

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/CS/SB 1262

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

SUBJECT: Mental Health and Substance Abuse

DATE: February 25, 2022

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. <u>Delia</u>	<u>Cox</u>	<u>CF</u>	Fav/CS
2. <u>Sneed</u>	<u>Money</u>	<u>AHS</u>	Recommend: Fav/CS
3. <u>Sneed</u>	<u>Sadberry</u>	<u>AP</u>	Fav/CS

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1262 makes several changes to procedures surrounding voluntary and involuntary examinations of individuals under the Baker and Marchman Acts. The bill prohibits restrictions on visitors, phone calls, and written correspondence for Baker Act patients unless certain qualified medical professionals document specific conditions are met. The bill requires law enforcement officers to search certain electronic databases for emergency contact information of Baker and Marchman Act patients being transported to a receiving facility.

Under the bill, patients subject to an involuntary Baker Act examination who do not meet the criteria for a petition for involuntary services must be released at the end of 72 hours, regardless of whether the examination period ends on a weekend or holiday, as long as certain discharge criteria are met. The bill also permits psychiatric APRNs practicing under the protocols of a psychiatrist in a nationally accredited community mental health center to conduct discharge examinations for patients held under an involuntary Baker Act.

The bill makes it a first degree misdemeanor for a person to knowingly and willfully:

- Furnish false information for the purpose of obtaining emergency or other involuntary admission for any person;
- Cause, or conspire with another to cause, any emergency or other involuntary mental health procedure for the person under false pretenses; or,

- Cause, or conspire with another to cause, without lawful justification, any person to be denied their rights under the Baker Act statutes.

The bill requires receiving facilities to offer voluntary Baker and Marchman Act patients the option to authorize the release of clinical information to certain individuals known to the patient within 24 hours of admission.

The bill clarifies that telehealth may be used when discharging patients under an involuntary Baker Act examination, and directs facilities receiving transportation reports detailing the circumstances of a Baker Act to share such reports with the Department of Children and Families (DCF) for use in analyzing annual Baker Act data.

The bill also makes several changes to the Commission on Mental Health and Substance Abuse (Commission), including:

- Authorizing the Commission to conduct meetings in person at locations throughout the state or via teleconference or other electronic means;
- Authorizing members to receive per diem and reimbursement and travel expenses;
- Authorizing the Commission to access information and records necessary to carry out its duties, including exempt and confidential information, provided that the Commission does not disclose such exempt or confidential information; and
- Modifying the due date for the Commission's interim report from September 1, 2022 to January 1, 2023.

The bill is expected to have a negative fiscal impact on state government. See Section V. Fiscal Impact Statement.

The bill takes effect July 1, 2022.

II. Present Situation:

Refer to Section III (Effect of Proposed Changes) for discussion of the relevant portions of current law.

III. Effect of Proposed Changes:

The Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.¹ The Baker Act deals with Florida's mental health commitment laws, and includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations.² The Baker Act also protects the rights of all individuals examined or treated for mental illness in Florida.³

¹ Ch. 71-131, LO.F.; The Baker Act is contained in ch. 394, F.S.

² Sections 394.451-394.47891, F.S.

³ Section 394.459, F.S.

Involuntary Examination

Individuals suffering from an acute mental health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.⁴ An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; and
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.⁵

The involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;⁶
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;⁷ or
- A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion.⁸

A law enforcement officer who delivers an individual to a receiving facility must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.⁹ Any facility accepting the patient based on this certificate must send a copy of the certificate to the DCF within 5 working days.¹⁰ The same reporting requirements apply in instances where a law enforcement officer delivers a person to a receiving facility pursuant to a certificate executed by a health care professional.¹¹

Involuntary patients must be taken to either a public or a private facility that has been designated by the DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold, or refer, as appropriate, involuntary patients under emergency conditions for psychiatric

⁴ Sections 394.4625 and 394.463, F.S.

⁵ Section 394.463(1), F.S.

⁶ Section 394.463(2)(a)1., F.S. In addition, the order of the court must be made a part of the patient's clinical record.

⁷ Section 394.463(2)(a)2., F.S.

⁸ Section 394.463(2)(a)3., F.S.

⁹ Section 394.463(2)(a)2., F.S.

¹⁰ *Id.*

¹¹ Section 394.463(2)(a)3., F.S.

evaluation and to provide short-term treatment or transportation to the appropriate service provider.¹²

The patient must be examined by the receiving facility within 72 hours of the initiation of the involuntary examination. The examination may be performed by:

- A physician;¹³
- A clinical psychologist;¹⁴ or
- A psychiatric nurse¹⁵ performing within the framework of an established protocol with a psychiatrist at a facility.¹⁶

Under current law, a receiving facility may not release an involuntary examination patient without the documented approval of a psychiatrist, or a clinical psychologist.¹⁷ However, if the receiving facility is owned or operated by a hospital or health system, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness who has completed the involuntary examination.¹⁸ A psychiatric nurse may not approve a patient's release if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.¹⁹

Because of the current setting restrictions on where a psychiatric nurse may approve Baker Act releases, there are 28 nationally accredited community mental health providers in Florida that operate receiving facilities licensed under chapter 394, F.S., but cannot allow their psychiatric nurses to discharge a Baker Act patient under the protocol of their psychiatrists.²⁰

By the end of the 72 hour period, or if the period ends on a weekend or holiday, no later than the next working day, one of the following actions must be taken to address the individual needs of the patient:

- The patient must be released, unless he or she is charged with a crime, in which case the patient is to be returned to the custody of a law enforcement officer;
- The patient must be released for voluntary outpatient treatment;

¹² Section 394.455(40), F.S.

¹³ "Physician" means a medical practitioner licensed under ch. 458, F.S., or ch. 459, F.S., who has experience in the diagnosis and treatment of mental illness or a physician employed by a facility operated by the United States Department of Veterans Affairs or the United States Department of Defense. Section 394.455(33), F.S.

