

HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: CS/CS/HB 7021 PCB CFS 24-01 Mental Health and Substance Abuse
SPONSOR(S): Health & Human Services Committee and Health Care Appropriations Subcommittee and Children, Families & Seniors Subcommittee, Maney and others
TIED BILLS: CS/HB 7023 **IDEN./SIM. BILLS:** CS/SB 1784

FINAL HOUSE FLOOR ACTION: 111 Y's 0 N's **GOVERNOR'S ACTION:** Approved

SUMMARY ANALYSIS

CS/CS/HB passed the House on March 4, 2024. The bill was amended in the Senate on March 7, 2024, and returned to the House. The House concurred in the Senate amendment and subsequently passed the bill as amended on March 8, 2024. The bill includes portions of CS/HB 915 and CS/HB 951.

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 and Marchman Acts to improve the processes for obtaining mental health and substance abuse examinations and treatment and to align certain provisions to be consistent between both acts.

The bill amends the Baker Act in that it:

- Combines processes for court orders to streamline the process for obtaining involuntary services; expands courts' authority to commit a person to involuntary services; and authorizes courts to order a person to a combination of involuntary outpatient services and involuntary inpatient placement, based on the needs of the individual.
- Grants law enforcement officers discretion on initiating involuntary examinations.
- Requires the 72-hour examination period to begin when a patient arrives at the facility.
- Extends the maximum period a person may be ordered to involuntary outpatient services from 90 days to 6 months.
- Authorizes remote appearances for the state attorney and witnesses for hearing proceedings.
- Removes the 30-bed cap for crisis stabilization units.

The bill amends the Marchman Act in that it:

- Combines the two-petition process—for assessment and stabilization, and for treatment—into one process.
- Requires the court to inform a respondent of the right to request an independent assessment.
- Reduces the court's timeframe to schedule a hearing from 15 days to 10 days.
- Allows the person who filed a petition for an initial treatment order to petition to extend such treatment if the petition includes supporting documentation from the service provider.
- Allows service providers to exceed licensed bed capacity on a limited basis under certain circumstances.
- Authorizes a witness to appear remotely for hearing proceedings.

The bill amends both acts in that it:

- Creates a more comprehensive and personalized discharge planning process.
- Requires the Louis de la Parte Florida Mental Health Institute to prepare and publish certain reports on its website.

The bill appropriates \$50,000,000 in recurring funds to DCF to implement its provisions, and has no fiscal impact on local government.

The bill was approved by the Governor on June 14, 2024, ch. 2024-245, L.O.F., and will become effective on July 1, 2024.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Background

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 the 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. Nearly one in five adults lives with a mental illness.⁴ During their childhood and adolescence, almost half of children will experience a mental disorder, though the proportion experiencing severe impairment during childhood and adolescence is much lower, at about 22%.⁵

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. SAMH 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.⁶ The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.⁷ MEs were fully implemented statewide in 2013, serving all geographic regions.

¹ World Health Organization, *Mental Health: Strengthening Our Response*, <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response> (last visited January 3, 2024).

² Centers for Disease Control and Prevention, *Mental Health Basics*, <http://medbox.iab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm> (last visited January 3, 2024).

³ *Id.*

⁴ National Institute of Mental Health (NIH), *Mental Illness*, <https://www.nimh.nih.gov/health/statistics/mental-illness> (last visited January 3, 2024).

⁵ *Id.*

⁶ Ch. 2001-191, Laws of Fla.

⁷ Ch. 2008-243, Laws of Fla

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.⁸

Current Situation - Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.⁹ 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.¹⁰ 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 improvement grants to managing entities.¹¹ 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.¹² DCF must use performance-based contracts to award grants.¹³

There are several essential elements which make up a coordinated system of care, including:¹⁴

- 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:¹⁵

- 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

⁸ DCF, *Managing Entities*, available at <https://www.myflfamilies.com/services/samh/providers/managing-entities>, (last visited January 8, 2024).

⁹ S. 394.9082(5)(d), F.S.

¹⁰ S. 394.4573(1)(c), F.S.

¹¹ S. 394.4573(3), F.S. The Legislature has not funded system improvement grants.

¹² *Id.*

¹³ *Id.*

¹⁴ S. 394.4573(2), F.S.

¹⁵ S. 394.495(4), F.S.

- Trauma-informed services for children who have suffered sexual exploitation.

DCF must define the priority populations which would benefit from receiving care coordination.¹⁶ 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-region.¹⁷ The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.¹⁸

Commission on Mental Health and Substance Use Disorder

The Marjory Stoneman Douglas High School Public Safety Commission

In response to the shooting at Marjory Stoneman Douglas High School on February 14, 2018, the Florida Legislature passed the Marjory Stoneman Douglas High School Public Safety Act (Act).¹⁹ The Act's provisions addressed school safety and security by creating the Office of Safe Schools and requiring increased coordination among state and local agencies serving students with or at-risk of mental illness, among other provisions. The Act also created the Marjory Stoneman Douglas High School Public Safety Commission (MSD Commission), to investigate system failures in the Marjory Stoneman Douglas High School shooting and prior mass violence incidents and develop recommendations for system-wide improvements.

The MSD Commission is authorized to issue annual reports and is scheduled to sunset on July 1, 2026.²⁰ The MSD Commission submitted its initial report on January 2, 2019, which contained numerous school safety and security recommendations²¹ that the Legislature addressed in SB 7030 (2019), Implementation of Legislative Recommendations of the Marjory Stoneman Douglas High School Public Safety Commission.²² The MSD Commission's second report, submitted on November 1, 2019, provided recommendations related to safe-school officers, threat assessments, juvenile diversion programs, and mental health, among other recommendations.²³

In February 2019, Governor Ron DeSantis requested, and the Florida Supreme Court convened, a grand jury to study systemic school safety failures. The grand jury was tasked with investigating whether specific public entities failed to act or committed fraud that undermined the school safety activities that the Act and subsequent legislation required.²⁴ The Grand Jury's third report, issued in December 2020, included an analysis of the state's mental health infrastructure and found systemic problems are impacting mental health:²⁵

¹⁶ S. 394.9082(3)(c), F.S.

¹⁷ S. 394.9082(5)(b), F.S.

¹⁸ S. 394.75(3), F.S.

¹⁹ Ch. 2018-3, L.O.F.

²⁰ Section 943.687(9), F.S.

²¹ Marjory Stoneman Douglas High School Public Safety Commission, *Initial Report* (Jan. 2, 2019), <http://www.fdle.state.fl.us/MSDHS/CommissionReport.pdf> (last visited March 21, 2024).

²² Chapter 2019-22, L.O.F.

²³ Marjory Stoneman Douglas High School Public Safety Commission, *Second Report* (Nov. 1, 2019), <http://www.fdle.state.fl.us/MSDHS/MSD-Report-2-Public-Version.pdf> (last visited March 21, 2024).

²⁴ Ron DeSantis, Governor of Florida, *Petition for Order to Impanel a Statewide Grand Jury*, (Feb. 13, 2019), https://efactssc-public.flcourts.org/casedocuments/2019/240/2019-240_petition_72393_e83.pdf (last visited March 21, 2024); *In re Statewide Grand Jury #20*, No. SC19-240, 2019 WL 908518 (Fla. Feb. 25, 2019), https://efactssc-public.flcourts.org/casedocuments/2019/240/2019-240_disposition_145442_d04i.pdf (last visited March 21, 2024).

²⁵ Statewide Grand Jury # 20, *Third Interim Report of the Twentieth Statewide Grand Jury*, (Dec. 10, 2020), https://efactssc-public.flcourts.org/casedocuments/2019/240/2019-240_miscdoc_365089_e20.pdf (last visited March 21, 2024).

- The current mental health system is underfunded leading to an inability to diagnose and properly treat mental health problems;
- The system is too decentralized with national, state, and local entities providing parallel and duplicative resources with little to no coordination;
- Many of the entities involved work for different agencies with different goals; and
- DCF is not currently equipped or empowered to exercise the degree of leadership and control necessary to correct problems in the system.

