APPROPRIATIONS SUBCOMMITTEE ON ARTICLE V IMPLEMENTATION AND JUDICIARY

Rod Smith, Chair

Meeting Packet

Tuesday, April 13, 2004
9:15 a.m. – 11:15 a.m.
309 The Capitol

(Please bring this packet to the committee meeting. Duplicate materials will not be available.)

E X P A N D E D A G E N D A

APPROPRIATIONS SUBCOMMITTEE ON ARTICLE V IMPLEMENTATION AND JUDICIARY

Senator Smith, CHAIR

DATE: Tuesday, April 13, 2004
TIME: 9:15 a.m. -- 11:15 a.m.
PLACE: The *Verle A. Pope Committee Room,* 309 Capitol

(MEMBERS: Senators Campbell, Haridopolos, Lee, Villalobos and Wise)

TAB	BILL NO. AND INTRODUCER	BILL DESCRIPTION AND SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	CS/SB 0602 Children and Families / Smith et al (Linked CS/S 0606, Similar H 0515, Compare H 0517)	Children's Advocacy Centers/Funding; imposes additional court cost against persons who plead guilty or nolo contendere to, or who are found guilty of, certain crimes against minors; requires clerk of court to deposit proceeds of court cost into State Treasury for deposit into specified trust fund to be used to fund children's advocacy centers; requires compliance with specified statutory provisions in order for such center to receive certain funding, etc. Creates 938.10; amends 39.3035. CJ 03/02/04 WITHDRAWN CF 03/02/04 WITHDRAWN FT 03/02/04 WITHDRAWN AAV 03/02/04 WITHDRAWN AP 03/02/04 WITHDRAWN CF 03/10/04 CS CJ 03/24/04 FAVORABLE FT 04/01/04 FAVORABLE AAV AP	
2	CS/CS/CS/SB 0700 Criminal Justice / Peaden et al (Similar H 0463)	Mental Health; defines & redefines terms used in "the Baker Act"; amends provision re guardian advocates; amends provision re confidentiality of clinical records; revises criteria for involuntary examination; provides for involuntary outpatient placement; provides for voluntary examination for outpatient placement; provides for petition for involuntary outpatient placement, etc. Amends Ch. 394. CF 02/18/04 CS JU CJ 03/31/04 CS/CS/CS AAV AP	

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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 602

SPONSOR: Children and Families Committee and Senators Smith and Lynn

SUBJECT: Crimes Against Children

DATE: April 13, 2004 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Collins	Whiddon	CF	Fav/CS
2.	Dugger	Cannon	CJ	Favorable
3.	Fournier	Johansen	FT	Favorable
4.	Martin	Martin	AAV	
5.			AP	
6.				

I. Summary:

The Committee Substitute for Senate Bill 602 proposes that additional court costs be imposed in cases of certain crimes against children. These crimes include battery of a child, kidnapping or false imprisonment, sexual battery, procuring persons under the age of 18 for prostitution, lewd or lascivious offenses on or in the presence of persons less than sixteen years of age, abuse of children, buying or selling of minors, and sexual misconduct of Juvenile Justice employees. An additional court cost of $101 would be imposed against each offender pleading guilty or nolo contendere to, or is found guilty of, regardless of adjudication, any of the specified offenses against a minor.

The committee substitute also directs the Clerk of the Court to transfer $100 from each court cost collected to the State Treasury for deposit into the Child Advocacy Trust Fund for disbursement to the Florida Network of Children's Advocacy Centers, Inc., for the purpose of funding children's advocacy centers that are members of the network. One dollar from each court cost collected is to be retained by the Clerk of the Court as a service charge.

At the end of the fiscal year each Children's Advocacy Center must provide the network's board of directors a report reflecting expenditures, sources of revenue, and standardized outputs that include the number of clients served, client demographic information, and the number and types of services provided. The report must also provide verification that the center is in compliance with s. 39.3035, F.S. The Florida Network of Children's Advocacy Centers must compile the reports obtained from the centers and provide a report to the Legislature no later than August of each year, beginning in 2005.

The committee substitute amends s. 39.3035(3), F.S., prohibiting a CAC from receiving any state revenue or federal funds through a state agency unless the statutorily required standards are met. The Florida Network of Children's Advocacy Centers is required to document this compliance.

This bill creates section 938.10, F.S., and amends section 39.3035, F.S.

II. Present Situation:

Children's Advocacy Centers (CAC) are primarily designed and governed at the local level to provide support to the child protective investigations process. These centers work to coordinate the activities of the several agencies involved in the child abuse investigation to reduce the number of times the child must be interviewed, thereby reducing trauma to the child, to facilitate joint investigations, and to provide for prompt access to mental health and other appropriate services.

While the services offered by child advocacy centers vary based upon their funding and needs of the community, each center offers some combination of the following services:

- a neutral, child-friendly setting where all the agencies can interview and examine the child;
- medical evaluations of the child;
- coordination of multi-discipline team meeting of all of the agencies involved in a case;
- on-site victim advocacy; and
- mental health services.

The CACs have local governing boards to address organizational issues such as fiscal policies and public relations and are composed of volunteers from the community. Although they are locally governed, CACs operate under the auspices of the National Children's Alliance (NCA). The alliance is a not-for-profit organization that provides training, technical assistance, and networking opportunities to CACs operating nationwide. The NCA establishes standards for CAC accreditation and offers full membership and non-competitive grant funding to those CACs meeting 10 standards. Centers that do not meet all of the standards for full membership are designated as associate members and are eligible to apply for competitive grants. Seventeen of the 21 CACs in Florida are full members of the NCA.

The Florida Network of Children's Advocacy Centers, Inc., is a state chapter of the National Children's Alliance. All 21 of Florida's children advocacy centers participate in this network. Membership is voluntary, and the organization provides guidance and technical assistance to the CACs. The network is staffed with an Executive Director and one half-time assistant. A board of directors organizes activities.

Minimum standards for membership in the Florida Network are established in ch. 39.3035, F.S., and are similar to those for membership in the National Children's Alliance. These criteria require that a center:

- be a private, not-for-profit incorporated agency or governmental entity;

- be a Child Protection Team (CPT) or have a written agreement that incorporates the participation and service of the CPT;
- have a neutral, child-focused facility;
- have staff that is supervised and approved by a local board of directors or governmental agency;
- have a multi-disciplinary case review team that minimally consists of representation from the State Attorney's office, Department of Children and Family Services (DCF), the CPT, mental health services, law enforcement, and the child advocacy center staff;
- track the cases seen through the child advocacy center with minimum requirements on the data to be collected identified;
- provide referrals for medical exams and mental health services;
- provide training in the community; and
- have interagency agreements for the multidisciplinary approach to handling child sexual abuse and serious child abuse.

Child advocacy centers in Florida are required to meet these standards and be full members of the Florida Network of Children's Advocacy Centers in order to be eligible to receive state funds appropriated by the Legislature [s. 39.3035(3), F.S.].

Funding for CACs is received from a variety of sources including local donations, grants from local governments, private foundations and contracts with state agencies such as the Department of Children and Families, Department of Juvenile Justice, and the Department of Health. Since FY 1999-2000, the Legislature has appropriated funds ranging from $400,000 to $750,000 annually for up to five of the children's advocacy centers. Funds were appropriated by the Legislature for three CACs for FY 2002-2003. Currently, no CACs directly receive legislative funding. Since May, 2003, the Florida Network has received funding from a grant provided by the Children's Justice Act that is managed by the Department of Children and Families. According to DCF, this grant provides $150,000 to be used to collect data regarding existing centers and to provide staff training and technical assistance. This funding is due to expire on June 30, 2005.

The Florida Network of Children's Advocacy Centers reports that the budgets of the 21 advocacy centers vary based upon the types of services that are provided to local communities. The funding is primarily used for salaries and benefits, with staffing patterns ranging from one-half of a full time position to 25 positions. Specific funding sources vary across centers as well as the degree to which these centers rely on a single funding source.

The Joint Legislative Auditing Committee directed the Office of Program Policy Analysis and Government Accountability to review CACs. Their report, released in August 2002, reflects that local stakeholders are highly supportive of the centers and indicates that the centers improve the coordination of child abuse investigations and their outcomes. The child welfare literature supports the benefits of CACs, particularly in reducing trauma experienced by the child during investigations.

However, Children's Advocacy Centers are primarily responsible to their boards and do not have a comprehensive accountability system which reports their inputs, outputs, and outcomes. The

seventeen centers that are full members and accredited by the NCA must maintain client information in a case tracking system and report caseloads, client demographics, and case disposition biannually. The four Florida associate members do not have the same reporting requirements. Neither the state nor the NCA requires the CACs to report accountability data such as cost per case or whether services are provided in a timely manner. However, one of the requirements of receiving funding from the Children's Justice Act grant is that the network develop the capacity to collect certain data and provide information regarding the CACs in Florida.

Prevalence of Specified Crimes Against Minors

The prevalence of the crimes against children specified in this bill is unclear. In calendar year 2001, The Office of the State Courts Administrator estimated the following prevalence for felonies listed in SB 602:

Violation	Number of Charges
s. 784.085, F.S., Battery of a child	0
ch. 787, F.S., Kidnapping, false imprisonment	1,108
ch. 794, F.S., Sexual battery	1,190
s. 796.03, F.S., Procuring person under age 18 for prostitution	11
s. 800.04, F.S., Lewd or lascivious offenses	2,403
ch. 827, F.S., Abuse of children	3,614
s. 847.0145, F.S., Buying or selling of minors	0
s. 985.4045, F.S., Sexual misconduct of Juvenile Justice employees	2
Total	**8,328**

The Florida Department of Law Enforcement (FDLE) collects information on crime. However, the definitions used for reporting, while compatible with other law enforcement systems, are not inclusive of all crimes against children that are specified by this legislation. The January - December 2002 Crime in Florida report indicates that in the category of domestic violence, more than 9,000 victims of crimes such as manslaughter, homicide, forcible sex offenses, or assault were children.

Current Court Costs

Persons who are convicted of crimes against minors specified by this bill currently may incur fines ranging from $500 to $15,000 depending upon the type of conviction. Counties may also adopt ordinances to impose additional fines of $50 for felony offenses or $20 for misdemeanor offenses. The county fines are not contingent on conviction.

