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 Children, Families, and Elder Affairs

BILL:	CS/SB 870
INTRODUCER:	Children, Families, and Elder Affairs and Senator Book
SUBJECT:	Mental Health
DATE:	January 29, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon	CF	**Fav/CS**
2.			JU	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 870 makes several changes to both the Baker Act and the Marchman Act. The bill broadens the criteria to serve additional individuals under both the Baker Act and Marchman Act.

The bill makes significant changes to court procedures, filing deadlines, and responsibilities for Marchman Act petitioners.

The bill will have an indeterminate state and local fiscal impact on the Department of Children and Families (DCF), courts, state attorneys, and public defenders, and has an effective date of July 1, 2020.

II. Present Situation:

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[1] The Act authorized treatment programs for mental, emotional, and behavioral disorders. The Baker Act required programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery.

[1] Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.

Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Mental illness creates enormous social and economic costs.[2] Unemployment rates for persons having mental disorders are high relative to the overall population.[3] Rates of unemployment for people having a severe mental illness range between 60 percent and 100 percent.[4] Mental illness increases a person's risk of homelessness in America threefold.[5] Approximately 33 percent of the nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are untreated.[6] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future recidivism.[7]

Marchman Act

In 1993, the Legislature adopted the Hal S. Marchman Alcohol and Other Drug Services Act. The Marchman Act provides a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services. Services must be available and provided in the least restrictive environment to promote long-term recovery. The Marchman Act includes various protections and rights of patients served.

Individual Bill of Rights

Both the Marchman Act and the Baker Act provide an individual bill of rights.[8] Rights in common include the right to dignity, right to quality of treatment, right to not be refused treatment at a state-funded facility due to an inability to pay, right to communicate with others, right to care and custody of personal effects, and the right to petition the court on a writ of habeus corpus. The individual bill of rights also imposes liability for damages on persons who violate individual rights.[9] The Marchman Act bill of rights includes the right to confidentiality of clinical records. The individual is the only person who may consent to disclosure.[10] The Baker Act addresses confidentiality in a separate section of law and permits limited disclosure by the individual, a guardian, or a guardian advocate.[11] The Marchman Act ensures the right to habeus corpus, which means that a petition for release may be filed with the court by an individual

[2] MentalMenace.com, *Mental Illness: The Invisible Menace; Economic Impact,* http://www.mentalmenace.com/economicimpact.php (last visited January 24, 2020).
[3] MentalMenace.com, *Mental Illness: The Invisible Menace: More impacts and facts,* http://www.mentalmenace.com/impactsfacts.php (last visited January 24, 2020).
[4] *Id.*
[5] Family Guidance Center for Behavioral Health Care, *How does Mental Illness Impact Rates of Homelessness,* http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/. (last visited January 24, 2020).
[6] *Id.*
[7] *Id.*
[8] Section 397.501, F.S., provides "Rights of Individuals" for individuals served through the Marchman Act; s. 394.459, F.S., provides "Rights of Individuals" for individuals served through the Baker Act.
[9] Sections 397.501(10)(a) and 394.459(10), F.S.
[10] Section 397.501(7), F.S.
[11] Section 394.4615(1) and (2), F.S.

involuntarily retained or his or her parent or representative.[12] In addition to the petitioners authorized in the Marchman Act, the Baker Act permits the DCF to file a writ for habeus corpus on behalf of the individual.[13]

Transportation to a Facility

The Marchman Act authorizes an applicant seeking to have a person admitted to a facility, the person's spouse or guardian, a law enforcement officer, or a health officer to transport the individual for an emergency assessment and stabilization.[14]

The Baker Act requires each county to designate a single law enforcement agency to transfer the person in need of services. If the person is in custody based on noncriminal or minor criminal behavior, the law enforcement officer will transport the person to the nearest receiving facility. If, however, the person is arrested for a felony the person must first be processed in the same manner as any other criminal suspect. The law enforcement officer must then transport the person to the nearest facility, unless the facility is unable to provide adequate security.[15]

The Marchman Act allows law enforcement officers, however, to temporarily detain substance-impaired persons in a jail setting. An adult not charged with a crime may be detained for his or her own protection in a municipal or county jail or other appropriate detention facility. Detention in jail is not considered to be an arrest, is temporary, and requires the detention facility to provide if necessary the transfer of the detainee to an appropriate licensed service provider with an available bed.[16] However, the Baker Act prohibits the detention in jail of a mentally ill person if he or she has not been charged with a crime.[17]

