FINANCING MENTAL HEALTHCARE: A BUDGET-SAVING PROPOSAL FOR RETHINKING AND REVITALIZING FLORIDA'S INVOLUNTARY ASSISTED OUTPATIENT TREATMENT LAW

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> *It must be remembered that for the person with severe mental illness who has no treatment the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our own powers to describe.*[1]

I. INTRODUCTION

The outcry in New York City was immense.[2] Kendra Webdale, a thirty-two-year-old talented journalist and photographer, had just been killed.[3] She had been pushed in front of an oncom-

 J.D., Stetson University College of Law, 2011; B.A., *magna cum laude*, Vanderbilt University, 2005. I dedicate this Article to my brother, who in battling schizophrenia for most of his life has been a model of courage and fortitude.

1. *Olmstead v. Zimring ex rel. L.C.*, 527 U.S. 581, 609–610 (1999) (Kennedy, J., concurring in part and concurring in the judgment).

2. *See generally* Nina Bernstein, *Frightening Echo in Tales of Two in Subway Attacks*, N.Y. Times, http://www.nytimes.com/1999/06/28/nyregion/frightening-echo-in-tales-of-two-in-subway-attacks.html (June 28, 1999) (noting the "mounting criticism of New York State's mental health system" after Kendra Webdale's murder); Anemona Hartocollis, *Nearly 8 Years Later, Guilty Plea in Subway Killing*, N.Y. Times, http://www.nytimes.com/2006/10/11/nyregion/11kendra.html (Oct. 11, 2006) (discussing the public uproar created by Kendra Webdale's murder and how it prompted the New York State legislature to enact Kendra's Law).

3. Hartocollis, *supra* n. 2.

ing train while waiting at a subway station in Manhattan.[4] About three months later, Edgar Rivera, a father of three and an athletic man, had also been thrust in front of a moving train.[5] He lost his legs.[6] Although a different assailant was responsible for each attack, both shared a disturbing commonality: they were untreated schizophrenics.[7] The first attack was particularly heartrending not only because of the loss of life but also because that loss of life was preventable. Kendra Webdale's murderer, Andrew Goldstein, had been diagnosed with schizophrenia ten years before the attack, but even with his history of violent behavior and his requests for continued treatment, mental health professionals repeatedly released him.[8] Over time, he stopped taking his anti-psychosis medication.[9]

While the second attack did not result in the loss of life, it too was nevertheless particularly tragic because the attacker, Julio Perez—a forty-three-year-old homeless man who had been in and out of homeless shelters, mental health institutions, and outpatient clinics in New York City—had also sought treatment for his illness and was largely ignored.[10] Two weeks before he attacked Edgar Rivera, he called a friend, desperate for help because his Medicaid card had been cancelled, and he knew he needed his medication.[11] Two days before the attack he called his friend again, requesting to be hospitalized.[12] On the day of the attack, he

4. Amy Waldman, *Woman Killed in a Subway Station Attack*, N.Y. Times, http://www.nytimes.com/1999/01/04/nyregion/woman-killed-in-a-subway-station-attack.html?n=Top%2FReference%2FTimes+Topics%2FSubjects%2FT%2FTransit+Systems&pagewanted=print (Jan. 4, 1999).

5. Katherine E. Finkelstein, *Victim of Subway Push Faces His Attacker*, N.Y. Times, http://www.nytimes.com/2000/09/27/nyregion/victim-of-subway-push-faces-his-attacker.html?ref=edgar_rivera (Sept. 27, 2000); *see also* Andrew Jacobs, *Man Is Pushed in the Subway and Loses Legs*, N.Y. Times, http://www.nytimes.com/1999/04/29/nyregion/man-is-pushed-in-the-subway-and-loses-legs.html?ref=edgar_rivera (Apr. 29, 1999) (discussing the tragedy that befell Edgar Rivera).

6. Finkelstein, *supra* n. 5.

7. *See generally* Bernstein, *supra* n. 2 (noting that the two cases echoed one another not only in the way the assailants carried out the attacks but also because both assailants were severely mentally ill).

8. Hartocollis, *supra* n. 2.

9. *Id.*

10. Bernstein, *supra* n. 2.

11. *Id.*

12. *Id.*

visited a psychiatrist at an emergency room, then a police station, and then a courthouse, complaining about his "enemies."[13]

In response to these attacks and public concern, the New York State legislature enacted Kendra's Law,[14] an involuntary assisted outpatient treatment law named in honor of Kendra Webdale.[15] Involuntary assisted outpatient treatment laws (or simply, outpatient treatment laws) require the mentally ill who are likely to commit violent acts to adhere to a prescribed medication program "as a condition of living in the community."[16] Under Kendra's Law, for example, a hospital director or a treating or supervising psychiatrist, among others,[17] may petition a court to

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13. *Id.*

14. N.Y. Mental Hygiene Law (Kendra's Law) § 9.60 (McKinney 2006). Kendra's Law went into effect in late 1999. Marc Santora, *Court Upholds Law for Forced Treatment*, N.Y. Times, http://www.nytimes.com/2004/02/18/nyregion/court-upholds-law-for-forced-treatment.html?src=pm (Feb. 18, 2004).