¹⁴ "Clinical psychologist" means a psychologist as defined in s. 490.003(7), F.S., with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility. Section 394.455(5), F.S.

¹⁵ "Psychiatric nurse" means an advanced practice registered nurse licensed under s. 464.012, F.S., who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 2 years of post-master's clinical practice experience under the supervision of a physician. Section 394.455(36), F.S.

¹⁶ Section 394.463(2)(f), F.S.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ Florida Behavioral Health Association, *Psychiatric APRNs in a Community Behavioral Healthcare Setting* (on file with the Senate Committee on Appropriations).

- The patient, unless he or she is charged with a crime, must be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient must be admitted as a voluntary patient; or
- A petition for involuntary services must be filed in the circuit court if inpatient treatment is deemed necessary or with the criminal county court, as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition must be made available. A petition for involuntary inpatient placement must be filed by the facility administrator.²¹

Receiving facilities must also ensure that a patient's discharge plan considers all of the following prior to the patient's release:

- The patient's transportation resources;
- The patient's access to stable living arrangements;
- How assistance in securing needed living arrangements or shelter will be provided to patients at risk of readmission within the 3 weeks immediately following discharge due to homelessness or transient status. The discharging facility must document that, before discharging the patient, it has requested a commitment from a shelter provider that assistance will be rendered;
- The availability of assistance in obtaining a timely aftercare appointment for needed services, including continuation of prescribed psychotropic medications. Aftercare appointments for psychotropic medication and case management must be requested to occur not later than 7 days after the expected date of discharge; if the discharge is delayed, the discharging facility must document notification of the delay to the aftercare provider. The discharging facility shall coordinate with the aftercare service provider and document the aftercare planning;
- The availability of, and access to, prescribed psychotropic medications in the community. To ensure a patient's safety and provision of continuity of essential psychotropic medications, such prescribed psychotropic medications, prescriptions, multiple partial prescriptions for psychotropic medications, or a combination thereof, must be provided to the patient upon discharge to cover the intervening days until the first scheduled psychotropic medication aftercare appointment, up to a maximum of 21 calendar days;
- The provision of education and written information about the patient's illness and psychotropic medications, including other prescribed and over-the-counter medications; the common side-effects of any medications prescribed; and any common adverse clinically significant drug-to-drug interactions between that medication and other commonly available prescribed and over-the-counter medications;
- The provision of contact and program information about, and referral to, any community-based peer support services in the community;
- The provision of contact and program information about, and referral to, any needed community resources;
- Referral to substance abuse treatment programs, trauma or abuse recovery-focused programs, or other self-help groups, if indicated by assessments; and
- The provision of information about advance directives, including how to prepare and use them.²²

²¹ Section 394.463(2)(g), F.S.

²² Rule 65E-5.1303, F.A.C.

Involuntary Inpatient Placement

A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

- He or she is mentally ill and because of his or her mental illness:
 - He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement or is unable to determine for himself or herself whether placement is necessary; and
 - He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services; and
 - Without treatment, is likely to suffer from neglect or refuse to care for himself or herself; and
 - Such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
 - There is a substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
- All available less restrictive treatment alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.²³

The administrator of the receiving or treatment facility that is retaining a patient for involuntary inpatient treatment must file a petition for involuntary inpatient placement in the court in the county where the patient is located.²⁴ Upon filing, the clerk of the court must provide copies to the DCF, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located.²⁵ The court must hold a hearing on involuntary inpatient placement within 5 court working days, unless a continuance is granted.²⁶

The Marchman Act

In the early 1970s, the federal government enacted laws creating formula grants for states to develop continuums of care for individuals and families affected by substance abuse.²⁷ The laws resulted in separate funding streams and requirements for alcoholism and drug abuse. In response to the laws, the Florida Legislature enacted chs. 396 and 397, F.S., relating to alcohol and drug abuse, respectively.²⁸ Each of these laws governed different aspects of addiction, and thus had different rules promulgated by the state to fully implement the respective pieces of legislation.²⁹ However, because persons with substance abuse issues often do not restrict their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not adequately address Florida's substance abuse problem.³⁰

²³ Section 394.467(1), F.S.

²⁴ Section 394.467(2) and (3), F.S.

²⁵ Section 394.467(3), F.S.

²⁶ Section 394.467(5), F.S.

²⁷ The DCF, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5. (On file with the Senate Children, Families, and Elder Affairs Committee).

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

In 1993, legislation was adopted to combine ch. 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act).³¹

The Marchman Act encourages individuals to seek services on a voluntary basis within the existing financial and space capacities of a service provider. An individual who wishes to enter treatment may apply to a service provider for voluntary admission.³² Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service provider.³³ However, denial of addiction is a prevalent symptom of SUD, creating a barrier to timely intervention and effective treatment.³⁴ As a result, treatment typically must stem from a third party providing the intervention needed for SUD treatment.³⁵

Involuntary Admissions

The Marchman Act establishes a variety of methods under which substance abuse assessment, stabilization, and treatment can be obtained on an involuntary basis. There are five involuntary admission procedures that can be broken down into two categories depending upon whether the court is involved.³⁶ Three of the procedures do not involve the court, while two require direct petitions to the circuit court. The same criteria for involuntary admission apply regardless of the admission process used.³⁷

An individual meets the criteria for an involuntary admission under the Marchman Act when there is good faith reason to believe the individual is substance abuse impaired and, because of such impairment, has lost the power of self-control with respect to substance use, and either:

- Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision in that regard;³⁸ or
- Without care or treatment:
 - The person is likely to suffer from neglect or refuse to care for himself or herself;
 - Such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and
 - It is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
 - There is substantial likelihood that the person:
 - Has inflicted, or threatened to or attempted to inflict physical harm on himself, herself, or another; or

³¹ Ch. 93-39, s. 2, L.O.F. (creating ch. 397, F.S., effective October 1, 1993).

