SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 2748

SPONSOR: Committee on Judiciary and Senator Peaden

SUBJECT: Mental Health

DATE: April 22, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matthews	Roberts	JU	Fav/CS
2.			CF	
3.				
4.				
5.				
6.				

I. Summary:

This bill substantially amends the Baker Act, Florida's involuntary civil commitment law, to incorporate provisions for court-ordered outpatient mental health services and voluntary agreements for outpatient services. Specifically, the bill makes the following major changes:

- Adds a process for involuntary placement for outpatient services for certain persons who meet the criteria for involuntary outpatient placement, provided services or programs, space and funding are available.
- Adds a process for continued involuntary placement for outpatient services.
- Creates a 13-member Involuntary Outpatient Placement Implementation Task Force.
- Grants rulemaking authority to the Department of Children and Family Services.

This bill substantially amends the following sections of the Florida Statutes: 394.455, 394.4598, 394.463 and 394.467. The bill creates section 394.4655 of the Florida Statutes.

II. Present Situation:

Baker Act

Florida's Baker Act is a civil commitment law which provides a process for the *involuntary examination* and *involuntary admission* of a person for treatment of a mental, emotional or behavioral disorder. Specifically, a person may be brought in for an *involuntary examination* at a receiving facility for short-term emergency service and maximum 72-hour detention until an

evaluation and treatment of the disorder are completed.[1] The process for *involuntary examination* is initiated in one of three ways:

- Ex parte court order: A judge may enter an ex parte order stating that the person meets the statutory criteria for emergency admission. The order must include findings and must direct the law enforcement officer to take the person to the nearest receiving facility for examination and treatment. A copy of the order must be sent to the Agency for Health Care Administration (AHCA).[2] The order is valid for the time frame specified in the order, or for 7 days after the date the order is signed.

- Law enforcement officer report: A law enforcement officer may take into custody a person who appears to meet the statutory criteria for involuntary examination and deliver that person to the nearest receiving facility. The law enforcement officer must provide a written report detailing the underlying basis for taking the person into custody. The receiving facility must forward a copy of the report to AHCA.

- Mental health professional certificate: A physician, clinical psychologist, psychiatric nurse or clinical social worker may execute a certificate stating that the person has been examined within the preceding 48 hours and that the person appears to meet the statutory criteria for involuntary examination. The certificate must include the observations underlying the determination. A law enforcement officer must take into custody and deliver the person to the nearest receiving facility for involuntary examination. The law enforcement officer must execute a written report. A copy of the certificate must be sent to AHCA.

The statutory criteria for bringing someone to a receiving facility for *involuntary examination* are based on whether there is reasonable cause to believe that the person is mentally ill and due to such illness:

1. The person refuses voluntary examination after conscientious explanation and disclosure, or
2. The person is unable to make a determination as to whether the examination is needed

and

1. The person is likely to suffer from neglect without care or treatment which poses threat of substantial harm to the person and is unavoidable even with family or friends' assistance, or

[1] *See* Part I, ss. 394.451-394.4789, F.S. In Florida, 84,162 Baker Act examinations were conducted during the 2001-2002 calendar year of which 12,186 constituted multiple examinations of the same people. This represents an increase from 61,906 examinations conducted in 2000. *See* Special Report of Baker Act Data, February 12, 2003. The average age of a person subjected to the Baker Act is 38 years old. *See The Florida Mental Health Act (The Baker Act) 2001 Annual Report*, Florida Agency for Health Care Administration.

[2] The Policy and Services Research Data Center at the Louis de la Parte Florida Mental Health Institute in agreement with the AHC serves as the repository for these forms, and carries out the data entry and analytic functions for the AHCA. During the calendar year 2001, the Center received and entered data from 95,990 Baker Act Initiation Forms. See *The Florida Mental Health Act (The Baker Act) 2001 Annual Report*, Florida Agency for Health Care Administration.