15. A few months after the attack on Kendra Webdale, the New York State Senate highlighted the purpose and significance of establishing an effective outpatient treatment law in New York:

> The core principle behind [Kendra's Law] is that true compassion for the mentally ill requires us to acknowledge that some patients, though capable of functioning well in the community with treatment, have great difficulty taking responsibility for their own care. Denial of the need for treatment is a common manifestation of mental illness. A patient who repeatedly exhibits such tendencies should be carefully monitored. And if the patient abandons treatment again and rebuffs efforts to solicit compliance, a doctor should have some recourse *before* the patient deteriorates further. Under current New York law, families and caregivers are forced to stand by helplessly and watch their loved ones and patients repeat the heartbreaking cycle of release, noncompliance, decompensation, dangerous behavior, and more hospitalization.
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> This legislation takes a significant step towards addressing this problem by establishing a process of "assisted outpatient treatment" for mentally ill individuals with a history of noncompliance with treatment who are unlikely to survive safely without supervision. If such an individual needs treatment to prevent a relapse or deterioration and is unlikely to participate in treatment voluntarily, then the bill authorizes family members, caregivers[,] and certain others to file a petition—supported by a psychiatrist—to obtain a court order requiring compliance with a treatment plan.

Memo. from Kathy A. Bennett, Chief, Legis. Bureau, to James M. McGuire, Counsel to the Gov., *RE: S.5762–A* 12–13 (Aug. 20, 1999) (available as part of N.Y. Bill Jacket, N.Y. Sen. 5762, 222d Leg., 1999–2000 Reg. Sess. (June 3, 1999)).

16. *See generally* E. Fuller Torrey, *Compassion, Compulsion and the Mentally Ill*, Wall St. J. (June 9, 2008) (available at http://online.wsj.com/article/SB121297144756555917.html?mod=opinion_main_commentaries) (discussing the complexion of outpatient treatment laws in general).

17. N.Y. Mental Hygiene Law § 9.60(e). Under the statute, the parties who may file a petition for outpatient treatment on a patient's behalf include a parent, spouse, sibling, or child of the patient; the director of an organization, agency, or home that provides mental

order a patient to participate in an outpatient treatment program as a requirement for the patient's release from an inpatient setting.[18] Upon receiving this petition, a court may grant it if the petitioner has shown by clear and convincing evidence that the patient meets certain statutory criteria, one of which necessitates outpatient treatment when a patient has a deteriorative condition that could cause him or her to harm others.[19]

New York experienced tremendous success following its enactment of Kendra's Law. According to a 2005 report by the New York State Office of Mental Health, acts of physical violence, hospitalizations, arrests, incarcerations, and homelessness declined steeply in just six months among those who participated in outpatient treatment under Kendra's Law.[20] Researchers behind a series of published articles known as the "Duke [University] Studies"[21] also found that among individuals with multiple hospital readmissions, arrests, and/or violent behavior in a prior year, long-term outpatient treatment reduced hospitalization by up to seventy-four percent, arrests by seventy-four percent, and violence by up to fifty percent.[22] In the words of Alexander Sasha

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health services to the patient; the patient's psychologist; a director of community services or social worker in the city or county in which the patient resides; or the patient's parole or probation officer. *Id.* at § 9.60(e)(i)–(ii), (iv), (vi)–(viii).

18. *Id.* at § 9.60(e)(iii), (v). For the purposes of this Article, the term *inpatient setting* is synonymous with *hospital* and *receiving facility*, and vice versa.

19. *Id.* at § 9.60(c)(6), (j). In addition, a court cannot grant an order for outpatient treatment unless the patient also meets the following statutory prerequisites: (1) is at least eighteen years old; (2) suffers from a mental illness; (3) is unlikely to live in the community without supervision, according to a clinical determination; (4) has a history of noncompliance with treatment for mental illness that has resulted in: (i) hospitalization at least twice in the last three years or the receipt of mental health services in a correctional facility or (ii) serious violent behavior or the threat of physical harm toward others within the past four years; (5) is unlikely to participate voluntarily in outpatient treatment because of his or her mental illness; and (6) is likely to benefit from outpatient treatment. *Id.* at § 9.60(c)(1)–(5), (7).

20. *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment* 16–18 (N.Y. St. Off. of Mental Health Mar. 2005) (available at http://bi.omh.ny.gov/aot/files/AOTFinal2005.pdf).

21. *See generally* Treatment Advoc. Ctr., *A Benefit of Outpatient Commitment Often Overlooked—Preventing Victimization*, http://www.treatmentadvocacycenter.org/GeneralResources/index.php?option=com_content&task=view&id=493&Itemid=97) (accessed Feb. 8, 2013) (describing the Duke Studies and providing links to each of the articles that comprise the Duke Studies).

22. Alexander Sasha Bardey, *Tampa Tribune, Treatment before Tragedy: Lessons from Kendra's Law*, http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=444&Itemid=197 (Mar. 15, 2003) (providing data from various articles of the Duke Studies).