³² Section 397.601(1), F.S.

³³ Section 397.601(2), F.S.

³⁴ Darran Duchene and Patrick Lane, *Fundamentals of the Marchman Act*, Risk RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Programs, available at <http://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/> (last visited January 19, 2022) (hereinafter cited as “Fundamentals of the Marchman Act”).

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ Section 394.675(2)(a), F.S. However, mere refusal to receive services does not constitute evidence of lack of judgment with respect to the person’s need for such services.

- Is likely to inflict, physical harm on himself, herself, or another unless he or she is admitted.³⁹

Non-Court Involved Involuntary Admissions

The three types of non-court procedures for involuntary admission for substance abuse treatment under the Marchman Act include protective custody, emergency admission, and the alternative involuntary assessment for minors.

Law enforcement officers use the protective custody procedure when an individual is substance-impaired or intoxicated in public and such impairment is brought to the attention of the officer.⁴⁰ The purpose of this procedure is to allow the person to be taken to a safe environment for observation and assessment to determine the need for treatment. A law enforcement officer may take the individual to their residence, a hospital, a detoxification center, or an addiction receiving facility, whichever the officer determines is most appropriate.⁴¹ The officer is also required to execute a written report⁴² detailing the circumstances under which the individual was taken into custody.⁴³ The current version of the form developed and disseminated by the DCF must also include information on transportation, family members or others present when the individual was taken into custody, and next of kin or other contact information, if known.⁴⁴

If the individual in these circumstances does not consent to protective custody, the officer may do so against the person's will, without using unreasonable force. I, the officer has the option of taking an individual to a jail or detention facility for his or her own protection. Such detention cannot be considered an arrest for any purpose and no record can be made to indicate that the person has been detained or charged with any crime.⁴⁵ However, if the individual is a minor, the law enforcement officer must notify the nearest relative of a minor in protective custody without consent.⁴⁶

The second process, emergency admission, authorizes an individual who appears to meet the criteria for involuntary admission to be admitted to a hospital, an addiction receiving facility, or a detoxification facility for emergency assessment and stabilization, or to a less intensive component of a licensed service provider for assessment only.⁴⁷ Individuals admitted for involuntary assessment and stabilization under this provision must have a certificate from a specified health professional⁴⁸ demonstrating the need for this type of placement and

³⁹ Section 397.675(2)(b), F.S.

⁴⁰ Section 397.677, F.S. The individual can be a minor or adult under this process.

⁴¹ Section 397.6771, F.S. A person may be held in protective custody for no more than 72 hours, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.

⁴² The DCF is required to develop the form pursuant to s. 397.321(19), F.S.

⁴³ Section 397.6772(1)(a), F.S.

⁴⁴ The current version of the form is available at

<https://eds.myflfamilies.com/DCFFormsInternet/Search/OpenDCFForm.aspx?FormId=1061> (last visited January 19, 2022).

⁴⁵ Section 397.6772(1), F.S.

⁴⁶ Section 397.6772(2), F.S.

⁴⁷ Section 397.679, F.S.

⁴⁸ Section 397.6793(1), F.S., provides a list of professionals that include a physician, a clinical psychologist, a physician assistant working under the scope of practice of the supervising physician, a psychiatric nurse, an advanced practice registered nurse, a mental health counselor, a marriage and family therapist, a master's-level-certified addictions professional for substance abuse services, or a clinical social worker.

recommending the least restrictive type of service that is appropriate to the needs of the individual.⁴⁹

Lastly, the alternative involuntary assessment for minors provides a way for a parent, legal guardian, or legal custodian to have a minor admitted to an addiction receiving facility to assess the minor's need for treatment by a qualified professional.⁵⁰

Telehealth (Sections 1 and 5)

Section 456.47, F.S., defines the term “telehealth” as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

“Synchronous” telehealth refers to the live, real-time, or interactive transmission of information between a patient and a health care provider during the same time period. The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

“Asynchronous” telehealth refers to the transfer of data between a patient and a health care provider over a period of time and typically in separate time frames. This is commonly referred to as “store-and-forward.”

“Remote patient monitoring” refers to the collection, transmission, evaluation, and communication of individual health data to a health care provider from the patient's location through technology such as wireless devices, wearable sensors, implanted health monitors, smartphones, and mobile apps.⁵¹ Remote monitoring is used to monitor physiologic parameters, including weight, blood pressure, blood glucose, pulse, temperature, oximetry, respiratory flow rate, and more. Remote monitoring can be useful for ongoing condition monitoring and chronic disease management. Depending upon the patient's needs, remote monitoring can be synchronous or asynchronous.

Florida Telehealth Providers

In 2019, the Legislature passed and the Governor approved CS/CS/HB 23, creating s. 456.47, F.S., which became effective on July 1, 2019.⁵² It authorized Florida-licensed health care providers⁵³ to use telehealth to deliver health care services within their respective scopes of practice.

⁴⁹ Section 397.6793, F.S. The certificate can be from a physician, advanced practice registered nurse, a psychiatric nurse, a clinical psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, or a physician assistant working under the scope of a practice of the supervising physician, or a master's-level-certified addictions professional for substance abuse services.

⁵⁰ Section 397.6798, F.S.

⁵¹ American Board of Telehealth, *Telehealth: Defining 21st Century Care*, available at <https://www.americantelemed.org/resource/why-telemedicine/> (last visited January 19, 2022).

⁵² Chapter 2019-137, s. 6, L.O.F.

⁵³ Section 456.47(1)(b), F.S.

