Crisis Behavioral Health
Medical Home for Adults
Three-Year Outcomes and Findings
2011-2014

Mary Ruiz, MBA
Melissa Larkin-Skinner, LHMC
Melanie Teves Bell, LMFT
February 2015
Summary

Floridians in behavioral health crisis experience unplanned admissions to emergency rooms, hospitals and crisis centers. Local jails and state prisons have become the largest institutions in Florida for psychiatric care. State mental hospitals struggle with volumes beyond their capacity. While all these efforts offer immediate safety, they cannot forestall the next crisis. So the cycle continues.

In 2009, the Suncoast Region of the Department of Children and Families and Central Florida Behavioral Health Network funded a pilot crisis behavioral health medical home for adults at Manatee Glens community behavioral health hospital and outpatient practice in Bradenton, Florida. The purpose of launching the crisis behavioral health medical home, originally known as the Intensive Outpatient Team, was to reduce the likelihood of another cycle of crisis by assisting in transitions from crisis centers, state hospital and prison or jail. The payment model was a monthly rate for all services allowing flexibility for personalized care.

The crisis behavioral health medical home pilot addressed all medical and social needs of enrollees and bridged personal and public safety by supporting recovery in the community. Assisted outpatient treatment (AOT) commitment under the Florida “Baker Act” and supervised release were invested in the medical home to support diversion from incarceration to treatment.

This three-year evaluation from 2011 to 2014 indicates the crisis behavioral health medical home is highly successful in achieving its mission of recovery from crisis for enrollees. Comparing six months before enrollment to six months after discharge or enrollment for 203 seriously mentally ill adults, the medical home:

- Reduced crisis admissions from 322 to 88 admissions (73%);
- Diverted 174 of 176 Baker Act BA-8 commitments from state hospital (99%);
- Diverted 22 of 23 involved in criminal justice system from jail (96%);
- Diverted 15 of 15 in outpatient assisted treatment and supervised release from jail (100%); and
- Alleviated homelessness by 91% from 55 to 5 persons.
Introduction

The crisis behavioral health medical home for adults bridges the gap between community and crisis care by providing enrollees and families:

- Counselors on 24 hour call
- Availability of daily services in home or in the community
- One integrated care team addressing multiple problems including co-occurring substance abuse and physical health issues
- Integrated care management for behavioral, medical and social needs
- Coaching for recovery, health and wellness
- Family support including counseling, education and assistance with consumer expenses for incidentals, housing and medication
- Access to a psychiatric inpatient bed to provide 24-hour medically supervised longer term stabilization (about 3 weeks)
- Support for court-ordered Involuntary Outpatient Assisted Treatment and Supervised Release

Integrated care management within the crisis behavioral health medical home assures rapid enrollment and care for persons identified at risk for repeated behavioral health crisis episodes. Referral sources include:

- Baker Act Receiving Facilities
- Emergency Rooms
- State and Local Hospitals
- Family Members
- Law Enforcement
- Courts
- Jails and Prisons
- Social Services

Crisis behavioral health medical home services are demand-response but average less than six months. Service intensity is titrated to the individual circumstances of each adult and family over time. The medical home’s community-based approach deals with all challenges that might confront the individual and their loved ones at home or in the community.

Services include not only behavioral health needs, but also medical, criminal justice, family, relationship, housing, transportation, financial and recovery services. Enrollees become versed in their health care conditions and social needs. They are engaged in personal care strategies allowing for achievement of individual recovery and life goals. Stress levels of family members are reduced so the family can sustain supportive relationships with their loved ones.
Three-Year Findings

Goal 1:

*Ensure safety in the community for adults with recurring acute episodes of psychosis, depression, and/or mania with emphasis on those with co-occurring substance abuse, suicidality and/or comorbid complex medical conditions*

Outcome: Serve high risk, multiple problem enrollees

Finding: Enrolled 214 cases meeting criteria

Referrals were accepted on a demand-response basis with about half of enrollees exhibiting symptoms of active psychosis and the remainder experiencing symptoms of bipolar mania or clinical depression. Co-occurring alcohol and drug abuse was encountered in 70% of all cases suggesting this is a major contributor to behavioral health crisis episodes.

More than half (57%) of enrollees experienced medically complex comorbid conditions such as cardiovascular, pulmonary or metabolic disorders requiring primary or specialist care. Linking to medical services and benefits as well as supporting follow up are important functions of the medical home.