Bardey, M.D., former director of the New York Bellevue Hospital Assisted Outpatient Treatment Program, "[a]ssisted outpatient treatment works."[23]

In the wake of the sea change in the mental health system in New York, a host of other states soon followed suit, passing their own outpatient treatment laws.[24] Today, forty-four states have enacted such laws.[25] Florida became one of those states in 2004,[26] after police took the life of an armed paranoid schizophrenic who killed a Seminole County Sheriff's deputy, concluding a thirteen-hour standoff.[27] Oddly, despite the number of states that have

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23. *Id.*

24. In 2002, for example, California enacted Laura's Law, named in honor of Laura Wilcox, a nineteen-year-old girl whom a paranoid schizophrenic man shot to death while she was working at California's Nevada County Behavioral Health Clinic. Nick & Amanda Wilcox, *A Family Determined to Help*, Catalyst (newsltr. of the Treatment Advoc. Ctr.) 9, 9 (Fall 2008); *Ten Years of Progress, More to Come*, Catalyst (newsltr. of the Treatment Advoc. Ctr.) 1, 2 (Fall 2008).

25. Phyllis Hanlon, *New England Psychologist*, *Maine Passes Assisted Outpatient Treatment Law*, http://www.nepsy.com/articles/leading-stories/maine-passes-assisted-outpatient-treatment-law/ (June 1, 2010).

26. *See* Fla. Stat. § 394.4655 (2011) (codifying Florida's outpatient treatment law); *see also New Help, New Hope, in Florida: Landmark Legislation Makes Florida the 42nd State to Authorize Assisted Outpatient Treatment*, Catalyst (newsltr. of the Treatment Advocacy Ctr.) 1, 1 (Summer 2004); *see also* John Petrila & Annette Christy, *Florida's Outpatient Commitment Law: A Lesson in Failed Reform?* 59 Psych. Servs. 21, 21 (2008) (available at http://www.ps.psychiatryonline.org/data/Journals/PSS/3833/08ps21.pdf) (stating that in 2004, the Florida legislature amended the State's civil commitment law to allow outpatient treatment and that the law took effect in 2005). Florida's outpatient treatment law is in many ways similar to Kendra's Law, described in pertinent part in *supra* note 15, but some important distinctions do exist between the two statutes. Under Florida's outpatient treatment law, a court cannot order a person to participate in outpatient treatment unless that person has a history of noncompliance with treatment for mental illness and that noncompliance has resulted in serious violent behavior toward others or the attempted harm of others within the past three years—not four years as defined under Kendra's Law. Fla. Stat. § 394.4655(1)(e)(2); N.Y. Mental Hygiene Law § 9.60(c)(4)(ii). In addition, the Florida statute is somewhat narrower than Kendra's Law in that Florida's courts cannot order a person to participate in an outpatient treatment program unless "[a]ll available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable." Fla. Stat. § 394.4655(1)(i). See *infra* Part II(D) for further comparison and contrast between Florida's law and Kendra's Law.

27. Dave DiMarko, *Seminole Deputy's Death Spurs Changes*, http://baynews9.com/content/news/baynews9/news/article.html/content/news/articles/ot/both/2010/07/08/Seminole_deputy_s_death_spurs_changes (last updated July 8, 2010); *see also* Petrila & Christy, *supra* n. 26, at 21 (stating that after years of deliberation following the murder of the deputy, the Florida legislature allowed involuntary outpatient commitment by amending the State's civil commitment law).

adopted outpatient treatment laws, few actually use them.[28] Even in New York, only a handful of counties regularly employ the State's outpatient treatment law.[29] E. Fuller Torrey, M.D., a research psychiatrist who specializes in schizophrenia and manic-depressive illness and who is the founder of the Treatment Advocacy Center in Arlington, Virginia, says that one reason for the under-utilization of these laws is the conception among states that outpatient treatment programs are expensive.[30]

This belief would hamper the use of outpatient treatment laws in Florida perhaps more so than in any other state because Florida has an impoverished mental health service system[31] and has made no funding available for the implementation of its outpatient treatment law.[32] Indeed, Florida's outpatient treatment law is all but moribund—during the law's first three years in effect, only seventy-one orders had been issued for outpatient treatment.[33] Researchers also argue that Florida lacks the community treatment resources—services that offer support and

28. *See generally* Torrey, *supra* n. 16 (stating that assisted outpatient treatment is hardly used in the states in which it is available and does not even exist in some states).