Voluntary Admission to a Facility

The Marchman Act authorizes persons who wish to enter treatment for substance abuse to apply to a service provider for voluntary admission. A minor is authorized to consent to treatment for substance abuse.[18] Under the Baker Act, a guardian of a minor must give consent for mental health treatment under a voluntary admission.[19]

When a person is voluntarily admitted to a facility, the emergency contact for the person must be recorded in the individual record.[20] When a person is involuntarily admitted, contact information for the individual's guardian, guardian advocate, or representative, and the individual's attorney must be entered into the individual record.[21] The Marchman Act does not address emergency contacts.

[12] Section 397.501(9), F.S.
[13] Section 394.459(8)(a), F.S.
[14] Section 397.6795, F.S.
[15] Section 394.462(1)(f) and (g), F.S.
[16] Section 397.6772(1), F.S.
[17] Section 394.459(1), F.S.
[18] Section 397.601(1) and (4)(a), F.S.
[19] Section 394.4625(1)(a), F.S.
[20] Section 394.4597(1), F.S.
[21] Section 394.4597(2), F.S.

The Baker Act requires an individualized treatment plan to be provided to the individual within five days after admission to a facility.[22] The Marchman Act does not address individualized treatment plans.

Involuntary Admission to a Facility

Criteria for Involuntary Admission

The Marchman Act provides that a person meets the criteria for involuntary admission if a good faith reason exists to believe that the person is substance abuse impaired and because of the impairment:

- Has lost the power of self-control with respect to substance abuse; and either
- Has inflicted, threatened to or attempted to inflict self-harm; or
- Is in need of services and due to the impairment, judgment is so impaired that the person is incapable of appreciating the need for services.[23]

Protective Custody

A person who meets the criteria for involuntary admission under the Marchman Act may be taken into protective custody by a law enforcement officer.[24] The person may consent to have the law enforcement officer transport the person to his or her home, a hospital, or a licensed detoxification or addictions receiving facility.[25] If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.[26]

Time Limits

A critical 72-hour period applies under both the Marchman and the Baker Act. Under the Marchman Act, a person may only be held in protective custody for a 72-hour period, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.[27] The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.[28] Within that 72-hour examination period, or, if the 72 hours ends on a weekend or holiday, no later than the next working day, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will resume custody;
- The patient must be released into voluntary outpatient treatment;
- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or
- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.[29]

[22] Section 394.459(2)(e), F.S.
[23] Section 397.675, F.S.
[24] Section 397.677, F.S.
[25] Section 397.6771, F.S.
[26] Section 397.6772(1), F.S.
[27] Section 397.6773(1) and (2), F.S.
[28] Section 394.463(2)(f), F.S.
[29] Section 394.463(2)(i)4., F.S.

Under the Marchman Act, if the court grants the petition for involuntary admission, the person may be admitted for a period of five days to a facility for involuntary assessment and stabilization.[30] If the facility needs more time, the facility may request a seven-day extension from the court.[31] Based on the involuntary assessment, the facility may retain the person pending a court decision on a petition for involuntary treatment.[32]

Under the Baker Act, the court must hold a hearing on involuntary inpatient or outpatient placement within five working days after a petition for involuntary placement is filed.[33] The petitioner must show, by clear and convincing evidence all available less restrictive treatment alternatives are inappropriate and that the individual:

- Is mentally ill and because of the illness has refused voluntary placement for treatment or is unable to determine the need for placement; and
- Is manifestly incapable of surviving alone or with the help of willing and responsible family and friends, and without treatment is likely suffer neglect to such an extent that it poses a real and present threat of substantial harm to his or her well-being, or substantial likelihood exists that in the near future he or she will inflict serious bodily harm on himself or herself or another person.[34]

Notice Requirements

The Marchman Act requires the nearest relative of a minor to be notified if the minor is taken into protective custody.[35] No time requirement is provided in law. Under the Baker Act, receiving facilities are required to promptly notify a patient's guardian, guardian advocate, attorney, and representative within 24 hours after the patient arrives at the facility on an involuntary basis, unless the patient requests otherwise.[36] In requiring notice on behalf of a patient, current law does not distinguish between adult and minor patients. The facility must provide notice to the Florida local advocacy council no later than the next working day after the patient is admitted.

