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:	SB 1784
INTRODUCER:	Senator Grall
SUBJECT:	Mental Health and Substance Abuse
DATE:	January 29, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hall	Tuszynski	CF	**Pre-meeting**
2.			FP	

I. Summary:

In Florida, the Baker Act provides a legal procedure for voluntary and involuntary mental health examination and treatment. The Marchman Act addresses substance abuse through a comprehensive system of prevention, detoxification, and treatment services. The Department of Children and Families (DCF) is the single state authority for substance abuse and mental health treatment services in Florida. The bill modifies the Baker Act and makes significant changes to the Marchman Act.

The bill amends the Baker Act by combining processes for courts to order individuals to involuntary outpatient services and involuntary inpatient placement in the Baker Act, to streamline the process for obtaining involuntary services, and providing more flexibility for courts to meet individuals' treatment needs. The bill also grants law enforcement officers discretion on initiating involuntary examinations.

The bill substantially amends the Marchman Act to:

- Repeal existing provisions for court-ordered involuntary assessments and stabilization in the Marchman Act, and creates a new consolidated involuntary treatment process.
- Prohibit courts from ordering an individual with a developmental disability who lacks a co-occurring mental illness to a state mental health treatment facility for involuntary inpatient placement.
- Revise the voluntariness provision under the Baker Act to allow a minor's voluntary admission after a clinical review, rather than a hearing, has been conducted.
- Authorize a witness to appear remotely upon a showing of good cause and with consent by all parties.
- Allow an individual to be admitted as a civil patient in a state mental health treatment facility without a transfer evaluation and prohibits a court, in a hearing for placement in a treatment facility, from considering substantive information in the transfer evaluation unless the evaluator testifies at the hearing.

For both the Baker and Marchman Acts, the bill:

- Creates a more comprehensive and personalized discharge planning process.
- Requires DCF to publish certain specified reports on its website.
- Removes limitations on advance practice registered nurses and physician assistants serving the physical health needs of individuals receiving psychiatric care.
- Allows a psychiatric nurse to release a patient from a receiving facility if certain criteria are met.
- Removes the 30-bed cap for crisis stabilization units.

The bill will have an indeterminate negative fiscal impact on state government.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Mental Health and Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities can cope with normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

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

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being. Mental illness affects millions of people in the United States each year. More than one in five adults lives with a mental illness.[4] Young adults aged 18-25 had the highest prevalence of any mental illness[5] (33.7%) compared to adults aged 26-49 (28.1%) and aged 50 and older (15.0%).[6]

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[1] World Health Organization, Mental Health: Strengthening Our Response, available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited Jan. 26, 2024).
[2] Centers for Disease Control and Prevention, Mental Health Basics, available at: http://medbox.iiab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm (last visited Jan. 26, 2024).
[3] *Id.*
[4] National Institute of Mental Health (NIH), Mental Illness, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited Jan. 26, 2024).
[5] Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness).
[6] National Institute of Mental Health (NIH), Mental Illness, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited Jan. 26, 2024).

Mental Health Safety Net Services

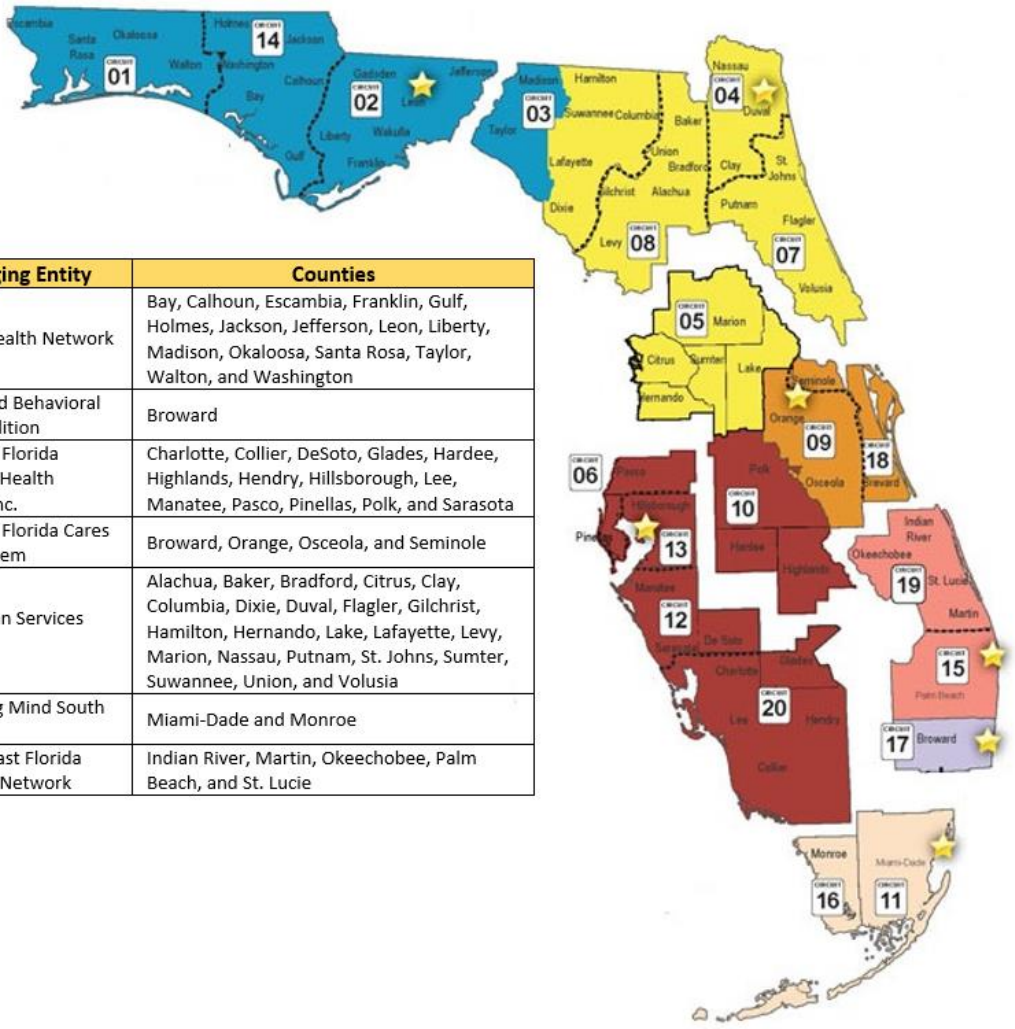
The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAM programs include a range of prevention, acute interventions (e.g., crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

Behavioral Health Managing Entities

In 2001, the Legislature authorized DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.[7] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[8] MEs were fully implemented statewide in 2013, serving all geographic regions.

DCF currently contracts with seven MEs for behavioral health services throughout the state. These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the state. The regions are divided as follows:[9]

[7] Ch. 2001-191, Laws of Fla.
[8] Ch. 2008-243, Laws of Fla.
[9] DCF, Managing Entities, available at: https://www.myflfamilies.com/services/samh/providers/managing-entities (last visited Jan. 26, 2024).



Managing Entity	Counties
NWF Health Network	Bay, Calhoun, Escambia, Franklin, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Walton, and Washington
Broward Behavioral Health Coalition	Broward
Central Florida Behavioral Health Network, Inc.	Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota
Central Florida Cares Health System	Broward, Orange, Osceola, and Seminole
Lutheran Services Florida	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia
Thriving Mind South Florida	Miami-Dade and Monroe
Southeast Florida Behavioral Network	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie

Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.[10] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[11] A community or region provides a coordinated system of care for those with a mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvements grants to managing entities.[12] MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.[13] DCF must use performance-based contracts to award grants.[14]

[10] Section 394.9082(5)(d), F.S.
[11] Section 394.4573(1)(c), F.S.
[12] Section 394.4573(3), F.S. The Legislature has not funded system improvement grants.
[13] *Id.*
[14] *Id.*

There are several essential elements which make up a coordinated system of care, including:[15]

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.

A coordinated system of care must include, but is not limited to, the following array of services:[16]

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

DCF must define the priority populations which would benefit from receiving care coordination.[17] In defining priority populations, DCF must consider the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-

[15] Section 394.4573(2), F.S.
[16] Section 394.495(4), F.S.
[17] Section 394.9082(3)(c), F.S.

region.[18] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[19]

The Baker Act

The Florida Mental Health Act, commonly referred to as the Baker At, was enacted in 1971 to revise the state's mental health commitment laws.[20] The Act includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It, additionally, protects the rights of all individuals examined or treated for mental illness in Florida.[21]

The Department of Children and Families (DCF) is responsible for the operation and administration of the Baker Act, including publishing an annual Baker Act report. According to the Fiscal Year (FY) 2021-2022 Baker Act Annual Report, over 170,000 individuals were involuntarily examined under the Baker Act; of those, just over 11,600 individuals were 65 years of age or older. This age group is the most likely to include individuals with Alzheimer's disease or related dementia. It is important to note the number of Baker Acts per year decreased during FY 2018-2019, FY 2019-2020, FY 2020-2021, across all age groups.[22]

Rights of Patients

The Baker Act protects the rights of patients examined or treated for mental illness in Florida, including, but not limited to, the right to give express and informed consent for admission or treatment and the right to communicate freely and privately with persons outside a facility, unless the facility determines that such communication is likely to be harmful to the patient or others.[23]

Each patient entering treatment must be asked to give express and informed consent for admission or treatment.[24] If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent must be obtained from the patient's guardian or guardian advocate. If the patient is a minor, consent must be requested from the patient's guardian unless the minor is seeking outpatient crisis intervention services.[25] In situations where emergency medical treatment is needed and the patient or the patient's guardian or guardian advocate are unable to provide consent, the administrator of the facility may, upon the recommendation of the patient's attending physician, authorize treatment, including a

[18] Section 394.9082(5)(b), F.S.
[19] Section 394.75(3), F.S.
[20] The Baker Act is contained in Part I of Ch. 394, F.S.
[21] Section 394.459, F.S.
[22] DCF, *Agency Bill Analysis* (2023), on file with the Senate Children, Families, and Elder Affairs Committee.
[23] Sections 394.459(3), F.S. and 394.459(5), F.S. Other patients' rights include the right to dignity; treatment regardless of ability to pay; express and informed consent for admission or treatment; quality treatment; possession of his or her clothing and personal effects; vote in elections, if possible; petition the court for a writ of habeas corpus to question the cause and legality of their detention in a receiving or treatment facility; and participate in their treatment and discharge planning. See, s. 394.456(1)-(11), F.S. Current law imposes liability for damages on those who violate or abuse patient rights or privileges. *See* s. 394.459(10), F.S.
[24] Section 394.459(3), F.S.
[25] Section 394.4784, F.S.

surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient.[26]

Currently, a facility must provide immediate patient access to a patient's family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney, unless such access would be detrimental to the patient or the patient exercises their right not to communicate or visit with the person.[27] If a facility restricts a patient's right to communicate or restrict visitors, the facility must provide written notice of the restriction and the reasons for it to the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative.[28] A qualified professional[29] must document the restriction within 24 hours, and a record of the restrictions and the reasons for the restrictions must be recorded in the patient's clinical record. Under current law, a facility must review patient communication restrictions at least every three days.[30]

Receiving Facilities and Involuntary Examination

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[31] Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by DCF as a receiving facility.