29. *Id.*

30. Treatment Advoc. Ctr., *Home*, *About Us*, *Dr. E. Fuller Torrey*, http://www.treatmentadvocacycenter.org/about-us/dr-e-fuller-torrey (accessed Feb. 8, 2013); Torrey, *supra* n. 16. Dr. Torrey maintains that these programs are not expensive, arguing that the failure to use outpatient treatment laws in fact results in greater costs for states. *Id.* Dr. Torrey cites the high costs of repeated hospital readmissions, incarcerations, and homicides and other forms of violence—the costs of all of which, he contends, are incurred by local and state coffers in the absence of outpatient treatment laws. *Id.*

31. Petrila & Christy, *supra* n. 26, at 22 (noting that Florida ranks forty-eighth in per capita spending on mental healthcare) (citing Fla. Dep't of Children & Fams., *Mental Health Transformation: Issue Summary* 16 (Nov. 2006) (available at http://www.dcf.state.fl.us/admin/publications/docs/visionvaluevoices2006full.pdf)); *see also* Fla. Sup. Ct. Mental Health Subcomm. of Steering Comm. on Fams. & Children in the Ct., *Transforming Florida's Mental Health System: Strategies for Planning, Leadership, Financing, and Service Development* 11 (Nov. 2007) (available at http://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf) [hereinafter *Transforming Florida's Mental Health System*] (stating that "the level of expenditures on front-end community-based services intended to promote recovery, resiliency, and adaptive life [among the severely mentally ill] in the community place the state near dead last").

32. Petrila & Christy, *supra* n. 26, at 22 (pointing out that in contrast to New York, where the State made significant new funds available to implement Kendra's Law, Florida made no new funding available to implement its outpatient commitment law).

33. *Id.* (stating that Florida's outpatient treatment law has been "virtually ignored" in Florida and that "[t]he fact that outpatient commitment orders have been issued in only [seventy-one] cases in nearly three years suggests that Florida's outpatient commitment law has had little effect on practice").

treatment for the mentally ill during the outpatient process[34]—and the enforcement mechanisms necessary to make its outpatient treatment law effective.[35] Although Julio Perez, Andrew Goldstein, and others[36] have awakened legislatures like Florida's to the fact that the severely mentally ill[37] are more likely to go untreated and become violent without outpatient treatment laws in place, these laws cannot be effective without implementation.

This Article's objective is not to discuss outpatient treatment in Florida as a follow-up program to the traditional inpatient setting—that is, hospitalization. Instead, this Article recommends how Florida's outpatient treatment law can be improved and extended to reach the hordes of severely mentally ill drifters—people like Julio Perez—who are ignored as they fight their diseases and have little, if any, recourse. These individuals are often homeless and find themselves in and out of Florida's jails and prisons,[38] which have become de facto mental health institutions over recent decades.[39] More so than almost all other states, Florida must find ways to rethink and revitalize its outpatient treatment law because of its unbridled homeless population,[40]

34. *See generally e.g.* Agency for Community Treatment Servs., Inc., *About Us*, http://actsfl.org/html/about_us.html (accessed Feb. 8, 2013) (providing background information about community treatment services).

35. Petrila & Christy, *supra* n. 26, at 22. For a discussion of enforcement mechanisms in the context of Florida's outpatient treatment law, consult *infra* Part II(B).

36. *See supra* nn. 24, 27 and accompanying text (discussing tragedies that occurred at the hands of the severely mentally ill in California and Florida, respectively).

37. Providing illumination to the term *severe mental illness*, one federal court noted a medical doctor's definition of the term: "[a disease] that has caused significant disruption in [a person's] everyday life and which prevents his [or her] functioning in the general population without disturbing or endangering others or himself [or herself]." *Tillery v. Owens*, 719 F. Supp. 1256, 1286 (W.D. Pa. 1989) (referring to a definition provided by the plaintiffs' witness, Dr. Metzner). See *infra* note 68 for further discussion of the term *severe mental illness* as defined by Dr. Metzner in the *Tillery* case. In addition, one researcher defines *severe mental illness* as "a lifetime clinical diagnosis of schizophrenia or other psychotic disorder, major depression, mania, or bipolar disorder." Jason C. Matejkowski et al., *Characteristics of Persons with Severe Mental Illness Who Have Been Incarcerated for Murder*, 36 J. Am. Acad. Psych. & L. 74, 76 (2008) (available at http://jaapl.org/content/36/1/74.full.pdf+html).

38. *See* John Monahan, *Mental Disorder and Violent Behavior*, 47 Am. Psychologist 511, 519 (1992) (stating that the relationship between severe mental illness and violent behavior "underscores the need for readily available mental health services . . . in correctional institutions").

39. See Part II(A) of this Article for a discussion of the role of jails and prisons as de facto mental health institutions.

40. See Part II(C) of this Article for a discussion of Florida's homeless population and the significant number of mentally ill among that population. Part II(C) also discusses

which eclipses that of every state except California and New York, and among which vast numbers are severely mentally ill.[41]

This Article argues that Florida has in place an unchampioned but cost-effective method—one that need not include the redesign of the current mental health system[42]—by which it may increase the efficacy of its outpatient treatment law. Florida should use its homeless ordinances, such as St. Petersburg's panhandling ordinance,[43] and the healthcare services available in its jails and prison systems to revitalize its outpatient treatment law. The enforcement of Florida's homeless ordinances provides the State with an ideal method for the identification of the severely mentally ill among the homeless. Although jails and prisons may not be model settings for the treatment of these individuals, they are nevertheless, as today's de facto mental health institutions, the most practical settings for providing the severely mentally ill with the care they need to prepare them for outpatient treatment. This approach would not only allow Florida to reach those who most need the law's services and who may pose an increased risk of violence to the public[44] but would also reduce the costs of care associated with its mental health system.

