HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1197 w/CS Relating to Baker Act
SPONSOR(S): Simmons
TIED BILLS: **IDEN./SIM. BILLS:** SB 2748

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder Affairs & Long-Term Care (Sub)	8 Y, 0 N	Walsh	Liem
2) Future of Florida's Families	14 Y, 1 N w/CS	Walsh	Liem
3) Judiciary	15 Y, 0 N	Billmeier	Havlicak
4) Appropriations		Davis	Hansen
5)			

SUMMARY ANALYSIS

Committee Substitute for HB 1197 amends the Baker Act to provide outpatient treatment options for persons subject to the Act.

The CS adds language permitting a person to be taken to a receiving center for an involuntary examination using the person's relevant medical and treatment history as evidence to be considered in the involuntary examination. It amends the criteria for involuntary examinations to include that, based on the person's present condition and well-established history, there is a substantial likelihood that without care or treatment in the reasonably foreseeable future the person's condition will deteriorate to the point where they pose a real and present threat of substantial harm to their own well being or that of others.

The CS expands "placement" to include involuntary outpatient placement as well as involuntary inpatient placement. The CS allows a person to agree to be examined on an outpatient basis for an involuntary outpatient placement certificate.

The CS requires a hearing for involuntary outpatient treatment. The CS requires that a petition for involuntary outpatient placement can be filed only if the full array of treatment programs or services are available in the patient's local community.

The CS establishes an Involuntary Outpatient Placement Implementation Task Force, which must provide a report by December 1, 2003.

The CS contains a severability clause.

The CS becomes effective on October 1, 2004, except as otherwise provided.

The Office of the State Courts Administrator (OSCA) estimates that, because of the delayed implementation date, the CS will cause no fiscal impact on the state courts system in FY 2003-2004. However, once the CS becomes effective (October 1, 2004), its fiscal impact will be $450,000 to $1.24 million. The Florida Sheriffs Association reports that substantial savings, up to $64.8 million, may result if there are fewer arrests and less need for county jail beds.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[]	N/A[x]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[x]	N/A[]
4. Increase personal responsibility?	Yes[]	No[x]	N/A[]
5. Empower families?	Yes[]	No[]	N/A[x]

For any principle that received a "no" above, please explain:

3.and 4. The bill limits individual freedom and decreases personal responsibility in that the criteria for involuntary outpatient placement allows a person to be involuntarily examined and treated based upon a third party's belief that "there is a substantial likelihood" that the person's condition will deteriorate taking into account the person's current reported or observed behavior and previous mental health history.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

Part I of Chapter 394, F.S., is known as the Florida Mental Health Act or the "Baker Act." The Baker Act contains all of the statutory provisions for the involuntary examination and the involuntary placement of persons who are mentally ill and require mental health treatment.

Section 394.463, F.S., specifies the criteria for an involuntary mental health examination. A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she is mentally ill and because of his mental illness the person:

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

Section 394.463(2)(f), F.S., states that a patient must be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may not be held in a receiving facility for involuntary examination longer than 72 hours. At the end of 72 hours, the patient must be released or a petition filed with the court for involuntary placement in a mental health receiving or treatment facility.

Section 394.467(1), F.S., includes the Baker Act provisions for the involuntary placement of a patient in a mental health treatment or receiving facility A person may be involuntarily placed for treatment upon a finding of the court by clear and convincing evidence that the person is mentally ill and because of the mental illness the person:

- has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
- is unable to determine for himself if placement is necessary; and
- is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself which poses a real and present threat of substantial harm to his well-being; or
- there is substantial likelihood, as evidenced by recent behavior, that in the near future he will inflict serious bodily harm on himself or another person, causing, attempting, or threatening harm; and
- all available less restrictive treatment alternatives which would offer an opportunity for improvement of his condition have been judged to be inappropriate.

According to Baker Act data collected by the Agency for Health Care Administration and analyzed by the Louis de la Parte Florida Mental Health Institute, 84,162 adults received an involuntary examination pursuant to s. 394.463, F.S., during 2002. Of those, 12,186 received multiple examinations. The table indicates the number of involuntary examinations completed and the number of adults with multiple exams in 2000, 2001, and 2002. The three-year total is also summarized.