In addition to potential fines, costs are assessed against a defendant. There are mandatory court costs in all cases (ss. 938.01 – 938.06, F.S.), mandatory costs in specific types of cases (ss. 938.07, 938.13, F.S.), mandatory costs authorized by local government entities (ss. 938.15-938.19, F.S.), and discretionary costs in specific types of cases (ss. 938.21-938.301, F.S.).

III. Effect of Proposed Changes:

The committee substitute for Senate Bill 602 proposes that additional court costs of $101 be imposed in cases of certain crimes against children. These crimes include battery of a child, kidnapping or false imprisonment, sexual battery, procuring persons under the age of 18 years for prostitution, lewd or lascivious offenses on or in the presence of persons less than 16 years of age, abuse of children, buying or selling of minors, and sexual misconduct of Department of Juvenile Justice employees. The additional court cost would be imposed against each offender pleading guilty or nolo contendere to, or found guilty of, regardless of adjudication, any of the specified offenses against a minor.

The committee substitute also directs the Clerk of the Court to transfer $100 from each court cost collected to the State Treasury for deposit into the Child Advocacy Trust Fund. The funds are to be disbursed to the Florida Network of Children's Advocacy Centers, Inc., for the purpose of funding child advocacy centers that are members of the network. One dollar from each court cost collected is to be retained by the Clerk of the Court as a service charge.

This committee substitute provides the opportunity for Children's Advocacy Centers to replace and, possibly, expand upon diminishing state funding. Some of the centers under the current funding configuration report having problems funding the services provided by the center. Providing the funding to the network for distribution to the children's advocacy centers will allow the network to develop an allocation methodology that is sensitive to community needs.

Court costs will be assessed and collected statewide to fund the CACs. Based upon the estimated prevalence of crimes against children in 2002 using the FDLE report, the fees collected may exceed $900,000 annually. Another estimate may be derived using the numbers obtained from the court data system, which is more than $800,000 annually.

While there appear to be many benefits to Children's Advocacy Centers, it is not always clear how local centers supplement the child protective investigative workload, whether some of the duties overlap, or whether a distinctly different population is served. Given the current variability in service arrays and funding streams across the individual centers, the specific needs and outcomes this funding will be used to support is unclear. Requiring annual reports to the Legislature verifying compliance with s. 39.3035, F.S., and of expenditures, sources of revenue, and outputs such as the number of clients served, client demographic information, and number and types of services provided will help ensure the non-duplication of funding and improve the consistency of information gathered across the centers. It will also help ensure that the centers are in compliance with required standards.

The committee substitute also amends s. 39.3035(3), F.S., to prohibit a child advocacy center from receiving funds administered by a state agency or appropriated by the Legislature unless all of the standards in ss. 39.3035(1) and (2), F.S., are met. The committee substitute further specifies that the Florida Network of Children's Advocacy Centers, Inc., is responsible for tracking and documenting that any child advocacy center receiving funds through the network is in compliance with these provisions. These changes will ensure that any child advocacy center receiving state funding will be in compliance with the statutorily required criteria and that all

employees and volunteers working at the center have received appropriate background screenings.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

The trust fund created by CS/SB 606, linked to this bill, restricts the disbursement of funds to the Florida Network of Children's Advocacy Centers, Inc. As with all disbursements from the State Treasury, these funds can only be disbursed to the network through legislative appropriations to the Department of Children and Families in general law.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

Persons who are found guilty or plead nolo contendere to crimes against children that are specified in this committee substitute are subject to an additional $101 in court costs.

B. Private Sector Impact:

The funds collected and placed in the Child Advocacy Trust Fund would benefit local child advocacy centers to the extent such funds are appropriated by law.

C. Government Sector Impact:

Data from the Office of the State Courts Administrator and the Florida Department of Law Enforcement indicate that the additional court costs imposed by this bill would generate between $800,000 and $900,000 for the Child Advocacy Trust Fund in the Department of Children and Families, and between $8,000 and $9,000 in service charges for the Clerks of the Circuit Court.

VI. Technical Deficiencies:

None.

VII. Related Issues:

CS/SB 602 is linked to CS/SB 606, a trust fund bill.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.

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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/CS/CS/SB 700

SPONSOR: Criminal Justice Committee, Judiciary Committee, Children and Families Committee, Senators Peaden, Fasano, Campbell, and others

SUBJECT: Mental Health

DATE: April 13, 2004 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Collins	Whiddon	CF	Fav/CS
2.	Matthews	Lang	JU	Fav/CS
3.	Cellon	Cannon	CJ	Fav/CS
4.	Martin	Martin		
5.				
6.				

I. Summary:

The CS for CS for CS substantially amends Florida's involuntary civil commitment law also known as the Baker Act under ch. 394, Part I, F.S., as follows:

- Establishes a process for long-term involuntary placement for outpatient services for persons 18 years of age or older who meet other statutory criteria but only if services or programs, space therein or funding are available in the person's local community;
- Provides the option for a person to agree voluntarily to submit to involuntary outpatient services;
- Adds a process for continued involuntary placement for outpatient services based on maximum 6-month intervals;
- Revises the criteria for involuntary examination under the Baker Act;
- Makes other conforming changes to the Baker Act to distinguish between the procedures for involuntary placement for inpatient treatment versus involuntary outpatient placement; and
- Provides rulemaking authority to the Department of Children and Family Services.

This CS for CS for CS substantially amends s. 394.455, s. 394.4598, s. 394.463, and s. 394.467, of the Florida Statutes and creates s. 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 subsequent *involuntary placement* (admission) of a person for inpatient treatment of a mental, emotional or behavioral disorder.[1] For purposes of the Baker Act, *mental illness* is defined as *an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology*. The term does not include retardation or developmental disability as defined in chapter 393, F.S., intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.[2]

Involuntary Examination
Specifically, a person may be brought in for an *involuntary examination* at a receiving facility for evaluation including short-term emergency service and treatment for no longer than 72 hours. The process for *involuntary examination* is initiated in one of three ways:[3]

a. *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).[4] The order is valid for 7 days or some other timeframe specified in the order.

b. *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.

c. *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

[1] *See* Part I, s. 394.451- s. 394.4789, F.S. The Act was first enacted in 1971. In Florida, 84,162 Baker Act examinations were conducted during the 2001-2002 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.
[2] *See* s. 394.455(18), F.S.
[3] *See The Florida Mental Health Act (The Baker Act) 2002 Annual Report*, Florida Agency for Health Care Administration (revised 11/25/03). Mental health professionals initiated fifty-one percent of the Baker Act initiations, followed by law enforcement officials (45 percent), and judges (4 percent). The average age of a person subjected to the Baker Act is 37 years old.
[4] 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.

enforcement officer must execute a written report. A copy of the certificate must be sent to AHCA.

In 2002, mental health professionals initiated fifty-one percent of the Baker Act initiations, followed by law enforcement officials (45 percent), and judges (4 percent).[5] The average age of a person subjected to the Baker Act is 37 years old.

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

(3)(a) The person is likely to suffer from neglect without care or treatment which poses a threat of substantial harm to the person and is unavoidable even with family or friends' assistance, or
(3)(b) There is substantial likelihood that the person will cause serious harm to self or others without care or treatment.[6]

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 cannot be detained longer than 72 hours[7] 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;[8]
- Asked for express and informed consent to voluntary placement and treatment;[9] 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 inpatient placement.[10]

[5] Id.
[6] *See* s. 394.463(1), F.S.
[7] 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.
[8] There are currently options in the Baker Act that permit involuntary outpatient placement. *See* s. 394.467, F.S.
[9] *See* s. 394.463(2)(i), F.S.
[10] *See* s. 394.467, F.S.

Only a qualified clinical psychologist[11] or a psychiatrist[12] or a hospital emergency department physician with diagnostic and treatment experience in mental and nervous disorders, provided the patient has undergone a medical screening and the hospital is designated as a receiving facility, can approve the release of a patient from a receiving facility.[13] A receiving facility is statutorily defined as a public[14] or private facility[15]specifically designated by the Department of Children and Families[16] to receive and hold patients involuntarily under emergency conditions or for psychiatric evaluation and to provide short-term treatment.[17] There are currently 112 receiving facilities in Florida.

Involuntary Placement for Inpatient Treatment

Petition: After the examination, if the 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 facility upon the filing of a petition by the receiving facility's administrator.[18] The petition must be supported by a psychiatrist's opinion and a second opinion from a clinical psychologist or psychiatrist. In counties populated by less than 50,000, the second opinion can be provided by a physician with special mental health training. Florida has 27 counties with less than 50,000 in population as of the 2000 U.S. Census.[19]

Appointment of counsel: If a person does not already have counsel, a public defender must be appointed within one day of the filing of the petition for involuntary placement for inpatient treatment. Most persons subject to the Baker Act do not have private counsel. The state attorney for the circuit appears at the hearing as a representative of the State.

Hearing; Determination of Competence and Appointment of Guardian Advocate, and Independent Expert Examination: The hearing on the petition must be held within five days. The court may appoint a general master to preside at the hearing. 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. One of the professionals who executed the involuntary placement certificate must also be a witness at the hearing. The individual who is the subject of the hearing has a right to an independent expert examination. If the individual cannot afford the examination, the court is directed to provide for one.

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[11] 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.

[12] 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.

[13] *See* s. 394.463(2)(g), F.S.

[14] 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.

[15]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.

[16] Criteria for designation as a receiving facility is set forth in s. 394.461, F.S.

[17] *See* s. 394.455(26), F.S.

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

[19] The following Florida counties have populations totaling less than 50,000 based on the 2000 official U.S. census: Baker, Bradford, Calhoun, Desoto, Dixie, Flagler, Franklin, Gadsden, Gilchrist, Glades, Gulf, Hamilton, Hardy, Hendry, Holmes, Jackson, Jefferson, Lafayette, Levy, Liberty, Madison, Okeechobee, Suwannee, Taylor, Wakulla, Walton, and Washington.