Part II of this Article briefly describes the history of the legal regulations affecting the mentally ill and introduces social and scientific evidence for the relationship among mental illness, violence, and the homeless. Part II also considers specific shortcomings of Florida's outpatient treatment statute. Part III of this Article proposes recommendations for rethinking and revitalizing Florida's outpatient treatment law and discusses how these rec-

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Florida's homeless population in comparison to the homeless populations of states like California and New York, the only two states that have more homeless than Florida.

41. *See* Part II(C) (discussing the large population of homeless in Florida).

42. In a 2007 report on the status of Florida's mental health system, a State-appointed executive subcommittee on mental health recommended that the State "invest in a redesigned and transformed system of care." *Transforming Florida's Mental Health System*, *supra* n. 31, at 12. For more on this report, see *infra* Part II(E).

43. St. Petersburg Code Ordin. (Fla.) § 20-79 (current through July 15, 2010) (available at http://search.municode.com/html/11602/level4/PTIISTPECO_CH20OFMIPR_ARTIVOFINPUPEOR_DIV1GE.html#PTIISTPECO_CH20OFMIPR_ARTIVOFINPUPEOR_DIV1GE_S20-79PA).

44. *See* Bardey, *supra* n. 22 (stating that in Florida, people like Andrew Goldstein do exist, and like Andrew Goldstein, some are "headed for tragedy" and in need of immediate help). See *infra* Part II(B) for a discussion of the relationship among severe mental illness, violence, and homelessness. See *infra* Part II(C) for an examination of the prevalence of severe mental illness among the homeless.

ommendations would not only make the law more effective but also save the State millions in mental healthcare costs. Part IV of this Article concludes that these recommendations provide a method by which Florida can commit to the well-being of the mentally ill, preserve the security of the public, and reduce the State's healthcare costs in the process.

II. BACKGROUND: MENTAL ILLNESS AND THE LAW

This Part begins by considering the history of the legal regulations affecting the mentally ill and examines how the mentally ill have transformed the role of jails and prisons over several decades. This Part also introduces some of the most prominent studies examining the relationship between severe mental illness and violence, in addition to the prevalence of severe mental illness among the homeless and the financial cost of recidivism. Then, this Part discusses the shortcomings of Florida's outpatient treatment law and presents the recommendations that a State-appointed subcommittee on mental health recently made for revamping Florida's mental health system.

A. Deinstitutionalization and the New Role of Jails and Prisons

Having begun in 1955 and still in progress today, *deinstitutionalization* is the release of the severely mentally ill from state mental hospitals into the community.[45] In 1955, state mental hospitals housed 559,000 mentally ill individuals nationwide, but by 2005, the number of hospital beds shrank to only forty-seven thousand.[46] This reduction has been and continues to be a pecuniary necessity for most states, which are desperate to defray the high costs of hospitalizing the mentally ill.[47] The advent of antipsychosis medications, which led to the belief that the mentally ill with symptoms of psychosis could be effectively treated while liv-

45. *See generally* Torrey, *supra* n. 16 (describing the process of deinstitutionalization).

46. *Id.*

47. *See generally Transforming Florida's Mental Health System*, *supra* n. 31, at 9 (stating that by the mid-1900s, state mental hospitals were "stretched beyond [their] limits and states desperately needed some alternative to addressing this costly and ever-expanding crisis").

ing in the community, has also led to the release of the severely mentally ill.[48]

In addition, with the exposure of abusive treatment of the mentally ill in various state mental hospitals,[49] federal lawsuits accelerated the process of deinstitutionalization.[50] One of these lawsuits originated in Florida and became a landmark case, placing the State in the thick of the deinstitutionalization movement.[51] In 1975, in *O'Connor v. Donaldson*,[52] the United States Supreme Court addressed whether a Florida mental hospital had violated a patient's constitutional right to liberty when administrators and staff had hospitalized him for fifteen years without evidence that he was a danger to himself or others.[53] The Court ruled that mental illness alone is insufficient to justify prolonged hospitalization of a person if the person is not a danger to others.[54]

With the *O'Connor* decision and other factors contributing to the influx of the mentally ill into the public, the term *deinstitutionalization* became something of a misnomer because large numbers of the mentally ill who were freed into the community eventually landed in jails and prisons.[55] Instead of remaining deinstitutionalized, they were "transinstitu[t]ionalized"[56]—transplanted from state mental hospitals to prisons.[57] Jails and prisons, for all practical purposes, became the new state mental hospitals, home to vast numbers of severely mentally ill individuals.[58] In fact, more Americans now receive treatment for mental illness in jails and prisons than hospitals or other facilities; the largest psychiatric facility in the nation, New York City's Rikers

48. *Id.*

49. *Id.* (noting that abusive treatment of the mentally ill in hospitals included the use of straightjackets and chains).

50. *Id.*

51. *Id.* at 18 (noting the influential nature of the *O'Connor* case on the process of deinstitutionalization in the United States).

52. 422 U.S. 563 (1975).

53. *Id.* at 564–574.

54. *Id.* at 575 (holding that "[a] finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement").

55. *Transforming Florida's Mental Health System*, *supra* n. 31, at 10.