Receiving facilities, often referred to as Baker Act receiving facilities, are public or private facilities designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[32] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.[33] Funds appropriated for Baker Act services may only be used to pay for services diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[34] Currently, there are 126 DCF designated receiving facilities.[35]

Crisis Stabilization Units

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. CSUs provide services 24 hours a day, seven days a week,

[26] Section 394.459(3)(d), F.S.
[27] Section 394.459(5)(c), F.S.
[28] Section 394.495(5)(d), F.S.
[29] A qualified professional is a physician or a physician assistant, a psychiatrist, a psychologist, or a psychiatric nurse. See s. 394.455(39), F.S.
[30] Section 394.459, F.S.
[31] Sections 394.4625 and 394.463, F.S.
[32] Section 394.455(40), F.S. This term does not include a county jail.
[33] Section 394.455(38), F.S.
[34] R. 65E-5.400(2), F.A.C.
[35] DCF, *Agency Bill Analysis* (2023), on file with the Senate Children Families, and Elder Affairs Committee.

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.[36] 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.

Although involuntary examinations under the Baker Act have recently been decreasing statewide, the population of Florida continues to grow, and there are counties where the number of involuntary examinations remain the same or are slightly increasing, while some receiving facilities within communities are closing. There has been some demonstrated success with mobile response teams diverting individuals from the receiving facilities, resulting in those persons who are admitted to a receiving facility for an involuntary examination having higher acuity and longer lengths of stay.

In 2011, statute directed DCF to implement a demonstration project in circuit 18 to assess the impact of expanding the number of authorized CSU beds from 30 to 50. The facility in circuit 18 reported that by adding 20 additional beds, they were able to alleviate capacity issues within the county through 2021. The facility also reported that there are days that they exceed 100% capacity. Additionally, the facility reported that the bed capacity expansion has allowed them to serve clients with complex needs (e.g., clients served by APD).[37]

Involuntary Examination

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, has refused voluntary examination, is likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to that person's well-being, and such harm is unavoidable through the help of willing family members or friends, or will cause serious bodily harm to him or herself or others in the near future based on recent behavior.[38]

An 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;[39] or
- A physician, clinical psychologist, psychiatric nurse, an autonomous advanced practice registered 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.[40]

Unlike the discretion afforded courts and medical professionals, current law mandates that law enforcement officers must initiate an involuntary examination of a person who appears to meet

[36] Section 394.875, F.S.
[37] DCF, Agency Bill Analysis (2023), on file with the Senate Children, Families, and Elder Affairs Committee.
[38] Section 394.463(1), F.S.
[39] Section 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[40] Section 394.463(2)(a)3., F.S. The report and certificate must be made a part of the patient's clinical record.

the criteria by taking him or her into custody and delivering or having the person delivered to a receiving facility for examination.[41] When transporting, officers are currently required to restrain the person in the least restrictive manner available and appropriate under the circumstances.[42] The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made part of the patient's clinical record. The report must also include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles.

Involuntary patients must be taken to either a public or private facility that has been designated by DCF as a Baker Act receiving facility. Under the Baker Act, a receiving facility has up to 72 hours to examine an involuntary patient.[43] During those 72 hours, an involuntary patient must be examined by a physician, clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met.[44] Current law does not indicate when the examination period begins for an involuntary patient. However, if the patient is a minor, a receiving facility must initiate the examination within 12 hours of arrival.[45]

Within that 72-hour examination period, one of the following must happen:[46]

- The patient must be released, unless he or she is charged with a crime, in which case, law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to be placed and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

If the patient's 72-hour examination period ends on a weekend or holiday, and the receiving facility:[47]

- Intends to file a petition for involuntary services, the patient may be held at a receiving facility through the next working day and the petition for involuntary services must be filed no later than such 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 upon documented approval from a psychiatrist or clinical psychologist.
- Does not intend to file a petition for involuntary services, the receiving facility may postpone release of a patient until the next working day if a qualified professional documents that adequate discharge planning and procedures and approval from a psychiatrist or clinical psychologist are not possible until the next working day.

[41] Section 394.463(2)(a)2., F.S.
[42] *Id.*
[43] Section 394.463(2)(g), F.S.
[44] Section 394.463(2)(f), F.S.
[45] Section 394.463(2)(g), F.S.
[46] *Id.*
[47] Section 394.463(2)(g)4., F.S.

The receiving facility may not release an involuntary examination patient without the documented approval of a psychiatrist or a clinical psychologist. However, if the receiving facility is owned or operated by a hospital or health system, or a nationally accredited community mental health center, a psychiatric nurse performing under the framework of an established protocol with a psychiatrist is permitted to release a Baker Act patient in specified community settings. However, a psychiatric nurse is prohibited from approving a patient's release if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.[48]

Baker Act Reporting Requirements

Section 394.461(4), F.S., directs facilities designated as public receiving or treatment facilities to report certain data to DCF on an annual basis. DCF must issue an annual report based on the data received, including individual facility data and statewide totals. The report is submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 394.463(2)(e), F.S., requires DCF to prepare and provide annual reports to the agency itself, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the senate and the House of Representatives. The annual reports analyze data obtained from ex parte orders, involuntary orders issued under the Baker Act, professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients.[49] Current law does not provide a due date for the report.

Section 394.463(4), F.S., also requires DCF to submit reports detailing findings on repeated involuntary Baker Act examinations of minors using data submitted by receiving facilities. DCF must analyze the data on:

- Both the initiation of involuntary examinations of children and the initiation of involuntary examination of students who are removed from a school;
- Identify any patters or trends and cases in which involuntary examinations are repeatedly initiated on the same child or student;
- Study root causes for such patterns, trends, or repeated involuntary examinations; and
- Make recommendations to encourage the use of alternatives to eliminate inappropriate initiations of such examinations.

The report must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1 of each odd-numbered year.

Involuntary Services

Involuntary services are defined as court-ordered outpatient services or inpatient placement for mental health treatment.[50]

[48] Section 394.463(2)(f). F.S.
[49] Section 394.463(2)(e), F.S.
[50] Section 394.455(23), F.S.

Involuntary Outpatient Services

A person may be ordered to involuntary outpatient services upon a finding of the court that by clear and convincing evidence, all of the following factors are met:[51]

- The person is 18 years of age or older;
- The person has a mental illness;
- The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
- The person has a history of lack of compliance with treatment for mental illness;
- The person has, within the immediately preceding 36 months:
  - Been involuntarily admitted to a receiving or treatment facility, or has received mental health services in a forensic or correctional facility, at least twice; or
  - Engaged in one or more acts of serious violent behavior towards self or others, or attempts at serious bodily harm to himself or herself or others;
- The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment or her or she is unable to determine for himself or herself whether placement is necessary;
- The person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being;[52]
- It is likely that the person will benefit from involuntary outpatient services; and
- All available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.

A petition for involuntary outpatient services may be filed by the administrator of either a receiving facility or a treatment facility.[53] The petition must allege and sustain each of the criterion for involuntary outpatient services and be accompanied by a certificate recommending involuntary outpatient services by a qualified professional and a proposed treatment plan.[54]

The petition for involuntary outpatient services must be filed in the county where the patient is located. However, if the patient is being placed from a state treatment facility, the petition must be filed in the county where the patient will reside.[55] The petition must be based on the opinions of two professionals who have personally examined the individual within the preceding 72 hours.[56] When the petition has been filed, the clerk of the court must provide copies of the petition and the proposed treatment plan to DCF, the managing entity, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel.[57]

[51] Section 394.4655(2), F.S.
[52] This factor is evaluated based on the person's treatment history and current behavior.
[53] Section 394.4655(4)(a), F.S.
[54] Section 394.4655(4)(b), F.S.
[55] Section 394.4655(4)(c), F.S.
[56] Section 394.4655(3)(a)1., F.S.
[57] *Id.*

Once a petition for involuntary outpatient services has been filed with the court, the court must hold a hearing within five business days, unless a continuance is granted.[58] Under current law, the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[59] The court may waive a patient's presence from all or any portion of the hearing if it finds the patient's presence is not in the patient's best interests and the patient's counsel does not object.[60] Otherwise, the patient must be present. The state attorney for the circuit in which the patient is located represents the state, rather than the petitioner, as the real party in interest in the proceeding.[61] The court must appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel.[62]

At the hearing on involuntary outpatient services, the court must consider testimony and evidence regarding the patient's competence to consent to treatment; if the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate.[63] If the court concludes that the patient meets the criteria for involuntary outpatient services, it must issue an order for those services.[64] The order must specify the duration of involuntary outpatient services, which may be up to 90 days, and the nature and extent of the patient's mental illness.[65] The order of the court and the treatment plan are to be made part of the patient's clinical record.[66]

If, at any time before the conclusion of the initial hearing on involuntary outpatient services, it appears to the court that the person does not meet the criteria for involuntary outpatient services, but instead meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary inpatient examination.[67]

<u>Involuntary Inpatient Placement</u>

A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:[68]

- 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 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

[58] Section 394.4655(7)(a)1., F.S.
[59] *Id.*
[60] *Id.*
[61] *Id.*
[62] Section 394.4655(5), F.S. This must be done within one court working day of filing the petition.
[63] Section 394.4655(7)(d), F.S.
[64] Section 394.4655(7)(b)1., F.S.
[65] *Id.*
[66] *Id.*
[67] Section 394.4655(7)(c), F.S. Additionally, if the person, instead, meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to the Marchman Act, the court may order the person to be admitted for involuntary assessment pursuant to the statutory requirements of the Marchman Act.
[68] Section 394.467(1), F.S.