At the hearing for involuntary placement, the court must determine if the person is competent to consent to treatment. If the person is not competent to consent and a guardian has not yet been appointed to consent on behalf of the person, the court must appoint a guardian advocate who will have that authority.[20] The guardian advocate has that authority for as long as the person is deemed incompetent to consent or is discharged from a facility or transferred from involuntary to voluntary status.[21] The court can grant additional powers to the guardian advocate as provided in this part. Upon sufficient evidence, the court can (or the hearing officer can recommend to) restore the person's competence. The patient and the guardian advocate must be given a copy of the order restoring competence, or the certificate of discharge containing the restoration of competence.[22] At that point the guardian advocate is discharged.

Criteria for Involuntary Inpatient Placement: In order for someone to be placed (i.e., admitted) involuntarily for inpatient treatment, the court must find by clear and convincing evidence that the person meets the following criteria:

(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, or 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 evidenced by recent behavior of actual, attempted or threatened harm;* and
3. *Less restrictive treatment alternatives are inappropriate.*[23]

If at any time during the hearing, the court determines that the patient otherwise meets the criteria for involuntary assessment, protective custody, or admission under the Marchman Act (chapter 397, F.S., relating to substance abuse), the court can order the person to be assessed involuntarily for 5 days as provided in s. 397.6811, F.S., for purposes of treatment under the Marchman Act.[24]

If the court determines that the patient does meet the criteria for involuntary placement for inpatient treatment under the Baker Act, the court must order the patient to be transferred for treatment to a treatment facility, if the patient is 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.[25] The order must specify the nature and extent of the patient's mental illness. From that point, the patient may be detained until the facility determines that the patient no longer meets

[20] *See* s. 394.4598, F.S.
[21] *See* s. 394.455(12), F.S.
[22] *See* s. 394.4598(7), F.S.
[23] *See* s. 394.467(1)(a), F.S.
[24] *See* s. 394.467(6)(c), F.S. & s. 397.675, F.S.
[25] *See* s. 394.467(6)(b), F.S.

the criteria for involuntary placement and must be released. Alternatively, the patient can be transferred to voluntary status. 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 actually own the receiving facility.

Continued Involuntary Placement for Inpatient Treatment
If a patient continues to meet the criteria for continued involuntary placement, the facility's administrator must file a petition for continued involuntary placement before the period of treatment in the order expires. The petition must include an attachment that contains the patient's physician or clinical psychologist's statement justifying the continuance, describing the patient's treatment, and specifying the individualized plan to be followed.

Hearings for continued involuntary placement are conducted by administrative law judges in the Division of Administrative Hearings. The hearings are not judicial. The patient must be represented by the public defender if the patient is not otherwise represented by private counsel. If the administrative law judge finds that the patient meets the criteria for continued placement, then he or she may order continued placement for a maximum of 6 additional months. This process is repeated prior to the expiration of each ordered period.

At all times during a person's involuntary inpatient placement, a patient (or guardian or guardian advocate on behalf of the patient) retains the right to request transfer from one facility to another, provided the other facility accepts the patient or the availability of appropriate facility resources in the case of transfer between public facilities.

Confidentiality of Clinical Records
All information about a person in a mental health facility is maintained as confidential in accordance with s. 394.4615, F.S., and only released with the consent of the person or a legally authorized representative. However, certain information can be released without consent to the person's attorney, in response to a court order, if there has been a threat of harm to parents, next-of-kin, or others. Persons in mental health facilities have the right to access their own clinical records under the patient's bill of rights.[26]

State's Mental Health Agency
The Department of Children and Families is designated as the State's Mental Health Authority. The department and the Agency for Health Care Administration (AHCA) exercise executive and administrative supervision over all mental health facilities, programs, and services.[27] The department is responsible for reporting any violations of the rights or privileges of patients and procedure provided by any facility or professional licensed or regulated by the AHCA. The AHCA is authorized to impose sanctions for such violations. The Florida Local Advocacy Council also has statutory responsibility to oversee the proper implementation of the Baker Act.[28] Any designated receiving and treatment facility must allow the council access to a patient and the clinical and legal records. The council is also required to receive notice of any person admitted as an involuntary patient.[29]

Recent Trends and Efforts in Mental Health Systems

[26] *See* s. 394.459, F.S.
[27] *See* s. 394.457, F.S.
[28] *See* s. 394.459, F.S.
[29] *See* s. 394.4599(2)(b), F.S.

Mental health advocates and professionals believe that early interventions and appropriate treatment services prior to a person's acute or chronic mental illness episode could avoid many hospitalizations. In addition, the issue of unaddressed mental illness is compounded by other issues such as homelessness, incarceration, suicide attempts, victimization, and violent episodes.

Judges and other professionals in Florida's criminal justice 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.[30] Reportedly, one of the more indirect consequences of the deinstitutionalization of persons with mental illness from the state mental health hospitals has been their re-institutionalization in the criminal justice system.[31] It is believed 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 returned 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 available community management and monitoring services for the client to ensure that service needs are being met.[32]

Florida, like many other states in the nation, has drastically reduced the number of inpatient beds as mental health treatment has moved from the state hospitals to the community. In 1979, there were 4,743 individuals in Florida's civil mental health facilities. Today, the three civil treatment facilities have a combined operating bed capacity of 1,369. The three state-operated civil treatment facilities exist in Gadsden, Broward, and Baker counties. Approximately 388, or 28 percent, of these beds are used for forensic step-down care and are not accessible for civil commitments. In 2001, the legislatively established Florida Commission on Mental Health and Substance Abuse recommended a significant increase in the number of crisis stabilization unit (CSU) beds for critical 24 hour psychiatric emergency and stabilization services.

Laws on Involuntary Outpatient Placement

Many states have adopted new treatment standards for commitment that are not based solely on a person's danger to self or others but are based on a person's well established medical and treatment history and other factors such as self-neglect, violence, or arrest for criminal behavior. Forty-one states and the District of Columbia have provisions for some process for involuntary *outpatient* treatment commensurate with increased funding.[33] Involuntary *outpatient* treatment is a form of civil commitment in which the court orders an individual to comply with specific mental health treatment(s) on an outpatient basis. Theoretically, this practice can allow the person with mental illness increased autonomy while extending the state's supervisory control beyond the hospital and into the community. Law enforcement in Florida are supportive of this concept 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

[30] *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.
[31] *Emerging Judicial Strategies for the Mentally Ill*, Bureau of Justice Assistance, April 2000.
[32] *Id.* to fnt. 28.
[33] *Briefing Paper*, Treatment Advocacy Center, Arlington, Virginia, March 2003. *See also* www.psychlaws.org.

issue and burden the criminal justice system, particularly as officers are not equipped or trained to handle these types of cases.

However, ongoing controversy surrounds involuntary outpatient treatment laws. Both philosophical and operational concerns have been expressed regarding the practice of involuntary outpatient commitment. Experts disagree about both the appropriateness and the effectiveness of involuntary *outpatient* commitment, and there are mixed results from states that have implemented these procedures. Recent evidence-based review was conducted by researchers of the empirical literature on involuntary outpatient treatment.[34] 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 re-hospitalization, 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. The Rand report identified three essential requirements for the successful implementation of a law implementing any system of involuntary outpatient placement: 1) the provision of a substantial legal infrastructure and treatment service system, 2) adequate funding, and 3) consistent enforcement.[35]

III. Effect of Proposed Changes:

The CS for CS for CS amends chapter 394, Part I, F.S., (the Baker Act) to include criteria and a process for involuntary outpatient placement that will allow individuals with mental illness who meet certain criteria to be ordered by the court to participate in community-based mental health treatment. In order for the court to order such services, the responsible service provider must certify to the court that the appropriate mental health services are available in the community. The court orders must address specific treatments that are to be provided to the individual and must be issued contingent upon the availability of treatment services in the community. Non-

[34] *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>.

[35] *See The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, M. Susan Ridgely, Randy Borum, John Petrila, 2001. The study included but was not limited to a review of literature, interviews with prosecuting and defense attorneys, psychiatrists and local behavioral health officials, an examination of ongoing clinical studies comparing differences between persons mandated to treatment and those who voluntarily received treatment - a well-known Duke study regarding outpatient treatment.

compliance with court-ordered outpatient treatment may result in the individual being evaluated for involuntary inpatient treatment if he or she is believed to meet the criteria.

Section 1: Amends s. 394.455, F.S., providing definitions for "service provider," "involuntary examination" and "involuntary placement."

Section 2: Amends s. 394.4598, F.S., to reference involuntary placement, as described in newly created s. 394.4655, F.S., specifying that the guardian advocate shall be discharged from an order for involuntary outpatient placement or involuntary inpatient placement when the patient is transferred from involuntary to voluntary status.

Section 3: Amends s. 394.4615(3), F.S., providing for the release of the patient's clinical record with consent from the patient or the patient's guardian advocate, if one has been appointed, in a manner that is consistent with applicable state and federal law. It should be noted that this provision will only apply to "facility" records, not the outpatient records that are governed by chapter 456, F.S. It also allows for the release to specified persons of a person's clinical record for determining where someone meets the criteria for involuntary outpatient placement or for preparing a proposed treatment plan.

It also allows for the release to specified persons of a person's clinical record for determining where someone meets the criteria for involuntary outpatient placement or for preparing a proposed treatment plan.

Section 4: Amends s. 394.463, F.S., to permit the person's current reported or observed behavior to be considered in implementing an involuntary examination. It is unclear how the report on behavior is to be verified and determined to be credible. Current law requires that a mental health professional personally conduct an examination to support the conclusion that the individual meets criteria for involuntary placement (s. 394.463(2), F.S.).

This section also directs that both involuntary inpatient placement orders as well as involuntary outpatient placement orders be provided to and maintained by the Agency for Health Care Administration (AHCA).

Section 5: Creates s. 394.4655, F.S., to provide criteria for involuntary outpatient placement, a process for initiating involuntary outpatient placement, mechanisms for filing a petition for involuntary outpatient placement, the appointment of counsel, continuance of hearing, the hearing for involuntary outpatient placement and makes provisions for continued involuntary outpatient placement.