Rapid access to medical home services immediately upon discharge from the crisis center or hospital is essential to assure continued safety of enrollees. While 50% (107) of enrollees demonstrated a risk of suicidality, the medical home achieved a zero suicide rate during enrollment.
Almost a third (32%) of admissions was in the 18-29 age groups. This suggests the need for prodromal identification and preventative treatment in Florida as primary diversion from crisis. Increasing transition services of 18-21 year olds from the youth to adult system such as has been adopted by Florida’s Community Action Team model deserves further attention as a tool in reducing behavioral health crisis in latter adulthood.

While enrollees were admitted to the medical home in crisis and with multiple life-threatening conditions, stabilization was accomplished in a matter of a few months. Most enrollees participated in the program six months or less before moving on to other forms of outpatient care.
Enrollment July 1, 2011 to June 30, 2014 N=214

<table>
<thead>
<tr>
<th>Length of Enrollment In Crisis Medical Home</th>
<th>Number of Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 4 weeks</td>
<td>13</td>
</tr>
<tr>
<td>4–8 weeks</td>
<td>31</td>
</tr>
<tr>
<td>9-12 weeks</td>
<td>31</td>
</tr>
<tr>
<td>13-16 weeks</td>
<td>22</td>
</tr>
<tr>
<td>17-20 weeks</td>
<td>24</td>
</tr>
<tr>
<td>21-24 weeks</td>
<td>27</td>
</tr>
<tr>
<td>25 weeks or more</td>
<td>66</td>
</tr>
</tbody>
</table>

Goal 2:

*Reduce frequency of crisis requiring inpatient levels of care*

Outcome: Extend frequency of crisis center behavioral admissions

Finding: Admissions decreased 73%

In a crisis, an inpatient behavioral health admission is often indicated and should be encouraged when needed. However, the crisis behavioral health medical home often successfully managed the most serious mental health symptoms and disorders without admission through prompt crisis intervention and intensive support in the community.

A summary of crisis center admissions six months before enrollment as compared to six months following discharge is as follows. These findings suggest that the gains made in the crisis behavioral health medical home are sustainable with outpatient support on disenrollment from the medical home.
Many public receiving facilities currently provide a number of unplanned extended stays, typically while awaiting a transfer to state hospital. The crisis behavioral health medical home found that for 31% (N=66) enrollees, planned extended stays promoted long-term medical stabilization. An average planned extended stay of about three weeks allowed for most enrollees to avoid state hospital altogether.

The use of planned extended stay days under a Baker Act-8 (BA-8) court commitment allowed the receiving facility to experience a significant overall reduction in total days for enrollees six months before enrollment and six months after discharge from enrollment in the crisis medical home. This suggests that
average length of stay is not an appropriate outcome for crisis centers as selective use of extended stays actually reduces overall utilization.

### Enrollees July 1, 2011 to June 30, 2014 N=66*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Subacute Extended Stays</td>
<td>74</td>
</tr>
<tr>
<td>Number of Extended Days</td>
<td>1,665</td>
</tr>
<tr>
<td>Average Days Per Admission</td>
<td>22.5</td>
</tr>
</tbody>
</table>

*Numbers do not total as some enrollees had multiple admissions

### Goal 3:

**Reduce risk of state hospital or incarceration**

**Outcome:** Divert BA-8 commitments from state hospital  
**Finding:** Diverted 99% from state hospital

**Outcome:** Divert at risk enrollees from incarceration  
**Finding:** Diverted 96% from incarceration

Despite the severity and complexity of cases, the crisis behavioral health medical home successfully diverted individuals from the state mental hospital, the state’s most costly level of mental health care. From July 2011 to June 2014, 176 individuals enrolled were at imminent risk of state hospitalization by court order under a Baker Act-8 commitment. Of these, 174 were successfully diverted from state hospital through enrollment in the medical home.
A break even analysis indicates avoidance of one state hospital admission equals the cost of serving eight medical home enrollees.

Of the total of 214 enrollees, 23 had pending legal charges and criminal justice involvement. In all but one case, the crisis behavioral medical home was able to assist in the settlement of legal issues without incarceration because of their ability to offer the criminal justice system outpatient assisted treatment or supervised release as a diversionary alternative.