- 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 which would offer an opportunity for improvement of his or her condition have been judged to be appropriate.

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.[69] The petition must be based on the opinions of two professionals who have personally examined the individual within the past 72 hours.[70] Upon filing, the clerk of the court must provide copies to 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.[71] Unlike the procedures for involuntary outpatient services, current law does not require a proposed treatment plan to be filed with the petition for involuntary inpatient placement.

Involuntary Inpatient Placement Hearing

The court proceedings for involuntary inpatient placement closely mirror those for involuntary outpatient services.[72] However, the laws governing involuntary inpatient placement are silent regarding the court's order becoming part of the patient's clinical record. Once a petition for involuntary inpatient placement has been field, the court must hold a hearing within five business days in the county or facility where the patient is located, unless a continuance is granted.[73] Presently, only the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[74] Similar to the procedures for involuntary outpatient services, the court may waive a patient's presence from all or any portion of the hearing if it finds the patient's presence is not in their best interests, and the patient's counsel does not object.[75] Otherwise, the patient must be present.

Current law permits the court to appoint a magistrate to preside at the hearing, in general.[76] At the hearing, the state attorney must represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding.[77] Although the state attorney has the evidentiary burden in Baker Act cases, current law does not require a facility to make the patient's clinical records available to the state attorney so that the state can evaluate and prepare its case before the hearing. Additionally, there is no requirement that the court allow testimony from family members regarding the patient's prior history and how it relates to their current condition.

[69] Section 394.467(2) and (3), F.S.
[70] Section 394.467(2), F.S.
[71] Section 394.467(3), F.S.
[72] *See* section 394.467(6) and (7), F.S.
[73] Section 394.467(6), F.S.
[74] Section 394.467(5), F.S.
[75] Section 394.467(6), F.S.
[76] *Id.*
[77] *Id.*

If, at any time before the conclusion of the hearing, it appears to the court that the person does not meet the criteria for involuntary inpatient placement, but rather meets the criteria for involuntary outpatient services, the court may order the person evaluated for involuntary outpatient services.[78] If the court concludes that the patient meets the criteria for involuntary inpatient placement, it has discretion to issue an order for involuntary inpatient services at a receiving facility for up to 90 days or in a state treatment facility[79] for up to six months.[80]

Current law prohibits a state treatment facility from admitting a civil patient unless he or she has undergone a transfer evaluation, the process by which the patient is evaluated for appropriateness of placement in a treatment facility.[81] Current law also requires the court to receive and consider the transfer evaluation's documented information before the involuntary placement hearing is held, but it does not specify that the evaluator must testify at the hearing in order for the court to consider any substantive information within it.[82] Under Florida law, if a court were to consider substantive information in the transfer evaluation without the evaluator testifying at the hearing, it would be a violation of the hearsay rule contained in Florida's Evidence Code.[83]

Current law requires the court's order to specify the nature and extent of the patient's illness and prohibits the court from ordering individuals with traumatic brain injuries or dementia who lack a co-occurring mental illness to be involuntary committed to a state treatment facility.[84] However, there is currently no prohibition against involuntarily committing individuals with developmental disabilities who also lack a co-occurring mental illness to these facilities.

Remote Hearings

In response to the COVID-19 pandemic, on March 21, 2020, the Chief Justice of the Florida Supreme Court issued Supreme Court of Florida Administrative Order AOSC20-23, Amendment 2, authorizing courts to conduct hearings remotely. However, on January 8, 2022, Supreme Court of Florida Administrative Order AOSC21-17 was issued, requiring in-person hearings unless the facility where the individual is located is closed to hearing participants due to the facility's COVID-19 protocols or the individual waives the right to physical presence at the hearing.

[78] Section 394.467(6)(c), F.S.

[79] A treatment facility is any state-owned, state-operated, or state-supported hospital, center, or clinic designated by DCF to provide mentally ill patients treatment and hospitalization that extends beyond that provided for by a receiving facility. Treatment facilities also include federal government facilities and any private facility designated by DCF. Only VA patients may be treated in federal facilities S. 394.455(48), F.S. A receiving facility is any public or private facility or hospital designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider. County jails are not considered receiving facilities. S. 394.455(40), F.S.

[80] Section 394.467(6)(b), F.S.

[81] Section 394.461(2), F.S.

[82] *Id.*

[83] Section 90.802, F.S. The basic hearsay rule states that courts cannot rely on out-of-court, unsworn statements (written or spoken) as proof of the matter asserted in the statement.

[84] Section 394.467(6), F.S.

Discharge Planning

Under current law, before a patient is released from a receiving or treatment facility, certain discharge planning procedures must be followed. Each facility must have discharge planning and procedures that include and document consideration of, at a minimum:

- Follow-up behavioral health appointments,
- Information on how to obtain prescribed medications, and
- Information pertaining to available living arrangements, transportation, and recovery support services.[85]

Additionally, for minors, information related to the Suicide and Crisis Lifeline must be provided.

Background Screening of Mental Health Care Personnel

Chapter 435, F.S., establishes standard procedures and requirements for criminal history background screening of prospective employees. There are two levels of background screening: level 1 and level 2. Level 1 screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE) and a check of Dru Sjodin National Sex Offender Public Website[86], and may include criminal records checks through local law enforcement agencies.[87] A level 2 background screening includes, but is not limited to, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.[88]

Mental health personnel are required to complete a level 2 background screening. Mental health personnel include all program directors, professional clinicians, staff members, and volunteers working in public or private mental health programs and facilities who have direct contact with individuals held for examination or admitted for mental health treatment.[89]

Section 456.0135, F.S., requires physicians, physician assistants, nurses, and other specified medical professionals to undergo a level 2 background screening as part of the licensure process.[90] The appropriate regulatory board reviews the background screening results to determine if the applicant or licensee has any offenses that would disqualify them from state licensure. A health care practitioner must also complete an additional level 2 background check as a condition of employment in mental health programs and facilities.

[85] Section 394.468, F.S.
[86] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. The website is available at https://www.nsopw.gov/ (last visited Jan. 26, 2024).
[87] Section 435.04, F.S.
[88] Section 435.04, F.S.
[89] Section 394.4572(1)(a), F.S.
[90] Section 456.0135, F.S.

Substance Abuse

Approximately 48.7 million people in the U.S. aged 12 and older had a substance use disorder (SUD).[91] It is estimated that 1.1 million Floridians have a substance use disorder.[92] Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[93] Abuse can result when a person uses a substance[94] in a way that is not intended or recommended, or because they are using more than prescribed. Drug abuse can cause individuals to experience one or more symptoms of another mental illness or even trigger new symptoms.[95] Additionally, individuals with mental illness may abuse drugs as a form of self-medication. Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance use disorder.[96]

A substance use disorder is determined by specified criteria included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). According to the DSM-5, a SUD diagnosis is based on evidence of impaired control, social impairment, risky use, and pharmacological indicators (tolerance and withdrawal). Substance use disorders occur when the chronic use of alcohol or drugs cause significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[97] Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs.[98] Brain imaging studies of persons with addiction show physical changes in areas of the brain that are critical to judgment, decision-making, learning and memory, and behavior control.[99] The most common substance use disorders in the U.S. are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[100]

According to the National Institute on Mental Health, a SUD is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such

[91] SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*, available at https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf (last visited Jan. 26, 2024).
[92] Substance Abuse and Mental Health Administration, *Behavioral Health Barometer, Florida, Volume 6*, (2020), available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32826/Florida-BH-Barometer_Volume6.pdf (last visited Jan. 26, 2024).
[93] World Health Organization, *Substance Abuse*, available at: https://www.afro.who.int/health-topics/substance-abuse (last visited Jan. 26, 2024).
[94] Substances can include alcohol and other drugs (illegal or not), as well as substances that are not drugs at all, such as coffee and cigarettes.
[95] Robinson, L, Smith, M, and Segal, J, (October 2023). *Dual Diagnosis: Substance Abuse and Mental Health*, HealthGuide.org, available at https://www.helpguide.org/articles/addictions/substance-abuse-and-mental-health.htm#:~:text=Substance%20abuse%20may%20sharply%20increase,symptoms%20and%20delaying%20your%20recovery (last visited Jan. 26, 2024).
[96] National Institute on Drug Abuse, *Drugs, Brains, and Behavior: the Science of Addition*, available at: https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction (last visited Jan. 26, 2024).
[97] Substance Abuse and Mental Health Services Administration, *Mental Health and Substance Use Disorders*, available at: https://www.samhsa.gov/find-help/disorders (last visited Jan. 26, 2024).
[98] National Institute of Mental Health, *Substance Use and Co-Occurring Mental Disorders*, available at: https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health (last visited Jan. 26, 2024).
[99] National Institute on Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction, available at: https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction (last visited Jan. 26, 2024).
[100] The Rural Health Information Hub, *Defining Substance Abuse and Substance Use Disorders*, available at https://www.ruralhealthinfo.org/toolkits/substance-abuse/1/definition (last visited Jan. 26, 2024).