To address such problems, the Grand Jury recommended the Legislature appoint a commission to specifically examine the provision of mental health services in the state.²⁶

- The Legislature should ensure that relevant stakeholders have an opportunity to participate in and provide knowledge to the commission.
- The commission should consider how to best provide and facilitate services in dual diagnosis cases.²⁷
- Additionally, the commission should be charged with structuring and staffing a permanent, agency-level entity to manage mental health, behavioral health, and substance abuse and addiction services throughout the state.²⁸
- Lastly, a cabinet-level agency should be created and funded to administer disparate sources of funding and services relating to the state’s mental health system.²⁹

Commission on Mental Health and Substance Use Disorder

In 2021, the Legislature created the Commission on Mental Health and Substance Use Disorder (Commission) to:³⁰

- Examine the current methods of providing mental health and substance use disorder services in the state;
- Improve the effectiveness of current practices, procedures, programs, and initiatives in providing such services;
- Identify barriers or deficiencies in the delivery of such services;
- Assess the adequacy of the current infrastructure of Florida’s 988 Suicide and Crisis Lifeline system and other components of the state’s crisis response services; and
- Recommend changes to existing laws, rules, and policies necessary to implement the Commission’s recommendations.

The Commission is required to submit annual interim reports by January 1 of each year through 2025 and a final report by September 1, 2026, on its findings and recommendations on how to best provide and facilitate mental health and substance use disorder services in the state. The reports must be submitted to the President of the Senate, the Speaker of the House of Representatives, and the Governor.³¹

The Commission’s January 1, 2024, annual interim report included 12 recommendations regarding four general areas: Strengthening Community Networks and Cross-Agency Collaboration, Enhancing the Crisis Care Continuum, Improving Data Collection and Management Processes, and

²⁶ Id. at p. 21

²⁷ The Grand Jury describes “dual diagnosis” cases as cases that lie at the nexus of mental health, substance abuse, and law enforcement interests.

²⁸ *Supra*, note 25 at p. 23.

²⁹ Id. at p. 24.

³⁰ S. 394.9086(2), F.S.

³¹ S. 394.9086(5), F.S.

To strengthen community networks and cross agency collaboration, the Commission recommended establishing regional collaboratives, lead by DCF and the Agency for Health Care Administration (AHCA), to address ongoing challenges at the local level and create opportunities to improve the accessibility, availability, and quality of behavioral health services in the state.³³

Effect of Bill - Coordinated System of Care

Office of Children's Behavioral Health Ombudsman

The bill creates the Office of Children's Behavioral Health Ombudsman (Office) within DCF for the purpose of being a central point to receive complaints on behalf of children and adolescents with behavioral health disorders receiving state-funded services and to use this information to improve the child and adolescent mental health treatment and support system. The bill requires the Office to:

- Receive and direct to the appropriate contact within the department, AHCA, or the appropriate organizations providing behavioral health services complaints from children and adolescents and their families about the mental health treatment and support system.
- Maintain records of complaints received and the actions taken.
- Be a resource to identify and explain relevant policies or procedures to children, adolescents and their families about the child and adolescent mental health treatment and support system.
- Provide recommendations to the department to address systemic problems within the mental health treatment and support system that are leading to complaints. The department shall include an analysis of complaints and these recommendations in the report required under s. 394.4573, F.S.
- Engage in functions that may improve the child and adolescent mental health treatment and support system.

DCF and managing entities must place contact information for the Office prominently on a webpage related to children's behavioral health services on their websites.

Behavioral Health Interagency Collaboration

To implement the recommendation of the Commission on Mental Health and Substance Use Disorder, bill creates the Behavioral Health Interagency Collaboration. The bill requires DCF and AHCA to work together to jointly establish regional behavioral health interagency collaboratives throughout the state. DCF is responsible for defining the region to be served by each collaborative and for facilitating meetings. The goal of the collaboratives are to identify and address ongoing challenges within the behavioral health system at the local level to improve the accessibility, availability, and quality of behavioral health services.

The regional collaborative membership shall, at a minimum, be composed of representatives from the following serving each region:

- Department of Children and Families;
- Agency for Health Care Administration;
- Agency for Persons with Disabilities;
- Department of Elder Affairs;
- Department of Health;

³² Commission on Mental Health and Substance Use Disorder Annual Interim Report, January 1, 2024, available at <https://www.myflfamilies.com/sites/default/files/2024-01/Commission%20on%20Mental%20Health%20Substance%20Abuse%20Interim%20Report%201.1.2024.pdf>, (last visited March 19, 2024).

³³ *Id.*, p. 29.

- Department of Education;
- School districts;
- Area Agencies on Aging;
- Community-based care lead agencies;
- Managing entities, as defined;
- Behavioral health services providers;
- Hospitals;
- Medicaid Managed Medical Assistance Plans;
- Police departments; and
- Sheriffs' Offices.

All entities represented on the regional collaboratives must provide assistance as appropriate and reasonably necessary to fulfill the goals of the regional collaboratives.

The Baker Act

The Florida Mental Health Act, commonly referred to as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.³⁴ 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.³⁵

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, and FY 2020-2021, across all age groups.³⁶

Patient Rights

Current Situation – Patient Rights

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.³⁷

Each patient entering treatment must be asked to give express and informed consent for admission or treatment.³⁸ If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment 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.³⁹ In situations where emergency medical treatment is needed and the patient or the patient's guardian or guardian advocate is unable to provide consent, the administrator of the facility may, upon the recommendation of the patient's

³⁴ The Baker Act is contained in Part I of ch. 394, F.S.

³⁵ S. 394.459, F.S.

³⁶ DCF, *Agency Bill Analysis*, (2023), on file with the House Children, Families, and Seniors Subcommittee.

³⁷ Ss. 394.459(3), and 394.459(5), F.S. Other patient 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 eligible; 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. 394.459(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.

³⁸ S. 394.459(3).

³⁹ S. 394.4784, F.S.

attending physician, authorize treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient.⁴⁰

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 the right not to communicate or visit with the person.⁴¹ If a facility restricts a patient's right to communicate or receive 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.⁴² A qualified professional⁴³ must document the restriction within 24 hours, and a record of the restriction and the reasons thereof must be recorded in the patient's clinical record. Under current law, a facility must review patient communication restrictions at least every three days.⁴⁴

Effect of Bill – Rights of Patients

If a facility restricts a patient's right to communicate, the bill requires a qualified professional to record the restriction and its underlying reasons in the patient's clinical file within 24 hours and to immediately serve the document of record to the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative.

Clinical Records

Current Situation – Clinical Records

Clinical records maintained by mental health facilities, which can include medical records, progress notes, charts and admission and discharge data, and all other information recorded by facility staff pertaining to the patient's hospitalization or treatment,⁴⁵ are confidential and exempt from public disclosure by law.⁴⁶ A patient's clinical records and other information may be released if authorized by the patient or the patient's guardian. The patient's guardian or guardian advocate must be provided access to the appropriate information and clinical records of the patient and may authorize the release of such information and records to the appropriate persons to ensure the continuity of the patient's health care or mental health care.⁴⁷ Current law does not grant a patient's legal custodian access to the patient's information and clinical records or permit the legal custodian to authorize the release of a patient's clinical records and information.

Effect of Bill – Clinical Records

The bill grants the patient's legal custodian access to the appropriate information and clinical records of the patient and allows the legal custodian to authorize the release of the patient's clinical records.⁴⁸ This provision ensures that a patient's legal custodian, like the Department of Juvenile Justice (DJJ), may authorize the release of the patient's clinical records to the appropriate persons to ensure the continuity of care of the patient's mental health care. For instance, when a child who is in the legal custody of DJJ is released to the department from a mental health facility, some facilities may not provide DJJ with the child's discharge paperwork. In this case, DJJ's healthcare practitioners would

⁴⁰ S. 394.459(3)(d), F.S.

⁴¹ S. 394.459(5)(c), F.S.

⁴² S. 394.459(5)(d), F.S.

⁴³ A qualified professional is a licensed physician or a physician assistant, a psychiatrist, a psychologist, or a psychiatric nurse. See s. 394.455(39), F.S.

⁴⁴ *Id.*

⁴⁵ S. 394.455(6), F.S.

⁴⁶ S. 394.4615, F.S.

⁴⁷ *Id.*

⁴⁸ Legal custody means the legal status created by a court which vests in a custodian of the person or guardian, whether an agency or an individual, the right to have physical custody of the child and the right and duty to protect, nurture, guide, and discipline the child and to provide him or her with food, shelter, education, and ordinary medical, dental, psychiatric, and psychological care. See s. 39.01, F.S.

have to contact the facility to get the information, or if the facility refused to release the information, the child's parent or guardian. If the child's parent or guardian is not responsive then DJJ would not have access to the child's discharge information for purposes of continuity of care.

