Health Care Appropriations Subcommittee

Wednesday, January 24, 2024
1:30 PM - 3:30 PM
Morris Hall (17 HOB)

MEETING PACKET

Paul Renner
Speaker

Sam Garrison
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Care Appropriations Subcommittee

Start Date and Time: Wednesday, January 24, 2024 01:30 pm

End Date and Time: Wednesday, January 24, 2024 03:30 pm

Location: Morris Hall (17 HOB)

Duration: 2.00 hrs

Consideration of the following proposed committee bill(s):

PCB HCA 24-01 -- Medicaid Supplemental Payment Programs

Consideration of the following bill(s):

HB 63 Protection from Surgical Smoke by Woodson
HB 725 Veterans' Long-term Care Facilities Admissions by Woodson, Snyder
HB 7021 Mental Health and Substance Abuse by Children, Families & Seniors Subcommittee, Maney

Chair's Budget Proposal for FY 2024-2025

To submit an electronic appearance form, and for information about attending or testifying at a committee meeting, please see the "Visiting the House" tab at www.myfloridahouse.gov.

NOTICE FINALIZED on 01/22/2024 3:37PM by EHP

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCA 24-01 Medicaid Supplemental Payment Programs
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Smith	Clark

SUMMARY ANALYSIS

PCB HCA 24-01 conforms statute to funding decisions related to supplemental payment programs included in PCB APC 24-01, the House proposed General Appropriations Act for Fiscal Year 2024-2025.

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. Florida delivers medical assistance to most Medicaid recipients using a comprehensive managed care model, the Statewide Medicaid Managed Care program, to provide comprehensive, coordinated benefits coverage to the Medicaid population, leveraging economic incentives to ensure provider participation and quality performance.

Federal Medicaid managed care programs are required to use actuarily sound capitation rates which represent the entirety of the Medicaid expenditures for such services. However, federal law or Florida waiver approvals authorize certain exceptions, allowing additional Medicaid payments to take place outside the managed care relationship for some provider types. These arrangements are called supplemental payment programs. AHCA collects local intergovernmental transfers (IGTs) to fund the state share of the Medicaid match funds from counties, local health care taxing districts, and publicly operated providers. Governmental sources of IGTs sign pledge letters with AHCA specifying their contribution amount.

The bill makes, for certain hospital classes, participation in the Low Income Pool and Indirect Graduate Medical Education supplemental payment programs contingent on the hospital's participation in the Hospital Directed Payment Program. The bill also provides definitions for Hospital Directed Payment Program, Indirect Graduate Medical Program, and Low Income Pool Program.

The bill would have an indeterminate fiscal impact on local government and the private sector. *See* Fiscal Comments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Health, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services (HHS) to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Section 1115 of the Social Security Act allows states to implement demonstrations of innovative service delivery systems that improve care, increase efficiency, and reduce costs. These laws allow HHS to waive federal requirements to expand populations or services, or to try new ways of service delivery.

Florida operates under a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, known as the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program. Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program.[4]

The Florida Medicaid program covers approximately 4.9 million low-income individuals, including approximately 2.4 million, or 49.6%, of the children in Florida.[5] Medicaid is the second largest single program funded in the state, behind public education, representing approximately one-third of the total FY 2023-2024 state budget.[6] As of September 2023, Florida's program is the 4th largest in the nation by enrollment and, for FY 2021-2022, the program is the 5th largest in terms of expenditures.[7]

Florida delivers medical assistance to most Medicaid recipients – approximately 72% - using a comprehensive managed care model, the SMMC program.[8] The SMMC program was intended to

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] S. 409.964, F.S.
[5] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, December 2023, available at https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited January 17, 2024)..
[6] Chapter 2023-239, Laws of Fla.
[7] The Henry J. Kaiser Family Foundation, *State Health Facts, Total Medicaid Spending FY 2022 and Total Monthly Medicaid and CHIP Enrollment Sep. 2023*, available at http://kff.org/statedata/ (last visited January 17, 2024).
[8] *Supra*, note 6.

provide comprehensive, coordinated benefits coverage to the Medicaid population, leveraging economic incentives to ensure a level of provider participation and quality performance that was impossible under the former, federally prescribed, fee-for-service delivery model.

Supplemental Payment Programs

Federal Medicaid managed care programs are required to use actuarily sound capitation rates which represent the entirety of the Medicaid expenditures for such services. However, federal law or Florida waiver approvals authorize certain exceptions, allowing additional Medicaid payments to take place outside the managed care relationship for some provider types. These arrangements are called supplemental payment programs.

Florida currently has ten supplemental payment programs to fund payments to Medicaid providers that are in addition to reimbursement they receive for services rendered to Medicaid enrollees. They are either authorized by statute or by the General Appropriations Act and are approved by the federal government. Non-General Revenue sources are used for the state share of Medicaid funds, which is used to draw down the federal matching payment. However, some supplemental payments are funded through General Revenue.

Intergovernmental Transfers

Certain programs, including but not limited to the Statewide Medicaid Residency Program, the Graduate Medical Education Startup Bonus Program, the Disproportionate Share Hospital (DSH), and certain hospital reimbursement exemptions are funded through county and other local tax dollars that are transferred to the state and used to draw federal match. Local dollars transferred to the state and used in this way are known as "intergovernmental transfers" or IGTs. IGTs may be used to augment hospital payments in other ways, specifically through direct payment programs authorized by the federal Centers for Medicare and Medicaid Services (CMS) through waivers or state plan amendments. Examples include the Hospital Directed Payment Program (DPP) and Low Income Pool (LIP) programs. All IGTs are contingent upon the willingness of counties and other local taxing authorities to transfer funds to the state in order to draw down federal match. The local taxing authorities commit to sending these funds to the state in the form of an executed Letter of Agreement with the AHCA. In order for AHCA to make timely payments to hospitals, AHCA must know which local governments will be submitting IGTs and the amount of the funds prior to using the funds to draw the federal match. Current law requires local governments who will be submitting IGTs to submit to AHCA the final executed letter of agreement containing the total amount of the IGTs authorized by the entity, no later than October 1 of each year.[9] Funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency.[10]

Low Income Pool

The terms and conditions of CMS Florida Managed Medical Assistance Waiver Approval Document created a Low Income Pool (LIP) to be used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. This pool constituted a new method for such supplemental payments, different from the prior program called Upper Payment Limit. The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured.

Hospital Directed Payment Program

The Hospital Directed Payment Program (DPP) was authorized in the state fiscal year 2021-22 General Appropriations Act[11], and provides directed payment to hospitals in an amount up to the Medicaid

[9] S. 409.908(26), F.S.
[10] *Id.*
[11] Chapter 2021-36, Laws of Fla.

shortfall, or the difference between the cost of providing care to Medicaid-eligible patients and the payments received for those services.[12]

The payment arrangement directs payments within each Medicaid region, to all hospitals in each class by an equal percentage for hospital services provided by hospitals and paid by Medicaid health plans. The DPP operates regionally. Each region's DPP operates independent of other regions once certain conditions are met.[13]

Participating hospitals must meet the following three criteria:

1. Fall into one of the following three mutually exclusive provider classes:
   - private hospitals
   - public hospitals; or
   - cancer hospitals
2. Operate in one of Florida's 11 SMMC regions; and
3. Provide inpatient and outpatient hospital services to Florida Medicaid managed care enrollees.[14]

For a region to participate in the DPP, all hospitals in at least one of the classes (private, public, cancer hospitals) within that region must agree to participate and be subject to an assessment to fund the state share of the DPP.

The DPP funding is contingent on Local Provider Participation Funds and IGTs. Private hospitals in the State of Florida must be partnered with a governmental entity in order to participate in the DPP. The hospital DPP is a local option that allows local governments to establish a non-ad valorem (non-property tax) special assessment that is charged solely to hospitals.

Indirect Graduate Medical Education

The Indirect Graduate Medical Education (IME) program was authorized in the state fiscal year 2021-22 General Appropriations Act, for the purpose of supporting hospitals with residents in graduate medical education (GME) who are in training to become physicians.[15] IME covers ancillary costs associated with the educational process and the higher case-mix intensity of teaching hospitals with residency programs, that may result in higher patient care costs relative to non-teaching hospitals.[16]

An eligible teaching hospital must have a resident to bed ratio between 0.1% and 100% and meet the criteria for at least one of the following groups:[17]

- Academic Medical Centers Group 1(AMC 1)
  - Statutory teaching hospital with greater than 650 beds per license and
    - Greater than 500 FTEs, or
    - affiliated with the University of Florida Health.
- Public Teaching Hospitals
  - Public hospital with residents in an approved GME program and is not classified as a statutory teaching hospital.
- Academic Medical Centers Group 2(AMC 2)
  - Statutory teaching hospital with greater than 650 beds per license.
- Children's Teaching Hospitals
  - Children's hospital that is excluded from the Medicare prospective payment system, or
  - Reginal Perinatal Intensive Care Center that does not meet the eligibility qualifications of the AMC1, AMC2 or Public Teaching Hospital groups.

[12] Agency for Health Care Administration, Presentation to the House Health Care Appropriations Subcommittee, *Medicaid Reimbursement Rates and Supplemental Payment Programs, available at* https://ahca.myflorida.com/content/download/20776/file/House_HHS_Approps-Medicaid_Supplemental_Programs_Overview.pdf (last visited January 17, 2024).
[13] *Id.*
[14] *Id.*
[15] *Supra*, note 10
[16] Centers for Medicare and Medicaid Services, *Appendix F to Florida Title XIX Inpatient Hospital Reimbursement Plan*, May 4, 2023, On file with the House Healthcare Appropriations Subcommittee.
[17] *Id.*

- Statutory Teaching Hospitals
    - Statutory teaching hospital with at least 200 beds per license that does not meet the requirements of AMC1, AMC2, Public Teaching Hospitals, or Children's Teaching Hospital groups.

IME payment amounts are determined by a distribution model, by hospital grouping, calculated using the most recently filed and available Medicare Cost Report[18] extracted from the Healthcare Cost Report. Providers are reimbursed on a quarterly basis, based on the hospital's IME costs for services provided.[19]

Effect of the Bill

PCB HCA 24-01 amends s. 409.908, F.S., requiring a hospital's participation in DPP as a precondition to the hospital's participation in LIP or IME. The bill specifies that the term "hospital" is a health care institution as defined in s. 395.002(12), F.S.[20], but does not include cancer hospitals, public hospitals, Medical School Physician Practices, Federally Qualified Health Centers, Rural Health Clinics or Behavioral Health Providers.

The bill also amends s. 409.901, F.S., codifying into statute definitions for hospital directed payment, indirect graduate medical education, and low income pool programs.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 409.901, F.S., relating to definitions.
Section 2: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 3: Amends s. 409.910, F.S., to conform a cross-reference.
Section 4: 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:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[18] CMS Form 2552
[19] *Id.*
[20] "Hospital" means any establishment that:
(a) Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and
(b) Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent, except that a critical access hospital, as defined in s. 408.07, shall not be required to make available treatment facilities for surgery, obstetrical care, or similar services as long as it maintains its critical access hospital designation and shall be required to make such facilities available only if it ceases to be designated as a critical access hospital.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill would have an indeterminate fiscal impact on hospitals that currently participate in LIP and IME but choose not to participate in DPP. The bill's requirement of DPP participation as a precondition to LIP and IME participation would reduce revenue to hospitals related to LIP and IME supplemental payments, if those hospitals choose not to participate in DPP.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to Medicaid supplemental payment programs; amending s. 409.901, F.S.; providing definitions relating to certain Medicaid supplemental payment programs; amending s. 409.908, F.S.; providing requirements for hospital participation in certain Medicaid supplemental payment programs; providing a definition; amending s. 409.910, F.S.; conforming a cross-reference; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (12) and subsections (13) through (28) of section 409.901, Florida Statutes, are renumbered as subsection (14) and subsections (16) through (31), respectively, and new subsections (12), (13), and (15) are added to that section, to read:

409.901 Definitions; ss. 409.901-409.920.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(12) "Hospital directed payment program" means a supplemental payment program approved by the Centers for Medicare and Medicaid Services to provide directed payments to hospitals in an amount up to the total difference between Medicaid reimbursement and costs of care for Medicaid

recipients.

(13) "Indirect graduate medical education program" means a supplemental payment program approved by the Centers for Medicare and Medicaid Services to provide payments directly to eligible teaching hospitals based on the hospitals' indirect graduate medical education costs for services provided.

(15) "Low Income Pool Program" means a supplemental payment program approved by the Centers for Medicare and Medicaid Services to provide payments directly to hospitals and other health care providers to reimburse hospitals and providers for the costs of uncompensated charity care for low-income individuals.

Section 2. Subsection (27) is added to section 409.908, Florida Statutes, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost

report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid-eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(27) A hospital's participation in the Low Income Pool Program and indirect graduate medical education program, as defined in s. 409.901, is contingent on the hospital's participation in the hospital directed payment program, as defined in s. 409.901. As used in this subsection, the term "hospital" has the same meaning as in s. 395.002(12) but does not include a cancer hospital that meets the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v), a public hospital, a medical

school physician practice, a federally qualified health center, a rural health clinic, or a behavioral health provider.

Section 3. Paragraph (a) of subsection (20) of section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(20)(a) Entities providing health insurance as defined in s. 624.603, health maintenance organizations and prepaid health clinics as defined in chapter 641, and, on behalf of their clients, third-party administrators, pharmacy benefits managers, and any other third parties, as defined in s. 409.901 ~~s. 409.901(27)~~, which are legally responsible for payment of a claim for a health care item or service as a condition of doing business in the state or providing coverage to residents of this state, shall provide such records and information as are necessary to accomplish the purpose of this section, unless such requirement results in an unreasonable burden.

Section 4. This act shall take effect July 1, 2024.

HB 63

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 63 Protection from Surgical Smoke
SPONSOR(S): Woodson and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 410

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	14 Y, 0 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee		Smith	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Surgical smoke is the gaseous by-product produced when tissue is dissected or cauterized by heat generating devices such as lasers, electrosurgical units, ultrasonic devices, and high-speed burrs, drills and saws. Surgical smoke contains chemicals, blood and tissue particles, bacteria, and viruses, and has been proven to exhibit potential risks for surgeons, nurses, anesthesiologists, and technicians in the operating room due to long term exposure.

The bill requires hospitals and ambulatory surgical centers to adopt and implement policies by January 1, 2025, that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke. Smoke evacuation systems must effectively capture, filter, and eliminate surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room.

The bill has no fiscal impact on state or local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Surgical Smoke

Surgical smoke is the gaseous by-product produced when tissue is dissected or cauterized by heat generating devices such as lasers, electrosurgical units, ultrasonic devices, and high-speed burrs, drills and saws.[1] During a surgical procedure, the heat generated from one of these devices causes the target cell membranes to rupture, and subsequently generates and releases a plume of smoke into the operating room.[2] Surgical smoke contains chemicals, blood and tissue particles, bacteria, and viruses, and has been proven to exhibit potential risks for surgeons, nurses, anesthesiologists, and technicians in the operating room due to long term exposure.[3]

Potential known health effects from the exposure to surgical smoke include eye, nose, and throat irritation; headache; cough; nasal congestion; and asthma and asthma-like symptoms, but little is known about the health effects from chronic exposure to surgical smoke.[4] Other risks include the transmission of viruses through surgical smoke; for example, transmission of Human Papillomavirus (HPV) through surgical smoke from lasers has been documented,[5] and some researchers have suggested that surgical smoke may act as a vector for cancerous cells that may be inhaled.[6]

Surgical Smoke Evacuation Systems

Smoke evacuators are devices which contain a suction unit (i.e. a vacuum), filter, hose, and inlet nozzle. They are designed, as recommended by the Center for Disease Control, to capture air from where the nozzle is targeted and filter the air through a HEPA filter.[7] These systems may be stationary, with permanent construction requirements, or handheld portable systems with disposable filters, hand pieces, and hoses. While costs for these products range greatly, with installation of a stationary system costing as much as $120,000,[8] the more common handheld systems have recurring costs associated with disposable parts of roughly $19 per surgery, and total recurring costs including filter replacement between $8,000 and $10,000 annually depending on frequency of use.[9]

[1] Liu Y, Song Y, Hu X, Yan L, Zhu X. Awareness of surgical smoke hazards and enhancement of surgical smoke prevention among the gynecologists. Journal of Cancer (June 2, 2019) available at https://www.jcancer.org/v10p2788.htm (last visited January 21, 2024).
[2] *Id*.
[3] *Id*.
[4] Steege AL, Boiano JM, Sweeney MH. NIOSH health and safety practices survey of healthcare workers: training and awareness of employer safety procedures, American Journal of Industrial Medicine (February 18, 2014) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504242/ (last visited January 21, 2024).
[5] *Id.*
[6] United States Department of Labor, Occupational Safety and Health Administration, *Surgical Suite >> Smoke Plume*, available at https://www.osha.gov/etools/hospitals/surgical-suite/smoke-plume, (last visited January 21, 2024).
[7] Centers for Disease Control, *Control of Smoke from Laser/Electrical Surgical Procedures*, available at https://www.cdc.gov/niosh/docs/hazardcontrol/hc11.html (last visited January 21, 2024).
[8] Relias Media, *Consider Overall Cost, Ease when Choosing Evacuators,* available at https://www.reliasmedia.com/articles/61664-consider-overall-cost-ease-when-choosing-evacuators (last visited January 21, 2024).
[9] *See* Relias Media, *OR Teams Often Exposed to Toxic Chemicals in Surgical Smoke*, Mar. 1, 2021, available at https://www.reliasmedia.com/articles/147530-or-teams-often-exposed-to-toxic-chemicals-in-surgical-smoke#:~:text=The%20estimated%20cost%20of%20using,for%20the%20standard%20electrosurgical%20pencil. (last visited January 21, 2024), Ohio Legislative Service Commission, *SB 161 Fiscal Note & Local Impact Statement*, available at https://www.legislature.ohio.gov/download?key=17773&format=pdf (last visited January 21, 2024); Kreuger, Steven, et al., *The Effect of a Surgical Smoke Evacuation System on Surgical Site Infections of the Spine*, available at https://www.oatext.com/pdf/CMID-3-132.pdf (last visited January 21, 2024).

Surgical Smoke Regulation

Hospitals and ambulatory surgical centers (ASCs) must comply with the 2021 National Fire Protection Association (NFPA) 101 Life Safety Code.[10] The 2021 version does not require the use of surgical smoke evacuation systems, but the 2024 version does. However, in Florida, the 2021 version will be enforceable until 2027, when the State Fire Marshal adopts the 2024 version.[11] The 2024 version requires facilities to capture surgical smoke using either a dedicated exhaust system (may share an established system for waste gas removal), a connection and return or exhaust duct after air cleaning through high efficiency particulate air (HEPA) and gas phase filtration, or a point of use smoke evacuator for air cleaning and return to the space. As a result, Florida will have no regulatory requirement to use surgical smoke evacuation systems in hospitals and ASCs until 2027.

The Occupational Safety and Health Administration (OSHA) recognizes potential risk factors and remedial measures, but it has not adopted regulations on protection from surgical smoke. OSHA's recognized controls and work practices for surgical smoke include:[12]

- Using portable local smoke evacuators and room suction systems with in-line filters.
- Keeping the smoke evacuator or room suction hose nozzle inlet within two inches of the surgical site to effectively capture airborne contaminants.
- Having a smoke evacuator available for every operating room where plume is generated.
- Evacuating all smoke, no matter how much is generated.
- Keeping the smoke evacuator "ON" (activated) at all times when airborne particles are produced during all surgical or other procedures.
- Considering all tubing, filters, and absorbers as infectious waste and dispose of them appropriately.
- Using new tubing before each procedure and replace the smoke evacuator filter as recommended by the manufacturer.
- Inspecting smoke evacuator systems regularly to ensure proper functioning.