as legal or illegal drugs, alcohol, or medications.[101] SUDs may co-occur with other mental disorders.[102] Approximately 19.4 million adults in the U.S. have co-occurring disorders.[103] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug use.[104]

The Marchman Act

In the early 1970s, the federal government furnished grants for states "to develop continuums of care for individuals and families affected by substance abuse."[105] The grants provided separate funding streams and requirements for alcoholism and drug abuse.[106] In response, the Florida Legislature enacted ch. 396, F.S., (alcohol) and ch. 397, F.S. (drug abuse).[107] In 1993, legislation combined chapters 396 and 397, F.S., into a single law, entitled the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act).[108] The Marchman Act supports substance abuse prevention and remediation through a system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

An individual may receive services under the Marchman Act through either voluntary[109] or involuntary admission.[110] The Marchman Act establishes a variety of methods under which substance abuse assessment, stabilization, and treatment can be obtained on an involuntary basis. The Marchman Act encourages individuals to seek services on a voluntary basis within the existing financial and space capacities of a service provider.[111] However, denial of addiction is a prevalent symptom of a SUD, creating a barrier to timely intervention and effective treatment.[112] As a result, a third party must typically provide a person the intervention needed to receive SUD treatment.[113]

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[101] National Institute of Mental Health, *Substance Use and Co-Occurring Mental Disorders*, available at: https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health (last visited Jan. 26, 2024).
[102] *Id.*
[103] Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2021 National Survey on Drug Use and Health, (December 2022), available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf (last visited Jan. 26, 2024).
[104] *Id.*
[105] Darran Duchene & Patrick Lane, *Fundamentals of the Marchman Act*, Risk RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Program, available at https://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited Jan. 26, 2024).
[106] *Id.*
[107] *Id.*
[108] Ch. 93-39, Laws of Fla., codified in Chapter 397, F.S. Reverend Hal S. Marchman was an advocate for persons who suffer from alcoholism and drug abuse.
[109] Section 397.601, F.S.
[110] Sections 397.675 – 397.6978, F.S.
[111] See section 397.601(1) and (2), F.S. An individual who wishes to enter treatment may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service provider.
[112] SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*, available at https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf (last visited on Jan. 26, 2024).
[113] *Id.*

Rights of Individuals

The Marchman Act protects the rights of individuals receiving substance abuse services in Florida, including, but not limited to the right to receive quality treatment at a state-funded facility, regardless of ability to pay and the right to counsel.[114] Under the Marchman Act, an individual must be informed that he or she has the right to be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment and that he or she may apply immediately to the court to have an attorney appointed if he or she cannot afford one. If the individual is a minor, the minor's parent, legal guardian, or legal custodian may apply to the court to have an attorney appointed.[115]

Involuntary Admissions

There are five voluntary admission procedures that can be broken down into two categories: non-court involved admissions and court involved admissions. Regardless of the nature of the proceedings, an individual meets the criteria for an involuntary admission under the Marchman Act where there is good faith reason to believe the individual is substance abuse impaired and, because of such impairment:[116]

- Has lost the power of self-control with respect to substance abuse; and
- The person's judgment has been so impaired because of substance abuse that he or she is incapable of appreciating the need for substance abuse services and of making a rational decision in regard to substance abuse services; or
- Without care or treatment, is likely to suffer from neglect or refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to their well-being and such harm is unavoidable through help of willing family members or friends; or
- The person has either inflicted, attempted or threatened to inflict, or unless admitted, is likely to inflict physical harm on himself or herself or another.

Under the Marchman Act, the be "impaired" or "substance abuse impaired," a person must have a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance, in a way that induces mental, emotional ,or physical problems and causes socially dysfunctional behavior.[117] Examples of psychoactive or mood-altering substances including alcohol and illicit or prescription drugs; however, only alcohol is explicitly named under current law. Although having a substance use disorder often leads to being impaired or substance abuse impaired, it is not presently included in the "impaired" or "substance abuse impaired" definition.

Unlawful activities relating to assessment and treatment

It is unlawful to give false information for the purpose of obtaining emergency or other involuntary admission for assessment and treatment. It is also unlawful to cause, conspire, or

[114] Section 397.501, F.S.
[115] *Id.*
[116] Section 397.675, F.S.
[117] Section 397.311, F.S.

assist with conspiring: to have a person involuntarily admitted without a reason to believe the person is actually impaired, or to deny the person the right to treatment.[118]

Non-Court Involved Involuntary Admissions

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

- Protective custody: this procedure is used by law enforcement officers when an individual is substance-impaired or intoxicated in public and is brought to the attention of the officer.[119]
- Emergency Admission: this procedure permits an individual who appears to meet the criteria for involuntary admission to be admitted to a hospital, an addiction receiving facility, or a detoxification facility for emergency assessment and stabilization. Individuals admitted for involuntary assessment and stabilization under this provision must have a physician's certificate for admission, demonstrating the need for this type of placement and recommending the least restrictive type of service that is appropriate to the needs of the individual.[120]
- Alternative Involuntary Assessment for Minors: this procedure 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.[121]

Court Involved Involuntary Admissions

Under Current law, courts have jurisdiction over involuntary assessment and stabilization, which provides for short-term court-ordered substance abuse services to assess and stabilize an individual, and involuntary services[122], which provides for long-term court-ordered substance abuse treatment. Both types of involuntary admissions involve filing a petition with the clerk of court in the county where the person is located, which may be different from where he or she resides. Current law permits the chief judge in Marchman Act cases to appoint a general or special magistrate to preside over all or part of the proceedings. Although this may include ancillary matters, such as writs of habeas corpus issued under the Marchman Act, this is not explicitly stated in current law.

Involuntary Assessment and Stabilization

A petition for involuntary assessment and stabilization must contain identifying information for all parties and attorneys and facts necessary to support the petitioner's belief that the respondent is in need of involuntary assessment and stabilization.[123] Once the petition is filed, the court

[118] Section 397.581, F.S. Committing an unlawful activity relating to assessment and treatment is a misdemeanor of the first degree, punishable by law and by a fine not exceeding $5,000.
[119] Sections 397.6771 – 397.6772, F.S. A law enforcement officer may take the individual to his or her residence, to a hospital, a detoxification center, or addiction receiving facility, or in certain circumstances, to jail. Minors, however, cannot be taken to jail.
[120] Section 397.679, F.S.
[121] Section 397.6798, F.S.
[122] The term "involuntary services" means "an array of behavioral health services that may be ordered by the court for a person with substance abuse impaired or co-occurring substance abuse impairment and mental health disorders." Section 397.311(23), F.S. SB 12 (2016), ch. 2016-241, Laws of Fla., renamed "involuntary treatment." For consistency, this analysis will use the term involuntary services.
[123] Section 397.6951, F.S.

issues a summons to the respondent and the court must schedule a hearing to take place within 10 days, or can issue an ex parte order immediately.[124] The court may appoint a magistrate to preside over all or part of the proceedings.[125]

After hearing all relevant testimony, the court determines whether the respondent meets the criteria for involuntary assessment and stabilization and must immediately enter an order that either dismisses the petition or authorizes the involuntary assessment and stabilization of the respondent.[126]

If the court determines the respondent meets the criteria, it may order him or her to be admitted for a period of five days[127] to a hospital, licensed detoxification facility, or addictions receiving facility, for involuntary assessment and stabilization.[128] During that time, an assessment is completed on the individual.[129] The written assessment is sent to the court. Once the written assessment is received, the court must either:[130]

- Release the individual and, if appropriate, refer the individual to another treatment facility or service provider, or to community services;
- Allow the individual to remain voluntarily at the licensed provider; or
- Hold the individual if a petition for involuntary services has been initiated.

Involuntary services

Involuntary services, synonymous with involuntary treatment, allows the court to require an individual to be admitted for treatment for a longer period if the individual meets the eligibility criteria for involuntary admission and has previously been involved in at least one of the four other involuntary admissions procedures within a specified period, including having been assessed by a qualified professional within five days.[131] Similar to a petition for involuntary assessment and stabilization, a petition for involuntary services must contain identifying information for all parties and attorneys and facts necessary to support the petitioner's belief that the respondent is in need of involuntary services.[132] Under current law, the petition must also

[124] Section 397.6815, F.S. Under the ex parte order, the court may order a law enforcement officer or other designated agent of the court to take the respondent into custody and deliver him or her to the nearest appropriate licensed service provider.
[125] Section 397.681, F.S.
[126] Section 397.6818, F.S.
[127] If a licensed service provider is unable to complete the involuntary assessment and, if necessary, stabilization of an individual within five days after the court's order, it may, within the original time period, file a request for an extension of time to complete its assessment. The court may grant additional time, not to exceed seven days after the date of the renewal order, for the completion of the involuntary assessment and stabilization of the individual. The original court order authorizing the involuntary assessment and stabilization, or a request for an extension of time to complete the assessment and stabilization that is timely filed, constitutes legal authority to involuntarily hold the individual for a period not to exceed ten days in the absence of a court order to the contrary. S. 397.6821, F.S.
[128] Section 397.6811, F.S. The individual may also be ordered to a less restrictive component of a licensed service provider for assessment only upon entry of a court order or upon receipt by the licensed service provider of a petition.
[129] Section 397.6819, F.S. The licensed service provider must assess the individual without unnecessary delay using a qualified professional. If an assessment performed by a qualified professional who is not a physician, the assessment must be reviewed by a physician before the end of the assessment period.
[130] Section 397.6822, F.S. The timely filing of a Petition for Involuntary Services authorizes the service provider to retain physical custody of the individual pending further order of the court.
[131] Section 397.693, F.S.
[132] Section 397.6951, F.S.

contain the findings and recommendations of the qualified professional that performed the assessment.

An individual's spouse, legal guardian, any relative, or service provider, or any adult who has direct personal knowledge of the individual's substance abuse impairment or prior course of assessment and treatment may file a petition for involuntary services on behalf of the individual. If the individual is a minor, only a parent, legal guardian, or service provider may file such a petition. [133] Current law does not permit the court or clerk of court to waive or prohibit process service fees for indigent petitioners.

