Review of the Impact of the Mentally Ill Population on County Jails

February 2005

Legislative Committee on Intergovernmental Relations

FLORIDA LEGISLATIVE COMMITTEE ON INTERGOVERNMENTAL RELATIONS

(As of January 2005)

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Executive Summary

Mentally ill individuals who are incarcerated are increasingly a national concern. Estimates of the percentage of the jail population suffering from mental illness are being reported as between 7 percent and 16 percent. In Florida, the incidence may be even higher in some locations. Once incarcerated, the mentally ill create legal liabilities and treatment challenges.

Sheriffs and Boards of County Commissions are becoming increasingly concerned about the number of mentally ill persons in the county jail population. Concerns encompass the increased costs of housing, medicating the mentally ill in jail and even the appropriateness of their incarceration. The availability and linkages with community mental health resources are central to these concerns.

This review describes and examines the scope of the problem, emphasizing changes that have occurred in the last five years. Developments in the mental health commitment process known as the Baker Act are described. The organization and funding of community mental health services in Florida are examined. Significant previous studies on the impact of the mentally ill population on county jails are presented. Jail diversion programs in Florida are depicted. Results of a survey developed for this review of Sheriffs and jail personnel in conjunction with recent studies of Orange and Sarasota Counties, as well as a recent Miami-Dade County Grand Jury Report, are summarized to give perspectives from the field. Federal level developments directed at funding programs to positively impact the mentally ill offender treatment are described. Finally, major findings of the review are summarized and LCIR recommendations are presented.

1. General Background

Much progress has been made in the treatment of the mentally ill, including identification and treatment of the frequently co-occurring disorder of substance abuse. Evidenced based practices (practices supported by outcomes based research), other best practices and emerging practices have been identified to divert the mentally ill from the judicial system and treat them appropriately in the community.

Despite advances in treatment options, deinstitutionalization of the mentally ill, starting in the 1960s in Florida, has created challenges for Florida's developing community mental health system. Chronically scarce community mental health services include appropriate case management, housing, medication, transportation, life and work skill training and other services for the mentally ill. Without adequate resources to maintain the mentally ill in the community, they are often left without treatment and continue to deteriorate. This often results in their coming in contact with law enforcement, and the "criminalization" of the underserved mentally ill.

Once in jail, the mentally ill are subject to the protections of the Eighth Amendment to the U.S. Constitution, prohibiting cruel and unusual punishment. This translates to a requirement to provide basic mental health care to inmates such as systematic screening and evaluation, treatment including making medications available, and suicide prevention. Safeguarding these judicially recognized rights of the mentally ill inmate compounds cost factors for jails

Community mental health services have largely supplanted mental health institutions

nationally and in Florida. The catalyst for change occurred with the onset of the deinstitutionalization, which gathered momentum in the early sixties with the passage of the federal Community Mental Health Centers Act and subsequent Community Mental Health Services Act.

The Florida legislature enacted the Baker Act in 1971 to establish rights and responsibilities for involuntary commitment to community and state mental health facilities. Funding arrangements had changed a year earlier, in 1970, to require local entities provide a 25% match to receive federal mental health funds. The funding of community mental health services was centralized with the state in what is now the Florida Department of Children and Families, although the locus of funding decisions has been decentralized to administrative districts under various public/private arrangements. In the 1980s, direct federal funding of community mental health was reduced with the introduction of community mental health block grants. Medicaid started in 1965 as a federal/state program that provides medical care for low-income individuals, became an increasingly important source of funding for community mental health services. Currently, Medicaid funds over 50% of community mental health services.

Community housing, combined with community mental health services, has been an area of concern in Florida since the early days of deinstitutionalization. The consensus opinion is that Florida, as well as all other states, lack adequate resources in these areas to meet demand. In recent years, Florida has been attempting to better allocate state funds to lessen disparities among Florida counties. However, there is a need for: (1) more initiatives to assure appropriate, safe housing; (2) more resources to provide supported living environments; (3) more free or low-cost medications for individuals without benefits; and (4) low-cost or free transportation.

2. Funding

Adult community mental health services in Florida are primarily funded by federal programs. Medicaid, with its 41% state matching requirement, is by far the largest, accounting for a federal/state total of $444.5 million appropriated in FY 2003-2004. The Community Mental Health Services Block Grant is the next federal program in size and importance, providing federal funds in the $20-$30 million range. State revenue provided $221.2 million in FY 2003-2004 to pay for adult community mental health services not paid for by federal or local sources. Local sources provide approximately $100 million in cash and in-kind matching funds.

Adults involuntarily committed under the Baker Act are funded by the state. Medications provided to residents in Baker Act receiving facilities or state mental hospitals are also paid for by state funds. Counties are responsible for the costs of medications and mental health services provided in the jails.

3. Relevant Studies

Several studies have been conducted in recent years that focus on Florida's jail system and the mentally ill. The findings and recommendations of these studies are remarkably consistent with national studies. All agree that the mentally ill cost more money to keep in jail than in community care and spend more time in jail than their non-mentally ill counterparts once incarcerated. Professionals in the criminal justice system believe that many persons commit minor criminal offenses because appropriate mental health evaluation,

treatment, and support services frequently are not provided to this population in a prompt manner. When a mentally ill person comes in contact with police, too often they are arrested and taken to jail rather than to a more appropriate community mental health facility. Mentally-ill jail inmates frequently have a co-occurring drug abuse problem.

Several themes emerge from the various studies reviewed in this report.

- First, deinstitutionalization has resulted in greater numbers of the mentally ill coming in contact with the judicial system.
- Second, it is less expensive and probably more appropriate to divert mentally ill misdemeanants to the community mental health system.
- Third, good communication and working relationships between community health professionals and those in the judicial system, especially at the county jails, help achieve appropriate and timely treatment for the mentally ill.
- Finally, adult community health systems necessary for the treatment of diverted individuals in the least restrictive and cost efficient manner include case management, supervised residential treatment, and day treatment programs.

Recommendations of these studies include

- Improving communication and coordination between personnel in the judicial system and personnel in the community mental health system to facilitate diversions of the mentally-ill from jail and coordinate aftercare of the mentally ill upon release from jail.
- Diversion programs are viewed as especially desirable. Diversion programs include pre-arrest programs and post-arrest programs.
- The preferred pre-arrest diversion program is the police-based Crisis Intervention Team.
- The post-arrest program commonly mentioned is the drug court that allows for a reduced sentence or dropped charge after successful completion of court-ordered community mental health treatment.
- Community based Assertive Community Treatment teams are favored for aftercare of severely mentally ill individuals upon release from jail.

4. Jail Diversion Programs in Florida

Jail diversion and aftercare programs in Florida are modeled on national standards. Pre-arrest Crisis Intervention Teams (CITs) are designed to divert the mentally ill to appropriate community mental health treatment upon contact with police in lieu of arrest. CITs are composed of volunteer police officers who have received at least 40 hours of specialized training. In Florida, standardized training modules are in development that includes customized components such as cultural diversity and mental health issues. Reporting standards that include outcome information are also in development by the coalition of mental health professionals and CIT practitioners who help develop the training modules and will be shared with the DCF mental health program office. CITs currently operate in five urban regions of Florida.

Post-arrest mental health courts are designed to reduce jail time and obtain treatment for the mentally ill. Mental health courts for non-violent misdemeanor violators exist in six counties in Florida. The mental health court was pioneered in Broward County. The Broward County mental health court continues as a national role model with the addition of a low level felony offender mental health court.

Post-incarceration jail linkage programs are designed to place a mentally ill inmate, upon release, in the care of the local community mental health system. Florida Assertive Community Treatment (FACT) teams are designed to provide 24 hours a day, 7 days a week, comprehensive mental health services delivered by a multidisciplinary treatment team that is responsible for identified individuals who have a serious mental illness. There are 30 FACT teams in 22 Florida counties treating over 2,000 individuals.

Long-term supervised housing is a key component in all mental health diversion programs in Florida. Mental health residential facilities, assisted living facilities and adult family-care homes provide such housing. However, the demand for such housing far exceeds their capacity in Florida.

5. Local Perspectives

As a part of this review, each Sheriff's office was sent a survey by the LCIR in the fall of 2004. The survey was designed to elicit information from the experts in the Sheriff's office on the processes, costs, and challenges relating to individuals with mental health problems that come in contact with the county jail system. Special emphasis was placed on how things have changed in the last five years. The survey questions were formulated to augment information collected at the state level on the impact of the mentally ill on county jails. Responses were received from twenty Sheriff's offices from small, medium and large counties. The information provided through this survey is supplemented by recent studies related to the community mental health systems in Orange and Sarasota counties and a recent Miami-Dade County Grand Jury Report.

The Sheriff is responsible for providing Baker Act transportation. The reported costs per Baker Act trip was higher in the rural areas such as Taylor County ($125/ trip), served by remote Baker Act receiving facilities, than in more urban areas such as Palm Beach County ($20/trip) with nearby receiving facilities. The reported yearly number of Baker Act trips ranged from 7 in Nassau County to 1,620 in Polk County.

In general, FACT teams are well regarded by survey respondents. FACT teams would likely be welcome by jail personnel in counties that are currently not served by them. Additional FACT teams would probably be welcome in areas where they already exist, especially if they operate like those in Palm Beach, Polk, and Duval (Jacksonville) counties.

Most respondents indicated that mentally ill inmates pose a greater problem now than five years ago. The most frequently reported challenge faced in managing inmates with mental illness was their housing once in jail. The general feeling is that they require more intensive supervision and are associated with disciplinary problems when mixed with the general jail population. In small jails, respondents note that there is no choice but to mix the mentally ill with the general population. Getting inmates to take prescribed medications and the rising costs of those medications was also a frequent problem cited along with the lack of training for jail staff in dealing with the mentally ill.

Most, but not all, respondents reported that the overall effectiveness of their jail's services for inmates with mental illness has declined in the last five years. Jurisdictions that reported improved services attributed the improvements to outsourcing of mental health services, increases in mental health

staffing levels or improvements in communication with the local community mental health system.

The biggest barriers identified by respondents to delivering more effective mental health services were reported as being the costs or availability of medications, the shortage or availability of community mental health resources, funding, and communication. Conversely, respondents' recommendations to alleviate the impact of the mentally ill on their county jails included, in order of decreasing frequency: (1) increase community health resources, (2) add secure community mental health facilities or state mental health hospital beds, (3) establish some form of diversion program, and (4) add more affordable or assisted living or long-term care beds in their communities. Additional comments amplify these concerns and recommendations.

In 2004, the Baker Act was amended to allow for involuntary outpatient commitment to begin on January 1, 2005. DCF is amending Ch. 65E-5, F.A.C., to comply with this change, with an effective date expected in early April. Respondents' comments on the potential impact of these changes were mixed, ranging from no opinion, to no change, to a possible slight increase in mental health inmates. Several respondents viewed the changes favorably. State funding was seen as a missing ingredient to potential benefits of the recent Baker Act changes by one respondent and echoed in the Miami-Dade County Grand Jury Report.

6. Significant Pending Federal Issues

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004, S.1194, became Public Law No: 108-414 on October 30, 2004. This law directs that grants be used to create or expand mental health courts or other court-based programs, in-jail transitional services, specialized mental health training and services, and support intergovernmental cooperation between State and local governments with respect to the mentally ill offender. The law authorizes $50 million in FY 2005 and such sums as necessary for fiscal years 2006 through 2009.

The Miami-Dade County Grand Jury Report filed January 11, 2005 reported that the Miami Criminal Mental Health project was awarded a one million dollar grant from the federal Substance Abuse and Mental Health Administration to expand the existing pre and post jail diversion programs. The pre-arrest program follows the CIT model. The post-arrest program diverts eligible misdemeanor defendants to community mental treatment within 24 to 48 hours of arrest. This project includes a comprehensive case management program that addresses transition and housing issues as well as substance abuse.

7. Major Findings

The major findings of the review are summarized below:

- Community mental health services in Florida are funded by federal, state, and local-matching funds. Local-matching funds are generally required by statute to draw down federal grants. Medicaid does not have a local-matching requirement and is now the major funding source in the federal-state-local mix.
- Complying with legal requirements regarding screening and treatment of the mentally ill inmates adds to the cost factors for jails.
- Increases in the costs of anti-psychotic medication as well as services provided

to the mentally ill in jail are funded by the county.

- Larger jails provide more elaborate treatment and in-jail housing options. Still the resources within the criminal justice system necessary to cope with the mentally ill are inadequate.
- Inadequate public funding for community mental health services is widely viewed as negatively impacting the treatment of the mentally ill in Florida communities, limits the ability of the criminal justice system to divert the mentally ill from jail to more appropriate community mental health settings, and limits aftercare of the mentally ill upon release from jail. The funding of recent changes to the Baker Act allowing involuntary outpatient placement is seen as important, if not essential, to its implementation.
- The most prevalent pre-booking diversion program in Florida is the police-based Crisis Intervention Team (CIT). CITs exist in various police departments in large urban counties. DCF mental health program staff indicates that training modules and reporting practices are still under development.
- Post-booking diversion programs, such as mental health courts must include a negotiation that reduces penalties or waives penalties pending successful completion. Such mental health courts exists in five Florida counties
- Post-incarceration programs rely on linkages to effective community treatment programs. The program of choice at this time is the Florida Assertive Community Treatment (FACT) team. Currently, there are 30 operational FACT teams in Florida, with others in the process of being activated. Essentially, FACT teams treat the most severely mentally ill individuals around the clock with diverse and specialized mental health and vocational services, assisted living and intensive team case management.

8. Recommendations

The LCIR approved the following recommendations:

- Monitor Florida's utilization of federal grant monies made available by P.L 108-414 and other federal sources and support future funding.
- Encourage and support the Department of Children and Families in developing the training and reporting components of the police-based Crisis Intervention Team programs and other pre-arrest diversion programs as deemed appropriate by local community mental health systems.
- Continue to fund and expand the Florida Assertive Community Treatment teams and encourage routine communication with the judicial system, especially appropriate jail personnel.
- Continue to utilize federal matching dollars to the extent possible for the delivery of community mental health case management and services.
- Encourage the Department of Children and Families to work with the federal government to promote that more flexible spending requirements be attached to federal funding sources, coupled with outcome reporting requirements.

INTRODUCTION

Sheriffs and Boards of County Commissions are becoming increasingly concerned about the number of mentally ill persons in the county jail population. Concerns encompass the increased costs of housing, medicating the mentally ill in jail and even the appropriateness of their incarceration. The availability and linkages with community mental health resources are central to these concerns.

Mental health services historically have been underfunded in Florida, as in most states. Inadequate funding results in scarce resources for jails to augment their ability to manage and divert individuals with mental health problems that come in contact with law enforcement and the judiciary. Many community mental health resources that do exist rely on Medicaid for over half the funding. However, Federal law does not allow for Medicaid funding for adults in jail.

This review describes and examines the scope of the problem, emphasizing changes that have occurred in the last five years. Developments in the mental health commitment process known as the Baker Act are described. The organization and funding of community mental health services in Florida are examined. Significant previous studies on the impact of the mentally ill population on county jails are presented. Jail diversion programs in Florida are depicted. Results of a survey developed for this review of Sheriffs and jail personnel in conjunction with recent studies of Orange and Sarasota Counties, as well as a recent Miami-Dade County Grand Jury Report, are summarized to give perspectives from the field. Federal level developments directed at funding programs to positively impact the mentally ill offender treatment are described. Finally, major findings of the review are summarized and recommendations are presented.

PART I
Scope of the Problem

People with mental illness frequently come in contact with law enforcement officers when they exhibit disruptive behaviors in public places. Often, the mentally ill individual is arrested on a minor violation and taken to the county jail. This response is time consuming, costly and usually not in the best interest of the judicial system or the individual.

According to the U.S. Department of Justice, Bureau of Justice Statistics, in 1998, 16% of the jail population in the United States reported a mental condition or a recent overnight stay in a mental hospital.[1] Multiplying this percentage by the Bureau of Justice Statistics jail population for 2002 translates to 106,476 jail inmates nationwide and 21,120 jail inmates in Florida with mental conditions. In Florida, in some counties, the percentage of mentally ill jail inmates likely is even higher. The Broward County Jail reports it dispenses anti-psychotic drugs to approximately 1,100 of 5,000 inmates on a daily basis—22% of their jail population.[2] Once incarcerated, the mentally ill create legal liabilities and treatment challenges. These mentally ill jail inmates cost more to house and generally stay in jail longer. It is perceived as a growing and costly problem at the county jail level.

Much progress has been made in the treatment of the mentally ill, including identification and treatment of the frequently co-occurring disorder of substance abuse. Evidence based practices (practices supported by outcomes based research), other best practices and emerging practices have been identified to divert the mentally ill from the judicial system and treat them appropriately in the community.

Despite advances in treatment options, deinstitutionalization of the mentally ill, starting in the 1960s in Florida, has created challenges for Florida's developing community mental health system. Chronically scarce community mental health services include appropriate case management, housing, medication, transportation, life and work skill training and other services for the mentally ill. Without adequate resources to maintain the mentally ill in the community, they are often left without treatment and continue to deteriorate. This often results in their coming in contact with law enforcement and the "criminalization" of the underserved mentally ill.

Once in jail, the mentally ill are subject to the protections of the Eighth Amendment to the U.S. Constitution, prohibiting cruel and unusual punishment. This translates to a requirement to provide basic mental health care to inmates such as systematic screening and evaluation, treatment including making medications available, and suicide prevention.[3] Safeguarding these judicially recognized rights of the mentally ill inmate compounds cost factors for jails.

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[1] Paula M. Ditton, U. S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers (July 1999, NCJ 174463).
[2] Carol Marbin Miller and Wanda J. DeMarzo, "Health firm for jail can't dispense medicine," The Miami Herald. December 3, 2004.
[3] New Freedom Commission on Mental Health, *Subcommittee on Criminal Justice: Background Paper.* DHHS Pub. No. SMA-04-3880. Rockville, MD: 2004 at 13.

PART II

Developments in Mental Health Commitment Process: The Baker Act

A. Florida's Baker Act

Every state has laws pertaining to involuntary examination and treatment for those individuals with mental illness. Florida's mental health commitment laws are found in "The Florida Mental Health Act," alternatively referred to as the "Baker Act."[4] This compendium of civil commitment laws was named after its sponsor, Maxine Baker, a Representative from Miami, who successfully ushered her bill through passage in 1971. Since that time, the Baker Act has undergone dozens of revisions. Most recently, the Baker Act was amended to include provisions for involuntary outpatient examination and commitment.[5]

B. Civil Commitment Prior to the Baker Act

Prior to the Baker Act, procedures for getting a person committed for psychiatric evaluation and treatment lacked consistency and notions of due process. Signed affidavits submitted to a judge by three people were all that was needed to have a person committed to a state psychiatric hospital. The period of commitment could be indeterminate, and no judicial review after the initial commitment was required. Poor people were delivered to local law enforcement for holding until hospitalization could be arranged. Access to the outside world was restricted. Abuse of the process was to be expected, as there were virtually no checks and balances or monitoring. Mentally ill people were being warehoused, sometimes indefinitely. In 1955, almost 560,000 were residing in state mental hospitals.

