HOUSE OF REPRESENTATIVES STAFF ANALYSIS

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

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder Affairs & Long-Term Care (Sub)		Walsh	Liem
2) Future of Florida's Families			
3) Judiciary			
4) Appropriations			
5)			

SUMMARY ANALYSIS

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

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

The bill requires a hearing for voluntary or involuntary treatment. The bill requires that an outpatient placement order can be issued only if the program or services are available in the local community, if there is space available, and if funding is available.

The placement order must specify that if the person does not comply with the treatment plan, the service provider may seek an ex parte order for involuntary examination to determine whether the outpatient placement is still the least restrictive treatment alternative for the person. If the person is deemed noncompliant with the treatment plan, the court shall use sanctions.

The bill provides for voluntary treatment agreements. The bill adds a procedure for continued involuntary outpatient placement.

The bill contains a severability clause and becomes effective on July 1, 2003.

There is a significant fiscal impact associated with this bill. The Department of Children and Families estimates appropriations consequences in excess of $16 million per year. The Office of the State Court Administrator (OSCA) conservatively estimates that the fiscal impact of the bill on the state courts system is $1.24 to $2.7 million in fiscal year 2003-2004. The Florida Sheriff's Association estimates potential savings of $64.8 million. There will also be costs to local governments relating to mental health treatment and court costs; however, until the Revision 7 transition to state funding has been completed, it is difficult to determine the fiscal impact on local government. Please see Fiscal Comments section for further information.

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 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

HB 1197 adds a definition of service provider to include public or private receiving facilities under contract with DCF, or a clinical psychologist, clinical social worker, physician, psychiatric nurse, community mental health center, or clinic.

The bill allows a service provider to seek an *ex parte* order pursuant to s. 394.463(2)(a), F.S., and allows the guardian advocate to consent to administration of medication over the objection of the person when he or she has been brought to a receiving center. The guardian advocate must be discharged when the person is discharged from an order for involuntary inpatient or outpatient placement.

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[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

The bill 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 well-established history includes having one or more acute psychiatric episodes resulting in serious physical violence or having two or more separate episodes within the preceding 36 months wherein the person has been admitted for examination or placement in a receiving or treatment facility or arrested for criminal behavior, not including the period the person was in a receiving or treatment facility or incarcerated.

The bill requires that AHCA receive and maintain copies of placement orders issued pursuant to s. 394.467(7)(b), F.S., and voluntary treatment agreements issued pursuant to s. 394.4625, F.S.

The bill provides that when treatment is deemed necessary, a petition for involuntary inpatient or outpatient placement is to be filed in the appropriate court by the petitioner.

The bill requires that a court must consider a person's relevant medical and treatment history when placing a person in involuntary inpatient treatment.

The bill expands "placement" to include outpatient placement as well as inpatient placement. Criteria for ordering involuntary outpatient treatment are added that closely follow the language authorizing inpatient placement. The involuntary outpatient placement can be required when all available less restrictive treatment alternatives which would offer an opportunity for improvement have been determined to be inappropriate. Examiners must include a determination as to whether the patient is competent to provide consent for a voluntary treatment agreement.

The bill allows a person to agree to be examined on an outpatient basis for an involuntary outpatient placement certificate. The certificate must be supported by a psychiatrist and a second opinion by a psychologist, another psychiatrist, or a qualified licensed physician. Both must have examined the person in the preceding 14 days and both must have determined that the person meets the criteria for involuntary outpatient placement.

The bill adds a second means by which a petition for involuntary placement may be filed. One of the examining professionals may file a petition requesting involuntary outpatient placement. The petition is to be filed in the circuit court in the county where the patient is located. The bill requires appointment of a public defender for persons the subject of a petition for involuntary inpatient or outpatient treatment.

The bill requires a hearing for voluntary or involuntary treatment. The court shall permit relevant testimony from family, friends, and other individuals regarding the person's prior history and how that prior history relates to their current condition. The bill requires the court to issue an order for outpatient placement if it concludes that the person meets the criteria for involuntary outpatient placement. This order shall be for a period of up to six months. However, the facility or service provider must discharge the patient from outpatient placement when the person no longer meets the criteria for involuntary outpatient treatment.

The bill requires that the placement order must specify the nature and extent of the person's mental illness and whether treatment shall be on an inpatient or outpatient basis.

For an outpatient treatment order, the bill requires that the service provider have primary treatment responsibility. Prior to the hearing, the service provider must prepare and submit a treatment plan to

the court, which plan will be included in the outpatient placement order. The plan may include an extensive range of services such as: case management, assertive community treatment, medication, substance abuse treatment, urinalysis and periodic testing, therapy, day treatment, educational and vocational training, supervision of living arrangements, and other services prescribed to treat the person's mental illness and to assist in maintaining the person living and functioning in the community or to attempt to prevent a relapse or deterioration. The bill requires that the service provider must certify to the court that these services are available and will be provided.