Mental Illness and Substance Abuse

According to the National Alliance on Mental Illness (NAMI), about 50 percent of persons with severe mental health disorders are affected by substance abuse.[37] NAMI also estimates that 29 percent of people diagnosed as mentally ill abuse alcohol or other drugs.[38] When mental health disorders are left untreated, substance abuse likely increases. When substance abuse increases, mental health symptoms often escalate as well or new symptoms are triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance

[30] Section 397.6811, F.S.
[31] Section 397.6821, F.S.
[32] Section 397.6822, F.S.
[33] Sections 394.4655(6) and 394.467(6), F.S.
[34] Section 394.467(1), F.S.
[35] Section 397.6772(2), F.S.
[36] Section 394.4599(2)(a) and (b), F.S.
[37] Donna M. White, OPCI, CACP, *Living with Co-Occurring Mental & Substance Abuse Disorders, available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occuring-mental-substance (last visited on January 24, 2020).
[38] *Id.*

abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[39]

Advance Directive for Mental Health or Substance Abuse Treatment

Florida law currently allows an individual to create an advance directive which designates a surrogate to make health care decisions for the individual and provides a process for the execution of the directive.[40] Current law also allows an individual to designate a separate surrogate to consent to mental health treatment for the individual if the individual is determined by a court to be incompetent to consent to treatment.[41] A mental health or substance abuse treatment advance directive is much like a living will for health care; acute episodes of mental illness temporarily destroy the capacity required to give informed consent and often prevent people from realizing they are sick, causing them to refuse intervention.[42] Even in the midst of acute episodes, many people do not meet commitment criteria because they are not likely to injure themselves or others and are still able to care for their basic needs.[43] If left untreated, acute episodes may spiral out of control before the person meets commitment criteria.[44]

Mental Health Courts

Mental health courts are a type of problem-solving court that combines judicial supervision with community mental health treatment and other support services in order to reduce criminal activity and improve the quality of life of participants. Mental health court programs are not established or defined in Florida Statutes. A key objective of mental health courts is to prevent the jailing of offenders with mental illness by diverting them to appropriate community services or to significantly reduce time spent incarcerated.

Crisis Stabilization Units

Individuals experiencing severe emotional or behavioral problems often require emergency treatment to stabilize their situations before referral for outpatient services or inpatient services can occur. Emergency mental health stabilization services may be provided to individuals on a voluntary or involuntary basis. Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by DCF as a "receiving facility" as defined in Part I of ch. 394, F.S.[45]

Receiving facilities, often referred to as Baker Act Receiving Facilities, are public or private facilities designated by DCF for the purposes of receiving and examining individuals on an involuntary basis under emergency conditions and to provide short-term treatment. Receiving facilities that receive public funds from one of the managing entities to provide mental health

[39] *Id.*
[40] Section 765.202, F.S.
[41] Section 765.202(5), F.S.
[42] Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute,* 14 YALE J. HEALTH POL'Y, L. & ETHICS 1, (Winter 2014).
[43] *Id* at 17.
[44] *Id.*
[45] Section 394.455(26), F.S.

services to all persons regardless of their ability to pay are considered public receiving facilities.[46]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding and provide a less intensive and less costly alternative to inpatient psychiatric hospitalization for individuals presenting as acutely mentally ill. CSUs screen, assess, and admit individuals brought to the unit under the Baker Act, as well as those individuals who voluntarily present themselves, for short-term services.[47] CSUs provide services 24 hours a day, seven days a week, through a team of mental health professionals. The purpose of the CSU is to examine, stabilize, and redirect people to the most appropriate and least restrictive treatment settings, consistent with their mental health needs. Individuals often enter the public mental health system through CSUs. Managing entities must follow current statutes and rules that require CSUs to be paid for bed availability rather than utilization.

III. Effect of Proposed Changes:

Section 1 amends s. 394.455, F.S., defining "neglect or refuse to care for himself or herself" to include evidence that a person is unable to provide adequate food or shelter for themselves, is substantially unable to make an informed treatment choice, or needs care or treatment to prevent deterioration. The bill also adds criteria for a "real and present threat of substantial harm" to include evidence that an untreated person will lack, refuse, or not receive health services or will suffer severe harm leading to an inability to function cognitively or in their community generally.