<table>
<thead>
<tr>
<th>Enrollees July 1, 2011 to June 30, 2014 N=203*</th>
<th>At Risk</th>
<th>Diverted</th>
<th>% Diverted</th>
</tr>
</thead>
<tbody>
<tr>
<td>BA-8 Commitment Order</td>
<td>176</td>
<td>174</td>
<td>99%</td>
</tr>
<tr>
<td>Criminal Justice Involved</td>
<td>23</td>
<td>22</td>
<td>96%</td>
</tr>
<tr>
<td>Outpatient Assisted Treatment</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>Supervised Release</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Numbers do not total as one or more individuals fall within multiple categories

Families and law enforcement experience frustration and concern when a person requiring medication to maintain their stability and safety in the community is unable to adhere to recommended medication therapy regimens. When all else fails and the enrollee cannot adhere to recommended medication therapy, the Florida Mental Health Act known as the “Baker Act” authorizes both involuntary inpatient (hospital) and outpatient (community) treatment. Florida is the 43rd state with involuntary outpatient treatment under 394.4655 Florida Statutes. See Appendix C for the full statutory citation.

The crisis behavioral health medical home accepted seven involuntary commitments and was successful in encouraging all outpatient assisted treatment enrollees to adhere to the court order. Numbers of involuntary commitments were not higher because the crisis behavioral health medical home found that in most cases enrollees eventually
welcomed services due to the personalized nature of the care offered. Customized care was an important element in voluntary acceptance of medication services.

The crisis behavioral health medical home was able to demonstrate that with treatment services assisted outpatient treatment is an effective last resort for both the criminal justice system and the enrollee. Assisted outpatient treatment is not commonly used in Florida. Many judges are neither familiar nor trained in its provisions and application. Judges experienced in assisted outpatient treatment are aware that there is not adequate crisis behavioral health treatment available in Florida communities to effectively utilize assisted outpatient treatment. Certification of available treatment resources is a requirement under the statutes.

The crisis behavioral health medical home also proved an effective diversionary alternative for judges who wish to order supervised release to the medical home. Many times, persons in behavioral health crisis violate the terms of their probation because their medical conditions render them unable to adhere to the terms of their probation. Eight enrollees were released to the crisis medical home for community supervision by local judges. All were able to successfully complete the terms ordered by the judge.

Goal 4:

Successful transition of enrollees to outpatient services

Outcome: Promote Outpatient Engagement
Finding: Outpatient Engagement Achieved at 89%

Outcome: Eliminate Homelessness
Finding: Reduced Homeless by 91%
Most enrollees successfully transitioned to traditional outpatient services such as medication therapy, case management or FACT Team services after discharge from the medical home. Failure to follow up after repeated crisis admissions is more common than not in many communities. The crisis behavioral health medical home was able to assure outpatient engagement in the overwhelming majority of cases as 180 enrollees successfully engaged in outpatient services.

### Enrollees July 1, 2011 to June 30, 2014 N= 203*

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Number*</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Behavioral Health</td>
<td>168</td>
<td>82.8%</td>
</tr>
<tr>
<td>FACT Team</td>
<td>12</td>
<td>5.9%</td>
</tr>
<tr>
<td>State Hospital</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Jail or Prison</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Against Medical Advice</td>
<td>19</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

*Data not available for 11 enrollees

Crisis behavioral health medical home clinical specialists report several factors as essential to continued outpatient engagement:

- Flexible payment model allowing recovery-based behavioral health care addressing substance use, trauma and comorbid medical conditions;
- Possession of behavioral and medical prescriptions and support in adhering to dosing regimens through funding of prescriptions until benefits are secured and provision of medication supports such as bubble packs and care management;
- Access to planned extended inpatient stays of about three weeks;
- Subsidies for housing first allowing enrollee choice and engagement; and
- Securing prescription assistance, insurance and disability benefits for continued support past disenrollment from the medical home.

The availability of funding for medications, housing and other emergency supports in the crisis behavioral health medical home budget were significant elements in sustaining recovery in the community after six months from disenrollment in medical home services. Six months after disenrollment, homelessness was incurred at a rate 91% lower than six months prior to enrollment. Likewise, rates of institutionalization in state hospital or jail dropped by almost half.

### Enrollees July 1, 2011 to June 30, 2014

<table>
<thead>
<tr>
<th>Housing Status</th>
<th>6 months prior to enrollment in medical home</th>
<th>6 months after enrollment in medical home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless/Shelter</td>
<td>55</td>
<td>5</td>
</tr>
<tr>
<td>State Hospital/Jail</td>
<td>27</td>
<td>14</td>
</tr>
</tbody>
</table>
Conclusions

Within the crisis behavioral health medical home, care management is at first aimed toward safety and stabilization. As safety and stabilization goals are met, the medical home addresses additional care management goals of engaging, informing and activating enrollees in their own self-care and life management of behavioral, medical and social needs.