Additionally, the Joint Commission, an accrediting organization for hospitals and ASCs, recommends the following actions to protect patients and staff from the dangers of surgical smoke:

- Implement standard procedures for the removal of surgical smoke and plume through the use of engineering controls, such as smoke evacuators and high filtration masks.
- Use specific insufflators for patients undergoing laparoscopic procedures.
- During laser procedures, use standard precautions to prevent exposure to the aerosolized blood, blood by-products and pathogens contained in surgical smoke plumes.
- Establish, review, and make available policies and procedures for surgical smoke safety and control.
- Provide surgical team members with initial and ongoing education and competency verification on surgical smoke safety, including the organization's policies and procedures.
- Conduct periodic training exercises to assess surgical smoke precautions and consistent evacuation for the surgical suite or procedural area."[13]

As of August 2023, 11 states have adopted legislation to require the use of surgical smoke evacuation systems in certain health care facilities. Of those 11 states, 8 states require surgical smoke evacuation systems to be used in hospitals and ASCs for procedures that generate surgical smoke, and 3 states require them to be used in all health care facilities for procedures that produce surgical smoke.[14]

[10] Rule 69A-3.012, F.A.C., and s. 633.206(1)(b), F.S.
[11] S. 633.202(1), F.S., requires the State Fire Marshal to adopt a new version of the fire prevention code every third year. The 2021 version becomes effective December 31, 2024, so the 2024 version will not become effective until December 31, 2027.
[12] *Id.*
[13] The Joint Commission, *Quick Safety Issue 56: Alleviating the Dangers of Surgical Smoke*, available at https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-56/quick-safety-issue-56/ (last visited January 21, 2024).
[14] Staff of the Select Committee on Health Innovation conducted a 50-state analysis on laws relating to surgical smoke evacuation.

Effect of the Bill

The bill requires hospitals and ASCs to adopt and implement policies by January 1, 2025, that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke. Smoke evacuation systems must effectively capture, filter, and eliminate surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 395.1013, F.S., relating to smoke evacuation systems required.
Section 2: 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:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will have a negative fiscal impact on hospitals and ASCs who do not currently use surgical smoke evacuation systems during procedures that generate surgical smoke. Such hospitals and ASCs could incur costs of up to $10,000 per surgical suite annually.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None. The bill does not appear to affect local or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not necessitate rule-making for implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to protection from surgical smoke; creating s. 395.1013, F.S.; defining the terms "smoke evacuation system" and "surgical smoke"; requiring hospitals and ambulatory surgical centers to, by a specified date, adopt and implement policies requiring the use of smoke evacuation systems during certain surgical procedures; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.1013, Florida Statutes, is created to read:

395.1013 Smoke evacuation systems required.—

(1) As used in this section, the term:

(a) "Smoke evacuation system" means equipment that effectively captures, filters, and eliminates surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room.

(b) "Surgical smoke" means the gaseous byproduct produced by energy-generating devices such as lasers and electrosurgical devices. The term includes, but is not limited to, surgical plume, smoke plume, bio-aerosols, laser-generated airborne contaminants, and lung-damaging dust.

(2) By January 1, 2025, each licensed facility shall adopt

and implement policies that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke.

Section 2. This act shall take effect July 1, 2024.

HB 725

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 725 Veterans' Long-term Care Facilities Admissions
SPONSOR(S): Woodson, Snyder & others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Local Administration, Federal Affairs & Special Districts Subcommittee	15 Y, 0 N	Mwakyanjala	Darden
2) Health Care Appropriations Subcommittee		Aderibigbe	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida Department of Veterans' Affairs (FDVA) operates a network of nine veterans' homes and provides statewide outreach to connect veterans with services, benefits, and support. State veterans' home may be either nursing homes or domiciliary homes. Both veterans of wartime service and of peacetime service are eligible for admission.

The bill expands the eligibility for residency at a state veterans' home to include a spouse or surviving spouse of a qualifying veteran. The bill revises the priority of admittance to veterans' homes and places the spouse or surviving spouse of a veteran last in priority. These rankings preserve a higher priority of admittance to veterans over non-veterans.

The bill does not have a fiscal impact on state or local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Veterans' Services

Florida Department of Veterans' Affairs (FDVA)

FDVA is a nearly 1,500-member constitutionally chartered[1] department with a budget of $201 million for FY 2023-2024.[2] FDVA operates a network of nine state veterans' homes and provides statewide outreach to connect veterans with services, benefits, and support.[3] FDVA offers benefits and services in the fields of health care, mental health and substance abuse, claims support, education, employment, housing, burial benefits, and legal assistance.[4]

Health Care

The U.S. Department of Veterans' Affairs (VA) is principally responsible for the delivery of health care services to veterans.[5] Eligibility for hospital, nursing home, and domiciliary care depends on a number of factors. Veterans qualify for specified health care services depending on disability status, time of service, active duty status during service, toxic exposure during service, annual income, and need for support.[6]

Veterans Homes

Cost and Funding of Resident Care

A resident of a state veterans' home must contribute to the cost of his or her care if the resident receives a pension, compensation, gratuity from the federal government, or income from any other source of more than $160 per month.[7]

The average cost of care at a state veterans' nursing home in Florida is $394.15 a day.[8] The cost of care is funded through multiple sources, including from the resident. Costs charged to residents range from an average $98.63 a day for a resident with limited income to the average cost of $358.93 a day for a self-paying resident. If a resident veteran has a disability rating between 70 and 100 percent, the resident has no out-of-pocket cost.

In addition to the resident's portion of payment, a VA provides a reimbursement care subsidy based on a per diem rate.[9] The current VA per diem for basic care is set at $129.97 a day, while per diem for disabled veterans who are determined to be at least 70 percent disabled is set at $474.45 a day.[10] To qualify for reimbursement, federal law requires at least 75 percent of the population of the facility to be veterans. This threshold drops to 50 percent if the facility was constructed or renovated solely by the state. Federal law authorizes a state veterans' home to house non-veteran residents who

[1] Art. IV, s. 11, Fla. Const.
[2] Ch. 2023-239, Laws of Florida.
[3] Florida Dept. of Veterans Affairs, *Florida Department of Veterans' Affairs – Our Vision and Mission*, https://www.floridavets.org/leadership/ (last visited Jan. 21, 2024).
[4] Florida Department of Veterans Affairs, *Benefits & Services*, https://www.floridavets.org/benefits-services/ (last visited Jan. 21, 2024).
[5] Florida Dept. of Veterans Affairs, *Health Care*, https://www.floridavets.org/benefits-services/health-care/ (last visited Jan. 21, 2024).
[6] 38 U.S.C. s. 1710.
[7] S. 296.37(1), F.S. This contribution for care may be 100 percent of the cost if an otherwise eligible veteran is able to fund his or her own support. S. 296.37(2), F.S.
[8] Florida Dept. of Veterans' Affairs, *2023 Agency Legislative Bill Analysis*, *SB 174* (Nov. 7, 2023) (on file with the House Local Administration, Federal Affairs, & Special Districts Subcommittee).
[9] 38 CFR 51.210 (2023).
[10] *Supra* note 8.

are spouses of veterans or parents whose children died while in military service.[11] These residents are required to pay for the full cost of their care.

Eligibility for Admission

To be considered for admission to a veterans' home in Florida, a veteran must have been discharged from the military with either an honorable or an upgrade to an honorable discharge.[12]

The state provides care for veterans' in both domiciliary homes[13] and nursing facilities.[14] Both veterans of wartime and peacetime service are eligible for admission.[15] Veterans are admitted to both types of facilities based on a priority ranking.[16]

Domiciliary Homes

Domiciliary care which is defined as shelter, sustenance, and incidental medical care on an ambulatory self-care basis for eligible veterans who are disabled by age or disease, but not in need of hospitalization or nursing home care services.[17] A domiciliary home is a type of assisted living facility.[18]

To be eligible for admission, a veteran must:

- Have wartime service or peacetime service;
- Be a resident of the state at the time of application;
- Not be mentally ill, habitually inebriated, or addicted to drugs;
- Not owe money to FDVA for services rendered during a previous stay at a FDVA facility;
- Have applied for all financial assistance reasonably available through governmental sources; and
- Have been approved as eligible for care and treatment by the VA.[19]

Residents are admitted in order of priority as follows:

- A veteran with wartime service who has a service-connected disability but is not in need of hospitalization or nursing home care.
- A veteran with wartime service who has a non-service-connected disability but is not in need of hospitalization or nursing home care.
- A veteran with wartime service and no disability.
- A veteran with peacetime service.[20]

An applicant must file with the facility administrator all information necessary for admission, including a certificate of eligibility, a certified copy of the veteran's discharge, and any other information the administrator determines is necessary.[21]

Nursing Homes

In addition to assisted-living facilities, Florida law provides for veterans' nursing homes.[22] Each nursing home is overseen by an administrator who is selected by the Executive Director (director) of FDVA.[23]

[11] 38 CFR 51.210(d) (2023).
[12] Ss. 296.02(9) and 1.01(14), F.S.
[13] A Veterans' Domiciliary Home of Florida is a home for veterans established by the state. Ss. 296.02 (10), and 296.03, F.S.
[14] Ch. 296, F.S.
[15] Ss. 296.08 and 296.36, F.S. "Wartime service" is defined as is service in any of the following campaigns or expeditions: Spanish-American War (1898-1902); Mexican Border Period (1916-1917); World War I (1917-1918, with qualifying extensions until 1921); World War II (1941-1946); Korean War (1950-1955); Vietnam War, (1961-1975); Persian Gulf War (1990-1992); Operation Enduring Freedom (2001-date prescribed by presidential proclamation or by law); Operation Iraqi Freedom (2003-date prescribed by presidential proclamation or by law). Peacetime service is defined as any Army, Navy, Marines, Coast Guard, Air Force, or Space Force service that not in any of the campaigns or expeditions. S. 1.01(14), F.S.
[16] Ss. 296.08 and 296.36, F.S.
[17] S. 296.02(4), F.S.
[18] *See* Florida Dept. of Veterans Affairs, *State Veterans' Homes*, https://floridavets.org/locations/state-veterans-nursing-homes/ (last visited Jan. 21, 2024) (describing care provided by the Robert H. Jenkins Jr. Veterans' Domiciliary Home).
[19] S. 296.06(2), F.S.,
[20] S. 296.08, F.S.
[21] S. 296.08(2), F.S.
[22] Ch. 296, Part II, F.S.
[23] S. 296.34, F.S.

To be eligible for admission, a veteran must:

- Be in need of nursing care;
- Be a resident of the state at the time of application;
- Not owe money to the FDVA for services rendered during a previous stay at a FDVA facility;
- Have applied for all financial assistance reasonably available through governmental sources; and
- Have been approved as eligible for care and treatment by the VA.[24]

Eligible veterans are given priority for admission in the following order:

- Residents of the state.
- Those who have a service-connected disability as determined by the VA, or who were discharged or released from service for a disability incurred or aggravated in the line of duty and the disability is the condition for the nursing home need.
- Those who have a non-service-connected disability and are unable to defray the cost of nursing home care.[25]

Veterans Facilities in Florida

The FDVA currently operates nine state veterans' homes in the state: eight skilled nursing facilities and one assisted living facility. Nursing homes are located in Daytona Beach, Orlando, Land O'Lakes, Pembroke Pines, Panama City, Port Charlotte, Port St. Lucie and St. Augustine, Florida. [26] The assisted living facility is located in Lake City.

Effect of Proposed Changes

The bill expands the eligibility for residency at state veterans' homes to include the spouse or surviving spouse of a qualifying veteran. The bill updates the priority order of admission to reflect this change, placing the spouse or surviving spouse last in the admission priority list, ensuring that higher priority of admittance will be given to veterans over non-veterans.

The bill revises language relating to residents of state veterans' homes to reflect that such homes may have non-veteran residents.

B. SECTION DIRECTORY:

Section 1: Amends s. 296.02, F.S., revising definitions.
Section 2: Amends s. 296.03, F.S., revising eligibility for residency in the Veterans' Domiciliary Home of Florida.
Section 3: Amends s. 296.08, F.S., adding spouses and surviving spouses of veterans to the priority of admittance schedule.
Section 4: Amends s. 296.32, F.S, conforming provisions to changes made by the bill.
Section 5: Amends s. 296.33, F.S., revising the definition of the term "resident".
Section 6: Amends s. 296.36, F.S., revising the admission eligibility for veterans' nursing homes to include spouses and surviving spouses of veterans.
Section 7: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[24] S. 296.36(1), F.S.
[25] S. 296.36(3), F.S.
[26] Florida Dept. of Veterans Affairs, *State Veterans' Homes*, https://floridavets.org/locations/state-veterans-nursing-homes/ (last visited Jan. 21, 2024).

2. Expenditures:

The bill has no fiscal impact on state revenues or state expenditures, as a qualifying non-veteran resident will be charged the private resident rate, which is equivalent to the full cost of care and housing.[27]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill neither authorizes nor requires administrative rulemaking by executive branch agencies.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

None.

[27] *Supra* note 8

A bill to be entitled

An act relating to veterans' long-term care facilities admissions; amending s. 296.02, F.S.; revising definitions; amending s. 296.03, F.S.; revising eligibility for residency in the Veterans' Domiciliary Home of Florida to include specified individuals; amending s. 296.08, F.S.; adding such individuals to the priority of admittance schedule; amending s. 296.32, F.S.; conforming provisions to changes made by the act; amending s. 296.33, F.S.; revising the definition of the term "resident"; amending s. 296.36, F.S.; revising the admission eligibility for veterans' nursing homes to include specified persons; revising the priority of admittance to include such persons; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (1), (4), (8), and (10) of section 296.02, Florida Statutes, are amended to read:

296.02 Definitions.—For the purposes of this part, except where the context clearly indicates otherwise:

(1) "Applicant" means a veteran with wartime service or peacetime service, as defined in this section, or the spouse or surviving spouse of such veteran, who is not in need of

hospitalization or nursing home care.

(4) "Domiciliary care" means shelter, sustenance, and incidental medical care provided on an ambulatory self-care basis to assist eligible applicants ~~veterans~~ who are disabled by age or disease~~,~~ but who are not in need of hospitalization or nursing home care services.

(8) "Resident" means any eligible applicant ~~veteran~~ admitted to residency in the home.

(10) "Veterans' Domiciliary Home of Florida," hereinafter referred to as the "home," means a home established by the state for veterans who served in wartime service or in peacetime service, as defined in this section, or the spouses or surviving spouses of such veterans.

Section 2. Section 296.03, Florida Statutes, is amended to read:

296.03 Veterans' Domiciliary Home of Florida.—The Veterans' Domiciliary Home of Florida is for veterans who served in wartime service or peacetime service, as defined in s. 296.02, or the spouses or surviving spouses of such veterans, and is maintained for the use of those individuals ~~veterans~~ who are not in need of hospitalization or nursing home care and who can attend to their personal needs, dress themselves, and attend a general dining facility, or who are in need of extended congregate care.

Section 3. Paragraph (e) is added to subsection (1) of

section 296.08, Florida Statutes, to read:

296.08 Priority of admittance.—

(1) In determining the eligibility of applicants to the home, the administrator shall give admittance priority in accordance with the following schedule:

(e) The spouses or surviving spouses of veterans described in this subsection.

Section 4. Section 296.32, Florida Statutes, is amended to read:

296.32 Purpose.—The purpose of this part is to provide for the establishment of basic standards for the operation of veterans' nursing homes for eligible veterans and the spouses or surviving spouses of such veterans who are in need of such services.

Section 5. Subsection (5) of section 296.33, Florida Statutes, is amended to read:

296.33 Definitions.—As used in this part, the term:

(5) "Resident" means any eligible veteran, or the spouse or surviving spouse of such veteran, who is admitted to the home.

Section 6. Subsections (1) and (3) of section 296.36, Florida Statutes, are amended to read:

296.36 Eligibility and priority of admittance.—

(1) To be eligible for admittance to the home, the person must be a veteran as provided in s. 1.01(14) or have eligible

peacetime service as defined in s. 296.02, or be the spouse or surviving spouse of a veteran, and must:

(a) Be in need of nursing home care.

(b) Be a resident of the state at the time of application for admission to the home.

(c) Not owe money to the department for services rendered during any previous stay at a department facility.

(d) Have applied for all financial assistance reasonably available through governmental sources.

(e) Have been approved as eligible for care and treatment by the United States Department of Veterans Affairs.

(3) Admittance priority must be given to eligible persons ~~veterans~~ in the following order of priority:

(a) An eligible veteran who is a resident of the State of Florida.

(b) An eligible veteran who has a service-connected disability as determined by the United States Department of Veterans Affairs, or was discharged or released from military service for disability incurred or aggravated in the line of duty and the disability is the condition for which nursing home care is needed.

(c) An eligible veteran who has a non-service-connected disability and is unable to defray the expense of nursing home care and so states under oath before a notary public or other officer authorized to administer an oath.

(d) The spouse or surviving spouse of a veteran described in this subsection.

Section 7. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

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

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	18 Y, 0 N	Curry	Brazzell
1) Health Care Appropriations Subcommittee		Fontaine	Clark
2) Health & Human Services Committee			

SUMMARY ANALYSIS

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. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and drugs. In Florida, the Baker Act provides a legal procedure for voluntary and involuntary mental health examination and treatment. The Marchman Act addresses substance abuse through a comprehensive system of prevention, detoxification, and treatment services. The Department of Children and Families (DCF) is the single state authority for substance abuse and mental health treatment services in Florida.

The bill modifies the Baker Act and makes significant changes to the Marchman Act, the statutory processes for mental health and substance abuse examinations and treatment, respectively.

The bill amends the Baker Act in that it:

- Combines processes for courts to order individuals to involuntary outpatient services and involuntary inpatient placement in the Baker Act, to streamline the process for obtaining involuntary services, and providing more flexibility for courts to meet individuals' treatment needs.
- Grants law enforcement officers discretion on initiating involuntary examinations.

The bill amends the Marchman Act in that it:

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

The bill amends both acts in that it:

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

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED 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.

Current Situation - 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.iiab.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]

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. [19] 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. [20]

The Department of Children and Families (DCF) is responsible for the operation and administration of the Baker Act, including publishing an annual Baker Act report. According to the Fiscal Year (FY) 2021-2022 Baker Act annual report, over 170,000 individuals were involuntarily examined under the Baker Act; of those, just over 11,600 individuals were 65 years of age or older. This age group is the most likely to include individuals with Alzheimer's disease or related dementia. It is important to note the number of Baker Acts per year decreased during FY 2018-2019, FY 2019-2020, and FY 2020-2021, across all age groups.[21]

Rights of Patients

Current Situation

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.[22]

Each patient entering treatment must be asked to give express and informed consent for admission or treatment.[23] 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.[24] In situations where emergency medical treatment is needed and the patient or the patient's guardian or guardian advocate are unable to provide consent, the administrator of the facility may, upon the recommendation of the patient's

[16] S. 394.9082(3)(c), F.S.
[17] S. 394.9082(5)(b), F.S.
[18] S. 394.75(3), F.S.
[19] The Baker Act is contained in Part I of ch. 394, F.S.
[20] S. 394.459, F.S.
[21] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.
[22] 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.
[23] S. 394.459(3).
[24] 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.[25]

Currently, a facility must provide immediate patient access to a patient's family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney, unless such access would be detrimental to the patient or the patient exercises their right not to communicate or visit with the person.[26] 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.[27] A qualified professional[28] 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.[29]

Effect of Bill – Rights of Patients

The bill authorizes the facility administrator to authorize emergency medical treatment for a patient upon the recommendation of the patient's licensed medical practitioner.[30]

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.