The ease with which a person could be deprived of his or her liberty through this process received a considerable amount of attention throughout the nation in the 1960's and 1970's. Many states legislated a movement away from institutionalizing mentally ill persons to a more community based treatment environment. The individual freedom of the mentally ill was perhaps an outgrowth or corollary of the larger civil rights movement of that era. When advocating for passage of her bill, Representative Baker reportedly said in speaking of the mentally ill, "In the name of mental health, we deprive them of their most precious possession – liberty."[6]

C. Deinstitutionalization

Thus, the Baker Act was consistent with laws being passed in other states at a time when mental health experts, policy makers and advocates were searching for ways to deal with the mentally ill without resorting to widespread institutionalization. By 2002, the number of people with severe mental illnesses in public mental hospitals nationwide had fallen to 70,000.[7] In fact, by mid 2001, there were 1,334,255 persons in the custody of federal and state prisons, and 631,240

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[4] These laws are found in Part I, ss. 394.451-4789, Fla. Stat.
[5] See section 394.4655, Fla. Stat. (2004).
[6] "History of the Baker Act – Its Development and Intent," State of Florida Department of Children and Families Mental Health Program Office, May 2002 at 1, retrieved at http://www.dcf.state.fl.us/mentalhealth/laws/histba.pdf.
[7] The Sentencing Project, "Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription," January 2002 at 3.

inmates in the custody of local jails.[8] In Florida, it was reported that 2,671 patients were in state mental hospitals in 1999, while county jails housed 5,300 inmates with mental illnesses and state prisons housed 6,800 such inmates.[9]

D. Criminalization

For reasons still being analyzed and debated, the deinstitutionalization of the mentally ill resulted, to a certain extent, in the criminalization of the mentally ill. While patients were being released from psychiatric hospitals, too few receiving facilities with adequate treatment plans, personnel and funding were established. Community facilities, and families, were ill-equipped to contend with the rapid outflow of hundreds of thousands of mentally ill persons. The lack of community willingness or expertise to provide a therapeutic environment for the mentally ill, funding limitations, and procedural challenges to involuntary commitment process all contributed to the unmet needs faced by the mentally ill.

Unmonitored, untreated mentally ill people with little or no support system in place quickly posed challenges for law enforcement agencies across the nation. Despite their lack of mental health training, police officers and sheriff's deputies are generally the first ones called to respond to a conflict in which one or more parties is mentally ill. The numbers of calls received by law enforcement officers to respond to situations involving a mentally ill person are significant.[10] For this reason, many mental health professionals and law enforcement agencies have joined forces to formulate training and programs to enable law enforcement agencies to be better prepared to deal with the mentally ill. These programs do not seek to substitute law enforcement activity for mental health treatment, but rather strive to ensure more appropriate police behavior when responding to the mentally ill. Such training and programs better serve the safety needs of the officer, the patient and the public.

E. Movement Toward Civil Outpatient Commitment

Balancing the interests of these groups continued to be a challenge. In 1996, concerns regarding patients' rights in commitment proceedings lead to significant revision of the Baker Act. Procedural and substantive changes were made to ensure more individual control by the mentally ill person throughout the commitment process and significantly improved patients' rights and access.[11] The Act was also amended to require all facilities receiving patients under the Baker Act to submit a copy of any court order, report by law enforcement, or certificate executed by an authorized clinician that serves as the basis for involuntary commitment to the Agency for Health

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[8] Allen J. Beck, Jennifer C. Karberg and Paige M. Harrison, Bureau of Justice Statistics Bulletin: Prison and Jail Inmates at Midyear 2001, April 2002 at1., retrieved at http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim01.pdf .
[9] *Id.*, citing Debbie Salamone Wickham, "Society Criminalizes Their Mental Illness," Orlando Sentinel, October 31, 1999.
[10] Melissa Reuland, "A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness," Technical Assistance and Policy Analysis Center for Jail Diversion, January 2004, p. 2.
[11] Chapter Law 96-169, L.O.F. 1996 (HB 903).

care Administration.[12] The agency must use these and other documents to prepare annual reports analyzing the data.[13]

Until the legislative changes made in 2004, the Baker Act provided for the involuntary inpatient commitment of an individual if certain criteria were met. The statute provided in part:

> 394.467 **Involuntary placement.**--
> (1) CRITERIA.--A person may be involuntarily placed for treatment upon a finding of the court by clear and convincing evidence that:
> (a) He or she is mentally ill and because of his or her mental illness:
> 1.a. He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
> b. He or she is unable to determine for himself or herself whether placement is necessary; and
> 2.a. He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
> b. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
> (b) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

The fact that the Baker Act provided only for involuntary inpatient commitment has generated debate for many years. Other states have grappled with the public perception that mandated treatment would make the citizenry safer. New York passed one of the more controversial laws allowing court ordered outpatient treatment after a woman, Kendra Webdale, was pushed onto the subway tracks by a man whose psychiatric condition would deteriorate whenever he was released from inpatient treatment. In response to the death of Ms. Webdale and other similar events, New York passed "Kendra's Law" in 1999.[14] The law in New York and similar laws in other states are challenged from time to time as being too restrictive of the liberty and privacy rights of the mentally ill, but thus far, the laws remain valid.

In Florida, efforts to include provisions for involuntary outpatient commitment have been made in the last several legislative sessions. In the 2004 legislative session, discussion of the balancing of law enforcement, patients and the public's interests continued, and resulted in the passage of Chapter Law 2004-385. This bill was strongly advocated for by law enforcement

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[12] *Id.*, section 16; Section 394.463(2)(a)1-3, Fla. Stat. (2003).
[13] The responsibility for preparing the annual reports has been redirected to the Policy and Services Research Data Center at the Louis de la Parte Florida Mental Health Institute at the University of South Florida. The annual reports are available online at http://bakeract.fmhi.usf.edu .
[14] N.Y. Mental Hyg. Law § 9.60(c) (McKinney 1999).

agencies. Among other things, this bill amended the Baker Act to clarify that section 394.467, Fla. Stat., applies to *inpatient* commitment. The most significant change to the Baker Act, however, created a process for involuntary *outpatient* commitment. Florida joined in a trend that several states, including New York and California, have followed in recent years. The following language was added to the Baker Act:

> **394.4655 Involuntary outpatient placement.--**
> (1) CRITERIA FOR INVOLUNTARY OUTPATIENT PLACEMENT.--A person may be ordered to involuntary outpatient placement upon a finding of the court that by clear and convincing evidence:
> (a) The person is 18 years of age or older;
> (b) The person has a mental illness;
> (c) The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
> (d) The person has a history of lack of compliance with treatment for mental illness;
> (e) The person has:
> 1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or
> 2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months;
> (f) The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;
> (g) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1);
> (h) It is likely that the person will benefit from involuntary outpatient placement; and
> (i) All available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.

This language is similar to statutes in some, but not all, states that allow for involuntary outpatient commitment without a finding of dangerousness on the part of the patient to be

committed.[15] The standard for involuntary outpatient commitment is less stringent than that required for involuntary inpatient commitment.

The impact of these amendments may be difficult to predict or measure in the future. The reason for this is that a petition for involuntary outpatient commitment can be filed only if the services necessary for the individual's treatment are available. If the services in the proposed treatment plan "are not available in the patient's local community to respond to the person's individual needs, the petition may not be filed."[16] Thus, although the process for securing involuntary outpatient commitment is now available, there is no indication that the resources for treatment are available as required by statute prior to filing a petition.

Annual reports are prepared by the Louis de la Parte Mental Health Institute for the Agency for Health Care Administration. The reports analyze data contained in forms submitted to the Institute (as required by statute) such as the source of the commitment petition, type of evidence provided (i.e., harm, neglect or both), timeliness of the forms being submitted, and demographics of those being examined or committed under the Act. It is anticipated that similar statistics will be kept for those patients subject to the new involuntary outpatient commitment provisions. This information may shed a little light on the availability of resources, as well as any trends that may arise under the new law.

[15] See Attachment 1 for a state by state summary of standards for assisted outpatient treatment (court ordered outpatient treatment).
[16] Section 394.4655(3), Fla. Stat. (2004).

Part III
Organization of Community Mental Health Services in Florida

A. Institutions

Florida has three public mental health hospitals. The Florida State Hospital at Chattahoochee opened in 1876 as a publicly funded institution for the mentally ill. MacClenny (Northeast State Hospital) and Pembroke Pines (South Florida State Hospital) opened by the late 1950s.[17] G. Pierce Wood Memorial Hospital, which opened in 1947, closed in February 2002. These remaining three facilities serve civil Baker Act (Ch.394, F.S.) and forensic (Ch. 916, F.S.) patients. In addition, two facilities (the North Florida Evaluation and Treatment Center and the South Florida Evaluation and Treatment Center) are run by the Florida Department of Corrections and only treat forensic patients. The bed capacity of all five facilities totals 2,385 and serves a Florida population that has grown from approximately 5 million in 1960 to projected population of 17.76 million in 2005.

Table 1 depicts the number of beds dedicated to civilian patients, male forensic patients, female forensic patients, and civil/forensic step-down patients. Forensic step-down patients are those who do not require a secure institutional setting.

Table I
Bed Capacity by Type of Patient and Florida State Mental Health Treatment Facility

Facility	Civil Beds	Male Forensic Beds	Female Forensic Beds	Civil/Forensic Step-Down Beds
Florida State Hospital	220	417	83	271
Northeast Florida State Hospital	481			72
North Florida Evaluation and Treatment Center		216		
South Florida Evaluation and Treatment Center		176	24	
Atlantic Shores Healthcare, Inc./South Florida State Hospital	280			45
Total Beds:	981	809	107	388

[17] Florida Department of Children and Families, *Mental Health and Substance Abuse Services Plan: 2003-2006* (Jan. 1, 2004) at 30.

Trends for both involuntary civil Baker Act admissions and forensic admissions to Florida State Mental Health Treatment Facilities are tracked by DCF. Between January and November of 2004 the reported monthly average waiting time for a civil admission ranged from 3 days to 38 days, depending on the facility. The civil admission waiting list, for the same time frame, ranged from 3 people to 21 people, again, depending on the facility. On the forensic side of the equation, the average wait for all facilities combined between January and November of 2004 ranged between 19.3 days and 36.3 days. According to DCF, a spike in the forensic waiting list occurred in September and October was attributed to hurricane activity in Florida. The forensic waiting list peaked in late September with a total of 74 of 150 patients waiting for more than 15 days—the legal requirement. Yearly forensic commitments have increased 22% to 1,257 from fiscal year ending June 30, 2000 to fiscal year ending June 30, 2004.

Advances in mental health medications have allowed for the possibility of community treatment.[18] The shift from institutional placement to community treatment that occurred in the 1960s and 1970s—deinstitutionalization—was viewed as a more humane, less restrictive, and more cost effective alternative for the mentally ill. The unintended consequences of deinstitutionalization have been the chronic shortage of essential community mental health support services that too often lead to contact of the mentally ill with the criminal justice system. The result is what many call the criminalization of the underserved mentally ill population. In fact, studies from around the country suggest that between 6 and 16% of all jail inmates have a severe mental illness.[19]

B. Community Services

Small guidance clinics for the mentally ill funded through county governments, United Way or other voluntary sources began to appear in late 1950s. Also during that time period, the Florida State Board of Health provided visiting public health nurses who would check on individuals discharged from state mental health treatment facilities. However, no organized, comprehensive, publicly funded community mental health services system existed in Florida.[20]

Deinstitutionalization started to take hold nationally in the 1960s and several key events affected Florida's development and growth in providing community mental health services. First, at the federal level, the Federal Community Mental Health Centers Act passed in 1963, providing federal funding to states for developing community-based systems of care, primarily by providing the means for the construction of comprehensive community mental health centers.[21] This legislation marked a major shift at the federal level to encourage the treatment of the mentally ill locally, rather than in large isolated state hospitals. This was followed two years later, in 1965, by the passage of the federal Community Mental Health Services Act which helped fund the actual mental health services delivered at comprehensive community mental health centers.[22]

[18] *Id.* at 30.
[19] Borum, R. & Rand, M. (1999). *Mental Health Diagnostic and Treatment Services in Florida's Jails.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida at 41.
[20] Florida Department of Children and Families, *supra* note 17 at 30.
[21] Florida Department of Children and Families, *supra* note 17 at 30.
[22] Florida Department of Children and Families, *supra* note 17 at 30.

As federal funds were made available, Florida enacted laws to develop a community mental health structure. In 1970, Florida established local contribution requirements to be eligible to receive federal funds now distributed through the state rather than directly to the community mental health centers or clinics from the federal government. This local match was 25%, including some allowable in-kind contributions.[23] At the same time, Florida created Mental Health Boards, composed of local citizens appointed by county commissions, for service areas defined by the state (Division of Mental Health). All community mental health services were provided through board contracts with private providers.[24]

As previously described, the Baker Act was enacted in 1971 to provide due process in involuntary admission proceedings and set uniform criteria for persons being admitted to state treatment facilities.

The Division of Mental Health was reorganized in 1975 within the newly formed Department of Health and Rehabilitative Services (HRS), as the Alcohol, Drug Abuse and Mental Health (ADM) Program Office. HRS was configured as a "matrix" organization to facilitate direct interaction among the program planning, administrative support, and district operations components without the hierarchal protocols of traditional organizations. The ADM program office performed planning and programmatic oversight, with the day-to-day mental health services coordination occurring at the district operations level. District mental health specialists reported to one of eleven district administrators, who reported to the deputy secretary for operations, who reported to the secretary of HRS. The actual contracting of mental health services remained with the mental health boards at the local level.[25]

In 1984, major revisions were made to the Baker Act. Mental health boards were replaced with planning councils. Planning councils retained the local mental health planning and evaluation role. However, authority to actually allocate resources through contract was shifted to the HRS district offices, with the condition that the contracts be consistent with the district mental health services plan.[26]

Also in the mid-1980s, federal mental health funding declined with the advent of block grants. Medicaid[27] was used increasingly to leverage federal funding of mental health services at the community level. Two Medicaid components, in particular, have been used for Medicaid Community Mental Health Services Rehabilitation and Targeted Case Management Programs. Currently, Medicaid funding accounts for over half of all state expenditures for the publicly-funded community mental health system in Florida.[28]

Upon the dissolution of HRS in 1996, the ADM program office was placed in the newly created Department of Children and Families, and the 11 districts were increased to 15. Subsequently,

[23] The Community Mental Health Act, Part IV of Ch. 394, F.S.
[24] Florida Department of Children and Families, *supra* note 17 at 31-32.
[25] Florida Department of Children and Families, *supra* note 17 at 32.
[26] Florida Department of Children and Families, *supra* note 17 at 32.
[27] Medicaid, enacted in 1965, is a state and federal partnership that provides health care to low-income, categorically eligible individuals.
[28] Florida Department of Children and Families, *supra* note 17 at 32-33.

districts 5 and 6, and Sarasota County and Desoto County from district 8 were merged into the Suncoast district, resulting in 14 districts currently. In 2003, the ADM program offices, now known as the Mental Health and Substance Abuse Offices, were given line authority over district programs and state mental health treatment facilities. The mental health program director was given direct control over the program's budget and contracts for services. A Deputy Secretary for Substance Abuse and Mental Health, with direct accountability to the Secretary, was created. Finally, the Florida Substance Abuse and Mental Health Corporation was formed as an independent entity with three major functions: (1) review the mental health and drug abuse service system; (2) assess the need for services, manpower and resources; and (3) provide a forum for direct advocacy with policymakers.[29] These changes in mental health services administration were designed to improve accountability and facilitate an equitable allocation of available resources.

C. Community Resources

Community resources to provide housing for those released from public mental health institutions were developed during the 1960s as deinstitutionalization was implemented. By the 1980s, Florida was one of the few states to attempt an organized response to deinstitutionalization through creation and funding of assisted living facilities that featured: (1) case management, (2) a continuum of residential care, and (3) day treatment programs. These programs were phased out in favor of less restrictive assisted living arrangements combined with community mental health services. Currently, community mental health services are delivered in a variety of settings, including short-term crisis stabilization units, residential facilities, individual homes, community support services, clubhouses, drop-in centers and other community settings.

According to a recent report of the Senate Appropriations Committee,[30] funds for mental health are usually appropriated in total, and then allocated by DCF by service district. However, over time, some districts accumulated larger shares of the statewide appropriations. In FY1997-98, a law was enacted in an attempt to address inequities in district funding: s. 394.908, F.S., provides that any funds allocated for community mental health by the state above the FY 1996-97 base be allocated by service district. Current funding levels in each district are supplemented by 75% of whatever increase above the FY 1996-97 base is contained in the current general appropriations act as enacted into law, taking into account the levels of the current target population. A pro rata share distribution is made that ensures districts below the statewide average funding level per person in each target population of "persons in need" receive funding necessary to achieve equity. The remaining 25% of the increase is allocated by service district strictly based on target populations without regard to current funding levels. Disparities in funding levels among service districts are expected to steadily decrease with each funding cycle.

Despite bureaucratic changes and more equitable funding measures, community resources to assist the mentally ill have never met the demand and remain in short supply. According to the

[29] Florida Department of Children and Families, *supra* note 17 at 33-34.
[30] The Florida Senate, Committee on Appropriations Subcommittee on Health and Human Services (2004), Interim Monitor Project 2004-318: Analysis of Mental Health, Drug Abuse and Child Protection Funding Distribution by District.

state FY2003-04 Community Mental Health Services Block Grant application submitted by the Florida Department of Children and Families (DCF), there is a need for: (1) more initiatives to assure appropriate, safe housing; (2) more resources to provide supported living environments; (3) more free or low-cost medications for individuals without benefits; and (4) low-cost or free transportation.[31]

D. Summary of Part III

Community mental health services have largely supplanted mental health institutions nationally and in Florida. The catalyst for change occurred with the onset of the deinstitutionalization, which gathered momentum in the early sixties with the passage of the federal Community Mental Health Centers Act and subsequent Community Mental Health Services Act.

Florida established the Baker Act in 1971 to establish rights and responsibilities for involuntary commitment to community and state mental health facilities. Funding arrangements were changed a year earlier, in 1970, to require local entities to provide a 25% match to receive federal mental health funds. The funding of community mental health services was centralized with the state in what is now the Florida Department of Children and Families, although the locus of funding decisions has been decentralized to administrative districts under various public/private arrangements. In the 1980s, direct federal funding of community mental health was reduced with the introduction of community mental health block grants. Medicaid started in 1965 as a federal/state program that provides medical care for low-income individuals, became an increasingly important source of funding for community mental health services. Currently, Medicaid funds over 50% of community mental health services.