Telehealth providers who treat patients located in Florida must be one of the licensed health care practitioners listed below and be either Florida-licensed, licensed under a multi-state health care licensure compact of which Florida is a member state, or registered as an out-of-state telehealth provider:

- Behavioral Analyst;⁵⁴
- Acupuncturist;⁵⁵
- Allopathic physician;⁵⁶
- Osteopathic physician;⁵⁷
- Chiropractor;⁵⁸
- Podiatrist;⁵⁹
- Optometrist;⁶⁰
- Nurse;⁶¹
- Pharmacist;⁶²
- Dentist;⁶³
- Dental Hygienist;⁶⁴
- Midwife;⁶⁵
- Speech Therapist;⁶⁶
- Occupational Therapist;⁶⁷
- Radiology Technician;⁶⁸
- Electrologist;⁶⁹
- Orthotist;⁷⁰
- Pedorthist;⁷¹
- Prosthetist;⁷²
- Medical Physicist;⁷³
- Emergency Medical Technician;⁷⁴
- Paramedic;⁷⁵

⁵⁴ Section 393.17, F.S.

⁵⁵ Chapter 457, F.S.

⁵⁶ Chapter 458, F.S.

⁵⁷ Chapter 459, F.S.

⁵⁸ Chapter 460, F.S.

⁵⁹ Chapter 461, F.S.

⁶⁰ Chapter 463, F.S.

⁶¹ Chapter 464, F.S.

⁶² Chapter 465, F.S.

⁶³ Chapter 466, F.S.

⁶⁴ *Id.*

⁶⁵ Chapter 467, F.S.

⁶⁶ Chapter 468, F.S.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ Chapter 458, F.S.

⁷⁰ Chapter 468, F.S.

⁷¹ *Id.*

⁷² *Id.*

⁷³ Chapter 483, F.S.

⁷⁴ Chapter 401, F.S.

⁷⁵ *Id.*

- Massage Therapist;⁷⁶
- Optician;⁷⁷
- Hearing Aid Specialist;⁷⁸
- Clinical Laboratory Personnel;⁷⁹
- Respiratory Therapist;⁸⁰
- Psychologist;⁸¹
- Psychotherapist;⁸²
- Dietician/Nutritionist;⁸³
- Athletic Trainer;⁸⁴
- Clinical Social Worker;⁸⁵
- Marriage and Family Therapist;⁸⁶ and
- Mental Health Counselor.⁸⁷

Effect of the Bill

The bill provides a definition for “telehealth,” specifically that telehealth has the same meaning as defined in s. 456.47, F.S. The bill permits receiving facilities holding patients for an involuntary examination under the Baker Act to authorize the release of a patient via telehealth.

Under the bill, if a patient’s 72-hour examination period ends on a weekend or holiday, and the receiving facility:

- Intends to file a petition for involuntary services, the patient may be held at a receiving facility through the next working day thereafter and the petition for involuntary services must be filed no later than that date. If the receiving facility fails to file a petition at the close of the next working day, the patient must be released from the receiving facility.
- Does not intend to file a petition for involuntary services, a receiving facility may postpone release of a patient until the next working day thereafter only if a qualified professional documents that adequate discharge planning and procedures in accordance with s. 394.468, F.S.,⁸⁸ are not possible until the next working day.

Specifically, receiving facilities must include, and document consideration of the following newly established discharge planning and procedure requirements delineated in s. 394.468, F.S.:

- Follow-up behavioral health appointments;

⁷⁶ Chapter 480, F.S.

⁷⁷ Chapter 484, F.S.

⁷⁸ *Id.*

⁷⁹ Chapter 483, F.S.

⁸⁰ Chapter 468, F.S.

⁸¹ Chapter 490, F.S.

⁸² Chapter 491, F.S.

⁸³ Chapter 468, F.S.

⁸⁴ Chapter 468, F.S.

⁸⁵ Chapter 491, F.S.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ Section 394.468, F.S., currently provides that admission and discharge and treatment policies of the DCF are governed solely by ch. 394, F.S., and are not subject to control by court procedure rules. The matters within the purview of this part are deemed to be substantive, not procedural.

- Information on how to obtain prescribed medications; and
- Information pertaining to:
 - Available living arrangements;
 - Transportation; and
 - Recovery support opportunities.

The bill applies these requirements to all patients discharged from a receiving or treatment facility.

These changes will help to ensure patients are not held by a facility for longer than necessary, while maintaining sound and proper discharge considerations.

The bill also revises the current restriction that requires a receiving facility to be owned or operated by a hospital or health system for a psychiatric nurse to approve a patient's release to include nationally accredited community mental health centers. This means that a psychiatric nurse, performing under the framework of an established protocol with a psychiatrist, will be allowed to release a Baker Act patient in specified community settings, which will likely improve discharge efficiencies in such settings. The bill retains the current law prohibition on a psychiatric nurse's approval of a patient's release if the involuntary examination was initiated by a psychiatrist, unless the release is approved by the initiating psychiatrist.

Notice Requirements (Sections 3 through 7)

Receiving facilities must give prompt notice⁸⁹ of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,⁹⁰ guardian advocate,⁹¹ health care surrogate or proxy, attorney, and representative.⁹² If the patient is a minor, the receiving facility must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice for an adult may be provided within 24 hours of arrival; however, notice for a minor must be provided immediately after the minor's arrival at the facility.⁹³ The facility may delay the notification for a minor for up to 24 hours if it has submitted a report to the central abuse hotline.

The receiving facility must attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until it receives confirmation that the notice has been received. Attempts must be repeated at least once every hour during the first 12 hours after the minor's arrival and then once every 24 hours thereafter until confirmation is received, the minor is released, or a petition for involuntary services is filed with the court.⁹⁴

⁸⁹ Notice may be provided in person or by telephone; however, in the case of a minor, notice may also be provided by other electronic means. Section 394.455(2), F.S.

⁹⁰ "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. Section 394.455(17), F.S.

⁹¹ "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment. Section 394.455(18), F.S.

⁹² Section 394.4599(2)(b), F.S.

⁹³ Section 394.4599(2)(b)-(c), F.S.

⁹⁴ Section 394.4599(c)2., F.S.

