FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 1091	**COMPANION BILL:** SB 1240 (Calatayud)
TITLE: Substance Abuse and Mental Health Care	**LINKED BILLS:** None
SPONSOR(S): Gonzalez Pittman	**RELATED BILLS:** SB 1240 (Calatayud)

Committee References

Human Services
16 Y, 0 N, As CS

SUMMARY

Effect of the Bill:

CS/HB 1091 makes substantive changes regarding mental health and substance use. The bill recognizes Florida's 988 Suicide and Crisis Lifeline (988 Lifeline) as a component of the coordinated system of care and requires DCF to authorize and provide oversight of the 988 Lifeline call centers.

The bill establishes clear roles for the courts and administrative law judges regarding continued involuntary inpatient placement proceedings.

The bill expands the training requirements for forensic evaluators, requiring annual training and coverage of specified topics.

The bill requires clinical psychologists to have at least three years of clinical experience to authorize the transfer of a patient from voluntary to involuntary status.

Further, the bill authorizes DCF to issue licenses to medication-assisted treatment providers without conducting an annual needs assessment.

Fiscal or Economic Impact:

None

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

Florida's 988 Suicide and Crisis Lifeline and the Coordinated System of Care

The federal government established the 988 Suicide and Crisis Lifeline in 2022 with the intention of turning over its oversight and funding responsibilities to the states in 2026.

The Department of Children and Families (DCF) is the entity responsible for mental health and suicide prevention in Florida. The department also manages the state's 988 Suicide and Crisis Lifeline call centers. Florida's 988 Suicide and Crisis Lifeline call centers provide free behavioral health support service, available 24/7, that connects Floridians experiencing suicidal thoughts, substance use disorder, mental health crises, or any kind of emotional distress to a highly trained crisis counselor in their immediate area.[1] Although, DCF is the entity responsible

[1] DCF, *988 Florida Lifeline*, available at https://www.myflfamilies.com/988#:~:text=Managed%20by%20the%20Florida%20Department,to%20a%20highly%20trained%20crisis, (last visited March 14, 2025).

managing the state's 988 Suicide and Crisis Lifeline call centers, current law does not grant DCF oversight of these centers.

Crisis services provided by a crisis call center, such as Florida's 988 Suicide and Crisis Lifeline, are key components of a crisis response system because the call centers help ensure that an individual who is experiencing an acute mental health or emotional crisis has someone to talk to while in crisis. Current law does not recognize Florida's 988 Suicide and Crisis Lifeline as a crisis service or as a component of the coordinated system of care.

The bill recognizes the 988 Suicide and Crisis Lifeline as a crisis service and a component of the coordinated system of care. The bill also designates DCF as the state agency responsible for oversight of the 988 Suicide and Crisis Lifeline call centers and prohibits a call center from conducting crisis services unless authorized by DCF. The bill specifies that a 988 Suicide and Crisis Lifeline call center must meet national accreditation and be recognized by DCF to receive 988 calls, texts, or other forms of communication in the state. The bill authorizes DCF to adopt rules establishing the following:

- Standards for authorizing 988 Suicide and Crisis Lifeline call centers, including but not limited to, service delivery, quality of care and performance outcomes; quality assurance standards; and
- The adequacy and consistency of 988 call center's personnel certifications and minimum training standards.

The bill directs DCF to require authorized 988 Suicide and Crisis Lifeline call centers to implement a cohesive plan to achieve statewide interoperability with the 911 system . The bill also authorizes DCF to adopt rules relating to 988/911 interoperability. (Sections 1, 6, and 7)

Involuntary Outpatient Services

Pursuant to s. 394.4655, F.S., a court may order a person to involuntary outpatient services if the person meets the criteria for such services under s. 394.467, F.S.[2] Section 394.467, F.S., establishes the criteria, processes and procedures for ordering a person to involuntary services, which includes both involuntary outpatient services and involuntary inpatient placement.

The bill makes it clear in s. 394.4655, F.S., that the criteria for ordering a person to involuntary outpatient services, including, but not limited to, the requirements and processes for placement, recommendations for involuntary outpatient placement, petitions to the courts, appointment of counsel, and hearings on involuntary outpatient services are provided in s. 394.467, F.S. (Section 4)

Continued Involuntary Services

Petitions for continued involuntary services are either filed and heard in the appropriate county or circuit court or handled administratively by the Division of Administrative Hearings (DOAH). Hearings for petitions filed with the courts are presided over by a judge and hearings for petitions filed with DOAH are presided over by an administrative law judge. Current law addresses the roles and responsibilities of the courts when handling continued involuntary services proceedings, but is at times unclear on the role of the administrative law judge.

The bill makes clear the roles and responsibilities of the courts and the administrative law judges regarding hearings for continued involuntary services. The bill requires immediate scheduling of hearings and directs the clerk of DOAH, as applicable, to provide copies of the petition for continued involuntary services and the patient's individualized plan of continued services to DCF and other specified individuals. The bill also authorizes the administrative law judge to waive a patient's attendance at a hearing, if certain criteria are met, and to issue orders for continued involuntary services if it is determined that the patient meets the criteria for such services. (Section 5)

Voluntary Admissions and Transfer to Involuntary Status

[2] S. 394.4655, F.S.