2. There is substantial likelihood that the person will cause serious harm to self or others without care or treatment.[3]

There are circumstances in which a patient may be evaluated or treated at a hospital for an emergency medical condition prior to transfer for the involuntary examination at a receiving facility. Within 12 hours after an attending physician documents that the patient's medical condition is stable or does not exist, the patient must be transferred to a receiving facility if the hospital is not a receiving facility.

At the receiving facility, the patient must be examined by a physician or clinical psychologist. A physician can order emergency treatment if necessary for the safety of the patient or others. The patient can not be detained longer than 72 hours[4] by the end of which the patient must be either:

- Released unless charged with a crime and subsequently delivered to law enforcement;
- Released for outpatient treatment;
- Asked for express and informed consent to voluntary placement and treatment;,[5] or
- Detained upon recommendation of the receiving facility pending transfer to a treatment facility and if at the treatment facility, until the disposition of the hearing on the petition for involuntary placement.[6]

Only a qualified clinical psychologist[7] or a psychiatrist[8] can approve the release of a patient from a receiving facility. A receiving facility is statutorily defined as a public[9] or private facility[10]specifically designated by the Department of Children and Families[11] to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment.[12] There are currently 113 receiving facilities in Florida.

If a patient is not released and will not voluntarily consent or otherwise refuses to be admitted for treatment, the patient may be involuntarily placed for treatment (admitted to) at a receiving facility pending transfer to a treatment facility or involuntarily placed for treatment in a treatment

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[3] *See* s. 394.463(1), F.S.
[4] For a patient who is being evaluated or treated at a hospital for an emergency medical condition prior to transfer for an examination at a receiving facility, the 72-hour period of detention begins from the time the patient arrives at the hospital to the time the attending physician documents the patient's emergency medical condition. *See* s. 394.463(2)(g), F.S.
[5] *See* s. 394.463(2)(i), F.S.
[6] *See* s. 394.467, F.S.
[7] Under the law, a "clinical psychologist" is qualified as one who has 3 years of postdoctoral experience in clinical psychology including licensure experience, or one who is a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility. *See* s. 394.455(2), F.S.
[8] A "psychiatrist" is qualified as a licensed medical practitioner who has primarily diagnosed and treated mental and nervous disorders for at least 3 years inclusive of a psychiatric residency *See* s. 394.455(24), F.S. Current law does not allow a physician to authorize the release of a patient. Under chapter 394, F.S., a physician is defined as a licensed medical practitioner *who has experience* in the diagnosis and treatment of mental and nervous disorders, or a physician employed by a facility operated by the United States Department of Veterans Affairs which qualifies as a receiving or treatment facility.
[9] A public facility is any facility that has contracted with the department to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose. *See* s. 394.455(25), F.S.
[10]A private facility is any hospital or facility operated by a for-profit or not-for profit corporation or association that provides mental health services. *See* s.394.455(22), F.S.
[11] Criteria for designation as a receiving facility is set forth in s. 394.461, F.S.
[12] *See* s. 394.455(26), F.S.

facility upon the filing of a petition by the receiving facility's administrator.[13] The petition must be supported by a psychiatrist's opinion and a second opinion from a clinical psychologist or psychiatrist or alternatively in those counties with less than 50,000 in population, a physician with special mental health training.

A patient must be appointed within one day of the filing of the petition. Typically, public defenders represent these persons. The hearing on the petition must be held within five days. The *criteria for involuntary placement for treatment* are based on a court's determination by clear and convincing evidence that:

> *(a) The patient is mentally ill and due to the illness, refuses to be involuntarily placed for treatment after sufficient and conscientious explanation and disclosure, and less restrictive treatment alternatives are inappropriate;*
>
> *or*
>
> *(b) The patient is mentally ill and due to the illness is unable to determine whether placement is necessary, and the patient:*
>
> *1. Is manifestly incapable of surviving alone or even with the help of family, friends services is likely to suffer from neglect or refuse to care for himself or herself and such neglect poses a real and present threat of substantial harm to the patient, or*
>
> *2. Will inflict serious bodily harm on himself or herself or another as evidence by recent behavior of actual, attempted or threatened harm; and*
>
> *3. Less restrictive treatment alternatives are inappropriate.*