	Data Received in Calendar Years			**2000 through 2002 (36 Month Period)**
	2000	**2001**	**2002**	
% Forms missing age	*9*	*6*	*4*	*8*
% Forms missing SSN (for adults)	*3*	*3*	*3*	*3*
# Examinations for adults	61,906	74,382	84,162	220,448
# Adults with multiple exams:	8,356	10,696	12,186	33,876
2 exams	5,649	7,157	7,957	19,627
3	1,599	1,998	2,278	6,658
4	566	775	919	2,993
5	247	332	437	1,625
6	113	178	235	939
7	67	98	139	589
8	47	52	75	420
9	23	29	51	258
10	9	30	23	193

Mental health advocates and professionals believe that many hospitalizations could be avoided if a person with serious mental illness received early interventions and appropriate treatment services prior to his mental decompensation. In many cases when persons with mental illness do not receive the proper services, other serious problems exist such as becoming homeless, incarcerated, suicidal, victimized or prone to violent episodes.

Judges and other professionals in Florida's criminal system and mental health system find that many persons with mental illness who commit misdemeanors cycle in and out of the county jails because they do not have access to the appropriate mental health treatment and support services.[1] These experts believe that persons with mental illness continue to commit misdemeanors for the following reasons:

[1] *Jail Diversion Strategies for Misdemeanor Offenders with Mental Illness: Preliminary Report*, Department of Mental Health Law & Policy, Florida Mental Health Institute, University of South Florida, 1999.

- many persons are not diagnosed and treated in jail immediately after arrest,
- many persons who are stabilized in jail or in a mental health facility decompensate quickly when returning to their home because the appropriate psychiatric medications or other treatment modalities that help maintain mental stability are discontinued, and
- there is a lack of managing and monitoring of the client in the community to assure that service needs are being met.

Mental health experts in Florida's community mental health system believe that one of the more subtle outcomes of the deinstitutionalization of persons with mental illness from the state mental health hospitals has been their reinstitutionalization in the criminal justice system.[2]

Many states have adopted new treatment standards that are not based solely on dangerousness to self or other but are based on a patient's well established medical and treatment history and other factors such as self-neglect, violence, or arrest for criminal behavior. Forty one other states have laws allowing courts to order participation in outpatient treatment.[3]

An evidence-based review was conducted by researchers of the empirical literature on involuntary outpatient treatment.[4] They found that only two randomized clinical trials of involuntary outpatient treatment have been conducted, one in New York City and one by Duke University investigators in North Carolina, and those studies produced conflicting conclusions.

The New York City study found no statistically significant differences in rates of rehospitalization, arrests, quality of life, psychiatric symptoms, homelessness or other outcomes between the involuntary outpatient treatment group and those who receive intensive services but without a commitment order. The researchers point out that the New York study included a small sample size, non-equivalent comparison groups, and a lack of enforcement of court orders that may have affected the findings making it difficult to draw definitive conclusions.

The Duke study suggests that a sustained outpatient commitment order (180+ days), when combined with intensive mental health services, may increase treatment adherence and reduce the risk of negative outcomes such as relapse, violent behavior, victimization, and arrest. According to the Duke investigators, two factors associated with reduced recidivism and improved outcomes among people with severe mental illness appear to be intensive mental health treatment and enhanced monitoring for a sustained period of time. In the Duke study, outcomes were only improved for those under court order who received intensive mental health services. The researchers could not conclude if court orders without intensive treatment make a difference in client outcomes.

EFFECTS OF THE BILL

The CS amends section 394.466, F.S., to add definitions of service provider and involuntary placement.

The CS amends section 394.4598, F.S., relating to the Guardian Advocate, to correct cross-references and to require that the guardian advocate be discharged from an order for involuntary inpatient or outpatient placement when the patient is transferred to voluntary status.