Current law requires a clinical psychologist to have three years of postdoctoral experience in the practice of clinical psychology to authorize the transfer of a patient from voluntary to involuntary status. The three years of postdoctoral experience includes two years of postdoctoral experience acquired prior to licensure and one year of clinical experience acquired after licensure. The bill requires a clinical psychologist to have at least three years clinical experience, post licensure, to authorize the transfer of a patient from voluntary to involuntary status. (Section 3)

Forensic Evaluators

DCF is responsible for developing and contracting with accredited institutions to provide training for mental health professionals on the application of protocols and procedures for performing forensic evaluations and providing reports to the courts. Current law does not require the training to include information on statutory updates or updates to rules related to competency restoration, nor does it require the training to include information regarding industry best practices or alternative treatment and placement options. The bill requires the training to include, but not be limited to, information on the statutes and rules related to competency restoration, evidence-based practices, least restrictive treatment alternatives and placement options. (Section 10)

Current law requires forensic evaluators (experts) to complete forensic evaluator training. Forensic evaluators who complete training, and meet certain other requirements, are placed on a list of available experts, from which criminal courts may appoint experts to determine the competency of defendants in certain criminal cases. This list is maintained and updated by DCF and provided to the courts annually. Current law does not require forensic evaluators to complete continual training and education to remain on the list of experts that DCF provides to the court or to ensure that the experts remain up to date on the latest protocols, procedures and statutory changes regarding forensic evaluations.

The bill requires forensic evaluators to complete initial and annual forensic evaluator training provided by DCF. If the evaluator performs juvenile evaluations, the evaluator must annually complete juvenile forensic competency evaluation training. The bill also requires existing evaluators as of July 1, 2024, to complete DCF-provided continuing education training by July 1, 2026, to remain active on the list that DCF provides to the court. (Section 11)

Mental Competence Evaluation

A criminal defendant is considered incompetent to proceed if the defendant does not have sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding or the defendant has no rational, as well as factual, understanding of the proceedings.[3] If an expert finds that a defendant is incompetent to proceed, the expert must report to the court the recommended treatment for the defendant to attain competence to proceed and specify the availability of acceptable treatment, and whether treatment is available in the community.[4]

Current law does not establish criteria for determining the availability of acceptable treatments within the community for the defendant. When determining what acceptable treatments are available in the community, the bill requires experts to, at a minimum, use current information or resources on less restrictive treatment alternatives, as described in s. 916.12(4)(c), F.S., and those obtained from training and continuing education provided by DCF. The treatment alternatives described in s. 916.12(4)(c), F.S., include at a minimum, mental health services, treatment services, rehabilitative services, support services, and case management services, which may be provided by or within multidisciplinary community treatment teams, such as Florida Assertive Community Treatment, conditional release programs, outpatient services or intensive outpatient treatment programs, and supportive employment and supportive housing opportunities in treating and supporting the recovery of the patient. (Section 12)

[3] s. 916.12(1), F.S.
[4] *Id.*

Medication-Assisted Treatment

DCF is required to conduct an annual needs assessment to determine the need for additional medication-assisted treatment (MAT) services throughout the state. The required federal data used in the methodology for determining such need, is often outdated. Due to the lag in data, the annual needs assessments do not reflect the true need for MAT providers in Florida and has resulted in a lack of new applicants and MAT licenses issued by the department. Current law does not permit DCF to issue MAT licenses outside of the annual needs determination process, which creates a barrier to access to care and treatment for those with opioid use disorders. The bill removes the requirement for DCF to conduct an annual needs assessments before issuing a license to a MAT provider. (Section 8)

The bill makes technical changes and updates cross-references. (Sections 2, 9, 13, and 14)

The bill provides an effective date July 1, 2025. (Section 15)

RULEMAKING:

The bill authorizes the Department of Children and Families to adopt rules establishing the process and minimum standards for authorization of 988 Suicide and Crisis Lifeline call centers. The bill also authorizes DCF to adopt rules relating to the implementation of a statewide plan for 988 Suicide and Crisis Lifeline call centers to achieve interoperability with the 911 system.

Lawmaking is a legislative power; however, the Legislature may delegate a portion of such power to executive branch agencies to create rules that have the force of law. To exercise this delegated power, an agency must have a grant of rulemaking authority and a law to implement.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Mental Health System

Mental illness affects millions of people in the United States each year. It is estimated that more than one in five adults live with a mental illness.[5] In 2023, approximately 22.8 percent of adults experienced mental illness.[6]

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.[7] The implementation

[5] National Institute of Mental Health (NIH), *Mental Illness*, https://www.nimh.nih.gov/health/statistics/mental-illness (last visited March 6, 2025).
[6] Substance Abuse and Mental Health Services Administration (SAMHSA), *Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health* https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf, (last visited March 6, 2025).
[7] Ch. 2001-191, Laws of Fla.

of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[8] MEs were fully implemented statewide in 2013, serving all geographic regions.

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

Coordinated System of Care

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

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

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

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

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;

[8] Ch. 2008-243, Laws of Fla.
[9] DCF, *Managing Entities,* available at https://www.myflfamilies.com/services/samh/prov*Id*ers/managing-entities, (last visited February 23, 2025).
[10] S. 394.9082(5)(d), F.S.
[11] S. 394.4573(1)(c), F.S.
[12] S. 394.4573(3), F.S. The Legislature has not funded system improvement grants.
[13] *Id.*
[14] *Id.*
[15] S. 394.4573(2), F.S.
[16] S. 394.495(4), F.S.

- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

Crisis Response System

A crisis response system, which is a network of crisis services, processes and structures put in place to help those who are in crisis, is an essential element of a coordinated system of care. Crisis services are short-term evaluation, stabilization, and brief intervention services provided to a person experiencing an acute mental or emotional crisis or an acute substance abuse crisis to prevent further deterioration of the person's mental health.[17] Crisis services are provided in settings such as a crisis stabilization unit, an inpatient unit, a short-term residential treatment program, a detoxification facility or an addictions receiving facility, at the site of the crisis by a mobile response team, or at a hospital on an outpatient basis.[18]

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) identifies three components to an ideal crisis response system: someone to talk to, someone to respond, and somewhere to go. Florida has various crisis support services that address the different components. The 988 Suicide and Crisis Lifeline helps to ensure that an individual has someone to talk to. Mobile response teams respond to the crisis, and the centralized receiving facilities, crisis stabilization units, and hospitals provide some place to go.

As the single state authority for mental health and substance abuse, DCF administers the Statewide Office for Suicide Prevention and facilitates the development of strategies for preventing suicide. The agency also oversees and sets policy for mobile response team services, centralized receiving facilities, and crisis stabilization units, as well as other crisis services. Although, the 988 Suicide and Crisis Lifeline is an important component of the crisis response system, current law, does not recognize the 988 Suicide and Crisis Lifeline as a component of crisis services in Florida.

National 988 Suicide and Crisis Lifeline

The National Suicide Hotline Designation Act of 2020, designated 988 as the universal telephone number for the nation's suicide prevention and mental health crisis hotline.[19] This designation was made to simplify calling and to redirect mental health crises currently coming into the nation's 911 emergency system. The 988 dialing code became available nationally in July 2022.[20]

The 988 Suicide and Crisis Lifeline (988 Lifeline or Lifeline) connects callers who are in suicidal crisis or emotional distress to free and confidential emotional support.[21] The 988 Lifeline is composed of a national network of over 200 local, independent, and state-funded crisis centers. Vibrant Emotional Health (Vibrant) is the administrator of the service, which is funded by SAMHSA.[22]

Florida's 988 Suicide and Crisis Lifeline System

All 988 Lifelines nationwide must be fully accredited by Vibrant to take 988 calls, texts, or chats. In Florida, there are 12 active 988 Lifeline or local crisis call centers that are a part of the 988 network.[23] Ten of the state's 988

[17] S. 394.67, F.S.
[18] Id.
[19] National Suicide Hotline Designation Act of 2020 (Pub. L. No. 116-172).
[20] SAMHSA, *988 America's Suicide Prevention and Mental Health Crisis Lifeline,* at https://www.samhsa.gov/sites/default/files/988-factsheet.pdf (last visited February 24, 2023).
[21] 988 Suicide & Crisis Lifeline at https://988lifeline.org/about/ (last visited February 24, 2025). Also see DCF Office of SAMH, *Suicide Prevention Coordinating Council 2023 Annual Report,* available at https://www.myflfamilies.com/sites/default/files/2024-01/2023%20Suicide%20Prevention%20Coordinating%20Council%20Annual%20Report.pdf, (last visited February 24, 2025).
[22] 988 Suicide & Crisis Lifeline at https://988lifeline.org/about/ (last visited February 24, 2025).
[23] DCF, *Agency Bill Analysis HB 1901 (2025),* p. 2, on file with the House Health Services Subcommittee. Also, see DCF Office of SAMH, *Suicide Prevention Coordinating Council 2021 Annual Report,* available at https://www.myflfamilies.com/sites/default/files/2022-12/2021%20Suicide%20Prevention%20Coordinating_%20Council%20Annual%20Report%20-%20Final.pdf (last visited February 24, 2025).

Lifeline centers are affiliated with 2-1-1 United Way, while the other centers are housed in comprehensive non-profit or county mental health centers.[24]

Although, most of Florida's 988 call centers are also part of the 211 network, 988 and 211 provide very different services. Florida's 211 network is the state's single point of coordination for information and referral for health and human services.[25] The 211 network provides information and referral services that connect callers to a referral specialist who provides the caller with information on various services and programs.[26] An individual who contacts Florida's 988 Lifeline call center is connected with a highly trained crisis counselor who provides early intervention services to callers that are experiencing a suicidal crisis, mental health and/or substance abuse crisis, or emotional distress.

988/911 Interoperability

The implementation of the 988 Lifeline, brought awareness to the need for standardized interoperability practices between Public Service Answering Points (PSAP)[27]/Emergency Communications Centers (ECC) and the 988 Lifeline centers.[28] In January 2025, the National Emergency Number Association (NENA) released NENA Standards for 911/988 Interactions.[29] NENA is a non-profit professional organization that solely focuses on 911 operations, technology, education, and policy issues. The purpose of NENA is to ensure that 911 is able to meet the needs of those requesting emergency services, which includes establishing standards to make the 911 system work, providing training and best practices for 911 professionals, and educating the public and policymakers about 911 and its proper use.[30]

The NENA Standards for 911/988 Interactions[31] provide recommendations and best practices to help callers who are experiencing mental health crises.[32] They also provide standards and best practices for interoperability between 911/988 and outline operational and technical considerations for PSAPs and ECCs to establish an effective working relationship with the 988 community.

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.[33] The Baker 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.[34] The Baker Act also governs voluntary and involuntary admissions for mental health care, among other aspects of the state's mental health program.