This evaluation demonstrates that complex behavioral and comorbid medical conditions benefit greatly from crisis behavioral health medical home services. With intensive community support, the overwhelming majority of enrollees achieved stabilization and recovery in the community and avoided jail and state mental hospital.

Over this three-year period, the crisis behavioral health medical home proved its capability to navigate individual care management on a 24/7 basis and fully integrate behavioral, medical, social and criminal justice services through care management and a multidisciplinary clinical team. By many measures, such as reduced inpatient care, decreased homelessness, increased outpatient engagement and reduced incarceration, the crisis behavioral health medical home demonstrated it can prepare enrollees for sustained recovery in the community and end the cycle of recurring crisis.

---

*Crisis behavioral health medical homes end the cycle of crisis, increase recovery and decrease impact on crisis centers, jails and state hospitals.*

---

Florida is at a crossroads in its behavioral health policy. Does it build and fund more crisis beds, state hospitals, jails and prisons? Or does it invest in a proven, cost-effective service delivery model that addresses behavioral health crises in the community? As demonstrated by these three-year outcomes, crisis behavioral health medical homes offer a viable policy alternative for Florida.
Case Studies

Sam  At 25 Sam was diagnosed with Bipolar Disorder with Psychotic Features. He was also abusing cocaine. Sam’s family was very supportive but often became the focus of his delusion. Living at home was not a possibility. With the support of the medical home—daily medication observations, medication management, therapy, and nursing services—Sam was able to find a medication treatment he felt was effective. Sam became educated about his illness and was able to move back into his home and improve family relationships. He achieved sobriety and started working part-time.

Jessica was first hospitalized right after her graduation from high school. Jessica’s mother had limited financial means and was overwrought with worry about Jessica’s wellbeing. Jessica worked closely with medical home psychiatric staff to find a medication that helped her effectively manage her illness. Jessica was approved for disability income and health insurance which gave her the financial means to remain healthy in the community. She currently attends a local technical institute and works part-time during school breaks.

Carla was despondent, stating “I lost everything. I used to be a teacher. I used to have a nice home. I am never going to have anything again.” The medical home team completed daily well-checks, observed medications, and ensured Carla’s safety until she was less despondent. The medical home team was able to assist with rent at a boarding home to provide her with stable housing while she recovered. She received medication management and therapy from team members. While receiving medical home services, Carla resolved her legal issues with her husband and was able to negotiate her return to work as a teacher. She gained the courage to be hopeful about her future; obtaining a new apartment and planning for her children to return home to her care.
Appendix A

Adult Crisis Behavioral Health Medical Home Service Description

Adults experiencing recurring behavioral health crises have complex needs that benefit from the services of a medical home care responsible for navigating individual care management on a 24/7 basis. The crisis behavioral health medical home fully integrates behavioral, medical and social services through complex care management. Care management is at first aimed toward safety and stabilization. As safety and stabilization goals are met, the medical home addresses additional care management goals of engaging, informing and activating enrollees in their own self-care and life management.

The crisis behavioral health medical home for adults bridges the gap between home and institutional care by providing enrollees and families with services such as:

- Counselors on 24 hour call
- Availability of daily services in home or in the community
- One integrated team of experts addressing multiple problems including co-occurring substance abuse and physical health issues
- Integrated care management for behavioral, medical and social needs
- Coaching for recovery, health and wellness
- Family support including counseling, education and assistance with consumer expenses for incidentals, housing and medication
- Access to an inpatient bed to provide 24-hour medically supervised psychiatric care in a safe environment for up to 3 to 4 weeks

Integrated care management assures rapid enrollment to the medical home immediately upon inpatient admission. Medical home services are demand-response but time-limited. Service intensity is titrated to the individual circumstances of each adult and family over time. The medical home’s community-based approach deals with all challenges that might confront the individual and their loved ones at home or in the community.

Services include not only behavioral health needs, but also medical, criminal justice, family, relationship, housing, transportation, financial and recovery services. Enrollees become versed in their health care conditions and engaged in personal care strategies allowing for achievement of individual recovery and life goals. Stress levels of family members are reduced so the family can sustain supportive relationships with their loved ones. After an average of six months, the goal is for enrollees to transition to traditional outpatient services with less intensive case management.
The Adult Crisis Behavioral Health Medical Home provides community based services through a multi-disciplinary team at intensity and frequency required to prevent individuals from experiencing multiple crisis center/hospital admissions and long term state hospital admissions. Primary referral sources are crisis stabilization units and psychiatric hospitals. The medical home assesses individuals upon referral and approves enrollment in the medical home based on their acute stabilization and recovery needs on a demand/response basis. Provision for extended inpatient stay allows for medical stabilization in a secure environment over multiple weeks.