A hearing on a petition for involuntary services must be held within five days unless a continuance is granted.[134] A copy of the petition and notice of hearing must be provided to all parties and anyone else the court determines. Current law specifies that the court, not the clerk, must issue a summons to the person whose admission is sought.[135] However, typically the clerk of course, not the court, issues summons. Current law does not specify who must effectuate service (i.e., a law enforcement agency or private process servers). Current law requires the respondent to be present, unless the court finds appearance to be harmful, in which case the court must appoint a guardian advocate to appear on the respondent's behalf.[136]

In a hearing for involuntary services, the petitioner must prove by clear and convincing evidence that:[137]

- The individual is substance abuse impaired and has a history of a lack of compliance with treatment for substance abuse; and
- Because of such impairment the person is unlikely to voluntarily participate in the recommended services or is unable to determine for himself or herself whether services are necessary and:
    - Without services the individual is likely to suffer from neglect or refuse to care for himself or herself and such neglect or refusal proses a real and present threat of substantial harm to his or her well-being; and that there is a substantial likelihood that without services the individual will cause serious bodily harm to himself, herself, or another in the near future, as evidenced by recent behavior; or
    - The individual's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.

At the hearing, the court must hear and review all relevant evidence, including the results of the involuntary assessment by a qualified professional, and either dismiss the petition or order the individual to receive involuntary services from his or her chosen licensed service provider, if possible and appropriate.[138]

[133] Section 397.695(5), F.S.
[134] Section 397.6955, F.S.
[135] Section 397.6955(3), F.S.
[136] Section 397.6957(1), F.S.
[137] Section 397.6957(2), F.S.
[138] Section 397.6957(4), F.S.

If the court finds that the conditions for involuntary services have been proven, it may order the respondent to receive services from a publicly funded licensed service provider for up to 90 days.[139] If an individual continues to need involuntary services, at least ten days before the 90-day period expires, the service provider can petition the court to extent the services an additional 90 days.[140] A hearing must, then, be held within fifteen days.[141] Unless an extension is requested, the individual is automatically released after 90 days.[142] Current law does not require facilities to offer discharge planning to assist the respondent with post-discharge care.

However, substance abuse treatment facilities other than addictions receiving facilities are not locked; therefore, individuals receiving treatment in such unlocked facilities under the Marchman Act may voluntarily leave treatment at any time, and the only legal recourse is for a judge to issue a contempt of court charge and impose brief jail time.[143] Current law does not permit courts to drug test respondents in Marchman Act cases.

Substance Abuse Treatment in Florida

DCF provides treatment for substance abuse through a community-based provider system that offers detoxification, treatment and recovery support for adolescents and adults affected by substance misuse, abuse, or dependence:[144]

- Detoxification Services: detoxification focuses on the elimination of substance use. Detoxification services use medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.
- Treatment Services: treatment services[145] include a wide array of assessment, counseling, case management, and support services that are designed to help individuals who have lost their abilities to control their substance use on their own and require formal, structured intervention and support. Some of these services may also be offered to the family members of the individual in treatment.
- Recovery Support: recovery support services, including transitional housing, life skills training, parenting skills, and peer-based individual and group counseling, are offered during and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery.

Licensed Bed Capacity for Substance Abuse Service Providers

DCF regulates substance abuse treatment providers, establishing licensure requirements and licensing service providers and individual service components under ch. 397, F.S. and rule 65D-

[139] Section 397.697(1), F.S.
[140] Section 397.6975, F.S.
[141] *Id.*
[142] Section 397.6977, F.S.
[143] If the respondent leaves treatment, the facility will notify the court and a status conference hearing may be set. If the respondent does not appear at the hearing, a show cause hearing may be set. If the respondent does not appear at the show cause hearing, the court may find the respondent in contempt of court.
[144] Department of Children and Families, *Treatment for Substance Abuse*, available at: https://www.myflfamilies.com/services/samh/treatment (last visited Jan. 26, 2024).
[145] Id. Research that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child protective system, employment, increased earnings, and better health.

30, F.A.C. Currently, there are over 2,800 DCF licensed substance abuse providers.[146] Licensed service components include a continuum of substance abuse prevention[147], intervention[148], and clinical treatment services, including, but not limited to:[149]

- Addictions receiving facilities;
- Detoxification;
- Intensive inpatient treatment;
- Residential treatment;
- Day or night treatment, including, day or night treatment with host homes, and community housing;
- Intensive outpatient treatment;
- Outpatient treatment;
- Continuing care;
- Intervention;
- Prevention; and
- Medication-assisted treatment for opiate addiction.

For licenses issued to addictions receiving facilities, inpatient detoxification, intensive inpatient treatment, and residential treatment, DCF must certify and include on the service provider's license, the licensed bed capacity for each facility.[150] The licensed bed capacity is the total bed capacity[151], or total number of operational beds, within the facility. The service provider must notify DCF of any change in the provider's licensed bed capacity equal to or greater than 10 percent, within 24 hours of the change.[152] Upon notification, DCF must update the service provider's license to reflect the increased licensed bed capacity.[153]

State Forensic System

Criminal Defendants and Competency to Stand Trial

The Due Process Clause of the 14th Amendment to the United States Constitution prohibits the states from trying and convicting criminal defendants who are incompetent to stand trial.[154] The

[146] DCF, Agency Bill analysis (2023), on file with the Senate Children, Families, and Elder Affairs Committee.
[147] Section 297.311(26)(c), F.S. Prevention is a process involving strategies that are aimed at the individual, family, community, or substance and that preclude, forestall, or impede the development of substance use problems and promote responsible lifestyles.
[148] Section 397.311(2)(b), F.S. Intervention is structured services directed toward individuals or groups at risk of substance abuse and focused on reducing or impeding those factors associated with the onset or the early stages of substance abuse and related problems.
[149] Section 397.311(26), F.S.
[150] *Id.*
[151] Bed capacity is total number of operational beds and the number of those beds purchased by DCF. *DCF, substance Abuse and Mental Health Financial and Service Accountability Management System (FASAMS), Pamphlet 155-2 Chapter 8 Acute Care Data* (May 2021), available at https://www.myflfamilies.com/sites/default/files/2022-12/chapter_08_acute_care.pdf (last visited Jan. 26, 2024).
[152] *Id.*
[153] DCF, *Operating Procedures*, CF Operating Procedure No. 155-31 Mental Health/Substance Abuse, available at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-31_district_substance_abuse_licensing_and_regulatory_policies_and_procedures.pdf (last visited Jan. 26, 2024).
[154] *Pate v. Robinson*, 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed. 815 (1966); *Bishop v. U.S.*, 350 U.S. 961, 76 S.Ct. 440, 100 L.Ed. 835 (1956); *Jones v. State*, 740 So.2d 520 (Fla. 1999).

states must have procedures in place that adequately protect the defendant's right to a fair trial, which includes his or her participation in all material stages of the process.[155] Defendants must be able to appreciate the range and nature of the charges and penalties that may be imposed, understand the adversarial nature of the legal process, and disclose to counsel facts pertinent to the proceedings. Defendants must also manifest appropriate courtroom behavior and be able to testify relevantly.[156]

If a defendant is suspected of being mentally incompetent, the court, counsel for the defendant, or the state may file a motion for examination to have the defendant's cognitive state assessed.[157] If the motion is well-founded, the court will appoint experts to evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing.[158] If the defendant is found to be mentally competent, the criminal proceeding resumes.[159] If the defendant is found to be mentally incompetent to proceed, the proceeding may not resume unless competency is restored.[160]

Involuntary Commitment of a Defendant Adjudicated Incompetent

Chapter 916, F.S., governs the state forensic system, which is a network of state facilities and community services for persons who have mental health issues, an intellectual disability, or autism, and who are involved with the criminal justice system. Offenders who are charged with a felony and adjudicated incompetent to proceed due to mental illness[161] and offenders who are adjudicated not guilty by reason of insanity may be involuntarily committed to state civil[162] and forensic[163] treatment facilities by the circuit court.[164] However, in lieu of such commitment, the offender may be released on conditional release[165] by the circuit court if the person is not serving a prison sentence.[166] The committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.[167]

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[155] *Id. See also* Rule 3.210(a)(1), Fla.R.Crim.P.
[156] *Id. See also* s. 916.12, 916.3012, and 985.19, F.S.
[157] Rule 3.210, Fla.R.Crim.P.
[158] *Id.*
[159] Rule 3.212, Fla.R.Crim P.
[160] *Id.*
[161] "Incompetent to proceed" means "the defendant does not have sufficient present ability to consult with her or his lawyer with a reasonable degree of rational understanding" or "the defendant has no rational, as well as factual, understanding of the proceedings against her or him." S. 916.12(1), F.S.
[162] A "civil facility" is a mental health facility established within the Department of Children and Families (DCF) or by contract with DCF to serve individuals committed pursuant to chapter 394, F.S., and defendants pursuant to chapter 916, F.S., who do not require the security provided in a forensic facility; or an intermediate care facility for the developmentally disabled, a foster care facility, a group home facility, or a supported living setting designated by the Agency for Persons with Disabilities (APD) to serve defendants who do not require the security provided in a forensic facility. Section 916.106(4), F.S. The DCF oversees two state-operated forensic facilities, Florida State Hospital and North Florida Evaluation and Treatment Center, and two privately-operated, maximum security forensic treatment facilities, South Florida Evaluation and Treatment Center and Treasure Coast Treatment Center.
[163] Section 916.106(10), F.S.
[164] Sections 916.13, 916.15, and 916.302, F.S.
[165] Conditional release in release into the community accompanied by outpatient care and treatment. Section 916.17, F.S.
[166] Section 916.17(1), F.S.
[167] Section 916.16(1), F.S.