The bill authorizes the service provider to supervise other individuals relevant to specific aspects of the treatment plan. A physician, clinical psychologist, psychiatric nurse, or clinical social worker who consults with or is employed by the service provider must determine that the services ordered are clinically appropriate.

The bill requires that an outpatient placement order can be issued only if the program or services are available in the local community, if there is space available, and if funding is available. The court order shall specify if outpatient placement could not be ordered.

The bill requires that after the outpatient placement order is issued, the service provider and the patient may agree to modify provisions of the plan. If both agree on the plan revisions, the service provider must notify the court of the revisions. If both do not agree on the revisions, the court will decide what revisions may be made.

The placement order must specify that if the person does not comply with the plan, the service provider may seek an *ex parte* order for involuntary examination to determine whether the outpatient placement is still the least restrictive treatment alternative for the person. If the receiving facility determines that inpatient treatment is not necessary, the service provider should determine whether the plan should be modified and an attempt be made to continue to engage the person in treatment. The plan may be modified as stated in the above paragraph**. If the person is deemed noncompliant with the treatment plan, the court shall use sanctions** other than monetary fines or placement in a county or regional jail or work camp.

The bill adds a requirement that if the patient is found incompetent to consent to treatment and has an involuntary outpatient treatment order that includes medication, and the patient refuses the medication, the service provider may seek an *ex parte* order, and the guardian advocate may consent to administration of medications over the objections of the patient.

The bill provides for voluntary treatment agreements. The requirement that a hearing to be held within five days of a petition being filed for involuntary examination, may be waived by a person for a period not to exceed 90 days from the date of the waiver, if the person and the state attorney appointed under s. 394.467, F.S., agree anytime after the beginning of the proceedings that the person shall obtain treatment under a voluntary treatment agreement. An assessment of the person's ability to give consent shall be performed during the examination.

The bill requires that voluntary treatment agreements must be in writing and provide a treatment plan that provides treatment in the least restrictive manner consistent with the needs of the person. If, within 90 days from the date of the waiver, the person fails to comply with the voluntary treatment agreement, the service provider shall file a sworn affidavit of noncompliance with the court. The service provider shall also provide a copy of this affidavit to the state attorney and the person's attorney.

Upon receipt of the affidavit, the bill requires that the court shall issue a notice of hearing and proceed with the hearing on involuntary outpatient placement. The basis for a final disposition at the hearing may be the alleged facts for involuntary outpatient placement prior to the waiver of the hearing. The person or their counsel may file a motion requesting the issue of noncompliance with the agreement to be heard at the involuntary outpatient placement hearing. Such motions must be filed at least 72 hours prior to the hearing. The burden of proof shall be by a preponderance of the evidence.

When a person remains compliant for the period of the voluntary treatment agreement, the petition for involuntary outpatient placement shall be dismissed.

The bill adds a procedure for continued involuntary outpatient placement: If the person continues to meet the criteria for involuntary outpatient placement, the service provider shall file a continued involuntary outpatient placement certificate prior to the expiration of the person's treatment period. This certificate shall be accompanied by a statement from the person's physician or psychologist justifying the request, a brief description of the treatment received during the involuntary placement, and a plan for continued treatment.

The bill requires that hearings on this type of petition shall be a judicial hearing. If the court orders additional periods of involuntary outpatient placement, such placement is not restricted to a maximum of six months. The same procedure shall be repeated prior to the expiration of each additional period the person is placed in treatment. If the person has been previously found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the person's competence. If the person is found competent to consent to treatment, the guardian advocate is to be discharged.

The bill provides that if this act or the way it is applied to any individual is held to be invalid, the parts that are held invalid do not affect the remaining provisions that can be considered to be effective. The provisions of this act are severable.

The bill provides an effective date of July 1, 2003.

C. SECTION DIRECTORY:

Section 1: Amends s. 394.455, F.S.; adds definition of service provider.

Section 2: Amends s. 394.4598, F.S. relating to involuntary examination; corrects cross references; allows guardian advocate to consent to administration of medication; provides for guardian advocate's discharge.

Section 3: Amends s. 394.463, F.S., relating to involuntary examination; adds criteria under which person may be required to submit to an involuntary examination; adds criteria by which an involuntary examination may be initiated; requires AHCA to receive copies of outpatient placement orders and voluntary treatment agreements; requires that petitioner file petitions for involuntary inpatient or outpatient placement.