Criteria for Involuntary Outpatient Placement
In subsection (1) of s. 394.4655, F.S., the CS for CS for CS provides criteria that must be met for an individual to be court ordered for involuntary outpatient placement. The individual must, by clear and convincing evidence:

- Be 18 years old or older;
- Have a mental illness, along with a clinical determination that the person is unlikely to survive safely in the community;
- Have a history of non-compliance with mental health treatment;

- Have been involuntarily admitted to a receiving or treatment facility at least two times during the immediately preceding 36 months, not including any time the person was admitted or incarcerated, or have engaged in one or more acts of serious violent behavior or attempts at such acts within the preceding 36 months;
- Be unlikely to voluntarily participate in treatment as a result of mental illness;
- Based upon the individual's treatment history and current behavior, be in need of involuntary outpatient placement to prevent a relapse or deterioration that is considered likely to result in harm; and
- Be likely to benefit from involuntary outpatient placement.

All less restrictive alternatives must first have been deemed inappropriate.

The CS for CS for CS provides broader criteria for determining the need for involuntary outpatient placement than is currently provided for inpatient placement. Some of the additional criteria include involuntary admission to a treatment or receiving facility within the preceding 36 months; in light of the person's treatment history, the likelihood of relapse or deterioration that would cause serious bodily harm to self or others or substantial harm to his or her well being; the consideration of violent acts by the individual; and, as a result of his or her mental illness, the unlikelihood that the person would voluntarily cooperate with a treatment plan.[36]

Involuntary Outpatient Placement
In subsection (2), the CS for CS for CS specifies three areas from which an involuntary outpatient placement may be made: from a receiving facility, based upon a voluntary examination for outpatient placement or from a treatment facility. Recommendations for involuntary outpatient placement are made by the administrator of a receiving or treatment facility or the patient.

Recommendations for involuntary outpatient placement must be supported by the opinion of a psychiatrist or clinical psychologist and a second opinion by a clinical psychologist or another psychiatrist. Both of these experts must have examined the individual within the preceding 72 hours. In counties with populations of fewer than 50,000 residents, the second opinion may be provided by a licensed physician who has post graduate training and experience in diagnosis and treatment of mental disorders.

Recommendations for involuntary outpatient placement from a receiving facility must be made on an involuntary outpatient placement certificate. This certificate must authorize the receiving facility to retain the patient pending transfer to an involuntary outpatient placement or completion of the hearing. If the person becomes stabilized and no longer meets the criteria for involuntary examination provided in s. 394.463(1), F.S., the person must be released from the receiving facility while awaiting the hearing for involuntary outpatient placement.

Recommendations for involuntary outpatient placement that are made from a treatment facility must be made on the involuntary outpatient placement certificate. However, it is not specified that the individual must be released from the treatment facility while awaiting the involuntary

[36] Some of the criteria are unclear; for example, it is unclear how incidents of "serious violence" or "serious bodily harm" will be determined. Additionally, the information needed to be obtained comes from a variety of sources that may be difficult to access in a timely manner. Finally, there is no way to know if an individual obtained mental health services in the past with or without consent from the individual.

outpatient placement hearing. (It is not clear if individuals from treatment facilities who are recommended for involuntary outpatient treatment await the hearing at the treatment facility or if they are discharged and await the hearing in the community.)

Under the condition when a patient chooses to be examined on a voluntary basis for involuntary outpatient placement, the required examinations must have been completed by the two experts within the preceding 7 calendar days.

Petition for Involuntary Outpatient Placement
This CS for CS for CS specifies that a petition for involuntary outpatient placement may be filed by the administrator of a receiving facility, one of the qualified professionals conducting a voluntary examination or by the administrator of a treatment facility. The petition for involuntary outpatient placement must address each of the criteria required for outpatient placement and must be accompanied by the certificate recommending involuntary outpatient placement. This CS for CS for CS requires that a copy of the patient's treatment plan be attached to the petition at the time the petition is filed. Further, the service provider must also certify that the services proposed in the treatment plan are available. The petition may not be filed if the necessary services are not available in the community. A copy of the petition must be provided to the administrator of the designated receiving or treatment facility and must be filed in the county where the patient is located. When the petition is filed, the clerk of the court is required to provide copies of the petition and the proposed treatment plan to the Department of Children and Family Services, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located.

Appointment of Counsel and Hearings
The CS for CS for CS requires the court to appoint a public defender to represent the person under petition for involuntary outpatient placement unless the person is otherwise represented by counsel. The public defender must represent the person until the petition is dismissed, the court order expires, or the person is discharged from involuntary outpatient placement. The attorney representing the individual is specified to have access to the individual, witnesses, and records relevant to the presentation of the individual's case.

Public defenders currently represent persons who are being petitioned for inpatient treatment until the resolution of the case. The requirements specified in this CS for CS for CS will likely result in additional persons requiring representation by the public defender especially in counties where state mental health hospitals are located, and may also result in cases being held open for longer periods of time than they are currently.

The individual under petition is entitled to at least one continuance of hearing for four weeks with concurrence by counsel. Otherwise, the court must conduct the hearing on involuntary outpatient placement within five days. Hearings are required to be held in the county where the individual is located. If the court finds that the individual's presence at the hearing is not within the individual's best interests and counsel agrees, the court may waive the individual's presence from all or any portion of the hearing. The state attorney in the judicial circuit the individual is located in must represent the state in these proceedings.

During the hearings, individuals who executed the involuntary outpatient placement certificate must serve as a witness. Additionally, the individual has the right to an independent evaluation, and if the individual is unable to pay for an evaluation, the court must provide for one. The court

must allow testimony from individuals, including family members, if deemed by the court to be relevant, regarding the person's prior history and how that history relates to the person's present condition.

The CS for CS for CS authorizes the court to order involuntary outpatient placement for up to six months if the individual meets the criteria. The CS for CS for CS authorizes the service provider to discharge the individual when he or she no longer meets the criteria for involuntary outpatient placement.[37]

When an individual is ordered for involuntary outpatient placement, the administrator of the receiving facility or a designated department representative must identify the service provider that will have primary responsibility for providing court-ordered services. Prior to the hearing, the service provider is required to prepare a proposed treatment plan and submit it for the court's consideration for inclusion in the involuntary outpatient placement order. The treatment plan must specify the nature and extent of the individual's mental illness and may include provisions for certain treatment services. The plan may also require the individual to make use of the designated service provider to supply other services as well. This CS for CS for CS requires the service provider to certify to the court in the proposed treatment plan whether sufficient services for improvement and stabilization are available and whether the service provider agrees to provide those services. If services are unavailable in the community, the petition must be withdrawn. The court may not order services that are unavailable. Copies of court orders must be sent to the Agency for Health Care Administration by the service provider within one working day after it is received from the court.

Modifications may be made to the treatment plan by the service provider with agreement by the patient or the patient's guardian advocate. Notification of modifications must be provided to the court. If modifications are contested by either the patient or the patient's guardian advocate, they must be submitted in writing by the service provider to the court and approved by the court. If the patient fails to comply with the treatment ordered by the court and it is thought that the patient meets the criteria for involuntary examination, the patient made be brought to a receiving facility and evaluated. If the person does not meet the criteria for involuntary inpatient treatment, the person must be discharged from the receiving facility. If at any time prior to the initial hearing the individual meets the criteria for involuntary inpatient treatment, the court may order the person to involuntary inpatient placement.

The court is required to consider testimony and evidence regarding the individual's competence to consent to treatment. If the court finds the person incompetent to consent to treatment, a guardian advocate must be appointed for the person. The guardian advocate may be discharged if the person's competency to consent to treatment has been restored.

Procedure for Continued Involuntary Outpatient Placement
If an individual continues to meet the criteria for involuntary outpatient placement beyond the initial six months order, prior to the expiration of that order, the service provider must file a continued involuntary outpatient placement certificate along with justification of the request, a brief description of the individual's treatment during the six months, and an individualized plan of continued treatment. Hearings for continued involuntary outpatient placement must be held before the circuit court and follow the same process as the initial hearing. The outpatient and his

[37] It is unusual to allow the modification of court orders by someone other than the court.

or her attorney can agree to a period of continued outpatient placement without a court hearing. A public defender must be appointed if the person is not otherwise represented by counsel.

Section 6: Amends current language to be consistent with s. 394.4655, F.S.

Section 7: Provides the Department of Children and Family Services with rule making authority to implement the act. This CS for CS for CS directs that the rules developed for the implementation of this act are for the purpose of protecting the health, safety, and well-being of persons examined, treated, or placed under this act.

Section 8: Provides for the severability of sections.

Section 9: Provides an effective date of January 1, 2005.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

To the extent that political subdivisions, including cities and counties are obligated to pay for certain services or processes attendant with the new statutory framework for involuntary examination, involuntary placement and continued involuntary placement for outpatient services, the CS for CS for CS could constitute a mandate as defined in Article VII, Section 18(a) of the Florida Constitution for which no funding source is provided to such political subdivisions[38]:

> No county or municipality shall be bound by any general law requiring such county or municipality to spend funds or to take an action requiring the expenditure of funds unless the Legislature has determined that such law fulfills an important state interest and unless: funds have been appropriated that have been estimated at the time of enactment to be sufficient to fund such expenditure; the Legislature authorizes or has authorized a county or municipality to enact a funding source not available for such county or municipality on February 1, 1989 ... and the law requiring such expenditure is approved by two-thirds of the membership of each house of the Legislature...

For purposes of legislative application of Article VII, Section 18 of the Florida Constitution, the term "insignificant" has been defined as a matter of legislative policy as an amount not greater than the average statewide population for the applicable fiscal year times ten cents. Based on the 2000 census, a bill that would have a statewide fiscal impact on counties and municipalities in aggregate or in excess of $1,598,238 would be characterized as a mandate.

It is indeterminate at this time how much counties and cities would be required to spend to effectuate parts of this Act. The provisions of the CS for CS for CS will affect counties differently depending on whether outpatient services are available based on existence, space or funding at the time a person is subject to involuntary examination and

[38] Under current law, no filing fees may be assessed for Baker Act proceedings.

involuntary placement for outpatient services. If it is determined that the Act does constitute a mandate, it does not include constitutionally required language that provides that the Legislature has determined that this legislation fulfills an important state interest, in accordance with Article VII, Section 18 of the Florida Constitution.

See also discussion under Constitutional Issues.