Involuntary Examination

Individuals in an acute mental health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary

[24] Id.
[25] S. 408.918, F.S.
[26] DCF, *Agency Bill Analysis HB 1901 (2025),* p. 2, on file with the House Health Services Subcommittee.
[27] A PSAP is a call center where 911 calls are handled. Every 988 Lifeline call center in Florida has a least one formal agreement with a PSAP in their 988 catchment area. [27] DCF, *Agency Bill Analysis HB 1901 (2025),* p. 2, on file with the House Health Services Subcommittee.
[28] DOH, *Suicide Prevention Coordinating Council Annual Report 2023*, pg. 17, available at https://www.myflfamilies.com/sites/default/files/2024-01/2023%20Suicide%20Prevention%20Coordinating%20Council%20Annual%20Report.pdf, (last visited March 8, 2025).
[29] NENA The 9-1-1 Association, (January 31, 2025). *NENA Standard for 911/988 Interactions Now Available!* [Press Release], available at https://www.nena.org/news/692596/NENA-Standard-for-911988-Interactions-Now-Available.htm, (last visited March 14, 2025).
[30] NENA The 9-1-1 Association, *Who We Are*, available at https://www.nena.org/page/who-we-are, (last visited March 14, 2025).
[31] The NENA 911 Standards were developed over the course of four years through the collaboration and input of 108 contributors, including DCF's 988 Coordinator. DCF, *Agency Bill Analysis HB 1901 (2025),* p. 2, on file with the House Health Services Subcommittee.
[32] NENA Standards for 9-1-1/988 Interactions, NENA-STA-045.1-2025, available at https://cdn.ymaws.com/www.nena.org/resource/resmgr/standards/NENA-STA-045.1-202Y_911-988_.pdf, (last visited March 14, 2025).
[33] The Baker Act is contained in Part I of ch. 394, F.S.
[34] S. 394.459, F.S.

basis.[35] Certain courts or authorized individuals may initiate an involuntary examination if there is reason to believe that the person of concern has a mental illness and, because of that mental illness:

- Has refused voluntary examination;
- Is likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to that person's well-being, and
- Such harm is unavoidable through the help of willing, able, and responsible family members or friends, or will cause serious bodily harm to him or herself or others in the near future based on recent behavior.[36]

An involuntary examination may be initiated by:

- A circuit or county court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[37]
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;[38] 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.[39]

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 the patient.[40] 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 the facility, to determine if the criteria for involuntary services are met.[41] The 72-hour examination period begins when the patient arrives at the receiving facility. However, if the patient is a minor, a receiving facility must initiate the examination within 12 hours of arrival.[42]

Within the 72-hour examination period, one of the following must happen:[43]

- 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 services must be filed in a circuit or county court for involuntary outpatient or inpatient treatment.

Involuntary Services

Involuntary services are court-ordered inpatient and outpatient services for mental health treatment.[44] A court[45] may order a person to involuntary outpatient services, involuntary inpatient placement, or a combination of both

[35] Ss. 394.4625, F.S., and 394.463, F.S.
[36] S. 394.463(1), F.S.
[37] S. 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[38] 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. If transporting a minor and the parent or legal guardian of the minor is present, the law enforcement officer must provide the parent or legal guardian of the minor the name, address, and contact information of the receiving facility to which the minor is being transported.
[39] S. 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.
[40] S. 394.463(2)(g), F.S.
[41] S. 394.463(2)(f), F.S.
[42] S. 394.463(2)(g), F.S.
[43] *Id.*

types of involuntary services, based on the individual needs of the person, upon a finding of the court that by clear and convincing evidence, the person meets the criteria for the services ordered.[46]

A person ordered to involuntary services must meet the following criteria:[47]

- The person has a mental illness, and, because of that mental illness:
  - Is unlikely to participate in, and/or has refused, voluntary services for treatment, even after explanation of why the services are necessary, or is unable to determine for himself or herself whether services are necessary; and
    - Is unlikely to survive safely in the community without supervision, based on clinical determination;[48] or
    - Is incapable of surviving alone or with the help of willing, able, 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 without treatment is likely to suffer from neglect or refuse to care for himself or herself;[49] and
  - All available less restrictive treatment alternatives that would offer an opportunity for improvement of the person's condition have been deemed to be inappropriate or unavailable.

In addition to criteria above, a person ordered to involuntary outpatient services must also meet the following criteria:[50]

- Have a history of lack of compliance with treatment for mental illness;
- 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;[51] and
- Is likely to benefit from involuntary outpatient services.

Petition for Involuntary Services

A petition for involuntary services may be filed by either a facility administrator or a service provider who is treating the person. The petitioner must state the type of involuntary services (outpatient services, inpatient placement, or a combination of both) being recommended, the length of time recommended for each type of involuntary service, and the reasons for the recommendation.[52] The petition must be based on the opinions of two professionals who have personally examined the individual.[53] For recommendation to involuntary inpatient placement, the patient must have been examined within the preceding 72 hours.[54] For recommendations to involuntary outpatient services, the patient must have been examined within the preceding 30 days.[55]

A petition that includes a recommendation for a period of involuntary outpatient services must meet additional requirements. For such a petition, the petitioner must:

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[44] S. 394.455(23), F. S.
[45] S. 394.467(1)(a), F.S. defines the term "court" as a circuit court, or for commitments only to involuntary outpatient services, a county court.
[46] S. 394. 467(2) and (8)(a), F.S.
[47] S. 394.467(2)(a), F.S. and S. 394.467(2)(b), F.S.
[48] S. 394.467(2)(a), F.S.
[49] S. 394.467(2)(b), F.S.
[50] S. 394.467(2)(a), F.S.
[51] This factor is evaluated based on the person's treatment history and current behavior.
[52] S. 394.467(4)(a), F.S.
[53] S. 394.467(3), F.S.
[54] S. 394.467(3)(b), F.S.
[55] *Id.*

- Identity the service provider that has agreed to provide services for the person, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing; and[56]
- Prepare a written proposed services plan for the patient.[57] If a services plan is not available, the petitioner may not file the petition.

