HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 463 w/CS Mental Health
SPONSOR(S): Simmons
TIED BILLS: **IDEN./SIM. BILLS:** SB 700

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families	15 Y, 1 N w/CS	Walsh	Liem
2) Judiciary			
3) Human Services Appropriations			
4) Appropriations			
5)			

SUMMARY ANALYSIS

HB 463 amends the Baker Act to include voluntary and involuntary outpatient treatment as alternatives to inpatient commitment. The bill provides criteria and procedures for receipt of outpatient services, assuming such services and programs are available.

The bill grants DCF rulemaking authority to implement the act.

The Office of the State Courts Administrator estimates that the recurring fiscal impact of the bill will be $636,608 to $954,912.

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 treatment allow a person to be involuntarily examined and treated based upon a third party's belief that, taking into account the person's current reported or observed behavior and previous mental health history, there is a substantial likelihood that without care or treatment the person will pose a threat to self or others.

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, 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, 62,339 adults received an involuntary examination pursuant to s. 394.463, F.S., during Fiscal Year 2002-2003. Of those, 10,712 received multiple examinations, including 460 receiving six or more.[1]

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.[2] These experts believe 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.

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.[3]

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.[4]

In August, 1999, the state of New York passed Kendra's Law, named for Kendra Webdale, who died after being pushed onto the subway tracks in Manhattan by a man with a history of mental

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[1] *Special Report of Repeated Baker Act Examinations Statewide*, Department of Mental Health Law and Policy, Florida Mental Health Institute, University of South Florida, February, 2004.
[2] *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.
[3] *Emerging Judicial Strategies for the Mentally Ill*, Bureau of Justice Assistance, April 2000.
[4] *Briefing Paper*, Treatment Advocacy Center, Arlington, Virginia, March 2003. *See also* www.psychlaws.org

illness and hospitalizations. Kendra's Law put in place assisted outpatient treatment to ensure that individuals with mental illness and a history of hospitalizations or violence participate in community-based services. The New York State Office of Mental Health reports[5] that between November 1999 and December 3, 2002, almost 2500 court orders for assisted outpatient treatment were issued. Significantly, after six months of assisted outpatient treatment, participants' incidence of hospitalization, homelessness, arrest and incarceration all declined from pre-participation levels.[6]

Research conducted in North Carolina by Duke University 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.[7]

EFFECTS OF THE BILL

Definitions

HB 463 amends section 394.455, F.S., to add definitions of service provider, involuntary examination, and involuntary placement.

Guardian Advocates

The bill 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.

Clinical Record

The bill amends section 394.4615, F.S., relating to confidentiality of clinical records, to allow for release of information from the clinical record when determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan. The bill specifies that the records may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and the appropriate mental health professionals in accordance with state and federal laws

Involuntary Examination

The bill 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 bill requires that there must be a reason to believe that the person has a mental illness; that based on the person's current reported or observed behavior, and considering their past mental history, there is a substantial likelihood that without care or treatment the person will suffer from neglect or refuse to care for himself, or the person will cause serious bodily harm to himself or others in the future.

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[5] *Kendra's Law: An Interim Report on the Status of Assisted Outpatient Treatment*, New York State Office of Mental Health, January 1, 2003, page 6.
[6] *Id.*, Table 5, page 9.
[7] *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, M. Susan Ridgely, Randy Borum, John Petrilla, Santa Monica, CA, RAND, MR-1340-CSCR, 2001. *See* www.rand.org/publications/MR/MR1340.

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

The bill allows a patient to be offered voluntary placement if he does not meet the criteria for involuntary inpatient or outpatient placement.

It also provides that a petition for involuntary outpatient placement shall be filed in the circuit court by the administrator of a receiving or treatment facility or one of the examining professionals. A petition for involuntary inpatient placement is to be filed by the facility administrator.

Involuntary Outpatient Placement

The CS creates new section 394.4655, F.S., relating to involuntary outpatient placement.

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; and
- The person has
  - At least twice within the last 36 months been admitted for examination or placement in a receiving or treatment facility or received mental health services in a forensic or correctional facility, which period of time excludes any period during which the person was admitted or incarcerated; or
  - Engaged in one or more acts of serious violent behavior to self or others or engaged in attempts at serious bodily harm to self or others within the preceding 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 (see below).