Section 2 amends s. 394.459, F.S., relating to rights of patients, to require that a patient with a serious mental illness who has been released after being Baker Acted must be provided with information regarding the essential elements of recovery and provided with accessing a continuum of care regimen. DCF is provided with rulemaking authority to determine what services may-be available in such regimens and which serious mental illnesses will entitle an individual to services. Current law only requires the state to provide involuntary treatment at a state hospital.

Section 3 amends s. 394.4598, F.S., relating to guardian advocates to correct a cross reference.

Section 4 amends s. 394.4599, F.S., relating to involuntary admission, to correct a cross-reference.

Section 5 amends s. 394.461, F.S., to allow civil patients to be admitted to designated receiving facilities under the Baker Act without undergoing a transfer evaluation. The bill also provides that before the close of the State's case in a Baker Act hearing for involuntary placement, the state may establish that a transfer evaluation was performed and the document properly executed by providing the court with a copy of the transfer evaluation. The bill also prohibits the court

[46] Section 394.455(25), F.S.
[47] Section 394.875, F.S.

from considering the substantive information in the transfer evaluation unless the evaluator (typically a health care practitioner) testifies at the hearing.

Section 6 amends s. 394.4615, F.S., to eliminate provisions referring to s. 394.4655, F.S., relating to involuntary outpatient services, rendered inapplicable by the bill.

Section 7 amends s. 394.462, F.S., relating to transportation, to eliminate cross references to ss. 397.6811 and 397.6822, F.S.

Section 8 amends s. 394.4625, F.S., relating to voluntary admissions, requiring a person to show evidence of mental illness in order to be admitted to a facility on a voluntary basis. Adults must consent in writing, and minors may only be admitted on a voluntary basis if both the minor and their parent or guardian give express and informed consent. The minor's assent is considered an affirmative agreement to remain at the facility for examination. A minor's assent must be verified through a clinical assessment performed within 12 hours of arrival at the facility. The examining professional must provide the minor with an explanation as to why they are at the facility, what to expect, and when they can expect to be released, using language that is appropriate to the minor's age, experience, maturity, and condition. The professional must document that the minor can understand this information. The facility administrator must file notice with the court of the minor's voluntary placement within 1 day of admission.
A public defender shall be appointed by the court to review the voluntariness of the minor's admission and verify assent. The public defender can interview and represent the minor and shall have access to all relevant witnesses and records. If the public defender does not review their assent, the clinical record shall serve as verification of assent. If assent is not verified, a petition for involuntary placement must be filed or the minor must be released to their parent or guardian within 24 hours of arrival at the facility.

Section 9 amends s. 394.463, F.S., relating to involuntary examinations, providing that a person is subject to an involuntary examination if there is a substantial likelihood that without care or treatment the person will cause serious harm to themselves or others in the near future, as evidenced by his or her recent behavior, actions, or omissions, to include property damage.

The bill also adds criminal penalties for unlawful activities relating to examination and treatment. The unlawful activities detailed in the bill are: (a) knowingly furnishing false information for the purpose of obtaining emergency or other involuntary admission for any person; (b) causing or conspiring with another to cause, any involuntary mental health procedure for the person without a reason for believing a person is impaired; or, (c) causing, or conspiring to cause, any person to be denied their rights under the mental health statutes unlawful acts would be a misdemeanor of the first degree, punishable as provided by a fine up to $5,000. The bill provides law enforcement with discretion in transporting those who appear to meet Baker Act criteria to receiving facilities. It also requires receiving facilities to inform DCF of any person who has been Baker Acted 3 or more times within a 12 month period.

Section 10 amends s. 394.4655, F.S., relating to involuntary outpatient services, to provide that in lieu of inpatient treatment, a court may order a respondent in a Baker Act case into outpatient treatment for up to six months if it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment at least twice

during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician certifies that the respondent can be more appropriately treated on an outpatient basis, and can follow a treatment plan. Without private insurance or Medicaid, DCF would presumably be required to pay for such treatment.

The bill also requires that for the duration of their treatment, the respondent must have a willing, able, and responsible supervisor who will inform the court of any failure to comply with the treatment plan. The bill requires the court to retain jurisdiction over the parties for entry of further orders after a hearing, and the court may order inpatient treatment to stabilize a respondent who decompensates during their period of court-ordered treatment if they continue to meet the other statutorily required criteria for commitment. The bill eliminates all other existing procedures in this section pertaining to criteria and procedures for involuntary examination.