Emergency Contact Information and Florida Databases

On December 7, 2005, Tiffiany Marie Olson was killed in a traffic crash on U.S. 19 in Manatee County.⁹⁵ Following her mother not being notified of her death for several hours, her mother was instrumental in getting emergency contact information (ECI) added to a person's driver license or identification card record.⁹⁶ The Florida Department of Highway Safety and Motor Vehicles (the FLHSMV) launched the program on October 2, 2006, and it has since been adopted by 15 other states.⁹⁷

ECI allows law enforcement to contact designated individuals in the event of an emergency.⁹⁸ The system is securely maintained by the FLHSMV and can be accessed by law enforcement only in an emergency situation.⁹⁹ Floridians with a valid driver's license or ID card may enter up to two emergency contacts.¹⁰⁰ Residents can register or update their ECI without cost at flhsmv.gov/eci¹⁰¹ or at local driver license offices statewide.¹⁰²

Driver and Vehicle Information Database (DAVID)

The DAVID system is the FLHSMV's multifaceted database that provides accurate, concise, and up-to-date driver and motor vehicle information to law enforcement, criminal justice officials, and other state agencies.¹⁰³ To maintain the integrity of this information, the records are regulated and can only be accessed and used by authorized personnel in accordance with state and federal law.¹⁰⁴

The DAVID system also contains ECI for Florida drivers who have chosen to list emergency contacts.¹⁰⁵ ECI available through DAVID may only be accessed by law enforcement and may only be used in emergency situations.¹⁰⁶

Florida Crime Information Center (FCIC) System

The FCIC system is Florida's central database for tracking various crime-related information. The system is designed "to provide services, information, and capabilities to the law enforcement and criminal justice community" in the state, and gives them access to other criminal justice

⁹⁵ The Florida Highway Safety and Motor Vehicles (the FLHSMV), *Emergency Contact Information History*, available at <https://www.flhsmv.gov/driver-licenses-id-cards/emergency-contact-information-history/> (last visited January 19, 2022).

⁹⁶ *Id.*

⁹⁷ To Inform Families First, *About TIFF*, available at <https://www.toinformfamiliesfirst.org/> (last visited January 19, 2022) (hereinafter "About TIFF").

⁹⁸ The FLHSMV, *ECI Brochure*, available at https://flhsmv.gov/pdf/eci/eci_brochure.pdf (last visited January 19, 2022).

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ The FLHSMV, *Emergency Contact Information History*, available at <https://www.flhsmv.gov/driver-licenses-id-cards/emergency-contact-information-history/> (last visited February 9, 2022).

¹⁰² *Id.*

¹⁰³ The FLHSMV Office of Inspector General, *DAVID Audits*, p. 1, available at <https://www.flhsmv.gov/pdf/igoffice/20171823.pdf> (last visited January 19, 2022).

¹⁰⁴ *Id.*, s. 119.0712(2)(d), F.S.

¹⁰⁵ About TIFF.

¹⁰⁶ The Fort Lauderdale Police Department, *Access to Criminal Justice Information*, p. 4, available at <https://www.flpd.org/home/showpublisheddocument/4061/637662691735570000> (last visited January 19, 2022).

information systems nationwide.¹⁰⁷ All employees that access the FCIC must be certified by the Florida Department of Law Enforcement, and all information obtained through the system is restricted to criminal justice purposes.¹⁰⁸

Law enforcement can also use FCIC to access information pertaining to a driver's specific license, providing an officer with information including a driver's name, date of birth, residential address and licensure status. If a driver has chosen to add ECI, it will also be provided to an officer along with the rest of the driver-specific information at the bottom of the screen when he or she queries the FCIC database.¹⁰⁹

Effect of the Bill

Involuntary Admissions

Baker Act

The bill adds emergency contacts, identified by law enforcement through the DAVID or FCIC electronic databases, to the list of individuals a receiving facility may contact when a patient is brought to a receiving facility for an involuntary examination under the Baker Act. The bill also amends s. 119.0712, F.S., expanding the entities who can access the ECI to include:

- Receiving facilities;
- Hospitals; and
- Licensed detoxification and addictions receiving facilities.

The bill specifies that these additional entities can only use the ECI for the purposes of informing emergency contacts of a Baker Act patient's whereabouts.

Under the bill, an officer who delivers a patient to a receiving facility must include all ECI discoverable through FCIC, DAVID, or other electronic databases maintained by the FDLE or the FLHSMV in the report detailing the circumstances under which the person was taken into custody. Such information must be included in reports following instances where a law enforcement officer:

- Determines an individual meets the criteria for involuntary examination and delivers the individual to a receiving facility;
- Delivers an individual to a receiving facility pursuant to a certificate executed by a health care professional under s. 394.463(2)(a)3., F.S.; or
- Determines that a hospital or addictions receiving facility is the most appropriate place for a person who:
 - Is in protective custody; or
 - Refuses to consent to assistance.

¹⁰⁷ Florida Highway Patrol Policy Manual, *Criminal Justice Information Services: Policy 14.02.04C*. (Rev. Mar. 2015), available at <https://www.flhsmv.gov/fhp/Manuals/1402.pdf> (last visited Nov. 21, 2017).

¹⁰⁸ *Id.* at Policy 14.02.07C. and D.

¹⁰⁹ News 6 Orlando, *Do Florida Drivers Need to Set Up Emergency Contact Information?*, available at <https://www.clickorlando.com/news/local/2022/01/17/do-florida-drivers-need-to-set-up-emergency-contact-information/> (last visited January 19, 2022).

Such information may not be used for any purpose other than informing emergency contacts of a patient's whereabouts, and shall otherwise remain confidential and exempt from Florida's public records disclosure requirements.

Marchman Act

When a law enforcement officer delivers a person to a hospital or addictions receiving facility under the Marchman Act, the bill requires the officer to attempt to notify the nearest relative or emergency contact of the person and document such notification, and attempts at notification, in the report.