A civil facility is, in part, a mental health facility established within DCF or by contract with DCF to serve individuals committed pursuant to ch. 394, F.S., and defendants pursuant to ch. 916, F.S., who do not require the security provided in a forensic facility.[168]

A forensic facility is a separate and secure facility established within DCF or the Agency for Persons with Disabilities (APD) to service forensic clients committed pursuant to ch. 916, F.S.[169] A separate and secure facility means a security-grade building for the purpose of separately housing individuals with mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed from non-forensic residents.[170]

A court may only involuntarily commit a defendant adjudicated incompetent to proceed for treatment upon finding, based on clear and convincing evidence, that:[171]

- The defendant has a mental illness and because of that mental illness:
  - The defendant is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative service, and, without treatment, the defendant is likely to suffer from neglect or refuse to care for herself or himself and such neglect or refusal poses a real and present threat of substantial harm to the defendant's well-being; or
  - There is a substantial likelihood that in the near future the defendant will inflict serious bodily harm on herself or himself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm.
- All available, less restrictive treatment alternatives, including treatment in community residential facilities or community inpatient or outpatient settings, which would offer an opportunity for improvement of the defendant's condition have been judged to be inappropriate; and
- There is a substantial probability that the mental illness causing the defendant's incompetence will respond to treatment and the defendant will regain competency to proceed in the reasonably foreseeable future.

If a person is committed pursuant to chapter 916, F.S., the administrator at the commitment facility must submit a report to the court:[172]

- No later than 6 months after a defendant's admission date and at the end of any period of extended commitment; or
- At any time the administrator has determined that the defendant has regained competency or no longer meets the criteria for involuntary commitment.

[168] Section 916.106(4), F.S.
[169] Section 916.106(10), F.S. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed pursuant to chapter 916, F.S., from non-forensic residents.
[170] *Id.*
[171] Section 916.13(1), F.S.
[172] Section 916.13(2), F.S.

Incompetent and Non-Restorable Defendants

If, after being committed, the defendant does not respond to treatment and is deemed non-restorable, the administrator of the commitment facility must notify the court by filing a report in the criminal case.[173] Those who are found to be non-restorable must be civilly committed or released.[174]

Non-Restorable Competency

An individual's competency is considered non-restorable when it is not likely that he or she will regain competency in the foreseeable future.[175] The DCF must make every effort to restore the competency of those committed pursuant to chapter 916, F.S., as incompetent to proceed. To ensure that all possible treatment options have been exhausted, all competency restoration attempts in less restrictive, step-down facilities should be considered prior to making a recommendation of non-restorability, particularly for individuals with violent charges.

Individuals who are found to be non-restorable in less than five years of involuntary commitment under section 916.13, F.S., require civil commitment proceedings or release. After an evaluator of competency has completed a competency evaluation and determined that there is not a substantial probability of competency restoration in the current environment in the foreseeable future, the evaluator must notify the appropriate recovery team[176] coordinator that the individual's competency does not appear to be restorable.

After notification, the recovery team's psychiatrist and clinical psychologist members must complete an independent evaluation to examine suitability for involuntary placement. Once the evaluation to examine suitability for involuntary placement is complete, the recovery team meets to consider the following:[177]

- Mental and emotional symptoms affecting competency to proceed;
- Medical conditions affecting competency to proceed;
- Current treatments and activities to restore competency to proceed;
- Whether relevant symptoms and conditions are likely to demonstrate substantive improvement;
- Whether relevant and feasible treatments remain that have not been attempted, including competency restoration training in a less restrictive, step-down facility; and
- Additional information as needed (including barriers to discharge, pending warrants and detainers, dangerousness, self-neglect).

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[173] Section 916.13(2)(b), F.S.
[174] *Mosher v. State*, 876 So.2d 1230 (Fla. 1st DCA 2004).
[175] DCF Operating Procedures No. 155-13, *Mental Health and Substance Abuse: Incompetent to Proceed and Non-Restorable Status*, September 2021, at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-13_incompetence_to_proceed_and_non-restorable_status.pdf (last visited Jan. 26, 2024).
[176] A recovery team is an assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), community case manager, family member, and other treatment professionals commensurate with the resident's needs, goals, and preferences. DCF Operating Procedures, No. 155-16, *Recovery Planning and Implementation in Mental Health Treatment Facilities*, May 16, 2019, available at: https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-16_recovery_planning_and_implementation_in_mental_health_treatment_facilities.pdf (last visited Jan. 26, 2024).
[177] *Id.*

The recovery team must document the team meeting and considerations for review, and, if applicable, the extent to which the individual meets the criteria for involuntary examination pursuant to s. 394.463, F.S., or involuntary inpatient placement pursuant to s. 394.467(1), F.S. Each member of the recovery team must provide a recommendation for disposition. Individuals with competency reported as non-restorable may be considered, as appropriate, for recommendations of release without legal conditions or involuntary examination or inpatient placement.[178]

Competency Evaluation Report

Following the completion of the competency evaluation, the evaluation to examine suitability for involuntary placement, and consideration of restorability, the evaluator of competency must complete a competency evaluation report to the circuit court.[179] A competency evaluation report to the circuit court is a standardized mental health document that addresses relevant mental health issues and the individual's clinical status regarding competence to proceed. The report is completed, pursuant to s. 916.13(2), F.S., and DCF Operating Procedure 155-19 (Evaluation and Reporting of Competency to Proceed).[180] The operating procedures provide guidelines for the format and minimal content that must be included in the report. Evaluators may add other relevant and appropriate information as necessary to report on the individual's status and needs.[181] The report must include the following:

- A description of mental, emotional, and behavioral disturbances;
- An explanation to support the opinion of incompetence to proceed;
- The rationale to support why the individual is unlikely to gain competence to proceed in the foreseeable future;
- A clinical opinion that the individual no longer meets the criteria for involuntary forensic commitment pursuant to s. 916.13, F.S.; and
- A recommendation whether the individual meets the criteria for involuntary examination pursuant to s. 394.463, F.S.

In order for a criminal court to order an involuntary examination under the Baker Act, there must be sworn evidence that the defendant meets the Baker Act criteria. Reports from mental health treatment facilities, such as the competency evaluation report, provide the court with sufficient basis/evidence to enter an order for involuntary examination. These reports may be sworn upon request of the court.[182]

A competency evaluation report is used in the process of a forensic commitment becoming a civil commitment. However, to be considered in a criminal court proceeding as evidence that the defendant meets Baker Act criteria, the report must be sworn. Currently, competency evaluation reports are not sworn.

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[178] Chapter 394, F.S. or *Mosher v. State*, 876 So.2d 1230 (Fla. 1st DCA 2004).
[179] DCF's Operating Procedure 155-19, *Evaluation and Reporting of Competency to Proceed*, February 15, 2019, available at: https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-19_evaluation_and_reporting_of_competency_to_proceed.pdf (last visited Jan. 26, 2024).
[180] *Id.*
[181] *Id.*
[182] DCF, Agency Bill analysis HB 201 (2023), p. 2 (on file with the Senate Children Families, and Elder Affairs committee).

Civil Commitment after Determination of Non-Restorable Defendant

Civil commitment is initiated in accordance with Part I of Chapter 394, F.S. The procedures in that part ensure the due process rights of a person are protected and require examination of a person believed to meet Baker Act criteria at a designated receiving facility.

If a non-restorable defendant is returned to court in accordance with ch. 916, F.S., the criminal court has authority to enter an order for involuntary Baker Act examination, and the defendant is taken to the nearest receiving facility. If found to meet criteria, a separate civil case is opened and the criminal case may be dismissed.[183]

III. Effect of Proposed Changes:

Streamlining and Coordinating Baker Act Processes and Standards.

The bill makes numerous changes to ch. 394, the Baker Act. These changes streamline court processes, requirements, and allow for more coordinated service provision.

Section 5 of the bill amends s. 394.461, F.S., related to Baker Act transfer evaluations to receiving and treatment facilities by:

- Removing the requirement that the court receive and consider a transfer evaluation before a hearing for involuntary placement. Instead, it allows the state attorney to establish that a transfer evaluation was performed and that the document was properly executed by providing the court with a copy of the transfer evaluation before the close of the state's case in chief.
- Codifying current hearsay rules by specifying that the court may not consider substantive information in the transfer evaluation unless the evaluator testifies at the hearing.

The bill also removes the requirement for the annual Baker Act receiving facility and system report from being provided to the Governor, President of the Senate, and Speaker of the House of Representatives and instead requires the report be posted on the DCF's website.

Section 8 of the bill amends s. 394.4625, F.S., related to voluntary admissions to require the parent or legal guardian of a minor to provide express and informed consent for that minor's admission to a facility for observation, diagnosis, or treatment along with a clinical review by the facility to verify the voluntariness of the minor's consent.

Section 9 of the bill amends s. 394.463, F.S., related to involuntary examinations under the Baker Act and makes the following changes:

- Sets the start time for the required 72 hour examination period as when the patient arrives at the receiving facility and includes the hours before the ordinary business hours of the following workday morning when clarifying the procedure for what happens when a patient's 72-hour hold ends during a weekend or holiday.
- Allows discretion for law enforcement officers when deciding whether to take a person for involuntary examination.

[183] Section 916.145, F.S.

- Removes the prohibition of psychiatric nurses approving the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release was approved by the psychiatrist.
- Removes the requirement that a petition may only be filed by the facility administrator and, instead, cites to who may file a petition in s. 394.4655(4)(a) and adds the requirement that the court dismiss untimely filed petitions.
- Requires the DCF and AHCA to analyze service data of those defined as "high utilizers of crisis stabilization services" and identify patterns or trends and make recommendations to decrease admissions. These recommendations may be addressed in the DCF's contracts with MEs and in AHCA's contracts with Medicaid MMA plans.
- Requires the DCF to publish a report on its findings and recommendations to its website along with submitting the report to the Governor, President of the Senate, and Speaker of the House of Representatives by November 1 each odd-numbered year.

Section 10 of the bill amends s. 394.4655, F.S., to delete almost the entirety of the "involuntary outpatient services" section and combine that language with the "involuntary inpatient placement" section of statute as the titled "Involuntary Services" section of the Baker Act (section 11 of the bill).

