isolation.<sup>2</sup> Suicide rates increased in nearly every state from 1999 through 2016.<sup>3</sup> In 2017, suicide was the second leading cause of death nationwide for persons aged 10–14, 15–19,

---

<sup>1</sup> Heron M. *Deaths: Leading Causes for 2017*. National Vital Statistics Reports; Vol. 68 No 6. Hyattsville, MD: National Center for Health Statistics. 2019.

<sup>2</sup> Substance Abuse and Mental Health Service Administration, *Suicide Prevention*, available at: <https://www.samhsa.gov/suicide-prevention> (last visited November 7, 2019).

<sup>3</sup> Centers for Disease Control and Prevention, *Suicides Rising across the U.S.* (June 7, 2018), available at: <https://www.cdc.gov/vitalsigns/suicide/index.html> (last visited November 6, 2019).

and 20–24.<sup>4</sup> After stable trends from 2000 to 2007, suicide rates for persons aged 10–24 increased 56 percent from 2007 (6.8 per 100,000 persons) to 2017 (10.6 per 100,000 persons).<sup>5</sup>

While suicide is often characterized as a response to a single event or set of circumstances, suicide is the result of complex interactions among neurobiological, genetic, psychological, social, cultural, and environmental risk and protective factors.<sup>6</sup> The factors that contribute to any particular suicide are diverse; therefore, efforts related to suicide prevention must incorporate multiple approaches.<sup>7</sup>

In Florida, the rate of suicides increased by 10.6 percent from 1996 to 2016.<sup>8</sup> According to the 2017 Florida Morbidity Statistics Report, the total number of deaths due to suicide in Florida was 3,187 in 2017, a slight increase from 3,122 in 2016.<sup>9</sup> Suicide was the eighth leading cause of death in Florida, and the suicide rate per 100,000 population was 15.5. This is a slight increase from 2016 (15.4). Suicide was the second leading cause of death for individuals within the 25-34 age group in 2017, similar to the national ranking of 2016, and the third leading cause of death for individuals within 15-24 age group. Suicide was the fourth leading cause of death for individuals within the 5-14, 35-44, and 45-54 age groups.

### **Statewide Office for Suicide Prevention**

The Statewide Office of Suicide Prevention (Statewide Office), which is housed within the Department of Children and Families (DCF), must coordinate education and training curricula in suicide prevention efforts for law enforcement personnel, first responders to emergency calls, health care providers, school employees, and others who may have contact with persons at risk of suicide.<sup>10</sup>

The Statewide Office is allowed to seek and accept grants or funds from federal, state, or local sources to support the operation and defray the authorized expenses of the Statewide Office and the Suicide Prevention Coordinating Council.<sup>11</sup>

### **Suicide Prevention Coordinating Council**

The Suicide Prevention Coordinating Council (Council) is located within the DCF and develops strategies for preventing suicide and advises the Statewide Office regarding the development of a

---

<sup>4</sup> *Supra* note 1.

<sup>5</sup> Heron M., Curtin, S., *Death Rates Due to Suicide and Homicide Among Persons Aged 10-24: United States, 2007-2017*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention National Center for Health Statistics, available at: <https://www.cdc.gov/nchs/data/databriefs/db352-h.pdf> (last visited November 6, 2019).

<sup>6</sup> *Supra* note 1.

<sup>7</sup> *Id.*

<sup>8</sup> *Supra* note 2.

<sup>9</sup> Florida Department of Health, *2017 Florida Morbidity Statistics Report*, 2017, available at: <http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/data-and-publications/documents/2017-annual-morbidity-statistics-report.pdf> (last visited November 8, 2019).

<sup>10</sup> Section 14.2019, F.S.

<sup>11</sup> *Id.*

statewide plan for suicide prevention. A report on the plan is prepared and presented annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives.<sup>12</sup>

The Council is currently comprised of 27 voting members and 1 nonvoting member. Thirteen of the members are appointed by the director of the Statewide Office, four are appointed by the Governor, and ten are state agency directors or their designees.<sup>13</sup>

### **Suicide among First Responders**

First responders include law enforcement personnel, firefighters, and emergency medical services workers. In comparison to the general population, first responders are at heightened risk for depression, post-traumatic stress disorder (PTSD), and suicide. Further, police and firefighters are more likely to commit suicide than to die in the line of duty.<sup>14</sup> Many first responders previously served in the military, which likely exposed them to trauma prior to becoming a first responder.<sup>15</sup> Suicide amongst first responders is considered to be grossly underreported. For example, in a study conducted by the Firefighter Behavioral Health Alliance (FBHA), researchers estimate that only about 40 percent of firefighter suicides are reported.<sup>16</sup>