Receiving Facilities and Involuntary Examination

Current Situation – Receiving Facilities

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.⁴⁹ 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.⁵⁰ 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.⁵¹ Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.⁵² Currently, there are 126 DCF designed receiving facilities.⁵³

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, 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.⁵⁴ 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).⁵⁵

⁴⁹ Ss. 394.4625 and 394.463, F.S.

⁵⁰ S. 394.455(40), F.S. This term does not include a county jail.

⁵¹ S. 394.455(38), F.S.

⁵² R. 65E-5.400(2), F.A.C.

⁵³ DCF, *Agency Bill Analysis*, (2023), on file with the House Children, Families, and Seniors Subcommittee.

⁵⁴ S. 394.875, F.S.

⁵⁵ DCF, *Agency Bill Analysis*, (2023), on file with the House Children, Families, and Seniors Subcommittee.

Current Situation - Transportation to a Receiving Facility

Each county is required to develop and implement a transportation plan in collaboration with the managing entities to transport individuals to designated receiving facilities for involuntary examination.⁵⁶ A county may enter into an agreement with the governing boards of nearby counties to establish a shared transportation plan. When multiple counties enter into an agreement for this purpose, the counties must notify the managing entity and provide the managing entity with a copy of the agreement.⁵⁷

The transportation plan must describe the methods of transportation to a designated receiving facility and may identify responsibility for other transportation to a participating facility when necessary and agreed to by the facility. The plan may rely on emergency medical transport services or private transport companies, as appropriate.⁵⁸

Each county is required to designate a single law enforcement agency within the county, or portions thereof, to take a person in need of services to a receiving facility for involuntary examination.⁵⁹ The designated law enforcement agency may decline to transport the person to a receiving facility only if:

- The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities at the sole cost of the county; and
- The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.⁶⁰

Current Situation – 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.⁶¹ 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 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.⁶²

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;⁶³ 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.⁶⁴

⁵⁶ S. 394.462, F.S.

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ S. 394.462(1)(a), F.S.

⁶⁰ S. 394.462(1)(b), F.S.

⁶¹ Ss. 394.4625 and 394.463, F.S.

⁶² S. 394.463(1), F.S.

⁶³ S. 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.

⁶⁴ S. 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.

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 the criteria by taking him or her into custody and delivering or having the person delivered to a receiving facility for examination.⁶⁵ When transporting, officers are currently required to restrain the person in the least restrictive manner available and appropriate under the circumstances.⁶⁶ The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record. 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 a 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.⁶⁷ During that 72 hours, an involuntary patient must be examined by a physician or a 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.⁶⁸ 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.⁶⁹

An involuntary examination may be performed if there is reason to believe that the person has a mental illness and because of his or her mental illness:

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

Within that 72-hour examination period, one of the following must happen:⁷⁰

- 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:⁷¹

⁶⁵ S. 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.

⁶⁶ *Id.*

⁶⁷ S. 394.463(2)(g), F.S.

⁶⁸ S. 394.463(2)(f), F.S.

⁶⁹ S. 394.463(2)(g), F.S.

⁷⁰ *Id.*

⁷¹ S. 394.463(2)(g)4., F.S.

- 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 a 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 a clinical psychologist are not possible until the next working day.

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.⁷²

Current Situation - Involuntary Examination of Minors

During fiscal year (FY) 2021-2022, 170,048 involuntary examinations were conducted for 115,239 individuals under the Baker Act;⁷³ of those examined, just over 36,000 were minors.⁷⁴ Individuals with multiple involuntary examinations accounted for a disproportionate number of examinations. Of the total involuntary examinations, 21.78 percent of individuals had two or more exams in FY 2021-2022. These individuals accounted for 46.99 percent of involuntary exams during the three-year period for FY 2019-2020 through FY 2021-2022.⁷⁵

Approximately one in five (21.23 percent) of children with an involuntary examination in FY 2021-2022 had two or more involuntary exams. These children accounted for 44.93 percent of the involuntary examinations for the year.⁷⁶ According to the annual Baker Act Report, 12.40 percent of Baker Act examinations for children were initiated while at school.⁷⁷

Current Situation – Involuntary Examination of an Arrested Person

When a law enforcement officer arrests a person for a felony and it appears that the person meets the criteria for involuntary examination or placement, the officer must first process the person in the same manner as any other criminal suspect, then immediately notify the appropriate receiving facility to

⁷² S. 394.463(2)(f), F.S.

⁷³ DCF, *The Baker Act Florida Mental Health Act Fiscal Year 2021-2022 Report*, available at <https://www.myflfamilies.com/sites/default/files/2023-07/FY%202021%202022%20Annual%20Report.pdf>, (last visited February 16, 2024).

⁷⁴ DCF, *Report on Involuntary Examination of Minors*, available at https://www.usf.edu/cbcs/baker-act/documents/ba_minors_report_nov2023.pdf, (last visited February 16, 2024).

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ DCF, *The Baker Act Florida Mental Health Act Fiscal Year 2021-2022 Report*, available at <https://www.myflfamilies.com/sites/default/files/2023-07/FY%202021%202022%20Annual%20Report.pdf>, (last visited February 16, 2024).

arrange for the examination and treatment of the individual.⁷⁸ If the receiving facility determines and documents that it is unable to provide adequate security for the person charged with a crime, the facility may refuse to admit the person. However, the facility must provide involuntary examination and treatment for the person where he is she is held.⁷⁹ Current law does not specify whether the facility may provide the examination and treatment via telehealth.

Current Situation - Baker Act Reporting Requirements

Designated Receiving and Treatment Facilities

Facilities designated as public receiving or treatment facilities are required to report the following data to DCF on an annual basis:⁸⁰

- Number of licensed beds;
- Number of contract days;
- Number of admissions by payor class and diagnoses;
- Number of bed days by payor class;
- Average length of stay by payor class; and
- Total revenues by payor class.

DCF must issue an annual report based on the data received from the facilities. The report must include individual facilities' data and statewide totals and be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Baker Act Report

DCF is required to receive and maintain copies of ex parte orders, involuntary orders issued under the Baker Act, professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients. These documents shall be used to prepare annual reports analyzing the data from the documents, without information identifying patients. Copies of the report must be provided to DCF, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives.⁸¹ Current law does not specify the information that must be included in the annual reports or provide a due date for the reports.

Report on Involuntary Examination of Minors

DCF is required to submit reports detailing findings on repeated involuntary Baker Act examinations of minors using data collected from receiving facilities and school districts.⁸² The reports must analyze data on both the initiation of involuntary examinations of children and the initiation of involuntary examinations of students who are removed from a school; identify any patterns 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.

Baker Act Reporting Center

⁷⁸ S. 394.462(1)(h), F.S.

⁷⁹ *Id.*

⁸⁰ S. 394.461(3), F.S.

⁸¹ S. 394.463(2)(e), F.S.

⁸² S. 394.463(4), F.S.

The Baker Act Reporting Center (BARC) is located within the Louis de la Parte Florida Mental Health Institute at the University of South Florida.⁸³ BARC is contracted by the agency to analyze Baker Act data and produce the statutorily mandated Baker Act reports. Specifically, BARC is responsible for producing the annual Baker Act report and the Report on Involuntary Examinations of Minors.

Effect of Bill – Involuntary Examination

The bill requires an involuntary examination to include, but not be limited to, consideration of a patient's treatment history at the facility and any information regarding the patient's condition and behavior provided by knowledgeable individuals.

The bill amends the involuntary examination criteria to require willing family members or friends offering help to a patient to also be able and responsible. The bill allows a person's repeated admittance for involuntary examination to be considered evidence that the person meets the criteria for involuntary examination if the person was admitted to the facility three or more times within the immediately preceding 12 months. The bill also prohibits an individual's basic needs being served while admitted to a facility from being considered as evidence that the patient meets the criteria for involuntary examination.

The bill authorizes, rather than requires as in current law, law enforcement officers to transport those who appear to meet Baker Act criteria to receiving facilities. This gives law enforcement officers the same discretion that courts and medical professionals have to initiate an involuntary examination. By removing the legal mandate to initiate an involuntary examination, there could be a reduction in involuntary examinations, especially in cases involving minors and schools. This may lead to greater use of alternatives to involuntary examinations, such as mobile response teams.

The bill also authorizes the receiving facility to provide examination and treatment via telehealth to a person arrested for a felony who appears to meet the criteria for involuntary examination and treatment if the facility determines and documents that it is unable to provide adequate security for the person at the facility.