Section 11 amends s. 394.467, F.S., relating to involuntary inpatient placement, to add a likelihood of committing property damage to the criteria for involuntary inpatient placement. The bill provides that with respect to a hearing on involuntary inpatient placement, both the patient and the state are independently entitled to at least one continuance of the hearing. The patient's continuance may be for a period of up to 4 weeks and requires concurrence of the patient's counsel. The state's continuance may be for a period of up to 7 court working days and requires a showing of good cause and due diligence by the state before it can be requested. The state's failure to timely review and readily available document or failure to attempt to contact a known witness does not merit a continuance. The bill requires the court to increase the number of court working days in which the hearing may be held from 5 to 7. The bill allows for all witnesses to a hearing to appear telephonically or by other remote means. The bill also allows the state attorney to access the patient, any witnesses, and any records needed to prepare its case. The bill prohibits the court from ordering an individual with a developmental disability as defined under s. 393.063, TBI or dementia who lacks a co-occurring mental illness into a state treatment facility. Such individuals must be referred to the Agency for Persons with Disabilities or the Department of Elder Affairs for further evaluation and the provision of appropriate services for their individual needs. In addition, if it reasonably appears that the individual would be found incapacitated under chapter 744 and the individual does not already have a legal guardian, the receiving facility must inform any known next of kin and initiate guardianship proceedings. The receiving facility may hold the individual until the petition to appoint a guardian is heard by the court and placement is secured.

Section 12 amends s. 394.495, F.S., relating to programs and services for child and adolescent mental health systems of care, explicitly requiring that for assessments of children and adolescents under the Baker Act, a clinical psychologist, clinical social worker, physician, psychiatric nurse, psychiatrist, or a person working under the direct supervision of one of these professionals may perform an assessment. This is current law, however currently this statute refers to these professionals in a cross-reference rather than listing them in this section of statute.

Section 13 amends s. 394.496, F.S., relating to service planning, requiring that for assessments of children and adolescents under the Baker Act, a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist must be among the persons included in developing a services plan for the child or adolescent. This is current law, however currently this statute refers to these professionals in a cross-reference rather than listing them in this section of statute.

Section 14 amends s. 394.499, F.S., relating to integrated children's CSU/juvenile addiction receiving facility services, adding the terms "parent or legal" in front of guardian to state: a person under 18 years of age for whom voluntary application is made by his or her parent or legal guardian. Also, the bill adds a statutory reference to the voluntary admissions section in statute (s. 394.4625, F.S.).

Section 15 amends s. 394.9085, F.S., relating to behavioral provider liability, adding a cross reference to s. 394.455(41), F.S.

Section 16 amends s. 397.305, F.S., revising legislative intent related to the Marchman Act to include that patients be placed in the most appropriate and least restrictive environment conducive to long-term recovery while protecting individual rights.

Section 17 amends s. 397.311, F.S., relating to definition under the Marchman Act, to make the same changes to definitions in statute to the Marchman Act as the bill makes to the Baker Act.

Section 18 amends s. 397.416, F.S., to change a cross reference.

Section 19 amends s. 397.501, F.S., relating to rights of individuals, requiring that a patient with a serious substance abuse addiction who has been released after being Marchman Acted must be provided with information on the elements of a coordinated system of care. DCF is provided with rulemaking authority to determine what services may be provided to patients.

Section 20 amends s. 397.675, F.S., relating to criteria for involuntary admissions, to make the same changes to involuntary treatment criteria to the Marchman Act as the bill makes to the Baker Act, and to add history of noncompliance with substance abuse treatment and continued substance use as additional criterion.

Section 21 amends s. 397.6751, F.S., relating to service provider responsibilities regarding involuntary admissions, requiring that all patients admitted under the Marchman Act be placed in the most appropriate and least restrictive environment conducive to the patient's treatment needs.

Section 22 amends s. 397.681, F.S., relating to involuntary petitions, making the state attorney the real party of interest in all Marchman Act proceedings.

Section 23 repeals s. 397. 6811, F.S., relating to involuntary assessment and stabilization.

Section 24 repeals s. 397. 6814, F.S., relating to contents of a petition in an involuntary assessment and stabilization matter.

Section 25 repeals s. 397. 6815, F.S., relating to procedure in an involuntary assessment and stabilization matter.

Section 26 repeals s. 397. 6818, F.S., relating to court determination.

Section 27 repeals s. 397. 6819, F.S., relating to responsibility of a licensed service in an involuntary assessment and stabilization matter.