Regardless of the type of involuntary services being recommended, the administrator or service provider must file the petition in the appropriate court:

- A petition for involuntary inpatient placement, or inpatient placement followed by outpatient services must be filed in the court in the county where the patient is located.
- A petition for only involuntary outpatient services must be filed in the county where the patient is located, unless the patient is being held in a state treatment facility, in which case the petition must be filed in the county where the patient will reside.

Once the petition for involuntary services is filed, the court must hold a hearing within five business days, unless a continuance is granted.[58] If at the hearing the court concludes that the person meets the criteria for involuntary services, the court may order the person to involuntary inpatient placement, involuntary outpatient services, or a combination of involuntary services, for a period of up to six months.[59]

Continued Involuntary Services

If a patient continues to meet the criteria for involuntary services, a petition for continued involuntary services must be filed to extend treatment for the patient. The petition must be filed before the expiration of the initial order committing the patient to involuntary services.[60]

Petitions for Continued Involuntary Services

Petitions for continued involuntary outpatient services, and petitions for continued involuntary inpatient placement for patients being treated at a receiving facility, must be filed by the service provider or the administrator of the receiving facility, respectively, in the court that issued the initial order.[61] Petitions for continued involuntary inpatient placement for patients being treated at a state mental health treatment facility, must be filed with the Division of Administrative Hearings (DOAH), as proceedings regarding these petitions are handled administratively pursuant to s. 120.57(1), F.S.[62]

Hearings on Petitions for Continued Involuntary Services

Current law directs the court to immediately schedule a hearing, to be held within 15 days, after a petition for involuntary services is filed.[63] Current law defines "court" as a circuit or county court. This definition excludes DOAH, even though DOAH historically received petitions, scheduled and conducted hearings, and issued orders regarding petitions for continued involuntary services for patients who were being treated at a state mental health treatment facility.[64]

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[56] S. 394.467(4)(d)2, F.S.
[57] S. 394.467(4)(d)3, F.S. A services plan is an individualized plan detailing the recommended behavioral health services and supports based on a thorough assessment of the needs of the patient to safeguard and enhance the patient's health and well-being in the community. S. 394.467(1)(d), F.S. The proposed services plan must be prepared by the petitioner in consultation with the patient, or the patient's guardian advocate.
[58] S. 394.467(6), F.S.
[59] S. 394.467(8)(a), F.S.
[60] S. 394.467(11), F.S.
[61] S. 394.467(11(b), F.S.
[62] S. 394.467(11)(b)3., F.S., and s. 394.467(11), F.S.
[63] S. 394.467(11(b)4., F.S.
[64] S. 394.467(11)(b)3., F.S.

Hearings on petitions for continued involuntary outpatient services must be heard in the court that issued the initial order.[65] Hearings on petitions for continued involuntary inpatient placement for patients being treated at a receiving facility, and for patients ordered to involuntary outpatient services following involuntary inpatient placement, must be heard in the county or facility, as appropriate, where the patient is located.[66] If it is determined at the hearing that the patient continues to meet the criteria for involuntary services, the court may issue an order for continued involuntary outpatient services, involuntary inpatient placement, or a combination of involuntary services for up to six months.[67]

Hearings on petitions for continued involuntary inpatient placement for patients being treated at a state mental health treatment facility are administrative and are conducted by DOAH. If it is determined at the hearing that the patient continues to meet the criteria for involuntary services, current law states that the "court" may issue an order for continued involuntary services, as opposed to the administrative law judge presiding over the hearing.[68]

A patient is required to attend the hearing unless the patient's attendance at the hearing is waived. If the patient waives his or her attendance, the judge must determine that the patient knowingly, intelligently, and voluntarily waived his or her right to be present, before waiving the patient's presence at the hearing.[69] If at the hearing, the judge finds that the patient's attendance is not in the patient's best interest, the judge may also waive the patient's attendance.[70] Current law does not define "judge" or distinguish whether judge refers to a circuit or county judge or an administrative law judge.