At the hearing for involuntary placement, the court must determine if the patient is competent to consent to treatment. A guardian advocate must be appointed.[14] If at any time, the court determines that the patient actually meets the criteria for involuntary assessment, protective custody, or admission under the Marchman Act (relating to substance abuse), the court can order the person to be admitted for purposes of treatment under chapter 397, F.S. If the court determines that the patient does meet the criteria for involuntary placement for treatment under the Baker Act, the court shall order the patient to be transferred for treatment to a treatment facility, if not already there, or alternatively, that the patient receive services on an involuntary basis from a receiving or treatment facility for up to 6 months.[15] From that point, the patient may be detained until the facility determines that the patient no longer meets the criteria for involuntary placement and must be released.

Once released, a person may be referred for follow-up outpatient services and treatment. Such follow-up services are typically provided by local community mental health treatment centers that themselves own the receiving facility. Persons released from private receiving facilities typically can afford to pay for follow-up care and treatment from a private counseling agency or mental health professional in private practice. The availability and funding for these mental health services and programs in the local communities vary from county to county.

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[13] *See* s. 394.467, F.S.

[14] *See* s. 394.4598, F.S. A guardian advocate is appointed when the court finds the patient to be incompetent (if not already adjudicated as such) and there is no guardian yet appointed to consent to mental health treatment.

[15] *See* s. 394.467(6)(b), F.S.

Recent Trends and Efforts in Mental Health Systems

Mental health advocates and professionals believe that early interventions and appropriate treatment services prior to a person's mental illness acute or chronic episode could avoid many hospitalizations. In addition, the issue of mental issues if unaddressed is compounded by other issues such as homelessness, incarceration, suicide attempts, victimization, and 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.[16] Reportedly, 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.[17] There is the belief that persons with mental illness continue to commit misdemeanors for the following reasons:

- 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.

Many states have adopted new treatment standards for commitment that are not based solely on dangerousness to self or others 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 commensurate with increased funding allowing courts to order participation in outpatient treatment.[18]

Law enforcement in Florida have taken the charge on this issue subsequent to a 1998 incident involving the killing of a Florida sheriff by a person with a history of schizophrenia. Law enforcement agencies report that these types of cases, particularly those involving severe or violent mental illness impose a significant public safety issue and burden the criminal justice system, particularly as officers are not equipped or trained to handle these types of case.

However, recent evidence-based review was conducted by researchers of the empirical literature on involuntary outpatient treatment.[19] 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

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[16] *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.

[17] *Emerging Judicial Strategies for the Mentally Ill*, Bureau of Justice Assistance, April 2000.

[18] *Briefing Paper*, Treatment Advocacy Center, Arlington, Virginia, March 2003. *See also* www.psychlaws.org

[19] *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>

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.

III. Effect of Proposed Changes:

The bill amends the Baker Act to incorporate provisions that reflect that someone may now be involuntarily placed for either inpatient or outpatient mental health services or treatment. Specifically, the bill makes the following changes:

Involuntary Examination
The criterion for involuntary examination is revised to be based additionally on a person's current reported or observed behavior and consideration of any mental health history.

Involuntary Outpatient Placement for Mental Health Services and Treatment
Section 5 creates s. 394.4655, F.S., to provide the option of petitioning for involuntary placement for outpatient mental health services and treatment. This option is only available if the "full range of services that the person needs for mental health treatment and to live and function successfully are available in the patient's local community.

New criteria are provided for involuntary outpatient placement as follows if the person:

- Is 18 years of age or more.
- Has mental illness.
- Is unlikely to survive safely in the community without supervision, based on a clinical determination,
- Has a history of noncompliance
- Has a past history of either 2 or more involuntary commitments for examination or placement within last 3 years, or receipt of mental health services in a forensic or correctional facility, or one or more acts of serious violent behavior or attempts thereof within the last 3 years.
- Is unlikely to participate voluntarily in treatment.
- Is in need of involuntary placement to prevent relapse or deterioration.
- Is likely to benefit from involuntary outpatient placement.