Effect of Bill – Transportation to a Receiving Facility

When transporting a minor for involuntary examination, the bill requires law enforcement officers to provide the parent or legal guardian of the minor with the name, address, and contact information for the receiving facility to which the officer is transporting the minor to before departing, if the minor's parent or legal guardian is present, subject to any safety and welfare concerns for the minor.

The bill authorizes a county to include cost-sharing arrangements for transporting individuals to designated receiving facilities in the county's transportation plan. This will allow counties' to provide alternative transportation options to receiving facilities and share the cost with other entities.

Effect of Bill – Receiving Facilities

The bill:

- Specifies that the 72 hour Baker Act examination period begins when a patient arrives at the receiving facility.
- Prohibits a receiving facility from releasing a patient from involuntary examination outside of the facility's ordinary business hours if the 72 hour examination period ends on a weekend or holiday.

⁸³ The BARC is located within the Department of Mental Health Law & Policy, de la Parte Florida Mental Health Institute, College of Behavioral and Community Sciences at the University of South Florida. BARC, *College of Behavioral and Community Sciences*, available at <https://www.usf.edu/cbcs/baker-act/>, last visited February 15, 2024.

- Removes facility bed caps for CSUs. This change will allow receiving facilities to expand to meet the need created by population growth, receiving facility closures, and longer lengths of stay.

The bill requires the court to dismiss a petition for involuntary services if the petitioner fails to file the petition within the 72 hour Baker Act examination period.

Effect of Bill - Baker Act Reporting Requirements

Designated Receiving and Treatment Facilities

The bill requires DCF to publish the report on designated public receiving and treatment facilities' data on the department's website and removes the requirement to submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Baker Act Report

The bill requires DCF to provide the data collected and used to prepare the annual Baker Act reports to the Louis de la Parte Florida Mental Health Institute (Institute). The bill requires the Institute to use the data to prepare the annual Baker Act reports. The bill requires the annual reports to include, but need not be limited to, the following information:

- A state level analysis of involuntary examinations;
- A description of demographic characteristics of individuals and the geographic locations of involuntary examinations;
- Counts of the number of involuntary examinations at each receiving facility; and
- Reporting and analysis of trends for involuntary examinations within the state.

The report shall also include counts of and provide demographic, geographic, and other relevant information about individuals with a developmental disability or a traumatic brain injury or dementia who were taken to a receiving facility for involuntary examination pursuant to and determined not to have a co-occurring mental illness.

The bill requires the Institute to post the annual reports on its website and provide copies of the reports to DCF, the President of the Senate, and the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives by November 30 of each year.

Report on Involuntary Examination of Minors

The bill requires DCF to provide data collected by the agency on the initiation of involuntary examinations of children and students who are removed from a school. The bill also requires DCF to provide child welfare data related to involuntary examinations and the AHCA to provide Medicaid data related to the involuntary examination of children enrolled in Medicaid, to the Institute. The bill authorizes DCF and AHCA to enter into any necessary agreements with the Institute to provide the data. The bill requires the Institute to use the data to prepare reports analyzing the involuntary examination of minors.

The bill also requires the Institute to analyze service data collected on individuals who are high utilizers of crisis stabilization services provided in designated receiving facilities and identify patterns or trends and make recommendations to decrease avoidable admissions. The bill authorizes recommendations to be addressed in contracts with managing entities and in the contracts between AHCA for the Medicaid managed medical assistance plans. The Institute must publish the report on its website and submit the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, DCF, and AHCA.

Involuntary Services

Involuntary services are defined as court-ordered outpatient services or inpatient placement for mental health treatment.⁸⁴

Current Situation – Involuntary Outpatient Services

A circuit court or a criminal county court may order a person to involuntary outpatient services upon a finding of the court that by clear and convincing evidence, all of the following factors are met:⁸⁵

- 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 toward 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 he 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;⁸⁶
- 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.⁸⁷ The petition must allege and sustain each of the criteria for involuntary outpatient services and be accompanied by a certificate recommending involuntary outpatient services by a qualified professional and a proposed treatment plan.⁸⁸

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.⁸⁹ The petition must be based on the opinion of two professionals who have personally examined the individual within the preceding 72 hours.⁹⁰ 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.⁹¹

Current Situation – Involuntary Outpatient Services Hearing

⁸⁴ S. 394.455(23), F. S.

⁸⁵ S. 394.4655(2), F.S.

⁸⁶ This factor is evaluated based on the person's treatment history and current behavior.

⁸⁷ S. 394.4655(4)(a), F.S.

⁸⁸ S. 394.4655(4)(b), F.S.

⁸⁹ S. 394.4655(4)(c), F.S.

⁹⁰ S. 394.4655(3)(a)1., F.S.

⁹¹ *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.⁹² Under current law, the patient is entitled to a maximum four-week continuance, with the concurrence of the patient's counsel.⁹³ 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.⁹⁴ 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.⁹⁵ The court must appoint the public defender to represent the person who is the subject of the petition, unless that person is otherwise represented by counsel.⁹⁶

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.⁹⁷ If the court concludes that the patient meets the criteria for involuntary outpatient services, it must issue an order for those services.⁹⁸ 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.⁹⁹ The order of the court and the treatment plan are to be made part of the patient's clinical record.¹⁰⁰

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.¹⁰¹

Current Situation - Involuntary Inpatient Placement

A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:¹⁰²

- 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
 - 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 inappropriate.

⁹² S. 394.4655(7)(a)1., F.S.

⁹³ S. 394.4655(7)(a)1., F.S.

⁹⁴ S. 394.4655(7)(a)1, F.S.

⁹⁵ *Id.*

⁹⁶ S. 394.4655(5), F.S. This must be done within one court working day of filing of the petition.

⁹⁷ S. 394.4655(7)(d), F.S.

⁹⁸ S. 394.4655(7)(b)1., F.S.

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ S. 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.

¹⁰² S. 394.467(1), F.S.

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.¹⁰³ The petition must be based on the opinions of two professionals who have personally examined the individual within the past 72 hours.¹⁰⁴ 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.¹⁰⁵ 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.

Current Situation - Involuntary Inpatient Placement Hearing

The court proceedings for involuntary inpatient placement closely mirror those for involuntary outpatient services.¹⁰⁶ 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 filed, 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.¹⁰⁷ Presently, only the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.¹⁰⁸ 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 the patient's best interests, and the patient's counsel does not object.¹⁰⁹ Otherwise, the patient must be present.

Current law permits the court to appoint a magistrate to preside at the hearing, in general.¹¹⁰ 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.¹¹¹ 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.

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.¹¹² 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 facility¹¹³ for up to six months.¹¹⁴

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

¹⁰³ S. 394.467(2) and (3), F.S.

¹⁰⁴ S. 394.467(2), F.S.

¹⁰⁵ S. 394.467(3), F.S.

¹⁰⁶ See s. 394.467(6) and (7), F.S.

¹⁰⁷ S. 394.467(6), F.S.

¹⁰⁸ S. 394.467(5), F.S.

¹⁰⁹ S. 394.467(6), F.S.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² S. 394.467(6)(c), F.S.

¹¹³ 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.

¹¹⁴ S. 394.467(6)(b), F.S.

placement in a treatment facility.¹¹⁵ 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.¹¹⁶ 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.¹¹⁷

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 involuntarily committed to a state treatment facility.¹¹⁸ However, there is currently no prohibition against involuntarily committing individuals with developmental disabilities who also lack a co-occurring mental illness to these facilities.

Current Situation - 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 to determine whether a person should be involuntarily committed under the Baker or Marchman Act 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.

Current Situation - 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.¹¹⁹

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

Current Situation - Psychiatric Nurses Under the Baker Act

Psychiatric nurses are licensed as advanced practice registered nurses who have a master's or doctoral degree in psychiatric nursing, hold a national advanced practice certification as a psychiatric mental health advanced practice nurse, and have two years of post-master's clinical experience under the supervision of a physician.¹²⁰ The Board of Nursing within DOH oversees the licensure and regulation of advanced practice registered nurses.

Effect of Bill - Involuntary Outpatient Services and Inpatient Placement

The process and criteria for involuntary outpatient services and involuntary inpatient placement are very similar. The bill combines these statutes and creates an "Involuntary Services" statute to remove duplicative functions, simplify procedures and create a more streamlined and patient-tailored process

¹¹⁵ S. 394.461(2), F.S.

¹¹⁶ *Id.*

¹¹⁷ S. 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.

¹¹⁸ S. 394.467(6), F.S.