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.[31] Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by Department of Children and Families (DCF) as a receiving facility.

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

Crisis Stabilization Units

[25] S. 394.459(3)(d), F.S.
[26] S. 394.459(5)(c), F.S.
[27] *S. 394.459(5)(d), F.S.*
[28] A qualified professional is a physician or a physician assistant, a psychiatrist licensed, a psychologist, or a psychiatric nurse. See s. 394.455(39), F.S.
[29] *Id*.
[30] The bill defines a "licensed medical practitioner" as a medical provider who is a physician licensed under chapters 458 or 459, an advanced practiced registered nurse, or a physician assistant who works under the supervision of a licensed physician and an established protocol pursuant to ss. 458.347, 458.348, 464.003, and 464.0123, F.S.
[31] Ss. 394.4625 and 394.463, F.S.
[32] S. 394.455(40), F.S. This term does not include a county jail.
[33] S. 394.455(38), F.S
[34] R. 65E-5.400(2), F.A.C.
[35] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.

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.[36] Individuals often enter the public mental health system through CSUs. Managing entities must follow current statutes and rules that require CSUs to be paid for bed availability rather than utilization.

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

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

Current Situation – Involuntary Examination

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

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[39] or
- A physician, clinical psychologist, psychiatric nurse, an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion.[40]

Unlike the discretion afforded courts and medical professionals, current law mandates that law enforcement officers must initiate an involuntary examination of a person who appears to meet the criteria by taking him or her into custody and delivering or having the person delivered to a receiving facility for examination.[41] When transporting, officers are currently required to restrain the person in the least restrictive manner available and appropriate under the circumstances.[42] The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record. The report must also include all emergency

[36] S. 394.875, F.S.
[37] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.

[38] S. 394.463(1), F.S.
[39] S. 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[40] S. 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.
[41] 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.
[42] *Id.*

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.[43] 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.[44] Current law does not indicate when the examination period begins for an involuntary patient. However, if the patient is a minor, a receiving facility must initiate the examination within 12 hours of arrival.[45]

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

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

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

- Intends to file a petition for involuntary services, the patient may be held at a receiving facility through the next working day and the petition for involuntary services must be filed no later than such date. If the receiving facility fails to file a petition at the close of the next working day, the patient must be released from the receiving facility upon documented approval from a psychiatrist or 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. [48]

Current Situation - Baker Act Reporting Requirements

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

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

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

Section 394.463(4), F.S., also requires DCF to submit reports detailing findings on repeated involuntary Baker Act examinations of minors using data submitted by receiving facilities.[50] DCF must analyze the 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.

Effect of Bill – Involuntary Examination

One of the criteria for involuntary examination requires that the person to be likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to their well-being and such harm is unavoidable through the help of "willing" family members or friends. The bill amends this criteria to add that such family members or friends being considered for offering help also be able and responsible.

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 removes the restriction prohibiting a psychiatric nurse from approving a patient's release from involuntary examination when the examination was initiated by a psychiatrist.

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.
- 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.

[49] S. 394.463(2)(e). F.S.
[50] S. 394.463(4), F.S.

Effect of Bill - Baker Act Reports

The bill amends the reporting requirements in s. 394.461, F.S., to require DCF to publish the report on designated public receiving and treatment facility data on the department's website.

The bill amends s. 394.463(2)(e), F.S., to require DCF to publish the annual reports analyzing ex parte, involuntary outpatient services, and involuntary inpatient placement orders, and the professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients on the agency's website by November 30 of each year and eliminates the current requirement for DCF to provide annual reports to the department itself.

The bill also amends s. 394.463(4), F.S., to requires DCF and the Agency for Health Care Administration 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 permits recommendations to be addressed in contracts with managing entities or with Medicaid managed medical assistance plans.

Involuntary Services

Involuntary services are defined as court-ordered outpatient services or inpatient placement for mental health treatment.[51]

Current Situation – Involuntary Outpatient Services

A person may be ordered to involuntary outpatient services upon a finding of the court that by clear and convincing evidence, all of the following factors are met:[52]

- 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;[53]
- 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. [54] The petition must allege and sustain each of the criterion for involuntary

[51] S. 394.455(23), F. S.
[52] S. 394.4655(2), F.S.
[53] This factor is evaluated based on the person's treatment history and current behavior.
[54] S. 394.4655(4)(a), F.S.

outpatient services and be accompanied by a certificate recommending involuntary outpatient services by a qualified professional and a proposed treatment plan.[55]

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.[56] The petition must be based on the opinion of two professionals who have personally examined the individual within the preceding 72 hours.[57] 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.[58]

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.[59] Under current law, the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[60] 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.[61] 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.[62] 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.[63]

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.[64] If the court concludes that the patient meets the criteria for involuntary outpatient services, it must issue an order for those services.[65] 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.[66] The order of the court and the treatment plan are to be made part of the patient's clinical record.[67]

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.[68]

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: [69]

- He or she is mentally ill and because of his or her mental illness:

[55] S. 394.4655(4)(b), F.S.
[56] S. 394.4655(4)(c), F.S.
[57] S. 394.4655(3)(a)1., F.S.
[58] *Id*.
[59] S. 394.4655(7)(a)1., F.S.
[60] S. 394.4655(7)(a)1., F.S.
[61] S. 394. 4655(7)(a)1, F.S.
[62] *Id*.
[63] S. 394.4655(5), F.S. This must be done within one court working day of filing of the petition.
[64] S. 394.4655(7)(d), F.S.
[65] S. 394.4655(7)(b)1., F.S.
[66] *Id*.
[67] *Id*.
[68] 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.
[69] S. 394.467(1), F.S.

    - 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.

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.[70] The petition must be based on the opinions of two professionals who have personally examined the individual within the past 72 hours.[71] 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.[72] 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.[73] 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.[74] Presently, only the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[75] Similar to the procedures for involuntary outpatient services, the court may waive a patient's presence from all or any portion of the hearing if it finds the patient's presence is not in their best interests, and the patient's counsel does not object.[76] Otherwise, the patient must be present.

Current law permits the court to appoint a magistrate to preside at the hearing, in general.[77] 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.[78] 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.[79]

---

[70] S. 394.467(2) and (3), F.S.
[71] S. 394.467(2), F.S.
[72] S. 394.467(3), F.S.
[73] *See* s. 394.467(6) and (7), F.S.
[74] S. 394.467(6), F.S.
[75] S. 394.467(5), F.S.
[76] S. 394.467(6), F.S.
[77] *Id*.
[78] *Id*.
[79] S. 394.467(6)(c), F.S.

If the court concludes that the patient meets the criteria for involuntary inpatient placement, it has discretion to issue an order for involuntary inpatient services at a receiving facility for up to 90 days or in a state treatment facility[80] for up to six months.[81]

Current law prohibits a state treatment facility from admitting a civil patient unless he or she has undergone a transfer evaluation, the process by which the patient is evaluated for appropriateness of placement in a treatment facility.[82] 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.[83] 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.[84]

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.[85] 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 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.[86]

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

Effect of Bill - Involuntary Services

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 to create a more streamlined and patient-tailored process

[80] 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.
[81] S. 394.467(6)(b), F.S.
[82] S. 394.461(2), F.S.
[83] *Id*.
[84] 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.
[85] S. 394.467(6), F.S.
[86] S. 394.468, 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. The bill requires a court order for both involuntary outpatient services and involuntary inpatient placement be included in the patient's clinical record.

The bill authorizes civil patients to be admitted to state treatment facilities without undergoing a transfer evaluation. This could result in a greater number of admissions to state treatment facilities. The bill also 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.

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

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 states that magistrates may preside over hearings for the petition for involuntary inpatient placement and ancillary proceedings. The bill also allows the state attorney to have access to records to litigate at the hearing. However, the bill requires that the records remain confidential and may not be used 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 their current condition and from other specified individuals, including medical professions, which aligns this provision with the Marchman Act.

Effect of Bill - Remote Hearing

The bill allows for all witnesses to appear and testify remotely under oath at a hearing via audio-video teleconference, upon a showing of good cause and if all parties consent. 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.

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, ongoing treatment and 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. More specifically, the bill requires the provider to develop and include in discharge paperwork a personalized crisis prevention plan for the patient that identifies stressors, early warning signs of symptoms, and strategies to manage crisis.

The bill requires receiving facilities to have a master's level or licensed professional staff engage a family member, legal guardian, legal representative, or a natural support in discharge planning and meet with them face to face or through other electronic means to review the discharge plan. Further, the bill provides direction to set up interim outpatient services to continue care for instances where certain levels of care are not immediately available at discharge.

Health Care Practitioners

Current Situation

Current law authorizes an advanced practice registered nurse (APRN) who meets certain criteria to engage in autonomous practice and primary care practice without a supervisory protocol or supervision by a physician.[87] Physician assistants (PAs) are authorized to practice under the supervision of a physician with whom they have a working relationship with and may perform medical services that are delegated to them that are within the supervising physician's scope of practice.[88]

Chapters 394 and 916, F.S., only authorize physicians to perform certain clinical services within mental health facilities and programs. Many of these services, often relating the physical health care needs of the patients receiving psychiatric care, can lawfully be performed by APRNs and PAs outside of mental health facilities and programs. Recent changes to chapters 458 and 464, F.S., have allowed these medical practitioners more flexibility to work within their full scope of practice. However, these changes have not been made to chapters 394 and 916, F.S., governing mental health services in the community and in the criminal justice system. This has resulted in unnecessary limits to the scope of practice for APRNs and PAs under these chapters.

Effect of Bill – Health Care Practitioners

The bill amends s. 394.455, F.S., to define the term "licensed medical practitioner" to mean a medical provider who is a physician licensed under chapters 458 or 459, an advanced practiced registered nurse, or a physician assistant who works under the supervision of a licensed physician and an established protocol pursuant to ss. 458.347, 458.348, 464.003, and 464.0123, F.S. This will allow additional licensed medical providers recognized by the DOH to provide clinical services within the current scope of practice for APRNs as defined in chapter 464, F.S. and PAs in accordance with s. 458.347, F.S.

[87] S. 464.0123, F.S.
[88] S. 458.347, F.S.

The bill makes necessary conforming changes in chapters 394 and 916 due to the statutory changes made by the bill.

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,[89] and may include criminal records checks through local law enforcement agencies.[90] 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.[91]

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.[92]

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.[93] The appropriate regulatory board reviews the background screening results to determine if the applicant or licensee has any offenses that would disqualify them from state licensure. A health care practitioner must also complete an additional level 2 background check as a condition of employment in mental health programs and facilities.

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

The bill exempts licensed physicians and nurses who undergo background screening at initial licensure and licensure renewal from the background screening requirements for employment for mental health and substance use programs when providing service within their scope of practice. 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.

Substance Abuse

Approximately, 48.7 million people in the U.S. aged 12 and older had a substance use disorder (SUD).[94] It is estimated that 1.1 million Floridians have a substance use disorder.[95] Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[96] Abuse can result when a person uses a substance[97] in a way that is not intended or recommended, or because they are using more than prescribed. Drug abuse can cause individuals to experience one or

[89] 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).
[90] S. 435.03(1), F.S.
[91] S. 435.04, F.S.
[92] S. 394.4572(1)(a), F.S.
[93] S. 456.0135, F.S.
[94] 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).
[95] 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).
[96] *World Health Organization, Substance Abuse*, https://www.afro.who.int/health-topics/substance-abuse (last visited January 5, 2024).
[97] 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.

more symptoms of another mental illness or even trigger new symptoms.[98] 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.[99]

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.[100] Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs.[101] 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.[102] The most common substance use disorders in the U.S. are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[103]

According to the National Institute on Mental Health, a SUD is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications.[104] SUDs may co-occur with other mental disorders.[105] Approximately 19.4 million adults in the U.S. have co-occurring disorders.[106] 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.[107]

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."[108] The grants provided separate funding streams and requirements for alcoholism and drug abuse.[109] In response, the Florida Legislature enacted ch. 396, F.S., (alcohol) and ch. 397, F.S. (drug abuse).[110] 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).[111] 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.

---

[98] 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).
[99] 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).
[100] 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).
[101] 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).
[102] 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).
[103] 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).
[104] 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).
[105] *Id*.
[106] 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/rpt39443/2021NSDUHFFRRev010323.pdf, (last visited January 5, 2024).
[107] *Id*.
[108] 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 January 5, 2024).
[109] *Id*.
[110] *Id*.
[111] 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.

An individual may receive services under the Marchman Act through either voluntary[112] or involuntary admission.[113] 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.[114] However, denial of addiction is a prevalent symptom of a SUD, creating a barrier to timely intervention and effective treatment.[115] As a result, a third party must typically provide a person the intervention needed to receive SUD treatment.[116]

Rights of Individuals

Current Situation

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.[117] 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.[118]

Effect of Bill – Rights of Individuals

The bill amends s. 397.501, F.S., to require each individual receiving substance abuse services to be informed that the individual has the right to be represented by counsel in any judicial proceeding for involuntary substance abuse treatment.

Involuntary Admissions

Current Situation - Definitions

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: [119]

- 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 their well-being and such harm is unavoidable through help of willing family members or friends; or

[112] *See* s. 397.601, F.S.
[113] *See* ss. 397.675 – 397.6978, F.S.
[114] *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.
[115] 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).
[116] *Id*.
[117] S. 397.501, F.S.
[118] *Id*.
[119] S. 397.675, F.S.

- 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 alcoholic beverages or any psychoactive or mood-altering substance, in a way that induces mental, emotional, or physical problems and causes socially dysfunctional behavior.[120] Examples of psychoactive or mood-altering substances include alcohol and illicit or prescription drugs, however, only alcohol is explicitly named under current law. Although having a substance use disorder often leads to being impaired or substance abuse impaired, it is not presently included in the "impaired" or "substance abuse impaired" definition.

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.[121]

Effect of Bill – Definitions

The bill updates and expands the definition of "impaired" or "substance abuse impaired" to include having a substance use disorder or a condition involving the use of illicit or prescription drugs. 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.

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.

Current Situation - 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.[122]

[120] S. 397.311, F.S.
[121] S. 397.581, F.S. Committing an unlawful activity relating to assessment and treatment is misdemeanor of the first degree, punishable by law and by a fine not exceeding $5,000.
[122] 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.

- **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.[123]
- **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.[124]

Court Involved Involuntary Admissions

Current Situation – 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,[125] which provides for long-term court-ordered substance abuse treatment. Both types of involuntary admissions involve filing a petition with the clerk of court in the county where the person is located, which may be different from where he or she resides. Current law permits the chief judge in Marchman Act cases to appoint a general or special magistrate to preside over all or part of the proceedings. Although this may include ancillary matters, such as writs of habeas corpus issued under the Marchman Act, this is not explicitly stated in current law.

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. The bill also specifies that petitions may be filed with the clerk of court in the county where the subject of the petition resides instead of where he or she is located. The bill specifies that the chief judge may appoint a general or special magistrate to preside over all, or part, of the proceedings related to the petition or any ancillary matters, including but not limited to, writs of habeas corpus issued under the Marchman Act, rather than just over the proceedings.

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.[126] 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.[127] The court may appoint a magistrate to preside over all or part of the proceedings.[128]

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.[129]

---

[123] S. 397.679, F.S.
[124] S. 397.6798, F.S.
[125] 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.
[126] S. 397.6951, F.S.
[127] 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.
[128] S. 397.681, F.S., F.S.
[129] S. 397.6818, F.S.

If the court determines the respondent meets the criteria, it may order him or her to be admitted for a period of 5 days[130] to a hospital, licensed detoxification facility, or addictions receiving facility, for involuntary assessment and stabilization.[131] During that time, an assessment is completed on the individual.[132] The written assessment is sent to the court. Once the written assessment is received, the court must either: [133]

- 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.

Current Situation - 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.[134] Similar to a petition for involuntary assessment and stabilization, a petition for involuntary services must contain identifying information for all parties and attorneys and facts necessary to support the petitioner's belief that the respondent is in need of involuntary services.[135] 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.[136] Current law does not permit the court or clerk of court to waive or prohibit process service fees for indigent petitioners.

A hearing on a petition for involuntary services must be held within five days unless a continuance is granted.[137] 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.[138] 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

[130] 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.
[131] 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.
[132] 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.
[133] 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.
[134] S. 397.693, F.S.
[135] S. 397.6951, F.S.
[136] S. 397.695 (5), F.S.
[137] S. 397.6955, F.S.
[138] S. 397.6955(3), F.S.

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.[139]

In a hearing for involuntary services, the petitioner must prove by clear and convincing evidence that:[140]

- 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.

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.[141]

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.[142] 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.[143] A hearing must be then held within 15 days.[144] Unless an extension is requested, the individual is automatically released after 90 days.[145] 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.[146] Current law does not permit courts to drug test respondents in Marchman Act cases.

Effect of the Bill - Involuntary 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 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

[139] S. 397.6957(1), F.S.
[140] S. 397.6957(2), F.S.
[141] S. 397.6957(4), F.S.
[142] S. 397.697(1), F.S.
[143] S. 397.6975, F.S.
[144] *Id*.
[145] S. 397.6977, F.S.
[146] If the respondent leaves treatment, the facility will notify the court and a status conference hearing may be set. If the respondent does not appear at this hearing, a show cause hearing may be set. If the respondent does not appear for the show cause hearing, the court may find the respondent in contempt of court.

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 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.

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 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 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 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 their right to appear, or upon proof of service, the court finds that the respondent's presence is inconsistent with their best interests or will likely be harmful to the respondent.

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, upon a showing of good cause and if all parties consent. 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 prohibits a respondent from being involuntarily ordered into treatment if a clinical assessment is not performed, unless the respondent is present in court and expressly waives the assessment. Outside of emergency situations, if the respondent is not, or previously refused to be, assessed by a qualified professional and, based on the petition, testimony, and evidence presented, it appears that the respondent qualifies for involuntary treatment services, the bill requires the court to issue an involuntary assessment and stabilization order to determine the correct level of treatment for the respondent. In Marchman Act cases where an assessment was attached to the petition, the bill allows the respondent to request, or the court on its own motion to order, an independent assessment by a court-appointed physician or another physician agreed to by the court and the parties.

An assessment order issued 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.

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.

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

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.

Substance Abuse Treatment in Florida

Current Situation

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:[147]

- **Detoxification Services:** Detoxification focuses on the elimination of substance use. Detoxification services use medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.
- **Treatment Services:** Treatment services[148] 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.

[147] Department of Children and Families, *Treatment for Substance Abuse*, https://www.myflfamilies.com/services/samh/treatment, (last visited January 5, 2024).
[148] *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.

Licensed Bed Capacity for Substance Abuse Service Providers

Current Situation

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.[149] Licensed service components include a continuum of substance abuse prevention,[150] intervention,[151] and clinical treatment services, including, but not limited to:[152]

- 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.[153] The licensed bed capacity is the total bed capacity, [154] 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.[155] Upon notification DCF must update the service provider's license to reflect the increased licensed bed capacity.[156]

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 requirements for crisis stabilization units under the Baker Act.