Voluntary Admissions

The bill requires receiving facilities and substance abuse service providers serving Baker Act and Marchman Act patients, respectively, to document that individuals admitted on a voluntary basis have been provided with the option to authorize the release of clinical information, within 24 hours of admission, to the individual's:

- Health care surrogate or proxy;
- Attorney;
- Representative; or
- Other known emergency contact.

The release authorization will help to ensure patients admitted on a voluntary basis will have the option of sharing important information regarding health care decisions with the individuals specified above.

Individual Bill of Rights (Sections 2 and 5)

Both the Marchman Act and the Baker Act provide an individual bill of rights.¹¹⁰ Rights in common include the right to:

- Dignity;
- Quality of treatment;
- Not be refused treatment at a state-funded facility due to an inability to pay;
- Communicate with others;
- Care and custody of personal effects; and
- Petition the court on a writ of habeas corpus.¹¹¹

The individual bill of rights also imposes liability for damages on persons who violate individual rights.¹¹² The Marchman Act ensures the right to habeas corpus, which means that a petition for release may be filed with the court by an individual involuntarily retained or his or her parent or representative.¹¹³ In addition to the petitioners authorized in the Marchman Act, the Baker Act permits the DCF to file a writ for habeas corpus on behalf of the individual.¹¹⁴

¹¹⁰ Section 394.459, F.S., provides "Rights of Individuals" for individuals served through the Baker Act; section 397.501, F.S., provides "Rights of Individuals" for individuals served through the Marchman Act.

¹¹¹ *Id.*

¹¹² Sections 394.459(10) and 397.501(10)(a), F.S.

¹¹³ Section 397.501(9), F.S.

¹¹⁴ Section 394.459(8)(a), F.S.

The Marchman Act also makes it a first degree misdemeanor¹¹⁵ for a person to:

- Knowingly furnishing false information for the purpose of obtaining emergency or other involuntary admission for any person;
- Causing or otherwise securing, or conspiring with or assisting another to cause or secure, without reason for believing a person to be impaired, any emergency or other involuntary procedure for the person; or
- Causing, or conspiring with or assisting another to cause, the denial to any person of any right accorded under the Marchman Act.¹¹⁶

The Baker Act currently does not contain similar criminal penalties for activities that infringe upon patients' rights.

Right to Outside Communication and Visitation

All patients held at a receiving facility have the explicit right to communicate freely and privately with others outside the facility unless it is determined that communication will likely harm the patient or others.¹¹⁷ Similar conditions apply to the right of patients to send, receive, and mail correspondence, and to access outside visitors.¹¹⁸ Facilities must review restrictions on a patient's right to communicate, send or receive sealed, unopened correspondence, or receive visitors at least once every 7 days.¹¹⁹

Effect of the Bill

Patient Access and Communication

The bill prohibits receiving facilities from restricting any of the following patients' rights unless a qualified professional determines that failing to do so would be detrimental to the clinical well-being of any patient or the general well-being of staff, including:

- The right to communicate freely and privately with persons outside of the receiving facility;
- The right to receive, send, and mail sealed, unopened correspondence; and
- The right to access to any patient, subject to the patient's right to deny or withdraw consent at any time, by the patient's family, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney.

A "qualified professional" is defined in s. 394.455(39), F.S., to mean:

- A physician licensed under ch. 458, F.S.;
- A physician assistant licensed under ch. 459, F.S.;
- A psychiatrist licensed under ch. 458, F.S., or ch. 459, F.S.;
- A psychologist as defined in s. 490.003(7), F.S.; or
- A psychiatric nurse as defined in s. 394.455(36), F.S.

¹¹⁵ A first degree misdemeanor is punishable by a term of imprisonment not exceeding one year and a fine of \$1,000. Sections 775.082 and 775.083, F.S. However, s. 397.581, F.S., specifically provides that this offense is punishable by a fine of up to \$5,000.

¹¹⁶ Section 397.581, F.S.

¹¹⁷ Section 394.459(5)(a), F.S.

¹¹⁸ Section 394.459(5)(b)-(c), F.S.

¹¹⁹ Section 394.459(5)(c), F.S.

The bill also reduces the number of days within which a receiving facility must review restrictions on a patient's right to communicate or receive visitors from 7 days to 3 days. A qualified professional must document such restrictions within 24 hours of the restriction being implemented.

Criminal Penalty

The bill also makes it a first degree misdemeanor to knowingly and willfully:

- Furnish false information for the purpose of obtaining emergency or other involuntary admission for any person;
- Cause, or conspire with another to cause, any involuntary mental health procedure for the person without a reason for believing a person is impaired; or
- Cause, or conspire with another to cause, without lawful justification, any person to be denied their rights under the mental health statutes.

The bill also provides that a person who is convicted of this offense may be punished by a fine not exceeding \$5,000.

Mental Health Data Reporting and Analysis (Section 5)

The DCF collects and maintains copies of ex parte orders, involuntary outpatient services orders, involuntary inpatient placement orders, and professional certificates initiating Baker Act examinations.¹²⁰ Such documents are considered part of a patient's clinical record and are used to prepare annual reports analyzing the de-identified data contained therein.¹²¹ The DCF contracts with the Louis de la Parte Florida Mental Health Institute at the University of South Florida (the Institute) to perform the data analysis and prepare the reports.¹²² The Institute also analyzes other information relating to mental health and acts as a provider of crisis services to certain patients.¹²³ The reports are provided to the DCF, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives.¹²⁴

Transportation to a Facility

Baker Act

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

¹²⁰ Section 394.463(2)(e), F.S.

¹²¹ *Id.*

¹²² The University of South Florida, Baker Act Reporting Center, *About Us*, available at <https://www.usf.edu/cbcs/baker-act/about/index.aspx> (last visited January 19, 2022).