¹¹⁹ S. 394.468, F.S.

¹²⁰ Section 394.455, F.S.

for committing individuals to involuntary services. The new statute largely maintains current law for involuntary outpatient services and involuntary inpatient placement. However, the bill does make some substantive changes to the process, which are discussed below.

The bill 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.

The bill 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.

The bill 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. The bill also creates a single certificate for petitioning for involuntary services and requires the court order for both involuntary outpatient services and involuntary inpatient placement be included in the patient's clinical record.

The bill authorizes all county courts to order an individual to involuntary outpatient services. The bill also authorizes the court to retain jurisdiction of cases involving orders for involuntary outpatient services and parties for entry of further orders as circumstances require, including but not limited to, monitoring compliance with treatment or ordering inpatient treatment to stabilize a person who decompensates while under court-ordered outpatient treatment. The bill extends the maximum period a person may be ordered to involuntary outpatient services from 90 days to 6 months.

The bill replaces the term "treatment plan" with "services plan." This change helps ensure that the terminology aligns with the process. The bill authorizes a service provider to file a petition for involuntary services if the provider is treating the patient being petitioned. The bill also authorizes a treatment facility to petition for involuntary outpatient services for a patient in inpatient placement at the facility who meets the criteria for continued involuntary services. If a patient receiving involuntary outpatient services fails or refuses to comply with the court ordered services plan, the bill requires the service provider to report such noncompliance to the court. The bill requires a clinical psychologist or psychiatric nurse providing a second opinion to support a recommendation for involuntary outpatient services to have examined the patient within the preceding 30 days. The bill also requires the court to accept electronic signatures on petitions and other documentation attached to the petition.

The bill removes 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. This change will likely improve court efficiencies as hearings will not need to be delayed because a transfer evaluation is unavailable before the hearing. The bill codifies 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 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.

Effect of Bill - Involuntary Services Hearing

The bill 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 bill maintains the requirement that the patient's counsel have no objections for the waiver to take effect.

The bill requires the court to grant the patient and the state a request for a continuance of hearing for up to 7 calendar days and additional continuances for the patient for up to a total of 21 calendar days upon a showing of good cause and due diligence by the parties prior to requesting the continuance.

The bill allows the state attorney to have access to the patient's clinical records to litigate at the hearing. However, the bill requires that the records remain confidential and prohibits the use of the records for criminal investigation or prosecution purposes or any purpose other than civil commitment. Additionally, the bill requires the court to allow testimony deemed relevant from family members regarding the patient's prior history and how it relates to the patient's current condition and from other specified individuals, including medical professionals, which aligns this provision with the Marchman Act.

Effect of Bill - Remote Hearings

The bill allows the state attorney and witnesses to remotely attend the hearing, and as appropriate, testify under oath at a hearing via audio-video teleconference. The bill requires any witness appearing remotely to provide all parties with all relevant documents by the close of business the day prior to the hearing.

Effect of Bill - Discharge Planning

The bill amends the 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. The bill requires the facilities to 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.

During the discharge transition process, the bill requires the receiving facility to coordinate face-to-face or through electronic means, while in the presence of the patient, discharge plans to a less restrictive community behavioral health provider, a peer specialist, a case manager, or a care coordination service.

To further enhance the discharge planning process, the bill 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. The policies and procedures must include, at a minimum, a review of the effectiveness of previous discharge plans created by the facility for the patient, and the new discharge plan must address problems experienced with implementation of previous discharge plans. The bill also 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.

The bill requires receiving facilities to have a staff member engage a family member, legal guardian, legal representative, or a natural support of the patient's in discharge planning and meet with them face to face or through other electronic means to review the discharge plan. Further, the bill provides direction to initiate a referral to an appropriate provider to continue care for instances where certain levels of care are not immediately available at discharge.

Effect of Bill – Psychiatric Nurses Under the Baker Act

The bill requires psychiatric nurses working within receiving and treatment facilities to work within the framework of an established protocol with a psychiatrist when performing certain tasks under the Baker Act. Specifically, a psychiatric nurse must work within the framework of an established protocol with a psychiatrist when:

- Providing an opinion to a court on the competence of an individual, in a facility, to consent to treatment in a proceeding to appoint a guardian advocate;
- Documenting in the clinical records of a patient who was voluntarily admitted into a treatment facility that the patient is able to give express and informed consent for admission; and
- Providing a second opinion to support a recommendation that a patient receive involuntary services, after personally examining the patient to determine if he or she meets the criteria for such services.

Background Screening for Mental Health Care Personnel

Current Situation - Background Screening for Mental Health Care Personnel

Chapter 435, F.S., establishes standards 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 the Dru Sjodin National Sex Offender Public Website,¹²¹ and may include criminal records checks through local law enforcement agencies.¹²² 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.¹²³

Mental health personnel are required to complete 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.¹²⁴

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.¹²⁵ The appropriate regulatory board reviews the background screening results to determine if the applicant or licensee has any offenses that would disqualify him or her 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.

Effect of the Bill - Background Screening for Mental Health Care Personnel

The bill exempts physicians licensed under chapter 458 or 459 and nurses licensed under chapter 464 who were required to undergo background screening by the Department of Health as part of his or her initial licensure or licensure renewal, and who have an active and unencumbered license, from the background screening requirements for employment for mental health and substance use programs. Currently, these licensed medical professionals must undergo level 2 screening once for licensure and then again for employment purposes, which can cause delays for onboarding personnel. The bill will allow background screening for licensure of these medical professionals to satisfy employment screening when providing a service within their scope of practice.

The bill makes technical and conforming changes and updates cross references.

Voluntary Admissions of Minors

Current Situation – Voluntary Admission of Minors

¹²¹ 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 January 4, 2024).

¹²² S. 435.03(1), F.S.

¹²³ S. 435.04, F.S.

¹²⁴ S. 394.4572(1)(a), F.S.

¹²⁵ S. 456.0135, F.S.

An adult may apply for voluntary admission to a facility for observation, diagnosis, or treatment by giving express and informed consent.¹²⁶ The facility may admit the adult if it finds evidence of mental illness, the adult to be competent to provide express and informed consent, and the adult to be suitable for treatment. A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.¹²⁷ Additionally, a facility must discharge a patient within 24 hours if he or she is sufficiently improved such that admission is no longer appropriate, consent is revoked, or discharge is requested, unless the patient is qualified for and is transferred to involuntary status.¹²⁸

Under current law, a minor cannot be legally admitted to a facility for observation, diagnosis, or treatment on voluntary status unless the minor's parent or legal guardian applies for admission and a clinical review is conducted to verify the voluntariness of the minor's assent.

Unlike an adult, a minor lacks the capacity to consent to medical treatment unless the disability of nonage is removed,¹²⁹ but a minor may voluntarily assent to treatment. Assent recognizes that a minor might not, due to his or her developmental level, be capable of giving completely reasoned consent; however, a minor might be capable of having preferences and communicating them.¹³⁰ Assent also recognizes the importance of the involvement of a minor in the decision-making process, while also recognizing that a minor's level of participation is less than completely competent.¹³¹

Effect of the Bill – Voluntary Admission of Minors

The bill revises the voluntary admission requirements to require integrated children's crisis stabilization units/juvenile addictions receiving facilities to admit a minor on voluntary status if:

- There is evidence that the minor has mental illness and is suitable for treatment;
- The minor's parent or legal guardian provides expressed and informed consent; and
- The facility performs a clinical review to verify the voluntariness of the minor's assent.

This aligns the requirements for admission of minors to receiving and treatment facilities with the requirements of other facilities.

Substance Abuse

¹²⁶ S. 394.4625, F.S.

¹²⁷ S. 394.4625(1)(e), F.S.

¹²⁸ S. 394.4625(2), F.S.

¹²⁹ This disability of nonage is removed as a matter of law upon reaching the age of 18 (s. 74 3.07, F.S.), or upon marriage (s. 743.01, F.S.). See also, DCF, Minors, *Minority Defined*, available at <https://www.myflfamilies.com/sites/default/files/2022-11/Minors.pdf>, (last visited March 20, 2024). Also see Ch. 743, F.S., authorizes removal of nonage by circuit court proceeding for minors age 16 and over, and in other specified instances with and without a court order.

¹³⁰ American Academy of Child & Adolescent Psychiatry (AACAP), *Ethical Issues in Clinical Practice*, available at, https://www.aacap.org/AACAP/Member_Resources/Ethics/Ethics_Committee/Ethical_Issues_in_Clinical_Practice.aspx, (last visited March 20, 2024).