Section 4: Amends s. 394.467, F.S., relating to involuntary placement; amends criteria for involuntary inpatient treatment; adds criteria for involuntary outpatient placement; amends criteria for retaining or involuntarily placing a patient for involuntary examination; adds criteria for voluntary examination for outpatient placement; adds criteria for filing of petition for involuntary placement; requires court to hold hearing on involuntary inpatient or outpatient placement; requires testimony; adds requirements for content of placement order; provides grounds for guardian advocate to consent to administration of medication; adds criteria for voluntary treatment agreement; adds procedure for continued involuntary outpatient placement.

Section 5: Provides that provisions of this act are severable.

Section 6: Provides effective date of July 1, 2003.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Department of Children and Families reports that the appropriations consequences on the agency will be in excess of $16 million per full fiscal year.

   The Office of State Courts Administrator estimates a fiscal impact of $1.24 to $2.7 million in FY 2003-2004.

   The Florida Sheriffs Association estimates potential savings from the bill of up to $64.8 million.

   Please see "Fiscal Comments" below for further information.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   The Department of Children and Families reports as follows:

   > Increased department funding to service providers is needed to cover the estimated additional cost to public crisis stabilization units for additional days of care (for both the initial examination and "hold" until the hearing and when a person is returned for "violation" of his/her court order or voluntary treatment agreement) and for subsequently required additional community services. Local county governments would be adversely impacted by a corresponding increase equivalent up to 25% of the total additional cost that must be provided by local matching funds. Estimated cost for local county governments: $5,424,235.

   AHCA and the Office of the State Court Administrator advise that circuit courts, public defenders and states attorneys will experience increased costs related to the additional hearings required by the bill. The increased number and complexity of Baker Act filings and hearing will impact the workloads of state attorneys, public defenders, and clerks of court.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There will be an increase in the operating costs of community mental health centers, private counseling agencies, and counselors or therapists in private practice associated with the additional work required by this bill. Additional staff positions or staff time may be needed for court-related activities.

Some community mental health centers, private counseling agencies, or circuit courts may create additional jobs to handle the anticipated workload increase.

D. FISCAL COMMENTS:

DCF provides the following fiscal impact information:

Additional cost for increased involuntary examinations:

A criterion in the bill for involuntary examination for involuntary outpatient commitment is persons with two or more episodes in the previous 36 months wherein the person was admitted for examination or placement in a receiving or treatment facility and/or arrested for criminal behavior. Data from the Florida Mental Health Institute, dated February 12, 2003, show that 33,876 adults met the criteria of two or more episodes within the previous 36 months [the number of person admitted for examination (a person may be examined without being admitted) or placement in a receiving or treatment facility or who were arrested for criminal behavior is not known]. The department estimates meeting this broader criteria could require an additional 3,387 (10% of 33,876) persons (a conservative but unknown estimate just for illustration) to return to a receiving facility for an involuntary examination the first year this bill becomes effective. Those 3,387 persons would be required to have an involuntary examination and be admitted to a crisis stabilization unit (CSU) and held until the mandated judicial hearing. The annual cost for 3,387 persons (10% of 33,876) would be $9,695,724 for an eight-day admission (three days for the examination period and five days until the hearing). Based on $2,328 for eight days in a CSU ($291 per day) + $23 for an emergency screening + $501 for a three hour examination by a physician x 3,387 persons = $9,695,724 total cost. Based on the requirement that Baker Act funds are matched at a rate of 25%, the total cost of $9,695,724 is adjusted to reflect 75% of the total cost to the department, $7,271,793.

Another criterion for involuntary examination is at least one or more acute episodes resulting in serious physical violence. Last year 84,162 adults were transported for an involuntary examination. The percent of those persons who's acute episode resulted in physical violence is not known. However, the department estimates meeting this broader criteria could require an additional 4,208 persons (5% of 84,162 persons, a conservative but unknown estimate just for illustration) to return to a receiving facility for an involuntary examination the first year this bill becomes effective. Those 4,208 persons would be required to have an involuntary examination and be admitted to a crisis stabilization unit (CSU). The annual cost for those 4,208 persons (5% of 84,162) would be $12,001,216 for an eight-day admission (three days for the examination period and five days until the hearing). Based on $2,328 for eight days in a CSU ($291 per day) + $23 for an emergency screening + $501 for a three hour examination by a physician x 4,208 persons = $12,001,216 total cost. Based on the requirement that Baker Act funds are matched at a rate of 25%, the total cost is adjusted to reflect 75% of the total cost to the department, $9,000,912.