Section 28 repeals s. 397. 6821, F.S., relating to an extension of time for completion of an involuntary assessment and stabilization.

Section 29 repeals s. 397. 6822, F.S., relating to disposition of an individual after an involuntary assessment.

Section 30 amends s, 397.693, F.S., relating to involuntary treatment, providing that a person may be involuntary admitted under the Marchman Act if they reasonably appear to meet the relevant statutory critera.

Section 31 amends s. 397.695, F.S., relating to involuntary treatment, changing instances of 'treatment' to 'treatment services' throughout the section and allowing the court to waive or prohibit service of process fees for indigent respondents.

Section 32 amends 397.6951, F.S., relating to contents for a petition for involuntary treatment, changing instances of 'treatment' to 'treatment services' throughout the section and removing the requirement that a petition for involuntary treatment contain findings and recommendations of an assessment by a qualified professional.

The bill requires a petition for involuntary treatment to demonstrate that the petitioner believes that without treatment the respondent is likely to either:

- suffer from neglect or refuse to care for themselves which poses a real and substantial threat of harm and is unavoidable without the help of others or provisions of services; or
- inflict serious harm to themselves or others, including property damage.

The bill provides that a petition may be accompanied by a certificate or report of a qualified professional or licensed physician who has examined the respondent within the past 30 days. The certificate must contain the professional's findings and if the respondent refuses to submit to an examination must document the refusal.

The bill provides that in the event of an emergency requiring an expedited hearing, the petition must contain documented reasons for expediting the hearing.

Section 33 amends s. 397.6955, F.S., relating to the duties of the court upon the filing of a petition for involuntary treatment revising the duties of the court upon the filing of a Marchman Act petition for involuntary treatment. The bill requires the clerk of court to notify the state attorney upon the filing of such a petition if the petition does not indicate that the petitioner has retained private counsel, notify the respondent's counsel if any has been retained, and schedule a hearing on the petition within 10 court working days unless a continuance is granted.

In the case of an emergency, the bill allows the court to rely solely on the contents of a petition to enter an ex parte order authorizing the involuntary assessment and stabilization of the respondent. The bill allows the court to order a law enforcement officer to take the respondent into custody and deliver them to the nearest service provider while the full hearing is conducted.

Section 34 amends s. 397.6957, F.S., requires a respondent to be present during a hearing on an involuntary treatment petition unless the respondent has knowingly and willingly waived their right to appear. Testimony from family members familiar with the respondent's history and how it relates to their current condition is permissible. The bill allows witnesses to testify remotely via the most appropriate and convenient technological method of communication available to the court, including but not limited to teleconference, and allows any witnesses intending to remotely to attend and testify at the hearing as long as they provide the parties with all relevant documents in advance of the hearing.

The bill provides that if the respondent has not previously been assessed by a qualified professional, the court must allow 10 days for the respondent to undergo such evaluation, unless the court suspects that the respondent will not appear at a rescheduled hearing or refuses to submit to an evaluation, the court may enter a preliminary order committing the respondent to an appropriate treatment facility until the rescheduled hearing date. The court may also order the respondent to undergo drug screenings as part of the evaluation. The respondent's evaluation must occur within 72 hours of arrival at the treatment facility. If the facility cannot have the evaluation completed in this time period, they must petition the court for an extension of time not to extend beyond a period of 3 days before the reschedule hearing. If the period of time is extended and ends on a weekend or holiday, the court may only hold the respondent until the next court working day. Copies of the evaluation report must be provided to all parties and their counsel, and the respondent may be held and treatment initiated until the rescheduled hearing. The court may order law enforcement to transport the respondent as needed to and from a treatment facility to the court for the rescheduled hearing.

If the respondent is a minor, assessment must occur within 12 hours of admission. The service provider may petition the court for a 72-hour extension of time if the provider furnishes copies of the motion for extension of time to all parties. The court may expedite or grant additional time for the involuntary treatment hearing, but only if there is agreement among the parties on the hearing date or if there is statutorily appropriate notice and proof of service. If the period is extended and ends on a weekend or holiday, the court can only hold the respondent until the next court working day.

The bill requires the petitioner to prove, through clear and convincing evidence that the respondent is substance abuse impaired, has lost the power of self-control with respect to substance abuse, has a history of lack of compliance with treatment, and has demonstrated continued substance use. The bill requires the petitioner to also prove that it is likely that the respondent poses a threat of substantial harm to their own well-being and it is apparent that such harm may not be avoided through the help of willing, able, and responsible family member or friends or the provision of services, or that there is a substantial likelihood that, unless admitted, the respondent will cause harm to themselves or others, which may include property damage.