The CS amends section 394.4615, F.S., relating to confidentiality of clinical records, to allow for release of information from the clinical record to when determining whether a person meets the criteria for involuntary outpatient placement. The CS specifies that the records may be released to the state

[2] *Emerging Judicial Strategies for the Mentally Ill*, Bureau of Justice Assistance, April 2000.
[3] *Briefing Paper*, Treatment Advocacy Center, Arlington, Virginia, March 2003. *See also* www.psychlaws.org
[4] *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, M. Susan Ridgely, Randy Borum, John Petrila,, Santa Monica, CA, RAND, MR-1340-CSCR, 2001. *See* www.rand.org/publications/MR/MR1340

attorney, the public defender or the patient's private legal counsel, the court, and the appropriate mental health professionals.

The CS amends section 394.463, F.S., relating to involuntary examinations, to provide additional criteria to take a person to a receiving facility for involuntary examination. The CS requires that there must be a reason to believe that the person has a mental illness; that based on the person's past or current behavior there is a substantial likelihood that without care or treatment the person will neglect or refuse to care for himself, or the person will cause serious bodily harm to himself or others in the future.

The CS newly requires that the Agency for Health Care Administration (AHCA) receive and maintain copies of involuntary outpatient and involuntary inpatient placement orders.

The CS allows a patient to be offered voluntary placement if he does not meet the criteria for involuntary inpatient or outpatient placement. It also requires that a petition for involuntary inpatient or outpatient placement shall be filed in the appropriate court by the petitioner.

The CS creates new section 394.465, F.S., relating to involuntary outpatient placement, which is outlined hereunder.

Provides criteria for involuntary outpatient placement

Requires the court to find by clear and convincing evidence that

The person is 18 or older, **and**
The person has a mental illness, **and**
Based on a clinical determination the person is unlikely to survive safely in the community without supervision, **and**
The person has a history of noncompliance with treatment for mental illness.

The person has
At least twice within the last 36 months been admitted for examination or placement in a receiving or treatment facility or forensic or correctional facility, which period of time excludes any period during which the person was admitted or incarcerated immediately preceding the filing of the petition; **or**
Engaged in one or more acts or attempts of acts of violence to self or others within the last 36 months, **and**
The person is unlikely to voluntarily participate in treatment, **and**
The person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration of condition which would result in harm to self or others; **and**
The person will likely benefit from involuntary outpatient placement; **and**
All available less restrictive alternatives have been judged to be inappropriate.

Each of the criteria must be alleged and substantiated in a petition for involuntary outpatient placement which shall include a clinical determination by a qualified professional. The qualified professional must attend the hearing. The patient is allowed to present testimony and evidence and to rebut the allegations.

Provides procedure for involuntary outpatient placement

<u>From a receiving facility</u>

Upon recommendation of the facility administrator, a patient may be retained by a receiving facility unless the patient is stabilized and no longer meets the criteria for involuntary examination, in which case the patient must be placed in outpatient treatment while awaiting hearing.

The recommendation must be based on the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have examined the patient within the preceding 72 hours.

In counties of less than 50,000 persons and upon certification by the facility administrator that such a second opinion cannot be obtained, the second opinion may be provided by a licensed physician with training and experience in mental disorders or by a psychiatric nurse.

The recommendations are to be entered on an involuntary outpatient placement certificate.

Agreed examination for involuntary outpatient placement

A patient may be examined on an outpatient basis for an involuntary outpatient placement certificate in a manner similar to that from a receiving facility. However, the certificate must be supported by the opinion of a psychiatrist and clinical psychologist or another psychiatrist, both of whom have examined the patient within the preceding 14 days.

From a treatment facility

A patient may be examined in a treatment facility for an involuntary outpatient placement certificate in a manner similar to that from a receiving facility, prior to the expiration of the period during which the treatment facility is authorized to retain the patient.

Provides requirements for petition for involuntary outpatient placement

Allows petition for involuntary outpatient placement to be filed **only** when the full range of services that the person needs for mental health treatment and to live and function successfully in the patient's local community. It must be accompanied by an affidavit attesting to the availability of these services.