B. Public Records/Open Meetings Issues:

This CS for CS for CS may implicate the public records law. Under current law, a clinical record is confidential and exempt from disclosure. *See* s. 394.4615, F.S. However, as currently defined under s. 394.455(3), F.S., clinical records only refer to all records collected or maintained by the facility as pertains to involuntarily placed inpatients, and as additionally provided under s. 394.463(2)(e), F.S., to all documentation of ex parte orders, mental health professional certificates, and law enforcement officers reports that are used as a basis to initiate involuntary examination. Some of the clinical records for involuntarily placed outpatients may not be confidential since the definition of clinical records is not revised. Second, any change to the definition of clinical records to include additional records would constitute an implicit expansion of the existing provisions for confidentiality and exemption from disclosure. Such expansion would constitute a new exemption and necessitates a separate public records bill. [See page 6, lines 1-14. The CS for CS for CS adds that involuntary outpatient placement orders and involuntary inpatient placement orders which are to be maintained by AHCA are to be considered a part of the clinical record.]

Every person has the constitutional right to access public records and meetings in connection with official business of any public body, officer, or employee of the state, or persons acting on their behalf. *See* Art. I, s. 24, Fla. Const. The term "public records" has been defined by the Legislature in s. 119.011(1), F.S., to include: . . . all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency. This definition of "public records" has been interpreted by the Florida Supreme Court to include all materials made or received by an agency in connection with official business which are used to perpetuate, communicate or formalize knowledge. *Shevin v. Byron, Harless, Schaffer, Reid & Assocs., Inc.*, 379 So. 2d 633, 640 (Fla. 1980). Unless these public records are exempted by the Legislature, they are open for public inspection, regardless of their final form. *Wait v. Florida Power & Light Co.*, 372 So. 2d 420 (Fla. 1979). The State Constitution permits exemptions to open government requirements and states that these exemptions can be established by general law, provided: (1) the law creating the exemption states with specificity the public necessity justifying the exemption; and (2) the exemption is no broader than necessary to accomplish the stated purpose of the law.[39]

[39] In addition, the general law provides for a limited exemption period. The Open Government Sunset Review Act of 1995 establishes a review and repeal process for exemptions to public records or meetings requirements. Under s. 119.15(3) (a), F.S., a law that enacts a new exemption or substantially amends an existing exemption must state that the exemption is repealed at the end of five years. In the fifth year after enactment of a new exemption or the substantial amendment of an existing exemption, the exemption is repealed on October 2nd of the 5th year, unless the Legislature acts to reenact the exemption. Under the requirements of the Open Government Sunset Review Act, an exemption is to be maintained only if: (a) The exempted record or meeting is of a sensitive, personal nature concerning individuals;

C. Trust Funds Restrictions:

None.

D. Others Constitutional Issues:

- Provisions of the CS for CS for CS implicate implementation of Revision 7 to Article V of the Florida Constitution which shifts major costs of Florida's judicial system from the counties to the state. *See* Art. V, s. 14, Fla. Const. The Legislature is still in the process of identifying and determining the substantive and financial responsibilities of the state court system, the offices of the public defender, the offices of the state attorney, the counties, the clerks of the court and other interested stakeholders by the constitutional deadline of July 1, 2004.[40] At a minimum, the following costs incurred by provisions of the CS for CS for CS will be have to be borne or absorbed by the state or local government: 1) the cost of an independent expert examination in a hearing for involuntary outpatient placement if an indigent person exercises the right to an independent expert examination, 2) the cost of required recordings of proceedings on initial and continued involuntary outpatient placement, 3) the cost of *available* services or treatment under a proposed 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, 4) the cost of an appointed guardian advocate if the person is determined to be incompetent and without a guardian to make mental health decisions,[41] 5) the cost of legal representation (public defender if private counsel not otherwise available) required for petitions for initial involuntary placement who must then be retained for the duration of a person's court-ordered involuntary placement for outpatient services, 6) the cost of state attorneys representing the state at judicial hearings for the initial and continued involuntary placement for outpatient services, 7) the cost of evaluations of individuals, preparation of necessary reports, proposed treatment plans and the provision of witnesses and expert testimony for proceedings including a determination of competence, and 8) the court costs associated with taking testimony and evidence regarding a patient's competence including court reporting, disability accommodations, and court interpreting which are just some of the state due process services to be assumed by the state.

- The CS for CS for CS implicates 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 as a person subject to involuntary *inpatient* placement in the development of a treatment and discharge plan or to choose the service provider from whom they may receive treatment or services as

(b) The exemption is necessary for the effective and efficient administration of a governmental program; or
(c) The exemption affects confidential information concerning an entity.

[40] *See* e.g., chapter 2003-402, L.O.F.

[41] Issues pertaining to guardianship were of such concern that in June, 2003, the Governor established by Executive Order a Joint Work Group on Guardianship for the Developmentally Disabled. Some of the key findings of this work group reflect that there are an insufficient number of people willing to serve as guardians or guardian advocates and that there is a significant fiscal impact associated with increasing the availability of these services. Aside from the issue of availability, guardian advocates are required to submit to minimum educational and training requirements in order to serve.

a person subject to involuntary *inpatient* placement. The administrator of a facility or a designated department representative selects the service provider who unilaterally develops the treatment plan. The first opportunity the involuntarily placed person has to provide input or seek modification of an outpatient service plan is *after* the proposed recommended treatment plan is court-approved and incorporated into the involuntary *outpatient* placement order.

- No requisite hearing or established process exists for how an outpatient or appointed guardian advocate or other legally delegated authorized person may either refuse to consent or otherwise contest any material modification to a court-ordered treatment plan. Although the court must be notified of any material modification (which is undefined in the CS for CS for CS) to which the service provider and patient must agree, actual court approval of a material modification is not required unless the outpatient contests the material modification. [*See* page 16, lines 17-21.] It is not clear whether the court even has discretion to disapprove a contested material modification as the contested material modification must be in writing and "prepared for approval by the court." Additionally, if those material modifications are not reflected in the court order which incorporates the original treatment plan, there could be unintended consequences for someone who is subsequently alleged to be non-compliant with a court-ordered treatment plan which is one of the criterion for seeking re-examination and continued involuntary placement. [*See* page 16, line 22 through page 17, line 9.]

- The CS for CS for CS provides an expansive gamut of treatment options which could substantively affect a person's liberty interest and privacy interest, particularly as the person may not have input into the services or treatment options and those service or treatment options are incorporated into a court order which empowers a service provider to enforce compliance. The services or treatment options include, but are not limited to, periodic urinalysis to confirm compliance with treatment (presumably medications), periodic testing of drugs and alcohol, and supervision of living arrangements, and any other services as part of the treatment plan, all of which could constitute a substantial restriction of liberty without the other attendant procedural safeguards which are accorded persons who are involuntarily physically confined. No probable cause is required. Potential violations of search and seizure may be triggered. [*See* page 15, lines 8-29.]

- A person subject to a petition for *continued* involuntary *outpatient* placement is not accorded the same right as a person subject to continued involuntary *inpatient* placement to receive advance notice of a service provider's intent to petition the court for continued involuntary *outpatient* placement which could result in an additional 6-month restriction. [*See* page 18, lines 10-19. Compare with s. 394.467(7)(b), F.S., as revised by s. 124 of chapter 96-410, Laws of Florida.]

- The CS for CS for CS revises the criteria for bringing someone in for an involuntary examination to include a criterion that it may be based in part on the current *reported or observed behavior of the person, considering any mental health history*. No specific timeframe is offered, and no regard is given to the time, nature or scope of treatment associated with the mental health history.

Moreover, no process is provided for verifying these alleged reports or observed behavior. [*See* page 5, lines 7-31.]

- Although the court is required to take testimony and evidence regarding the patient's competence prior to appointing a guardian advocate, it does not appear to require that the court find out if a guardian or other legally delegated person is available to consent (or refuse to consent) on behalf of the person. [*See* page 17, lines 23-29.]

- A provision which allows a person to *voluntarily* agree to be examined for purposes of *involuntary outpatient* placement may raise due process concerns about whether such person has actually given express and informed consent. No requirement exists to determine whether the person was competent to consent. At what point this process evolves from voluntary to involuntary implicates a person's rights under this chapter and may have unintended consequences for such person, particularly if the person is competent and believes that he or she is acting voluntarily and retains the right to refuse to consent and not bound by any subsequent court-ordered obligation to comply with an involuntary outpatient placement order. [*See* page 10, lines 10-25.]

- The CS for CS for CS requires a service provider to prepare and submit a treatment plan with the petition [see page 12, lines 17-23] to the court to be included in an involuntary placement order for outpatient services. The availability of this proposed treatment plan prior to the hearing may unduly influence the court's findings before testimony and evidence have been taken at the hearing.

- Unlike a hearing on involuntary placement for *inpatient* treatment under s. 394.467(6), F.S., the CS for CS for CS requires that a hearing on involuntary placement for *outpatient* treatment include testimony from individuals such as family members, deemed by the court to be relevant under state law, regarding the person's prior history, and how that prior history relates to the person's current condition. This may raise issues regarding the scope of permissible testimony allowed under the Evidence Code including hearsay exceptions if the person refuses to testify or the court deems it is not in the person's best interest to be at hearing. It may also raise issues of whether the person would actually be entitled to receive notice of potential witnesses and have an opportunity to confront and cross-examine such witnesses. [*See* page 14, lines 14-20.]

- The CS for CS for CS allows the court at any time before conclusion of a hearing on involuntary *outpatient* placement to alternatively order someone for involuntary *inpatient* examination under s. 394.463, F.S., or involuntary assessment for admission under the Marchman Act, respectively, if its finds that the person meets the criteria thereunder. Although a court has the same authority under s. 394.467(6)(c), F.S., to alternatively order someone to an assessment under the Marchman act in hearings on involuntary *inpatient* placement, a person subject to involuntary *outpatient* placement would not necessarily expect the same loss of liberty as a person who is the subject of an involuntary placement for *inpatient* treatment. Therefore, the person would have been denied fair notice and

opportunity for representation at the hearing. [*See* page 17, lines 10-22.] Additionally, this provision appears to establish a circular path in which the person who is the subject of a pending petition for involuntary outpatient placement must undergo another involuntary examination to determine whether he or she meets the criteria for a petition for involuntary outpatient or involuntary inpatient placement.