Voluntary Admissions and Transfer to Involuntary Status

A Baker Act receiving facility may also admit any adult making application by expressed and informed consent for admission, or any minor for whom application is made by his or her parent or legal guardian.[71] If an adult is found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, he or she may be admitted to the facility. A minor may be admitted if the parent or legal guardian provide express and informed consent and the facility performs a clinical review to verify the voluntariness of the minor's assent.[72]

A facility must discharge a voluntary patient if the patient has sufficiently improved and retention of the facility is no longer needed, the patient is discharged to the care of a community facility, the patient revokes consent to admission or the patient, or an authorized person on behalf of the patient, requests discharge.[73]

When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, unless the request is freely and voluntarily rescinded, the request must be communicated to a physician, a clinical psychologist with at least three years of postdoctoral experience in the practice of clinical psychology, or a psychiatrist. If it is determined that the patient meets the criteria for involuntary placement, the administrator of the facility must petition the court to transfer the patient to involuntary status.[74]

Psychologists

A clinical psychologist is an individual who is licensed to practice psychology in Florida.[75] A psychologist may be licensed by examination or by endorsement.[76] To be licensed by examination an applicant must:

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[65] S. 394.467(11)(e), F.S.
[66] S. 394.467(11)(f), F.S.
[67] s. 394.467(11)(j), F.S.
[68] The court may issue an order for continued involuntary outpatient services, involuntary inpatient placement or a combination of involuntary services for up to six months. See s. 394.467(11)(j), F.S.
[69] S. 394.467(11)(i), F.S.
[70] *Id.*
[71] S. 394.4625(1), F.S.
[72] *Id.*
[73] S. 394.4625(2), F.S.
[74] S. 394.4625, F.S.
[75] S. 394.455(5), F.S.

- Hold a doctoral degree from a program accredited by the American Psychological Association;[77]
- Have at least two years or 4,000 hours of supervised experience in the field of psychology;
- Pass the Examination for Professional Practice in Psychology; and
- Pass an examination on Florida laws and rules.[78]

Applicants seeking licensure are titled a psychology resident or a postdoctoral fellow.[79] This title follows the applicant until licensure is acquired. A psychology resident or postdoctoral fellow is an individual who has met Florida's educational requirements for licensure and intends to meet the postdoctoral supervised experience requirement.[80] Each applicant for licensure must complete a total of two years or 4,000 hours of supervised experience. One year or 2,000 hours of the supervised experience may be satisfied through a doctoral level psychology internship. The second year or the remaining 2,000 hours must be completed as postdoctoral supervised experience, which is supervised experience acquired prior to licensure.

Current law only requires a clinical psychologist to have three years of postdoctoral experience in the practice of clinical psychology to authorize the transfer of a patient from voluntary to involuntary status. The three years of postdoctoral experience includes two years of postdoctoral experience acquired prior to licensure and one year of clinical experience acquired after licensure.

State Forensic System

Criminal Defendants and Competency to Stand Trial

The Due Process Clause of the 14th Amendment to the United States Constitution prohibits states from trying and convicting criminal defendants who are incompetent to stand trial.[81] 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.[82] 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.[83]

Involuntary Commitment of Defendant Adjudicated Incompetent

Chapter 916, F.S., governs the state forensic system, which is a network of state facilities and community services for persons who have mental health issues, an intellectual disability, or autism, and who are involved with the criminal justice system. Offenders who are charged with a felony and adjudicated incompetent to proceed due to mental illness[84] and offenders who are adjudicated not guilty by reason of insanity may be involuntarily committed to state civil[85] and forensic[86] treatment facilities by the circuit court,[87] or in lieu of such commitment, may be

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[76] Ss. 490.005, F.S., and 490.006, F.S.
[77] Alternatively, the applicant may have received the equivalent of a doctoral-level education from a program at a school or university located outside of the United States, which is officially recognized by the government of the country in which it is located as a program or institution to train students to practice professional psychology. The burden is on the applicant to establish that this requirement has been met.
[78] S. 490.005, F.S., and R. 64B19-11.001, F.A.C.
[79] R. 64B19-11.005, F.A.C.
[80] R. 64B19-11.005(1)(b), F.A.C.
[81] *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).
[82] *Id*. See also Rule 3.210(a)(1), Fla.R.Crim.P.
[83] *Id*. See also ss. 916.12, F.S., 916.3012, F.S., and s. 985.19, F.S.
[84] "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.
[85] A "civil facility" is a mental health facility established within 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

released on conditional release[88] by the circuit court if the person is not serving a prison sentence.[89] The committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.[90]

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.[91]

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.[92] 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.[93]

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.[94] If the motion is well-founded, the court will appoint experts to evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing.[95] If the defendant is found to be mentally competent, the criminal proceeding resumes.[96] If the defendant is found to be mentally incompetent to proceed, the proceeding may not resume unless competency is restored.[97]

Mental Competence Evaluation

A defendant is considered incompetent to proceed if the defendant does not have sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding or the defendant has no rational, as well as factual, understanding of the proceedings.[98]

Under current law, the court may appoint no more than three experts (forensic evaluators) to determine the mental condition of a defendant in a criminal case, including competency to proceed, insanity, involuntary placement, and treatment. The experts may evaluate the defendant in jail or in another appropriate local facility or in a facility of the Department of Corrections.[99] A defendant must be evaluated by at least two experts before the court commits the defendant or takes other action, except if one expert finds that the defendant is incompetent to

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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. S. 916.106(4), F.S. 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.

[86] S. 916.106(10), F.S.

[87] S. 916.13, 916.15, and s. 916.302, F.S.

[88] Conditional release is release into the community accompanied by outpatient care and treatment. S. 916.17, F.S.

[89] S. 916.17(1), F.S.

[90] S. 916.16(1), F.S.

[91] S. 916.106(4), F.S.

[92] 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.

[93] *Id*.

[94] Rule 3.210, Fla.R.Crim.P.

[95] *Id*.

[96] Rule 3.212, Fla.R.Crim.P.

[97] *Id*.

[98] s. 916.12(1), F.S.