It is must determined that all available less restrictive alternatives are not appropriate.
Whereas only an administrator at a receiving facility can file a petition for involuntary inpatient placement, the bill allows either the receiving or treating facility administrator or in cases involving persons who have voluntarily agreed to examination, an examining professional, to file

a petition for involuntary outpatient placement. The petition must be supported by a psychiatrist's opinion and a second opinion by a clinical psychologist or psychiatrist. If the petition is being filed by the administrator of a receiving facility or treatment facility, then those mental health professionals must have examined the person within the preceding 72 hours. If the petition is being filed by an examining professional on behalf of someone who has agreed to voluntary examination for outpatient placement, then such professional must have examined the person within the preceding 14 days. Such examining professional must forward a copy of the petition for the administrator of the receiving facility or designated department representative. Such petition must be filed in the county where the patient is located. Copies of the petition are to be forwarded to the department, the patient, the patient's guardian or representative, the state attorney and the public defender.

As in the process for petitioning for involuntary inpatient placement, a person must be appointed a public defender within 1 day of the filing unless the person has already retained private counsel. A hearing must held with 5 days unless there is a continuance of which a patient is entitled to at least one continuance for a maximum period of 4 weeks. The hearing must be held where the patient is located and in a location convenient to the patient. The state attorney for the circuit is the true party in interest and not the petitioner. A general master may be appointed to conduct the hearing. Testimony shall be taken. The patient is given the right to an independent expert examination regardless of ability to pay. The hearing must be recorded.

If the patient meets the criteria for involuntary outpatient placement, the court must issue an order for a period not to exceed 6 months. The service provider must discharge the patient once the patient no longer meets the criteria. The service provider is to be designated by the receiving facility or the designated department representative. Apparently, the designation occurs before the hearing because the service provider is required to submit a detailed proposed treatment plan. The treatment plan may include the gamut of services such medication, period urine tests, therapy, training activities, counseling, alcohol and drug testing, supervision, and other services. The service provider must certify that these services are available and that the service provider agrees to provide these services. If the program is not available, there is no space available, or no funding available, then the court can order the patient to comply with the treatment plan.

Post-modifications of the underlying treatment plan in the involuntary outpatient placement order may be made. Notice of any material modification must be sent to the court. Court approval is required for any material modification that the patient contests.

A person under an involuntary outpatient placement order can be brought to involuntary re-examination under the Baker Act if not in the opinion of a physician the person is not complying with the order and underlying treatment plan, resists efforts to obtain compliance, and might meet the criteria for involuntary examination. If the person does not meet the criteria for involuntary inpatient placement, then the person must be discharged from the receiving facility. The service provider must then determine whether other modifications to the treatment plan should be made to solicit compliance from the person. The same requirements following post-modifications of the underlying treatment plan in the involuntary outpatient placement order apply.

At any time within the hearing on the involuntary outpatient placement, the court finds that the person meets the criteria for involuntary assessment, protective custody or involuntary admission under the Marchman Act (relating to substance abuse), then the court may order the person to undergo the assessment within 5 days. All subsequent proceedings are then governed by chapter 397. This provision is the same as the one provided for in hearings for involuntary inpatient placement under existing law.

The person's competency to consent to treatment must be determined for purposes of appointing a guardian advocate. The guardian advocate is granted civil immunity. A copy of the involuntary outpatient placement order must also be providers to the patient's service provider.

Continued Involuntary Outpatient Placement
Before the period of the underlying treatment plan in the involuntary outpatient placement order expires and if a person continues to meet the criteria for involuntary outpatient placement, a service provider must file in the circuit court an involuntary outpatient placement certificate which must be accompanied by a supporting statement from patient's physician or clinical psychologist. A public defender must be appointed within 1 working day of the filing unless the person is already represented by another counsel. Hearings for continued involuntary outpatient placement must be held in circuit court. A master may be appointed to preside over the hearing. This process may be repeated for each additional period sought for continued placement. The court must reassess the patient's incompetency to consent to treatment for purposes of discharging the guardian advocate.