### **The Law Enforcement Mental Health and Wellness Act of 2017**

Signed into law January 2018, the Law Enforcement Mental Health and Wellness Act of 2017 calls for the U.S. Department of Justice to review and report to Congress on mental health practices and services in the U.S. Departments of Defense and Veterans Affairs that could be adopted by law enforcement agencies to support first responders.<sup>17</sup> The law additionally directs the Department of Justice to make recommendations on:

- Effectiveness of crisis lines for law enforcement officers;
- Efficacy of yearly mental health checks for law enforcement officers;
- Expanded peer mentoring programs; and
- Ensuring privacy for participants of these programs.<sup>18</sup>

The report, provided to Congress on March 2019, includes the following recommendations to enhance mental health and reduce suicide rates:

- Support the development of resources for community-based clinicians who interact with law enforcement and their families;
- Support placement of mental health professionals in law enforcement agencies;

---

<sup>12</sup> Section 14.20195, F.S.

<sup>13</sup> *Id.*

<sup>14</sup> Miriam Heyman, Jeff Dill, and Robert Douglas, *The Ruderman White Paper on Mental Health and Suicide of First Responders* (April 2018), pg. 7-12; available at: [https://issuu.com/rudermanfoundation/docs/first\\_responder\\_white\\_paper\\_final\\_ac270d530f8bfb](https://issuu.com/rudermanfoundation/docs/first_responder_white_paper_final_ac270d530f8bfb). PTSD rates amongst first responders, in contrast to the 6.8 percent reported for the general population, significantly increase to 14.6 percent to 22 percent for firefighters, and 35 percent for police officers.

<sup>15</sup> *Id.* at 9.

<sup>16</sup> *Id.*

<sup>17</sup> U.S. Department of Justice, *Community Oriented Policing Services (COPS), Law Enforcement Mental Health and Wellness Services (LEMHWA) Program Resources*; available at: <https://cops.usdoj.gov/lemhwareources> (last visited Feb. 5, 2020).

<sup>18</sup> Public Law 115-113 (115<sup>th</sup> Congress).

- Encourage programs that permit retired law enforcement officers to access departmental peer support programs after separating employment;
- Support the development of model policies and implementation guidelines for agencies to make substantial efforts to reduce suicide;
- Support the creation of a Law Enforcement Suicide Event report surveillance system;
- Evaluate the efficacy of crisis lines;
- Support the expansion of peer support programs; and
- Bolster privacy protections for officers seeking support from peer crisis lines and other support programs.<sup>19</sup>

### **First-Episode Psychosis**

The term “psychosis” is used to describe a condition that affects the mind and generally involves some loss of contact with reality. Psychosis can include hallucinations (seeing, hearing, smelling, tasting, or feeling something that is not real), paranoia, delusions (believing something that is not real even when presented with facts), or disordered thoughts and speech.<sup>20</sup> Psychosis may be caused by medications or alcohol or drug abuse but can also be a symptom of mental illness or a physical condition.<sup>21</sup>

Psychosis affects people from all walks of life. Approximately three out of 100 people will experience psychosis at some time in their lives, often beginning when a person is in their late teens to mid-twenties.<sup>22</sup> Researchers are still learning about how and why psychosis develops, but it is generally thought to be triggered by a combination of genetic predisposition and life stressors during critical stages of brain development.<sup>23</sup> Risk factors that may contribute to the development of psychosis include stressors such as physical illness, substance use, and psychological or physical trauma.<sup>24</sup>

Early psychosis, known as “first-episode psychosis,” is the most important time to connect an individual with treatment.<sup>25</sup> Studies have shown that it is common for a person to experience psychotic symptoms for more than a year before ever receiving treatment.<sup>26</sup> Reducing the duration of untreated psychosis is critical to improving a person’s chance of recovery. The most effective treatment for early psychosis is coordinated specialty care, which uses a team-based approach with shared decision-making that focuses on working with individuals to reach their

---

<sup>19</sup> Spence, Deborah L., Melissa Fox, Gilbert C. Moore, Sarah Estill, and Nazmia E.A.

Comrie, Community Oriented Policing Services (COPS), U.S. Dept. of Justice, *Law Enforcement Mental Health and Wellness Act, Report to Congress* (March 2019); available at: <https://cops.usdoj.gov/RIC/Publications/cops-p370-pub.pdf>

<sup>20</sup> National Institute of Mental Health, *Fact Sheet: First Episode Psychosis*, available at:

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml> (last visited November 7, 2019).

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> National Alliance on Mental Illness, *What is Early and First-Episode Psychosis?* (July 2016), available at:

<https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/What-is-Early-and-First-Episode-Psychosis.pdf> (last visited November 7, 2019).