For individuals that are not Medicaid eligible, the state must pay the full cost of involuntary examinations and subsequent services. Medicaid will only reimburse for services in a general hospital and only if considered medically necessary for acute care. Many of those individuals will not meet the criteria. Approximately 62% of the enrolled mental health consumers are Medicaid-eligible. Their community mental health coverage for services such as Targeted Case Management and Rehabilitation Option services allow Medicaid-eligible consumers to receive community based mental health services and supports. However, there are several limitations to this financial arrangement, including addressing the needs of the 38% of non-Medicaid eligible individuals, non-covered Medicaid services such as Crisis Stabilization and mobile crisis services, low reimbursement rates for providers that are well below the cost of providing the service. This results in a mental health system with consumers receiving services in lesser frequency and duration than consistent with their needs. The current public mental health system is not reflective of the enhanced community services described in the outpatient commitment studies.

The appropriations [sic] would cover the cost to the department to increase funds to contracted service providers for the estimated additional bed utilization and hours for staff to provide the estimated increased number of involuntary examinations. It is further

estimated if additional funding is not provided to contracted service providers, contractual adjustments would have to be made to curtail existing funded mental health services.

This analysis does not include the cost of providing involuntary outpatient services or the cost of additional involuntary examinations for those persons who are not compliant with their involuntary outpatient commitment court order and are returned to the public receiving facility for examination.

This fiscal analysis does not include any cost offset for the projected reduction in the number of individuals to be readmitted for involuntary placement to a crisis stabilization unit due to outpatient commitment.

OSCA provides the following fiscal impact information:

The fiscal impact of HB 1197 on the State Courts System is conservatively estimated to range from $1.24 million to $2.17 million in FY 2003-04. The bill would substantially increase judicial workload. Implementation will require additional judged, general masters, supplemental case management staff, staff attorneys, and other court staff.

HB 1197 enlarges the number of individuals subject to involuntary mental health examination and placement b y creating a new "likely to deteriorate" criteria. Hearings required to adhere to the provisions of the bill will be lengthier and more complex, which will necessitate more judicial time for consideration of each case. The legislation will increase the number of judicial reviews required to process Baker Act matters, require the preparation of more-detailed orders, and require judicial review of voluntary treatment agreements, among other provisions.

Judges assigned to Baker Act matters have many other duties. Passage of the proposed legislation would add more cases to an already burdened docket resulting in a serious workload impact on the courts. Additinally, the expedited hearing requirements for these cases will require priority attention from the courts, thereby potentially backlogging family, dependency, and other civil cases.

The Sheriff's Association provides the following information on cost savings:

The following assumptions are used in calculating cost savings:

Cost of arrest and incarceration:[5]
$4,740 for disorderly conduct arrest X 666 arrests = $3.2M

Cost of Baker Act cases:[6]
The average cost per day for crisis stabilization is $239 X 15,000 cases X 4 days = $14.3M

Cost of Baker Act law enforcement::[7]
$3,150/Baker Act case X 15,000 cases = $47.3M

Total savings from arrest and Baker Act cases: $3.2M + $14.3M = $47.3M = $64.8M

III. COMMENTS

[5]Cost of arrest from Lewin Group*, The Economic Costs Of Mental Illness*, 1992, National Institute of Mental Health 5-26 (July 2000)
[6]Average length of stay in a crisis stabilization unit is 3 to 5 days (4 days used to calculate costs). Data from e-mail correspondence dated August 29, 2001 from Ron Kizirian, Government Operations Consultant II, Department of Children & Families.
[7]Law enforcement cost of arrest used to estimate law enforcement costs for Baker Act case from Lewin Group, *The Economic Costs Of Mental Illness*, 1992, National Institute of Mental Health 5-26 (July 2000).

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. Pursuant to subsection (a) of section 18 of Article VII, Florida Constitution, no county or municipality shall be bound by any general law requiring such county or municipality to spend funds or to take action requiring the expenditure of such funds unless:

- The Legislature has determined that such law fulfills an important state interest, and unless:
- Funds have been appropriated sufficient to fund such expenditure;
- The Legislature has authorized a county or municipality to enact a funding source not available on February 1, 1989 that can be used to generate sufficient funds for such expenditure by a simple majority vote of the governing body;
- The Legislature approves the law by a 2/3 vote of each house;
- The expenditure is required to comply with a law that applies to all persons similarly situated, including the state and local government; or
- The law is required to comply with a federal requirement which contemplates actions by counties or municipalities for compliance.

The bill does not contain the required finding of an important state interest.

2. Other:

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. The bill restricts the court's contempt powers, raising separation of powers issues. The bill changes the burden of proving noncompliance to a preponderance of the evidence standard, from the current clear and convincing standard required by s. 90.503, F.S. (the Evidence Code). There are also potential due process and access to court concerns relative to ex parte hearings. In addition, some of the language is vague or needs additional definition[8], suggesting the potential for void for vagueness challenges.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill expands the court's authority to appoint guardian advocates. This will increase the need for additional volunteers to serve in this position.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

[8] *E.g.*, Section 1, line 27-28 "as defined in this part". Definitions for any of the terms preceding that phrase in the definition are not found within this part.