Involuntary Inpatient Placement
The provisions for involuntary placement are revised to specify that they apply to inpatient treatment or services and distinguish them from the new provisions relating to involuntary placement for outpatient treatment or services. No substantive changes are made other than a court may now order a person evaluated for involuntary outpatient placement if the court findings during a hearing on involuntary inpatient placement that the person meets the criteria for involuntary outpatient placement. This parallels a similar provision in existing law that permits the court to order a person to involuntary assessment under the Marchman Act during a hearing for involuntary inpatient placement under the Baker Act.

Clinical Records
The Agency for Health Care Administration will also serve as the repository for copies of involuntary outpatient placement orders and involuntary inpatient placement orders. These orders are to be considered a part of the clinical record.

Task Force
Section 7 establishes the 13-member Involuntary Outpatient Placement Implementation Task Force. The task force is to be co-chaired by the representative designated by the Florida Sheriff's Association and the circuit judge designated by the Chief Justice of the Florida Supreme Court. The members are to be appointed no later than July 1, 2003, and must convene no later than August 1, 2003. Other members consist of a representative designated by each of the following: the Florida Police Chiefs' Association, the Florida Public Defenders' Association, the Florida Prosecuting Attorneys Association, The Florida Association of Court Clerks, The Florida Association of Counties, the Department of Children and Family Services, the Florida Council

for Community Mental Health, and the Agency for Health Care Administration, the Senate President, the House Speaker and the Governor. Legislative staff has been designated to provide support solely for the initial meeting. Thereafter, the co-chairs are responsible for facilitating the meetings and arranging for staff support. The task force 'may' solicit and receive input from interested parties and 'may' addresses issues such as recommendations for an evaluation process to determine the effectiveness of involuntary outpatient placement and proposed statutory changes. All expenses associated with the meetings and the work hereunder are to be borne by the respective member's entities.

The task force is required to prepare an implementation plan for the bill's provisions to include recommendations and the collection of data regarding the impact of involuntary outpatient placements on the interested stakeholders. The report containing the implementation plan is to be submitted by December 1, 2003, to the Governor, the Senate President, the House Speaker, and the Chief Justice of the Florida Supreme Court.

Section 8 grants rulemaking authority to the Department of Children and Family Services to implement the provisions of the Act.

The bill provides an express severability clause.

The bill provides an effective date of October 1, 2004, unless otherwise expressly provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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.

Filing fees are prohibited in Baker Act proceedings. The bill does not contain the required finding of an important state interest.

B. Public Records/Open Meetings Issues:

The bill requires copies of involuntary inpatient placement orders and involuntary outpatient placement orders to be forwarded to the Agency for Health Care Administration and made a part of the clinical record. Under current law, a clinical record is confidential and exempt from disclosure. *See* s. 394.4615, F.S. It is not known whether this constitutes a material change in the existing exemption from public records which may warrant a separate public records bill.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

- The bill implicates potential issues regarding substantive and procedural due process affecting a person's liberty. For example:
  - A person subject to a petition for involuntary outpatient placement is not accorded the same opportunity or right to participate in the development of a treatment and discharge plan or to chose the service provider from whom they may receive treatment or services as a person subject to involuntary inpatient placement. It is the administrator of a facility or a designated department representative who selects the service provider. The first opportunity the person has to provide input or seek modification is *after* the proposed recommended treatment plan is court-approved and incorporated into the involuntary outpatient placement order. Only court notice is required if there is a material modification of the underlying treatment plan except if the patient contests the material modification, then court approval is required. It is not clear however if a hearing is required. There is also no provision allowing for an appointed guardian advocate to contest any material modification. Moreover, material modification is not defined. These provisions could have negative consequences for someone who is alleged to be non-compliant with the written involuntary placement order which is one of the criterion for seeking re-examination for involuntary inpatient placement. *See* page 14, line 8 through page 16, line 10.