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Supra* note 20.

recovery goals.<sup>27</sup> Coordinated specialty care programs provide people with early psychosis, greater improvement in their symptoms.<sup>28</sup>

## **Veterans and Mental Health**

### ***Mental Health among Veterans***

According to the National Center for Post-Traumatic Stress Disorder, between 11 and 20 percent of veterans who served in Operations Iraqi Freedom and Enduring Freedom have Post-Traumatic Stress Disorder (PTSD) in a given year.<sup>29</sup> Additionally, 12 percent of Gulf War Veterans and 15 percent of Vietnam Veterans have PTSD, and up to 30 percent of Vietnam Veterans will have PTSD in their lifetime.<sup>30</sup> Statistics on depression in veterans vary, but it is estimated that between 2 and 10 percent of servicemembers return from active military operations with major depression.<sup>31</sup>

The 2019 National Veteran Suicide Prevention Annual Report published by the United States Department of Veterans Affairs (USDVA) details veteran deaths from suicide from 2005 to 2017.<sup>32</sup> During that time span, veteran suicides increased from 5,787 in 2005 to 6,139 in 2017. The annual number of veteran suicide deaths has exceeded 6,000 every year since 2008, and the annual number of veteran suicide deaths increased by 129 from 2016 to 2017.

### **Mental Illness and Substance Abuse of Offenders in the Criminal Justice System**

As many as 125,000 adults with a mental illness or substance use disorder requiring immediate treatment are arrested and booked into Florida jails each year.<sup>33</sup> Between 2002 and 2010, the population of inmates with mental illness or substance use disorder in Florida increased from 8,000 to 17,000 inmates.

### **State Forensic System -- Mental Health Treatment for Criminal Defendants**

Chapter 916, F.S., governs the state forensic system, a network of state facilities and community services for persons with mental health issues involved with the criminal justice system. The forensic system serves defendants deemed incompetent to proceed or not guilty by reason of insanity. A defendant is deemed incompetent to proceed if he or she does not have sufficient

---

<sup>27</sup> *Supra* note 23.

<sup>28</sup> *First Episode Psychosis Programs: A Guide to State Expansion*, National Alliance on Mental Illness, (February 2017), available at: <https://www.nami.org/getattachment/Extranet/Advocacy/FEP-State-Advocacy-Toolkit/FEP-State-Advocacy-Guide.pdf> (last visited November 7, 2019).

<sup>29</sup> National Center for PTSD, *How Common is PTSD? PTSD and the Military*, available at: [https://www.ptsd.va.gov/understand/common/common\\_veterans.asp](https://www.ptsd.va.gov/understand/common/common_veterans.asp) (last visited November 6, 2019).

<sup>30</sup> *Id.*

<sup>31</sup> RAND Center for Military Health Policy Research, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, at 54 (Terri Tanielian and Lisa H. Jaycox, Eds.) (2008), available at: [http://www.rand.org/pubs/monographs/2008/RAND\\_MG720.pdf](http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf) (last visited November 6, 2019).

<sup>32</sup> U.S. Department of Veterans Affairs, *2019 National Veteran Suicide Prevention Annual Report*, 2019, available at: [https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019\\_National\\_Veteran\\_Suicide\\_Prevention\\_Annual\\_Report\\_508.pdf](https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf) (last visited November 6, 2019).

<sup>33</sup> The Florida Senate, *Forensic Hospital Diversion Pilot Program, Interim Report 2011-106*, (Oct. 2010), p. 1, available at: <https://www.flsenate.gov/UserContent/Session/2011/Publications/InterimReports/pdf/2011-106cf.pdf> (last visited February 27, 2020).

present ability to consult with his or her lawyer with a reasonable degree of rational understanding or if the defendant lacks both a rational and factual understanding of the proceedings against him or her.<sup>34</sup>

If a defendant is suspected of being incompetent, the court, defense counsel, or the State may file a motion to have the defendant's cognitive state assessed.<sup>35</sup> If the motion is granted, court-appointed experts will evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing.<sup>36</sup> If the defendant is found to be competent, the criminal proceeding resumes.<sup>37</sup> If the defendant is found to be incompetent to proceed, the proceeding may not resume unless competency is restored.<sup>38</sup> Competency restoration services teach defendants about the legal process, their charges, potential legal outcomes they might face, and their legal rights so as to prepare them to participate meaningfully in their own defense.<sup>39</sup>

Defendants may be adjudicated not guilty by reason of insanity pursuant to s. 916.15, F.S. The DCF must admit a defendant adjudicated not guilty by reason of insanity who is committed to the department<sup>40</sup> to an appropriate facility or program for treatment and must retain and treat the defendant.<sup>41</sup>

Offenders who are charged with a felony and deemed incompetent to proceed and offenders adjudicated not guilty by reason of insanity may be involuntarily committed to state civil<sup>42</sup> and forensic<sup>43</sup> treatment facilities by the circuit court,<sup>44, 45</sup> or in lieu of such commitment, may be released on conditional release by the circuit court if the person is not serving a prison sentence.<sup>46</sup>

---

<sup>34</sup> Section 916.12(1), F.S.