- The CS for CS for CS implicates right of privacy issues particularly as it affects the confidentiality of patient records protected under federal and state laws. The CS for CS for CS expands substantially the amount of detailed information that may be included in an order and the accompanying treatment plan. It also expands the list of persons to whom copies of the petition as well as the proposed treatment may or must be released. Some of these provisions may conflict with confidentiality laws governing patient records and the process for obtaining consent and the scope of the information to be released. For example, a receiving facility administrator or designated department representative must provide a copy of the court order for outpatient placement and adequate documentation of a patient's mental illness to the service provider. [*See* page 17, line 30 through page 18, line 3.] Another example is that the clinical record may be released to the state attorney, the public defender or the patient's private counsel, the court, and to the appropriate mental health professionals including the service provider in accordance with state and federal law. Another example is that the CS for CS for CS expands the group of persons to whom a patient's clinical records may be released for the purposes of determining whether someone satisfies the criteria for involuntary outpatient placement or for preparing a proposed outpatient treatment plan. [*See* page 4, line 27 through page 5, line 3.] No requirement exists to define the scope of the information to be released or to obtain the patient's or the patient's guardian or advocate's consent. Without expressly expanding the confidentiality and public records exemption for such records as pertains to a person subject to involuntary outpatient placement, concern arises that this information is not protected from disclosure.

  Section 459.059, F.S., governs the confidentiality of a psychiatrist's records but only pertains to communications between a person and a *psychiatrist.* Moreover, unlike persons in mental health facilities who have the right to access their own clinical records, it is not clear that involuntarily placed outpatients have that right.[42] There is also concern that therapy or other mental health communications between an involuntarily placed outpatient and a mental health personnel may not be protected depending on the qualifications of the mental health personnel. For example, communications between a psychiatric nurse and a person, which results in his or her recommendation for involuntary outpatient placement, may not be protected under the psychotherapist-patient privilege under The Evidence Code, since that person may not be recognized as one of the persons to whom the privilege would apply. The Evidence Code recognizes a psychotherapist-patient privilege under prescribed circumstances. but pertains primarily to persons who are engaged by the nature of

[42] *See* s. 394.4615(10), F.S.

their profession primarily in the diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction.[43]

- The CS for CS for CS raises potential equal protection issues. Since many provisions of the CS for CS for CS do not apply if services or programs are not available, accessible, or adequately funded in the local community, the Baker Act will not be applied equally to similarly situated persons in other counties resulting in disparate treatment among such persons who by virtue of their geographic location may not be targeted for involuntary outpatient treatment and attendant consequences including the receipt of outpatient services.

- The CS for CS for CS does not amend the patients' bill of rights under s. 394.459, F.S., in the Baker Act to reflect that these rights should equally apply to the rights of persons subject to involuntary placement for *outpatient* services. Unless otherwise stated, it is possible that involuntarily placed *outpatients* would not be accorded the same rights as an inpatient, including but not limited to a right to individual dignity, right to treatment, right to express and informed patient consent (or refusal to consent), right to transfer from one service provider to another if unsatisfied with the care received, and right to participate in the development of a treatment plan and discharge plan, the right to services individualized to a person's needs, and the right to skillful, safe and humane administration of services and treatment. Additionally, extensive provisions governing communication, reports of abuse and visits, care and custody of personal effects of patients, voting in public elections, and habeas corpus relief may not apply to persons involuntarily placed for outpatient services.

- The right to consent (or refuse to consent) to health care treatment under the right of privacy is implicated. The criteria for involuntary outpatient placement does not include a provision analogous to that found for requisite involuntary inpatient placement which requires expressed and informed consent. Under s. 394.467(1)(a)1., F.S., one of the criteria is that the person has refused voluntary placement treatment *after sufficient and conscientious explanation and disclosure of the purpose of placement or treatment; or that the person has been determined to be unable to determine for himself or herself whether placement is necessary*. Similarly the rights of involuntarily placed inpatients requires certain disclosures to be made prior to

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[43] See s. 90.503, F.S. A psychotherapist is a *person authorized to practice medicine* in any state or nation, or reasonably believed by the patient so to be, who is engaged in the diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction; 2. A person licensed or certified as a *psychologist* under the laws of any state or nation, who is engaged primarily in the diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction; 3. A person licensed or certified as a *clinical social worker, marriage and family therapist, or mental health counselor* under the laws of this state, who is engaged *primarily in the diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction*; or 4. *Treatment personnel of facilities licensed by the state pursuant to chapter 394, chapter 395, or chapter 397,* of facilities designated by the Department of Children and Family Services pursuant to chapter 394, F.S., as treatment facilities, or of facilities defined as community mental health centers pursuant to s. 394.907(1), F.S., who are engaged primarily in the diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction.

obtaining express and informed consent.[44] Under current law, a person is presumed to be capable of making health care decisions including consent and refusal to consent for herself or himself unless she or he is determined to be incapacitated and incapacity may not be inferred from a person's voluntary or involuntary hospitalization for *mental illness*. [*See* s. 765.204, F.S.] However, a physician can evaluate the person's capacity if it is in question whether the person can provide informed consent and if the person does lack capacity then the evaluation is entered in the person's medical record. Otherwise, the right to consent (or refuse to consent) may be made by a health care surrogate or other person with delegated authority to make such health care decisions.[*See* page 8, lines 9-31 through page 9, lines 1-14].

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Persons who may be subject to the Baker Act may benefit from the changes attendant in this CS for CS for CS 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 appropriate and affordable mental health services and other related services available and accessible to those who need them. The benefit to this targeted population is dependent on the extent to which such persons are more likely to comply under a court-order versus under voluntary participation. Involuntary outpatient placement has been found to have increased effectiveness when the sufficient community resources are present. Involuntary outpatient placement is also associated with reduced lengths of stay in subsequent hospitalizations. This may ultimately reduce recidivism, incarceration and homelessness. Many of the provisions of the CS for CS for CS, however, do not apply if there are no mental health services available or accessible in the county. The CS for CS for CS does not provide additional funding sources or revenues.

The CS for CS for CS provides an expansive gamut of treatment options that a service provider may recommend for involuntary placement for outpatient treatment. The CS for CS for CS is not entirely clear whether an involuntarily placed person who has full or partial ability to pay for outpatient services which are available would be financially responsible for paying for those services. For involuntarily placed persons for inpatient treatment, the current law requires "every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services to persons able to pay for services, including insurance or third-party payments," although treatment shall not be

[44] *See* s. 394.458(3), F.S. The following information must be provided: the reason for admission, the proposed treatment, the purpose of the treatment to be provided, the common side effects thereof, alternative treatment modalities, the approximate length of care, and that any consent given may be revoked orally or in writing prior to or during the treatment period by the patient, the guardian advocate, or the guardian. Specifically in cases involving medical procedures requiring the use of a general anesthetic or electroconvulsive treatment, express and informed consent must again be obtained. Additionally, if the department is the legal guardian of the patient, and the physician is unwilling to perform such medical procedure, a hearing must be held.

otherwise denied or delayed because of inability to pay.[45] Additionally, under the implementing law to Revision 7 to Article V, court costs, fines, and other dispositional assessments that may arise directly or indirectly from the proceedings under the Baker Act are no longer deemed waived for persons determined to be indigent but rather are considered deferred and may be enforced by the courts, and collected by the clerk of the circuit court. The cost to such involuntarily placed persons could be substantial.

Emergency room physicians and other clinical psychology staff will require reeducation regarding the new criteria for involuntary examination for a determination of involuntary placement for outpatient services.

C. Government Sector Impact:

LOCAL GOVERNMENT

The impact of this bill on local law enforcement is expected to be a positive savings as persons who are provided outpatient services are stabilized in the community and avoid future law enforcement intervention. During the 2003 legislative session, this impact was estimated by the Florida Sheriff's Association (FSA) to be a $54 million savings (for SB 2748) calculated on the basis of 666 disorderly conduct arrests per year and 15,000 other Baker Act law enforcement cases generated by 7,500 persons. However, most recently, in an analysis provided on April 7, 2004, the FSA assumes that the current version of this bill restricts significantly the criteria for invoking outpatient commitments such that only 736 persons would be affected per year. (The estimate of 736 persons is based on the number of annual petitions filed in the state of New York during that state's first year of outpatient services implementation ("Kendra's Law"), adjusted for Florida population.) According to representatives of the Treatment Advocacy Center, (TAC) based in Arlington, Virginia, who have provided technical assistance to the FSA, these 736 persons would be involved in an estimated 5,388 Baker Act cases per year. Using a cost factor of $3,150 per law enforcement case,[46] the projected maximum local law enforcement savings is approximately **$17 million** per year. However, the TAC also suggests that the provision of outpatient treatment will reduce the number of cases by only 57 percent, or 3, 071 of the 5,388 cases, generating a local law enforcement savings of **$9.7 million**.

The FSA analysis assumes that the CS for CS for CS does not expand the "net" for Baker Act eligibility. However, it is unkown how many persons may meet the criteria for outpatient placement by virtue of having engaged in one or more acts of serious violent behavior or attempts at such acts within the preceding 36 months.

The Florida Association of Counties reports that there will be an undetermined fiscal impact to counties due to the required 25 percent matching funds that must be provided

[45] *See* s. 394.459(2), F.S.
[46] The $3,150 cost of arrest is taken from Lewin Group, The Economic Costs of Mental Illness, 1992, National Institute of Mental Health 5-26 (July 2000).

for mental health services.[47] During the 2003 legislative session, the estimate for this cost to counties (pursuant to SB 2748) totaled $5.4 million, based on the estimate of 7,500 persons. Assuming the FSA estimate of 736 persons, this estimate of county costs for matching funds would be, at a minimum, over **$500,000** per year.

STATE GOVERNMENT

Courts: The CS for CS for CS will affect the courts' workload. The Office of the State Courts Administrator projects a workload increase for judges, state attorneys, public defenders, and clerks of court. The CS for CS for CS expands the class of persons 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. Applying the legislatively required Weighted Caseload System judicial workload methodology, the State Courts System estimates it will require the equivalent of two to three full-time circuit judges to implement the proposal at the trial court level, at a conservative estimate of an initial recurring cost in the range of **$636,608 to $954,912**. Additionally there will be modest non-recurring effects in FY 2004-05 for education programs to prepare the judiciary for implementation of the CS for CS for CS.