[149] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.
[150] 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.
[151] 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.
[152] S. 397.311(26), F.S.
[153] *Id.*
[154] 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).
[155] *Id.*
[156] 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).

State Forensic System

Criminal Defendants and Competency to Stand Trial

Current Situation

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.[157] 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.[158] 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.[159]

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.[160] 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.[161] If the defendant is found to be mentally competent, the criminal proceeding resumes.[162] If the defendant is found to be mentally incompetent to proceed, the proceeding may not resume unless competency is restored.[163]

Involuntary Commitment of a Defendant Adjudicated Incompetent

Current Situation

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[164] and offenders who are adjudicated not guilty by reason of insanity may be involuntarily committed to state civil[165] and forensic[166] treatment facilities by the circuit court.[167] However, in lieu of such commitment, the offender may be released on conditional release[168] by the circuit court if the person is not serving a prison sentence.[169] The

[157] *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).
[158] *Id*. See also Rule 3.210(a)(1), Fla.R.Crim.P.
[159] *Id*. See also s. 916.12, 916.3012, and 985.19, F.S.
[160] Rule 3.210, Fla.R.Crim.P.
[161] *Id*.
[162] Rule 3.212, Fla.R.Crim.P.
[163] *Id*.
[164] "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.
[165] 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.
[166] S. 916.106(10), F.S.
[167] S. 916.13, 916.15, and 916.302, F.S.
[168] Conditional release is release into the community accompanied by outpatient care and treatment. Section 916.17, F.S.
[169] S. 916.17(1), F.S.

committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.[170]

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.[171]

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.[172] 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.[173]

A court may only involuntarily commit a defendant adjudicated incompetent to proceed for treatment upon finding, based on clear and convincing evidence, that:[174]

- 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 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: [175]

- 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.

<u>Incompetent and Non-Restorable Defendants</u>

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.[176] Those who are found to be non-restorable must be civilly committed or released.[177]

[170] S. 916.16(1), F.S.
[171] S. 916.106(4), F.S.
[172] 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.
[173] *Id*.
[174] S. 916.13(1), F.S.
[175] S. 916.13(2), F.S.
[176] S. 916.13(2)(b), F.S.
[177] *Mosher v. State*, 876 So.2d 1230 (Fla. 1st DCA 2004).

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.[178] The DCF must make every effort to restore the competency of those committed pursuant to chapter 916, F.S., as incompetent to proceed. To ensure that all possible treatment options have been exhausted, all competency restoration attempts in less restrictive, step-down facilities should be considered prior to making a recommendation of non-restorability, particularly for individuals with violent charges.

Individuals who are found to be non-restorable in less than five years of involuntary commitment under section 916.13, F.S., require civil commitment proceedings or release. After an evaluator of competency has completed a competency evaluation and determined that there is not a substantial probability of competency restoration in the current environment in the foreseeable future, the evaluator must notify the appropriate recovery team[179] coordinator that the individual's competency does not appear to be restorable.

After notification, the recovery team's psychiatrist and clinical psychologist members must complete an independent evaluation to examine suitability for involuntary placement. Once the evaluation to examine suitability for involuntary placement is complete, the recovery team meets to consider the following:[180]

- 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.[181]

Current Situation - Competency Evaluation Report

Following the completion of the competency evaluation, the evaluation to examine suitability for involuntary placement, and consideration of restorability, the evaluator of competency must complete a competency evaluation report to the circuit court.[182] 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.

---

[178] 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).

[179] 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).

[180] *Id*.

[181] Chapter 394, F.S., or Mosher v. State, 876 So. 2d 1230 (Fla. 1st DCA 2004).

[182] 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).

916.13(2), F.S., and DCF Operating Procedure 155-19 (Evaluation and Reporting of Competency to Proceed).[183] 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.[184] 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. These reports may be sworn upon request of the court.[185]

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

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.[186]

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 in which the bill codifies into law, except that the bill authorizes the defendant to be considered for involuntary services, rather than an involuntary examination.[187] 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

[183] *Id*.
[184] *Id*.
[185] DCF, *Agency Bill Analysis HB 201 (2023), p. 2 (on file with the House Children Families, & Seniors Subcommittee).*
[186] S.916.145, F.S.
[187] *Id*, note 26.

- 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 authorized the remote appearance of witnesses.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 394.455, F.S., relating to definitions.
Section 2: Amends s. 394.4572, relating to screening of mental health personnel.
Section 3: Amends s. 394.459, F.S., relating to rights of patients.
Section 4: Amends s. 394.4598, F.S., relating to guardian advocate.
Section 5: Amends s. 394.4599, F.S., relating to notice.
Section 6: Amends s. 394.461, F.S., relating to designation of receiving and treatment facilities and receiving systems.
Section 7: Amends s. 394, 4615, F.S., relating to clinical records; confidentiality.
Section 8: Amends s. 394.462, F.S., relating to transportation.
Section 9: Amends s. 394.4625, F.S., relating to voluntary admissions.
Section 10: Amends s. 394.463, F.S., relating to involuntary examination.
Section 11: Amends s. 394.4655, F.S., relating to involuntary outpatient services.
Section 12: Amends s. 394.467, F.S., relating to involuntary inpatient placement.
Section 13: Amends s. 394.468, F.S., relating to admission and discharge procedures.
Section 14: Amends s. 394.495, F.S., relating to child and adolescent mental health system of care; programs and services.
Section 15: Amends s. 394.496, F.S., relating to service planning.
Section 16: Amends s. 394.499, F.S., relating to integrated children's crisis stabilization unit/juvenile addictions receiving facility services.
Section 17: Amends s. 394.875, F.S., relating to crisis stabilization units.
Section 18: Amends. S. 394.9085, F.S., relating to behavioral provider liability.
Section 19: Amends s. 397.305, F.S., relating to legislative findings, intent, and purpose.
Section 20: Amends s. 397.311, F.S., relating to definitions.
Section 21: Amends s. 397.401, F.S., relating to license required; penalty; injunction; rules waivers.
Section 22: Amends s. 397.4073, F.S., relating to personnel background checks; requirements and exceptions.
Section 23: Amends s. 397.501, F.S., relating to rights of individuals.
Section 24: Amends s. 397.581, F.S., relating to unlawful activities relating to assessment and treatment; penalties.
Section 25: Amends s. 397.675, F.S., relating to criteria for involuntary admissions.
Section 26: Amends s. 397.6751, F.S., relating to service provider responsibilities regarding involuntary admissions.
Section 27: Amends s. 397.681, F.S., relating to involuntary petitions; general provisions; court jurisdiction and right to counsel.
Section 28: Amends s. 397.693, F.S., relating to involuntary treatment.
Section 29: Amends s. 397.695, F.S., relating to involuntary services; persons who may petition.
Section 30: Amends s. 397.6951, F.S., relating to contents of petition for involuntary services.
Section 31: Amends s. 397.6955, F.S., relating to duties of court upon filing of petition for involuntary services.
Section 32: Amends s. 397.6818, F.S., relating to court determination.
Section 33: Amends s. 397.6957, F.S., relating to hearing on petition for involuntary services.
Section 34: Amends s. 397.6975, F.S., relating to extension of involuntary services period.

Section 35: Amends s. 397.6977, F.S., relating to disposition of individual upon completion of involuntary services.
Section 36: Repeals s. 397.6811, F.S., relating to involuntary assessment and stabilization.
Section 37: Repeals s. 397.6814, F.S., relating to involuntary assessment and stabilization; contents of petition.
Section 38: Repeals s. 397.6815, F.S., relating to involuntary assessment and stabilization; procedure.
Section 39: Repeals s. 397.6819, F.S., relating to involuntary assessment and stabilization; responsibility of licensed service provider.
Section 40: Repeals s. 397.6821, F.S., relating to extension of time for completion of involuntary assessment and stabilization.
Section 41: Repeals s. 397.6822, F.S., relating to disposition of individual after involuntary assessment.
Section 42: Repeals s. 397.6978, F.S., relating to guardian advocate; patient incompetent to consent; substance abuse disorder.
Section 43: Amends s. 916.106, F.S., relating to definitions.
Section 44: Amends s. 916.13, F.S., relating to involuntary commitment of defendant adjudicated incompetent.
Section 45: Amends s. 40.29, F.S., relating to payment of due-process costs; reimbursement for petitions and orders.
Section 46: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 47: Amends s. 464.012, F.S., relating to licensure of advanced practice registered nurses; fees; controlled substance prescribing.
Section 48: Amends s. 744.2007, F.S., relating to powers and duties.
Section 49: Amends s. 916.107, F.S., relating to rights of forensic clients.
Section 50: Amends s. 916.15, F.S., relating to involuntary commitment of a defendant adjudicated not guilty by reason of insanity.
Section 51: 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:

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

   Reporting Requirements- DCF will be required to create and publish a report on Marchman Act services. The bill also requires DCF and the Agency for Health Care Administration to analyze the service data collected on individuals who are high users of crisis stabilization services. There is 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.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not provide rulemaking authority to implement the bill. However, the department has sufficient rulemaking authority to comply with the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to mental health and substance abuse; amending s. 394.455, F.S.; defining the term "licensed medical practitioner"; conforming a provision to changes made by the act; amending s. 394.4572, F.S.; providing an exception to background screening requirements for certain licensed physicians and nurses; amending s. 394.459, F.S.; specifying a timeframe for recording restrictions in a patient's clinical file; requiring that such recorded restriction be immediately served on certain parties; conforming a provision to changes made by the act; amending s. 394.4598, F.S.; conforming a provision to changes made by the act; amending s. 394.4599, F.S.; revising written notice requirements relating to filing petitions for involuntary services; amending s. 394.461, F.S.; authorizing the state to establish that a transfer evaluation was performed by providing the court with a copy of the evaluation before the close of the state's case-in-chief; prohibiting the court from considering substantive information in the transfer evaluation; providing an exception; revising reporting requirements; amending ss. 394.4615 and 394.462, F.S.; conforming provisions to changes made by the act; amending s. 394.4625, F.S.; revising

requirements relating to voluntary admissions to a facility for examination and treatment; conforming provisions to changes made by the act; amending s. 394.463, F.S.; authorizing, rather than requiring, law enforcement officers to take certain persons into custody for involuntary examinations; requiring written reports by law enforcement officers to contain certain information; removing a provision prohibiting a psychiatric nurse from approving the release of a patient under certain circumstances; revising the types of documents that the department is required to receive and maintain and that are considered part of the clinical record; requiring the department to post a specified report on its website; revising requirements for releasing a patient from a receiving facility; revising requirements for petitions for involuntary services; requiring the department and the Agency for Health Care Administration to analyze certain data, identify patterns and trends, and make recommendations to decrease avoidable admissions; authorizing recommendations to be addressed in a specified manner; requiring the department to publish a specified report on its website and submit such report to the Governor and Legislature by a certain date; amending s. 394.4655, F.S.; defining the term

"involuntary outpatient placement"; authorizing a specified court to order an individual to involuntary outpatient treatment; removing provisions relating to criteria, retention of a patient, and petition for involuntary outpatient services and court proceedings relating to involuntary outpatient services; amending s. 394.467, F.S.; providing definitions; revising requirements for ordering a person for involuntary services and treatment, petitions for involuntary service, appointment of counsel, and continuances of hearings, respectively; revising the conditions under which a court may waive the requirement for a patient to be present at an involuntary inpatient placement hearing; authorizing the court to permit witnesses to attend and testify remotely at the hearing through specified means; providing requirements for a witness to attend and testify remotely; requiring facilities to make certain clinical records available to a state attorney within a specified timeframe; specifying that such records remain confidential and may not be used for certain purposes; revising the circumstances under which a court may appoint a magistrate to preside over certain proceedings; requiring the court to allow certain testimony from specified persons; revising the length of time a court may require a patient to

receive services; requiring facilities to discharge patients when they no longer meet the criteria for involuntary inpatient treatment; prohibiting courts from ordering individuals with developmental disabilities to be involuntarily placed in a state treatment facility; requiring courts to refer such individuals, and authorizing courts to refer certain other individuals, to specified agencies for evaluation and services; providing requirements for treatment plan modifications, noncompliance with involuntary outpatient services, and discharge, respectively; revising requirements for the procedure for continued involuntary services and return to facilities, respectively; amending s. 394.468, F.S.; revising requirements for discharge planning and procedures; providing requirements for the discharge transition process; amending ss. 394.495 and 394.496, F.S.; conforming provisions to changes made by the act; amending s. 394.499, F.S.; revising eligibility requirements for children's crisis stabilization unit/juvenile addictions receiving facility services; amending s. 394.875, F.S.; removing a limitation on the size of a crisis stabilization unit; removing a requirement for the department to implement a certain demonstration project; amending s. 394.9085, F.S.;

conforming a cross-reference to changes made by the act; amending s. 397.305, F.S.; revising the purpose to include the most appropriate environment for substance abuse services; amending s. 397.311, F.S.; revising definitions; amending s. 397.401, F.S.; prohibiting certain service providers from exceeding their licensed capacity by more than a specified percentage or for more than a specified number of days; amending s. 397.4073, F.S.; providing an exception to background screening requirements for certain licensed physicians and nurses; amending s. 397.501, F.S.; revising notice requirements for the right to counsel; amending s. 397.581, F.S.; revising actions that constitute unlawful activities relating to assessment and treatment; providing penalties; amending s. 397.675, F.S.; revising the criteria for involuntary admissions for purposes of assessment and stabilization, and for involuntary treatment; amending s. 397.6751, F.S.; revising service provider responsibilities relating to involuntary admissions; amending s. 397.681, F.S.; revising where involuntary treatment petitions for substance abuse impaired persons may be filed; revising the portion of such proceedings over which a general or special magistrate may preside; providing an exception to a respondent's

right to counsel relating to petitions for involuntary treatment; revising the circumstances under which courts are required to appoint counsel for respondents without regard to respondents' wishes; renumbering and amending s. 397.693, F.S.; revising the circumstances under which a person may be the subject of court-ordered involuntary treatment; renumbering and amending s. 397.695, F.S.; authorizing the court or clerk of the court to waive or prohibit any service of process fees for petitioners determined to be indigent; renumbering and amending s. 397.6951, F.S.; revising the information required to be included in a petition for involuntary treatment services; authorizing a petitioner to include a certificate or report of a qualified professional with such petition; requiring such certificate or report to contain certain information; requiring that certain additional information be included if an emergency exists; renumbering and amending s. 397.6955, F.S.; revising when the office of criminal conflict and civil regional counsel represents a person in the filing of a petition for involuntary services and when a hearing must be held on such petition; requiring a law enforcement agency to effect service for initial treatment hearings; providing an exception; amending

s. 397.6818, F.S.; authorizing the court to take certain actions and issue certain orders regarding a respondent's involuntary assessment if emergency circumstances exist; providing a specified timeframe for taking such actions; amending s. 397.6957, F.S.; expanding the exemption from the requirement that a respondent be present at a hearing on a petition for involuntary treatment services; authorizing the court to order drug tests and to permit witnesses to attend and testify remotely at the hearing through certain means; removing a provision requiring the court to appoint a guardian advocate under certain circumstances; prohibiting a respondent from being involuntarily ordered into treatment unless certain requirements are met; providing requirements relating to involuntary assessment and stabilization orders; providing requirements relating to involuntary treatment hearings; requiring that the assessment of a respondent occur before a specified time unless certain requirements are met; authorizing service providers to petition the court in writing for an extension of the observation period; providing service requirements for such petitions; authorizing the service provider to continue to hold the respondent if the court grants the petition; requiring a qualified

professional to transmit his or her report to the clerk of the court within a specified timeframe; requiring the clerk of the court to enter the report into the court file; providing requirements for the report; providing that the report's filing satisfies the requirements for release of certain individuals if it contains admission and discharge information; providing for the petition's dismissal under certain circumstances; authorizing the court to order certain persons to take a respondent into custody and transport him or her to or from certain service providers and the court; revising the petitioner's burden of proof in the hearing; authorizing the court to initiate involuntary proceedings and have the respondent evaluated by the Agency for Persons with Disabilities under certain circumstances; requiring that, if a treatment order is issued, it must include certain findings; amending s. 397.6975, F.S.; authorizing certain entities to file a petition for renewal of an involuntary treatment services order; revising the timeframe during which the court is required to schedule a hearing; amending s. 397.6977, F.S.; providing requirements for discharge planning and procedures for a respondent's release from involuntary treatment services; repealing ss.

397.6811, 397.6814, 397.6815, 397.6819, 397.6821, 397.6822, and 397.6978, F.S., relating to involuntary assessment and stabilization and the appointment of guardian advocates, respectively; amending s. 916.106, F.S.; providing a definition for the term "licensed medical practitioner"; amending s. 916.13, F.S.; requiring the Department of Children and Families to complete and submit a competency evaluation report to the circuit court to determine if a defendant adjudicated incompetent to proceed meets the criteria for involuntary civil commitment if it is determined that the defendant will not or is unlikely to regain competency; defining the term "competency evaluation report to the circuit court"; requiring a qualified professional to sign such report under penalty of perjury; providing requirements for such report; authorizing a defendant who meets the criteria for involuntary examination and court witnesses to appear remotely for a hearing; amending ss. 40.29, 409.972, 464.012, 744.2007, 916.107, and 916.15 F.S.; conforming provisions to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (26) through (50) of section 394.455, Florida Statutes, are renumbered as subsections (27) through (51), respectively, subsection (23) is amended, and a new subsection (26) is added to that section, to read:

394.455 Definitions.—As used in this part, the term:

(23) "Involuntary examination" means an examination performed under s. 394.463, s. 397.6772, s. 397.679, s. 397.6798, or s. 397.6957 ~~s. 397.6811~~ to determine whether a person qualifies for involuntary services.

(26) "Licensed medical practitioner" means a medical provider who is a physician licensed under chapter 458 or chapter 459 or an advanced practice registered nurse or physician assistant who works under the supervision of a licensed physician and an established protocol pursuant to ss. 458.347, 458.348, 464.003, and 464.0123.

Section 2. Paragraph (e) is added to subsection (1) of section 394.4572, Florida Statutes, to read:

394.4572 Screening of mental health personnel.—

(1)

(e) Any licensed physician or nurse who requires background screening by the Department of Health during initial licensure and the renewal of licensure is not subject to background screening pursuant to this section if he or she is providing a service that is within the scope of his or her licensed practice.

Section 3. Paragraph (d) of subsection (3) and paragraph (d) of subsection (5) of section 394.459, Florida Statutes, are amended to read:

394.459 Rights of patients.—

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.—

(d) The administrator of a receiving or treatment facility may, upon the recommendation of the patient's licensed medical practitioner ~~attending physician~~, authorize emergency medical treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient, and permission of the patient or the patient's guardian or guardian advocate cannot be obtained.

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.—

(d) If a patient's right to communicate with outside persons; receive, send, or mail sealed, unopened correspondence; or receive visitors is restricted by the facility, a qualified professional must record the restriction and its underlying reasons in the patient's clinical file within 24 hours. The notice of the restriction must immediately ~~written notice of such restriction and the reasons for the restriction shall~~ be served on the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative. ~~A qualified professional must document any restriction within 24 hours, and such restriction shall be recorded on the patient's clinical record with the reasons therefor.~~ The restriction of a patient's

right to communicate or to receive visitors shall be reviewed at least every 3 days. The right to communicate or receive visitors shall not be restricted as a means of punishment. Nothing in this paragraph shall be construed to limit the provisions of paragraph (e).