Community housing, combined with community mental health services, has been an area of concern in Florida since the early days of deinstitutionalization. The consensus opinion is that Florida, as well as all other states, lack adequate resources in these areas to meet demand. In recent years, Florida has been attempting to better allocate state funds to lessen disparities among Florida counties. However, there is a need for: (1) more initiatives to assure appropriate, safe housing; (2) more resources to provide supported living environments; (3) more free or low-cost medications for individuals without benefits; and (4) low-cost or free transportation.

[31] Florida application for FY 2003-2004 Community Mental Health Services Block Grant at 32.

Part IV

Florida Funding of Community Mental Health Services

Community mental health services in Florida are funded by federal, state, and local-matching funds. Federal monies account for most of the funding, especially Medicaid, and, to a lesser degree, a variety of other federal programs including the Community Mental Health Services Block Grant. Medicaid does not have a local-matching requirement. Medicaid, which is about 59% federal dollars and 41% state general revenue, is now the major federal funding source in the federal-state-local mix. Once a mentally ill person enters the correctional facility, Medicaid will not cover anything. State appropriations are next in importance, providing matching funds for Medicaid and funding Baker Act services. Local-matching funds, required by Florida law, provide an important but smaller source of funding than federal and state government. Local-matching funds are generally required by statute to draw down federal grant funds. "Local-matching funds" is defined by statute and means funds received from governing bodies of local government, including city commissions, county commissions, district school boards, special tax districts, private hospital funds, private gifts, both individual and corporate, and bequests and funds received from community drives or any other source.[32]

The adult population targeted for community mental health services is defined in Florida law.[33] Adults in mental health crisis, older adults in crisis, adults and older adults with serious and persistent mental illness (SPMI), and adults with forensic involvements are included in the adult community mental health side of the design of services. The Florida Department of Children and Families (DCF) have specific criteria defining these groups. The SPMI is considered the benchmark group by DCF. The prevalence of SPMI is calculated at 2.4% of the adult population, using estimates based on recommendations of the federal Center for Mental Health Services. The SPMI rate used to calculate the subgroup eligible for public mental health services is 1.3%. This is a median or midpoint, based on a range of prevalence, reported by the National Alliance for the Mentally Ill.[34]

DCF is responsible for identifying and coordinating programs and services for the mentally ill, primarily through contractual arrangements with local providers. The Agency for Health Care Administration (AHCA) is the State of Florida entity responsible for administering the approved Florida Medicaid Plan. AHCA is the fiduciary agent responsible for dispersing Medicaid funds use to provide approved services for eligible—primarily low income—individuals.

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[32] s. 394.67(14), F.S.
[33] s. 394.9082(7)(b), F.S.
[34] Florida Department of Children and Families, *Mental Health and Substance Abuse Services Plan: 2003-2006*, 47-48 (Jan. 1, 2004).

A. Figures and Tables

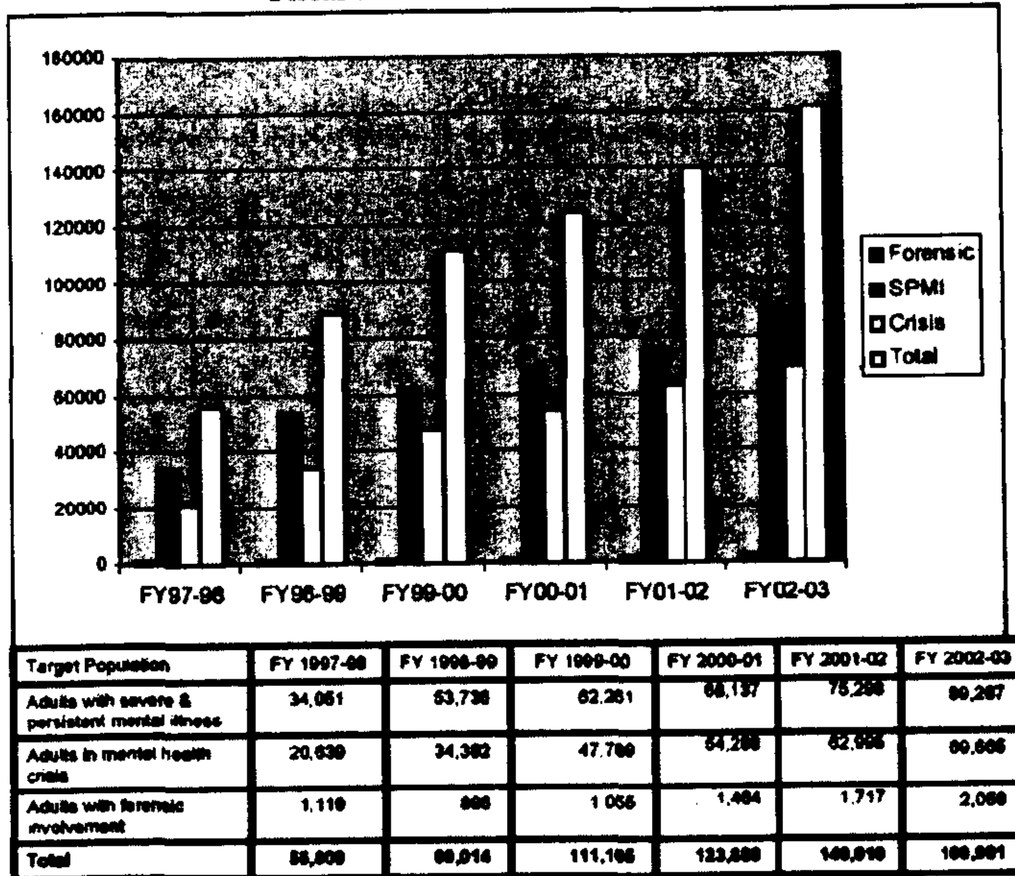
Table 2 depicts both the adult serious and persistent mental illness (SPMI) population and the adult SPMI population eligible for public mental health services for the five year period 1999-2003. The official April 1 Florida population estimates are provided by the Bureau of Economic and Business Research (BEBR) located at the University of Florida. The SPMI population in Florida has matched the percentage increase in total Florida population of 11.4% from 1999 to 2003, even though some yearly increases in percentage of adults to the general population differ.

Table 2
Growth in Severely and Persistently Mentally Ill (SPMI) in Florida, 1999-2003

Year (Apr. 1)	1999	2000	2001	2002	2003
Tot. Pop.	15,322,040	15,982,824	16,331,739	16674608	17,071,508
Percent Change: Total		4.3%	2.2%	2.1%	2.4%
Less than 18	3,363,091	3,646,450	3,646,340	3,720,208	3,750,347
Adult Pop.	11,958,949	12,336,374	12,685,399	12,954,400	13,321,161
Percent Change: Adults		3.2%	2.8%	2.1%	2.8%
SPMI @ 2.4%	287,015	296,073	304,450	310,906	319,708
SPMI @ 1.3%	155,466	160,373	164,910	168,407	173,175

Table 3 was taken from the DCF *Mental Health and Substance Abuse Services Plan: 2003-2006 (January 1, 2004).* It depicts the growth in the three adult target populations served from fiscal years ending June 30, 1998 through 2003. Comparing Table 2 with Table 3, with the population calculations based on April 1 estimates, two patterns emerge. First, a greater percentage of the adult public service eligible SPMI population is being served each year, increasing from 34.6% in 1999 to 51.5% in 2003. Second, there remains tremendous unmet need.

Table 3
Total Adult Target Population Individuals Served
Fiscal Years 1997-1998 to 2002-2003



Target Population	FY 1997-98	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03
Adults with severe & persistent mental illness	34,051	53,738	62,261	68,137	75,298	90,267
Adults in mental health crisis	20,639	34,382	47,789	54,288	62,998	69,666
Adults with forensic involvement	1,119	[illegible]	1 056	1,404	1,717	2,069
Total	55,809	89,014	111,105	123,889	140,010	160,991

The funding of community mental health services, especially adult community mental health funding, is examined from fiscal year ending June 30, 2001 until fiscal year ending June 30, 2005. The actual expenditures of funds may deviate by as much as 10% at the district level. Section 20.19(5)(b), F.S. grants authority to District Administrators to move 10% of their total district budget around with the Florida Department of Children and Families (DCF) Secretary's approval. State general revenue that is used to provide matching funds to pull down most, but not all, federal Medicaid funds for mental health services is included in DCF community mental health funding information. Federal Medicaid and Agency for Health Care Administration (AHCA) state funds for community mental health services are presented separately in this

section of the review. Differences between funding levels presented and the appropriation acts is due to gubernatorial vetoes of certain proviso language and line items.

Table 4 presents mental health yearly appropriations from fiscal year ending June 30, 2001 until fiscal year ending June 30, 2005. Adult mental health appropriations as a percent of total mental health appropriations rose from approximately 33% in FY 2000-2001 to approximately 40% in FY 2002-2003, where it has remained through FY 2004-2005. Slightly more money was allocated to the state mental health hospitals, except in FY 2002-2003. As previously mentioned, G. Pierce Wood closed in February of 2002. The shift that occurs in funding adult mental health is due to a shift to adult community mental health services in the catchment area served by G. Pierce Wood.

Table 4
Mental Health Appropriations for State FYs 2000-2001 thru 2004-2005

	State FY 2000-2001	State FY 2001-2002	State FY 2002-2003	State FY 2003-2004	State FY 2004-2005
Adult Mental Health Services	$203,056,826	$233,871,635	$267,296,193	$265,759,328	$272,291,807
Percent Change: Adult Mental Health		15.2%	14.3%	-0.6%	2.5%
Sexually Violent Predator Program	$20,018,040	$23,010,119	$23,266,344	$23,336,666	$23,339,273
Percent Change: SVPP		14.9%	1.1%	0.3%	0.0%
Children's Mental Health Services	$98,917,715	$98,272,931	$96,152,947	$95,364,437	$96,807,391
Percent Change: Children's MH		-0.7%	-2.2%	-0.8%	1.5%
Mental Health State Treatment Facilities	$280,265,693	$283,366,363	$260,614,703	$287,764,037	$284,350,084
Percent Change: MHSTF		1.1%	-8.0%	10.4%	-1.2%
Program Management and Compliance	$9,452,596	$9,484,475	$10,028,074	$9,547,745	$8,560,198
Percent Change: PM & C		0.3%	5.7%	-4.8%	-10.3%
Total Appropriation	$611,710,870	$648,005,523	$657,358,261	$681,772,213	$685,348,753
Percent Change: Total Appropriation		**5.9%**	**1.4%**	**3.7%**	**0.5%**

The year-to-year growth in funding of adult mental health services has been relatively flat since the fiscal year ending on June 30, 2003. Except for the transition fiscal years when G. Pierce Wood closed, funding for state mental health hospitals has also been flat. Children's mental health services have remained stable for the entire five year period depicted in Table 3. The Sexually Violent Predator Program received a several million dollar boost in FY 2001-2002, then remains flat. When all mental health programs are taken as a group, funding has increased 5.9% from FY 2000-2001 to 2001-2002, then 1.4%, 3.7%, and 0.5% for the subsequent year-to-year

funding comparisons. In general the nominal growth in state resources going into mental health has changed little in the past five years despite the increased number of people in need of services.

Table 5 presents adult mental health yearly appropriations from fiscal year ending June 30, 2001 until fiscal year ending June 30, 2005. Community mental health services represent the largest component, followed by Baker Act services and the Indigent Drug program. Other mental health programs and services, related to the closure of G. Pierce Wood mental health hospital, appear starting in FY 2001-2002. The variations in year-to-year percent changes in funding again reflect adjustments in the adult mental health system due to the closing of G. Pierce Wood. Funds formerly used to operate G. Pierce Wood were transferred to community mental health services in the area that was served by the mental health hospital. Overall changes in funding levels for FY 2004-2005 from FY 2003-2004 was a modest 2.5%, with no change in funding for Baker Act services or the Indigent Drug program.

Table 5
Adult Mental Health Appropriations for State
FYs 2000-2001 through 2004-2005

	State FY 2000-2001	State FY 2001-2002	State FY 2002-2003	State FY 2003-2004	State FY 2004-2005
Community Mental Health Services	$148,239,133	$156,467,200	$193,988,075	$197,311,582	$201,295,367
Percent Change: CMHS		5.6%	24.0%	1.7%	2.0%
Baker Act Services	$49,377,706	$55,517,650	$56,099,570	$56,099,570	$56,099,570
Percent Change: Baker Act		12.4%	1.0%	0.0%	0.0%
Indigent Drug Program	$5,439,987	$7,445,203	$8,280,276	$6,780,276	$6,780,276
Percent Change: IDP		36.9%	11.2%	-18.1%	0.0%
Other Mental Health Programs/Services		$14,441,582	$8,928,272	$5,567,900	$1,722,409
Total Appropriation	$203,056,826	$233,871,635	$267,296,193	$265,759,328	$272,291,807
Percent Change: Tot. Appr.		15.2%	14.3%	-0.6%	2.5%

Table 6 depicts the Florida Department of Children and Families funding sources for adult mental health programs from fiscal year ending June 30, 2001 until fiscal year ending June 30, 2005. General revenue consistently represents approximately 80% of the funding and includes some general revenue used to match Medicaid. A variety of other trust funds contribute 20%.

Table 6
Florida Department of Children and Families
Adult Mental Health Programs
Funding History from State FY 2000-2001 through FY 2004-2005

	FY 2000-01 Budget	FY 2001-02 State Funds	FY 2002-03 State Funds	FY 2003-04 State Funds	FY 2004-05 State Funds
Adult Mental Health					
General Revenue	162,401,605	184,018,916	212,498,742	210,044,427	218,494,080
Alcohol/DrugAbuse/ Men Hlth TF	15,110,914	19,480,914	19,480,914	20,480,914	19,480,914
Tobacco Settlement TF	8,692,633	8,892,633	8,872,633	8,872,633	8,872,633
Federal Grants TF	12,620,639	16,248,137	22,212,869	22,130,319	13,350,584
Grants and Donations TF	1,099,807	1,099,807	1,099,807	1,099,807	1,099,807
Operations and Maint TF	3,131,228	4,131,228	3,131,228	3,131,228	3,300,000
Welfare TF					7,693,789
TOTAL	***203,056,826***	***233,871,635***	***267,296,193***	***265,759,328***	***272,291,807***

Table 7 depicts the Medicaid funding of adult community health services for fiscal years ending June 30, 2000 through 2004. Note that some Medicaid funding is imbedded in the DCF budget. The first two rows of Table 6 provide detail to the third row total Medicaid adult mental health funding, separate from the DCF budget, and excluding Medicaid pharmacy funds. The overall growth of the complete Agency for Health Care Administration (AHCA) Medicaid budget for adult community mental health has fluctuated between 7.14% and 8.96% after June 30, 2001. Not surprisingly, costs of Medicaid adult mental health anti-psychotic drugs have increased the most since June 30, 2000—fluctuating between 18.4% and 24.12% yearly. This increase in the costs of anti-psychotic drugs provides insight to rising medication costs in similar drugs not paid by Medicaid provided in jails, Baker Act receiving facilities and Florida prisons. The total Medicaid contribution to community adult mental health that excludes Medicaid funds contained in the DCF budget topped $400 million in fiscal year ending June 30, 2004.

Table 7
Medicaid Funding of Adult Community Mental Health Services

	1999-00	2000-01	2001-02	2002-03	2003-04
Total Community Mental Health Services-Adults	68,218,029	55,280,940	54,375,019	54,489,787	58,463,887
Total Case Management Svcs-Adult Mental Health	24,862,193	29,446,683	31,735,604	32,684,674	28,176,533
Total Medicaid Adult Mental Health, Separate from DCF Budget, Excluding Drugs	93,080,222	84,727,623	86,110,623	87,174,461	86,640,420
Medicaid Funded Case Management Services in DCF Budget	8,942,749	13,472,581	0	1,254,631	0
Medicaid Funded Prepaid Mental Health Plan in DCF Budget*	5,083,992	4,536,778	5,208,353	5,715,478	44,514,994
Total Medicaid Adult Mental Health Anti-Psychotic Drugs Separate from DCF Budget	41,273,695	51,229,521	62,776,480	74,353,730	88,777,533
Percent Change from Previous Year		24.12%	22.54%	18.44%	19.40%
Total Medicaid Adult Mental Health All other drugs Separate from DCF Budget	89,597,806	95,578,210	107,659,478	118,423,413	137,957,468
Percent Change from Previous Year		6.67%	12.64%	10.00%	16.50%
Total AHCA Medicaid Adult Mental Health Budget	317,031,945	316,262,977	342,657,204	367,126,065	400,015,841
Percent Change from Previous Year		-0.24%	8.35%	7.14%	8.96%

* A major prepaid mental health managed care initiative is reflected in FY 2003-04.

Table 8 examines the combined AHCA and DCF appropriations for fiscal years ending June 30, 2001 through 2004. The Medicaid and other state and federal programs funded through DCF are separated into the "Total DCF Appropriation without Medicaid" row and the "Total Medicaid Appropriation" row. The bottom row represents the "Total Medicaid Appropriation" as a percentage of the combined appropriation—between 59% and 66.8%--in the years examined. With all the budget adjustments, Medicaid accounted for $444,530,835 in payments for community adult mental health in fiscal year ending June 30, 2004. The shift downward from fiscal year 2003 to 2004 for total DCF appropriation without Medicaid is attributed to the increase in the appropriation for Medicaid for community mental health services rehabilitation and especially targeted case management for those same years. This table does not include local government matching funds or funds from other state agencies that may provide ancillary support to adult community mental health programs. Table 8 illustrates that Florida utilizes the allowable federal match under Medicaid to fund the majority of adult community mental health services. Also, Table 8 shows that funding of adult community mental services has increased to $665.8 million in state fiscal year 2000-2001, representing a 28.2% increase from state fiscal year 2000-2001 to 2003-2004.

Table 8
Adult Mental Health Appropriations for State FYs 2000-2001 thru 2003-2004

	State FY 2000-2001	State FY 2001-2002	State FY 2002-2003	State FY 2003-2004
Total DCF Appropriation w/o Medicaid	$185,047,467	$228,663,282	$260,326,084	$221,244,334
Percent Change: Tot. DCF Appr.		23.6%	13.8%	-15.0%
Percent Change: 2001 to 2004				19.6%
Total Medicaid Appropriation	$334,272,336	$347,865,557	$374,096,174	$444,530,835
Percent Change: Tot. Medicaid Appr.		4.1%	7.5%	18.8%
Percent Change: 2001 to 2004				33.0%
Medicaid as Percent of Tot. Adult M.H. Appr.	64.4%	60.3%	59.0%	66.8%
Grand Total of Adult Mental Health Appropriations	$519,319,803			$665,775,169
Percent Change: 2001 to 2004				28.2%

Table 9 presents a summary of the local match by district for fiscal year ending June 30, 2002. All districts met or exceeded their local-matching requirements pursuant to s. 394.76, F.S. State Mental Health Program Office staff indicated that not all local entities eligible to participate in the match met their 25% share in certain counties, with the difference made up by local entities in other counties including county governments. As mentioned previously "local-matching funds" means funds received from governing bodies of local government, including city commissions, county commissions, district school boards, special tax districts, private hospital funds, private gifts, both individual and corporate, and bequests and funds received from community drives or any other source. The Suncoast District (composed of districts 5 and 6 and part of district 8 which includes Pasco, Pinellas, Hillsborough and Manatee, Sarasota, and Desoto Counties) exactly met their local matching requirement as did District 10 (Broward County) and District 12 (Palm Beach County).