  - The bill allows the court to sua sponte appoint a guardian advocate during a hearing on involuntary outpatient placement if the patient is determined to be incompetent to consent to treatment. There are no similar procedural safeguards as are found in proceedings for appointment of a guardian advocate pursuant to s. 394.4598, F.S. Although the court is required to take testimony and evidence regarding the patient's competence, it does not appear to require that such determination be based on a psychiatrist's opinion that the patient is incompetent, that it be found that the patient has been adjudicated incapacitated or that it be found that there otherwise no available guardian with authority to consent to mental health treatment on behalf of the person. *See* page 16, lines 11-23 of the bill.

- Under the bill, a person may agree to be voluntarily examined for outpatient placement. It is not clear whether this option is only available to someone already in involuntary inpatient placement or someone off the street. It is also unclear whether there must be a determination regarding the person's competency to provide express and informed consent and whether by voluntarily agreeing to the examination, there is an implied voluntary agreement to receive outpatient services. Whether this process is voluntary or involuntary implicates a person's rights under this chapter and may have unintended consequences for the person who believes that he or she is acting voluntarily and not under any court-ordered obligation to comply with an involuntary outpatient placement order.

- The bill requires a service provider to prepare and submit a treatment plan to the court to be included in an involuntary placement order for outpatient services. This presupposes that the court has already made a determination before the hearing that the person meets the criteria for involuntary outpatient placement which may unduly influence the court's determination.

- The bill implicates right of privacy issues. The bill authorizes the release of confidential patient information in clinical records for purposes of determining whether someone satisfies the criteria for involuntary outpatient placement. The protections or safeguards accorded the clinical records of persons for involuntary inpatient placement do not appear to be available to those persons involuntarily placed for outpatient services. For example, it is not clear whether good cause must be shown as the benefit of disclosure outweighs the possible harm and can only be released subject to a court order. *See* s. 394.4615, F.S., and page 4, lines 3-25 of the bill.

- The bill raises potential equal protection issues. There may arise disparate treatment of persons equally situated under a Baker Act but who by virtue of their geographic location may not receive the benefit of outpatient services because those services or programs are not available or accessible or adequately funded in the local community.

- The bill grants rulemaking authority to the Department of Children and Family Services to implement sections (1) through (7) of the bill. Section 7 of the bill relates to the task force and its responsibilities including the development of an implementation plan for court-ordered outpatient mental health orders and the submission of a report to the Legislature. To grant rulemaking authority to implement a plan relating to issues and proposed strategies for court-ordered mental health framework which has not yet been subjected to legislative review or input may constitute the unauthorized delegation of legislative authority. *See* page 27, lines 13-15.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

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.

Persons who may be subject to the Baker Act may benefit from the changes attendant in this bill provided that the existing judicial system can handle the influx of persons resulting from the additional requirements of the Baker Act, and provided there is an appropriate community-based infrastructure which makes needed mental health services available and accessible to those who need them. Many of the provisions of this bill do not apply if there are no mental health services available or accessible in the county. The bill does not contemplate additional funding sources or revenues.

It is indeterminate whether there will be greater compliance from persons involuntarily placed for outpatient services or treatment than those who voluntarily submit to outpatient treatment and services. According to the Department of Children and Family Services, there is a higher rate of non-compliance with outpatient treatment plans from persons involuntarily committed under the Baker Act although there is no statewide data available regarding the rate of compliance and the rate of persons subject to subsequent criminal activity or disturbances.

C. Government Sector Impact:

- The Department of Children and Families estimates appropriations consequences in excess of $16 million per year and other fiscal impact. The department projects an increase in the number of involuntary examinations based on the new criterion that broadens the class of persons subject to the Baker Act to include those 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 criterion 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 conservatively the following costs in the first year alone:

Criterion	*# of persons annually*	*Cost breakdown per person*	*Cost Total*	*Cost to DCF minus 25% for state match*
Persons with 2 or more episodes within previous 3 years who has been Baker Acted or arrest for criminal behavior	3,387 persons examined and admitted to a crisis stabilization unit (CSU)	$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 for an eight-day admission (three days for the examination period and five days until the hearing).	$7,271,793