Section 4. Subsection (3) of section 394.4598, Florida Statutes, is amended to read:

394.4598 Guardian advocate.—

(3) A facility requesting appointment of a guardian advocate must, prior to the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decisionmaking. Before asking a guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the patient, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. Before giving consent to treatment, the guardian advocate must meet and talk with the patient and the patient's licensed medical practitioner ~~physician~~ in person, if at all possible, and by telephone, if not. The decision of the guardian advocate may be reviewed by the court, upon petition of the

patient's attorney, the patient's family, or the facility administrator.

Section 5. Paragraph (d) of subsection (2) of section 394.4599, Florida Statutes, is amended to read:

394.4599 Notice.—

(2) INVOLUNTARY ADMISSION.—

(d) The written notice of the filing of the petition for involuntary services for an individual being held must contain the following:

1. Notice that the petition for:

a. Involuntary services ~~inpatient treatment~~ pursuant to s. 394.467 has been filed with the circuit court and the address of such court ~~in the county in which the individual is hospitalized and the address of such court~~; or

b. Involuntary outpatient services pursuant to s. 394.467 ~~s. 394.4655~~ has been filed with the criminal county court, as defined in s. 394.4655(1), ~~or the circuit court, as applicable, in the county in which the individual is hospitalized~~ and the address of such court.

2. Notice that the office of the public defender has been appointed to represent the individual in the proceeding, if the individual is not otherwise represented by counsel.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.

4. Notice that the individual, the individual's guardian, guardian advocate, health care surrogate or proxy, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the individual.

5. Notice that the individual is entitled to an independent expert examination and, if the individual cannot afford such an examination, that the court will provide for one.

Section 6. Subsection (2) and paragraph (d) of subsection (4) of section 394.461, Florida Statutes, are amended to read:

394.461 Designation of receiving and treatment facilities and receiving systems.—The department is authorized to designate and monitor receiving facilities, treatment facilities, and receiving systems and may suspend or withdraw such designation for failure to comply with this part and rules adopted under this part. The department may issue a conditional designation for up to 60 days to allow the implementation of corrective measures. Unless designated by the department, facilities are not permitted to hold or treat involuntary patients under this part.

(2) TREATMENT FACILITY.—The department may designate any state-owned, state-operated, or state-supported facility as a state treatment facility. A civil patient shall not be admitted to a state treatment facility without previously undergoing a transfer evaluation. Before the close of the state's case-in-

chief in ~~a court~~ hearing for involuntary placement ~~in a state treatment facility~~, the state may establish that the transfer evaluation was performed and the document was properly executed by providing the court with a copy of the transfer evaluation. The court may not ~~shall receive and~~ consider the substantive information ~~documented~~ in the transfer evaluation unless the evaluator testifies at the hearing. Any other facility, including a private facility or a federal facility, may be designated as a treatment facility by the department, provided that such designation is agreed to by the appropriate governing body or authority of the facility.

(4) REPORTING REQUIREMENTS.—

(d) The department shall issue an annual report based on the data required pursuant to this subsection. The report shall include individual facilities' data, as well as statewide totals. The report shall be posted on the department's website ~~submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives~~.

Section 7. Subsection (3) of section 394.4615, Florida Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(3) Information from the clinical record may be released in the following circumstances:

(a) When a patient has communicated to a service provider a specific threat to cause serious bodily injury or death to an

identified or a readily available person, if the service provider reasonably believes, or should reasonably believe according to the standards of his or her profession, that the patient has the apparent intent and ability to imminently or immediately carry out such threat. When such communication has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.

(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

For the purpose of determining whether a person meets the criteria for involuntary services ~~outpatient placement~~ or for preparing the proposed treatment plan pursuant to s. 394.4655 or s. 394.467 ~~s. 394.4655~~, the clinical record may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider under s. 394.4655 or s. 394.467 ~~identified in s. 394.4655(7)(b)2.~~, in accordance with state and federal law.

Section 8. Section 394.462, Florida Statutes, is amended to read:

394.462 Transportation.—A transportation plan shall be developed and implemented by each county in collaboration with the managing entity in accordance with this section. A county may enter into a memorandum of understanding with the governing boards of nearby counties to establish a shared transportation plan. When multiple counties enter into a memorandum of understanding for this purpose, the counties shall notify the managing entity and provide it with a copy of the agreement. The transportation plan shall describe methods of transport to a facility within the designated receiving system for individuals subject to involuntary examination under s. 394.463 or involuntary admission under s. 397.6772, s. 397.679, s. 397.6798, or s. 397.6957 ~~s. 397.6811~~, 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. The plan shall comply with the transportation provisions of this section and ss. 397.6772, 397.6795, ~~397.6822,~~ and 397.697.

(1) TRANSPORTATION TO A RECEIVING FACILITY.—

(a) Each county shall designate a single law enforcement agency within the county, or portions thereof, to take a person into custody upon the entry of an ex parte order or the

execution of a certificate for involuntary examination by an authorized professional and to transport that person to the appropriate facility within the designated receiving system pursuant to a transportation plan.

(b)1. The designated law enforcement agency may decline to transport the person to a receiving facility only if:

a. 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 pursuant to this section at the sole cost of the county; and

b. 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.

2. The entity providing transportation may seek reimbursement for transportation expenses. The party responsible for payment for such transportation is the person receiving the transportation. The county shall seek reimbursement from the following sources in the following order:

a. From a private or public third-party payor, if the person receiving the transportation has applicable coverage.

b. From the person receiving the transportation.

c. From a financial settlement for medical care, treatment, hospitalization, or transportation payable or

accruing to the injured party.

(c) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transport of the patient. Such company must be insured and provide no less than $100,000 in liability insurance with respect to the transport of patients.

(d) Any company that contracts with a governing board of a county to transport patients shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(e) When a law enforcement officer takes custody of a person pursuant to this part, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.

(f) When a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination pursuant to s. 394.463 or s. 397.675 and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.

(g) When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior

that meets the statutory guidelines for involuntary examination pursuant to s. 394.463, the law enforcement officer shall transport the person to the appropriate facility within the designated receiving system pursuant to a transportation plan. Persons who meet the statutory guidelines for involuntary admission pursuant to s. 397.675 may also be transported by law enforcement officers to the extent resources are available and as otherwise provided by law. Such persons shall be transported to an appropriate facility within the designated receiving system pursuant to a transportation plan.

(h) When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person must first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the appropriate facility within the designated receiving system pursuant to a transportation plan. The receiving facility shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide examination and treatment to the person where he or she is held.

(i) If the appropriate law enforcement officer believes that a person has an emergency medical condition as defined in

s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

(j) The costs of transportation, evaluation, hospitalization, and treatment incurred under this subsection by persons who have been arrested for violations of any state law or county or municipal ordinance may be recovered as provided in s. 901.35.

(k) The appropriate facility within the designated receiving system pursuant to a transportation plan must accept persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, for involuntary examination pursuant to s. 394.463.

(l) The appropriate facility within the designated receiving system pursuant to a transportation plan must provide persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, pursuant to s. 397.675, a basic screening or triage sufficient to refer the person to the appropriate services.

(m) Each law enforcement agency designated pursuant to paragraph (a) shall establish a policy that reflects a single set of protocols for the safe and secure transportation and transfer of custody of the person. Each law enforcement agency

shall provide a copy of the protocols to the managing entity.

(n) When a jurisdiction has entered into a contract with an emergency medical transport service or a private transport company for transportation of persons to facilities within the designated receiving system, such service or company shall be given preference for transportation of persons from nursing homes, assisted living facilities, adult day care centers, or adult family-care homes, unless the behavior of the person being transported is such that transportation by a law enforcement officer is necessary.

(o) This section may not be construed to limit emergency examination and treatment of incapacitated persons provided in accordance with s. 401.445.

(2) TRANSPORTATION TO A TREATMENT FACILITY.—

(a) If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting a voluntary or involuntary patient to a treatment facility, the transportation plan established by the governing board of the county or counties must specify how the hospitalized patient will be transported to, from, and between facilities in a safe and dignified manner.

(b) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transportation of the patient. Such company must be insured and provide no less than $100,000

in liability insurance with respect to the transport of patients.

(c) A company that contracts with one or more counties to transport patients in accordance with this section shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(d) County or municipal law enforcement and correctional personnel and equipment may not be used to transport patients adjudicated incapacitated or found by the court to meet the criteria for involuntary services ~~placement~~ pursuant to s. 394.467, except in small rural counties where there are no cost-efficient alternatives.

(3) TRANSFER OF CUSTODY.—Custody of a person who is transported pursuant to this part, along with related documentation, shall be relinquished to a responsible individual at the appropriate receiving or treatment facility.

Section 9. Paragraphs (a) and (f) of subsection (1) and subsection (5) of section 394.4625, Florida Statutes, are amended to read:

394.4625 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(a) A facility may receive for observation, diagnosis, or treatment any adult ~~person 18 years of age or older~~ who applies by express and informed consent for admission or any minor ~~person age 17 or younger~~ whose parent or legal guardian applies

for admission. Such person may be admitted to the facility if found to show evidence of mental illness and to be suitable for treatment, and:

1. If the person is an adult, is found~~,~~ to be competent to provide express and informed consent; or

2. If the person is a minor, the parent or legal guardian provides express and informed consent and the facility performs~~,~~ ~~and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility. A person age 17 or younger may be admitted only after~~ a clinical review to verify the voluntariness of the minor's assent.

(f) Within 24 hours after admission of a voluntary patient, the licensed medical practitioner ~~admitting physician~~ shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

(5) TRANSFER TO INVOLUNTARY STATUS.—When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a licensed medical practitioner ~~physician~~, clinical psychologist, or psychiatrist as quickly as possible, but not later than 12

hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient shall be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the ~~written~~ order of a licensed medical practitioner ~~physician~~, if it is determined that such treatment is necessary for the safety of the patient or others.

Section 10. Subsection (1), paragraphs (a), (e), (f), (g), and (h) of subsection (2), and subsection (4) of section 394.463, Florida Statutes, are amended to read:

394.463 Involuntary examination.—

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

2. The person is unable to determine for himself or herself whether examination is necessary; and

(b)1. 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, able, and responsible family members or friends or the provision of other services; or

2. 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.

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of

the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a time limit is not specified in the order, the order is valid for 7 days after the date that the order was signed.

2. A law enforcement officer may ~~shall~~ take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. A law enforcement officer transporting a person pursuant to this section ~~subparagraph~~ shall restrain the person in the least restrictive manner available and appropriate under the circumstances. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. The report must 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. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts pursuant to s. 119.0712(2)(d). Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, a physician assistant, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse registered under s. 464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute 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 and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody and include all emergency contact information required under subparagraph 2. The report must 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. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts pursuant to s. 119.0712(2)(d). The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

(e) The department shall receive and maintain the copies of ex parte orders, involuntary ~~outpatient~~ services orders issued pursuant to ss. 394.4655 and 394.467 ~~s. 394.4655, involuntary inpatient placement orders issued pursuant to s. 394.467~~, professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients.

These documents shall be considered part of the clinical record, governed by the provisions of s. 394.4615. These documents shall be used to prepare annual reports analyzing the data obtained from these documents, without including the personal identifying information of the patient. ~~identifying patients, and~~ The department shall post the reports on its website and provide copies of such reports to the ~~department, the~~ President of the Senate, 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.

(f) A patient shall 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 without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician if the physician determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist or, if the receiving facility is owned or operated by a hospital, health system, or nationally accredited community mental health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending

emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. ~~A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.~~ The release may be approved through telehealth.

(g) The examination period must be for up to 72 hours and begins when a patient arrives at the receiving facility. For a minor, the examination shall be initiated within 12 hours after the patient's arrival at the facility. Within the examination period, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to subparagraph 1., for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary services shall be filed in the circuit court ~~if inpatient treatment is deemed necessary~~ or with the criminal county court, as defined in s. 394.4655(1), as

applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. The ~~When a~~ petition ~~is to be filed for involuntary outpatient placement, it~~ shall be filed by one of the petitioners specified in s. 394.467, and the court shall dismiss an untimely filed petition ~~s. 394.4655(4)(a)~~. ~~A petition for involuntary inpatient placement shall be filed by the facility administrator.~~ If a patient's 72-hour examination period ends on a weekend or holiday, including the hours before the ordinary business hours on the morning of the next working day, and the receiving facility:

a. Intends to file a petition for involuntary services, such patient may be held at the ~~a receiving~~ facility through the next working day thereafter and the ~~such~~ petition ~~for involuntary services~~ must be filed no later than such date. If the ~~receiving~~ facility fails to file the ~~a~~ petition by ~~for involuntary services at~~ the ordinary close of business on the next working day, the patient shall be released from the receiving facility following approval pursuant to paragraph (f).

b. Does not intend to file a petition for involuntary services, the ~~a~~ receiving facility may postpone release of a patient until the next working day thereafter only if a qualified professional documents that adequate discharge planning and procedures in accordance with s. 394.468, and

approval pursuant to paragraph (f), are not possible until the next working day.

(h) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a facility within the examination period specified in paragraph (g). The examination period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary ~~outpatient~~ services pursuant to s. 394.467 ~~s. 394.4655(2) or involuntary inpatient placement pursuant to s. 394.467(1)~~, the patient may be offered voluntary outpatient or inpatient services ~~or placement~~, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary ~~inpatient~~ services ~~or involuntary outpatient placement~~ must be entered into the patient's clinical record. This paragraph is not intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital before stabilization if the requirements of s. 395.1041(3)(c) have been

met.

(4) DATA ANALYSIS.—

(a) Using data collected under paragraph (2)(a) and s. 1006.07(10), the department shall, at a minimum, 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.

(b) The department and the Agency for Health Care Administration shall analyze service data that the department and the agency collect on individuals who, as determined by the department and the agency, are high utilizers of crisis stabilization services provided in designated receiving facilities, and shall, at a minimum, identify any patterns or trends and make recommendations to decrease avoidable admissions. Recommendations may be addressed in the department's contracts with the behavioral health managing entities and in the agency's contracts with the Medicaid managed medical assistance plans.

(c) The department shall publish ~~submit~~ a report on its findings and recommendations on its website and submit the

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

Section 11. Section 394.4655, Florida Statutes, is amended to read:

394.4655 Involuntary outpatient services.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Court" means a circuit court or a criminal county court.

(b) "Criminal county court" means a county court exercising its original jurisdiction in a misdemeanor case under s. 34.01.

(c) "Involuntary outpatient placement" means involuntary outpatient services as defined in s. 394.467, F.S.

(2) A criminal county court may order an individual to involuntary outpatient placement under s. 394.467. ~~CRITERIA FOR INVOLUNTARY OUTPATIENT SERVICES.—A person may be ordered to involuntary outpatient services upon a finding of the court, by clear and convincing evidence, that the person meets all of the following criteria:~~

~~(a) The person is 18 years of age or older.~~

~~(b) The person has a mental illness.~~

~~(c) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.~~

~~(d) The person has a history of lack of compliance with treatment for mental illness.~~

~~(e) The person has:~~

~~1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or~~

~~2. 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, within the preceding 36 months.~~

~~(f) The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and has refused voluntary services for treatment after sufficient and conscientious explanation and disclosure of why the services are necessary or is unable to determine for himself or herself whether services are necessary.~~

~~(g) In view of the person's treatment history and current behavior, 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 as set forth in s. 394.463(1).~~

~~(h) It is likely that the person will benefit from~~

~~involuntary outpatient services.~~

~~(i) 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.~~

~~(3) INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. A patient who is being recommended for involuntary outpatient services by the administrator of the facility where the patient has been examined may be retained by the facility after adherence to the notice procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate that authorizes the~~

~~facility to retain the patient pending completion of a hearing. The certificate must be made a part of the patient's clinical record.~~

~~2. If the patient has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while awaiting the hearing for involuntary outpatient services. Before filing a petition for involuntary outpatient services, the administrator of the facility or a designated department representative must identify the service provider that will have primary responsibility for service provision under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.~~

~~3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary outpatient services. The treatment plan must specify the likely level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient~~

~~services. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(b) If a patient in involuntary inpatient placement meets the criteria for involuntary outpatient services, the administrator of the facility may, before the expiration of the period during which the facility is authorized to retain the patient, recommend involuntary outpatient services. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for~~

~~involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate, and the certificate must be made a part of the patient's clinical record.~~

~~(c)1. The administrator of the treatment facility shall provide a copy of the involuntary outpatient services certificate and a copy of the state mental health discharge form to the managing entity in the county where the patient will be residing. For persons who are leaving a state mental health treatment facility, the petition for involuntary outpatient services must be filed in the county where the patient will be residing.~~

~~2. The service provider that will have primary responsibility for service provision shall be identified by the designated department representative before the order for involuntary outpatient services and must, before filing a~~

~~petition for involuntary outpatient services, certify to the court whether the services recommended in the patient's discharge plan are available and whether the service provider agrees to provide those services. The service provider must develop with the patient, or the patient's guardian advocate, if appointed, a treatment or service plan that addresses the needs identified in the discharge plan. The plan must be deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in this chapter, who consults with, or is employed or contracted by, the service provider.~~

~~3. If the service provider certifies that the services in the proposed treatment or service plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(4) PETITION FOR INVOLUNTARY OUTPATIENT SERVICES.~~

~~(a) A petition for involuntary outpatient services may be filed by:~~

~~1. The administrator of a receiving facility; or~~

~~2. The administrator of a treatment facility.~~

~~(b) Each required criterion for involuntary outpatient services must be alleged and substantiated in the petition for~~

~~involuntary outpatient services. A copy of the certificate recommending involuntary outpatient services completed by a qualified professional specified in subsection (3) must be attached to the petition. A copy of the proposed treatment plan must be attached to the petition. Before the petition is filed, the service provider shall certify that the services in the proposed plan are available. If the necessary services are not available, the petition may not be filed. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(c) The petition for involuntary outpatient services must be filed in the county where the patient is located, unless the patient is being placed from a state treatment facility, in which case the petition must be filed in the county where the patient will reside. When the petition has been filed, the clerk of the court shall provide copies of the petition and the proposed treatment plan to the department, the managing entity, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel. A fee may not be charged for filing a petition under this subsection.~~

~~(5) APPOINTMENT OF COUNSEL.—Within 1 court working day after the filing of a petition for involuntary outpatient services, the court shall appoint the public defender to~~

~~represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of the appointment. The public defender shall represent the person until the petition is dismissed, the court order expires, or the patient is discharged from involuntary outpatient services. An attorney who represents the patient must be provided access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.~~

~~(6) CONTINUANCE OF HEARING.—The patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.~~

~~(7) HEARING ON INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. The court shall hold the hearing on involuntary outpatient services within 5 working days after the filing of the petition, unless a continuance is granted. The hearing must be held in the county where the petition is filed, must be as convenient to the patient as is consistent with orderly procedure, and must be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient and if the patient's counsel does not object, the court may waive the presence of the~~

~~patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioner, as the real party in interest in the proceeding.~~

~~2. The court may appoint a magistrate to preside at the hearing. One of the professionals who executed the involuntary outpatient services certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall ensure that one is provided, as otherwise provided by law. The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law, regarding the person's prior history and how that prior history relates to the person's current condition. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.~~