Table 9
Summary of Local Match by District for FY ending June 30, 2002

Districts	Total Match Required in Contracts	Actual Match Provided All Counties/District	Total Cash Match	Total In-Kind Match
01	$3,545,581	$4,661,198	$3,312,851	$1,348,347
02	$2,732,728	$3,400,709	$2,650,987	$749,722
03	$2,770,836	$4,766,507	$4,766,507	$0
04	$7,230,665	$9,810,837	$9,649,918	$160,919
SC	$13,785,942	$13,785,942	$13,785,942	$0
07	$7,035,399	$21,620,809	$18,075,811	$3,544,998
08	$5,073,671	$8,052,260	$5,593,589	$2,458,671
09	$4,520,483	$13,681,783	$11,162,354	$2,519,429
10	$5,455,190	$5,455,190	$5,455,190	$0
11	$9,002,460	$10,756,950	$10,756,950	$0
12	$2,849,761	$2,849,761	$2,836,038	$13,723
13	$3,128,658	$6,246,711	$6,227,766	$18,945
14	$1,620,618	$2,036,514	$1,582,533	$453,981
15	$2,399,490	$2,401,605	$2,013,877	$387,728
Total	$71,151,502	$109,626,776	$97,870,313	$11,656,463

Source: Florida Department of Children and Families, *Mental Health and Substance Abuse Services Plan: 2003-2006*, 188 (Jan. 1, 2004).
Note: SC means Suncoast.

Table 10 presents a DCF funding history summary by activity from fiscal year ending June 30, 2002 until fiscal year ending June 30, 2005. Overall, emergency stabilization is the costliest activity in publicly funded adult mental health. Emergency stabilization funding has increased modestly each year after a one year jump in FY 2002-2003. Residential care is the next most costly activity. Its funding has varied widely from year to year. Community support service funding has gradually increased after a bump in funding in FY 2002-2003. Florida Assertive Community Treatment (FACT) teams provide comprehensive support services to the severely and persistently mentally ill.

Table 10

ADULT MENTAL HEALTH

FUNDING HISTORY SUMMARY BY ACTIVITY FROM FY 2001-02 THROUGH FY 2004-05

	FY 01-02	FY 02-03	FY 03-04	FY 04-05
	Total	Total	Total	Total
Adult Mental Health				
Emergency Stabilization	64,428,054	76,180,980	76,324,063	79,048,939
Residential Care	36,084,578	56,721,677	66,193,337	55,855,517
Case Management	11,844,707	17,994,406	17,758,821	19,948,712
Outpatient Services	66,960,907	38,277,146	35,201,627	39,432,898
Community Suppt. Services	12,376,274	23,987,156	27,470,715	30,425,653
FACT Teams	22,392,639	37,631,820	35,517,239	35,834,055
*TOTAL **	214,087,159	250,793,185	258,465,802	260,545,774

**** Differences between activity totals and appropriation totals are due to funds being in either EOG reserve, in Approved Operating Budget "control," or a combination of both.***

B. Summary of Part IV

Adult community mental health services in Florida are primarily funded by federal programs. Medicaid, with its 41% state matching requirement, is by far the largest, accounting for a federal/state total of $444.5 million appropriated in FY 2003-2004. The Community Mental Health Services Block Grant is the next federal program in size and importance, providing federal funds in the $20-$30 million range. State revenue provided $221.2 million in FY 2003-2004 to pay for adult community mental health services not paid for by federal or local sources. Local sources provide approximately $100 million in cash and in-kind matching funds.

Adults involuntarily committed under the Baker Act are funded by the state. Medications provided to residents in Baker Act receiving facilities or state mental hospitals are also paid for by state funds. Counties are responsible for the costs of medications and mental health services provided in the jails.

PART V

Significant Previous Studies on the Impact of the Mentally Ill Population on County Jails

Since deinstitutionalization of the mentally ill began many researchers have attempted to assess the impact of the mentally ill on jails. All agree that the mentally ill cost more money to keep in jail than in community care and spend more time than their non-mentally ill counterparts there once incarcerated. Recent studies have focused on attempts to ameliorate the impact on jails while appropriately treating the mentally ill. This section provides an overview of some of the more significant studies conducted in recent years that apply to Florida's judicial and community mental health systems.

The Senate Committee on Children, Family and Seniors produced two reports: 1) a 1998 report on the role of county courts under the Forensic Client Services Act, and 2) a 1999 report on defining publicly funded mental health and substance abuse services and priority population groups. During this same period of time, the Louis de la Parte Florida Mental Health Institute published three Florida-based studies: 1) on jail diversion, 2) increasing court jurisdiction and supervision over misdemeanor offenders with mental illness, and 3) mental health diagnostic and treatment services in Florida jails. The final study reviewed is a National Association of Counties study on ending the cycle of recidivism. These studies provide a foundation upon which recent developments in Florida's treatment of mentally ill persons that come in contact with the judicial system may be analyzed.

A. Senate Report on the Role of the County Courts under the Forensic Client Services Act

In 1998, the Florida Senate Committee on Children, Families and Seniors reviewed the role of the County Courts under Ch. 916, F.S., the Forensic Client Services Act.[35] A survey was conducted of chief judges, state attorneys, public defenders, jail administrators, community mental health providers, and the Department of Children and Family Services district forensic coordinators. The purpose of the survey was to determine the problems and reasons for the recycling of persons with suspected or diagnosed mental illness who are arrested for or convicted of a misdemeanor. Information collected included the number arrested, the number who had their misdemeanor charges dropped, and the number receiving voluntary or involuntary treatment under the Baker Act. A review of pertinent literature, a site visit to the Fifteenth Judicial Circuit (Palm Beach County), and discussions with national forensic consultants were part of this effort.[36]

The report found that the Baker Act contains the provision for law enforcement officers to transport persons who are involved in minor criminal behavior to the nearest receiving facility for an involuntary psychiatric examination. The report also found that professionals in the criminal justice system believe that many persons commit minor criminal offenses because appropriate mental health evaluation, treatment, and support services frequently are not provided to this population in a prompt manner. In fact, transporting to receiving facilities does not always

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[35] The Florida Senate, Committee on Children, Families and Seniors (October 1998), Interim Project Report 98-06: *Role of the County Courts Under Chapter 916, F.S.: Responding to Persons with Mental Illness who Commit Misdemeanors.*
[36] *Id.* at 1-2.

occur as many of these persons with mental health problems are taken to county jails. Data specifying the number or percentage of these persons who are taken to Baker Act receiving facilities as opposed to a county detention facility was unavailable.[37]

Based on the findings of this review, Senate staff concluded that local community cooperative agreements between the criminal justice and mental health agencies are needed for diverting persons with mental illness who are arrested for a misdemeanor from the criminal justice system to the mental health system when appropriate. Because law enforcement plays a major role in this diversion, it is necessary to improve training programs for law enforcement officers in identifying mental illness and to assist them with difficult mental health cases. Other strategies are needed in the area of information sharing among pertinent community entities; referring misdemeanants for after care services upon release from jail and from Baker Act receiving facilities; and providing intensive case management services. It was also recommended that increasing judicial supervision of misdemeanants with serious mental health problems, the extent and quality of in-jail mental health services, and the effectiveness of the specialized mental health court in Broward County be reviewed.[38]

B. The Louis de la Parte Florida Mental Health Institute Studies

Four studies were published in 1999 by the Louis de la Parte Mental Health Institute in response to the provisions in ch. 99-396, L.O.F. Randy Borum, an Associate Professor at the Institute, was the principle investigator and author. Three of these studies are reviewed in this report. Section 18 of the chapter law resulted in *Jail Diversion Strategies for Misdemeanor Offenders with Mental Illness: Preliminary Report.*[39] Three connected studies published together and prefaced by an Executive Summary address sections 19-21 of the chapter law. They are titled *Misdemeanor Offenders with Mental Illness in Florida: Examining Police Response, Court Jurisdiction, and Jail Mental Health Services*[40]; *Increasing Court Jurisdiction & Supervision over Misdemeanor Offenders with Mental Illness*[41]; and *Mental Health Diagnostic and Treatment Services in Florida's Jails.*[42]

As summarized in the House Final Bill Analysis of Ch. 99-396, L.O.F.:

> Section 18 - Directs the Department of Children and Family Services to enter into cooperative agreements and develop strategies and community alternatives

[37] *Id.* at 1-2.
[38] *Id.* at 1.
[39] Borum, R. (1999). *Jail Diversion Strategies for Misdemeanor Offenders with Mental Illness: Preliminary Report.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida.
[40] Borum, R. (1999). *Misdemeanor Offenders with Mental Illness in Florida: Examining Police Response, Court Jurisdiction, and Jail Mental Health Services.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida at 1-17.
[41] Borum, R. (1999). *Increasing Court Jurisdiction & Supervision over Misdemeanor Offenders with Mental Illness.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida at 18-40.
[42] Borum, R. & Rand, M. (1999). *Mental Health Diagnostic and Treatment Services in Florida's Jails.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida at 41-56.

in each service district for diverting from the criminal justice system to the civil Baker Act system persons with mental illness who are arrested for a misdemeanor. Each district's strategies are to be developed through written cooperative agreements between the department, the judicial and criminal justice systems, and the local mental health providers. The Louis de la Parte Florida Mental Health Institute is directed to review strategies in Florida and other states and to recommend to the Legislature those strategies that are most effective.

Section 19 - Directs the Department of Children and Family Services and Department of Law Enforcement to recommend improvements in the training curriculum and training efforts for law enforcement officers in identifying mental illness as delivered by the Criminal Justice Standards and Training Commission and the Department of Children and Family Services.

Section 20 - Directs the Department of Children and Family Services and the Louis de la Parte Florida Mental Health Institute to study the concept of increasing court jurisdiction and supervision over persons with mental illness who are arrested for or convicted of a misdemeanor to assure compliance with an approved individualized treatment or service plan.

Section 21 - Directs the Louis de la Parte Florida Mental Health Institute and district forensic coordinators to assess the provision of in-jail mental health diagnostic and treatment services and reporting to the Legislature.

Section 22 - Requires all study reports generated in Sections 18, 19, 20 & 21 to be submitted to the Legislature by December 31, 1999.

Section 23 - Directs the Louis de la Parte Florida Mental Health Institute to evaluate the effectiveness of the specialized mental health court established in Broward County to determine client and system outcomes and cost efficiencies and proposing recommendations for establishing similar special courts in other judicial circuits.

Section 24 - Provides an appropriation of $100,000 for the studies.[43]

1. The Jail Diversion Study

The first study, *Jail Diversion Strategies for Misdemeanor Offenders with Mental Illness: Preliminary Report*, provides a concise statement of the problem in the following two paragraphs:[44]

> People with severe mental illness frequently have contact with police for disruptive behavior or minor infractions that occur because they are experiencing psychiatric symptoms or social disruptions related to their disability. These police encounters frequently result in arrest, leading to large numbers of mentally ill misdemeanants being held in jails and processed through the court system. This outcome is costly and largely unproductive.

[43] House of Representatives As Further Revised by the Committee on Children & Families Final Analysis (May7, 1999) HB 2003 (formerly PCB CF 99-02; Chapter #: 99-396, Laws of Florida), 14.
[44] Borum, *supra* note 39, at 3.

> Although some people with mental illness do commit offenses for which incarceration is the most appropriate disposition, many are confined as result of arrest for minor infractions. In these cases, confinement does not alleviate, and may exacerbate, the original problem—that is, an individual with mental illness is experiencing a crisis episode that has led to inappropriate behavior. If the goal is to reduce the likelihood of future episodes of that behavior, then mental health treatment will be a more appropriate disposition than routine criminal adjudication.

Borum also reports that studies from around the country show that between 6 and 16% of all jail inmates have a severe mental illness. Compounding the problem are co-existing conditions, especially alcohol and drug abuse. Approximately 75% of mentally ill jail inmates have a co-existing alcohol or drug abuse problem.[45]

The study found that there are two actions that are sometimes confused with jail diversion. The first action confused with diversion occurs when an inmate is transferred by the jail to a forensic psychiatric facility for evaluation. The second such action occurs when a mentally ill detainee is released to the community pending trial. In both of these actions the defendant remains in the criminal justice system. To be considered a diversion program, the mentally ill inmate would have to be managed by the community mental health system.[46]

The study reports that according to the National GAINS Center, Policy Research Associates, pre-booking diversions occur at the point of contact with law enforcement officers. It is considered pre-booking because formal charges have not been made against the suspect. Pre-booking diversion programs require effective interactions between police and community mental health and substance abuse services.[47]

Post-booking diversion occurs after a charge is made and the mentally ill individual is booked into jail. It is described in the study as the most prevalent type of diversion program in the United States. These diversion programs occur either in arraignment courts or jails. In either case, a person's eligibility for diversion is negotiated between key members of the justice system and diversion program staff in concert with community-based mental health and substance abuse providers. The key members of the justice system may include prosecutors, public defenders, attorneys, and the courts. A plan of treatment is developed and offered to the defendant as an alternative to jail or as a condition of reduction in charges, regardless of any formal conviction. Individuals who accept the conditions are then linked to the agreed upon community-based services.[48]

The study found that the model pre-booking diversion program which appears most promising is the Memphis Tennessee Police Department's Crisis Intervention Team (CIT) program. The CIT is a police-based program. Police officers who are CIT members receive 40 hours of training in a variety of mental health issues. The team operates on what is commonly referred to as a

[45] Borum, *supra* note 39, at 5.
[46] Borum, *supra* note 39, at 6.
[47] Borum, *supra* note 39, at 7 in text box.
[48] Borum, *supra* note 39, at 7 in text box.

generalist-specialist model. CIT officers have regularly assigned patrol duties, the generalist part of the model, but also provide a specialized response to "mental disturbance" crisis calls, the specialist part of the model. In Memphis, the CIT officers will leave their geographically based assignments to respond to mental health related calls anywhere in the city. The CIT officers are trained to resolve the situation on the scene. Common resolutions include de-escalation of the situation, negotiation with the individual or verbal crisis intervention. In some cases the officer may contact an individual's case manager or treatment provider, provide a referral to treatment services, or transport an individual directly to the psychiatric emergency center for further evaluation. Reported benefits of the CIT approach include reductions in arrest, little or no change in staffing or organizational structure, and very little associated costs. The partnership between the Memphis Police Department and the University of Tennessee-Memphis Medical Center's Psychiatric Emergency Center is an important element in the program's effectiveness.[49]

The Charleston, South Carolina, Mobile Crisis Team (MCT) represents a model pre-booking diversion program staffed by health and mental health professionals. According to Borum, in 1987, the Medical University of South Carolina began a public-academic emergency psychiatry program to provide psychiatric emergency services to Charleston County. In this model, the team consisted entirely of mental health and health professionals who were specially trained to provide in-the-field mental health consultation and assistance, at any time. The assistance techniques were derived from emergency room-based psychiatric services. The MCT consisted of several master's level mental health clinicians, a psychiatric intern, a medical student, a chief resident, attending psychiatrist, and a project manager. Protocols for MCT interactions with police for backup were developed and face-to-face contact between police officers and MCT members at each precinct was made at the start of the program to communicate operating procedures. The resulting partnership was reported as being highly successful.[50]

The MCT program in-the-field services and consultations has three basic components, resulting in several benefits according to Borum. First, relevant historical and clinical information is obtained from the subject and any other available sources. Second, the MCT delivers on-scene intervention. Third, advice is given to police on case disposition. Several benefits of this approach are mentioned. There is an immediate connection to the mental health system. The subject's assessment and intervention is performed by specialized mental health professionals. Finally, there is a reduction of unnecessary transports.[51]

2. Increasing Court Jurisdiction and Supervision over Misdemeanor Offenders with Mental Illness

As mentioned in a previous section of this report, court-ordered treatment that commits an individual to involuntary outpatient placement has been incorporated recently into the Florida Baker Act.[52] The study, *Increasing Court Jurisdiction & Supervision over Misdemeanor Offenders with Mental Illness,* reports that at least thirty-eight states and the District of Columbia have similar involuntary outpatient placement statutory authority. Civil commitment traditionally

[49] Borum, *supra* note 39, at 8-9, 20.
[50] Borum, *supra* note 39, at 15.
[51] Borum, *supra* note 39, at 15.
[52] Ch. 2004-385, L.O.F., Section 8, creating sec. 394.4655, F.S.

has been used as the legal procedure to place an individual into involuntary hospitalization. In recent years, civil commitment laws have been expanded to provide for involuntary outpatient treatment. Several advantages may result from outpatient commitment (OPC). First, the committed individual is permitted increased autonomy in a less restrictive treatment environment. Second, the judiciary can monitor compliance. Finally, early signs of relapse or decompensation detected in the course of outpatient treatment may be more effectively treated.[53]

The study summarizes conclusions from both initial and refined studies of mandatory outpatient mental health treatment. The initial studies indicate limited positive outcomes for a substantial number of people with mental disorders. The same finding applies to individuals who have chronic conditions. The refined or second generation studies of mandatory outpatient mental health treatment are consistent in their support for "the need for intensive community-based services to prevent relapse, violent behavior and criminal recidivism/arrest among people with severe mental illness," but "less consistent in their evidence concerning the importance of the court mandate *per se*."[54]

3. Mental Health Diagnostic and Treatment Services in Florida Jails

The Florida jail mental health survey, reported in *Mental Health Diagnostic and Treatment Services in Florida's Jails*, by Randy Borum and M. Rand, resulted in the following main recommendation: "County jails and district mental health programs should forge partnerships designed to address the challenges created by the subgroup of 'revolving door' clients who cycle through both the mental health and criminal justice systems." The report acknowledges that the jails will have to take responsibility for treatment within the facility, but suggests that the local community mental health system may be helpful for case identification and discharge planning. This suggestion was presented as very important for clients who have previously been involved in the public mental health system.[55]

C. Senate Report on Defining Publicly Funded Mental Health and Substance Abuse Services and Priority Population Groups

The passage of Ch. 99-396, L.O.F. and the resulting research by the Louis de la Parte Mental Health Institute appears to have stimulated further legislative interest. In 1999, the Florida Senate Committee on Children and Families reviewed the provisions of the "Community Alcohol, Drug Abuse, and Mental Health Services Act" that related to publicly funded mental health and substance abuse services and priority population groups.[56] The report of this committee noted that according to literature reviewed, great strides have been made in the last 20 years in the diagnosis and treatment of mental illness and addictive disorders. Further, current treatment for mental illness and substance abuse can reduce or eliminate the incapacitating effects of the illness, with the additional benefit of reducing risk to the individual and the public. Now treatment can ultimately lead to recovery. There have been significant improvements in

[53] Borum, *supra* note 41, at 22-23.
[54] Borum, *supra* note 41, at 28, 32.
[55] Borum, *supra* note 42, at 52-53.
[56] The Florida Senate, Committee on Children and Families (September 1999), Interim Project Report 2000-17: Defining Publicly Funded Mental Health and Substance Abuse Services and Priority Population Groups.

medications. The effective use of services that incorporate psychosocial rehabilitation techniques such as assertive community treatment and wraparound services is known. The report also recognized the key role that individuals can play in designing and taking responsibility for their own treatment. There are several benefits of current mental health treatment that extend beyond the individual recipient. Productivity increases, other health care costs decrease, and less demand is placed on use of other public systems, such as the local criminal justice system.[57] However, at the time of this review, in 1999, the Mental Health Program Office in Florida Department of Children and Families estimated that Florida's publicly funded mental health system was meeting approximately 12 percent of the treatment needs of adults.[58]

In addition to the literature review, as part of the Senate committee review, mental health experts were consulted and 35 key stakeholders of mental health and substance abuse services were surveyed. Twenty-six stakeholders responded to the survey. Many voiced concerns about the lack of statutory guidance for serving adults with or at risk of mental health or substance abuse problems. Suggestions were offered ranging from basic definitions, to updating descriptions of services, adding services, and changing the sliding fee schedule. Among the new categories of treatment services recommended by the stakeholders were aftercare services for persons discharged from the criminal justice system.[59] Recommendations of the review were considered in SB 358 during the 2000 general legislative session. Many of the recommendations were enacted into law by ch. 2000-349, L.O.F.