At inpatient discharge, the crisis behavioral medical home provides short-term intensive outpatient recovery services to acutely depressed, manic, and/or psychotic individuals to promote recovery in the community. The crisis behavioral health medical home intervenes at an earlier point in the recovery of a consumer who might otherwise require repeated hospitalization or long term state hospitalization. A psychiatrist or nurse practitioner supports the medical home with medication evaluations and monitoring. Incidental funding for medication and housing is also provided. Support for extended inpatient stays in the community provides a cost effective alternative to state hospitalization.

Admission Criteria/Target Population: Adults with one or more DSM mental health diagnoses, who are acutely depressed, manic, and/or psychotic, may participate voluntarily or by court order. Focus will be placed on adults who recidivate into inpatient facilities or the jail due to mental illness, as well as adults at risk of extended stays, including those with co-occurring addiction and complex medical issues.

Census and Length of Stay: Length of stay in the behavioral health medical home varies based upon consumer need, typically four to six months. Extended inpatient stays of about three weeks are available to individuals who require 24-hour inpatient medical services for extended stabilization to ensure their safety and their readiness for intensive outpatient services. After stabilization, participants will be transitioned to traditional outpatient services, or FACT teams if they meet FACT criteria.

Numbers Served: Up to 80 individuals receive medical home services per year, with 40 slots available at any one time.

Services:

- Integrated Care Management – behavioral, medical, social
- Medication Management
- Medication Delivery and Observation
- 24-hour on-call crisis intervention
- Psychosocial rehabilitation
- Individual and family therapy, support and education
- Wellness and recovery coaching
- Family education and participation
- Emergency Funds for food, clothing, medication, or housing
- Health care coordination and linkage

Discharge Planning: Discharge planning will begin on the day of admission to the medical home with the goal of transitioning to traditional outpatient services. Discharge planning will include assisting individuals with building a support network and linkage to community agencies providing services needed by the individual to achieve and maintain their health and wellness.
Community Partnerships: To enhance the effectiveness of the medical home, partnerships and agreements will be developed with other community providers to ensure individuals in the medical home are given priority access to services. Those service agencies include, but are not limited to:

- Crisis Stabilization Centers including extended stay
- Hospitals and Emergency Rooms
- Outpatient community mental health and substance abuse agencies
- Child welfare
- Primary care and specialty physicians
- Home health and hospice
- Transportation programs
- Housing programs (e.g. Shelter Plus Care, Supportive Housing)
- Local land lords
- Group Homes
- Assisted Living Facilities
- Adult Foster Programs
- Drop-in Centers
- Employment Programs
- Religious services

Admission and discharge criteria:

Admission
(a) Adults 18 years of age and older and
(b) Have a mental health diagnosis and
(c) Are experiencing acute symptoms such as depression, mania and psychosis and/or have been
(c) Recently hospitalized one or more times due to acute depression, psychosis or mania
(e) Special consideration will also be given to enrollees who have recently been jailed, experiencing co-occurring substance abuse or who are transitioning from the child mental health system to the adult mental health system and require intensive services for stabilization.

Discharge
Individuals will be discharged when symptoms have decreased such that medical home services are no longer needed and inpatient admission is not imminent; or when state hospitalization or incarceration is court ordered.
Appendix B
Adult Behavioral Health Crisis Medical Home Budget and Staffing Model

An integrated team of multiple behavioral health disciplines is required to provide services to 40 enrollees at a time for 24/7 care including on call, frequent or daily contact, in-home or in-community care, and coordination with primary care, assisted living, child welfare, and other agencies. Other expenses include emergency food or clothing, transportation, safety measures, emergency housing, and medication.