56. *Id.*

57. *Id.*

58. *Id.* (stating that prisons serve as "de facto mental health institutions" for the severely mentally ill).

Island, is not a hospital at all but a prison that houses approximately three thousand mentally ill inmates.[59] Similarly, mental health wards occupy nearly half of the nine floors in Miami–Dade's County Jail.[60] According to a 2006 report by the United States Department of Justice, fifty-six percent of state prisoners are mentally ill, as are sixty-four percent of local inmates.[61] In Florida, 125,000 mentally ill individuals who require immediate treatment are arrested and booked annually.[62] In summing up the effects of deinstitutionalization on the mentally ill and on state jails and prisons, Steve Leifman, advisor on criminal justice and mental health for the Florida Supreme Court, said, "'If you think [healthcare] in America is bad, you should look at mental [healthcare] . . . . The one institution that can never say no to anybody is jail.'"[63]

With deinstitutionalization on the rise, courts recognized the new roles of jails and prisons as de facto mental health institutions and began to define standards by which jail and prison systems must care for the mentally ill.[64] The courts have created an extensive body of caselaw[65] regarding the minimal healthcare standards that jail and prison systems must satisfy under the

59. M.J. Stephey, *De-Criminalizing Mental Illness*, Time, http://www.time.com/time/health/article/0,8599,1651002,00.html (Aug. 8, 2007).

60. *Id.*

61. Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* 1 (U.S. Dep't of Just., Sept. 2006) (revised Dec. 14, 2006) (available at http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf). The prisoners in this study exhibited symptoms of mental illness in the twelve months prior to their interviews. *Id.* According to the report, forty-three percent of state prisoners and fifty-four percent of jail inmates showed symptoms of mania; twenty-three percent of state prisoners and thirty percent of jail inmates showed symptoms of major depression; and fifteen percent of state prisoners and twenty-four percent of jail inmates showed symptoms of psychosis. *Id.*

62. *Transforming Florida's Mental Health System*, *supra* n. 31, at 34.

63. Stephey, *supra* n. 59 (quoting Steve Leifman).

64. *See e.g. Jones v. Wittenburg*, 509 F. Supp. 653, 659 (N.D. Ohio 1980) (stating that "[t]here was a time not too long ago when the federal judiciary took a completely 'hands-off' approach to the problem of jail administration. In recent years, however, these courts largely have discarded this 'hands-off' attitude and have waded into this complex arena").

65. *See generally* Memo. from David S. Niss, Staff Att'y, to L. & Just. Interim Comm., *Constitutional and Federal Law Requirements for Mental Health Care for Convicted Offenders, Jailed Persons, and Detainees in Montana* 4–5 (Sept. 14, 2007) (available at http://leg.mt.gov/content/committees/interim/2007_2008/law_justice/staff_reports/MENTAL%20HEALTH%20MEMO2.pdf) (describing the broad body of caselaw created by the federal courts regarding the minimal standards of mental healthcare that jails and prison systems must meet when treating the mentally ill).

Eighth Amendment.[66] In 1976, the Supreme Court first broached this topic in *Estelle v. Gamble*,[67] in which it underscored prisoners' rights to have adequate mental healthcare, holding that "deliberate indifference[68] [by prison officials] to serious medical needs[69] of prisoners" creates a cause of action under Title 42 U.S.C. Section 1983.[70] After *Estelle*, courts went on to establish minimal working standards that jails and prisons must meet when treating the mentally ill.[71] In *Ruiz v. Estelle*,[72] a prominent case in this vein, the United States District Court for the Southern District of Texas developed basic criteria for the treatment of the mentally ill in jails and prisons, holding that the Eighth Amendment requires:

66. U.S. Const. amend. VIII (stating, "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted").

67. 429 U.S. 97 (1976).

68. *Id.* at 104. Although the Court did not define the term *deliberate indifference* in *Estelle*, it did so several years later in *Farmer v. Brennan*, 511 U.S. 825, 835–840 (1994). "Although we have never paused to explain the meaning of the term 'deliberate indifference,'" the Court stated, "the [caselaw] is instructive. The term first appeared in the United States Reports in *Estelle v. Gamble* . . . ." *Id.* at 835. Refusing to adopt an objective test for deliberate indifference, the Court ruled that under the Eighth Amendment, a prison official cannot be held liable for violating minimal standards of healthcare unless that "official knows of and disregards an excessive risk to inmate health or safety." *Id.* at 837.

69. In *Tillery*, the United States District Court for the Western District of Pennsylvania brought clarification to the words *serious medical needs*, referring to a definition by Dr. Metzner, a medical doctor for the plaintiff's witness:

> [A] severe mental illness [is] one that has caused significant disruption in an inmate's everyday life and which prevents his [or her] functioning in the general population without disturbing or endangering others or himself [or herself]. Severely mentally ill inmates display symptoms of withdrawal, thought disorganization, bizarre behavior[,] and difficulty with reality, often manifested by hallucinations. Some of these people are repulsive due to their total disregard for personal hygiene. Such inmates increase tension for staff and other inmates in an already strained prison environment by screaming all night, talking loudly to themselves, laughing hysterically for no apparent reason, and even setting fires.