Several changes made by ch. 2000-349, L.O.F. are relevant to this study. Part IV of chapter 394, F.S., was renamed "The Community Substance Abuse and Mental Health Services Act." The intent language of this Act was changed to include the criminal justice system as one of the local systems and groups to be coordinated and integrated with in all activities related to mental health treatment and prevention services provided by the Department of Children and Family Services and the Agency for Health Care Administration and their respective contract providers.[60] "Crisis services" was defined and included the phrase "at the site of the crisis by a mobile crisis response team."[61] Finally, in defining "mental health services" reference is made to assertive community treatment in recognition of this treatment mode.[62]

D. National Association of Counties Study on Ending the Cycle of Recidivism: Best Practices for Diverting Mentally Ill Individuals from County Jails

A study of best practices for diverting mentally ill individuals from county jails, published in 2003 by the National Association of Counties (NACO) emphasizes that counties should provide leadership to develop programs to divert non-violent mentally ill offenders from county jails. Three types of diversion programs are mentioned. The first approach is a pre-arrest diversion program such as a Crisis Intervention Team where specially trained police officers divert the individual at the scene of the disturbance directly to a treatment or housing facility as an

[57] *Id.*, at 3-4.
[58] *Id.*, at 2.
[59] *Id.*, at 5-7.
[60] Section 394.66(5), Fl. Stat. (2004).
[61] Section 394.67(4), Fl. Stat. (2004).
[62] Section 394.67(16)(d), Fl. Stat. (2004).

alternative to jail. The second approach occurs after mentally ill individuals have been arrested and charged with an offense. A "mental health court" offers the offender an alternative course of action that typically involves having the individual enter into treatment and case management, while the court monitors the individual through probation. The third approach is a post-incarceration transition program that links a discharged offender to community based treatment services to help ensure that they do not re-offend and re-enter the criminal justice system. A key component in sustaining a comprehensive diversion system is the availability of a long-term, supervised residential housing program for individuals with mental illness.[63]

A variety of programs have been developed around the country, tailored to local needs and social infrastructure. According to the National GAINS Center, 7% of U.S. counties (229 of 3,142 counties) have one or more jail diversion programs. These diversion programs include 88 pre-arrest type programs, 204 post-arrest type programs, with 93 being mental health courts, and 111 other/combinations or variations of models.[64] Diversion programs can improve care for the mentally ill. County costs can be reduced while improving safety within the jails.[65]

E. Summary of Part V

Several studies have been conducted in recent years that focus on Florida's jail system and the mentally ill. The findings and recommendations of these studies are remarkably consistent with national studies. All agree that the mentally ill cost more money to keep in jail than in community care and spend more time in jail than their non-mentally ill counterparts once incarcerated. Professionals in the criminal justice system believe that many persons commit minor criminal offenses because appropriate mental health evaluation, treatment, and support services frequently are not provided to this population in a prompt manner. When a mentally ill person comes in contact with police, too often they are arrested and taken to jail rather than to a more appropriate community mental health facility. Mentally-ill jail inmates frequently have a co-occurring drug abuse problem.

Several themes emerge from the various studies reviewed in this report. First, deinstitutionalization has resulted in greater numbers of the mentally ill coming in contact with the judicial system. Second, it is less expensive and probably more appropriate to divert mentally ill misdemeanants to the community mental health system. Third, good communication and working relationships between community health professionals and those in the judicial system, especially at the county jails, help achieve appropriate and timely treatment for the mentally ill. Finally, adult community health systems necessary for the treatment of diverted individuals in the least restrictive and cost efficient manner include case management, supervised residential treatment, and day treatment programs.

[63] National Association of Counties, *Ending the Cycle of Recidivism: Best Practices for Diverting Mentally Ill Individuals from County Jails* (June 2003), at 4-5.
[64] Power Point presentation "Diverting the Mentally Ill from Jail to Treatment" by Lesley Buchan, National Association of Counties on June 24, 2004, to the Florida Association of Counties 2004 Annual Conference in Broward County, Florida, slide 26.
[65] National Association of Counties , *supra* note 63, at 5.

Recommendations of these studies include improving communication and coordination between personnel in the judicial system and personnel in the community mental health system to facilitate diversions of the mentally-ill from jail and coordinate aftercare of the mentally ill upon release from jail. Diversion programs are viewed as especially desirable. Diversion programs include pre-arrest programs and post-arrest programs. The preferred pre-arrest diversion program is the police-based Crisis Intervention Team. The post-arrest program commonly mentioned is the drug court that allows for a reduced sentence or dropped charge after successful completion of court-ordered community mental health treatment. Community based Assertive Community Treatment teams are favored for aftercare of severely mentally ill individuals upon release from jail.

PART VI

Jail Diversion Programs in Florida

Jail diversion of the mentally ill in Florida happens through pre-arrest, post-arrest, and post-incarceration programs. First, the pre-arrest diversion program, favored in recent research, and described in this report, is the "Memphis Model" Crisis Intervention Team (CIT). Next, Mental Health Courts, representing the post-arrest diversion program in Florida, are depicted. Finally, two key elements of post-incarceration jail linkage programs, comprehensive community mental health services as provided by Florida Assertive Community Treatment teams and the availability of residential treatment facilities for the mentally ill, are examined in this section of the report.

A. Pre-Arrest: the "Memphis Model" Crisis Intervention Teams (CITs) are popular in Florida.

Several progressive law enforcement agencies throughout Florida have embraced the Crisis Intervention Team (CIT)/Memphis Model. CIT is a law enforcement initiative, in collaboration with community mental health professionals including community providers and state/district mental health program office staff and the National Alliance for the Mentally Ill (NAMI). The model is based on the best practice program initiated in Memphis, Tennessee, in the 1980's, in response to a shooting incident of a mentally ill individual. The goals of CIT are to divert the mentally ill from the criminal justice system, to provide law enforcement with the tools needed to handle encounters with the mentally ill, and to ensure the delivery of proper care for the individual in crisis through a collaboration of the mental health and criminal justice systems.[66]

CIT officers volunteer to serve on the teams in each agency. Each agency has a selection process which considers the following traits of each applicant: 1) communication skills; 2) active listening skills; 3) ability to work well under pressure; 4) ability to maintain a positive attitude under stressful conditions; 5) ability to absorb verbal abuse without negative responses; and 6) ability to exercise good judgment and decision making skills. Upon selection, the CIT candidates participate in a 40 hour training conducted by mental health professionals, CIT officers, and NAMI members in their communities. The 40 hour training curriculum is minimally comprised of the following: signs and symptoms of mental illness, medications and medical conditions, substance abuse and dual diagnosis, suicide awareness and prevention, risk assessment, family and consumer perspectives, the Baker Act and Marchman Act,[67] visits to community providers and positive interaction with mentally ill individuals, crisis intervention, and community resources. The training is a combination of lectures and role playing exercises. Several communities have added topics, such as cultural diversity, post traumatic stress disorder, and

[66] Florida Department of Children and Families, Mental Health Program Office, CIT information provided by e-mail, with phone conversation follow-up.

[67] Marchman Act Involuntary Assessment - Section 397.6811, F.S. The act provides for a Petition for Involuntary Assessment for individuals believed to be impaired by substance abuse. A General Master presides at the hearing and may enter an Order for Involuntary Assessment. The court may direct the Sheriff's Department to take the patient into custody and deliver him/her to a public facility that will assess and stabilize the patient for a period not to exceed 5 days. A written assessment is sent to the court and the court may proceed with the Petition For Involuntary Treatment.

child/adolescent issues, in response to community need. An effort is underway to standardize these CIT topics/components in Florida.

Each agency develops a dispatch protocol to ensure that certified CIT officers are dispatched to calls involving a confirmed or suspected mentally ill person in crisis or when an individual specifically asks for a CIT officer. The first CIT officer on the scene assumes responsibility for the entire call, which includes dialogue with the mentally ill individual, determining the appropriate action to be taken and the necessary paperwork. Other officers on the scene provide backup.

The following communities are implementing CITs:

- Broward County--Three law enforcement agencies (Broward County Sheriffs Office, Ft. Lauderdale Police Department and Wilton Manors Police Department).
- Palm Beach County--CIT training in this county began in 2003. Twelve law enforcement agencies (Atlantis, Belle Glade, Boca Raton, Delray Beach, Lantana, Lake Worth, Palm Beach, Palm Beach Gardens, Palm Beach Sheriff's Office, Veteran's Administration Police, and West Palm Beach).
- Orlando/Orange County/Seminole County—The Central Florida CIT group began training in 2001. Thirteen agencies (Apopka, Edgewood, Eatonville, Maitland, Oakland, Ocoee, Orlando, Orange County Sheriff's Office, Seminole County Sheriff's Office, University of Central Florida Police Department, Windermere, Winter Garden, and Winter Park)
- Daytona Beach/Jacksonville
- Miami-Dade County--City of Miami and Miami Beach and 8 other police agencies

Several communities, such as Tallahassee, have initiated CIT training. There was a forum, sponsored by Eli Lilly and Central Florida CIT, in March 2004 that included many of the agencies with active CIT programs in an effort to standardize the procedures and data collection. At this point, each agency has its own method of collecting data related to CIT calls and outcomes. The data collected includes the number of arrests/diversions, number of Baker Acts/Marchman Acts, consumer injury, officer injury, and the participation of mobile crisis teams. Upon standardization, the state mental health program office will have access to the outcome data. Anecdotal information on the effectiveness of CITs has been positive. In fact, a Miami-Dade County Grand Jury Report filed on January 11, 2004 recommends more extensive CIT training for both corrections and police officers in Miami-Dade County.

B. Post-Arrest: Mental Health Courts

In 1997, Broward County pioneered Mental Health Courts for individuals with mental illnesses who have been charged with a non-violent misdemeanor offense. Currently, such Mental Health Courts are in operation in Alachua, Brevard, Broward, Lee, Marion, and Sarasota counties. In addition, a Felony Mental Health Court was established in Broward County in November 2003

to serve individuals with mental illnesses who have been charged with low level felony offenses. The purpose of these courts is to reduce jail time and obtain treatment for the mentally ill.[68]

Mental health courts involve collaboration among correctional personnel, judges, officers of the court, and community mental health providers. Typically, a mentally ill inmate is arraigned in special mental health court as soon as possible after being arrested. A community mental health treatment plan for the inmate is agreed upon by the judge, prosecutor, public defender, and community mental health provider. The inmate is released to community mental health care under the supervision of the court. Usually the judge will allow for a reduced sentence or drop the charges against the inmate upon successful completion of the court-approved treatment plan.

According to John Petrila, Chair and Professor at the Department of Mental Health Law & Policy, University of South Florida, the Broward Mental Health Court (1) appears to increase access to care compared to traditional court, (2) participants perceive court as non-coercive and fair, and (3) individuals in mental health court spend less time in jail without increased risk to public safety. He did raise some unanswered questions about the Felony Mental Health Court, including the impact of sanctions or the threat of sanctions and the assurance of access to treatment.[69]

C. Post-Incarceration Jail Linkage Programs

Jail linkage programs attempt to place an inmate, upon release from jail, in the care of the local community mental health system. The sophistication and effectiveness of linkage programs depends on the available community mental health resources and the cooperation and communication between the judicial system, especially jail personnel, and community mental health professionals. Two components that are important to providing an effective jail linkage program in Florida are described below. Comprehensive mental health services provided by Florida Assertive Community Treatment (FACT) teams is the standard recommended by the National Alliance for the Mentally Ill (NAMI). Residential treatment facilities are the other key component.

1. FACT programs

As of June 30, 2004, there were 30 operational Florida Assertive Community Treatment (FACT) teams treating 2,291 individuals with mental illness. FACT teams provide comprehensive mental health services delivered by a multidisciplinary treatment team that is responsible for identified individuals who have a serious mental illness. FACT teams operate 24 hours a day, every day. FACT teams assume total responsibility for the treatment, rehabilitation and support of persons enrolled, with most of these services taking place outside an office setting. Funding is through general revenue and Medicaid, with availability of housing and medication enhancement funds. The Florida Department of Children and Families states that FACT teams are the Florida equivalent of the national Program of Assertive Community Treatment (PACT) teams model; an

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[68] National Association of Counties, *supra* note 63, at 44.
[69] Power Point presentation by John Petrila on June 24, 2004, to the Florida Association of Counties 2004 Annual Conference in Broward County, Florida.

evidenced-based model with 39 years of proven effectiveness in areas of (1) reduction in state hospitalization, (2) reduced cost over time, and (3) increase in quality of life of persons served.[70]

FACT teams are located in the following counties: Alachua, Brevard, Broward, Charlotte, Collier, Duval (2 teams), Escambia, Hillsborough (2 teams), Lake, Lee (2teams), Leon, Manatee, Martin, Miami-Dade (2 teams), Orange, Osceola, Palm Beach, Pasco, Pinellas (3 teams), Polk (2 teams), St. Lucie, Sarasota and Volusia. One more team is expected to be operational in Miami-Dade County by June 30, 2005.
Criteria for FACT team admission is established by DCF, and includes:

1. Individuals eligible for FACT team services must have a diagnosis within one of the following categories as referenced in the American Psychiatric Association's Diagnostic and Statistical Manual-IV, 4th Edition:
   - schizophrenia and other psychotic disorders
   - mood disorders
   - anxiety disorders
   - personality disorders.
2. Additionally, individuals must meet **one** of the following three criteria:
   - demonstrate a high risk for hospital admission or readmission
   - have prolonged inpatient days, more than 90 days; or
   - have repeated crisis stabilization contacts, more than three admissions.
3. And meet at least **three** of the following six characteristics:
   - inability to consistently perform the range of practical daily living tasks required for basic adult interact ional roles in the community (e.g., maintaining personal hygiene; meeting nutritional needs; caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family or relatives)
   - inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting or child-care tasks and responsibilities)
   - inability to maintain a safe living situation (repeated evictions, loss of housing, or no housing)
   - coexisting substance use disorder of significant duration (greater than six months)
   - destructive behavior to self or others; or
   - high risk or recent history of criminal justice involvement (arrest and incarceration).[71]

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[70] See http://www.dcf.state.fl.us/mentalhealth/forensic/fact.shtml
[71] See http://www.dcf.state.fl.us/mentalhealth/forensic/factadm.shtml .

2. Long-Term Supervised Housing

The availability of long-term supervised housing is a key element in all diversion programs. Three types of residences may house individuals with mental illnesses. These include mental health residential treatment facilities, assisted living facilities, and adult family-care homes. Also, these facilities may qualify as Medicaid assistive cares service providers if they house fewer than seventeen individuals. Statewide there are 116 mental health residential treatment facilities with a bed capacity of 1,925 and 747 assisted living facilities with a bed capacity of 13,962. A January 1, 2004 estimate of the number of severely and persistent mentally ill population in Florida is 320,007, with half of that population estimated to be eligible for publicly funded adult community mental health services. Obviously, there is a shortage of long-term supervised housing that would benefit this population.

D. Summary of Part VI

Jail diversion and aftercare programs in Florida are modeled on national standards. Pre-arrest Crisis Intervention Teams (CITs) are designed to divert the mentally ill to appropriate community mental health treatment upon contact with police in lieu of arrest. CITs are composed of volunteer police officers who have received at least 40 hours of specialized training. In Florida, standardized training modules are in development that include customized components such cultural diversity mental health issues. Reporting standards that include outcome information are also in development and will be shared with the state mental health program office. CITs currently exist in a five urban regions of the State of Florida.

Post-arrest mental health courts are designed to reduce jail time and obtain treatment for the mentally ill. Mental health courts for non-violent misdemeanor violators exist in six counties in the State of Florida. The mental health court was pioneered in Broward County. The Broward County mental health court continues as a national role model with the addition of a low level felony offender mental health court.

Post-incarceration jail linkage programs are designed to place a mentally ill inmate, upon release, in the care of the local community mental health system. Florida Assertive Community Treatment (FACT) teams are designed to provide 24 hours a day, 7 days a week, comprehensive mental health services delivered by a multidisciplinary treatment team that is responsible for identified individuals who have a serious mental illness. There are 30 FACT teams in 22 Florida counties treating over 2,000 individuals.

Long-term supervised housing is a key component in all mental health diversion programs in Florida. Mental health residential facilities, assisted living facilities and adult family-care homes provide such housing. However, the demand for such housing far exceeds their capacity in Florida.

PART VII

Perspectives from the Field: Survey Results from Sheriffs, Recent Studies of Orange and Sarasota Counties, and a Recent Miami-Dade County Grand Jury Report

In 1999, a survey of mental health services and procedures was conducted by the Louis de la Parte Mental Health Institute of the University of South Florida in each Florida jail with the assistance of DCF District Forensic Specialist. Initially, LCIR staff planned to perform a similar five-year follow-up survey for this review. However, four hurricanes then hit Florida in the summer of 2004 and these plans were curtailed because of county and DCF workload disruptions. Instead, a modified survey was sent to each Sheriff through the Florida Sheriffs Association. The original survey was sent out on September 30, 2004 and a follow-up request was sent on October 25, 2004. Twenty responses have been received to date from large, medium and small counties. Sometimes survey respondents did not answer all the questions or gave multiple responses to a question. Also, each Sheriff's Office that responded relied on several different individuals to complete the survey. The information provided through the LCIR survey of the Sheriff's office is supplemented by recent studies related to the community mental health systems in Orange and Sarasota counties and a recent Miami-Dade County Grand Jury Report.