<table>
<thead>
<tr>
<th>POSITION</th>
<th>FTE</th>
<th>ANNUAL SALARY</th>
<th>RATE</th>
<th>ALLOCATED SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist/ARNP</td>
<td>0.25</td>
<td>200,000</td>
<td>96.16</td>
<td>$ 50,000</td>
</tr>
<tr>
<td>RN/LPN</td>
<td>1</td>
<td>54,080</td>
<td>26.00</td>
<td>54,080</td>
</tr>
<tr>
<td>Team Leader/Lic Clinician</td>
<td>1</td>
<td>50,000</td>
<td>24.04</td>
<td>50,000</td>
</tr>
<tr>
<td>Licensed Clinician</td>
<td>1</td>
<td>45,760</td>
<td>22.00</td>
<td>45,760</td>
</tr>
<tr>
<td>Bachelor's Case Manager</td>
<td>2</td>
<td>32,552</td>
<td>15.65</td>
<td>65,104</td>
</tr>
<tr>
<td>Project Assistant</td>
<td>1</td>
<td>30,784</td>
<td>14.80</td>
<td>30,784</td>
</tr>
<tr>
<td><strong>Total Salary Expense</strong></td>
<td>6.25</td>
<td></td>
<td></td>
<td>$ 295,728</td>
</tr>
<tr>
<td>On-call</td>
<td></td>
<td></td>
<td></td>
<td>10,000</td>
</tr>
<tr>
<td>Benefits (25%)</td>
<td></td>
<td></td>
<td></td>
<td>73,932</td>
</tr>
<tr>
<td><strong>Subtotal Staffing Expense</strong></td>
<td></td>
<td></td>
<td></td>
<td>$ 379,660</td>
</tr>
<tr>
<td>Direct Operating Expense</td>
<td></td>
<td></td>
<td></td>
<td>$ 195,340</td>
</tr>
<tr>
<td>Incidental (Housing, Medications etc)</td>
<td></td>
<td></td>
<td></td>
<td>$ 50,000</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td></td>
<td></td>
<td></td>
<td>$ 625,000</td>
</tr>
</tbody>
</table>

The payment model entails a monthly rate for all medical home services.
Appendix C

INVOLUNTARY OUTPATIENT PLACEMENT
FLORIDA STATUTES

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.

(2) INVOLUNTARY OUTPATIENT PLACEMENT.—

(a) A patient who is being recommended for involuntary outpatient placement by the
administrator of the receiving facility where the patient has been examined may be retained by the
facility after adherence to the notice procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient placement are met. However, in a county having a population of fewer than 50,000, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient placement certificate that authorizes the receiving facility to retain the patient pending completion of a hearing. The certificate shall be made a part of the patient’s clinical record.

2. If the patient has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the receiving facility while awaiting the hearing for involuntary outpatient placement. Before filing a petition for involuntary outpatient treatment, the administrator of a receiving facility or a designated department representative must identify the service provider that will have primary responsibility for service provision under an order for involuntary outpatient placement, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.

3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient’s guardian advocate, if appointed, for the court’s consideration for inclusion in the involuntary outpatient placement order. The service provider shall also provide a copy of the proposed treatment plan to the patient and the administrator of the receiving facility. The treatment plan must specify the nature and extent of the patient’s mental illness, address the reduction of symptoms that necessitate involuntary outpatient placement, and include measurable goals and objectives for the services and treatment that are provided to treat the person’s mental illness and assist the person in living and functioning in the community or to prevent a relapse or deterioration. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the treatment plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed treatment plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition.
If a patient in involuntary inpatient placement meets the criteria for involuntary outpatient placement, the administrator of the treatment facility may, before the expiration of the period during which the treatment facility is authorized to retain the patient, recommend involuntary outpatient placement. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient placement are met. However, in a county having a population of fewer than 50,000, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient placement certificate, and the certificate must be made a part of the patient’s clinical record.

The administrator of the treatment facility shall provide a copy of the involuntary outpatient placement certificate and a copy of the state mental health discharge form to a department representative in the county where the patient will be residing. For persons who are leaving a state mental health treatment facility, the petition for involuntary outpatient placement must be filed in the county where the patient will be residing.

The service provider that will have primary responsibility for service provision shall be identified by the designated department representative prior to the order for involuntary outpatient placement and must, prior to filing a petition for involuntary outpatient placement, certify to the court whether the services recommended in the patient’s discharge plan are available in the local community and whether the service provider agrees to provide those services. The service provider must develop with the patient, or the patient’s guardian advocate, if appointed, a treatment or service plan that addresses the needs identified in the discharge plan. The plan must be deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in this chapter, who consults with, or is employed or contracted by, the service provider.

If the service provider certifies that the services in the proposed treatment or service plan are not available, the petitioner may not file the petition.