Section 11 amends s. 394.467, F.S., to substantially reword the section and combine the language for the criteria and processes for involuntary inpatient placement and involuntary outpatient services as "involuntary services." As these two sections were very similar, the newly drafted section contains mainly current law. However, the bill does make multiple substantive changes:

- Clarifies that a patient can be recommended for either inpatient or outpatient involuntary services or a combination of both.
- Criteria for involuntary services:
  - Allows those under age 18 access to all involuntary services. This will increase access to services, as current law required the individual be 18 or older for involuntary outpatient services.
  - Removes the involuntary outpatient services 36-month involuntary commitment criteria, which required the person to have been committed to a receiving or treatment facility or received mental health services in a forensic or correctional facility within the preceding 36-month period.
  - Expands the requirement that a recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have examined the patient in the preceding 72 hours, to all involuntary services, not just inpatient services.
  - For outpatient services only, includes a physician assistant or social worker may provide a second opinion on a recommendation should a psychiatrist or clinical psychologist not be available.
  - Changes the requirement that a recommendation for involuntary services be entered on a petition for involuntary inpatient placement certificate that authorizes the facility to retain the patient pending transfer to a facility or completion of a hearing. Instead, recommendations are must be on the certificate and included in the clinical record.
  - Adds in a requirement for outpatient services only: if the individual has been stabilized, and no longer meets the criteria, the patient must be released while waiting for a hearing.

- Hearings for Involuntary Services:
  - Creates a single petition process for involuntary services. This gives the court more flexibility and authority to order a person to either involuntary outpatient services, involuntary inpatient placement, or a combination of both.
  - Creates a single certificate for petitioning for involuntary services.
  - Clarifies that the hearing must be within 5 court working days of the filing of the petition.
  - Requires the facility to make the patient's clinical records available to the state attorney and the patient's attorney for preparation for the hearing.
  - Requires the documents to maintain confidentiality and prohibits the use of the documents for prosecution, investigation, or any other purpose than the hearing.
  - Expands the grounds under which a patient's presence at the hearing may be waived. Specifically, the bill authorizes the court to waive a patient's presence if the patient knowingly, intelligently, and voluntarily waives the right to be present. However, the language maintains the requirement that the patient's counsel have no objections for the waiver to take effect.
  - Prohibits the court from ordering an individual with a developmental disability as defined under s. 393.063, F.S., who lacks a co-occurring mental illness, into a state treatment facility. This expands current law which prohibits such orders for persons with traumatic brain injury or dementia and ensures that limited state treatment facility beds remain for individuals who are appropriate for treatment.
- Petition for Involuntary Services:
  - Expands who may be allowed to file a petition for involuntary services to both administrators of receiving and treatment facilities.
  - Provides what must be in the petition, including, but not limited to:
    - Whether the petitioner is recommending inpatient, outpatient, or both services.
    - The length of time recommended for each type.
    - Requires the services in the plan be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed/contracted by, the service provider.
    - Requires certification to the court that services are currently available and whether the service provider agrees to provide the services.
  - Prohibits the petition from being filed if the recommended services are not available and requires the managing entity be notified if the services are not available.
  - Requires the managing entity to document efforts to obtain the requested service.
  - Requires each criterion be included in the petition as well as substantiated. Requires a copy of the certificate and the proposed plan be attached to the petition.
  - Requires the clerk to provide a copy of the filed petition, along with all attachments, to:
    - The department
    - Managing entity
    - Patient
    - Patient's guardian or representative
    - State attorney
    - Public defender or private counsel.
  - Allows the State at least one continuance of the hearing for a period of up to 5 court working days and requires a showing of good cause and due diligence before the request

is made. Clarifies the state's failure to timely review the documents or failure to attempt to contact a witness does not warrant a continuance.

- Orders of the court:
  - Allows the court to order a patient to involuntary inpatient, outpatient or a combination based on the criteria met and which meets the needs of the patient best.
  - Allows an order for inpatient placement or combination of inpatient and outpatient be for up to six months.
  - Requires an order to specify the length of time a patient shall be ordered for inpatient and outpatient when a combination of both has been ordered.
  - For inpatient placement, the court is allowed to:
    - Order the patient be transferred to the facility;
    - Order the patient be retained at the facility if they are already there;
    - Order the patient receive services on an involuntary basis.
  - Allows documentation of the patient's illness to the service provider for outpatient services to include evaluations of the patient performed by a psychiatric nurse, marriage and family therapist, mental health counselor, and not just psychologists and clinical social workers as under current law.
  - Allows the administrator of a facility to refuse admission to a patient whom has been ordered to be there if they do not have the proper documentation.

- Procedure for Continued Involuntary services:
  - Requires a copy of the petition and its attachments be provided to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or public defender.
  - Requires the court to appoint counsel to represent the patient unless they have their own counsel or are ineligible.
  - Requires a petition for an order authorizing continued involuntary inpatient placement if the patient was admitted while serving a criminal sentence and the sentence is about to expire or a patient who was a minor and is about to reach the age of 18.
  - Requires this procedure to be followed prior to the expiration of each additional time period.

Section 12 of the bill amends s. 394.468, F.S., to amend the discharge procedures for an individual that was ordered to involuntary inpatient placement. These changes include:

- Revising discharge procedures to require receiving and treatment facilities to include in their discharge planning and procedures documentation of the patient's needs and actions to address those needs and also refer patients being discharged to care coordination services if the patient meets certain criteria and to recovery support opportunities through coordinated specialty care programs, including, but not limited to, connection to a peer specialist.
- Requires the receiving facility to coordinate face-to-face or through electronic means, while in the presence of the patient, ongoing treatment and discharge plans to a less restrictive community behavioral health provider, a peer specialist, a case manager, or a care coordination service.
- Requires receiving facilities to implement policies and procedures outlining strategies for how they will comprehensively address the needs of the individuals who demonstrate a high utilization of receiving facility services to avoid or reduce future use of crisis stabilization

services. More specifically, the bill requires the provider to develop and include in discharge paperwork a personalized crisis prevention plan for the patient that identifies stressors, early warning signs of symptoms, and strategies to manage crisis.
- Requires receiving facilities to have a master's level or licensed professional staff engage a family member, legal guardian, legal representative, or a natural support in discharge planning and meet with them face to face or through other electronic means to review the discharge plan.
- Requires the receiving facility to set up interim outpatient services to continue care for instances where certain levels of care are not immediately available at discharge.

Section 15 of the bill amends s. 394.499, F.S., to allow eligibility for voluntary crisis stabilization for a minor upon the parent's express and informed consent and removes the requirement for the minor's consent and the hearing to verify the voluntariness of that minor's consent.

Section 16 of the bill amends s. 394.875, F.S., to remove the requirement in s. 394.875, F.S., that crisis stabilization units are limited to a maximum of 30 beds and removes the requirement for a DCF demonstration project in Circuit 18 to test the impact of expanding the authorized amount of beds from 30 to 50.

Marchman Act

The bill makes numerous changes to ch. 397, the Marchman Act. These changes change the court processes of Marchman act by removing the two-petition process; closer aligning the petition, hearing, and order requirements with the Baker Act; and making court proceedings more efficient and streamlined.

Sections 18 and 26 of the bill amend ss. 397.305 and 397.6751, F.S., to require services be provided that are **most appropriate** and least restrictive, instead of just least restrictive

Section 20 of the bill amends s. 397.401, F.S., related to licensed service providers to prohibit the operators of addictions receiving facilities or providing detoxification in a non-hospital setting from exceeding licensed capacity by more than ten percent and exceeding licensed capacity for more than three consecutive working days or more than seven days in one month.

Currently these service providers are required to notify DCF within 24 hours of any change to bed capacity equal to or greater than 10 percent. DCF then must update the service provider's license to reflect increased bed capacity.

Section 24 of the bill amends s. 397.675, F.S., to add substance use disorder to the list of criteria for admission to involuntary treatment.

One of the criteria for involuntary admission for substance abuse treatment requires a person to be likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to their well-being and it is not apparent that such harm may be avoided through the help of **willing** family members or friends. This section amends this criteria to add that such family members or friends being considered for offering help also be **able and responsible**.

Section 25 of the bill amends s. 397.681, F.S., related to general provisions of the Marchman Act to:

- Allow the chief judge to appoint a magistrate to all or part of the proceedings related to the petition or any ancillary matters thereto.
- Clarify that a respondent has the right to counsel at every state of a judicial proceeding in they need or desire counsel, unless the respondent was present and the court finds he or she knowingly, intelligently, and voluntarily waived legal representation.

Section 27 of the bill amends s. 397.6818, F.S., related to court determinations under the Marchman Act as follows:

- In the case of an emergency, or when upon review of the petition the court determines that an emergency exists, the court may rely exclusively upon the contents of the petition and, without an attorney being appointed, enter an ex parte order for the respondent's involuntary assessment and stabilization which must be executed during the period when the hearing on the petition for treatment is pending.
- The court may further order a law enforcement officer or other designated agent of the court to:
  - Take the respondent into custody and deliver him or her to either the nearest appropriate licensed service provider or a licensed service provider designated by the court to be evaluated; and
  - Serve the respondent with the notice of hearing and a copy of the petition.
- In such instances, a service provider must promptly inform the court and parties of the respondent's arrival and refrain from holding the respondent for longer than 72 hours of observation thereafter, unless:
  - The service provider seeks additional time in accordance with the law and the court, after a hearing, grants that motion;
  - The respondent shows signs of withdrawal, or a need to be either detoxified or treated for a medical condition, which will serve to extend the amount of time the respondent may be held for observation until the issue is resolved; or
  - The original or extended observation period ends on a weekend or holiday, in which case the provider may hold the respondent until the next court working day.
- If an ex parte order is not executed by the initial hearing date, it is deemed void. If the respondent does not appear at the hearing for any reason, including lack of service, and upon reviewing the petition, testimony, and evidence presented, the court reasonably believes the respondent meets the Marchman Act commitment criteria and that a substance abuse emergency exists, the court is allowed to issue or reissue an ex parte assessment and stabilization order that is valid for 90 days. If the respondent's location is known at the time of the hearing, the court:
  - Must continue the case for no more than 10 court working days; and
  - May order a law enforcement officer or other designated agent of the court to:
- Take the respondent into custody and deliver him or her to be evaluated; and
- If a hearing date is set, serve the respondent with notice of the rescheduled hearing and a copy of the involuntary treatment petition if the respondent has not already been served.