[99] S. 916.115, F.S.

proceed and the parties stipulate to that finding.[100] The court may commit the defendant or take other action without further evaluation or hearing, or the court may appoint no more than two additional experts to evaluate the defendant. Notwithstanding any stipulation by the state and the defendant, the court may require a hearing with testimony from the expert or experts before ordering the commitment of a defendant.[101]

In considering the issue of competence to proceed, an examining expert must first consider and specifically include in the expert's report the defendant's capacity to:[102]

- Appreciate the charges or allegations against the defendant;
- Appreciate the range and nature of possible penalties, if applicable, that may be imposed in the proceedings against the defendant;
- Understand the adversarial nature of the legal process;
- Disclose to counsel facts pertinent to the proceedings at issue;
- Manifest appropriate courtroom behavior; and
- Testify relevantly.

In addition, an examining expert must consider and include in the expert's report any other factor deemed relevant by the expert. If an expert finds that the defendant is incompetent to proceed, the expert must report on any recommended treatment for the defendant to attain competence to proceed. In considering the issues relating to treatment, the examining expert must report on the following:[103]

- The mental illness causing the incompetence;
- The completion of a clinical assessment by approved mental health experts trained by the department to ensure safety of the patient and the community;
- The treatment or treatments appropriate for the mental illness of the defendant and an explanation of each of the possible treatment alternatives, including, at a minimum, mental health services, treatment services, rehabilitative services, support services, and case management, which may be provided by or within multidisciplinary community treatment teams, such as Florida Assertive Community Treatment, conditional release programs, outpatient services or intensive outpatient treatment programs, and supportive employment and supportive housing opportunities in treating and supporting the recovery of the patient;
- The availability of acceptable treatment and, if treatment is available in the community, the expert must so state in the report; and
- The likelihood of the defendant's attaining competence under the treatment recommended, an assessment of the probable duration of the treatment required to restore competence, and the probability that the defendant will attain competence to proceed in the foreseeable future.

The examining expert's report to the court must also include full and detailed explanations regarding why the alternative treatment options referenced in the evaluation are insufficient to meet the needs of the defendant.

Forensic Evaluator Training

To be appointed by the court, an expert must be a psychiatrist, licensed psychologist, or physician and have completed DCF-approved forensic evaluator training.[104] DCF is required to maintain and annually provide the courts with a list of available experts who have completed the required training.[105] Courts may appoint experts who are on the DCF provided list.

DCF is required to develop and contract with accredited institutions to provide:[106]

[100] S. 916.12(2), F.S.
[101] *Id.*
[102] S. 916.12(3), F.S.
[103] S. 916.12(4), F.S.
[104] S. 916.115(1)(a), F.S.
[105] S. 916.115(1)(b), F.S.
[106] S. 916.111(1), F.S.

- A plan for training mental health professionals to perform forensic evaluations and to standardize the criteria and procedures to be used in the evaluations;
- Clinical protocols and procedures based upon the criteria of Rules 3.210 and 3.216, Florida Rules of Criminal Procedure;
- Training for mental health professionals in the application of the protocols and procedures in performing forensic evaluations and providing reports to the courts; and
- To compile and maintain the necessary information for evaluating the success of the training program, including the number of persons trained, the cost of operating the program, and the effect on the quality of forensic evaluations as measured by appropriateness of admissions to state forensic facilities and to community-based care programs.[107]

Substance Use Disorder

A substance use disorder (SUD) is a complex medical condition in which there is an uncontrolled continued use of a substance or substances despite the harmful consequences and long-lasting changes to the brain.[108] A SUD is considered both a complex brain disorder and a mental illness. Approximately, 48.5 million people in the U.S. aged 12 and older had a substance use disorder (SUD) in 2023.[109] The most common substance use disorders in the U.S. are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[110]

Safety Net System

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. DCF provides substance abuse treatment through a community-based provider system that offers detoxification, treatment and recovery support for adolescents and adults affected by substance misuse, abuse or dependence:[111]

- **Detoxification Services:** Detoxification services use medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.[112]
- **Treatment Services:** Treatment services[113] 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.[114]
- **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.[115]

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[107] s. 916.111(2), F.S.
[108] American Psychiatric Association, *What is a Substance Use Disorder?*, available at https://www.psychiatry.org/patients-families/addiction-substance-use-disorders/what-is-a-substance-use-disorder, and Substance Use Disorder Defined by NIDA and SAMHSA, *What is Drug Addiction*, available at https://wyoleg.gov/InterimCommittee/2020/10-20201105Handoutfor6JtMHSACraig11.4.20.pdf, (last visited March 5, 2025).
[109] SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*, available https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf, (last visited on February 23, 2025).
[110] 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 February 23, 2025).
[111] Department of Children and Families, *Treatment for Substance Abuse* https://www.myflfamilies.com/services/samh/treatment, (last visited February 23, 2025).
[112] *Id.*
[113] *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 protection system, employment, increased earnings, and better health.
[114] Department of Children and Families, *Treatment for Substance Abuse* https://www.myflfamilies.com/services/samh/treatment, (last visited February 23, 2025).
[115] *Id.*

The Marchman Act

In the early 1970s, the federal government furnished grants for states "to develop continuums of care for individuals and families affected by substance abuse."[116] The grants provided separate funding streams and requirements for alcoholism and drug abuse.[117] In response, the Florida Legislature enacted ch. 396, F.S., (alcohol) and ch. 397, F.S. (drug abuse).[118] 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).[119] The Marchman Act supports substance abuse prevention and remediation through a system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