719 F. Supp. at 1286.

70. 429 U.S. at 104–105. Title 42 U.S.C. Section 1983 is "the federal [statute] under which most federal constitutional rights may be enforced against a state or political subdivision of a state in state or federal court." Memo. from David S. Niss, *supra* n. 65, at 2.

71. Memo. from David S. Niss, *supra* n. 65, at 3–4 (stating that courts gradually adopted these working standards for jails and prisons and providing examples of cases that the courts addressed in this vein).

72. 503 F. Supp. 1265 (S.D. Tex. 1980), *modified in part*, *vacated in part*, 688 F.2d 266 (5th Cir. 1982).

> (1) a systematic program by which personnel can screen for mentally ill individuals;
>
> (2) treatment that includes close supervision of the mentally ill;
>
> (3) trained mental health professionals who are present in sufficient numbers to provide treatment to the mentally ill;
>
> (4) accurate, complete, and confidential records regarding the treatment of the mentally ill;
>
> (5) the prescription and administration of psychotropic medications under appropriate supervision; and
>
> (6) a basic program by which personnel can identify, treat, and supervise mentally ill individuals with suicidal tendencies.[73]

In analyzing the six components that comprise these minimal standards, courts have adopted a case-by-case approach to addressing emerging issues like the quality, timeliness, and applicability of treatment in jails and prisons that provide mental healthcare.[74] Regarding the quality of treatment, in *Jones v. Wittenburg*,[75] the United States District Court for the Northern District of Ohio found that the lack of availability of a psychiatrist in a jail where numerous inmates had psychiatric problems did not satisfy the minimal standards of treatment.[76] Regarding timeliness, in *Coleman v. Wilson*,[77] the United States District Court for the Eastern District of California held that a prison is liable for deliberate indifference when delays in medical treatment prevent inmates from seeing a psychiatrist for up to three months.[78] The court reasoned that "delay [in prisoners' treatment] perpetuates the human suffering caused by the violations of the federal Con-

73. *Id.* at 1339.

74. Memo. from David S. Niss, *supra* n. 65, at 4–5 (discussing the case-by-case approach that courts have adopted when determining compliance under the minimal standards of treatment and noting that courts have reviewed particular issues like the quality, timeliness, and applicability of treatment in the context of one or more of the six components that comprise the minimal standards).

75. 509 F. Supp. 653 (N.D. Ohio 1980).

76. *Id.* at 686–687.

77. 912 F. Supp. 1282 (E.D. Cal. 1995).

78. *Id.* at 1309.

stitution . . . . Deliberate indifference is nothing if it is not that."[79] The court rejected the argument that a "chronic problem of understaffing" and a low budget absolved the defendants from liability under the Eighth Amendment.[80] Regarding the applicability of treatment, the United States Court of Appeals for the Third Circuit held that the minimal standards of treatment apply not only to treatment that prisons provide but also to treatment that county or municipal jails provide.[81] In addition, although the United States Court of Appeals for the Eleventh Circuit held that municipal jails meet the minimal standards of treatment if they transport inmates to local hospitals when treatment is not available at the jails, jail personnel must still be able recognize when mentally ill inmates require transportation.[82]

To assess the body of caselaw that the federal courts have forged, the American Psychiatric Association created a Task Force on Psychiatric Services in Jails and Prisons, which reports on the legal standards for the treatment of the mentally ill in jails and prisons. In 2000, the American Psychiatric Association released its latest edition of *Psychiatric Services in Jails and Prisons: A Task Force Report of the American Psychiatric Association*,[83] which includes a two-part report from the Task Force—the first part titled "Principles Governing the Delivery of Psychiatric Services in Jails and Prisons" and the second part titled "Guidelines for Psychiatric Services in Jails and Prisons."[84] The Task Force's fundamental position is that "mental health service

79. *Id.* at 1319.

80. *Id.* at 1317–1318.

81. *See e.g. Inmates of Allegheny Co. Jail v. Pierce*, 612 F.2d 754, 762 (3d Cir. 1979) (holding that for pretrial detainees, as opposed to convicted prisoners, the court must conduct its analysis under the Fourteenth Amendment rather than the Eighth Amendment, but "at a minimum the 'deliberate indifference' standard of *Estelle v. Gamble* . . . must be met"); *Young v. Augusta*, 59 F.3d 1160, 1171 (11th Cir. 1995) (holding that a claim that jail personnel are inadequately trained to recognize the need to transport a mentally ill inmate to a hospital or administer prescribed medication is cognizable if the personnel demonstrate deliberate indifference).

82. *Augusta*, 59 F.3d at 1171.

83. *Psychiatric Services in Jails and Prisons: A Task Force Report of the American Psychiatric Association* (2d ed., Am. Psychiatric Ass'n). "For the past decade, the first edition of these unique guidelines . . . has lighted the way for those seeking to navigate the perilous shoals of providing psychiatric services in jails and prisons. These guidelines have been used and cited extensively in many contexts." *Id.* at xiii.