- If the respondent has not been assessed within 90 days, the bill requires the court to dismiss the case.

Section 29 of the bill amends and renumbers s. 397.695 to s. 397.68112, F.S., to allow the court to prohibit service of process fees if a petitioner is indigent and allows a law enforcement agency to waive the fee for the same reason.

Section 30 of the bill amends and renumbers s. 397.6951 to s. 397.68141, F.S., to change the requirements for a petition for involuntary treatment services to:
- Remove the requirement that findings and recommendations of the qualified professional's assessment be in the petition; and instead
- Requires the petition to be accompanied by a certificate or report of a qualified professional who examined the respondent within 30 days before the petition was filed. If the respondent was not assessed before the petition or refused to submit to an evaluation this lack of assessment or refusal must be noted in the petition.

If an emergency, the bill requires the petition to describe the exigent circumstances and include a request for an ex parte assessment and stabilization order.

Section 31 of the bill amends and renumbers s. 397.6955 to s. 397.68151, F.S., to make changes to the duties of the court upon the filing of a petition for involuntary services. These changes:
- Allow the office of criminal conflict and civil regional counsel to stop representation once the office is discharged by the court;
- Increase of the time in which the court is required to hold a hearing on the petition to within 10 working days from 5 days; and
- Require law enforcement to serve a person whose admission is sought for initial hearing unless the chief judge authorizes private process servers.

Section 32 of the bill amends s. 397.6957, F.S., to make multiple substantive changes to the hearing on a petition for involuntary treatment under the Marchman Act. The bill requires the respondent be present at a hearing, unless the court finds a knowing, intelligent, and voluntary waiver of the right to be present. The other substantive changes the bill makes:
- Requires relevant evidence to include testimony from individuals familiar with the respondent's history and how it relates to his or her current condition.
- Allows the court to order drug testing.
- Allows, upon good cause, medical professionals involved with respondent's treatment to appear remotely.
- Prohibits a respondent from being involuntarily ordered into treatment if a clinical assessment is not performed, unless the respondent is present in court and expressly waives the assessment. Outside of emergency situations, if the respondent is not, or previously refused to be, assessed by a qualified professional and, based on the petition, testimony, and evidence presented, it appears that the respondent qualifies for involuntary treatment services, the bill requires the court to issue an involuntary assessment and stabilization order to determine the correct level of treatment for the respondent. In Marchman Act cases where an assessment was attached to the petition, the bill allows the respondent to request, or the

court on its own motion to order, an independent assessment by a court-appointed physician or another physician agreed to by the court and the parties.

- An assessment order issued by the court is valid for 90 days. If the respondent is present or there is proof of service or the respondent's whereabouts are known the involuntary treatment hearing may be continued for no more than 10 court working days. Otherwise, the petitioner and the service provider are required to promptly inform the court that the respondent has been assessed in order for the court to schedule a hearing as soon as practicable.
- If there is evidence indicating that the respondent will not voluntarily appear at the hearing, or is a danger to self or others, the bill permits the court to enter a preliminary order committing the respondent to an appropriate treatment facility for further evaluation until the new hearing date.
- Requires the court to dismiss the case if the respondent still has not been assessed after 90 days.
- An assessment conducted by a qualified professional must occur within 72 hours after the respondent arrives at a licensed service provider unless the respondent displays signs of withdrawal or a need to be either detoxified or treated for a medical condition. In such cases, the amount of time the respondent may be held for observation is extended until that issue is resolved.
- If the respondent is a minor, the bill requires the assessment to begin within the first 12 hours after the respondent is admitted, in alignment with the Baker Act, and the service provider may file a motion to extend the 72 hours of observation by petitioning the court in writing for additional time.
- Requires a service provider to provide copies of the motion to all parties in accordance with applicable confidentiality requirements. After the hearing, the court may grant additional time or expedite the respondent's involuntary treatment hearing. If the court grants the service provider's petition, the service provider is permitted to hold the respondent until its extended assessment period expires or until the expedited hearing date. In cases where the original or extended observation period ends on a weekend or holiday, the provider is only permitted to hold the respondent until the next court working day.
- Requires the qualified professional, in accordance with applicable confidentiality requirements, to provide copies of the completed report to the court and all relevant parties and counsel no later than ordinary close of business the day before the hearing. The report is required to contain a recommendation on the level, if any, of substance abuse and any co-occurring mental health treatment the respondent may need. The qualified professional's failure to include a treatment recommendation results in the petition's dismissal.
- Allows the court to initiate involuntary examination proceedings at any point during the hearing if it has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, is likely to neglect or injure himself, herself, or another if not committed, or otherwise meets the involuntary commitment provisions covered under the Baker Act.

Section 33 of the bill amends s. 397.6975, F.S., to allow a petition for the extension of involuntary services to be filed by the service provider or the person who filed the initial petition for treatment if accompanied by supporting documentation from the service provider. This petition must be filed with the court at least 10 days before expiration of the current court-

ordered services period. The bill requires the court to immediately schedule a hearing within 10 court working days, to be held not more than 15 days after filing of the petition. The bill requires counsel be noticed with the petition and notice of hearing. The bill also deletes multiple subsections to conform with the overall substantive changes in the bill.

Section 34 of the bill amends s. 397.6977, F.S., to require discharge planning and procedures for any respondent's release from involuntary treatment services to include and document the respondent's needs and actions to address such needs for, at a minimum:

- Follow-up behavioral health appointments;
- Information on how to obtain prescribed medications;
- Information pertaining to available living arrangements and transportation; and
- Referral to recovery support opportunities, including, but not limited to, connection to a peer specialist.

Forensic System Changes

Section 38 of the bill amends s. 916.13, F.S., to make changes related to the involuntary commitment of a defendant adjudicated incompetent. The DCF is currently required to conduct a competency evaluation and submit a report upon determination that a defendant will not, or is unlikely to, regain competency. The bill language:

- Requires the DCF to submit this report within 30 days of the determination.
- Requires the report to be sworn and provided to counsel in addition to the court.
- Establishes the minimum information that must be included in the competency evaluation report. The report must include, at a minimum, the following information regarding the defendant:
  - A description of mental, emotional, and behavioral disturbances;
  - An explanation to support the opinion of incompetency to proceed;
  - The rationale to support why the defendant is unlikely to gain competence to proceed in the foreseeable future;
  - A clinical opinion regarding whether the defendant no longer meets the criteria for involuntary forensic commitment; and
  - A recommendation on whether the defendant meets the criteria for involuntary services pursuant to s. 394.467, F.S.
- Authorizes a defendant, who meets the criteria for involuntary examination as determined by an independent clinical opinion, to appear remotely for the hearing

Other Changes

Sections 2 and 21 of the bill amend ss. 394.4572 (Baker Act) and 397.4073 (Marchman Act) F.S., to exempt physicians and nurses from background screenings by both DCF and AHCA if providing a service within their scope of practice.

Sections 39 through 45 of the bill repeal sections of law related to the Marchman Act. The requirements of these repealed sections have been included in the substantive changes throughout the bill streamlining the processes of the Baker and Marchman acts.

Sections 1, 3, 4, 6, 7, 13, 14, 17, 19, 22, 23, 28, 35, 36, and 37 of the bill are amended to make non-substantive style and language changes or conforming and cross-reference changes to put into effect the substantive provisions of the bill.

Section 46 of the bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill has an indeterminate significant fiscal impact to DCF and the state court system as a result of the following provisions:

Reporting Requirements
DCF will be required to create and publish a report on Marchman Act services. The bill also requires DCF and the Agency for Health Care Administration to analyze the service data collected on individuals who are high users of crisis stabilization services. There is an indeterminate, likely significant, negative fiscal impact as workload for the DCF and AHCA associated with these provisions.

Involuntary Services
The bill provides judges with greater flexibility regarding the order of involuntary services, rather than being required to order the specific services for which the petition was filed or no services at all. This will likely increase demand for involuntary outpatient services. There is an indeterminate, likely significant, negative fiscal impact for the likely increase in orders for these services.

Marchman Act Services
The bill makes it easier for family and friends of individuals with substance use disorder to file pro se for Marchman Act services by streamlining the two-petition process. There is an indeterminate, likely significant, negative fiscal impact for the likely increase in orders for services as judges act on these petitions.

Discharge Planning
The bill modifies the discharge procedures for receiving facilities by requiring the referral of patients to follow-up supports and services; face-to-face or electronic interaction with the patient and persons in their support system to communicate about follow-up care; and development of a personalized crisis prevention plan for the patient in an effort to mitigate repeated utilization of receiving facility services. There is an indeterminate, likely significant, negative fiscal impact as workload to the facilities to implement these provisions.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: ss. 394.455, 394.4572, 394.459, 394.4599, 394.461, 394.4615, 394.462, 394.4625, 394.463, 394.4655, 394.467, 394.468, 394.495, 394.496, 394.499, 394.875, 394.9085, 397.305, 397.311, 397.401, 397.4073, 397.501, 397.581, 397.675, 397.681, 397.6751, 397.6818, 397.693, 397.695, 397.6951, 397.6955, 397.6957, 397.6975, 397.6977, 409.972, 464.012, 744.2007, 916.13, F.S.

This bill creates the following sections of the Florida Statutes: ss. 397.68111, 397.68112, 397.68141, and 397.68151, F.S.

This bill repeals the following sections of the Florida Statutes: ss. 397.6811, 397.6814, 397.6815, 397.6819, 397.6821, 397.6822, 397.6978, F.S.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.