<sup>35</sup> Rule 3.210, Fla.R.Crim.P.

<sup>36</sup> *Id.*

<sup>37</sup> Rule 3.212, Fla.R.Crim.P.

<sup>38</sup> *Id.*

<sup>39</sup> OPPAGA, *Juvenile and Adult Incompetent to Proceed Cases and Costs*, Report. No. 13-04, Feb. 2013, p. 1, available at: <http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1304rpt.pdf> (last visited February 27, 2020).

<sup>40</sup> The court may also order outpatient treatment at any other appropriate facility or service or discharge the defendant. Rule 3.217, Fla.R.Crim.P.

<sup>41</sup> Section 916.15(3), F.S.

<sup>42</sup> A "civil facility" is a mental health facility established within the DCF or by contract with the DCF to serve individuals committed pursuant to chapter 394, F.S., and defendants pursuant to chapter 916, F.S., who do not require the security provided in a forensic facility; or an intermediate care facility for the developmentally disabled, a foster care facility, a group home facility, or a supported living setting designated by the Agency for Persons with Disabilities (APD) to serve defendants who do not require the security provided in a forensic facility. Section 916.106(4), F.S.

<sup>43</sup> A "forensic facility" is a separate and secure facility established within the DCF or APD to service forensic clients. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed pursuant to chapter 916, F.S., from non-forensic residents. S. 916.106(10), F.S.

<sup>44</sup> "Court" is defined to mean the circuit court. Section 916.106(5), F.S.

<sup>45</sup> Sections 916.13, 916.15, and 916.302, F.S.

<sup>46</sup> Sections 916.17(1), F.S.

## Sharing Medical Information between County Jails and the DCF

Forensic clients committed to the DCF's state mental health treatment facilities are transferred to the facilities directly from the county jails, and often need immediate or continuous medical treatment. Jail physicians must provide a current psychotropic medication<sup>47</sup> order at the time a forensic client is transferred to the state mental health treatment facility or upon request of the admitting physician following an evaluation.<sup>48</sup> However, there is no timeframe within which a jail physician must respond to a request by the DCF for such information, nor is there any requirement for jail physicians to provide other medical information about individuals being transferred to the DCF. While the DCF currently requests medical information from the county jails when a commitment packet is received from the courts, there is no time requirement within which the DCF must make the request.<sup>49</sup>

## Continuation of Psychiatric Medications

When forensic clients are released from state mental health treatment facilities, most are returned to the county jail to await resolution of their court cases. Some individuals are maintained by county jails on the same psychiatric medication regimen prescribed and administered at the state mental health treatment facility, while others are not. One possible outcome of discontinuing the previous medication regimen is the individual again losing competency, in which case the jail must return him or her to a secure forensic facility due to an inability to stand trial or proceed with resolution of his or her court case.<sup>50</sup>

## Licensure Requirements for Substance Abuse Service Providers

The DCF regulates substance abuse treatment by licensing individual treatment components under statute and rule.<sup>51</sup> All private and publicly-funded entities providing substance abuse services must be licensed for each service component they provide.<sup>52</sup> However, current law exempts:

- Hospitals licensed under ch. 395, F.S.;
- Nursing home facilities;
- Substance abuse education program established pursuant to s. 1003.42, F.S.;
- Facilities operated by the Federal Government;
- A physician or physician assistant licensed under chs. 458 or 459, F.S.;
- Psychologist licensed under ch. 490, F.S.;
- Social workers, marriage and family therapist or mental health counselors licensed under ch. 491, F.S.;

---

<sup>47</sup> Psychotropic medication is a broad term referring to medications that affect mental function, behavior, and experience; these medications include anxiolytic/hypnotic medications, such as benzodiazepines, antidepressant medications, such as selective serotonin reuptake inhibitors (SSRIs), and antipsychotic medications. Pamela L. Lindsey, *Psychotropic Medication Use among Older Adults: What All Nurses Need to Know*, J. GERONTOL NURS., (Sept. 2009), available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128509/> (last visited February 27, 2020).

<sup>48</sup> Section 916.107(3)(a)2.a., F.S.

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> Ch. 397, F.S. and R. 65D-30, F.A.C.

<sup>52</sup> Section 397.403, F.S.