Based on revised estimates from public defenders submitted on April 1, 2004 that they would file approximately 500 appeals in the first year of implementation, and using the 350 filings-per-DCA-judge workload standard, it is estimated that two full-time district court of appeal judges plus support staff and expenses would require approximately **$840,000** annually to implement at the district courts of appeal level.

Court rules will also have to be revised to reflect statutory changes initiated by the CS for CS for CS.

Public Defenders: The CS for CS for CS requires the appointment of a public defender for a person subject to its provisions who must be retained to represent the person until the person is officially discharged from involuntary outpatient services. Whether appointed or re-appointed, once appointed a public defender may be required to represent an involuntarily placed outpatient until he or she is discharged from involuntary outpatient services, which could be in perpetuity as a service provider may petition indefinitely for a person's continued involuntary placement. This requirement and others will have a potentially significant fiscal impact on the offices of public defenders.

[47] The Florida Association of Counties recommends that a detailed evaluation of involuntary outpatient placement be conducted prior to its implementation statewide to assure the proper community infrastructure is in place. The Association recommends the use of a pilot program in order to better prepare for specific changes that need to be made to help divert mentally ill persons from jails, and cites the New York State Legislature's enabling legislation providing for a 3-year pilot program to test the process 5 years prior to passage of final legislation governing involuntary outpatient commitment orders.

Moreover, provisions in chapter 2003-402, L.O.F., relating to the implementation of Revision 7 to Article V will have to be revised to reflect the new duties of public defenders to appear in involuntary placement for outpatient services and continued involuntary placement. The Florida Public Defenders Coordination Office reports that the fiscal impact for all 20 public defenders annually is approximately **$2.2 million** for 34 new staff.

State Attorneys: The CS for CS for CS requires state attorneys to represent the state in the hearings for involuntary outpatient placement although they do not appear required to appear in the circuit court hearings for the continued involuntary placement for outpatient services. The State Attorneys have submitted a supplemental budget request for FY 2004-05, due to the expected impact of this bill, for 28 additional attorneys that will be needed in the 20 judicial circuits at an annual cost of **$1.7 million**. Similarly to the public defenders, provisions in chapter 27, F.S., relating to the implementation of Revision 7 to Article V will have to be revised to reflect the new duties of state attorneys to appear in involuntary placement for outpatient services and continued involuntary placement.

Department of Children and Families: The department has not provided updated fiscal analysis of the appropriations consequences of the CS for CS for CS. [48] The state is currently required to pay the full cost of involuntary examinations and subsequent services for individuals that are not Medicaid eligible. Medicaid only reimburses for services in a general hospital and only if considered medically necessary for acute care. Many of those individuals subject to the CS for CS for CS would not meet the criterion. The current public mental health system is not reflective of the enhanced community services described in the outpatient commitment studies. Those states that have implemented involuntary outpatient commitment procedures have typically infused their mental health treatment systems with significant funding. It is not clear that resources in Florida are sufficient to support such an initiative and continue to provide services to persons who currently receive services. The current capacity to provide crisis services in the community is likely to experience further strain with the potential increase in the number of persons being brought in for mental health evaluations as well as an increased length of stay while awaiting hearings. 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.

[48] Last year based on a substantially similar bill (SB 2748), the Department of Children and Families estimated appropriations consequences in excess of **$16 million** per year and other fiscal impact. The department projected 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. The department also projected 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 did 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.

Gadsden, Broward, and Baker counties where state-operated civil treatment facilities are located will potentially experience the greatest pressures for funding increases. The Department of Children and Families Mental Health Program reports that during fiscal year 2002-2003, slightly more than 2,000 persons were discharged from state inpatient treatment facilities. It is estimated that up to 10 percent of the persons discharged may meet the criteria for involuntary outpatient placement. Initiating outpatient commitment procedures for persons being discharged from state treatment facilities will result in an additional staff workload in order to complete assessments, paperwork and to appear at judicial hearings.

The department will have to revise rules and enact new rules to accommodate the provisions of the CS for CS for CS by January 1, 2005, which is a relatively abbreviated implementation schedule to adopt rules, train personnel, and secure necessary funds given the significant changes initiated by the CS for CS for CS.

Agency for Health Care Administration: No fiscal impact statement has been provided to date. Some increase in workload, if not fiscal impact, will be incurred as the CS for CS for CS requires the AHCA to also receive copies of involuntary outpatient placement orders including continued placement orders and involuntary inpatient placement orders. [*See* page 6, lines 1-5.]

VI. Technical Deficiencies:

On page 11, lines 28-30, and page 12, lines 9-11, a person is referred to as someone who may be "involuntarily committed." Although the Baker Act is a civil commitment law, this terminology is not used anywhere in the statute, and may need to be reworded to avoid any other unintended connotation.

On page 17, lines 15-16, the CS for CS for CS erroneously refers to the involuntary examination under s. 394.463, F.S., as the involuntary *inpatient* examination. The examination is not directed towards one specific type of outcome but is an evaluation tool for determining the appropriate least restrictive one consistent with the optimum improvement of the patient's condition.

VII. Related Issues:

- Clarity is needed regarding whether the court is ordering placement or ordering treatment. If the latter, the CS for CS for CS significantly changes the court's role in Baker Act proceedings from one of appointing a person to make treatment decisions for or on behalf of an individual who has been found incompetent to consent to his or her own treatment to one of issuing orders for a specific mental health treatment and appointing someone to monitor the provision of that treatment. If the court is placed in this role, the court will need more information and guidance obtained through evaluations of the person, written reports to the court, certification of expert witnesses, testimony, advanced directives, express and informed consent, comprehensive treatment plans, and other invasive treatment modalities, and disclosure regarding side effects, benefits and alternatives to recommended services particularly if they involve the administration of psychotropic medications.

- 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 for community mental health centers or clinics 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 13-19.]

- The CS for CS for CS changes the law governing the discharge of a guardian advocate to add that such advocate is to be released when a person is discharged from involuntary placement for inpatient services. However, this provision does not account for the possibility that a person may be transferred from involuntary *inpatient* placement to involuntary *outpatient* placement services in which case the issue of a person's competency may still be at issue and the guardian advocate needs to remain appointed in order to continue to make mental health decisions on behalf of the person. It should be clarified whether this will necessitate the appointment of a different guardian advocate or whether the intent is to retain the same guardian advocate through the inpatient or outpatient treatment time provided the person's competency has not been restored. [*See* page 3, lines 26-29.]

- The provisions governing the release of confidential clinical records as revised in s. 394.4615, F.S., may be in conflict with existing subsections. The CS for CS for CS revises subsection (3) of s. 394.4615, F.S., to authorize the release of clinical records to the state attorney, the public defender or private counsel or the patient's private legal counsel, the service provider, the court and other appropriate mental health professional but this appears somewhat in conflict with the existing provision of subsection (2), governing when clinical records shall or may be released. [*See* page 4, line 27 through page 5, line 3.]

- The CS for CS for CS requires a petition for involuntary placement to be filed if a person, subsequent to an involuntary examination, *fails to consent* to voluntary inpatient or outpatient treatment which is deemed necessary, and that the petition must seek involuntary placement of the patient in the least restrictive treatment consistent with the optimum improvement of the patient's condition. First, the provision does not allow for the possibility that the person has *the right to refuse* to consent which is implied in the right to consent unless the person has been determined to be incompetent to consent. Second, the provision does not cross-reference s. 94.4655(1), F.S., regarding the criteria for involuntary outpatient placement and which is required to be alleged and substantiated as provided under s. 394.4655(1)F.S. The criterion provided herein does not state that it must be alleged that all available less restrictive alternatives that would offer an opportunity for improvement is not appropriate or is unavailable. Additionally, this provision does not note that a petition cannot be filed in the first place if outpatient services are not available. [*See* page 7, line 23 through page 8, line 6, page 9, lines 10-14, page 12, lines 1-23.]

- Liability issues for the state and local governments arise under a provision that allows a patient who is stabilized and no longer meets the criteria for involuntary examination to be released from a receiving facility while awaiting a hearing for involuntary outpatient placement. It is not known to what extent facilities are currently held liable or accountable for release of persons who are repeatedly brought back under the Baker Act. This provision

also raises the issue of whether the patient even qualifies for involuntary outpatient placement at that point. [*See* page 10, lines 1-9.]

- The CS for CS for CS allows a person to *voluntarily* submit to be examined for *involuntary outpatient* placement if such arrangement can be made. It is unclear why a person who is capable of voluntarily seeking help would submit to involuntary conditions of treatment when he or she is not precluded from seeking voluntary outpatient treatment without a restriction or loss of liberty. A prior examination within the last 7 days constitutes a significant lapse of time particularly if a person suffers from periodic episodes of mental illness, compared to the 72-hour (3-day) prior examination period for involuntary outpatient placement from a receiving facility.[*See* page 10, lines 10-22.]

- A conflict exists between provisions governing the time to submit a proposed treatment plan for involuntary outpatient service. The new s. 394.4655(3)(b), F.S., requires that the treatment plan, including a certification that the services are available, be submitted at the same time the petition for involuntary placement for outpatient treatment is filed. [*See* page 12, lines 12-23.] However, the new s. 394.4655(6)(b), F.S., relating to the hearing, states that the service provider is to provide the court with a copy of a treatment plan just *before* the hearing which presumes that the treatment plan is not being submitted at the time the petition is filed. At this juncture, the service provider is required to provide a copy of the treatment plan to the petitioner which could be the administrator of a receiving or treatment facility, or any one of the professionals who examined a person on a voluntary outpatient basis. It is unclear why the petitioner would be entitled to a copy of the treatment plan as the person subject to the hearing would no longer necessarily be within their oversight. Moreover, no mention is made of providing a copy to the patient or other authorized legal representative as discussed earlier. [*See* page 14, line 31 through page 15, line 3.]

- Unlike an order for involuntary placement of *inpatient* treatment under s. 394.467(6)(b), F.S., the CS for CS for CS does not require that an order for involuntary placement for *outpatient* treatment specify the nature and extent of the person's mental illness but that it be included as a part of the treatment plan which is to be made a part of the order. [*See* page 15, lines 1-10.]