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 must be entered on an involuntary outpatient placement certificate.

Voluntary examination for 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 7 days.

From a treatment facility

A patient in involuntary inpatient treatment 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

The petition for involuntary outpatient placement must allege and substantiate each of the criteria and shall include a clinical determination by a qualified professional. The petition for involuntary outpatient placement 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 proposed treatment plan and the petition to DCF, the patient, his guardian or representative, the state attorney and the public defender. No filing fee may be charged.

Appointment of counsel

The bill 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 public defender represents the person until dismissal of the petition, expiration of the court order, or discharge from involuntary outpatient placement.

Continuances

The bill entitles the patient 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 bill requires that the hearing shall be held within five 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 bill requires that the receiving facility administrator or designated DCF 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 and to the petitioner prior to the hearing for consideration by the court for inclusion in the involuntary outpatient placement order. The plan

may provide for multiple services deemed clinically appropriate by the provider's treatment professional.

The bill requires that the service provider must certify that the services are available and will be provided. If the service provider certifies that treatment services are not available, the petition must be withdrawn. The court cannot order services that are not available in the patient's local community or in which there is no space available.

The bill provides that 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 and after efforts to solicit compliance, 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. If after examination a person no longer meets the criteria, the person must be discharged. Otherwise, the service provider must determine whether modifications should be made to the treatment plan and 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 disagree 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, the court may order the person admitted for involuntary examination. If the person meets the criteria for 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.

Procedure for continued involuntary outpatient placement

The bill requires that 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, a description of the existing treatment plan, and a plan for continued treatment.

The public defender shall be appointed to represent the person on the petition within one court working day of receipt. The patient and his attorney may agree to a period of continued involuntary outpatient placement without a hearing.

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 received mental health services in a 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 of serious violent behavior to self or others or engaged in attempts at serious bodily harm to self or others within the preceding 36 months.

This procedure shall be repeated prior to expiration of each additional treatment period. If the patient previously was found incompetent, 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.

Involuntary inpatient placement

The bill amends existing law on involuntary placement to clarify that it relates to involuntary inpatient placement and to conform cross-references.

Rulemaking

The bill provides DCF authority to adopt rules necessary to implement the act.

C. SECTION DIRECTORY:

Section 1: Amends s. 394.455(3), F.S.; adds definitions of "involuntary placement" and "service provider;" renumbers sections.

Section 2: Amends ss. 394.4598(1) and (7), F.S.; conforms reference; provides for discharge of guardian advocate when patient is discharged from an order for involuntary outpatient placement.

Section 3: Amends s. 394.4615(3), F.S.; provides for release of patient records to certain persons for the purposes of determining whether patient meets criteria for involuntary outpatient placement or preparing proposed treatment plan.

Section 4: Amends ss. 394.463(1) and (2), F.S.; requires consideration of person's current behavior and mental health history as basis for taking a person to a receiving facility for involuntary examination; requires receipt and maintenance of involuntary outpatient and inpatient orders as part of the clinical record; allows those patients not meeting the criteria for involuntary outpatient or inpatient treatment to be offered voluntary treatment; requires that a petition for involuntary placement be filed in the circuit court; requires that the petition for involuntary outpatient treatment be filed by the administrator of the receiving facility, or one of the examining professionals for persons examined on a voluntary outpatient basis, or the administrator of a treatment facility; requires that the petition for involuntary inpatient treatment be filed by the facility administrator.

Section 5: Creates section 394.4655, 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; allows court to order person admitted for involuntary inpatient placement at any time before conclusion of the initial hearing on involuntary outpatient placement if it appears that the person does not meet the criteria for outpatient placement; 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 conforms cross-references.

Section 7: Amends ss. 394.495(3)(a) and (c), F.S.; conforms references to renumbered paragraphs.

Section 8: Amends s. 394.496(6), F.S.; conforms references to renumbered paragraphs.

Section 9: Amends ss. 394.498(4)(a) and (c), F.S.; conforms references to renumbered paragraphs.

Section 10: Amends s. 419.001(1)(d), F.S.; conforms references to renumbered paragraphs.