¹³¹ *Id.*

Approximately, 48.7 million people in the U.S. aged 12 and older had a substance use disorder (SUD) in 2022.¹³² It is estimated that 1.1 million Floridians have a substance use disorder.¹³³ Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.¹³⁴ Abuse can result when a person uses a substance¹³⁵ in a way that is not intended or recommended, or because of using more than prescribed. Drug abuse can cause individuals to experience one or more symptoms of another mental illness or even trigger new symptoms.¹³⁶ 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.¹³⁷

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.¹³⁸ Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs.¹³⁹ 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.¹⁴⁰ The most common substance use disorders in the U.S. are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.¹⁴¹

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 use of substances such as legal or illegal drugs, alcohol, or medications.¹⁴² SUDs may co-occur with other mental disorders.¹⁴³ Approximately 19.4 million adults in the U.S. have co-occurring disorders.¹⁴⁴ Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.¹⁴⁵

The Marchman Act

¹³² 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 January 5, 2024).

¹³³ Substance Abuse and Mental Health Administration, *Behavioral Health Barometer, Florida, Volume 6*, (2020), https://www.samhsa.gov/data/sites/default/files/reports/rpt32826/Florida-BH-Barometer_Volume6.pdf (last visited January 5, 2024).

¹³⁴ World Health Organization, *Substance Abuse*, <https://www.afro.who.int/health-topics/substance-abuse> (last visited January 5, 2024).

¹³⁵ 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.

¹³⁶ 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 January 5, 2024).

¹³⁷ National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction> (last visited January 5, 2024).

¹³⁸ Substance Abuse and Mental Health Services Administration, *Mental Health and Substance Use Disorders*, <http://www.samhsa.gov/disorders/substance-use> (last visited January 5, 2024).

¹³⁹ National Institute of Mental Health, *Substance Use and Co-Occurring Mental Disorders*, <https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health> (last visited January 5, 2024).

¹⁴⁰ National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction> (last visited January 5, 2024).

¹⁴¹ 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 January 5, 2024).

¹⁴² National Institute of Mental Health, *Substance Use and Co-Occurring Mental Disorders*, <https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health> (last visited January 5, 2024).

¹⁴³ *Id.*

¹⁴⁴ 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), <https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRRev010323.pdf>, (last visited January 5, 2024).

¹⁴⁵ *Id.*

In the early 1970s, the federal government furnished grants for states “to develop continuums of care for individuals and families affected by substance abuse.”¹⁴⁶ The grants provided separate funding streams and requirements for alcoholism and drug abuse.¹⁴⁷ In response, the Florida Legislature enacted ch. 396, F.S., (alcohol) and ch. 397, F.S. (drug abuse).¹⁴⁸ 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).¹⁴⁹ 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 voluntary¹⁵⁰ or involuntary admission.¹⁵¹ 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.¹⁵² However, denial of addiction is a prevalent symptom of a SUD, creating a barrier to timely intervention and effective treatment.¹⁵³ As a result, a third party must typically provide a person the intervention needed to receive SUD treatment.¹⁵⁴

Rights of Individuals

Current Situation – 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.¹⁵⁵ 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.¹⁵⁶

Effect of Bill – Rights of Individuals

The bill amends current law to require each individual receiving substance abuse services to be informed of his or her right to be represented by counsel in any judicial proceeding for involuntary substance abuse treatment services. This amendment makes it clear that the individual’s right to counsel applies to judicial proceedings, as opposed to any other proceedings, for involuntary substance abuse treatment services.

¹⁴⁶ 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 <http://fbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/> (last visited January 5, 2024).

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ 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.

¹⁵⁰ See s. 397.601, F.S.

¹⁵¹ See ss. 397.675 – 397.6978, F.S.

¹⁵² See s. 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.

¹⁵³ 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 January 5, 2024).

¹⁵⁴ *Id.*

¹⁵⁵ S. 397.501, F.S.

¹⁵⁶ *Id.*

Involuntary Admissions

Current Situation – Criteria for Involuntary Admission

There are five involuntary 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 when there is good faith reason to believe the individual is substance abuse impaired and, because of such impairment:¹⁵⁷

- Has lost the power of self-control with respect to substance use; 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 his or her 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, to be "impaired" or "substance abuse impaired," a person must have a condition involving the use of alcoholic beverages or any psychoactive¹⁵⁸ or mood-altering substance, in a way that induces mental, emotional, or physical problems and causes socially dysfunctional behavior.¹⁵⁹ While the term psychoactive substance often refers to illegal or illicit substances, psychoactive substances also include alcohol and prescription medication; however, under current law alcohol is the only psychoactive substance explicitly named in statute. Although having a substance use disorder often leads to being impaired or substance abuse impaired, it does not currently qualify as a predicate for involuntary admission under the Marchman Act.

Current Situation - 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 assist with conspiring to have a person involuntarily admitted without a reason to believe the person is actually impaired or to deny a person the right to treatment.¹⁶⁰

Effect of Bill – Criteria for Involuntary Admission

The bill includes having a substance use disorder or a condition involving the use of illicit or prescription drugs as a predicate for involuntary admission under the Marchman Act. This change reflects current DSM-5 criteria and takes into consideration the use of drugs other than alcohol by substance abuse impaired individuals.

This change will likely grant courts more latitude in who may be ordered for involuntary treatment due to the expansion of the criteria for involuntary admission under the Marchman Act.

¹⁵⁷ S. 397.675, F.S.

¹⁵⁸ A psychoactive substance is a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior. Examples of psychoactive substances include alcohol, caffeine, nicotine, marijuana, and certain pain medicines. Many illegal drugs, such as heroin, LSD, cocaine, and amphetamines are also psychoactive substances. See. National Cancer Institute, *Psychoactive Substance*, available at <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/psychoactive-substance>, (last visited March 26, 2024).

¹⁵⁹ S. 397.311, F.S.

¹⁶⁰ S. 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.

Effect of Bill - Unlawful Activities Relating to Assessment and Treatment

The bill amends s. 397.581, F.S., to make it unlawful for a person to *knowingly and willfully* (as opposed to just *willfully* under current law):

- Furnish false information for the purpose of obtaining emergency or other involuntary admission of another person;
- Cause or otherwise secure, or conspire with or assist another to cause or secure, any emergency or other involuntary procedure of another person under false pretenses; or
- Cause, or conspire with or assist another to cause, without lawful justification, the denial to any person of the right to involuntary procedures under chapter 397.

The bill expands the scope of law and makes it not only unlawful for an individual to knowingly and willfully provide false information, or to conspire or assist with conspiring, to obtain involuntary admission for his or herself, but also makes it unlawful for the individual to commit such acts against another person.

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.¹⁶¹
- **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.¹⁶²
- **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.¹⁶³

Current Situation - Court Involved Involuntary Admissions

General Provisions

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,¹⁶⁴ which provides for long-term court-ordered substance abuse treatment.

¹⁶¹ Ss. 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.

¹⁶² S. 397.679, F.S.

¹⁶³ S. 397.6798, F.S.

¹⁶⁴ The term "involuntary services" means "an array of behavioral health services that may be ordered by the court for a person with substance abuse impairment or co-occurring substance abuse impairment and mental health disorders." S. 397.311(23), F.S. SB 12 (2016), ch. 2016-241, Laws of Fla., renamed "involuntary treatment" as "involuntary services" in ss. 397.695 – 397.6987, F.S., however some sections of the Marchman Act continue to refer to "involuntary treatment." For consistency, this analysis will use the term involuntary services.

Both types of involuntary admissions involve filing a petition with the clerk of court in the county where the person is located.

Effect of Bill – Court Involved Involuntary Admissions

The bill revises language to specify that courts have jurisdiction over involuntary treatment petitions, rather than involuntary assessment and stabilization petitions.

Current Situation - 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.¹⁶⁵ Once the petition is filed, the court 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.¹⁶⁶ The court may appoint a magistrate to preside over all or part of the proceedings.¹⁶⁷

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.¹⁶⁸

If the court determines the respondent meets the criteria, it may order him or her to be admitted for a period of 5 days¹⁶⁹ to a hospital, licensed detoxification facility, or addictions receiving facility, for involuntary assessment and stabilization.¹⁷⁰ During that time, an assessment is completed on the individual.¹⁷¹ The written assessment is sent to the court. Once the written assessment is received, the court must either:¹⁷²

- 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.