¹²³ See The University of South Florida, Baker Act Reporting Center, *What We Do*, available at <https://www.usf.edu/cbcs/baker-act/about/whatwedo.aspx> (last visited Jan. 7, 2022); and The University of South Florida, Louis de la Parte Florida Mental Health Institute, *About the Institute*, available at <https://www.usf.edu/cbcs/fmhi/about/> (last visited January 19, 2022).

¹²⁴ *Id.*

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.¹²⁵ Law enforcement must then relinquish the person, along with corresponding documentation, to a responsible individual at the facility.¹²⁶

Marchman Act

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.¹²⁷

If a person in circumstances which justify protective custody¹²⁸ fails or refuses to consent to assistance and a law enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving facility is the most appropriate place for the person, the officer may, after giving due consideration to the expressed wishes of the person:

- Take the person to a hospital or to a licensed detoxification or addictions receiving facility against the person's will but without using unreasonable force; or
- In the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility.¹²⁹

The officer must use a standard form developed by the DCF to execute a written report detailing the circumstances under which the person was taken into custody, and the written report shall be included in the patient's clinical record.

Effect of the Bill

The bill adds reports completed by law enforcement when a person is transported to a receiving facility to the documents received and maintained by the DCF for use in preparing annual reports on Baker Act data. The bill also makes such reports a part of a patient's clinical record. The transportation reports will allow the Baker Act Reporting Center to provide a more comprehensive overview of Baker Act data statewide.

Commission on Mental Health and Substance Abuse

In 2021, the Legislature created the Commission on Mental Health and Substance Abuse (Commission), adjunct to the DCF, in response to recommendations of the 20th Statewide Grand Jury.¹³⁰ The DCF is required to provide administrative staff and support services for the Commission.¹³¹

The purposes of the Commission include:

¹²⁵ Section 394.462(1)(f)-(g), F.S.

¹²⁶ Section 394.462(3), F.S.

¹²⁷ Section 397.6795, F.S.

¹²⁸ Section 397.677, F.S., states that a law enforcement officer may implement protective custody measures when a minor or an adult who appears to meet the involuntary admission criteria in s. 397.675, F.S., is brought to the attention of law enforcement or in a public space.

¹²⁹ Section 397.6772(1)(a)-(b), F.S.

¹³⁰ Chapter 2021-170, L.O.F.

¹³¹ Section 394.9086(1), F.S.

- Examining the current methods of providing mental health and substance abuse services in the state;
- Improving the effectiveness of current practices, procedures, programs, and initiatives in providing such services;
- Identifying any barriers or deficiencies in the delivery of such services; and
- Recommending changes to existing laws, rules, and policies necessary to implement the Commission's recommendations.¹³²

The Commission is comprised of 19 members, including the Secretaries of AHCA and DCF.¹³³ Membership of the Commission also includes:

- Seven members appointed by the Governor, including:
 - A psychologist licensed under ch. 490, F.S., practicing within the mental health delivery system;
 - A mental health professional licensed under ch. 491, F.S.;
 - A representative of mental health courts;
 - An emergency room physician;
 - A representative from the field of law enforcement;
 - A representative from the criminal justice system; and
 - A representative of a child welfare agency involved in the delivery of behavioral health services.
- Five members appointed by the President of the Senate, including:
 - A member of the Senate;
 - A person living with a mental health disorder;
 - A family member of a consumer of publicly funded mental health services;
 - A representative of the Louis de la Parte Mental Health Institute within the University of South Florida; and
 - A representative of a county school district.
- Five members appointed by the Speaker of the House of Representatives, including:
 - A member of the House of Representatives;
 - A representative of a treatment facility;
 - A representative of a managing entity;
 - A representative of a community substance abuse provider; and
 - A psychiatrist licensed under chs. 458 or 459, F.S., practicing within the mental health delivery system.¹³⁴

The Governor appoints the Commission chair from among its members, and members serve at the pleasure of the officer who appointed the member.¹³⁵ The Commission is required to hold its meetings via teleconference or other electronic means.¹³⁶ A vacancy on the Commission is required to be filled in the same manner as the original appointment.¹³⁷

¹³² Section 394.9086(2), F.S.

¹³³ Section 394.9086(3)(a), F.S.

¹³⁴ *Id.*

¹³⁵ Section 394.9086(3)(b), F.S.

¹³⁶ Section 394.9086(3)(c), F.S.

¹³⁷ Section 394.9086(3)(b), F.S.

The duties of the Commission include:

- Conducting a review and evaluation of the management and functioning of existing publicly supported mental health and substance abuse systems in the DCF, AHCA, and all other relevant state departments;
 - At a minimum, such review must include a review of current goals and objectives, current planning, service strategies, coordination management, purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms.
- Considering the unique needs of people who are dually diagnosed;
- Addressing access to, financing of, and scope of responsibility in the delivery of emergency behavioral health care services;
- Addressing the quality and effectiveness of current service delivery systems and professional staffing and clinical structure of services, roles, and responsibilities of public and private providers;
- Addressing priority population groups for publicly funded services, identifying the comprehensive delivery systems, needs assessment and planning activities, and local government responsibilities for funding services;
- Reviewing the implementation of ch. 2020-107, Laws of Fla.;¹³⁸
- Identifying gaps in the provision of mental health and substance abuse services;
- Providing recommendations on how managing entities may promote service continuity;
- Making recommendations about the mission and objectives of state-supported mental health and substance abuse services and the planning, management, staffing, financing, contracting, coordination, and accountability of mechanisms best suited for the recommended mission and objectives; and
- Evaluating and making recommendations regarding the establishment of a permanent, agency-level entity to manage mental health, behavioral health, substance abuse, and related services statewide, including the:
 - Duties and organizational structure;
 - Resource needs and possible sources of funding;
 - Impact on access to and the quality of services;
 - Impact on individuals with behavioral health needs, and their families, who are currently receiving services and those who are in need of services; and
 - Relation to and integration with service providers, managing entities, communities, state agencies, and provider systems.¹³⁹

The Commission is required to submit an initial report by September 1, 2022, and a final report by September 1, 2023, to the Governor, President of the Senate, and Speaker of the House of Representatives on its findings and recommendations on how to best provide and facilitate mental health and substance abuse services.¹⁴⁰

¹³⁸ HB 945 (2020) required managing entities to implement the features of a coordinated system of mental health care for children and expands the use of mobile response teams (MRT) across the state. It required the Florida Mental Health Institute within the University of South Florida to develop a model protocol for school use of MRTs. The bill also required the AHCA and the DCF to identify children and adolescents who are the highest users of crisis stabilization services and take action to meet the needs of such children. Lastly, the bill required the AHCA to continually test the Medicaid managed care provider network databases to ensure behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

¹³⁹ Section 394.9086(4)(a), F.S.