The bill allows the court to initiate involuntary proceedings at any point during the hearing if it reasonably believes that the respondent is likely to injure themselves if allowed to remain free. Any treatment order entered by the court at the conclusion of the hearing must contain findings

regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

Section 35 amends s, 397.697, F.S., relating to court determinations and the effect of a court order for involuntary services, providing that in order to qualify for involuntary outpatient treatment an individual must be accompanied by a willing, able, and responsible advocate, or a social worker or case manager of a licensed service provider, who will inform the court if the individual fails to comply with their outpatient program. The bill also requires that if outpatient treatment is offered in lieu of inpatient treatment, it must be available in the county where the respondent resides and it may be offered for up to six months if it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment at least twice during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician certifies that the respondent can be more appropriately treated on an outpatient basis and can follow a treatment plan.

The bill requires the court to retain jurisdiction in all cases resulting in involuntary inpatient treatment so that it may monitor compliance with treatment, change treatment modalities, or initiate contempt of court proceedings as needed.

The bill also provides that in cases involving minors who violate an involuntary treatment order, the court may hold the minor in contempt for the same amount of time as their court-ordered treatment, so long as the court informs the minor that the contempt can be immediately ended by compliance with the treatment plan. If a contempt order results in incarceration, status conference hearings must be held every 2 to 4 weeks to assess the minor's well-being and inquire whether the minor will enter treatment. If the minor agrees to enter treatment, service providers are required to prioritize their entry into treatment.

Finally the bill clarifies that while subject to the court's oversight, a service provider's authority is separate and distinct from the court's continuing jurisdiction.

Section 36 amends s. 397.6971, related to early release from involuntary services, to change all instances of the word 'services' to the word 'treatment.'

Section 37 amends s. 397.6975, F.S., related to extension of involuntary services periods, allowing a service provider to petition the court for an extension of an involuntary treatment period if an individual in treatment is nearing the end of their court-ordered time period in treatment and it appears that they will require additional care. The bill provides that such a petition will preferably be filed at least 10 days before the expiration of the current scheduled treatment period. The bill requires the court to immediately schedule a hearing to be held not more than 10 court working days after the filing of the petition. The bill allows the court to order additional treatment if the original time period will expire before the hearing is concluded and it appears likely to the court that additional treatment will be required.

Section 38 amends s. 397.6977, F.S., relating to disposition of individual completion of involuntary treatment services, to change all instances of the word 'services' to the word 'treatment.'

Section 39 repeals s. 397.6978, F.S., relating to guardian advocates; patients incompetent consent; and substance abuse disorder.

Section 40 amends s. 409.972, F.S., relating to mandatory and voluntary enrollment in Medicaid programs, to change a cross reference.

Section 41 amends s. 464.012, F.S., relating to the scope of practice for advanced registered nurse practitioners to correct a cross reference.

Section 42 amends s. 744.2007, F.S., relating to powers and duties of guardians, to correct a cross-reference.

Section 43 amends s. 790.065, relating to the sale and delivery of firearms, to eliminate cross references.

Section 44 provides an effective date 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 idenified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may impact private service providers who will be required to update forms to accommodate new requirements and to train service provider staff and administrators on the new requirements.[48]

C. Government Sector Impact:

There will be an indeterminate fiscal impact on public defenders throughout the state and on the state courts system by virtue of additional clients and hearings entering the system.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 394.455, 394.459, 394.4598, 394.4599, 394.461, 394.4615, 394.462, 394.4625, 394.463, 394.4655, 394.467, 394.495, 394.496, 394.499, 394.9085, 397.305, 397.311, 397.416, 397.501, 397.675, 397.6751, 397.681, 397.693, 397.695, 397.6951, 397.6955, 397.6957, 397.697, 397.6971, 397.6975, 397.6977, 409.972, 464.012, 744.2007, and 790.065 of the Florida Statutes.

This bill repeals sections 397.6811, 397.6814, 397.6815, 397.6818, 397.6819, 397.6821 and 397.6822, and 397.6978-of the Florida Statutes.