PETITION FOR INVOLUNTARY OUTPATIENT PLACEMENT.—

(a) A petition for involuntary outpatient placement may be filed by:

1. The administrator of a receiving facility; or
2. The administrator of a treatment facility.

(b) Each required criterion for involuntary outpatient placement must be alleged and substantiated in the petition for involuntary outpatient placement. A copy of the certificate recommending involuntary outpatient placement completed by a qualified professional specified in subsection (2)
must be attached to the petition. A copy of the proposed treatment plan must be attached to the petition. Before the petition is filed, the service provider shall certify that the services in the proposed treatment plan are available. If the necessary services are not available in the patient’s local community to respond to the person’s individual needs, the petition may not be filed.

(c) The petition for involuntary outpatient placement must be filed in the county where the patient is located, unless the patient is being placed from a state treatment facility, in which case the petition must be filed in the county where the patient will reside. When the petition has been filed, the clerk of the court shall provide copies of the petition and the proposed treatment plan to the department, the patient, the patient’s guardian or representative, the state attorney, and the public defender or the patient’s private counsel. A fee may not be charged for filing a petition under this subsection.

(4) APPOINTMENT OF COUNSEL.—Within 1 court working day after the filing of a petition for involuntary outpatient placement, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of the appointment. The public defender shall represent the person until the petition is dismissed, the court order expires, or the patient is discharged from involuntary outpatient placement. An attorney who represents the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient’s case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

(5) CONTINUANCE OF HEARING.—The patient is entitled, with the concurrence of the patient’s counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.

(6) HEARING ON INVOLUNTARY OUTPATIENT PLACEMENT.—

(a)1. The court shall hold the hearing on involuntary outpatient placement within 5 working days after the filing of the petition, unless a continuance is granted. The hearing shall be held in the county where the petition is filed, shall be as convenient to the patient as is consistent with orderly procedure, and shall be conducted in physical settings not likely to be injurious to the patient’s condition. If the court finds that the patient’s attendance at the hearing is not consistent with the best interests of the patient and if the patient’s counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petition, as the real party in interest in the proceeding.

2. The court may appoint a master to preside at the hearing. One of the professionals who executed the involuntary outpatient placement certificate shall be a witness. The patient and the patient’s guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall provide for one. The independent expert’s report shall be confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law, regarding the person’s
prior history and how that prior history relates to the person’s current condition. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.

(b)1. If the court concludes that the patient meets the criteria for involuntary outpatient placement pursuant to subsection (1), the court shall issue an order for involuntary outpatient placement. The court order shall be for a period of up to 6 months. The order must specify the nature and extent of the patient’s mental illness. The order of the court and the treatment plan shall be made part of the patient’s clinical record. The service provider shall discharge a patient from involuntary outpatient placement when the order expires or any time the patient no longer meets the criteria for involuntary placement. Upon discharge, the service provider shall send a certificate of discharge to the court.

2. The court may not order the department or the service provider to provide services if the program or service is not available in the patient’s local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. A copy of the order must be sent to the Agency for Health Care Administration by the service provider within 1 working day after it is received from the court. After the placement order is issued, the service provider and the patient may modify provisions of the treatment plan. For any material modification of the treatment plan to which the patient or the patient’s guardian advocate, if appointed, does agree, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient’s guardian advocate, if appointed, must be approved or disapproved by the court consistent with subsection (2).

3. If, in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the physician, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement pursuant to s. 394.467, the patient must be discharged from the receiving facility. The involuntary outpatient placement order shall remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient placement or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which the patient or the patient’s guardian advocate, if appointed, does agree, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient’s guardian advocate, if appointed, must be approved or disapproved by the court consistent with subsection (2).

(c) If, at any time before the conclusion of the initial hearing on involuntary outpatient placement, it appears to the court that the person does not meet the criteria for involuntary outpatient placement under this section but, instead, meets the criteria for involuntary inpatient placement, the court may
order the person admitted for involuntary inpatient examination under s. 394.463. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings shall be governed by chapter 397.

(d) At the hearing on involuntary outpatient placement, the court shall consider testimony and evidence regarding the patient’s competence to consent to treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598. The guardian advocate shall be appointed or discharged in accordance with s. 394.4598.

(e) The administrator of the receiving facility or the designated department representative shall provide a copy of the court order and adequate documentation of a patient’s mental illness to the service provider for involuntary outpatient placement. Such documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a clinical psychologist or a clinical social worker.