- Churches or nonprofit religious organizations providing substance abuse services that are solely religious, spiritual or ecclesiastical in nature;
- Facilities licensed under ch. 393, F.S.;
- Crisis stabilization units licensed under ch. 394, F.S.;
- DUI education and screening services provider under chs. 316 or 322, F.S.<sup>53</sup>

The exemptions from licensure do not apply if the entity provides state-funded services through the DCF managing entity system or provides services under a government-operated substance abuse program.<sup>54</sup>

Licensed service components include a continuum of substance abuse prevention,<sup>55</sup> intervention,<sup>56</sup> and clinical treatment services.<sup>57</sup> Clinical treatment is a professionally directed, deliberate, and planned regimen of services and interventions that are designed to reduce or eliminate the misuse of drugs and alcohol and promote a healthy, drug-free lifestyle.<sup>58</sup> “Clinical treatment services” include, but are not limited to, the following licensable service components:<sup>59</sup>

- Addictions receiving facility;
- Day or night treatment;
- Day or night treatment with community housing;
- Detoxification;
- Intensive inpatient treatment;
- Intensive outpatient treatment;
- Medication-assisted treatment for opiate addiction;
- Outpatient treatment; and
- Residential treatment.

### **Certification of Community Substance Abuse Prevention Coalitions**

Section 397.321, F.S., requires the DCF to license and regulate all substance abuse providers in the state. It also requires the DCF to develop a certification process by rule for community substance abuse prevention coalitions (prevention coalitions).

<sup>53</sup> Section 397.4012, F.S.

<sup>54</sup> *Id.*

<sup>55</sup> Section 397.311(26)(c), F.S. Prevention is a process involving strategies that are aimed at the individual, family, community, or substance and that preclude, forestall, or impede the development of substance use problems and promote responsible lifestyles. *See also*, Department of Children and Families, *Substance Abuse: Prevention*, <https://www.myflfamilies.com/service-programs/samh/prevention/> (last visited Jan. 21, 2020). Substance abuse prevention is best accomplished through the use of ongoing strategies such as increasing public awareness and education, community-based processes and evidence-based practices. These prevention programs are focused primarily on youth, and, recent years, have shifted to the local level, giving individual communities the opportunity to identify their own unique prevention needs and develop action plans in response. This community focus allows prevention strategies to have a greater impact on behavioral change by shifting social, cultural and community environments.

<sup>56</sup> Section 397.311(26)(b), F.S. Intervention is structured services directed toward individuals or groups at risk of substance abuse and focused on reducing or impeding those factors associated with the onset or the early stages of substance abuse and related problems.

<sup>57</sup> Section 397.311(25), F.S.

<sup>58</sup> *Id.*

<sup>59</sup> Section 397.311(25)(a), F.S.

Prevention coalitions are local partnerships between multiple sectors of the community that respond to community conditions by developing and implementing comprehensive plans that lead to measurable, population-level reductions in drug use and related problems.<sup>60</sup> They do not provide substance abuse treatment services, and certification is not a requirement for eligibility to receive federal or state substance abuse prevention funding. However, to receive funding from the DCF, a coalition must follow a comprehensive process that includes a detailed needs assessment and plan for capacity building, development, implementation, and sustainability to ensure that data-driven, evidence-based practices are employed for addressing substance misuse for state-funded coalitions.<sup>61</sup>

Some prevention coalitions choose to apply for certification from nationally-recognized credentialing entities. Additionally, the Florida Certification Board, a non-profit professional credentialing entity, offers certifications for Certified Prevention Specialists and Certified Prevention Professionals, for those individuals who desire professional credentialing. However, Florida is the only state that requires prevention coalitions to be certified. Only one other state, Ohio, has established a certification program for prevention coalitions, and it is voluntary.<sup>62</sup>

### **Continuing Education Requirements for Health Care Practitioners**

Compliance with continuing education (CE) requirements is a condition of renewal of licensure for health care practitioners. Boards, or the Department of Health (DOH) when there is no board, require each licensee to demonstrate competency by completing CEs during each licensure cycle. The number of required CE hours varies by profession. The requirements for CEs may be found in ch. 456, F.S., professional practice acts, administrative rules, or a combination of these references. Failure to comply with CE requirements may result in disciplinary action against the licensee, in accordance with the disciplinary guidelines established by the applicable board, or the DOH if there is no board.

The DOH or boards, when applicable, monitor health care practitioner's compliance with the CE requirements in a manner required by statute. The statutes vary as to the required method to use. For example, the DOH or a board, when applicable, may have to randomly select a licensee to request the submission of CE documentation,<sup>63</sup> require a licensee to submit sworn affidavit or statement attesting that he or she has completed the required CE hours,<sup>64</sup> or perform an audit. Licensees are responsible for maintaining documentation of the CE courses completed.

### **The Good Samaritan Act**

The "Good Samaritan Act," codified in s. 768.13, F.S., provides immunity from civil liability for damages to any person who:

---

<sup>60</sup> Department of Children and Families, Agency Bill Analysis, SB 1678, January 14, 2020. On file with the Senate Children, Families, and Elder Affairs Committee.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> Section 457.107, F.S.

<sup>64</sup> Sections 458.347(4)(e), 466.0135(6), 466.014, and 466.032(5), F.S.