An individual may receive services under the Marchman Act through either voluntary[120] or involuntary admission.[121] 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.[122] However, denial of addiction is a prevalent symptom of a SUD, creating a barrier to timely intervention and effective treatment.[123] As a result, a third party must typically provide a person the intervention needed to receive SUD treatment.[124]

Opioid Use Disorder

An opioid use disorder is a chronic mental health condition characterized by the compulsive misuse of opioid drugs.[125] Opioids are a class of medications derived from the opium poppy plant or mimic its naturally occurring substances.[126] Opioids function by binding to specific receptors in the brain that are associated with pain sensation, resulting in pain relief.[127] The opioid family includes several drugs, such as oxycodone, fentanyl, morphine, codeine, and heroin.[128] These drugs are effective at reducing pain; however, they can be highly addictive even when prescribed by a doctor. Overtime, individuals who use opioids can develop a tolerance to the drug, a physical dependence on it, and ultimately, succumb to an opioid use disorder. This condition can have grave consequences, including a heightened risk of overdose and even death. Effective treatment of opioid use disorders includes the use of medication, counseling and behavioral therapy.[129]

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[116] 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://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited October 5, 2024).
[117] *Id.*
[118] *Id*.
[119] 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.
[120] *See* s. 397.601, F.S.
[121] *See* ss. 397.675, F.S. – 397.6977, F.S.
[122] *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.
[123] 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 March 6, 2025).
[124] *Id*.
[125] Cleveland Clinic, *Opioid Use Disorder*, available at https://my.clevelandclinic.org/health/diseases/24257-opioid-use-disorder-oud, and Yale Medicine, *Opioid Use Disorder,* available at https://www.yalemedicine.org/conditions/opioid-use-disorder, (last visited February 23, 2025).
[126] John Hopkins Medicine, *Opioids*, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/opioids (last visited February 23, 2025).
[127] *Id.*
[128] *Id.*
[129] Yale Medicine, *Opioid Use Disorder,* available at https://www.yalemedicine.org/conditions/opioid-use-disorder, (last visited February 23, 2025).

Medication-Assisted Treatment

Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to treat substance use disorders.[130] MAT helps treat opioid use disorders by helping to normalize brain chemistry, blocking the euphoric effects of opioids, and relieving physical cravings. There are three medications approved by the Federal Drug Administration to treat opioid use disorder: methadone, buprenorphine, and naltrexone.[131]

DCF is responsible for regulatory oversight and licensure of methadone MAT clinics in accordance with state and federal regulations. Under Florida law, DCF may not license any new MAT programs for opioid addiction unless it conducts a needs assessment to determine whether additional providers are needed.[132] DCF must annually perform the assessments using methodology based on federal data from the National Survey on Drug Use and Health.[133]

Once the assessment is complete, DCF must publish the results for the assessment in the Florida Administrative Register.[134] The publication must direct interested providers where to submit a letter of intent to apply for licensure to provide MAT services for opioid use disorders.[135] The letter of intent must identify the fiscal year of the needs assessment to which the interested provider is responding to and the number of awards the provider is applying for per county identified in the assessment.[136] If the number of letters of intent received is equal to or less than the determined need, interested parties are awarded the opportunity to proceed to apply for licensure.[137] Applications may not be rolled over for consideration in response to a needs assessment published in a different year and may only be submitted for a current fiscal year needs assessment.[138]

DCF's first cycle of needs assessment was published for fiscal year (FY) 2018-2019.[139] However, several of the federal data points that must be used in the methodology for determining need are not updated annually. Due to the lag in federal data updates, the needs assessments published since the 2018-2019 FY have been duplicative. Although, there is dire need of MAT providers throughout the state, the annual needs assessment does not reflective this need and has resulted in a lack of new applicants.[140] Current law does not permit DCF to issue MAT licenses outside of the annual needs determination process. This extends an already lengthy licensure process and creates a barrier to access to care and treatment for those with opioid use disorders.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Human Services Subcommittee	16 Y, 0 N, As CS	3/18/2025	Mitz	Curry

THE CHANGES ADOPTED BY THE COMMITTEE: Click or tap here to enter text.

[130] DCF, *Treatment for Substance* Abuse, available at https://www.myflfamilies.com/services/samh/treatment, (last visited March 5, 2025).
[131] Illinois Department of Public Health, *Medication-Assisted Treatment FAQ*, available at https://dph.illinois.gov/topics-services/opioids/treatment/mat-faq.html#:~:text=What%20Is%20Medication%2DAssisted%20Treatment,to%20treat%20substance%20use%20disorders., (last visited March 5, 2025).
[132] s. 397.427, F.S.
[133] The methodology used for the needs assessment is detailed in DCF's report on, *Methodology of Determination of Need Methadone Medication-Assisted Treatment*, CF-MH 4038, May 2019 [65D-30.0141, F.A.C.], available at https://www.myflfamilies.com/sites/default/files/2024-07/Attachment%202%20-%20Data%20Methodology.pdf, (last visited February 24, 2025).
[134] Rule 65D-30.0141, F.A.C. and s. 397.427, F.S.
[135] *Id.*
[136] *Id.*
[137] *Id.*
[138] *Id.*
[139] DCF, *Treatment for Substance Abuse*, available at https://www.myflfamilies.com/services/samh/treatment, (last visited March 6, 2025).
[140] *Id.*

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.