Effect of the Bill - Involuntary Assessment and Stabilization

The bill repeals all provisions relating to court-ordered, involuntary assessments and stabilization under the Marchman Act and consolidates them into a new involuntary treatment process under ss. 397.6951-397.6975, F.S.

¹⁶⁵ S. 397.6951, F.S.

¹⁶⁶ S. 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.

¹⁶⁷ S. 397.681, F.S.

¹⁶⁸ S. 397.6818, F.S.

¹⁶⁹ If a licensed service provider is unable to complete the involuntary assessment and, if necessary, stabilization of an individual within 5 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 7 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 10 days in the absence of a court order to the contrary. S. 397.6821, F.S.

¹⁷⁰ S. 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.

¹⁷¹ S. 397.6819, F.S., The licensed service provider must assess the individual without unnecessary delay using a qualified professional. If an assessment is 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.

¹⁷² S. 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.

In light of this consolidation, the bill replaces the term “involuntary services” with “involuntary treatment services.” This term includes court-ordered involuntary assessment and stabilization.

Current Situation - Involuntary Services

Petition for 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.¹⁷³ Similar to a petition for involuntary assessment and stabilization, an initial 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.¹⁷⁴ Under current law, the petition must also 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.¹⁷⁵ Current law does not permit the court or clerk of court to waive or prohibit process service fees for indigent petitioners.

Hearing on Petition for Involuntary Services

A hearing on a petition for involuntary services must be held within five days unless a continuance is granted.¹⁷⁶ 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.¹⁷⁷ However, typically the clerk of court, 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.¹⁷⁸

In a hearing for involuntary services, the petitioner must prove by clear and convincing evidence that:¹⁷⁹

- The individual is substance abuse impaired and has a history of 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 poses 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.

¹⁷³ S. 397.693, F.S.

¹⁷⁴ S. 397.6951, F.S.

¹⁷⁵ S. 397.695(5), F.S.

¹⁷⁶ S. 397.6955, F.S.

¹⁷⁷ S. 397.6955(3), F.S.

¹⁷⁸ S. 397.6957(1), F.S.

¹⁷⁹ S. 397.6957(2), F.S.

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.¹⁸⁰

Order for Involuntary Services

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.¹⁸¹ If an individual continues to need involuntary services, at least 10 days before the 90-day period expires, the service provider can petition the court to extend services an additional 90 days.¹⁸² A hearing must be then held within 15 days.¹⁸³ Unless an extension is requested, the individual is automatically released after 90 days.¹⁸⁴ 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.¹⁸⁵ Current law does not permit courts to drug test respondents in Marchman Act cases.

Effect of the Bill - Involuntary Treatment Services

The bill amends the involuntary services criteria to allow the court to involuntarily admit an individual who *reasonably appears to meet*, rather than meets, the eligibility criteria and has previously been involved in at least one of the four other involuntary admissions procedures within a specified period. However, it amends the period for when the person has been assessed by a qualified professional to within the past 30 days, rather than five days.

The bill grants the court the authority to order a law enforcement officer or another designated agent of the court to take the respondent into custody and deliver him or her to either the nearest licensed service provider or a licensed service provider designated by the court for evaluation; and to serve the respondent with notice of hearing and a copy of the petition.

Petition for Involuntary Treatment Services

The bill allows a petition to be accompanied by a certificate or report of a qualified professional or licensed physician who has examined the respondent within 30 days before the petition was filed. The certificate must contain the professional's findings and, if the respondent refuses to submit to an examination, must document the refusal. The bill specifies that in the event of an emergency requiring an expedited hearing, the petition must contain documented reasons for expediting the hearing.

The bill requires the petitioner and the service provider to promptly inform the court that the respondent has been assessed so that the court can schedule a hearing as soon as is reasonable. The bill requires the service provider to serve the respondent, before his or her discharge, with the notice of hearing and

¹⁸⁰ S. 397.6957(4), F.S.

¹⁸¹ S. 397.697(1), F.S.

¹⁸² S. 397.6975, F.S.

¹⁸³ *Id.*

¹⁸⁴ S. 397.6977, F.S.

¹⁸⁵ If the respondent leaves treatment, the facility will notify the court and a status conference hearing maybe set. If the respondent does not appear at this hearing, a show cause hearing maybe set. If the respondent does not appear for the show cause hearing, the court may find the respondent in contempt of court.

a copy of the petition. If the respondent has not been assessed within 90 days, the bill requires the court to dismiss the case.

The bill expands who may file a petition to extend treatment to include the person who filed the petition for the initial treatment order if the petition includes supporting documentation from the service provider. The bill removes the current requirement that the petition be filed at least 10 days before the expiration of the current court-ordered treatment period. The bill also reduces the court's requirement for scheduling a hearing from 15 days to within 10 court working days of the petition to extend being filed.

Hearing on Petition for Involuntary Treatment Services

The bill amends the time period in which the court is required to schedule a hearing on the petition to within 10 court working days, rather than five, unless a continuance is granted. With the elimination of the separate involuntary assessment and stabilization procedures, this means the total time for when a court would have to hear a petition for involuntary assessment and stabilization (within 10 days) and a petition for involuntary services (within 5 days) has been reduced from 15 to 10 court working days under the consolidated procedure.

The bill specifies that the clerk, rather than the court, must issue the summons to the respondent and requires a law enforcement agency to effectuate service for the initial hearing, unless the court authorizes disinterested private process servers to serve parties. The bill authorizes the court to waive or prohibit service of process fees for respondents deemed indigent under current law.

The bill provides an exception to the requirement that a respondent be present at the hearing, allowing absence from the hearing if he or she knowingly, intelligently, and voluntarily waives the right to appear, or upon proof of service, the court finds that the respondent's presence is inconsistent with the respondent's best interest or will likely be harmful to the respondent. The bill also removes court's requirement to appoint a guardian advocate to appear on the respondent's behalf if the court finds that the respondent's presence at the hearing is likely to be harmful to him or herself.

To be consistent with the changes in the Baker Act, the bill allows for all witnesses to appear and testify remotely under oath at a hearing via audio-video teleconference. The bill further requires any witness appearing remotely to provide all parties with all relevant documents by the close of business the day prior to the hearing. The bill requires the court to hear and review all relevant evidence, including testimony from family members familiar with the respondent's history and how it relates to the respondent's current condition.

The bill provides that the court may 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. The bill requires any treatment order to include findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

Court Orders

Order for Involuntary Treatment Services

In light of the consolidation of the court involved involuntary admission procedures, the bill provides that, 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, the bill requires a service provider to 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.

Under the bill, if the ex parte order was 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 bill allows the court 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 either by the nearest appropriate licensed service provider or by a licensed service provider designated by the court; 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.

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

For cases resulting in an order for involuntary treatment services, the bill authorizes the court to retain jurisdiction over the case, including but not limited to, monitoring compliance with treatment, changing the treatment modality, or initiating contempt of court proceedings for violations of court orders. The bill authorizes hearings for involuntary services to be set by the motion of the parties or under the court's own authority. The motion of notice for such hearings must be served in accordance with relevant court procedural rules.

The bill permits the court to order drug tests for respondents in Marchman Act cases.

Order for Involuntary Assessment and Stabilization

The bill 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. The bill requires the court to inform the respondent of his or her right to an independent assessment.

An involuntary assessment order issued in accordance with the bill is valid for 90 days, and if the respondent is present or there is either proof of service or the respondent's whereabouts are known, the bill provides that 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. The bill mandates that the service provider serve the respondent, before his or her discharge, with the notice of hearing and a copy of the petition. The bill requires the assessment to occur before the new hearing date. However, 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. As stated above, the bill requires the court to dismiss the case if the respondent still has not been assessed after 90 days.

Assessments conducted by a qualified professional under the bill 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 assessment is conducted by someone other than a licensed physician, the bill requires review by a licensed physician within the 72-hour period.

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. The bill requires a service provider to provide copies of the motion to all parties in accordance with applicable confidentiality requirements. After the hearing, the bill permits the court to grant additional time or expedite the respondent's involuntary treatment hearing. However, the involuntary treatment hearing can only be expedited by agreement of the parties on the hearing date or if there is notice and proof of service. 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.

The bill 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. 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.

Discharge Planning

The bill requires the treatment facility to implement discharge planning and procedures for a respondent's release from involuntary treatment services. In alignment with the bill's new Baker Act

requirements, discharge planning and procedures must include and document the respondent's needs, and actions to address those needs, for, at a minimum:

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

Marchman Act Report

The bill requires the court to provide copies of involuntary treatment services orders to DCF and the Louis de la Parte Florida Mental Health Institute. The bill also requires the Institute to publish an annual Marchman Act report on its website and provide copies of the report to DCF, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each year.