- Gratuitously and in good faith renders emergency care or treatment either in direct response to declared state emergencies or at the scene of an emergency situation, without objection of the injured victim, if that person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.<sup>65</sup>
- Participates in emergency response activities of a community emergency response team if that person acts prudently and within the scope of his or her training.<sup>66</sup>
- Gratuitously and in good faith renders emergency care or treatment to an injured animal at the scene of an emergency if that person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.<sup>67</sup>

The Good Samaritan Act, however, does not specifically address immunity from liability for individuals who attempt to render aid to others at risk of dying or attempting to die by suicide. Several states have implemented such measures in their Good Samaritan statutes in order to shield those who make a good faith effort to render aid from civil liability.<sup>68</sup>

### **Suicide Prevention Certified Schools**

Section 1012.583, F.S., requires the Department of Education (DOE), in consultation with the Statewide Office for Suicide Prevention and suicide prevention experts, to develop a list of approved youth suicide awareness and prevention training materials and suicide screening instruments that may be used for training in youth suicide awareness, suicide prevention and suicide screening for school instructional personnel. The approved list of materials:<sup>69</sup>

- Must identify available standardized suicide screening instruments appropriate for use with a school-age population and which have validity and reliability and include information about obtaining instruction in the administration and use of such instruments.
- Must include training on how to identify appropriate mental health services and how to refer youth and their families to those services;
- May include materials currently being used by a school district if such materials meet any criteria established by the department; and
- May include programs that instructional personnel can complete through a self-review of approved youth suicide awareness and prevention materials.

A school is considered a “Suicide Prevention Certified School” if it:

- Has at least two school-based staff members certified or otherwise deemed competent in the use of a DOE-approved suicide screening instrument; and
- Chooses to incorporate 2 hours of the DOE-approved training materials and requires all of its instructional personnel to participate in the training.

Currently, neither public school instructional personnel nor charter school instructional personnel are required to participate in suicide prevention training, or be certified or deemed competent in

---

<sup>65</sup> Section 768.13(2)(a), F.S.

<sup>66</sup> Section 768.13(2)(d), F.S.

<sup>67</sup> Section 768.13(3), F.S.

<sup>68</sup> Schiff, Damien, *Samaritans: Good, Bad and Ugly: A Comparative Law Analysis*, 11 Roger Williams Univ. L. Rev. 95 (2005).

<sup>69</sup> Section 1012.583(1), F.S.

the use of a suicide risk screening instrument. Additionally, neither public schools nor charter schools are required to use a suicide risk screening instrument to evaluate a student's suicide risk prior to initiating or requesting to initiate the Baker Act.

### III. Effect of Proposed Changes:

**Section 1** amends s. 14.2019, F.S., adding veterans and service members to the list of stakeholders that comprise the network of community-based programs intended to improve suicide prevention initiatives. The bill also requires the Statewide Office to coordinate education and training curricula in suicide prevention efforts for veterans and service members. The bill requires the Statewide Office to act as a clearinghouse for information and resources related to suicide prevention by disseminating evidence-based practices and by collecting and analyzing data on trends in suicide by various population demographics. The bill requires the Statewide Office to advise the Florida Department of Transportation (DOT) on the implementation of evidence-based suicide deterrents when designing new infrastructure projects.

The bill establishes the First Responders Suicide Deterrence Task Force within and supported by the Statewide Office for Suicide Prevention. The purpose of the task force is to make recommendations on how to reduce the incidence of suicide among current and retired first responders. The task force is made up of representatives of the Florida Professional Firefighters, the Florida Police Benevolent Association, the Florida Fraternal Order of Police, the Florida Sheriffs Association, the Florida Police Chiefs Association, and the Florida Fire Chiefs' Association.

The bill also requires the task force to identify or develop training programs and materials to better enable first responders to cope with life and work stress and foster an organizational culture that supports first responders. The bill identifies a supportive organizational culture as one that:

- Promotes mutual support and solidarity among first responders;
- Trains agency supervisors and managers to identify suicidal risk among first responders;
- Improves the use of existing resources by first responders; and
- Educates first responders on suicide awareness and resources for help.

The bill requires the task force to identify public and private resources to implement the training programs and materials. The task force must report its findings and recommendations to the Governor and Legislature each July 1, beginning in 2021. Consistent with s. 20.03, F.S., the task force expires after 3 years.

**Section 2** amends s. 14.20195, F.S., directing the Suicide Prevention Coordinating Council (Council) to make findings and recommendations regarding suicide prevention specifically related to the implementation of evidence-based mental health awareness and assistance training programs and gatekeeper training throughout the state. The bill requires the Council to work with the DCF to advise the public on the locations and availability of local behavioral health providers.