~~(b)1. If the court concludes that the patient meets the criteria for involuntary outpatient services pursuant to subsection (2), the court shall issue an order for involuntary outpatient services. The court order shall be for a period of up to 90 days. The order must specify the nature and extent of the~~

~~patient's mental illness. The order of the court and the treatment plan must be made part of the patient's clinical record. The service provider shall discharge a patient from involuntary outpatient services when the order expires or any time the patient no longer meets the criteria for involuntary placement. Upon discharge, the service provider shall send a certificate of discharge to the court.~~

~~2. The court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court. The order may be submitted electronically through existing data systems. After the order for involuntary services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the~~

~~patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).~~

~~3. If, in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the physician, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement pursuant to s. 394.467, the patient must be discharged from the facility. The involuntary outpatient services order shall remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).~~

~~(c) 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 under this section but, instead, meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary inpatient examination under s. 394.463. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings are governed by chapter 397.~~

~~(d) At the hearing on involuntary outpatient services, the court shall consider testimony and evidence regarding the patient's competence to consent to services. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598. The guardian advocate shall be appointed or discharged in accordance with s. 394.4598.~~

~~(e) The administrator of the receiving facility or the designated department representative shall provide a copy of the court order and adequate documentation of a patient's mental illness to the service provider for involuntary outpatient services. Such documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a psychologist~~

~~or a clinical social worker.~~

~~(8) PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. If the person continues to meet the criteria for involuntary outpatient services, the service provider shall, at least 10 days before the expiration of the period during which the treatment is ordered for the person, file in the court that issued the order for involuntary outpatient services a petition for continued involuntary outpatient services. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.~~

~~2. The existing involuntary outpatient services order remains in effect until disposition on the petition for continued involuntary outpatient services.~~

~~3. A certificate shall be attached to the petition which includes a statement from the person's physician or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was receiving involuntary services, and an individualized plan of continued treatment.~~

~~4. The service provider shall develop the individualized plan of continued treatment in consultation with the patient or the patient's guardian advocate, if applicable. When the petition has been filed, the clerk of the court shall provide copies of the certificate and the individualized plan of~~

~~continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.~~

~~(b) Within 1 court working day after the filing of a petition for continued involuntary outpatient services, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. The public defender shall represent the person until the petition is dismissed or the court order expires or the patient is discharged from involuntary outpatient services. Any attorney representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.~~

~~(c) Hearings on petitions for continued involuntary outpatient services must be before the court that issued the order for involuntary outpatient services. The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this paragraph must meet the requirements of subsection (7), except that the time period included in paragraph (2)(c) is not applicable in determining the appropriateness of additional periods of involuntary outpatient placement.~~

~~(d) Notice of the hearing must be provided as set forth in s. 394.4599. The patient and the patient's attorney may agree to a period of continued outpatient services without a court hearing.~~

~~(e) The same procedure must be repeated before the expiration of each additional period the patient is placed in treatment.~~

~~(f) If the patient has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient's competence. Section 394.4598 governs the discharge of the guardian advocate if the patient's competency to consent to treatment has been restored.~~

Section 12. Section 394.467, Florida Statutes, is amended to read:

394.467 Involuntary services ~~inpatient placement~~.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Court" means a circuit court.

(b) "Involuntary inpatient placement" means services provided on an inpatient basis to a person 18 years of age or older who does not voluntarily consent to services under this chapter, or a minor who does not voluntarily assent to services under this chapter.

(c) "Involuntary outpatient services" means services provided on an outpatient basis to a person who does not voluntarily consent to services under this chapter.

(2)~~(1)~~ CRITERIA FOR INVOLUNTARY SERVICES.—A person may be ordered by a court to be provided ~~for~~ involuntary services ~~inpatient placement for treatment~~ upon a finding of the court, by clear and convincing evidence, that the person meets the following criteria:

(a) The person ~~He or she~~ has a mental illness and because of his or her mental illness:

1.a. Is unlikely to voluntarily participate in the recommended treatment plan and has refused voluntary services or ~~He or she has refused~~ voluntary inpatient placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of ~~inpatient placement for~~ treatment; or

b. ~~He or she~~ Is unable to determine for himself or herself whether services or inpatient placement is necessary; and

2.a. Is unlikely to survive safely in the community without supervision, based on clinical determination;

b.~~2.a. He or she~~ 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

c.~~b.~~ Without treatment, there is a substantial likelihood

that in the near future the person ~~he or she~~ will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting to cause, or threatening to cause such harm.~~; and~~

(b) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services to prevent a relapse or deterioration of his or her mental health that would be likely to result in serious bodily harm to self or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1).

(c) The person has a history of lack of compliance with treatment for mental illness.

(d) It is likely that the person will benefit from involuntary services.

(e)~~(b)~~ All available less restrictive treatment alternatives that would offer an opportunity for improvement of the person's ~~his or her~~ condition have been deemed ~~judged~~ to be inappropriate or unavailable.

(3)~~(2)~~ RECOMMENDATION FOR INVOLUNTARY SERVICES AND ~~ADMISSION TO A~~ TREATMENT ~~FACILITY~~.—A patient may be recommended for involuntary inpatient placement, involuntary outpatient services, or a combination of both.

(a) A patient may be retained by a facility for involuntary services ~~or involuntarily placed in a treatment facility~~ upon the recommendation of the administrator of the

facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. However, if a patient who is being recommended for only involuntary outpatient services has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while awaiting the hearing for involuntary outpatient services.

(b) The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary services ~~inpatient placement~~ are met.

(c) If ~~However, if the administrator certifies that~~ a psychiatrist or clinical psychologist is not available to provide a ~~the~~ second opinion, the administrator must certify that a clinical psychologist is not available and the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness or by a psychiatric nurse. If the patient is being recommended for involuntary outpatient services only, the second opinion may be provided by a physician assistant who has at least 3 years' experience and is supervised by a licensed physician or psychiatrist or a clinical social worker.

(d) Any opinion authorized in this subsection may be conducted through a face-to-face or in-person examination, ~~in~~

~~person,~~ or by electronic means. Recommendations for involuntary services must be ~~Such recommendation shall be~~ entered on an ~~a petition for~~ involuntary services ~~inpatient placement~~ certificate, which shall be made a part of the patient's clinical record. The certificate must either authorize the facility to retain the patient pending completion of a hearing or authorize ~~that authorizes~~ the facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

(4)~~(3)~~ PETITION FOR INVOLUNTARY SERVICES ~~INPATIENT PLACEMENT~~.—

(a) A petition for involuntary services may be filed by:

1. The administrator of a receiving ~~the~~ facility; or

2. The administrator of a treatment facility.

(b) A ~~shall file 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.

(c) A petition for involuntary outpatient services must be filed in the county where the patient is located, unless the patient is being placed from a state treatment facility, in which case the petition must be filed in the county where the patient will reside.

(d)1. The petitioner must state in the petition:

a. Whether the petitioner is recommending inpatient

placement, outpatient services, or both.

b. The length of time recommended for each type of involuntary services.

c. The reasons for the recommendation.

2. If recommending involuntary outpatient services, or a combination of involuntary inpatient placement and outpatient services, the petitioner must identify the service provider that will have primary responsibility for providing such services under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.

3. If recommending an immediate order to involuntary outpatient placement, the service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary outpatient services. The treatment plan must specify the likely level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient services. Service providers

may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested service.

(e) Each required criterion for the recommended involuntary services must be alleged and substantiated in the petition. A copy of the certificate recommending involuntary services completed by a qualified professional specified in subsection (3) and, if applicable, a copy of the proposed treatment plan must be attached to the petition.

(f) When the petition has been filed ~~Upon filing~~, the clerk of the court shall provide copies of the petition and, if applicable, the proposed treatment plan to the department, the managing entity, the patient, the patient's guardian or

representative, ~~and~~ the state attorney, and the public defender or the patient's private counsel ~~of the judicial circuit in which the patient is located~~. A fee may not be charged for the filing of a petition under this subsection.

(5)~~(4)~~ APPOINTMENT OF COUNSEL.—Within 1 court working day after the filing of a petition for involuntary services ~~inpatient placement~~, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel or ineligible. The clerk of the court shall immediately notify the public defender of such appointment. The public defender shall represent the person until the petition is dismissed, the court order expires, or the patient is discharged from involuntary services. Any attorney who represents ~~representing~~ the patient shall be provided ~~have~~ access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

(6)~~(5)~~ CONTINUANCE OF HEARING.—The patient and the state are independently ~~is~~ entitled~~, with the concurrence of the patient's counsel,~~ to at least one continuance of the hearing. The patient's continuance may be for a period of up to 4 weeks and requires the concurrence of the patient's counsel. The state's continuance may be for a period of up to 5 court working days and requires a showing of good cause and due diligence by

the state before requesting the continuance. The state's failure to timely review any readily available document or failure to attempt to contact a known witness does not warrant a continuance.

(7) ~~(6)~~ HEARING ON INVOLUNTARY SERVICES ~~INPATIENT PLACEMENT~~.—

(a)1. The court shall hold a ~~the~~ hearing on the involuntary services petition ~~inpatient placement~~ within 5 court working days after the filing of the petition, unless a continuance is granted.

2. The court must hold any hearing on involuntary outpatient services in the county where the petition is filed. A hearing on involuntary inpatient placement, or a combination of involuntary inpatient placement and involuntary outpatient services, ~~Except for good cause documented in the court file, the hearing~~ must be held in the county or the facility, as appropriate, where the patient is located, except for good cause documented in the court file.

3. A hearing on involuntary services must be as convenient to the patient as is consistent with orderly procedure, and shall be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient, or the patient knowingly, intelligently, and voluntarily waives his or her right to be

present, and if the patient's counsel does not object, the court may waive the attendance ~~presence~~ of the patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioner, as the real party in interest in the proceeding. The facility shall make the respondent's clinical records available to the state attorney and the respondent's attorney so that the state can evaluate and prepare its case. However, these records shall remain confidential, and the state attorney may not use any record obtained under this part for criminal investigation or prosecution purposes, or for any purpose other than the patient's civil commitment under this chapter ~~petitioning facility administrator, as the real party in interest in the proceeding~~.

(b)~~3.~~ The court may appoint a magistrate to preside at the hearing on the petition and any ancillary proceedings, including, but not limited to, writs of habeas corpus issued pursuant to s. 394.459. Upon a finding of good cause, the court may permit all witnesses, including, but not limited to, medical professionals who are or have been involved with the patient's treatment, to remotely attend and testify at the hearing under oath via audio-video teleconference. A witness intending to remotely attend and testify must provide the parties with all relevant documents by the close of business on the day before the hearing. One of the professionals who executed the ~~petition~~

~~for~~ involuntary services ~~inpatient placement~~ certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall ensure that one is provided, as otherwise provided for by law. The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The court shall allow testimony from persons, including family members, deemed by the court to be relevant under state law, regarding the person's prior history and how that prior history relates to the person's current condition. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.

(c) ~~(b)~~ At the hearing, the court shall consider testimony and evidence regarding the patient's competence to consent to services and treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598.

(8) ORDERS OF THE COURT.—

(a)1. If the court concludes that the patient meets the criteria for involuntary services, the court may order a patient to involuntary inpatient placement, involuntary outpatient services, or a combination of involuntary services depending on

the criteria met and which type of involuntary services best meet the needs of the patient. However, if the court orders the patient to involuntary outpatient services, the court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court.

2. The order must specify the nature and extent of the patient's mental illness.

3.a. An order for only involuntary outpatient services shall be for a period of up to 90 days.

b. An order for involuntary inpatient placement, or a combination of inpatient placement and outpatient services, may be up to 6 months.

4. An order for a combination of involuntary services shall specify the length of time the patient shall be ordered for involuntary inpatient placement and involuntary outpatient services.

5. The order of the court and the patient's treatment

plan, if applicable, must be made part of the patient's clinical record.

(b) If the court orders a patient into involuntary inpatient placement, the court ~~it~~ may order that the patient be transferred to a treatment facility, or~~,~~ if the patient is at a treatment facility, that the patient be retained there or be treated at any other appropriate facility, or that the patient receive services~~,~~ on an involuntary basis~~, for up to 90 days~~. ~~However, any order for involuntary mental health services in a treatment facility may be for up to 6 months. The order shall specify the nature and extent of the patient's mental illness.~~ The court may not order an individual with a developmental disability as defined in s. 393.063 or a traumatic brain injury or dementia who lacks a co-occurring mental illness to be involuntarily placed in a state treatment facility. ~~The facility shall discharge a patient any time the patient no longer meets the criteria for involuntary inpatient placement, unless the patient has transferred to voluntary status.~~

(c) If at any time before the conclusion of a ~~the~~ hearing on involuntary services, ~~inpatient placement~~ it appears to the court that the patient ~~person does not meet the criteria for involuntary inpatient placement under this section, but~~ instead meets the criteria for involuntary ~~outpatient services, the court may order the person evaluated for involuntary outpatient services pursuant to s. 394.4655. The petition and hearing~~

~~procedures set forth in s. 394.4655 shall apply. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary~~ admission or treatment pursuant to s. 397.675, then the court may order the person to be admitted for involuntary assessment ~~for a period of 5 days~~ pursuant to s. 397.6757 ~~s. 397.6811~~. Thereafter, all proceedings are governed by chapter 397.

~~(d) At the hearing on involuntary inpatient placement, the court shall 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 as provided in s. 394.4598.~~

(d) ~~(c)~~ The administrator of the petitioning facility or the designated department representative shall provide a copy of the court order and adequate documentation of a patient's mental illness to the service provider for involuntary outpatient services or the administrator of a treatment facility if the patient is ordered for involuntary inpatient placement~~, whether by civil or criminal court~~. The documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a psychiatric nurse, a clinical psychologist, a marriage and family therapist, a mental health counselor, or a clinical social worker. The administrator of a treatment facility may refuse admission to any patient directed to its facilities on an

involuntary basis, whether by civil or criminal court order, who is not accompanied by adequate orders and documentation.

(9) TREATMENT PLAN MODIFICATION—After the order for involuntary outpatient services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (4).

(10) NONCOMPLIANCE WITH INVOLUNTARY OUTPATIENT SERVICES.—If, in the clinical judgment of a physician, a patient receiving involuntary outpatient services has failed or has refused to comply with the treatment plan ordered by the court, and, in the clinical judgment of the physician, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement under this section, the patient must be discharged from the facility. The involuntary outpatient services order shall remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services or

until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (4).

(11) ~~(7)~~ PROCEDURE FOR CONTINUED INVOLUNTARY SERVICES ~~INPATIENT PLACEMENT~~.—

(a) A petition for continued involuntary services shall be filed if the patient continues to meets the criteria for involuntary services.

(b)1. If a patient receiving involuntary outpatient services continues to meet the criteria for involuntary outpatient services, the service provider shall file in the court that issued the order for involuntary outpatient services a petition for continued involuntary outpatient services.

2. If the patient in involuntary inpatient placement

~~(a) Hearings on petitions for continued involuntary inpatient placement of an individual placed at any treatment facility are administrative hearings and must be conducted in accordance with s. 120.57(1), except that any order entered by~~

~~the administrative law judge is final and subject to judicial review in accordance with s. 120.68. Orders concerning patients committed after successfully pleading not guilty by reason of insanity are governed by s. 916.15.~~

~~(b) If the patient~~ continues to meet the criteria for involuntary inpatient placement and is being treated at a treatment facility, the administrator shall, before the expiration of the period the treatment facility is authorized to retain the patient, file a petition requesting authorization for continued involuntary inpatient placement.

3. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.

4. The existing involuntary services order shall remain in effect until disposition on the petition for continued involuntary services.

(c) A certificate for continued involuntary services must be attached to the petition and shall include ~~The request must be accompanied by~~ a statement from the patient's physician, psychiatrist, psychiatric nurse, or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was receiving involuntary services ~~involuntarily placed~~, and, if requesting involuntary outpatient services, an individualized plan of continued treatment. The individualized plan of continued treatment shall be developed in consultation with the patient or the patient's

guardian advocate, if applicable. When the petition has been filed, the clerk of the court shall provide copies of the certificate and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.

(d) The court shall appoint counsel to represent the person who is the subject of the petition for continued involuntary services in accordance to the provisions set forth in subsection (5), unless the person is otherwise represented by counsel or ineligible.

(e) Hearings on petitions for continued involuntary outpatient services must be before the court that issued the order for involuntary outpatient services. However, the patient and the patient's attorney may agree to a period of continued outpatient services without a court hearing.

(f) Hearings on petitions for continued involuntary inpatient placement must be held in the county or the facility, as appropriate, where the patient is located.

(g) The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this paragraph must meet the requirements of subsection (7).

(h) Notice of the hearing must be provided as set forth ~~provided~~ in s. 394.4599.

(i) If a patient's attendance at the hearing is

voluntarily waived, the ~~administrative law~~ judge must determine that the patient knowingly, intelligently, and voluntarily waived his or her right to be present, ~~waiver is knowing and voluntary~~ before waiving the presence of the patient from all or a portion of the hearing. Alternatively, if at the hearing the ~~administrative law~~ judge finds that attendance at the hearing is not consistent with the best interests of the patient, the ~~administrative law~~ judge may waive the presence of the patient from all or any portion of the hearing, unless the patient, through counsel, objects to the waiver of presence. The testimony in the hearing must be under oath~~,~~ and the proceedings must be recorded.

(j) Hearings on petitions for continued involuntary inpatient placement of an individual placed at any treatment facility are administrative hearings and must be conducted in accordance with s. 120.57(1), except that any order entered by the judge is final and subject to judicial review in accordance with s. 120.68. Orders concerning patients committed after successfully pleading not guilty by reason of insanity are governed by s. 916.15.

~~(c) Unless the patient is otherwise represented or is ineligible, he or she shall be represented at the hearing on the petition for continued involuntary inpatient placement by the public defender of the circuit in which the facility is located.~~

(k)~~(d)~~ If at a hearing it is shown that the patient

continues to meet the criteria for involuntary services ~~inpatient placement~~, the court ~~administrative law judge~~ shall issue an ~~sign the~~ order for continued involuntary services ~~inpatient placement~~ for up to 90 days. However, any order for involuntary inpatient placement, or ~~mental health services in~~ a combination of involuntary services ~~treatment facility~~ may be for up to 6 months. The same procedure shall be repeated before the expiration of each additional period the patient is retained.

(l) If the patient has been ordered to undergo involuntary services and has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient's competence. If the patient's competency to consent to treatment is restored, the discharge of the guardian advocate shall be governed by s. 394.4598. If the patient has been ordered to undergo involuntary inpatient placement only and the patient's competency to consent to treatment is restored, the administrative law judge may issue a recommended order, to the court that found the patient incompetent to consent to treatment, that the patient's competence be restored and that any guardian advocate previously appointed be discharged.

(m) ~~(c)~~ If continued involuntary inpatient placement is necessary for a patient in involuntary inpatient placement who was admitted while serving a criminal sentence, but his or her

sentence is about to expire, or for a minor involuntarily placed, but who is about to reach the age of 18, the administrator shall petition the administrative law judge for an order authorizing continued involuntary inpatient placement. The procedure required in this section ~~subsection~~ must be followed before the expiration of each additional period the patient is involuntarily receiving services.