Section 11: Amends s. 744.704(7), F.S.; conforms references to renumbered paragraphs.

Section 12: Provides a grant of rulemaking authority to DCF.

Section 13: Provides that the provisions of this act are severable.

Section 14: Provides an effective date of October 1, 2004.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   The Florida Association of Counties advises that there will be an undetermined fiscal impact to counties due to the required 25 percent matching funds that must be provided for mental health services.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

HB 463 amends the criteria for involuntary examination to include persons who have at least twice within the last 36 months been admitted for examination.[8] 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, over the 36 month period from July 2000 through June 2003, 149,693 adults received an involuntary examination pursuant to s. 394.463, F.S. Of those, 31,285 adults received more than one examination, including 17,957 (12.24 percent) who received two or more, and 6,257 (4.27 percent) who received three or more.[9]

DCF reports that although this bill will result in an increase in involuntary examinations for persons who do not comply with their involuntary outpatient placement treatment plan, the department estimates that service providers will be able to implement the requirements of the bill within existing resources.

[8] Or for placement in a receiving or treatment facility or received mental health services in a forensic or correctional facility, which period of time excludes any period during which the person was admitted or incarcerated.
[9] *Ibid*.

AHCA reports that the annual cost for receiving and processing forms required by this bill is estimated to be $65,000 for the first year and $80,000 for each additional year due to anticipated growth. This includes the equivalent of 1.5 FTE staff positions (three separate individuals, each a part-time employee): one person to prepare the data for database entry, a second to enter the data, and a third to check the data for accuracy. In addition a 0.5 FTE supervisor would be needed. AHCA will contract with an outside source to perform these functions.

The Office of the State Courts Administrator reports as follows:

> Statewide implementation of HB 463 in the trial courts will require the equivalent of two to three fulltime circuit judges. Accordingly, the initial recurring fiscal impact of HB 463 on the circuit courts is conservatively estimated to range from $636,608 to $954,912. State due process expenses for independent expert examinations, court reporting, disability accommodations, and court interpreting can also be expected to increase.
>
> There will be modest non-recurring effects in FY 2004-05 for education programs to prepare the judiciary for implementation of the bill. There will also be moderate non-recurring effects in either FY 2004-05 or FY 2005-06, in order to study and adjust the Weighted Caseload System judicial workload weight assigned to Baker Act cases.
>
> While previously funded by the counties, pursuant to Chapter 2003-402, Laws of Florida, due process costs of independent expert examinations, court reporting, disability accommodations, and court interpreting will become state obligations on July 1, 2004. Because the number and length of court hearings will increase under the legislation, the state's costs for these due process services are expected to increase as well.

It is anticipated that there will be some fiscal impact on the offices of States Attorney and Public Defenders throughout the state associated with the increased workload occasioned by the requirements of the bill.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable.

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.

B. RULE-MAKING AUTHORITY:

DCF is authorized to adopt any rules necessary to implement the provisions of the act.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

At its March 9, 2004, meeting, the Committee on the Future of Florida's Families adopted a Committee Substitute, which amended HB 463 in the following ways:

Definitions

Further amend s. 394.466, F.S., to add a definition of "involuntary examination."

Clinical Record

Further amend s. 394.4615, F.S., relating to confidentiality of clinical records, to allow for the release of information from the clinical record in accordance with state and federal laws.

Involuntary Outpatient Placement

Voluntary examination for outpatient placement

Amend new s. 394.4655(2)(b) to require that the involuntary outpatient placement 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 7 [rather than 14] days.

Provides requirements for petition for involuntary outpatient placement

Further amend new s. 394.4655(3)(c) to require that the Clerk of Court provide copies of the proposed treatment plan and the petition [rather than just the petition] to DCF, the patient, his guardian or representative, the state attorney and the public defender.

Provides requirements for hearing on involuntary outpatient placement

Further amend new s. 394.4655(6)(c) to require that if prior to the conclusion of the initial hearing it appears that the person meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary examination [rather than involuntary placement].

Procedure for continued involuntary outpatient placement

Further amend new s. 394.4655(7)(d) to allow the patient and the patient's attorney to agree to a period of continued involuntary outpatient placement without a hearing.

This analysis is drafted to the Committee Substitute.