The bill also adds five new voting members to the Council and requires that 18, rather than 13, members be appointed by the director of the Statewide Office. The bill amends the list of organizations appointed by the Statewide Office to include:

- The Florida Behavioral Health Association (the bill eliminates the individual memberships of the Florida Alcohol and Drug Abuse Association and the Florida Council for Community Mental Health because these organizations have merged to form the Florida Behavioral Health Association);
- The Florida Medical Association;
- The Florida Osteopathic Medical Association;
- The Florida Psychiatric Society;
- The Florida Psychological Association;
- Veterans Florida; and
- The Florida Association of Managing Entities.

**Section 3** amends s. 334.044, F.S., requiring the DOT to work with the Statewide Office in developing a plan to consider evidence-based suicide deterrents on all newly planned infrastructure projects throughout the state.

**Section 4** amends s. 394.455, F.S., defining “coordinated specialty care programs” as evidence-based programs that use intensive case management, individual or group therapy, supported employment, family education and supports, and appropriate psychotropic medication to treat individuals who are experiencing early indications of serious mental illness, especially first-episode psychosis. The bill also redefines the term “mental illness” related to Baker Act and post-adjudication commitment to exclude dementia and traumatic brain injury.

**Section 5** amends s. 394.4573, F.S., establishing coordinated specialty care programs as an essential element of a coordinated system of care and requires the DCF to conduct an assessment of the availability of and access to coordinated specialty care programs in the state, including any gaps in availability or access that may exist. This assessment must be included in the DCF’s annual report to the Governor and Legislature on the assessment of behavioral health services in the state.

**Section 6** amends s. 394.463, F.S., requiring facilities who hold and release Baker Act patients who are minors to provide information regarding the availability of mobile response teams, suicide prevention resources, social supports, and local self-help groups to the patient’s guardian upon release.

**Section 7** amends s. 394.658, F.S., to include “coordinated specialty care programs” in the list of support programs or diversion initiatives eligible for an implementation or expansion grant under the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program.

**Section 8** amends s. 394.67, F.S., to define a “coordinated specialty care program” as an evidence-based program for individuals who are experiencing early indications of serious mental illness, such as symptoms of a first psychotic episode, including, but not limited to, intensive case management, individual or group therapy, supported employment, family education and supports, and the provision of appropriate psychotropic medication as needed.

**Section 9** amends s. 397.311, F.S., to replace the term “medication-assisted treatment for opiate addiction” with “medication-assisted treatment opioid use disorders.”

**Section 10** amends s. 397.321, F.S., to delete the requirement that the DCF develop a certification process by rule for community substance abuse prevention. As a result, prevention coalitions would no longer be subject to a certification process.

**Section 11** amends s. 397.4012, F.S., to allow the following substance abuse service providers to be exempt from licensure if they contract with the DCF or a managing entity:

- A hospital or hospital-based component;
- A nursing home facility;
- An allopathic or osteopathic physician or physician assistant;
- A psychologist;
- A social worker;
- A marriage and family therapist;
- A mental health counselor; and
- A crisis stabilization unit.

Allowing certain substance abuse service providers an exemption from licensure may increase the number of providers available to the DCF and managing entities to provide substance abuse services.

**Section 12** creates s. 456.0342, F.S., adding suicide prevention to the continuing education (CE) requirements for allopathic physicians, osteopath physicians, and nurses, effective January 1, 2022. Such licensees must complete two hours of CE courses on suicide risk assessment, treatment, and management. The bill requires the respective licensing board for each of the three professions to include the hours required for completion in the total hours of continuing education required by law.

**Section 13** creates s. 786.1516, F.S., defining ‘emergency care’ to mean assistance or advice offered to avoid or attempt to mitigate a suicide emergency. The bill defines a ‘suicide emergency’ as an occurrence that reasonably indicates one is at risk of dying of or attempting suicide. The bill provides civil immunity for persons who provide emergency care at or near the scene of a suicide emergency.

**Section 14** amends s. 916.106, F.S., the Forensic Client Services Act, to exclude defendants with dementia and traumatic brain injury who do not have a co-occurring mental illness from the definition of “mental illness.”

**Section 15** amends s. 913.13, F.S., relating to the involuntary commitment of a defendant adjudicated incompetent, to require jail physicians to continue to administer the same psychotropic medication from a mental health treatment facility, unless there is a documented need to change or discontinue the medication. The bill requires jail physicians to collaborate with the DCF treating physicians to ensure any changes to the medication regimen do not adversely impact the ability of the defendant to proceed with court proceedings. The bill provides that jail

physicians have the final authority for determining which medication to administer to jail inmates.

The bill requires the DCF to request medical information from a jail within two days of receipt of a commitment order and jails are required to send the information to the DCF within three days after the receipt of a request from the DCF.

**Section 16** applies the same provisions under Section 15 of the bill to s. 916.15, F.S., relating to the involuntary commitment of a defendant adjudicated not guilty by reason of insanity.