Persons with at least one or more acute episodes resulting in serious physical violence.	4,208 persons (5% of 84,162 persons, a conservative estimate (The percent of those persons whose acute episode resulted in physical violence is not historically known)	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	$12,001,216 The annual cost for those 4,208 persons (5% of 84,162) would be for an eight-day admission (three days for the examination period and five days until the hearing).	$9,000,912

According to the department, the state must pay the full cost of involuntary examinations and subsequent services for individuals that are not Medicaid eligible. 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 criterion. 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, noncovered 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 needs demand. The current public mental health system is not reflective of the enhanced community services described in the outpatient commitment studies.

The department also projects a need for additional funding for service providers 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), hours for staff to accommodate the increased number of involuntary examinations, and for subsequently required additional community services. 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. The department's analysis does not include the cost of providing involuntary outpatient services, the cost of additional involuntary examinations for those persons who do not comply with their involuntary outpatient commitment court order and are returned to the public receiving facility for examination, or 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.

- 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 bill expands the class of person who may be subject to involuntary examination and placement under the Baker Act, makes the process lengthier and more complex, increases the number of judicial reviews, and requires the preparation of more detailed orders. These changes will increase costs and substantially impact the workloads of the court, state attorneys, public defenders, and clerks of court. Implementation will require additional court system staff including judges, general masters, supplemental case management staff, staff attorneys, and other court staff. Additionally, the expedited

hearing requirements for these cases will require priority attention from the courts, thereby potentially backlogging family, dependency, and other civil cases.

- The Florida Sheriff's Association estimates the bill will free up law enforcement personnel and result potential savings of $64.8 million based on the availability of mental health services and other assumptions as follows:

Cost of arrest and incarceration:[20]	$4,740 for disorderly conduct arrest	X 666 arrests =	$3.2M
Cost of Baker Act cases:[21]	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:[22]	$3,150/Baker Act case	X 15,000 cases =	$47.3M
Total savings from arrest and Baker Act cases:			=$64.8M

- 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. 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.

- Even if outpatient services are available or accessible or funded, it is not entirely clear who will bear the costs arising under certain provisions in the bill such as: 1) the cost of an independent expert examination in a hearing for involuntary outpatient placement if the person exercises the right to an independent expert examination but who can not otherwise afford such examination 2) the cost of recording proceedings on involuntary outpatient placement, and 3) the cost of a recommended treatment plan recommended by a service provider which may run the gamut of intensive case management, periodic urinalysis, therapy, counseling, period drug or alcohol testing, and other services.

VI. Technical Deficiencies:

On page 18, line 13 of the bill, there is reference made to a time period as provided in "sub-subparagraph 4. There is no sub-subparagraph 4. in this subsection. It is presumed but not certain that the time period intended is actually the criterion which allows for involuntary placement for outpatient services based on a well-established history of two or more episodes of involuntary examination or placement within the last 3 years or one or more violent psychotic episodes within the last 3 years. Therefore, the cross-reference should be made to sub-subparagraph (1)(a)5. of section 394.4655 of the Florida Statutes.

[20] Cost of arrest from Lewin Group, *The Economic Costs of Mental Illness*, 1992, National Institute of Mental Health 5-26 (July 2000).
[21] Average length of stay in a CSU is 3-5 days. Data from e-mail correspondence dated August 29, 2001, from Ron Kizirian, Government Operations Consultant II, Department of Children and Families.
[22] See *The Economic Costs of Mental Illness*, supra.

VII. Related Issues:

- The bill allows the court to appoint a master to preside at a hearing for involuntary outpatient placement or a hearing for continued involuntary outpatient placement. Clarification is needed that a general master does not have the authority to issue orders but only has authority to issue a recommendation to the court which in turn may approve, modify or reject the recommendation. *See* page 13, lines 16-31, and page 18, lines 8-15.

- There may be a conflict of interest between service providers and the receiving or treatment facilities. There are no limitations regarding whether the service provider has some financial or ownership interest between the facility and the service provider. The service provider who makes the determination to continue the treatment may have a financial interest in retaining a person for continued treatment.