(12) ~~(8)~~ RETURN TO FACILITY.—If a patient has been ordered to undergo involuntary inpatient placement ~~involuntarily~~ held at a treatment facility under this part leaves the facility without the administrator's authorization, the administrator may authorize a search for the patient and his or her return to the facility. The administrator may request the assistance of a law enforcement agency in this regard.

(13) DISCHARGE—The patient shall be discharged upon expiration of the court order or at any time the patient no longer meets the criteria for involuntary services, unless the patient has transferred to voluntary status. Upon discharge, the service provider or facility shall send a certificate of discharge to the court.

Section 13. Subsection (2) of section 394.468, Florida Statutes, is amended and subsection (3) is added to that section to read:

394.468 Admission and discharge procedures.—

(2) Discharge planning and procedures for any patient's

release from a receiving facility or treatment facility must include and document the patient's needs, and actions to address such needs, for ~~consideration of~~, at a minimum:

(a) Follow-up behavioral health appointments;

(b) Information on how to obtain prescribed medications; and

(c) Information pertaining to:

1. Available living arrangements;

2. Transportation; and

(d) Referral to:

1. Care coordination services. The patient must be referred for care coordination services if the patient meets the criteria as a member of a priority population as determined by the department under s. 394.9082(3)(c).

2.~~3.~~ Recovery support opportunities under s. 394.4573(2)(l), including, but not limited to, connection to a peer specialist.

(3) During the discharge transition process and while the patient is present unless determined inappropriate by a licensed medical practitioner, a receiving facility shall coordinate, face-to-face or through electronic means, ongoing treatment and discharge plans to a less restrictive community behavioral health provider, a peer specialist, a case manager, or a care coordination service. The transition process must include all of the following criteria:

(a) Implementation of policies and procedures outlining strategies for how the receiving facility will comprehensively address the needs of patients who demonstrate a high use of receiving facility services to avoid or reduce future use of crisis stabilization services.

(b) Developing and including in discharge paperwork a personalized crisis prevention plan that identifies stressors, early warning signs or symptoms, and strategies to deal with crisis.

(c) Requiring a master's-level staff member or licensed professional-level staff member to engage a family member, legal guardian, legal representative, or natural support in discharge planning and meet face to face or through electronic means to review the discharge instructions, including prescribed medications, follow-up appointments, and any other recommended services or follow-up resources, and document the outcome of such meeting.

(d) When the recommended level of care at discharge is not immediately available to the patient, the receiving facility must initiate a referral to an appropriate provider to meet the needs of the patient and make appointments for interim services to continue care until the recommended level of care is available.

Section 14. Subsection (3) of section 394.495, Florida Statutes, is amended to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(3) Assessments must be performed by:

(a) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist, as those terms are defined in s. 394.455 ~~professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~;

(b) A professional licensed under chapter 491; or

(c) A person who is under the direct supervision of a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist, as those terms are defined in s. 394.455, ~~qualified professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~ or a professional licensed under chapter 491.

Section 15. Subsection (5) of section 394.496, Florida Statutes, is amended to read:

394.496 Service planning.—

(5) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist, as those terms are defined in s. 394.455, ~~professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~ or a professional licensed under chapter 491 must be included among those persons developing the services plan.

Section 16. Paragraph (a) of subsection (2) of section 394.499, Florida Statutes, is amended to read:

394.499 Integrated children's crisis stabilization unit/juvenile addictions receiving facility services.—

(2) Children eligible to receive integrated children's crisis stabilization unit/juvenile addictions receiving facility services include:

(a) A minor whose parent makes ~~person under 18 years of age for whom~~ voluntary application based on the parent's express and informed consent, and the requirements of s. 394.4625(1)(a) are met ~~is made by his or her guardian, if such person is found to show evidence of mental illness and to be suitable for treatment pursuant to s. 394.4625. A person under 18 years of age may be admitted for integrated facility services only after a hearing to verify that the consent to admission is voluntary~~.

Section 17. Paragraphs (a) and (d) of subsection (1) of section 394.875, Florida Statutes, are amended to read:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.—

(1)(a) The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation,

medication prescribed by a licensed medical practitioner ~~physician~~ or psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay ~~and shall be limited in size to a maximum of 30 beds~~.

~~(d) The department is directed to implement a demonstration project in circuit 18 to test the impact of expanding beds authorized in crisis stabilization units from 30 to 50 beds. Specifically, the department is directed to authorize existing public or private crisis stabilization units in circuit 18 to expand bed capacity to a maximum of 50 beds and to assess the impact such expansion would have on the availability of crisis stabilization services to clients.~~

Section 18. Subsection (6) of section 394.9085, Florida Statutes, is amended to read:

394.9085 Behavioral provider liability.—

(6) For purposes of this section, the terms "detoxification ~~services~~," "addictions receiving facility," and "receiving facility" have the same meanings as those provided in ss. 397.311(26)(a)4. ~~397.311(26)(a)3.~~, 397.311(26)(a)1., and 394.455(41) ~~394.455(40)~~, respectively.

Section 19. Subsection (3) of section 397.305, Florida Statutes, is amended to read:

397.305 Legislative findings, intent, and purpose.—

(3) It is the purpose of this chapter to provide for a

comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services in the most appropriate and least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

Section 20. Subsections (19) and (23) of section 397.311, Florida Statutes, are amended to read:

397.311 Definitions.—As used in this chapter, except part VIII, the term:

(19) "Impaired" or "substance abuse impaired" means having a substance use disorder or a condition involving the use of alcoholic beverages, illicit or prescription drugs, or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems or ~~and~~ cause socially dysfunctional behavior.

(23) "Involuntary treatment services" means an array of behavioral health services that may be ordered by the court for persons with substance abuse impairment or co-occurring substance abuse impairment and mental health disorders.

Section 21. Subsection (6) is added to section 397.401, Florida Statutes, to read:

397.401 License required; penalty; injunction; rules

waivers.—

(6) A service provider operating an addictions receiving facility or providing detoxification on a nonhospital inpatient basis may not exceed its licensed capacity by more than 10 percent and may not exceed their licensed capacity for more than 3 consecutive working days or for more than 7 days in 1 month.

Section 22. Paragraph (i) is added to subsection (1) of section 397.4073, Florida Statutes, to read:

397.4073 Background checks of service provider personnel.—

(1) PERSONNEL BACKGROUND CHECKS; REQUIREMENTS AND EXCEPTIONS.—

(i) Any licensed physician or nurse who requires background screening by the Department of Health during initial licensure and the renewal of licensure is not subject to background screening pursuant to this section if he or she is providing a service that is within the scope of his or her licensed practice.

Section 23. Subsection (8) of section 397.501, Florida Statutes, is amended to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(8) RIGHT TO COUNSEL.—Each individual must be informed

that he or she has the right to be represented by counsel in any judicial ~~involuntary~~ proceeding for involuntary substance abuse ~~assessment, stabilization, or~~ treatment and that he or she, or if the individual is a minor his or her parent, legal guardian, or legal custodian, may apply immediately to the court to have an attorney appointed if he or she cannot afford one.

Section 24. Section 397.581, Florida Statutes, is amended to read:

397.581 Unlawful activities relating to assessment and treatment; penalties.—

(1) A person may not knowingly and willfully:

(a) Furnish ~~furnishing~~ false information for the purpose of obtaining emergency or other involuntary admission of another person ~~for any person is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000~~.

(b) ~~(2)~~ Cause or otherwise secure, or conspire with or assist another to cause or secure ~~Causing or otherwise securing, or conspiring with or assisting another to cause or secure, without reason for believing a person to be impaired,~~ any emergency or other involuntary procedure of another ~~for the~~ person under false pretenses ~~is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000~~.

(c) ~~(3)~~ Cause, or conspire with or assist another to cause,

without lawful justification ~~Causing, or conspiring with or assisting another to cause~~, the denial to any person of any right accorded pursuant to this chapter.

(2) A person who violates subsection (1) commits ~~is~~ a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

Section 25. Section 397.675, Florida Statutes, is amended to read:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.—A person meets the criteria for involuntary admission if there is good faith reason to believe that the person is substance abuse impaired or has a substance use disorder and a co-occurring mental health disorder and, because of such impairment or disorder:

(1) Has lost the power of self-control with respect to substance abuse; and

(2)(a) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision in that regard, although mere refusal to receive such services does not constitute evidence of lack of judgment with respect to

his or her need for such services; or

(b) Without care or treatment, is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services, or there is substantial likelihood that the person has inflicted, or threatened to or attempted to inflict, or, unless admitted, is likely to inflict, physical harm on himself, herself, or another.

Section 26. Subsection (1) of section 397.6751, Florida Statutes, is amended to read:

397.6751 Service provider responsibilities regarding involuntary admissions.—

(1) It is the responsibility of the service provider to:

(a) Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;

(b) Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;

(c) Provide for the admission of the person to the service component that represents the most appropriate and least restrictive available setting that is responsive to the person's

treatment needs;

(d) Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;

(e) Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and

(f) Take all necessary measures to ensure that each individual in treatment is provided with a safe environment, and to ensure that each individual whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

Section 27. Section 397.681, Florida Statutes, is amended to read:

397.681 Involuntary petitions; general provisions; court jurisdiction and right to counsel.—

(1) JURISDICTION.—The courts have jurisdiction of ~~involuntary assessment and stabilization petitions and~~ involuntary treatment petitions for substance abuse impaired persons, and such petitions must be filed with the clerk of the court in the county where the person resides ~~is located~~. The clerk of the court may not charge a fee for the filing of a petition under this section. The chief judge may appoint a general or special magistrate to preside over all or part of the

proceedings related to the petition or any ancillary matters thereto. The alleged impaired person is named as the respondent.

(2) RIGHT TO COUNSEL.—Unless the respondent is present and the court finds he or she knowingly, intelligently, and voluntarily waived legal representation, a respondent has the right to counsel at every stage of a judicial proceeding relating to a petition for his or her ~~involuntary assessment and a petition for his or her~~ involuntary treatment for substance abuse impairment. A respondent who desires counsel and is unable to afford private counsel has the right to court-appointed counsel and to the benefits of s. 57.081. If the court believes that the respondent needs or desires the assistance of counsel, the court shall appoint such counsel for the respondent without regard to the respondent's wishes. If the respondent is a minor not otherwise represented in the proceeding, the court shall immediately appoint a guardian ad litem to act on the minor's behalf.

Section 28. Section 397.693, Florida Statutes, is renumbered as 397.68111, Florida Statutes, and amended to read:

397.68111 ~~397.693~~ Involuntary treatment.—A person may be the subject of a petition for court-ordered involuntary treatment pursuant to this part~~,~~ if that person:

(1) Reasonably appears to meet ~~meets~~ the criteria for involuntary admission provided in s. 397.675; ~~and:~~

(2)~~(1)~~ Has been placed under protective custody pursuant

to s. 397.677 within the previous 10 days;

(3)~~(2)~~ Has been subject to an emergency admission pursuant to s. 397.679 within the previous 10 days; or

(4)~~(3)~~ Has been assessed by a qualified professional within 30 ~~5~~ days~~;~~

~~(4) Has been subject to involuntary assessment and stabilization pursuant to s. 397.6818 within the previous 12 days; or~~

~~(5) Has been subject to alternative involuntary admission pursuant to s. 397.6822 within the previous 12 days~~.

Section 29. Section 397.695, Florida Statutes, is renumbered as section 397.68112, Florida Statutes, and amended to read:

397.68112 ~~397.695~~ Involuntary services; persons who may petition.—

(1) If the respondent is an adult, a petition for involuntary treatment services may be filed by the respondent's spouse or legal guardian, any relative, a service provider, or an adult who has direct personal knowledge of the respondent's substance abuse impairment and his or her prior course of assessment and treatment.

(2) If the respondent is a minor, a petition for involuntary treatment services may be filed by a parent, legal guardian, or service provider.

(3) The court may prohibit, or a law enforcement agency

may waive, any service of process fees if a petitioner is determined to be indigent.

Section 30. Section 397.6951, Florida Statutes, is renumbered as 397.68141, Florida Statutes, and amended to read:

397.68141 ~~397.6951~~ Contents of petition for involuntary treatment services.—A petition for involuntary services must contain the name of the respondent; the name of the petitioner ~~or petitioners~~; the relationship between the respondent and the petitioner; the name of the respondent's attorney, if known; ~~the findings and recommendations of the assessment performed by the qualified professional;~~ and the factual allegations presented by the petitioner establishing the need for involuntary ~~outpatient~~ services for substance abuse impairment. The factual allegations must demonstrate:

(1) The reason for the petitioner's belief that the respondent is substance abuse impaired;

(2) The reason for the petitioner's belief that because of such impairment the respondent has lost the power of self-control with respect to substance abuse; and

(3)(a) The reason the petitioner believes that the respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless the court orders the involuntary services; or

(b) The reason the petitioner believes that the respondent'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.

(4) The petition may be accompanied by a certificate or report of a qualified professional who examined the respondent within 30 days before the petition was filed. The certificate or report must include the qualified professional's findings relating to his or her assessment of the patient and his or her treatment recommendations. If the respondent was not assessed before the filing of a treatment petition or refused to submit to an evaluation, the lack of assessment or refusal must be noted in the petition.

(5) If there is an emergency, the petition must also describe the respondent's exigent circumstances and include a request for an ex parte assessment and stabilization order that must be executed pursuant to s. 397.68151.

Section 31. Section 397.6955, Florida Statutes, is renumbered as section 397.68151, Florida Statutes, and amended to read:

397.68151 ~~397.6955~~ Duties of court upon filing of petition for involuntary services.—

(1) Upon the filing of a petition for involuntary services for a substance abuse impaired person with the clerk of the court, the court shall immediately determine whether the respondent is represented by an attorney or whether the

appointment of counsel for the respondent is appropriate. If the court appoints counsel for the person, the clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel, created pursuant to s. 27.511, of the appointment. The office of criminal conflict and civil regional counsel shall represent the person until the petition is dismissed, the court order expires, ~~or~~ the person is discharged from involuntary treatment services, or the office is otherwise discharged by the court. An attorney that represents the person named in the petition shall have access to the person, witnesses, and records relevant to the presentation of the person's case and shall represent the interests of the person, regardless of the source of payment to the attorney.

(2) The court shall schedule a hearing to be held on the petition within 10 court working ~~5~~ days unless a continuance is granted. ~~The court may appoint a magistrate to preside at the hearing.~~

(3) A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent, guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the respondent's spouse or guardian, if applicable; and such other persons as the court may direct. If the respondent is a minor, a copy of the petition and notice of the hearing must be personally delivered to the respondent. The clerk ~~court~~ shall

also issue a summons to the person whose admission is sought and unless a circuit court's chief judge authorizes disinterested private process servers to serve parties under this chapter, a law enforcement agency must effect such service on the person whose admission is sought for the initial treatment hearing.

Section 32. Section 397.6818, Florida Statutes, is amended to read:

397.6818 Court determination.—

(1) When the petitioner asserts that emergency circumstances exist, or when upon review of the petition the court determines that an emergency exists, the court may rely solely on the contents of the petition and, without the appointment of an attorney, 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.

(2) The court may further order a law enforcement officer or another designated agent of the court to:

(a) Take the respondent into custody and deliver him or her for evaluation to either the nearest appropriate licensed service provider or a licensed service provider designated by the court.

(b) Serve the respondent with the notice of hearing and a copy of the petition.

(3) The service provider may not hold the respondent for

longer than 72 hours of observation, unless:

(a) The service provider seeks additional time under s. 397.6957(1)(c) and the court, after a hearing, grants that motion;

(b) The respondent shows signs of withdrawal, or a need to be either detoxified or treated for a medical condition, which shall extend the amount of time the respondent may be held for observation until the issue is resolved but no later than the scheduled hearing date, absent a court-approved extension; or

(c) The original or extended observation period ends on a weekend or holiday, including the hours before the ordinary business hours of the following workday morning, in which case the provider may hold the respondent until the next court working day.

(4) If the ex parte order was not executed by the initial hearing date, it shall be deemed void. However, should the respondent 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 this chapter's commitment criteria and that a substance abuse emergency exists, the court may 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:

(a) Shall continue the case for no more than 10 court

working days; and

(b) May order a law enforcement officer or another designated agent of the court to:

1. Take the respondent into custody and deliver him or her for evaluation to either the nearest appropriate licensed service provider or a licensed service provider designated by the court; and

2. 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.

Otherwise, the petitioner must inform the court that the respondent has been assessed so that the court may schedule a hearing as soon as is practicable. However, if the respondent has not been assessed within 90 days, the court must dismiss the case. ~~At the hearing initiated in accordance with s. 397.6811(1), the court shall hear all relevant testimony. The respondent must be present unless the court has reason to believe that his or her presence is likely to be injurious to him or her, in which event the court shall appoint a guardian advocate to represent the respondent. The respondent has the right to examination by a court-appointed qualified professional. After hearing all the evidence, the court shall determine whether there is a reasonable basis to believe the~~

~~respondent meets the involuntary admission criteria of s. 397.675.~~

~~(1) Based on its determination, the court shall either dismiss the petition or immediately enter an order authorizing the involuntary assessment and stabilization of the respondent; or, if in the course of the hearing the court has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, is likely to injure himself or herself or another if allowed to remain at liberty, the court may initiate involuntary proceedings under the provisions of part I of chapter 394.~~

~~(2) If the court enters an order authorizing involuntary assessment and stabilization, the order shall include the court's findings with respect to the availability and appropriateness of the least restrictive alternatives and the need for the appointment of an attorney to represent the respondent, and may designate the specific licensed service provider to perform the involuntary assessment and stabilization of the respondent. The respondent may choose the licensed service provider to deliver the involuntary assessment where possible and appropriate.~~

~~(3) If the court finds it necessary, it may order the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order or, if none is specified, to the nearest appropriate~~

~~licensed service provider for involuntary assessment.~~

~~(4) The order is valid only for the period specified in the order or, if a period is not specified, for 7 days after the order is signed.~~

Section 33. Section 397.6957, Florida Statutes, is amended to read:

397.6957 Hearing on petition for involuntary treatment services.—

(1)(a) The respondent must be present at a hearing on a petition for involuntary treatment services~~,~~ unless the court finds that he or she knowingly, intelligently, and voluntarily waives his or her right to be present or, upon receiving proof of service and evaluating the circumstances of the case, that his or her presence is inconsistent with his or her best interests or is likely to be injurious to self or others. The court shall hear and review all relevant evidence, including testimony from individuals such as family members familiar with the respondent's prior history and how it relates to his or her current condition, and the ~~review of~~ results of the assessment completed by the qualified professional in connection with this chapter. The court may also order drug tests. Upon a finding of good cause, the court may permit all witnesses, including, but not limited to, medical professionals who are or have been involved with the respondent's treatment, to remotely attend and testify at the hearing under oath via audio-video

teleconference. A witness intending to remotely attend and testify must provide the parties with all relevant documents by the close of business on the day before the hearing ~~the respondent's protective custody, emergency admission, involuntary assessment, or alternative involuntary admission. The respondent must be present unless the court finds that his or her presence is likely to be injurious to himself or herself or others, in which event the court must appoint a guardian advocate to act in behalf of the respondent throughout the proceedings~~.