The petition may be filed by the receiving or treatment facility administrator or one of the examining professionals. It must be filed in county where patient is located. The Clerk of Court shall provide copies of the petition to DCF, the patient, his guardian or representative, the state attorney and the public defender.

Appointment of counsel

The CS requires that the public defender be appointed to represent the person who is the subject of the petition within one working day of receipt. The patient is entitled to one continuance of the hearing of up to four weeks with consent of his counsel.

Provides requirements for hearing on involuntary outpatient placement

The hearing shall be held within 5 days in the county where the patient is located. The state attorney shall represent the state as the real party in interest.

A master may be appointed to preside. One of the examining professionals must testify at the hearing. The patient has the right to an independent expert examination. The court must allow testimony from individuals, including the person's family members, deemed by the court to be relevant, regarding the person's prior history and how it relates to the person's current condition. The testimony must be under oath and the proceedings recorded. The patient may refuse to testify.

The court shall issue an order for involuntary outpatient placement for up to six months if the court concludes the patient meets the criteria. The service provider shall discharge the patient at any time the patient no longer meets the criteria.

The receiving facility administrator or designated department representative shall identify a service provider having primary responsibility for the patient. The service provider shall prepare a written treatment plan for submittal to the court prior to the hearing for consideration by the court for inclusion in the involuntary outpatient treatment order. The plan may provide for multiple services. The service provider will certify that the services are available and will be provided, and are deemed clinically appropriate by the provider's treatment professional.

The court cannot order services which are not available in the patient's local community or in which there is no space available or for which no funding is available. The treatment plan can be modified after the placement order is entered upon agreement of the patient and the service provider. Agreed modifications require notice to the court; modifications with which the patient disagrees must be approved by the court.

When, in the clinical judgment of a physician, the patient fails or refuses to comply with the ordered involuntary outpatient treatment plan, and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility to determine whether modifications should be made to the treatment plan and to attempt to engage the patient in involuntary outpatient treatment. The treatment plan can be modified upon agreement of the patient or his guardian advocate and the service provider. Agreed modifications require notice to the court; modifications with which the patient or his guardian advocate disagrees must be approved by the court.

If prior to the conclusion of the initial hearing it appears that the person meets the criteria for involuntary inpatient placement or involuntary assessment, protective custody, or involuntary admission, the court may order the person admitted for involuntary assessment for a period of five days.

At the hearing, the court shall consider testimony and evidence regarding the patient's competence to consent to treatment. If the patient is found to be incompetent, the court must appoint a guardian advocate.

The service provider must be provided with necessary documentation regarding the patient's mental illness, advance directives, and evaluations.

Guardian Advocate

The guardian advocate must be appointed by the court from a list of qualified and available guardian advocates submitted to the court with the petition.

The role of the guardian advocate is to monitor the patient's care to ensure that the patient's rights are protected.

The guardian advocate is immune from liability under this provision.

Procedure for continued involuntary outpatient placement

The service provider shall file a continued involuntary outpatient placement certificate prior to expiration of the ordered treatment plan if the person continues to meet the criteria for involuntary outpatient placement. The certificate must be accompanied by a physician's statement justifying the request.

The public defender shall be appointed to represent the person on the petition within one court working day of receipt.

Procedures for hearings for continued involuntary outpatient placement are the same as for the initial hearing except that the court need not consider whether the person has at least twice within the last 36 months been admitted for examination or placement in a receiving or treatment facility or forensic or correctional facility, which period of time excludes any period during which the person was admitted or incarcerated immediately preceding the filing of the petition; or engaged in one or more acts or attempts of acts of violence to self or others within the last 36 months.

This procedure shall be repeated prior to expiration of each additional treatment period.

Involuntary inpatient placement

The CS amends section 394.467, F.S., to clarify that it relates to involuntary inpatient treatment and to correct cross-references.

Involuntary Outpatient Placement Implementation Task Force

The CS establishes an Involuntary Outpatient Placement Implementation Task Force (Task Force) to develop a plan for implementation of the procedures established in this act.