- The bill provides civil immunity to guardian advocates appointed in a hearing for involuntary outpatient placement. It is not clear what the scope of immunity is for such appointed guardian advocate. There is no existing immunity for guardian advocates appointed at any other stage of the Baker Act under current law. *See* page 16, line 24 through page 17, line 3.

- The bill provides a procedure for petitioning for continued involuntary outpatient placement. The provisions need to be clarified as to whether the filing of the continued involuntary outpatient certificate constitutes the petition for continued involuntary outpatient placement or whether the certificate must accompany a separate petition. *See* page 16, lines 21 through page 18, line 15.

- The bill provides that if a physician determines that a patient has failed or refuses to comply with court-ordered treatment, that efforts were made to solicit compliance, and the patient meets the criteria for involuntary examination, a person can be resubjected to involuntary examination. However, this does not provide for the possibility that someone may be obtaining treatment from someone other than a physician such as such as a clinical social worker, clinical psychologist or psychiatric nurse. *See* page 15, lines 23 through page 16, line 10.

- The term "service provider" is defined to mean any public or private receiving facility, an entity under contract with the department to provide mental health services, or a clinical psychologist, clinical social worker, physician, psychiatric nurse, community mental health center, or clinic, as defined in this part. Other than those facilities designated by the department as receiving facilities and those entities under contract with the department, there are no provisions for licensure, uniform standards, or other background checks as is found in part II of chapter 397, F.S., governing service providers of substance abuse services. The enumerated listing of service providers suggests that all these terms are already defined in part I of chapter 394, F.S., which they are not. *See* page 2, lines 13-18.

- The bill allows a receiving facility to detain a person unless he or she is stabilized and no longer meets the criteria for involuntary examination. However, this is incorrectly stated as the criteria for involuntary examination goes to the threshold for bringing someone in for purposes of being examined, not for determining whether a person meets the criteria for

involuntary placement which is made after the examination or screening is complete. *See* s. 394.463(2)(g), F.S. and page 9, lines18-27 of the bill.

- The bill requires a petition for involuntary outpatient placement to be filed and a subsequent hearing to be held in the county where the patient is located. However, a patient may have been involuntarily Baker-acted in a county other than a county of residence. Contrary to the scenario involving involuntary inpatient placement where a patient resides in the facility where he or she is being treated, a patient who is involuntary placed for outpatient treatment may be inconveniently subject to receiving services or attending a hearing in a county where he or she does not reside. This may also complicate a person's efforts to comply. *See* page 12, line 9 through page 13, line 15.

- The bill requires that copies of the petition for involuntary outpatient placement be forwarded to the public defender. However, it does not provide for the circumstance in which the person may be presented by private counsel in lieu of a public defender. *See* page 12, lines 10-16 of the bill.

- It is not known whether it is an oversight or intent not to require that copies of a petition for continued involuntary outpatient placement be forwarded to persons specified as is required for petitions for involuntary outpatient placement.

- The bill provides that a guardian advocate is discharged when a patient is discharged from an order for involuntary outpatient placement or involuntary inpatient placement. However, a person is not discharged from a court order for involuntary placement but rather from a facility or a program or a treatment plan. Such discharge may occur if it is found that the person is competent to consent or refuse to consent to treatment and no longer satisfies the criteria for involuntary examination or placement. In contrast, an order expires, terminates, or is superseded by another order including an order of discharge. The process should be clarified as to how the court acknowledges that someone is no longer obligated to comply or has completed a treatment plan underlying an involuntary outpatient placement order. *See* page 3, lines 19-23.

- Under the bill, the Task Force is directed to solicit and receive input from interested parties and address issues such as recommendations for an evaluation process to determine the effectiveness of involuntary outpatient placement and for proposed statutory changes. However, the word "should" is used in lieu of "shall" which raises the question of whether the intent is that the Task Force must or may do the aforementioned.. *See* page 26, line 16 and lines 30-31.

VIII. Amendments:

None.