**Section 17** amends s. 1002.33, F.S., requiring all charter schools to incorporate 2 hours of suicide prevention training for all instructional personnel by October 1, 2020. The bill also requires all charter schools to have at least 2 school-based staff members certified or otherwise competent in the use of an approved suicide screening instrument and have a policy in place to utilize the instrument to gauge a student's suicide risk before initiating a Baker Act or requesting the initiation of a Baker Act. The bill requires each charter school to report their compliance with these provisions to the DOE.

**Section 18** amends s. 1012.583, F.S., putting in place the same requirements for public schools as those detailed in Section 15 for charter schools. The bill also eliminates the 'Suicide Prevention Certified School' designation in statute.

**Section 19** amends s. 39.407, F.S., to correct a cross-reference related to medical, psychiatric, and psychological examination and treatment of a child.

**Section 20** amends s. 394.495, F.S., to correct cross-references related to child and adolescent mental health systems of care.

**Section 21** amends s. 394.496, F.S., to correct cross-references related to service planning.

**Section 22** amends s. 394.674, F.S., to correct a cross-reference related to fee collection requirements for eligibility for publicly funded substance abuse and mental health services.

**Section 23** amends s. 394.74, F.S., to correct a cross-reference related to contracts for provision of local substance abuse and mental health programs.

**Section 24** amends s. 394.9085, F.S., to correct a cross-reference related to behavioral provider liability.

**Section 25** amends s. 409.972, F.S., to correct a cross-reference related to mandatory and voluntary enrollment in Medicaid.

**Section 26** amends s. 464.012, F.S., to correct a cross-reference related to licensure of advanced registered nurse practitioners, fees, and controlled substance prescribing.

**Section 27** amends s. 744.2007, F.S., to correct a cross-reference related to powers and duties of public guardians.

**Section 28** requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to perform a review of suicide prevention programs in other states and make recommendations on their applicability to Florida. The bill also requires the OPPAGA to submit a report containing the findings and recommendations to the President of the Senate and the Speaker of the House of Representatives by January 1, 2021.

**Section 29** provides the DCF with two full-time equivalent positions, salary rate of 90,384, and an appropriation for Fiscal Year 2020-2021 of \$418,036 in recurring and \$8,896 nonrecurring funds from the General Revenue Fund to implement the bill.

**Section 30** provides an effective date for the bill of July 1, 2020.

**IV. Constitutional Issues:**

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

**V. Fiscal Impact Statement:**

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.



**C. Government Sector Impact:**

CS/SB 7012 provides the DCF with two full-time equivalent positions, salary rate of 90,384, and an appropriation for Fiscal Year 2020-2021 of \$418,036 in recurring and \$8,896 nonrecurring funds from the General Revenue Fund to implement the bill.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends the following sections of the Florida Statutes: 14.2019, 14.20195, 39.407, 334.044, 394.455, 394.4573, 394.463, 394.495, 394.496, 394.658, 394.67, 394.674, 394.74, 394.9085, 397.311, 397.321, 397.4012, 409.972, 464.012, 744.2007, 916.106, 916.13, 916.15, 1002.33, and 1012.583.

This bill creates the following sections of the Florida Statutes: 456.0342 and 786.1516.

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

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

**CS by Appropriations on February 27, 2020:**

The committee substitute:

- Creates the First Responders Suicide Deterrence Task Force within the Statewide Office of Suicide Prevention for the purpose of providing recommendations on reducing suicide rates amongst active and retired first responders.
- Requires the task force to identify or develop training programs, materials, and resources to better enable first responders to cope with life and work stress and foster a supportive organizational culture.
- Provides for the membership of the task force.
- Requires the task force to report findings and recommendations on preventing suicide to the Governor and Legislature each July 1, from 2021 through 2023.
- Provides for the expiration of the task force in 3 years.
- Defines “coordinated specialty care programs” as an essential element of a coordinated system of care and requires the DCF to report annually on gaps in availability or access of such programs in the state. Makes coordinated specialty care programs eligible for Criminal Justice, Mental Health, and Substance Abuse Reinvestment grants.
- Allows licensed health care professional and facilities to contract with the DCF and managing entities to provide mental health services without obtaining a separate license from the DCF.

- Provides two full-time equivalent positions, associated salary rate, and appropriations of \$418,036 in recurring funds and \$8,896 in nonrecurring funds from the General Revenue Fund to the DCF to carry out the duties for the Office of Suicide Prevention provided for in the bill.
- Redefines “mental illness” related to the Baker Act and post-adjudication commitment to exclude dementia and traumatic brain injury.
- Replaces the term “first episode psychosis program” with “coordinated specialty care program” and replaces the term “opiate addiction” with “opioid use disorder” in the definition of medication assisted treatment.
- Removes all bill provisions relating to federal mental health parity laws.

B. Amendments:

None.