The bill makes technical and conforming changes, including changing instances of 'treatment' or 'services' to 'treatment services' in reference to involuntary petitions and admissions under the Marchman Act. This change ensures consistency in usage of the terms.

Substance Abuse Treatment in Florida

In the state substance abuse treatment safety net. 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.¹⁸⁶

- **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 services¹⁸⁷ 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.

Current Situation - 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-30, F.A.C. Currently, there are over 2,800 DCF licensed substance abuse providers.¹⁸⁸ Licensed service components include a continuum of substance abuse prevention,¹⁸⁹ intervention,¹⁹⁰ and clinical treatment services, including, but not limited to:¹⁹¹

¹⁸⁶ Department of Children and Families, *Treatment for Substance Abuse*, <https://www.myflfamilies.com/services/samh/treatment>, (last visited January 5, 2024).

¹⁸⁷ *Id.* Research indicates 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.

¹⁸⁸ DCF, *Agency Bill Analysis*, (2023), on file with the House Children, Families, and Seniors Subcommittee.

¹⁸⁹ S. 397.311(26)(c), F.S. Prevention is a process involving strategies that are aimed at the individual, family, community, or substance and that preclude, forestall, or impede the development of substance use problems and promote responsible lifestyles.

¹⁹⁰ S. 397.311(26)(b), F.S. Intervention is structured services directed toward individuals or groups at risk of substance abuse and focused on reducing or impeding those factors associated with the onset or the early stages of substance abuse and related problems.

¹⁹¹ S. 397.311(26), F.S.

- 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.¹⁹² The licensed bed capacity is the total bed capacity,¹⁹³ 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.¹⁹⁴ Upon notification DCF must update the service provider's license to reflect the increased licensed bed capacity.¹⁹⁵

Effect of Bill - Licensed Bed Capacity for Substance Abuse Service Providers

The bill prohibits a service provider operating an addictions receiving facility or providing detoxification on a non-hospital inpatient basis from exceeding its licensed capacity by more than 10 percent. A service provider also may not exceed its licensed capacity for more than three consecutive working days or for more than 7 days in a month. This is similar to the requirements for crisis stabilization units under the Baker Act.

State Forensic System

Criminal Defendants and Competency to Stand Trial

The Due Process Clause of the 14th Amendment to the United State Constitution prohibits the states from trying and convicting criminal defendants who are incompetent to stand trial.¹⁹⁶ The 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.¹⁹⁷ 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 also must manifest appropriate courtroom behavior and be able to testify relevantly.¹⁹⁸

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.¹⁹⁹ If the

¹⁹² *Id.*

¹⁹³ 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 January 8, 2024).

¹⁹⁴ *Id.*

¹⁹⁵ 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 January 8, 2024).

¹⁹⁶ *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).

¹⁹⁷ *Id.* See also Rule 3.210(a)(1), Fla.R.Crim.P.

¹⁹⁸ *Id.* See also s. 916.12, 916.3012, and 985.19, F.S.

¹⁹⁹ Rule 3.210, Fla.R.Crim.P.

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.²⁰⁰ If the defendant is found to be mentally competent, the criminal proceeding resumes.²⁰¹ If the defendant is found to be mentally incompetent to proceed, the proceeding may not resume unless competency is restored.²⁰²

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 illness²⁰³ and offenders who are adjudicated not guilty by reason of insanity may be involuntarily committed to state civil²⁰⁴ and forensic²⁰⁵ treatment facilities by the circuit court.²⁰⁶ However, in lieu of such commitment, the offender may be released on conditional release²⁰⁷ by the circuit court if the person is not serving a prison sentence.²⁰⁸ The committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.²⁰⁹

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.²¹⁰

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.²¹¹ 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.²¹²

A court may only involuntarily commit a defendant adjudicated incompetent to proceed for treatment upon finding, based on clear and convincing evidence, that:²¹³

- The defendant has a mental illness and because of the mental illness:
 - The defendant is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, the defendant is likely to suffer from neglect or refuse to care for herself or

²⁰⁰ *Id.*

²⁰¹ Rule 3.212, Fla.R.Crim.P.

²⁰² *Id.*

²⁰³ "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.

²⁰⁴ 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.

²⁰⁵ S. 916.106(10), F.S.

²⁰⁶ S. 916.13, 916.15, and 916.302, F.S.

²⁰⁷ Conditional release is release into the community accompanied by outpatient care and treatment. Section 916.17, F.S.

²⁰⁸ S. 916.17(1), F.S.

²⁰⁹ S. 916.16(1), F.S.

²¹⁰ S. 916.106(4), F.S.

²¹¹ S. 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.

²¹² *Id.*

²¹³ S. 916.13(1), F.S.

- 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:²¹⁴

- 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.

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.²¹⁵ Those who are found to be non-restorable must be civilly committed or released.²¹⁶

Current Situation - 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.²¹⁷ 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 team²¹⁸ 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

²¹⁴ S. 916.13(2), F.S.

²¹⁵ S. 916.13(2)(b), F.S.

²¹⁶ *Mosher v. State*, 876 So.2d 1230 (Fla. 1st DCA 2004).

²¹⁷ 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 March 13, 2023).

²¹⁸ 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, 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 March 20, 2023).

examine suitability for involuntary placement is complete, the recovery team meets to consider the following:²¹⁹

- 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).

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.²²⁰

Current Situation - Competency Evaluation Report

Following the completion of the competency evaluation, the evaluator to examine suitability for involuntary placement, and consideration of restorability, the evaluator of competency must complete a competency evaluation report to the circuit court.²²¹ 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).²²² 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.²²³ 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 is believed to meet 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.

Currently, competency evaluation reports are not required to be sworn. However, these reports may be sworn upon request of the court.²²⁴

²¹⁹ *Id.*

²²⁰ Chapter 394, F.S., or *Mosherv. State*, 876 So. 2d 1230 (Fla. 1st DCA 2004).

²²¹ DCF's Operating Procedure 155-19, *Evaluation and Reporting of Competency to Proceed*, February 15, 2019, at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-19_evaluation_and_reporting_of_competency_to_proceed.pdf (last visited March 20, 2023).

²²² *Id.*

²²³ *Id.*

²²⁴ DCF, *Agency Bill Analysis HB 201 (2023)*, p.2 (on file with the Children Families, & Seniors Subcommittee).

Current Situation - 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.²²⁵

Effect of Bill - Involuntary Commitment of a Defendant Adjudicated Incompetent

Current law requires DCF to conduct a competency evaluation and submit a report to the circuit court, upon determination that a defendant will not, or is unlikely to, regain competency to proceed. The bill requires DCF to submit this report within 30 days of the determination. The bill also requires the report to be sworn and provided to counsel in addition to the court. Further, the bill establishes the minimum information that must be included in the competency evaluation report. The minimum reporting requirements are current DCF procedures which the bill codifies into law; except that the bill authorizes the defendant to be considered for involuntary services, rather than an involuntary examination.²²⁶ 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.

These provisions ensure that the appropriate report is submitted to the court to initiate the process of moving a forensic commitment to a civil commitment. They also ensure that all relevant information is received timely and that the court may respond to the information in a timely manner.

The bill authorizes a defendant, who meets the criteria for involuntary examination as determined by an independent clinical opinion, to appear remotely for the hearing. The bill also authorizes the remote appearance of witnesses.

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

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

²²⁵ S. 916.145, F.S.

²²⁶ *Id.*, note 26.

The bill has a significant fiscal impact to DCF, its contracted service providers, and the state court system as delineated below. The bill provides \$50,000,000 to DCF with the flexibility to fund the various provisions of the bill.

- 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 a resulting workload cost associated with these provisions.
- Involuntary Services - The bill provides judges with greater flexibility regarding the type of involuntary services to which to order a person, rather than being required to order the specific services for which the petition was filed or no services at all. This is likely to increase demand for involuntary outpatient services, as these services have lower utilization rates.
- Marchman Act Services - The bill makes it easier for family and friends of individuals with substance use disorder to successfully file pro se for Marchman Act services by streamlining the complicated two-petition process. This may result in increased demand for substance abuse treatment services as judges act on these petitions to order individuals into those services.
- 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 expected workload increase to the facilities to implement these provisions.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.