(b) A respondent may not be involuntarily ordered into treatment under this chapter without a clinical assessment being performed, unless he or she is present in court and expressly waives the assessment. In nonemergency situations, if the respondent was not, or had previously refused to be, assessed by a qualified professional and, based on the petition, testimony, and evidence presented, it reasonably appears that the respondent qualifies for involuntary treatment services, the court shall issue an involuntary assessment and stabilization order to determine the appropriate level of treatment the respondent requires. Additionally, in cases where an assessment was attached to the petition, the respondent may request, or the court on its own motion may order, an independent assessment by a court-appointed or otherwise agreed upon qualified professional. If an assessment order is issued, it is valid for

90 days, and if the respondent is present or there is either proof of service or his or her location is known, the involuntary treatment hearing shall be continued for no more than 10 court working days. Otherwise, the petitioner must inform the court that the respondent has been assessed so that the court may schedule a hearing as soon as is practicable. The assessment must occur before the new hearing date, and if there is evidence indicating that the respondent will not voluntarily appear at the forthcoming hearing or is a danger to self or others, the court may enter a preliminary order committing the respondent to an appropriate treatment facility for further evaluation until the date of the rescheduled hearing. However, if after 90 days the respondent remains unassessed, the court shall dismiss the case.

(c)1. The respondent's assessment by a qualified professional must occur within 72 hours after his or her arrival at a licensed service provider unless the respondent shows signs of withdrawal or a need to be either detoxified or treated for a medical condition, which shall extend the amount of time the respondent may be held for observation until such issue is resolved but no later than the scheduled hearing date, absent a court-approved extension. If the respondent is a minor, such assessment must be initiated within the first 12 hours of the minor's admission to the facility. The service provider may also move to extend the 72 hours of observation by petitioning the

court in writing for additional time. The service provider must furnish copies of such motion to all parties in accordance with applicable confidentiality requirements, and after a hearing, the court may grant additional time. If the court grants the service provider's petition, the service provider may continue to hold the respondent, and if the original or extended observation period ends on a weekend or holiday, including the hours before the ordinary business hours of the following workday morning, the provider may hold the respondent until the next court working day.

2. No later than the ordinary close of business on the day before the hearing, the qualified professional shall transmit, in accordance with any applicable confidentiality requirements, his or her clinical assessment to the clerk of the court, who shall enter it into the court file. The report must contain a recommendation on the level of substance abuse treatment the respondent requires, if any, and the relevant information on which the qualified professional's findings are based. This document must further note whether the respondent has any co-occurring mental health or other treatment needs. For adults subject to an involuntary assessment, the report's filing with the court satisfies s. 397.6758 if it also contains the respondent's admission and discharge information. The qualified professional's failure to include a treatment recommendation, much like a recommendation of no treatment, shall result in the

petition's dismissal.

(2) The petitioner has the burden of proving by clear and convincing evidence that:

(a) The respondent is substance abuse impaired and has a history of lack of compliance with treatment for substance abuse; and

(b) Because of such impairment the respondent is unlikely to voluntarily participate in the recommended services or is unable to determine for himself or herself whether services are necessary and:

1. Without services, the respondent is likely to suffer from neglect or refuse to care for himself or herself; that 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 respondent will cause serious bodily harm to himself, herself, or another in the near future, as evidenced by recent behavior; or

2. The respondent'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.

(3) ~~One of the qualified professionals who executed the involuntary services certificate must be a witness. The court shall allow testimony from individuals, including family~~

~~members, deemed by the court to be relevant under state law, regarding the respondent's prior history and how that prior history relates to the person's current condition. The~~ Testimony in the hearing must be taken under oath, and the proceedings must be recorded. The respondent ~~patient~~ may refuse to testify at the hearing.

(4) If at any point during the hearing the court has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, meets the involuntary commitment provisions of part I of chapter 394, the court may initiate involuntary examination proceedings under such provisions.

(5) ~~(4)~~ At the conclusion of the hearing the court shall either dismiss the petition or order the respondent to receive involuntary treatment services from his or her chosen licensed service provider if possible and appropriate. Any treatment order must include findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

Section 34. Section 397.6975, Florida Statutes, is amended to read:

397.6975 Extension of involuntary treatment services period.—

(1) Whenever a service provider believes that an individual who is nearing the scheduled date of his or her

release from involuntary treatment services continues to meet the criteria for involuntary services in s. 397.68111 or s. 397.6957 ~~s. 397.693~~, a petition for renewal of the involuntary treatment services order may be filed with the court at least 10 days before the expiration of the court-ordered services period. The petition may be filed by the service provider or by the person who filed the petition for the initial treatment order if the petition is accompanied by supporting documentation from the service provider. The court shall immediately schedule a hearing within 10 court working days to be held not more than 15 days after filing of the petition and~~.~~ the court shall provide the copy of the petition for renewal and the notice of the hearing to all parties and counsel to the proceeding. The hearing is conducted pursuant to ss. 397.6957 and 397.697 and must be held before the circuit court unless referred to a magistrate ~~s. 397.6957~~.

(2) If the court finds that the petition for renewal of the involuntary treatment services order should be granted, it may order the respondent to receive involuntary treatment services for a period not to exceed an additional 90 days. When the conditions justifying involuntary treatment services no longer exist, the individual must be released as provided in s. 397.6971. When the conditions justifying involuntary services continue to exist after an additional 90 days of service, a new petition requesting renewal of the involuntary treatment

services order may be filed pursuant to this section.

~~(3) Within 1 court working day after the filing of a petition for continued involuntary services, the court shall appoint the office of criminal conflict and civil regional counsel to represent the respondent, unless the respondent is otherwise represented by counsel. The clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel of such appointment. The office of criminal conflict and civil regional counsel shall represent the respondent until the petition is dismissed or the court order expires or the respondent is discharged from involuntary services. Any attorney representing the respondent shall have access to the respondent, witnesses, and records relevant to the presentation of the respondent's case and shall represent the interests of the respondent, regardless of the source of payment to the attorney.~~

~~(4) Hearings on petitions for continued involuntary services shall be before the circuit court. The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this section shall be in accordance with s. 397.697.~~

~~(5) Notice of hearing shall be provided to the respondent or his or her counsel. The respondent and the respondent's counsel may agree to a period of continued involuntary services without a court hearing.~~

~~(6) The same procedure shall be repeated before the expiration of each additional period of involuntary services.~~

~~(7) If the respondent has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the respondent's competence.~~

Section 35. Section 397.6977, Florida Statutes, is amended to read:

397.6977 Disposition of individual upon completion of involuntary services.—

(1) At the conclusion of the 90-day period of court-ordered involuntary services, the respondent is automatically discharged unless a motion for renewal of the involuntary services order has been filed with the court pursuant to s. 397.6975.

(2) Discharge planning and procedures for any respondent's release from involuntary treatment services must include and document the respondent's needs, and actions to address such needs, for, at a minimum:

(a) Follow-up behavioral health appointments.

(b) Information on how to obtain prescribed medications.

(c) Information pertaining to available living arrangements and transportation.

(d) Referral to recovery support opportunities, including, but not limited to, connection to a peer specialist.

Section 36. Section 397.6811, Florida Statutes, is

repealed.

Section 37. Section 397.6814, Florida Statutes, is repealed.

Section 38. Section 397.6815, Florida Statutes, is repealed.

Section 39. Section 397.6819, Florida Statutes, is repealed.

Section 40. Section 397.6821, Florida Statutes, is repealed.

Section 41. Section 397.6822, Florida Statutes, is repealed.

Section 42. Section 397.6978, Florida Statutes, is repealed.

Section 43. Subsections (14) through (17) of section 916.106, Florida Statutes, are renumbered as subsections (15) through (18), respectively, and a new subsection (14) is added to that section, to read:

916.106 Definitions.—For the purposes of this chapter, the term:

(14) "Licensed medical practitioner" means a medical provider who is a physician licensed under chapter 458 or chapter 459 or an advanced practice registered nurse or physician assistant who works under the supervision of a licensed physician and an established protocol pursuant to ss. 458.347, 458.348, 464.003, and 464.0123.

Section 44. Section (2) of section 916.13, Florida Statutes, is amended to read:

916.13 Involuntary commitment of defendant adjudicated incompetent.—

(2) A defendant who has been charged with a felony and who has been adjudicated incompetent to proceed due to mental illness, and who meets the criteria for involuntary commitment under this chapter, may be committed to the department, and the department shall retain and treat the defendant.

(a) Immediately after receipt of a completed copy of the court commitment order containing all documentation required by the applicable Florida Rules of Criminal Procedure, the department shall request all medical information relating to the defendant from the jail. The jail shall provide the department with all medical information relating to the defendant within 3 business days after receipt of the department's request or at the time the defendant enters the physical custody of the department, whichever is earlier.

(b) Within 60 days after the date of admission and at the end of any period of extended commitment, or at any time the administrator or his or her designee determines that the defendant has regained competency to proceed or no longer meets the criteria for continued commitment, the administrator or designee shall file a report with the court pursuant to the applicable Florida Rules of Criminal Procedure.

(c)1. If the department determines at any time that a defendant will not or is unlikely to regain competency to proceed, the department shall, within 30 days after the determination, complete and submit a competency evaluation report to the circuit court to determine if the defendant meets the criteria for involuntary civil commitment under s. 394.467. A qualified professional, as defined in s. 394.455, must sign the competency evaluation report for the circuit court under penalty of perjury. A copy of the report shall be provided, at a minimum, to the court, state attorney, and counsel for the defendant before initiating any transfer of the defendant back to the committing jurisdiction.

2. For purposes of this paragraph, the term "competency evaluation report to the circuit court" means a report by the department regarding a defendant's incompetence to proceed in a criminal proceeding due to mental illness as set forth in this section. The report shall include, at a minimum, the following regarding the defendant:

a. A description of mental, emotional, and behavioral disturbances.

b. An explanation to support the opinion of incompetence to proceed.

c. The rationale to support why the defendant is unlikely to gain competence to proceed in the foreseeable future.

d. A clinical opinion regarding whether the defendant no

longer meets the criteria for involuntary forensic commitment pursuant to this section.

e. A recommendation on whether the defendant meets the criteria for involuntary services pursuant to s. 394.467.

(d) ~~(c)~~ The defendant must be transported, in accordance with s. 916.107, to the committing court's jurisdiction within 7 days after ~~of~~ notification that the defendant is competent to proceed or no longer meets the criteria for continued commitment. A determination on the issue of competency must be made at a hearing within 30 days of the notification. If the defendant is receiving psychotropic medication at a mental health facility at the time he or she is discharged and transferred to the jail, the administering of such medication must continue unless the jail physician documents the need to change or discontinue it. To ensure continuity of care, the referring mental health facility must transfer the patient with up to 30 days of medications and assist in discharge planning with medical teams at the receiving county jail. The jail and facility's licensed medical practitioners ~~department physicians~~ shall collaborate to ensure that medication changes do not adversely affect the defendant's mental health status or his or her ability to continue with court proceedings; however, the final authority regarding the administering of medication to an inmate in jail rests with the jail physician. Notwithstanding this paragraph, a defendant who meets the criteria for

involuntary examination pursuant to s. 394.463 as determined by an independent clinical opinion shall appear remotely for the hearing. Court witnesses may appear remotely.

Section 45. Subsection (6) of section 40.29, Florida Statutes, is amended to read:

40.29 Payment of due-process costs; reimbursement for petitions and orders.—

(6) Subject to legislative appropriation, the clerk of the circuit court may, on a quarterly basis, submit to the Justice Administrative Commission a certified request for reimbursement for petitions and orders filed under ss. 394.459, 394.463, 394.467, and 394.917, ~~and 397.6814,~~ at the rate of $40 per petition or order. Such request for reimbursement shall be submitted in the form and manner prescribed by the Justice Administrative Commission pursuant to s. 28.35(2)(i).

Section 46. Paragraph (b) of subsection (1) of section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455 ~~s. 394.455(49)~~.

Section 47. Paragraph (e) of subsection (4) of section 464.012, Florida Statutes, is amended to read:

464.012 Licensure of advanced practice registered nurses; fees; controlled substance prescribing.—

(4) In addition to the general functions specified in subsection (3), an advanced practice registered nurse may perform the following acts within his or her specialty:

(e) A psychiatric nurse, who meets the requirements in s. 394.455(37) ~~s. 394.455(36)~~, within the framework of an established protocol with a psychiatrist, may prescribe psychotropic controlled substances for the treatment of mental disorders.

Section 48. Subsection (7) of section 744.2007, Florida Statutes, is amended to read:

744.2007 Powers and duties.—

(7) A public guardian may not commit a ward to a treatment facility, as defined in s. 394.455 ~~s. 394.455(49)~~, without an involuntary placement proceeding as provided by law.

Section 49. Subsection (3) of section 916.107, Florida Statutes, is amended to read:

916.107 Rights of forensic clients.—

(3) RIGHT TO EXPRESS AND INFORMED CONSENT.—

(a) A forensic client shall be asked to give express and informed written consent for treatment. If a client refuses such treatment as is deemed necessary and essential by the client's

multidisciplinary treatment team for the appropriate care of the client, such treatment may be provided under the following circumstances:

1. In an emergency situation in which there is immediate danger to the safety of the client or others, such treatment may be provided upon the ~~written~~ order of a licensed medical practitioner ~~physician~~ for up to 48 hours, excluding weekends and legal holidays. If, after the 48-hour period, the client has not given express and informed consent to the treatment initially refused, the administrator or designee of the civil or forensic facility shall, within 48 hours, excluding weekends and legal holidays, petition the committing court or the circuit court serving the county in which the facility is located, at the option of the facility administrator or designee, for an order authorizing the continued treatment of the client. In the interim, the need for treatment shall be reviewed every 48 hours and may be continued without the consent of the client upon the continued ~~written~~ order of a licensed medical practitioner ~~physician~~ who has determined that the emergency situation continues to present a danger to the safety of the client or others.

2. In a situation other than an emergency situation, the administrator or designee of the facility shall petition the court for an order authorizing necessary and essential treatment for the client.

a. If the client has been receiving psychotropic medication at the jail at the time of transfer to the forensic or civil facility and lacks the capacity to make an informed decision regarding mental health treatment at the time of admission, the admitting licensed medical practitioner ~~physician~~ shall order continued administration of psychotropic medication if, in the clinical judgment of the licensed medical practitioner ~~physician~~, abrupt cessation of that psychotropic medication could pose a risk to the health or safety of the client while a court order to medicate is pursued. The administrator or designee of the forensic or civil facility shall, within 5 days after a client's admission, excluding weekends and legal holidays, petition the committing court or the circuit court serving the county in which the facility is located, at the option of the facility administrator or designee, for an order authorizing the continued treatment of a client with psychotropic medication. The jail physician shall provide a current psychotropic medication order at the time of transfer to the forensic or civil facility or upon request of the admitting licensed medical practitioner ~~physician~~ after the client is evaluated.

b. The court order shall allow such treatment for up to 90 days after the date that the order was entered. Unless the court is notified in writing that the client has provided express and informed written consent or that the client has been discharged

by the committing court, the administrator or designee of the facility shall, before the expiration of the initial 90-day order, petition the court for an order authorizing the continuation of treatment for an additional 90 days. This procedure shall be repeated until the client provides consent or is discharged by the committing court.

3. At the hearing on the issue of whether the court should enter an order authorizing treatment for which a client was unable to or refused to give express and informed consent, the court shall determine by clear and convincing evidence that the client has mental illness, intellectual disability, or autism, that the treatment not consented to is essential to the care of the client, and that the treatment not consented to is not experimental and does not present an unreasonable risk of serious, hazardous, or irreversible side effects. In arriving at the substitute judgment decision, the court must consider at least the following factors:

a. The client's expressed preference regarding treatment;

b. The probability of adverse side effects;

c. The prognosis without treatment; and

d. The prognosis with treatment.

The hearing shall be as convenient to the client as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the client's

condition. The court may appoint a general or special magistrate to preside at the hearing. The client or the client's guardian, and the representative, shall be provided with a copy of the petition and the date, time, and location of the hearing. The client has the right to have an attorney represent him or her at the hearing, and, if the client is indigent, the court shall appoint the office of the public defender to represent the client at the hearing. The client may testify or not, as he or she chooses, and has the right to cross-examine witnesses and may present his or her own witnesses.

(b) In addition to the provisions of paragraph (a), in the case of surgical procedures requiring the use of a general anesthetic or electroconvulsive treatment or nonpsychiatric medical procedures, and prior to performing the procedure, written permission shall be obtained from the client, if the client is legally competent, from the parent or guardian of a minor client, or from the guardian of an incompetent client. The administrator or designee of the forensic facility or a designated representative may, with the concurrence of the client's attending licensed medical practitioner ~~physician~~, authorize emergency surgical or nonpsychiatric medical treatment if such treatment is deemed lifesaving or for a situation threatening serious bodily harm to the client and permission of the client or the client's guardian could not be obtained before provision of the needed treatment.

Section 50. Subsection (5) of section 916.15, Florida Statutes, is amended to read:

916.15 Involuntary commitment of defendant adjudicated not guilty by reason of insanity.—

(5) The commitment hearing shall be held within 30 days after the court receives notification that the defendant no longer meets the criteria for continued commitment. The defendant must be transported to the committing court's jurisdiction for the hearing. Each defendant returning to a jail shall continue to receive the same psychotropic medications as prescribed by the facility's licensed medical practitioner ~~facility physician~~ at the time of discharge from a forensic or civil facility, unless the jail physician determines there is a compelling medical reason to change or discontinue the medication for the health and safety of the defendant. If the jail physician changes or discontinues the medication and the defendant is later determined at the competency hearing to be incompetent to stand trial and is recommitted to the department, the jail physician may not change or discontinue the defendant's prescribed psychotropic medication upon the defendant's next discharge from the forensic or civil facility.

Section 51. This act shall take effect July 1, 2024.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	_____	

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee
Representative Maney offered the following:

Amendment

Remove lines 1764-1798 and insert:

the department under s. 394.9082(3)(c) and is in need of such services.

2.~~3.~~ Recovery support opportunities under s. 394.4573(2)(l), including, but not limited to, connection to a peer specialist.

(3) During the discharge transition process and while the patient is present unless determined inappropriate by a licensed medical practitioner, a receiving facility shall coordinate, face-to-face or through electronic means, discharge plans to a less restrictive community behavioral health provider, a peer

specialist, a case manager, or a care coordination service. The transition process must include all of the following criteria:

(a) Implementation of policies and procedures outlining strategies for how the receiving facility will comprehensively address the needs of patients who demonstrate a high use of receiving facility services to avoid or reduce future use of crisis stabilization services.

(b) Developing and including in discharge paperwork a personalized crisis prevention plan that identifies stressors, early warning signs or symptoms, and strategies to deal with crisis.

(c) Requiring a staff member to seek to engage a family member, legal guardian, legal representative, or natural support in discharge planning and meet face to face or through electronic means to review the discharge instructions, including prescribed medications, follow-up appointments, and any other recommended services or follow-up resources, and document the outcome of such meeting.

(d) When the recommended level of care at discharge is not immediately available to the patient, the receiving facility must at a minimum initiate a referral to an appropriate provider to meet the needs of the patient to continue care until the recommended level of care is available.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___ (Y/N)
ADOPTED AS AMENDED	___ (Y/N)
ADOPTED W/O OBJECTION	___ (Y/N)
FAILED TO ADOPT	___ (Y/N)
WITHDRAWN	___ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Maney offered the following:

Amendment (with title amendment)

Between lines 2746 and 2747, insert:

Section 51. For the 2024-2025 fiscal year, the sum of $50,000,000 of recurring funds from the General Revenue Fund are provided to the Department of Children and Families to implement provisions of the bill.

T I T L E A M E N D M E N T

Remove line 222 and insert:

providing an appropriation; providing an effective date.