(7) PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT PLACEMENT.—

(a)1. If the person continues to meet the criteria for involuntary outpatient placement, the service provider shall, before the expiration of the period during which the treatment is ordered for the person, file in the circuit court a petition for continued involuntary outpatient placement.
   2. The existing involuntary outpatient placement order remains in effect until disposition on the petition for continued involuntary outpatient placement.
   3. A certificate shall be attached to the petition which includes a statement from the person’s physician or clinical psychologist justifying the request, a brief description of the patient’s treatment during the time he or she was involuntarily placed, and an individualized plan of continued treatment.
   4. The service provider shall develop the individualized plan of continued treatment in consultation with the patient or the patient’s guardian advocate, if appointed. When the petition has been filed, the clerk of the court shall provide copies of the certificate and the individualized plan of continued treatment to the department, the patient, the patient’s guardian advocate, the state attorney, and the patient’s private counsel or the public defender.

(b) Within 1 court working day after the filing of a petition for continued involuntary outpatient placement, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. The public defender shall represent the person until the petition is dismissed or the court order expires or the patient is discharged from involuntary outpatient placement. Any attorney representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient’s case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

(c) Hearings on petitions for continued involuntary outpatient placement shall be before the circuit court. The court may appoint a master to preside at the hearing. The procedures for obtaining
an order pursuant to this paragraph shall be in accordance with subsection (6), except that the time period included in paragraph (1)(e) is not applicable in determining the appropriateness of additional periods of involuntary outpatient placement.

(d) Notice of the hearing shall be provided as set forth in s. 394.4599. The patient and the patient’s attorney may agree to a period of continued outpatient placement without a court hearing.

(e) The same procedure shall be repeated before the expiration of each additional period the patient is placed in treatment.

(f) If the patient has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient’s competence. Section 394.4598 governs the discharge of the guardian advocate if the patient’s competency to consent to treatment has been restored.

History.—s. 8, ch. 2004-385; s. 3, ch. 2006-171; s. 4, ch. 2009-38.
Appendix D
Crisis Behavioral Health Medical Home Sponsors

Florida Department of Children and Families
www.myflfamilies.com

The Florida Department of Children and Families is committed to its mission of protecting the vulnerable, promoting strong and economically self-sufficient families, and advancing personal and family recovery and resiliency. The Office of Substance Abuse and Mental Health is the legislatively appointed state authority for oversight of a statewide system of care for the prevention, treatment, and recovery of children and adults with serious mental health conditions or substance use disorders. The statewide system of care is built on a regional foundation of community involvement and coordination with internal and external partners that provide behavioral health services.

Central Florida Behavioral Health Network
www.cfbhn.org

Central Florida Behavioral Health Network designs and manages value-driven integrated systems of specialty healthcare services as a managing entity under contract with the Florida Department of Children and Families. The network subcontracts with providers from Pasco in the north, throughout the Tampa Bay area, east through Polk, Highlands and Hardee and south from Desoto to Lee counties. The range of services for mental health and addictions includes acute care, residential treatment, housing, medical, outpatient and recovery and resiliency support services for all ages.

Manatee Glens
www.manateeglens.org

Manatee Glens community behavioral hospital and outpatient practice is headquartered in Bradenton on the west coast of Florida offering specialty care to children and adults in mental health, addictions and child welfare. Manatee Glens is an innovator in new behavioral health delivery systems including Florida’s first behavioral health walk in center and first Community Action Treatment Teams or CAT Teams for severely emotionally disturbed youth and young adults. A leader in clinical education, Manatee Glens provides an adult psychiatric residency general medical education program as well as one of the largest pre and post psychology doctoral training programs in the country.
Appendix E
Authors

Mary Ruiz MBA
Ms. Ruiz is a senior behavioral healthcare executive with 25 years of experience in hospital administration, managed care systems, marketing and business development. She is a fellow with the Florida Council for Community Mental Health and twice awarded Administrator of the Year by the Florida Alcohol and Drug Abuse Association. She is President and CEO of Manatee Glens.

Melissa Larkin-Skinner LMHC
Ms. Larkin-Skinner is a senior clinical manager with 20 years of experience in crisis and trauma services, child welfare, intensive outpatient and inpatient services. She is an innovator in the field developing the original clinical models for Florida Community Action Teams and Crisis Behavioral Health Medical Home. She is Chief Clinical Officer at Manatee Glens.

Melanie Teves Bell LMFT
Melanie Teves Bell has been working in the behavioral health field for the past 19 years with experience in crisis intervention, couples and family counseling and intensive outpatient and traditional outpatient services. She is Senior Vice President of Outpatient Clinical Services at Manatee Glens.