¹⁴⁰ Section 394.9086(5), F.S.

Effect of the Bill

The bill amends s. 394.9086, F.S., making the following changes to the Commission, including:

- Authorizing the Commission to conduct meetings in person at locations throughout the state or via teleconference or other electronic means;
- Authorizing Commission members to receive per diem and reimbursement and travel expenses;
- Authorizing the Commission to access information and records necessary to carry out its duties, including exempt and confidential information, provided that the Commission does not disclose such exempt or confidential information; and
- Changes the due date for the Commission's interim report from September 1, 2022 to January 1, 2023.

Cross-References

The bill amends ss. 409.972 and 744.2007, F.S., relating to mandatory and voluntary managed care enrollment, and the powers and duties of public guardians, respectively, to conform cross-references to changes made by the act.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

The bill does not appear to require cities and counties to expend funds or limit their authority to raise revenue or receive state-shared revenues as specified by Article VII, Section 18 of the Florida Constitution.

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:

The Department of Children and Families (DCF) contracts with the Baker Act Reporting Center at the University of South Florida (USF) to collect and analyze Baker Act data. The USF Baker Act Reporting Center is responsible for producing an Annual Baker Act report on behalf of the DCF for submission to the Legislature. The DCF will need to amend its contract with the Reporting Center to require collection and analysis of transportation forms. The cost for DCF to contract with the Reporting Center is anticipated to be \$90,000 for the first year, and \$75,000 for each subsequent year.¹⁴¹

CS/CS/SB 1262 also requires the Commission on Mental Health and Substance Abuse (Commission) to conduct their meetings in person at locations throughout the state. The bill entitles commission members to receive reimbursement for per diem and travel expenses. The 18 commission members may hold meetings in-person at locations throughout the state or may use teleconference or other electronic means as an alternative to in-person meetings. The cost to the DCF for the commission's travel and per diem is indeterminate, however, it is likely that these costs can be absorbed within the department's base budget.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 119.0712, 394.455, 394.459, 394.4599, 394.4615, 394.463, 394.468, 394.9086, 397.601, 397.6772, 409.972, and 744.2007.

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

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

CS/CS by Appropriations on February 24, 2022:

The committee substitute:

- Clarifies that a person who without lawful justification, knowingly or willfully causes, conspires with or assists another to cause the denial to any person any right

¹⁴¹ The DCF, *Agency Analysis for SB 1262*, p. 5, February 11, 2022 (on file with the Senate Committee on Children, Families, and Elder Affairs).

accorded to that person pursuant to ch. 394, F.S., commits a first degree misdemeanor.

- Clarifies that the Commission on Mental Health and Substance Abuse may hold meetings in person at locations throughout the state or via teleconference or other electronic means.
- Authorizes the Commission on Mental Health and Substance Abuse to access any information or records, including exempt and confidential records and information that may be necessary for the commission to have to carry out its duties. The commission may not disclose such exempt or confidential information.
- Expands the entities who may obtain emergency contact information under ch. 119 to include hospitals and receiving facilities, clarifying these entities can receive the information to inform a patient's emergency contact of their arrival at the facility.
- Allows psychiatric APRNs practicing in a receiving facility to perform discharge exams of Baker Act patients if operating under the protocol of a psychiatrist.

CS by Children, Families, and Elder Affairs on January 25, 2022:

The committee substitute:

- Revises the conditions for restricting a patient's access to telephonic communications, mail correspondence, and in-person visitation to instances where the restriction is necessary to ensure the clinical well-being of the patient, clinical well-being of another patient, or general well-being of staff.
- Requires that any restrictions on in-person visitation be reviewed every 3 days, rather than every 4 days as currently provided for in the bill, and requires a qualified professional to document any such restrictions within 24 hours of implementation.
- Provides that, under both the Baker and Marchman Acts, emergency contact information obtained through electronic databases used by law enforcement cannot be used for purposes other than letting the contact know the whereabouts of the patient.
- Clarifies that a receiving facility can hold a patient until the next working day after the weekend or holiday if the intent is to file a petition for involuntary services, but requires that the facility release the patient if such petition is not filed by the next working day.
- Provides that a person commits a first degree, rather than second degree misdemeanor if he or she knowingly and willfully, rather than only knowingly commits any of the acts listed in section 5 of the bill.
- Makes the following changes to provisions related to discharge planning and procedures:
 - Moves the discharge planning requirements from s. 394.463, F.S. to s. 394.468, F.S.;
 - Applies the requirements to all patients being discharged from a receiving or treatment facility under ch. 394, F.S.; and
 - Modifies the requirements such that receiving facilities must document and consider, at a minimum, follow-up behavioral health appointments and information on how to obtain prescribed medications and pertaining to available living arrangements, transportation, and recovery support opportunities.
- Makes the following changes to the Commission on Mental Health and Substance Abuse:

- Requires the Commission on Mental Health and Substance Abuse to conduct their meetings in person at locations throughout the state. Currently, the Commission is holding meetings remotely.
- Requires Commission members to be reimbursed for travel expenses.
- Moves the due date of the Commission's interim report from September 1, 2022 to January 1, 2023.
- Provides an effective date of July 1, 2022.

B. Amendments:

None.