The survey was designed to examine the processes, costs, and challenges relating to individuals with mental health problems that come in contact with the county jail system. The survey questions were formulated to augment information collected at the state level on the impact of the mentally ill on county jails. This survey does not include questions on pre-arrest (Crisis Intervention Teams) and post-arrest (Mental Health Courts) diversion programs that are known to exists in certain jurisdictions.

The questionnaire was organized in five sections (A- E). The sections include:

A. Baker Act Transportation Costs (Sheriff's Office and Jail)
B. Utilization of Florida Assertive Community Treatment (FACT) Programs
C. Challenges and Recommendations (opinions)
D. Potential Impact of Recent Baker Act Legislation (Ch. 2004-385, L.O.F. also known as SB 700)
E. Additional Comments

A. Baker Act Transportation Costs

Respondents from 17 county Sheriffs' offices provided enough fiscal information on Baker Act transportation costs to calculate cost per trip to a Baker Act receiving facility such as a Crisis Stabilization Unit. A Crisis Stabilization Unit provides secure residential short-term acute care mental health services 24 hours a day seven days a week. The responses indicate that in the more rural counties without nearby receiving facilities, costs per trip were much higher than areas with nearby receiving facilities.

The respondent from Taylor County reported that Baker Act transportation costs per trip averaged $125 in fiscal years ending September 30, 2003 and 2004. At the other end of the cost spectrum was Palm Beach County, reporting $20 per trip in 2003 and $19 per trip in 2004. Ten Sheriffs' offices reported accounting for these costs in the Sheriff's general operating budget,

while jails paid for these costs in 4 counties. The lowest number of trips reported was 7 in 2003 in Nassau County. The most trips reported were 1,620 in 2004 in Polk County.

B. FACT Programs

The questionnaire asked about the utilization of the Florida Assertive Community Treatment (FACT) programs, if such programs exist in the community mental health system that serves inmates in the respondent's jail jurisdiction. In particular, the questionnaire asked about the effectiveness of the FACT program in lessening the impact of individuals with mental health problems on the Sheriff's deputies and the jail. Information on the FACT program was provided in 10 questionnaire responses as well as in two studies that examine mental health services in Orange and Sarasota Counties. Most of the comments were favorable, though some were qualified.

The Palm Beach County Sheriff's Office responded to the LCIR survey that there is the Psycho Therapeutic Services/ Palm Beach County FACT in its jurisdiction. The survey response states that the FACT helps by reducing recidivism.

> *If recidivism does occur the severity of mental illness is tempered by the FACT involvement in treatment. The frequency and intensity of behavioral problems are also reduced. The FACT team also maintains community support systems during a subject's incarceration, open communication with our mental health staff, advocacy services in the court system and routine on site supplementary visits.*

The Sheriff's Office in Polk County responded in a similar manner.

> *There are two mental health Programs in Polk County that provide community based FACT teams: Winter Haven Hospital and Peace River Center. They each have a FACT team. The case managers are required to monitor the individuals while they are incarcerated. They assist with getting the jail information helpful to the individual's treatment and also assist with aftercare plans upon the inmate's release.*

The Jacksonville Sheriff's Office stated that persons in its FACT program are arrested less often and released sooner. The Sheriff's Office in adjacent Nassau County reports that Baker Act individuals from their jail use the Mental Health Center of Jacksonville. However, admission to the Jacksonville FACT is infrequent, thus minimizing any benefit to the Nassau County jail.

The Alachua County Sheriff's Office response relative to the benefits of its FACT program was very positive. However, only two or three inmates receive FACT services at any given time due to funding limitations.

Santa Rosa County is served by the FACT program in adjacent Escambia County, which is contacted and initiates the person's release.

The St. Lucie Sheriff's Office reserved judgment on the effectiveness of the two FACT teams in their county in reducing arrest and jail admissions, saying they have not received, to date, any supporting data from the teams.

In contrast, the Mental Health Coordinator at the Leon County Jail expressed the following frustration with the local FACT Team.

> *Apalachee Center's FACT team does not provide any services to inmates in the Leon County Jail. Now and then a FACT client will be arrested and brought to the jail and FACT is aware the inmate is in jail. They fail to do anything to assist the inmate in getting released. There currently is a FACT inmate in the jail who is going through the competency evaluation procedure and most likely will be found incompetent to proceed.*

In summary, the survey results indicate FACT teams are well regarded. FACT teams would likely be welcome by jail personnel in counties that are currently not served by them. Additional FACT teams would probably be welcome in areas where they already exist, especially if they operate like those in Palm Beach, Polk, and Duval (Jacksonville) counties.

In addition to the survey, LCIR staff became aware of two relevant studies and a Grand Jury Report that provided some information relevant to the questions being asked in the survey. This information is presented, when appropriate, as no surveys were submitted by the Sheriff's Office of the three counties covered by these studies and the Grand Jury Report.

The Orange County study was conducted by the Center for Community Partnerships, College of Health and Public Affairs of the University of Central Florida and was funded by DCF and the Orange County Board of County Commissioners. The study focused the Orange County Central Receiving Center and reviewed best practices in community mental health and substance abuse services. The Orange County study concluded that its FACT program, operated by Lakeside Alternative, adheres to all the national standards that are associated with positive outcomes for its clients.

These FACT program national standards include a clinical staff/client ratio of 1:10, with specific specialist, including psychiatrists, a program assistant, a team leader, registered nurses, licensed mental health professionals, licensed or non-licensed masters level mental health/substance abuse specialist, mental health client peer specialist, mental health workers, and vocational educators. Other national standards that are empirically defined include staff roles, program size (100 maximum) and intensity, admission and discharge criteria, office space, hours of operation, team communication and planning, policy and procedure manual, and records and documentation. Although the study indicates that forensic mental health services are permissible if the eligibility criteria is met, no indication of actual involvement was mentioned. At the time this study was published in August of 2004, this FACT program served 100 people, with a waiting list of 28.

The Community Alliance of Sarasota County issued an Acute Care System Issue Analysis Report on January 27, 2003. According to this report, their FACT program, which serves

Sarasota and Desoto counties, was gearing up its capacity to the optimal maximum size of 100 clients, with 65 active clients at that time. No mention was made regarding the program's relationship with the judicial system.

C. Challenges and Recommendations

Knowledgeable personnel in each Sheriff's office were asked a series of questions in the LCIR survey related to the challenges and recommendations of delivering services to the mentally ill in their jails. Again, opinions were solicited on how the situation has changed in the last five years. The specific questions, listed as subheadings below, solicit responses about the biggest problems, challenges, effectiveness of services, barriers, and recommendations relating to the treatment and care of their jail's mentally ill inmates. The Orange County and Sarasota County reports as well as the Miami-Dade County Grand Jury Report are integrated into the responses when appropriate.

1. Relative to other problems your county's jails face, how big of a problem do inmates with mental illness pose compared to five years ago? [much less, less, about the same, more, much more]

Seventeen Sheriffs responded to this question. Eight of the respondents indicated that mentally ill inmates pose "much more" of a problem and six respondents said they pose "more" of a problem now than five years ago. Responses from Nassau and Okeechobee counties indicated "no change", while the Polk county response indicated having "less" of a problem now than five years ago. The Osceola and Hernando Counties Sheriffs' Offices indicated that the jails in their counties are separate from the Sheriff's Office.

The Alachua Sheriff's Office offered the following reasons why there is more of problem now posed by inmates with mental illness than five years ago:

1. *Longer waiting lists for state hospital beds*
2. *The judiciary in this community is beginning to use 'trans-institutionalization' as an option (i.e., using the county jail as a place to hold those inmates found incompetent to do incompetency training or further evaluation for determination of appropriate placement.)*

The long waiting list for state hospital beds was also mentioned in response to other questions in the Leon County and Santa Rosa County survey responses.

The Miami-Dade County Grand Jury Report provided a 20 year snapshot of change that illustrates the dramatic increase in inmates with psychiatric problems.

> *In fact, one of the clearest indicators of the crisis that exists in our community is the present situation at the Pre-trial Detention Center, commonly referred to as the Dade County Jail. The jail has nine (9) floors. In 1985, inmates with psychiatric problems occupied 2 out of 3 wings on one floor in the jail. Each inmate had his own bed and there were approximately eighty (80) such inmates.*

Today there are more than eight hundred to twelve hundred such inmates in the jail at any given time who are experiencing some form of mental illness. Some of their conditions are so severe, that they cannot be housed in the general population. Instead, these "chronic" cases now occupy 3 wings on three floors! Included in the group of inmates are defendants whose mental illness is so "acute" they are placed in safety cells and checked every fifteen minutes to prevent suicides or serious bodily injury.

2. What is the biggest challenge faced in managing inmates with a mental illness in your jails? Has this changed in the last five years?

Next, Sheriffs were asked to describe the biggest challenge faced in managing inmates with a mental illness in their jails. Seventeen responded, many citing multiple challenges. Only one respondent (Alachua) views its biggest challenge ("resources") as remaining the same over the last five years. All other respondents view their challenges as increasing in size.

The most frequently reported challenge was the housing of mentally ill inmates (7 mentions). The general feeling is that they require more intensive supervision and are associated with disciplinary problems when mixed with the general jail population. In small jails, respondents note that there is no choice but to house the mentally ill with the general jail population, which creates problems. Getting inmates to take prescribed medications and the rising costs of those medications was also a frequent response (4 mentions each). Lack of training for jail staff in dealing with the mentally ill was mentioned three times.

The Levy County Sheriff's Office response illustrates several challenges in rural counties:

> *When they arrive, court proceedings seem to stop. For example, two inmates could have the same charges and arrive at the same time to the jail. If one of them has a mental illness, they could face up to three times the length of stay verses the one that presents without any mental illness. For the jail, it is hard to keep them separated from the other inmates due to the overcrowding. In addition, the cost of medication for these inmates once they are treated with medication averages between $580.00 to $800.00 (depending on the prescriptions). This has greatly increased in the past five years.*

An interesting observation was made by the Medical Department Supervisor of the Nassau County Jail:

> *The biggest challenge faced by the jail in managing inmates with a mental illness has changed in the last five years. The tracking of medication and treatments administered through outside resources to inmates coming into or returning to jail with a mental illness has become more difficult.*

A final illustration of challenges faced in managing inmates with a mental illness comes from the Okaloosa County Department of Corrections.

There are several challenges that include the following:

- *a.* *Officers are not trained to deal with the mentally ill*
- *b.* *Health services in jails are not staffed to deal with the mentally ill*
- *c.* *A jail cannot force medication on a inmate that is non-compliant until they become dangerous*
- *d.* *It is a revolving door as they get out and quit taking medications then return to jail*
- *e.* *As they continue to come back the charges usually become more serious.*

3. How has the overall effectiveness of your jail's services for inmates with mental illness changed in the last five years?

Seventeen Sheriffs described changes in the overall effectiveness of their jails' services for inmates with mental illness. Five responses indicated a decline in effectiveness. Alachua County responded that the mentally ill population has gone up without an increase in staff, resulting in a decrease in effective services. Taylor County voiced a similar complaint. Nassau County cited increasing costs and decreasing availability of mental health professionals as problems. Palm Beach County mentioned that comprehensive mental health services have decreased. Levy County indicated that the local mental health service provider has cut down their service to 'emergency crisis screening' only and does not accept inmates needing hospitalization or counseling. The Levy county jail does not provide mental health services.

Two Sheriffs, in Bradford County and Santa Rosa County, indicated that the effectiveness of services for the mentally ill in their jails has changed little in the past five years. The Washington County response was that the jail staff was better prepared, but the lack of resources rendered them ineffective.

The responses of the Sheriffs' survey in seven counties were more positive. Duval County (Jacksonville) reported the effectiveness of their jails services for inmates with mental illness has improved in the last five years. Duval County further stated that this was

> *due to having a full time psychiatrist as part of our medical services contract, an increase in the number and availability of our mental health counselors, daily contact with the first appearance court judges by our court liaison and intensive training of our correction officers supervising the mentally ill. We divert more mentally ill inmates from the system sooner, and personnel trained in managing the mentally ill supervise those who remain incarcerated.*

The Leon County response illustrates a change toward privatization of mental health services in jail.

> *The Sheriff's Office now contracts with a private corporation, Prison Health Service (PHS) to provide all health care, including mental health. The decision to contract with a private corporation was largely due to the difficulty in hiring qualified personnel and the ever increasing costs associated with mental health care. On the average, the jail has a population of between 1,100 and 1,200*

inmates on any given day. There is one part-time psychiatrist and one full-time mental health coordinator responsible for delivering mental health services to the entire jail population.

The Okaloosa County response further amplifies potential benefits and challenges of privatizing mental health care.

The effectiveness has increased with the contracting of PHS as they screen all inmates entering the jail to determine if there is a history of mental illness as well as other medical problems. They also get medication verification quickly to provide a continuity of care in continuation of medication. The challenge has been that these inmates are causing an increase in Use of Force incidents of officers which leads to increase in costs and liability.

The Okeechobee County Sheriff's Office responded that changes are made yearly to mental health services, depending on changing needs, and seems to work well. The Polk county response emphasized improved effectiveness through developing relationships with local mental health facilities and utilizing special needs units.

The mental health staff now can assist with placement of individuals who are to be released. Aftercare appointments are scheduled and contact with local mental health facilities have improved over the years. The special needs unit is a good idea in managing inmates while in jail.

The Martin County Sheriff's Office responded in a similar manner to Okeechobee County and Polk County.

The service our facility provides has improved greatly. Our facility contracts its mental health services with New Horizons of the Treasury Coast and they provide all mental health services needed. We are continually reviewing our needs and institute changes when necessary. Statistics show the services provided have increased steadily over the past few years. This increase is partly from an increase in population, but can also be contributed to the increase of the services we provide, such as FACT team, drug treatment, etc.

Finally, St. Lucie County identified the improvements to the provision of effective mental health service in their jail.

We have instituted processes that identify these patients immediately upon arrival at the facility and attempt to contact the attending medical provider to ascertain current medications, therapy, diet, etc. If the information can be obtained immediate action is taken to remain within established protocols of the community physician. Early identification, continuity of care during incarceration and upon release has increased the overall effectiveness in the St. Lucie County Sheriff's Office mental health program. Our community mental health provider

(New Horizon) has a legislative budget request in for a Family Intervention Treatment Center to assist and enhance the current jail diversion program.

4. What is the biggest barrier to delivering more effective mental health services to inmates? Has this changed in the last five years, and if so how?

Sheriffs in 15 counties provided meaningful comments on barriers to delivering more effective mental health services to inmates. Costs or availability of medications was cited four times (Alachua, Duval, Leon, and Marion). The shortage or availability of community mental health resources was also mentioned four times (Duval, Leon, Levy, and Okaloosa). Funding issues were mentioned three times (Levy, Palm Beach, and Washington). A variety of other barriers were described in the responses, with several relating to communication.

Nassau County jail personnel describe a classic problem cited in research regarding communication.

> *Lack of communication between community mental health workers and the facility medical staff seems to be the biggest barrier in delivering more effective services to inmates. Without prior knowledge of former and current treatments an inmate has undergone the facility medical staff and mental health providers must evaluate the inmate and possibly administer treatments that have failed in the past. Therefore, prolonging a positive treatment outcome.*

This is a similar observation to that relayed by a Leon County respondent cited earlier in the survey results. The St. Lucie response lays some of the blame for difficulties in obtaining medical histories on the newer federal legislation that increases confidentiality of medical histories such as the Health Insurance Portability and Accountability Act of 1996.

There is another type of classic communication barrier that is described by the following response from Polk County jail staff.

> *The biggest barrier is communication between all the mental health parties involved with the inmate. Communication is poor between the public defender's office, the state attorney's office and even judges. It is difficult to schedule such things as aftercare appointments and placement when it is not known when an inmate is getting out of jail or what is happening with his case.*

Several other comments about barriers deserve mention. Palm Beach noted that the interaction of tight budgets, lack of physical facilities and an increasing mentally ill jail population has led to scaled back mental health services. The Taylor county jail administrator wants more receiving facilities, presumably closer by and made available to mentally ill inmates at his jail. Finally, personnel from the Sheriff's Office in Monroe County responded that they want a

> *Court Diversion Program for the mentally ill inmate, where they can be court ordered to a mental health institution.*

5. What would you recommend to alleviate the impact of the mentally ill on your county's jails?

The final policy-related question in the Challenges and Recommendations section asked for recommendations on how to alleviate the impact of the mentally ill on their county's jail. Seventeen survey responses were received on this question. Nine respondents advocated an increase in community mental health resources (Alachua, Bradford, Duval, Martin, Nassau, Okaloosa, Palm Beach, Polk, and St. Lucie Counties). Six respondents mentioned the need for additional secure community mental health facilities such as Crisis Stabilization Units or additional secure state mental health hospital beds (Marion, Okaloosa, Okeechobee, Santa Rosa, Taylor, and Washington Counties). Six respondents wanted to see the establishment of some form of diversion program such as a pre-arrest Crisis Intervention Team (Bradford, Duval, and St. Lucie Counties) or post-arrest Mental Health Court (Leon, Monroe, and Levy Counties). Four respondents mentioned the need for more affordable or assisted living or long-term care beds in their communities (Alachua, Marion, Polk, and St. Lucie Counties). Several responses are quoted below to illustrate these patterns.

Interestingly, the judicial circuit serving Alachua County has a respected mental health court as mentioned in the response from Taylor County. The Alachua Sheriff's recommendation for alleviating the impact of the mentally ill on the county jail follows.

1. *Community, judiciary and local government education in reference to the severity of this problem and address the need for funding further both for the jail and community programs to deal with mentally ill defenders. Locally, a Crisis Intervention Task Force has recently been formed and will assist with education and training.*
2. *Affordable community housing—housing in this community, as a result of being the home of a large University, is very expensive. The lack of affordable housing causes problems for people living on SSI as a result of mental illness. The lack of housing directly impacts the number of arrests for this population.*

Next, the Duval (Jacksonville) response addresses the dual need of pre-arrest diversion programs and maintaining sufficient community mental health resources. To lessen the impact of the mentally ill on the jail population:

> *Provide the appropriate amount of funding to maintain community based mental health services and ensure the community providers are considered a stakeholder in the criminal justice process for the mentally ill. Ensure the continuance of our mental health diversion program and our Crisis Intervention Team, a group of police, corrections and civilian personnel who receive advanced training in managing the mentally ill and are more familiarized with community resources.*

The Okaloosa County Department of Corrections response addresses the importance of community resource and nearby secure mental health receiving facilities.