The Task Force is composed of one representative from each of the following entities, designated no later than July 1, 2003:

- Florida Sheriff's Association
- Florida Police Chief's Association
- Florida Public Defender Association, Inc.
- Florida Prosecuting Attorneys Association
- Florida Association of Court Clerks
- DCF
- Florida Council for Community Mental Health
- AHCA
- A Member of the House of Representatives, appointed by the Speaker of the House
- A Member of the Senate, appointed by the President of the Senate
- Executive Office of the Governor, designated by the Governor
- A Circuit Judge, appointed by the Chief Justice of the Supreme Court

Co-chairs shall be the circuit judge appointed by the Chief Justice and the representative of the Florida Sheriff's Association.

The Task Force shall convene by August 1, 2003. Staff support for the initial meeting shall be provided by staff of the House Committee on the Future of Florida's Families and the Senate Committee on Children & Families. Co-chairs will arrange for Staff support for subsequent meetings and preparation of the implementation plan and report. Expenses for participation will be borne by each entity.

The implementation plan and report shall include at a minimum:

- Identification of issues and proposed strategies for court-ordered outpatient mental health treatment
- Evaluation process to determine effectiveness of involuntary outpatient treatment
- Proposed technical amendments to Florida Statutes if necessary and appropriate
- Recommended process to collect data on the impact on the courts, state attorneys, public defenders, clerks of court, law enforcement, jails, and mental health treatment system

The implementation plan and report is to be submitted to the Speaker of the House, the President of the Senate, the Governor, and the Chief Justice of the Supreme Court by December 1, 2003.

The CS provides that the provisions of this act are severable.

The CS provides that the act is effective October 1, 2004, except as otherwise provided.

C. SECTION DIRECTORY:

Section 1: Amends section 394.455, F.S., to add definitions of service provider and involuntary placement.

Section 2: Amends section 394.4598, F.S., relating to the Guardian Advocate, to correct cross-references; to require that the guardian advocate be discharged from an order for involuntary inpatient or outpatient placement when the patient is transferred to voluntary status.

Section 3: Amends section 394.4615, F.S., relating to confidentiality of clinical records, to allow for release of information to the state attorney, public defender or the patient's private legal counsel, the court, and the appropriate mental health professionals from the clinical record when determining whether a person meets the criteria for involuntary outpatient placement.

Section 4: Amends section 394.463, F.S., relating to involuntary examinations, to provide additional criteria to take a person to a receiving facility for involuntary examination; requires that there must be a reason to believe that the person has a mental illness; requires that based on the person's past or observed behavior there is a substantial likelihood that without care or treatment the person will neglect or refuse to care for himself, or the person will cause serious bodily harm to himself or others in the future; requires that AHCA receive and maintain copies of certain orders; allows patient to be offered voluntary placement if he does not meet the criteria for involuntary inpatient or outpatient placement; requires that a petition for involuntary inpatient or outpatient placement shall be filed in the appropriate court by the petitioner.

Section 5: Creates section 394.465, F.S., relating to involuntary outpatient placement; provides criteria for involuntary outpatient placement; provides procedure for involuntary outpatient placement from a receiving facility and from a treatment facility; provides for voluntary examination for outpatient placement; provides requirements for petition for involuntary outpatient placement; provides for appointment of counsel; provides for continuance of hearing; provides requirements for hearing on involuntary outpatient placement; provides that a person may be brought to a receiving facility to determine whether modifications should be made to the treatment plan and to attempt to engage the patient in involuntary outpatient treatment; provides procedure for continued involuntary outpatient placement

Section 6: Amends section 394.467, F.S., relating to involuntary inpatient placement; clarifies that the section relates to involuntary inpatient treatment and corrects cross-references.

Section 7: Provides that the provisions of this act are severable.

Section 8: Establishes Involuntary Outpatient Placement Implementation Task Force; names members; requires designation of representatives by July 1, 2003; requires that Task Force receive input from interested parties; requires that Task Force convene by August 1, 2003; provides for staff support; requires implementation plan; specifies contents; requires report by December 1, 2003.