- A conflict exists between two provisions governing the filing of a petition for involuntary placement for outpatient services. The first provision prohibits the filing of a petition for involuntary placement for outpatient services if the services are not available. [See page 12, line 12-23.] A second provision allows for the withdrawal of such petition if the services are not available. This appears to imply the petition was filed without the certification that the services were available. [*See* page 16, lines1-5.]

- Confusion surrounds the enforcement provision for noncompliance which provides that if a physician or clinical psychologist (based on his or her clinical judgment) finds that a patient has failed or refused to comply with the court-ordered treatment plan and that efforts were made to solicit compliance, such person may be brought to a receiving facility for an involuntary examination provided the person may meet the criteria for involuntary examination. [See page 16, lines 22-28.] First, this provision does not harmonize with other law (s. 394.363(2)(a)3., F.S.), that provides that other mental health professionals such as a clinical psychologist, a clinical social worker or psychiatric nurse may execute a certificate to find that a person appears to meet the criteria for involuntary examination. Second, this

provision does not require a certificate to be executed as is required under current law, and without a certificate it is unclear upon what basis a law enforcement officer may rely for authority to bring an outpatient into a receiving facility. Without specific legislative authority given to anyone else, this will represent a workload issue for law enforcement. Four, it is unclear what the involuntary *outpatient* status is subsequent to an involuntary re-examination in which it is determined that the *outpatient* does not meet the criteria for involuntary *inpatient* placement or if it were determined that the *outpatient* no longer met the criteria for involuntary outpatient placement. The option is not available. The process presumes that the *outpatient* remains incompetent and that the *outpatient* therefore does not have the opportunity to provide express and informed consent to being a voluntary patient.

- The CS for CS for CS requires the court to take testimony and evidence to determine a person's competence to consent to treatment and subsequent appointment of a guardian advocate. This provision does not consider the possibility that a guardian or other legally authorized representative such as a surrogate may already be available to make medical decisions including mental health decisions on behalf of the person. [*See* page 17, lines 23-29.]

- The CS for CS for CS requires the hearings on petitions for *continued* involuntary placement for *outpatient* services to be held in circuit court. This is in contrast to the hearings for *continued* placement for *inpatient* services under s. 394.467(7), F.S., which are conducted as administrative hearings in the Division of Administrative Hearings. Moreover, although a public defender (or other counsel) must be present to represent the patient, the CS for CS for CS does not require the state attorney to be present in the circuit court hearing although the state represents the state as the real party (petitioner) in interest. This may have ramifications for the state's ability to appeal any orders. [*See* page 18, line 8 through page23.]

- A conflict exists between provisions governing representation by the public defender for persons subject to a petition for initial and continued involuntary *outpatient* placement. One provision requires the court to appoint a public defender to represent a person subject to a petition for involuntary outpatient placement if the person does not already have other counsel. The public defender must continue to represent the person until the petition is discharged, the applicable court order expires, or the person is discharged from involuntary outpatient services. [*See* page 13, lines 3-16 and page 18, line 20 through page 19, line 2.] However, another provision requires the public defender to be appointed if counsel is not available for continued involuntary placement for outpatient services which presumes that a public defender was not appointed and retained as required under the earlier provision. Whether appointed or re-appointed, the public defender shall continue to represent the person until the continued involuntary placement petition is dismissed, the court order expires or the person is discharged from involuntary outpatient services which could be in perpetuity. Moreover, provisions in chapter 2003-402, L.O.F., relating to the implementation of Revision 7 to Article V will have to be revised to reflect the new duties of public defenders and state attorneys to appear in involuntary placement for outpatient services and continued involuntary placement.

- 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.

- Clarification is needed as to whether the *continued* involuntary *outpatient* placement certificate which contains a psychiatrist's, clinical psychologist's or physician's or specified nurse's opinion for continued treatment serves as the petition for continued placement or whether the certificate is a separate document which must accompany a petition, as is the case with petitions for involuntary *outpatient* placement. [*See* page 18, lines 10-19.]

- The CS for CS for CS allows a receiving facility to detain a person unless he or she is stabilized and no longer meets the criteria for involuntary examination. Once the person is stabilized and no longer meets the criteria for involuntary examination, the person can be released pending the hearing for involuntary outpatient placement. It is uncertain whether the state or the county would bear responsibility for any consequential actions taken by a person who is not under any mental health care monitoring or treatment pending the outcome of a hearing based on a petition that the person meets the criteria for involuntary outpatient treatment. [*See* page 9, line 16 through page 10, line 9.]

- The CS for CS for CS requires a petition for involuntary outpatient placement to be filed and a subsequent hearing to be held in the county where the person is located, not in the county where the person resides. This presents more of an issue for a person who is not going to be residing involuntarily in a facility and receiving treatment therein. In contrast, a patient who is involuntary placed for outpatient treatment may be inconveniently subjected to receiving services or attending a hearing in a county where he or she does not reside. This may also impede a person's ability or efforts to comply. [*See* page 12, line 9 through page 13, line 15.]

- The CS for CS for CS 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 represented by private counsel in lieu of a public defender. [*See* page 12, lines 24-30.]

- Although notice of a hearing for continued involuntary outpatient placement is required, no mention is made of whether the clerk of the court should forward copies of the petition and continued treatment plan to the outpatient, and outpatient's guardian or representative, the department, public defender, and state attorney as is required for an initial petition for involuntary outpatient placement. [*See* page 12, lines 12-23 and contrast with page 18, lines 20-31.]

- The process needs to be clarified as to how the court acknowledges or receives a certificate of completion or compliance that someone is no longer obligated to comply or has completed a treatment plan underlying an involuntary outpatient placement order or is otherwise discharged from a treatment program. A discharge may occur outside the realm of a court order if it is found by the facility that the person is competent to consent or refuse to consent to treatment and no longer satisfies the criteria for involuntary examination or placement. [*See e.g.,* page 3, line 26 through page 4, line 8, and page 19, lines 18-23.]

- The CS for CS for CS is ambiguous regarding the extent to which the Legislature intends for the court to impose civil and indirect criminal contempt for a person's failure or refusal to comply with court-ordered involuntary outpatient treatment. Typically a person held in

contempt for failure to comply with a court order can be fined $500 and incarcerated for up to one year. *See* s. 775.02, F.S.

VIII. Amendments:

- None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.

APPROPRIATIONS SUBCOMMITTEE ON ARTICLE V IMPLEMENTATION AND JUDICIARY

Rod Smith, Chair

ADDITIONAL AMENDMENT PACKET

Tuesday, April 13, 2004
9:15 a.m. – 11:15 a.m.
309 The Capitol

(Please bring this packet to the committee meeting. Duplicate materials will not be available.)

Bill No. CS for CS for CS for SB 700

Amendment No. 1 193244

CHAMBER ACTION

Senate | House

Consideration of this amendment requires a 2/3 vote of members present

Senator Villalobos moved the following amendment:

Senate Amendment

On page 3, line 3, delete that line

and insert: psychiatrist or a licensed clinical psychologist that the patient is incompetent to consent to

Bill No. CS for CS for CS for SB 700

Amendment No. 2 533794

CHAMBER ACTION

Senate | House

Consideration of this amendment requires a 2/3 vote of members present

Senator Villalobos moved the following amendment:

Senate Amendment

On page 9, lines 21-22, delete those lines

and insert: supported by the opinion of a psychiatrist or licensed clinical psychologist and the second opinion of another licensed clinical psychologist or another psychiatrist,

Bill No. CS for CS for CS for SB 700

Amendment No. 3 264612

CHAMBER ACTION

Senate | House

Consideration of this amendment requires a 2/3 vote of members present

Senator Villalobos moved the following amendment:

Senate Amendment

On page 10, lines 14-15, delete those lines

and insert: must be supported by the opinion of a psychiatrist or licensed clinical psychologist and the second opinion of another licensed clinical psychologist or another

Bill No. CS for CS for CS for SB 700

Amendment No. 4 301670

CHAMBER ACTION

Senate | House

Consideration of this amendment requires a 2/3 vote of members present

Senator Villalobos moved the following amendment:

Senate Amendment

On page 11, line 2, delete that line

and insert: psychiatrist or licensed clinical psychologist and the second opinion of another licensed clinical psychologist

Bill No. CS for CS for CS for SB 700

Amendment No. 5 430702

CHAMBER ACTION

Senate | House

Consideration of this amendment requires a 2/3 vote of members present

Senator Villalobos moved the following amendment:

Senate Amendment

On page 16, line 20, delete that line

and insert:

3. If, in the clinical judgment of a physician or licensed clinical psychologist, the

Bill No. CS for CS for CS for SB 700

Amendment No. 6 652736

CHAMBER ACTION

Senate | House

Consideration of this amendment requires a 2/3 vote of members present

Senators Wise and Campbell moved the following amendment:

Senate Amendment

On page 16, lines 23 and 24, delete the phrase "or clinical psychologist with a Ph.D., Psy.D., or Ed.D."

Bill No. CS for CS for CS for SB 700

Amendment No. 7 501912

CHAMBER ACTION

Senate | House

Consideration of this amendment requires a 2/3 vote of members present

Senator Villalobos moved the following amendment:

Senate Amendment

On page 16, lines 23-24, delete those lines

and insert: physician or clinical psychologist, efforts were made to solicit compliance and the patient

Bill No. CS for CS for CS for SB 700

Amendment No. 8 950572

CHAMBER ACTION

Senate | House

Consideration of this amendment requires a 2/3 vote of members present

Senators Wise and Campbell moved the following amendment:

Senate Amendment

On page 20, lines 26 and 27, delete the phrase "or a clinical psychologist with a Ph.D., Psy.D., or Ed.D."

Bill No. CS for CS for CS for SB 700

Amendment No. 9 645614

CHAMBER ACTION

Senate | House

Consideration of this amendment requires a 2/3 vote of members present

Senator Villalobos moved the following amendment:

Senate Amendment

On page 20, lines 26-28, delete those lines

and insert: supported by the opinion of a psychiatrist or a licensed clinical psychologist and the second opinion of another licensed ~~a~~ clinical psychologist or another psychiatrist,