The way to reduce the impact of the mentally ill in jails is to provide increased funding that would help provide services for them outside of the jails. There are not enough beds or agencies that provide emergency services nor is there enough funding to assist in follow-up care once they are released from custody. This county has two receiving facilities for Baker Act emergencies and both are located 40 to 50 minutes from the jail. Many law enforcement officers located in the vicinity of the jail will bring the mentally ill to jail as opposed to transporting them the extra hour to take them to a receiving facility.

The Miami-Dade County Grand Jury Report strongly recommended that every police department in Miami-Dade County create Crisis Intervention Teams with its uniformed officers. In addition, the report recommended that Miami-Dade county correctional officers in contact with mentally ill inmates receive CIT training.

D. Potential Impact of Recent Baker Act Legislation (Ch. 2004-385, L.O.F. also known as SB700)

In 2004, the Baker Act was amended to allow for involuntary outpatient commitment to begin on January 1, 2005. DCF is amending Ch. 65E-5, F.A.C., to comply with this change, with an effective date expected in early April, 2005.

Sixteen comments were received on how the implementation of SB700 will impact their Sheriff's Office and Jail. Results were mixed. Four responded that they did not know (Hernando, Marion, Nassau, and Palm Beach Counties). Three respondents stated there would be no change (Alachua, Okeechobee, and Taylor Counties). One respondent stated that there would be little change, unless funded (Leon County). Another respondent (Washington County) stated that their "facility is ill equipped and underfunded to deal with any mandated adjustments." Four respondents stated that their jails may receive a few more mentally ill inmates (Duval, Levy, Okaloosa, and Osceola Counties). In contrast, three respondents stated that implementation of involuntary outpatient commitments will have a positive impact on their Sheriff's Office and jail (Monroe, Polk, and St. Lucie Counties).

The Orange County Central Receiving Center study published in August of 2004 contains a section on involuntary outpatient placement. Major components include:

1. *ACT, Intensive Case Management, or other case management*
2. *Medication Evaluation and Management*
3. *Supportive Housing*
4. *Supportive Education/Supportive Employment*
5. *Psychotherapy (individual, family, group, rehabilitation, etc.)*
6. *Consumer Self-Help Initiatives.*

The report states that it is unknown what impact this change will have on Orange County's community mental health and substance abuse system and does not address any impacts on the jail system.

The Miami-Dade County Grand Jury Report noted that the Baker Act reform bill had no appropriation attached to it. The Report recommends that the Florida legislature:

> *provide funding to increase the number of community based mental health facilities and thereby increase the number and level of services available to the mentally ill in our state.*

E. Additional Comments

Respondents to the LCIR survey of the Sheriff's Office were invited to make any additional comments with regard to the mentally ill population and the county jail system. Fourteen responded. The thrust of the Alachua County Sheriff's Office's response was echoed by several other respondents as well as the Miami-Dade County Grand Jury Report. A portion of the Alachua County Sheriff's Office's response follows:

> *...unfortunately, the county jails have become de facto mental health institutions for counties. Detention Officers are not trained to handle these individuals versus mental health caseworkers, who would be; yet, they have charges placed against them and find themselves incarcerated. More dedicated community mental health dollars should be explored versus having these challenged individuals face arrest and/or conviction for crimes that could, perhaps, have been avoided with expanded community mental health treatment.*

The tenacity of community mental health workers is also seen as an important element in preventing the mentally ill from coming in contact with county jails. The Registered Nurse for the Levy County Jail, who also works as a part-time employee for Shands Hospital Vista, a mental health facility in Gainesville, Florida, offered the following comments.

> *I have seen many mental health clients get arrested when they have stopped taking their medications. This is very dangerous! If mental health clients were followed closer and not considered a 'closed case' when the client has missed appointments or landed themselves in jail, the end result might be beneficial for all.*

The Medical Contract Monitor for the Marion County Jail made the following comments.

> *In the past few years we have seen more severe and acute cases in our jails. These inmates get caught up in the Criminal Justice System and spend sometimes years going between jails and the State Hospital facilities. It appears that there are not enough beds in the State Mental Health System and inmates with Mental Illnesses get bottle necked in the County Jails.*

The Program Manager for the Okaloosa County Department of Corrections made the following comments on why the number of mentally ill is increasing in their jail population and suggests some changes.

It has been reviewed by many committees in an effort to learn why there is an increased level of mentally ill persons incarcerated. The problem seemed to increase with the closing of many residential treatment facilities. There have been fewer and fewer residential treatment facilities that offer housing and care to those who have criminal histories and there are no secure housing areas available other than the Florida State Hospital that assist in helping forensic clients become stable then return to the community. There are step programs available for those people with drug and alcohol problems that are secure then give them more freedom as they become able to accept it but with mental illness, the client is either in a secure setting such as jail or lockdown or in a non-secure setting where they can leave anytime they want. There is nothing that starts them in a secure setting, holds them until they are stable and gradually allows them passes into the community. This should be a process that evolves over three to six months of treatment then allows them to return to a non-secure setting. This state has reduced funding to programs across the state that offers any type of long term residential treatment to those with mental illness. This county has made progress, although slight, in attempting to increase the continuity of care once they are no longer incarcerated but since the court decisions are not known prior to court dates, many times the inmate is released without the case manager's knowledge so the inmate has very little medication and no follow-up doctor's appointment or even a place to live.

The Community Alliance of Sarasota County Acute Care Issue Analysis mentions that a lack of diversion programs for those persons with a mental illness who are arrested for misdemeanors and end up in jail is a major concern. Related concerns about community mental health services in general include a lack of publicly funded mental health and detoxification treatment beds; a lack of well-defined written protocols among mental health service providers, including law enforcement, out-of-county and transportation providers; and the lack of a well-defined leadership group that should be responsible for developing a community mental health system.

The Orange County study notes that the percentage of CIT trained law enforcement officers varies among law enforcement agencies within Orange County, generally falling below the nationally recommendations designed to achieve 24 hour full area coverage. Wide variation regarding communication between police dispatchers in the numerous police departments in Orange County and trained CIT personnel is cited as causing CIT officers not arriving on the scene in a timely manner.

F. Summary of Part VII

As a part of this review, each Sheriff's office was sent a survey by the LCIR in the fall of 2004. The survey was designed to elicit information from the experts in the Sheriff's office on the processes, costs, and challenges relating to individuals with mental health problems that come in contact with the county jail system. Special emphasis was placed on how things have changed in the last five years. The survey questions were formulated to augment information collected at the state level on the impact of the mentally ill on county jails. Responses were received from twenty

Sheriff's offices from small, medium and large counties. The information provided through this survey is supplemented by recent studies related to the community mental health systems in Orange and Sarasota counties and a recent Miami-Dade County Grand Jury Report.

The Sheriff is responsible for providing Baker Act transportation. The reported costs per Baker Act trip was higher in the rural areas such as Taylor County ($125/ trip), served by remote Baker Act receiving facilities, than in more urban areas such as Palm Beach County ($20/trip) with nearby receiving facilities. The reported yearly number of Baker Act trips ranged from 7 in Nassau County to 1,620 in Polk County.

In general, FACT teams are well regarded as evidenced by the study and survey results reported in this section of the review. FACT teams would likely be welcome by jail personnel in counties that are currently not served by them. Additional FACT teams would probably be welcome in areas where they already exist, especially if they operate like those in Palm Beach, Polk, and Duval (Jacksonville) counties.

Most respondents indicated that mentally ill inmates pose a greater problem now than five years ago. The most frequently reported challenge faced in managing inmates with mental illness was this housing once in jail. The general feeling is that they require more intensive supervision and are associated with disciplinary problems when mixed with the general jail population. In small jails, respondents note that there is no choice, but to mix the mentally ill with the general population. Getting inmates to take prescribed medications and the rising costs of those medications was also a frequent problem cited along with the lack of training for jail staff in dealing with the mentally ill.

Most, but not all, respondents reported that the overall effectiveness of their jail's services for inmates with mental illness has declined in the last five years. Jurisdictions that reported improved services attributed the improvements to outsourcing of mental health services, increases in mental health staffing levels or improvements in communication with the local community mental health system.

The biggest barriers to delivering more effective mental health services were reported as being the costs or availability of medications, the shortage or availability of community mental health resources, funding, and communication. Conversely, respondents' recommendations to alleviate the impact of the mentally ill on their county jails included, in order of decreasing frequency: (1) increase community health resources, (2) add secure community mental health facilities or state mental health hospital beds, (3) establish some form of diversion program, and (4) add more affordable or assisted living or long-term care beds in their communities. Additional comments amplify these concerns and recommendations.

In 2004, the Baker Act was amended to allow for involuntary outpatient commitment to begin on January 1, 2005. DCF is amending Ch. 65E-5, F.A.C., to comply with this change, with an effective date expected in early April. Respondents' comments on the potential impact of these changes were mixed, ranging from no opinion, to no change, to a possible slight increase in mental health inmates. Several respondents viewed the changes favorably. State funding was

seen as a missing ingredient to potential benefits of the recent Baker Act changes by one respondent and echoed in the Miami-Dade County Grand Jury Report.

PART VIII
Significant Pending Issues at the Federal Level

Issues regarding the mentally ill and jail are not unique to Florida. In recognition of a nationwide mental health problem, President George W. Bush created the New Freedom Commission on Mental Health in 2002 to study national mental health issues, including those related to the criminal justice system, and make recommendations.[72] The Commission's Final Report was issued in July of 2003.[73] In addressing mental health problems in the criminal justice and juvenile justice systems, the Commission made the recommendation to widely adopt:

> *diversion and re-entry strategies to avoid the unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illnesses. HHS and the Department of Justice, in consultation with the Department of Education, should provide Federal leadership to help States and local communities develop, implement, and monitor a range of adult and youth diversion and re-entry strategies.*

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004, S.1194, became Public Law No: 108-414 on October 30, 2004. This law directs that grants be used to create or expand mental health courts or other court-based programs, in-jail transitional services, specialized mental health training and services, and support intergovernmental cooperation between State and local governments with respect to the mentally ill offender. The law authorizes $50 million in FY 2005 and such sums as necessary for fiscal years 2006 through 2009.

The Miami-Dade County Grand Jury Report filed January 11, 2005 reported that the Miami Criminal Mental Health project was awarded a one million dollar grant from the federal Substance Abuse and Mental Health Administration to expand the existing pre and post jail diversion programs. The pre-arrest program follows the CIT model. The post-arrest program diverts eligible misdemeanor defendants to community mental treatment within 24 to 48 hours of arrest. This project includes a comprehensive case management program that addresses transition and housing issues as well as substance abuse.

The cost savings of a federally supplemented project such as the Miami Criminal Mental Health project pointed out in the Miami-Dade County Grand Jury Report are numerous:

1. The daily jail costs for housing which includes the feeding and treating the inmates in jail and the additional correctional officers who are needed to monitor the mentally ill jail population (for example, $125/day for mentally ill defendants versus $18/day for general population defendants in Miami-Dade County and $125/day for mentally ill defendants versus $78/day for general population defendants at the Broward County Jail).
2. The length of time mentally ill defendants stays in jail (up to eight times longer than the general population).

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[72] Executive Order 13263, President's New Freedom Commission on Mental Health.

[73] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

3. Court Costs (may include at least one court-ordered and sometimes three psychiatric evaluations if requested by the public defender and state prosecutor for accused felons at the rate of $150/ evaluation in Miami-Dade County).
4. Expenses of the judge, court clerk, bailiff, prosecutor, defense attorney, court reporter, correctional officers and others who are present every time the case appears on a court calendar.
5. Costs of taking police officers off the street to appear for trials and hearings.

Federal funds dedicated to adult mental health and especially the mental health of those incarcerated are scarce but do exist.

PART IX
Major Findings

This part describes major findings, drawn from previous studies, the LCIR survey of Sheriffs' offices in Florida, and recent studies related to the community mental health systems in Orange and Sarasota counties and a recent Miami-Dade County Grand Jury Report.

- Community mental health services in Florida are funded by federal, state, and local-matching funds. Local-matching funds are generally required by statute to draw down federal grants. Medicaid does not have a local-matching requirement and is now the major funding source in the federal-state-local mix.
- The courts have interpreted the 8th Amendment to the U.S. Constitution, prohibiting cruel and unusual punishment, to require the provision of basic mental health care in prisons and jails such as systematic screening and evaluation, treatment including making medications available, and suicide prevention.
- Medications and services provided to the mentally ill in jail are funded by the county. Increases in the costs of anti- psychotic medication are a frequently cited problem by Florida jail personnel.
- Although jails in Florida screen for mental illness and have suicide prevention programs, with larger jails providing more elaborate treatment and in-jail housing options, resources within the criminal justice system necessary to cope with the mentally ill are inadequate.
- Inadequate public funding for community mental health services is widely viewed as negatively impacting the treatment of the mentally ill in Florida, limiting the ability of the criminal justice system to divert the mentally ill from jail to more appropriate community mental health settings, and limits aftercare of the mentally ill upon release from jail. Funding of recent changes to the Baker Act allowing involuntary outpatient placement is seen as important, if not essential, to its implementation.
- The most prevalent pre-booking diversion program recognized as a best practice and present in Florida is the police-based Crisis Intervention Team (CIT). CITs exist in various police departments in large urban counties. Recent studies report that not all elements of a model CIT in at least some CITs. Florida state mental health program staff indicates that training modules and reporting practices are still under development.
- Post-booking diversion programs must include a negotiation that reduces penalties or waives penalties pending successful completion. Studies indicate that a significant number of jails that claim to have a jail diversion programs fail in this criterion. Mental health courts for individuals with mental illness who have been charged with a non-violent misdemeanor offense are another type of post-arrest diversion program, existing in five Florida counties. Broward County has the longest standing mental health court and now includes individuals charged with low-level felonies.
- Post-incarceration programs rely on linkages to effective community treatment programs. The program of choice at this time is the Florida Assertive Community Treatment (FACT) team. Currently, there are 30 operational FACT teams in Florida, with others in the process of being activated. Essentially, FACT teams treat the most severely mentally ill individuals around the clock with diverse and specialized mental health and vocational services, assisted living and intensive team case management.

PART X
Recommendations

The LCIR approved the following recommendations:

- Monitor Florida's utilization of federal grant monies made available by P.L 108-414 and other federal sources and support future funding.
- Encourage and support the Department of Children and Families in developing the training and reporting components of the police-based Crisis Intervention Team programs and other pre-arrest diversion programs as deemed appropriate by local community mental health systems. In the past, costs have been shared among the program developers and program beneficiaries.
- Continue to fund and expand the Florida Assertive Community Treatment teams and encourage routine communication with the judicial system, especially appropriate jail personnel.
- Continue to utilize federal matching dollars to the extent possible for the delivery of community mental health case management and services.
- Encourage the Department of Children and Families to work with the federal government to promote that more flexible spending requirements be attached to federal funding sources, coupled with outcome reporting requirements.

Attachment 1

Standards for Assisted Treatment: State by State Summary

Standards for Assisted Treatment: State by State Summary

Last updated July 12, 2004
print the PDF version of this file

ADDITIONAL INFORMATION
text summary by state | database of preventable tragedies | consequences of nontreatment | myths about assisted treatment | press room

This chart captures the most essential information about the laws for assisted treatment in each state, including the following information.

Need For Treatment
States with this column marked have a standard for assisted treatment that includes eligibility criteria permitting the placement in treatment of those overcome by mental illness based on the need for treatment. The standard in such a state normally includes other requirements, such as the inability to make an informed medical decision. Some standards that are arguably need for treatment based standards have not been classified as such because of their limited scope. For instance, the first generation "gravely disabled" standard found in many states requires that a person be unable to access food, shelter, etc., to a degree that causes a substantial physical danger has not been classified as a need for treatment standard. Whereas, those gravely disabled standards that allow for treatment based on a person's inability to provide for needed psychiatric care have been designated as need for treatment based criteria. The standards of exactly half of the states and the District of Columbia met or exceeded this limited need for treatment threshold.

Assisted Outpatient Treatment (AOT)
States with this column marked allow for assisted outpatient treatment, which is a form of court-ordered treatment on an outpatient basis. Classified as states that do not have AOT are those that allow for the conditional release of patients already under inpatient treatment orders but not direct placement in court-ordered outpatient treatment of those who are not. Forty-two states have laws for assisted outpatient treatment (although far fewer make effective use of those laws).

Relevant Code Sections
The sections of the state's code containing the standard for treatment placement. Language is available at www.psychlaws.org.

Standard
This is a summary of the state's standard for treatment placement. These are the key elements of the state's requirements for the placement in treatment of a person who refuses treatment because of the symptoms of mental illness. Please take note that while these descriptions do contain much of each standard's actual language, they are summaries of only the most crucial provisions of the pertinent statutes for each state.

[illegible]	[illegible]	AOT	[illegible]	[illegible]
Alabama	x	x	Ala. Code § 22-52-10.4 § 22-52-10.2	**Inpatient:** A real and present danger to self/others, without treatment will continue to suffer mental distress and deterioration of ability to function independently, and unable to make a rational and informed decision concerning treatment. **Outpatient:** Without treatment will continue to suffer mental distress and deterioration of the ability to function independently and the respondent is unable to make a rational and informed decision concerning treatment.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Arizona	x	x	Ariz. Rev. Stat. § 36-540(A) § 36-501(5), (6), (16), (33)	**Inpatient and Outpatient:** (1) Danger to *self/others*; (2) *in danger from* inability to provide basic physical needs; or (3) likely to suffer severe and abnormal mental emotional or physical harm without treatment, likely to benefit from treatment, and substantially impaired capacity to make informed decisions regarding treatment.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible] injury, or serious physical or mental [illegible]
California		‡	Calif. Welf. & Inst. Code § 5250; § 5008(h)(1); § 5346(a)	**Inpatient:** (1) Danger to self/others or (2) unable to provide for basic personal needs for food, clothing, or shelter. **Outpatient:** Condition likely to substantially deteriorate, unlikely to survive safely in community without supervision, history of noncompliance which includes two hospitalizations in past 36 months or act/threat/attempt of violence to self/others in 48 months immediately preceding petition filing, likely needs to prevent meeting inpatient standard, and likely to benefit from assisted treatment. **‡Note:** Separate outpatient standard only available in counties that have adopted provisions established by Assembly Bill 1421 (2002) (a.k.a. Laura's Law); otherwise mandated outpatient treatment only permitted via conservatorship process.

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Connecticut			Conn. Gen. Stat. Ann. § 17a-498(c) § 17a-495(a)	**Inpatient:** (1) Danger to self/others or (2) in danger of serious harm from inability to provide for basic needs such as essential food, clothing, shelter or safety and unable to make a rational and informed decision concerning treatment.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
District of Columbia		x	D.C. Code Ann. § 21-545(b)	**Inpatient and Outpatient:** Danger to self/others.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Georgia	x	x	Ga. Code Ann. § 37-3-1(9.1) § 37-3-1(12.1)	**Inpatient:** In need of involuntary treatment AND (1) imminent danger to self/others, evidenced by recent overt acts or expressed threats of violence OR (2) unable to care for physical health and safety so as to create an imminently life-endangering crisis and in need of involuntary treatment. **Outpatient:** Based on treatment history or current mental status, requires outpatient treatment in order to avoid predictably and imminently becoming an inpatient and unable to voluntarily seek or comply with outpatient treatment.