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 Children, Families, and Elder Affairs on January 28, 2020:

- Requires that a patient be informed of services available rather than requiring the provision of services under the Baker Act.
- Eliminates the requirement that a public defender be appointed to represent a minor in Baker Act proceedings.
- Requires a person to show evidence of mental illness in order to be admitted to a receiving facility for a Baker Act on a voluntary basis. Adults must consent in writing, minors may only be admitted on a voluntary basis if both the minor and their parent or guardian give express and informed consent. The minor's assent is considered an affirmative agreement to remain at the facility for examination. A minor's assent must be verified through a clinical assessment performed within 12

[48] Department of Children and Families Agency Analysis of SB 870, November 18, 2019. On file with the Senate Committee on Children, Families, and Elder Affairs.

hours of arrival at the facility. The examining professional must provide the minor with an explanation as to why they are at the facility, what to expect, and when they can expect to be released, using language that is appropriate to the minor's age, experience, maturity, and condition. The professional must document that the minor can understand this information. The facility administrator must file notice with the court of the minor's voluntary placement within 1 day of admission.

- A public defender shall be appointed by the court to review the voluntariness of the minor's admission and verify assent. The public defender can interview and represent the minor and shall have access to all relevant witnesses and records. If the public defender does not review their assent, the clinical record shall serve as verification of assent. If assent is not verified, a petition for involuntary placement must be filed or the minor must be released to their parent or guardian within 24 hours of arrival at the facility.
- Provides law enforcement with discretion in transporting those who appear to meet Baker Act criteria to receiving facilities. Requires receiving facilities to inform DCF of any person who has been Baker Acted more than 3 times within a 12 month period. Removes the requirement that a receiving facility must inform DCF of a Baker Acted minor's admission and their outcome.
- Removes the requirement that a person is not likely to become dangerous, suffer more serious harm or illness, or further deteriorate if a treatment plan is followed from the three criteria for a court ordering 6-month outpatient treatment following a Baker Act admission. Adds the ability of the court, in retaining jurisdiction over the case, to order inpatient treatment to stabilize a respondent who decompensates during their 6-month period of court-ordered treatment if they also meet the commitment criteria of s. 394.467.
- Removes the ability of the court to refer cases to DCF to initiate adult protective services or child protective services under chapter 39 or 415. Prohibits the court from ordering an individual with a developmental disability as defined under s. 393.063, TBI or dementia who lacks a co-occurring mental illness into a state treatment facility.
- Requires any witnesses intending to remotely attend and testify at a Baker Act hearing to provide all parties with all relevant documents in advance of the hearing.
- Requires that a patient be informed of services available rather than requiring the provision of services under the Marchman Act.
- Adds the requirement that the clerk must only notify the state attorney of a petition for involuntary treatment services for substance abuse if the petition does not indicate that the petitioner has retained private counsel.
- Adds that a service provider must promptly inform the court and parties of the respondent's arrival under the Marchman Act and cannot hold the respondent for longer than the 72 hour observation period unless the original or extended observation period ends on a weekend or holiday, in which case the provider may hold the respondent until the next working day.
- Adds that the court may order drug tests and consider specific symptoms of a respondent's condition as an example of a showing of good cause for holding a respondent for an extended period of time under the Marchman Act.

- Allows witnesses in Marchman Act hearings to testify remotely via the most appropriate and convenient technological method of communication available to the court, including but not limited to teleconference.
- Adds that any witnesses intending to remotely attend and testify at a Marchman Act hearing must provide the parties with all relevant documents in advance of the hearing.
- Adds that if the respondent in a Marchman Act proceeding is a minor, an assessment must occur within 12 hours of admission. The bill llows the service provider to petition the court for a 72-hour extension of time if the provider furnishes copies of the motion for extension of time to all parties. It allows the court to expedite or grant additional time for the involuntary treatment hearing, but only if there is agreement among the parties on the hearing date or if there is statutorily appropriate notice and proof of service. If the period is extended and ends on a weekend or holiday, the court can only hold the respondent until the next court working day.
- Removes the ability to refer the respondent to a specific treatment provider in a treatment order following a hearing.
- Adds that to qualify for an outpatient treatment plan under the Marchman Act, the individual must be supported by a social worker or case manager of a licensed service provider or willing able and responsible individual.
- Adds that services must be available in the county in which the respondent is located and removes the requirement that it must appear unlikely that the respondent will become dangerous, suffer more harm or illness, or deteriorate.

B. Amendments:

None.