Section 9: Provides an effective date of October 1, 2004, except as otherwise provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None

2. Expenditures:

The Department of Children and Families advises that, because the CS removed two broad criteria for involuntary examination present in the original bill, there will be a minimal fiscal impact that will be absorbed within existing department resources.[5] However, it appears that those "two broad criteria for involuntary examination" have been moved to new section 394.466(1), F.S., Criteria for involuntary outpatient placement, within the CS.

The Office of the State Courts Administrator estimates no fiscal impact to the state courts system in FY 2003-2004 due to the delayed implementation date. However, once the CS becomes effective (October 1, 2004), its fiscal impact will be $450,000 to $1.24 million.

There could be increased workload on State Attorneys and Public Defenders. No fiscal note is on file from either association.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

The Florida Sheriffs Association reports that substantial savings, up to $64.8 million, may result if there are fewer arrests and less need for county jail beds.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The bill may require a city or county to expend funds or take action requiring the expenditure of funds. However, there is no showing that any required expenditures would exceed an amount considered insignificant.

2. Other:

[5] E-mail from Ron Kizirian, Management Analyst, Mental Health Program Office, Department of Children and Families, dated March 31, 2003.

The bill raises concerns regarding the constitutionality of depriving persons of their liberty based upon past history as a precursor of future action, i.e., whether the criteria for involuntary outpatient placement will withstand a state or federal liberty interest challenge.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The CS grants the guardian advocate "immunity from liability." The immunity does not specifically relate to the stated role of the guardian advocate and may be drawn too broadly to protect the interests of the patient.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On April 1, 2003, the Subcommittee on Elder Affairs & Long-Term Care adopted a strike all amendment to HB 1197. The amendment made the following major changes to the bill as filed:

- Amend s. 394.455, F.S., to add definition of involuntary placement;
- Amend s. 394.4615, F.S., to allow for release of information from the clinical record when determining whether a person meets the criteria for involuntary outpatient placement;
- Amend s. 394.463, F.S., to provide additional criteria to take a person to a receiving facility for involuntary examination; requires that there must be a reason to believe that the person has a mental illness; requires that based on the person's past or current behavior there is a substantial likelihood that without care or treatment the person will neglect or refuse to care for himself, or the person will cause serious bodily harm to himself or others in the future;
- Reorganized the proposed statutory scheme to create new s. 394.465, F.S., relating to involuntary outpatient placement; provided new criteria for involuntary outpatient placement; provided procedure for involuntary outpatient placement from a receiving facility and from a treatment facility; provided for voluntary examination for outpatient placement; provided requirements for petition for involuntary outpatient placement; provided requirements for hearing on involuntary outpatient placement; provided that a person may be brought to a receiving facility to determine whether modifications should be made to the treatment plan and to attempt to engage the patient in involuntary outpatient treatment; provided for voluntary treatment agreements; provided procedure for continued involuntary outpatient placement.

On April 14, 2003, the Committee on the Future of Florida's Families adopted a substitute amendment to that amendment as a Committee Substitute. The substitute amendment made the following major changes to the strike all amendment:

- Removes authority of service provider to seek order to bring person to receiving facility for the administration of medications
- Restricts access to clinical records to certain named individuals
- Reduces the number of months during which a person must not have engaged in acts of violence to self or others
- Allows patient to present evidence to rebut allegations in petition for involuntary outpatient treatment
- Requires that the patient be retained in a receiving facility unless the patient is stabilized and no longer meets the criteria for an involuntary examination
- Allows the patient to agree to voluntary examination
- Adds requirement that a petition for involuntary outpatient examination be filed only when a full range of services to enable the person to live and function in the community are available
- Adds requirements that testimony about the patient must be deemed relevant under Florida law by the court
- Removes guardian advocate as person who can seek or contest modification of a treatment plan

- Removes limits on contempt powers of the court
- Adds immunity from liability for guardian advocate
- Removes authority of guardian advocate to seek order to bring person to receiving facility for the administration of medications
- Establishes Involuntary Outpatient Placement Implementation Task Force and requires report by December 1, 2003
- Changes effective date to October 1, 2004