Hawaii	x	x	Haw. Rev. Stat. [illegible]	Inpatient: In need of treatment AND either (1) imminent danger to self/others, including that of substantial emotional injuries to others OR (2) unable to provide for basic personal needs for food, clothing, or shelter [illegible] personal welfare [illegible] treatment. Outpatient: [illegible] substance abuse OR previously been imminently dangerous to self/others OR meets no.2, above AND capable of surviving safely in the community with available supervision; based on the treatment history and current behavior, treatment is needed to prevent [illegible]
Idaho	x	x	Idaho Code § 66-329(k) § 66-317(k), (m) § 66-339A	Inpatient: (1) Danger to self/others or (2) in danger of serious physical harm due to inability to provide for essential needs. Outpatient: Without treatment likely to become danger to self /others, lacks capacity to make informed treatment decisions, previous psychiatric hospitalization, previously failed to substantially comply with the prescribed course of outpatient treatment, and patient's disorder likely to respond to the treatment.
Illinois		x	405 Ill. Comp. Stat. [illegible]	[illegible] assistance of others.
Indiana	x	x	Ind. Code Ann. § 12-7-2-53 § 12-7-2-96 § 12-26-7-5(a) § 12-26-14-1 § 12-26-6-8-(a)	Inpatient: (1) danger to self/others; or in danger of coming to harm because either (2) unable to provide for food, clothing, shelter, or other essential human needs OR (3) substantial impairment or obvious deterioration that results in inability to function independently. Outpatient: Same as for inpatient except must also be likely to benefit from the recommended outpatient treatment program and not be likely to meet inpatient standard if compliant with the recommended program.
Iowa		x	Iowa Code § 229.14 § 229.1(15)	Inpatient and Outpatient: Lacks sufficient judgment to make responsible decisions concerning treatment AND is either (1) a danger to self/others, including that of serious emotional injuries to family members and others OR (2) unable to satisfy need for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death.

Kansas		x	Kan. Stat. Ann. § 59-2946a(f)(1) § 59-2967(a)	**Inpatient**: Lacks capacity to make informed decision concerning treatment AND either (1) danger to self/others/property OR (2) substantially unable to provide for basic needs, such as food, clothing, shelter, health or safety. **Outpatient**: Same as for inpatient except must also be likely to comply with outpatient treatment order and not likely be danger to self/others/community while subject to outpatient treatment order.
Kentucky [illegible]	[illegible]	[illegible]	Ky. Rev. Stat. Ann. § 202A.026 [illegible] 202A.011([illegible])	**Inpatient and Outpatient**: [illegible] self/others/family, [illegible] self/others/family of [illegible] as provision for [illegible] clothing; can reasonably [illegible] and hospitalization [illegible] treatment [illegible] [illegible] Kentucky [illegible] Act [illegible] that [illegible]
Maine	[illegible]	[illegible]	[illegible]	**Inpatient**: [illegible]
Maryland			Md. Code Ann., Health-Gen. § 10-632(e)(2)	**Inpatient:** Danger to self/others, in need of treatment, and unable or unwilling to be voluntarily admitted.
Massachusetts			Mass. Gen. Laws Ann. ch. 123, § [illegible] ch. 123, § 1	**Inpatient**: (1) Danger to self/others or (2) [illegible] substantial risk of physical impairment or injury because unable to protect himself/herself in the community.
Michigan	x	x	Mich. Comp. Laws Ann. § 330.1401	**Inpatient and Outpatient**: (1) Danger to self others; (2) unable to attend to basic physical needs such as food, clothing, or shelter necessary to avoid serious harm in the near future; or (3) unable to understand need for treatment and continued behavior reasonably expected to result in significant physical harm to self/others.

Minnesota [illegible]	[illegible]	[illegible]	[illegible]	Inpatient: (1) [illegible] ... OR (5) [illegible]
Mississippi	x	x	Miss. Code Ann. § 41-21-73(4) § 41-21-61(e)	**Inpatient and Outpatient:** A substantial likelihood of physical harm to self/others as demonstrated by (1) a recent attempt or threat to harm self/others or (2) failure to provide necessary food, clothing, shelter or medical care. Explicitly includes person who, based on treatment history, is in need of treatment to prevent further disability or deterioration predictably resulting in danger to self/others if unable to make informed decisions concerning treatment.
[illegible]	[illegible]	[illegible]	[illegible] § 632.005 [illegible] § 632.350(5)	[illegible] decisions, [illegible] basic necessities of food, clothing, [illegible] medical care, or necessary mental health care. Evidence may also include past patterns of [illegible]
Montana	x	x	Mont. Code Ann. § 53-21-126(1) § 53-21-127(7)	**Inpatient and Outpatient:** In determining whether the respondent requires commitment, the court shall consider the following (1) whether substantially unable to provide for basic needs of food, clothing, shelter, health, or safety; (2) whether recently caused self-injury or injury to others; (3) whether imminent danger to self/others; and (4) whether the respondent's mental disorder, demonstrated by the respondent's recent acts or omissions, will, if untreated, predictably result in deterioration to meet considerations nos. 1, 2 or 3. Predictability may be established by the respondent's relevant medical history. Commitments based solely on consideration no. 4 must be on an outpatient basis.

Nebraska		x	Neb. Rev. Stat. § 83-1009 § 83-1008	Inpatient and Outpatient: (1) Danger [illegible] self/others, all manifested by recent [illegible] violence or (2) substantial risk of serious harm [illegible] evidenced by inability to provide for basic human needs, including food, clothing, shelter, [illegible] medical care, or personal safety.
Nevada			Nev. Rev. Stat. § 433A.310(1) § 433A.115	Inpatient: Clear and present danger of harm to self/others and diminished capacity to conduct affairs, social relations, or care for personal needs. Explicitly includes the inability, without assistance, to satisfy need for nourishment, personal/medical care, shelter, self-protection or safety which will result in a reasonable probability that death, serious bodily injury or physical debilitation will occur within the next following 30 days.
New Hampshire	x	x	N.H. Rev. Stat. Ann. § 135-C:[illegible] § 135-C:[illegible]	Inpatient and Outpatient: A potentially serious likelihood of danger to self/others as evidenced by either (1) recent infliction of serious bodily injury [illegible] attempted suicide [illegible] [illegible]
New Jersey			N.J. Stat. Ann. § 30:4-27.2(m), (r), (h), (i)	Inpatient: Danger to self/others/property, unwilling to be *admitted* voluntarily, and in need of treatment. Danger to self explicitly includes the inability, without assistance, to satisfy need for nourishment, essential medical care or shelter.
New Mexico			N.M. Stat. Ann. [illegible] § [illegible]	Inpatient: Danger to self/others, likely to benefit from treatment, and proposed commitment is consistent with treatment needs and least drastic means. Harm to self including grave passive neglect.
New York	x	x	N.Y. Mental Hyg. Law § 9.31(c) § 9.01 § 9.60(C)	Inpatient: Danger to self/others, treatment in hospital is essential to welfare, and is unable to understand need for care and treatment. Outpatient: Unlikely to survive safely in community without supervision, history of noncompliance which includes two hospitalizations in past 36 months or acts/threat/attempt of violence to self/others in 48 months immediately preceding petition filing, unlikely to voluntarily participate, needs in order to prevent relapse or deterioration likely to result in serious harm to self/others, and likely to benefit from assisted treatment.

North Carolina	x	x	N.C. Gen. Stat. § 122C-268(j) § 122C-3(11) § 122C-267(h) § 122C-263(d)(1) § 122C-271(a)	Inpatient: Danger to self/others/property. [illegible] includes reasonable probability of suffering serious physical debilitation [illegible] without assistance, either [illegible] self-control, judgment, and discretion in conduct and social relations, or satisfy need for nourishment, personal or medical care, shelter, or self-protection and safety. Outpatient: Capable of surviving safely in the community with available supervision; in need of treatment to prevent further disability or deterioration predictably resulting in dangerousness; and inability to make informed decision to seek/comply with voluntary treatment.
North Dakota	x	x	N.D. Cent. Code § 25-03.1-07 § 25-03.1-02(12)	**Inpatient and Outpatient**: Danger to self/others/property if not treated. Harm to self includes substantial likelihood of deterioration in physical health/substantial injury/disease/death, based upon recent poor self-control or judgment in providing shelter/nutrition/personal care; or substantial deterioration in mental health predictably resulting in danger to self/others/property based upon objective facts of loss of cognitive or volitional control over thoughts or actions or based upon history, current condition, effect of mental condition on ability to consent.
Ohio	[illegible]	x	Ohio Rev. Code Ann. [illegible] 5122.10(C) [illegible] 5122.01(B)	Inpatient and Outpatient: (1) Danger to [illegible] serious physical [illegible] [illegible]
Oklahoma	x	x	Okla. Stat. Ann. tit. 43A, § 1-103(13)a. tit. 43A, § 1-103(18)	**Inpatient and outpatient**: (1) Danger to self/others evidenced by recent acts/threats; (2) severe impairment/injury will result from inability to avoid/protect self from impairment/injury; (3) serious harm in near future from inability to provide basic needs and needs not immediately available in community; or (4) person appears to require inpatient treatment and treatment is reasonably believed to prevent progressively more debilitating mental impairment.
Oregon	x	x	Or. Rev. Stat. § 426.005(1)([illegible]	**Inpatient and Outpatient**: (1) Danger to self/others; (2) unable to provide for basic personal needs and is not receiving care necessary for health/safety; or (3) chronic mental illness, two hospitalizations in previous three years, symptoms/behavior substantially similar to those that led to the previous hospitalizations, and will continue to physically or mentally deteriorate to either standard (1) or (2) if untreated.

Pennsylvania		x	50 Pa. Cons. Stat. Ann. § 7301(A), § 7304(f)	**Inpatient and Outpatient**: Clear and present danger to self/others; includes inability, without assistance, to *satisfy need for nourishment*, personal or medical care, shelter, or self-protection *and safety*, and reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days.
Rhode Island		x	R.I. Gen. Laws § 40.1-5-2(f) § 40.1-5-2 [illegible] § 40.1-5-[illegible]	**Inpatient and Outpatient**: In need of care/treatment in a facility and, [illegible] in the community, would be a danger [illegible]. Explicitly includes substantial [illegible] manifested by grave, clear and present [illegible] physical health and safety.
South Carolina	x	x	S.C. Code Ann. § 44-17-580 § 44-23-10(1),(2)	**Inpatient and Outpatient**: Needs treatment and either (1) unable to make responsible decisions with respect to treatment; OR (2) likelihood of serious harm to self/others, including the substantial risk of physical impairment from inability to protect oneself in community and provisions for protection are *unavailable*.
South Dakota	x	x	[illegible] § 27A-[illegible] § 27A-[illegible]	[illegible]
Tennessee			Tenn. Code Ann. § 33-6-501	**Inpatient**: Substantial likelihood of serious harm, which includes the inability to avoid severe impairment or injury from specific risks.
Texas	x	x	Tex. Health & Safety Code Ann. § 574.0[illegible] § 574.0[illegible] § 574.0[illegible] § 574.0[illegible]	[illegible] exhibited by the inability to provide for basic needs, including food, clothing, health or safety [illegible] *Outpatient*: [illegible] severe and abnormal mental, emotional, or physical distress, and deterioration of the ability to function independently and inability to live safely in community, and inability to voluntarily and effectively participate in outpatient treatment as demonstrated by actions of past two years or the inability to make an informed treatment decision.
Utah		x	Utah Code Ann. § 62A-15-631 (10)62A-15-	**Inpatient and Outpatient**: Inability to make *rational treatment decision and immediate* danger to self/others, explicitly including both inability to provide basic necessities such as food, clothing, and shelter and substantial risk of extreme physical

			602 (12) 62A-15-602 (13)	pain, protracted and obvious disfigurement, or protracted loss or impairment of mental faculty.
Vermont	[illegible]	[illegible]	Vt. Stat. Ann. [illegible] 7101(1)[illegible] 7101(1)[illegible]	Inpatient and Outpatient: (1) [illegible] self/others and (2) [illegible] adequate treatment [illegible] Danger to others [illegible] danger to persons [illegible] can be the inability, without assistance [illegible] need for nourishment, personal [illegible] shelter, or self-protection and safety [illegible] probable death, substantial physical [illegible] serious mental deterioration or physical [illegible] or disease will ensue.
Virginia	h	x	Va. Code Ann. § 37.1-67.3 § 37.1-67.3	**Inpatient:** (1) Imminent danger to self/others; or (2) so seriously mentally ill as to be substantially unable to care for self. **Outpatient:** Same as for inpatient plus is competent to understand the stipulations of treatment, wants to live in community and agrees to abide by treatment plan, has capacity to comply with treatment plan, ordered treatment can be delivered on outpatient basis, and can be monitored by community services board or designated providers.
Washington	[illegible]	x	[illegible] 71.05.020[illegible] [illegible]	[illegible] (2) [illegible] Outpatient: Same as [illegible] treatment is in best interest [illegible]
West Virginia		x	W. Va. Code § 27-5-4(l) §27-1-12	**Inpatient and Outpatient**: Danger to self/others. Danger to others includes presenting a danger to persons in his/her care. Danger to self can be the inability, without assistance, to satisfy need for nourishment, personal or medical care, shelter, or self-protection and safety, so that probable death, substantial physical bodily injury, serious mental deterioration or physical debilitation or disease will ensue.

Wisconsin	[illegible]	[illegible]	Wis. Stat. Ann. [illegible] § 51.20(1)(a)1 [illegible] § 51.20(1)(a)2	Inpatient and Outpatient: (1) Danger to self/others as evidenced by recent acts/threats; (2) substantial probability of [illegible] impairment/injury to self as evidenced by [illegible] inability to satisfy basic [illegible] medical care, shelter or safety so that substantial probability of imminent death, serious physical injury, serious physical debilitation or serious physical disease; or (4) [illegible] make informed treatment [illegible] treatment to prevent [illegible] and substantial probability that [illegible] health or safety [illegible] emotional or physical harm that will result in loss of ability to function in community or loss of cognitive or volitional control over thoughts or actions.
Wyoming	x	x	Wyo. Stat. Ann. § 25-10-110(l) § 25-10-101(a)(ix) § 25-10-101(a)(ii) § 25-10-110(i)(ii)	**Inpatient and Outpatient:** (1) Danger to self/others; (2) unable, without available assistance, to satisfy basic needs for nourishment, essential medical care, shelter or safety so it is likely that death, serious physical injury, serious physical debilitation, *serious mental debilitation*, destabilization from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition or serious physical disease will imminently ensue.

Attachment 2

LCIR Survey Respondents and Other Sources of Information by County

Sheriff's Response	Response
ALACHUA	Yes
BRADFORD	Yes
DUVAL	Yes
HERNANDO	Yes
LEON	Yes
LEVY	Yes
MARION	Yes
MARTIN	Yes
MIAMI-DADE	Grand Jury Report
MONROE	Yes
NASSAU	Yes
OKALOOSA	Yes
OKEECHOBEE	Yes
ORANGE	Study
OSCEOLA	Yes
PALM BEACH	Yes
POLK	Yes
SAINT LUCIE	Yes
SANTA ROSA	Yes
SARASOTA	Study
TAYLOR	Yes
VOLUSIA	Yes
WASHINGTON	Yes
TOTAL	20 Survey responses

Attachment 3

LCIR Survey

Mental Health Issues and County Jails

The Florida Legislative Committee on Intergovernmental Relations (LCIR) is conducting an interim research project examining the processes, costs, and challenges relating to individuals with mental health problems that come in contact with the county jail system.

This questionnaire is designed to be answered by each Sheriff. These questions are designed to augment information collected at the state level on the impact of the mentally ill on county jails. This survey does not include questions on pre-arrest (Crisis Intervention Teams) and post-arrest (Mental Health Courts) diversion programs that are known to exists in certain jurisdictions.

The questionnaire is organized in five sections (A.- E.), preceded by some basic contact questions. The sections include:

F. Baker Act Transportation Cost (Sheriff's Office and Jail)
G. Utilization of Florida Assertive Community Treatment (FACT) Programs
H. Challenges and Recommendations (opinions)
I. Potential Impact of Recent Baker Act Legislation (Ch. 2004-385, L.O.F. also known as SB 700)
J. Additional Comments are Solicited

We would like to thank you in advance for your cooperation. Please return the completed survey by **Friday, October 16th by e-mail** to Dick Drennon, Senior Legislative Analyst with the LCIR at drennon.dick@leg.state.fl.us or by facsimile transmission at 850-4876587. Please contact Dick Drennon at 850-410-1478 if you have any questions regarding this study.

Basic Contact Information

1. Sheriff
County:
Sheriff's Name:
Person/Title for Follow-up Contact:
Contact's Phone:
Contact's E-mail:

A. Baker Act Transportation Cost (Countywide Sheriff's Office and Jails)

1. How much did transportation of persons under the Baker Act cost the Sheriff's Office in county fiscal year ending September 30, 2003? How many trips does that represent? How much time does that represent in terms of full-time employees? [For example, 1.25 full time deputies].
2. How much do you estimate that the transportation of persons under the Baker Act will cost the Sheriff's Office in county fiscal year ending September 30, 2004? How many trips does that represent? How much time does that represent in terms of full-time employees?
3. Are these costs accounted for in the county jail budget or the Sheriff's general operating budget?
4. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.

B. Utilization of Florida Assertive Community Treatment (FACT) Program

1. Does the community mental health system that serves inmates of this jail have a FACT Program? If so, please describe its effectiveness in lessening the impact of individuals with mental health problems on your deputies and the jail.
5. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.

C. Challenges and Recommendations

1. Relative to other problems your county's jails face, how big of a problem do inmates with mental illness pose compared to five years ago? {much less, less, about the same, more, much more]
2. What is the biggest challenge faced in managing inmates with a mental illness in your jails? Has this changed in the last five years?
3. How has the overall effectiveness of your jails' services for inmates with mental illness changed in the last five years?
4. What is the biggest barrier to delivering more effective mental health services to inmates? Has this changed in the last five years, and if so how?
5. What would you recommend to alleviate the impact of the mentally ill on your county's jails?
6. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.

D. Potential Impact of Recent Baker Act Legislation (Ch. 2004-385, L.O.F. also known as SB 700)

1. Please comment on how the implementation of SB700 will impact your Sheriff's Office and your jails.
2. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.

E. Additional Comments are Solicited

1. Please make any additional comments you have with regard to the mentally ill population and the county jail system.
2. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.