84. *Id.* at 1–30, 31–46.

should . . . provide the same level of care to patients in the criminal justice process that is available in the community."[85]

B. The Relationship between Severe Mental Illness and Violence

As the courts grappled with the issue of deinstitutionalization, the link between severe mental illness and violence—and by extension, between deinstitutionalization and violence—became a hot-button subject among researchers and mental health professionals.[86] The traditional viewpoint is that no such relationship exists "at greater than chance levels."[87] The majority in this camp are either advocates for the mentally ill[88] or sociological and psychological researchers.[89] One scholar who formerly subscribed to the traditional viewpoint is Dr. John Monahan, professor of law, psychology, and psychiatric medicine at the University of Virginia School of Law.[90] Courts have often cited Dr. Monahan's works,[91] including the California Supreme Court in the landmark case *Tarasoff v. Regents of the University of California*.[92] In addition, the United States Supreme Court noted an expert witness's reli-

85. *Psychiatric Services in Jails and Prisons: Position Statement*, 146 Am. J. Psych. 1244, 1244 (1988) (available at http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps1988_Jails.pdf). Two practicing psychiatrists echo the Task Force's position in *Manual of Psychiatric Quality Assurance: A Report of the American Psychiatric Association Committee on Quality Assurance*, noting, in the conclusion of their piece "Quality Assurance in Jails and Prisons," that "[a]lthough prisons and jails represent a unique and often difficult setting for psychiatric treatment," access to treatment "should be the same for inmates as [it is] for citizens in the community." Robert L. Eisler & Henry C. Weinstein, *Quality Assurance in Jails and Prisons*, in *Manual of Psychiatric Quality Assurance: A Report of the American Psychiatric Association Committee on Quality Assurance* 107, 110 (Marlin R. Mattson, ed., Am. Psychiatric Ass'n 1992).

86. *See generally* Monahan, *supra* n. 38, at 513–514 (discussing the competing viewpoints regarding whether a relationship exists between mental illness and violence).

87. *Id.* at 511, 513.

88. *Id.* at 513. *See e.g.* Rena Scheffer, *Addressing Stigma: Increasing Public Understanding of Mental Illness* 6 (Ctr. for Addiction & Mental Health May 28, 2003) (available at http://knowledgex.camh.net/policy_health/diversity_hr/Documents/addressing_stigma_senatepres03.pdf) (stating that the relationship between mental illness and violent crimes is based on "myths").

89. Monahan, *supra* n. 38, at 513; *e.g.* John Monahan, *The Clinical Prediction of Violent Behavior* (U.S. Dep't of Health & Human Servs. 1981).

90. Dr. Monahan is the John S. Shannon Distinguished Professor of Law, the Horace W. Goldsmith Research Professor of Law, and Professor of Psychology and Psychiatric Medicine. His homepage is located at http://www.law.virginia.edu/lawweb/faculty.nsf/PrFMPbW/jtm9p (accessed Feb. 8, 2013).

91. *Id.* (mentioning the cases in which courts have cited Dr. Monahan's works).

92. 551 P.2d 334, 344–345 n. 10 (Cal. 1976).

ance on Dr. Monahan as "'the leading thinker on [the] issue'" of violence risk assessment.[93]

In the early 1980s, Dr. Monahan examined hundreds of studies on the relationship between crime and mental illness to determine whether a nexus exists between mental illness and violent behavior.[94] He concluded that no such relationship exists; instead, he attributed crime to historical and demographic characteristics such as age, race, gender, social class, and previous institutionalization—but not mental illness.[95] Less than a decade later, however, Dr. Monahan retracted his conclusion, stating in a new study, *Mental Disorder and Violent Behavior*,[96] that it was premature and likely incorrect.[97] Relying primarily on newfound epidemiological data and evidence,[98] Dr. Monahan now states, "[M]any social science researchers and the patient advocates who cite them seem equally convinced that no such connection exists. Although I have long been in [agreement], . . . I now believe that there may be a relationship between mental disorder and violent behavior . . . ."[99]

Roughly a decade after Dr. Monahan changed his position, Dr. Jeffrey W. Swanson, professor of psychiatry and behavioral science at Duke University Medical Center, and his colleagues examined the prevalence of violent behavior among severely mentally ill patients and identified risk factors associated with their violence.[100] Having collected data from over eight-hundred

93. *Barefoot v. Estelle*, 463 U.S. 880, 899 n. 7 (1983). One of the petitioner's expert witnesses, Dr. Dickerson, cautioned the trial court that "psychiatric predictions of future dangerousness . . . are often inaccurate." *Id.* Dr. Dickerson, however, conceded that a study by Dr. Monahan was "'excellently done.'" *Id.*

94. *See* John Monahan & Henry J. Steadman, *Crime and Mental Disorder: An Epidemiological Approach*, 4 Crime & Just. 145, 145 (1983) (examining the relationship between crime and mental illness).

95. *Id.* at 152. Dr. Monahan wrote, "When appropriate statistical controls are applied for factors such as age, gender, race, social class, and previous institutionalization, whatever relations between crime and mental disorder are reported tend to disappear." *Id.*

96. Monahan, *supra* n. 38, at 514.

97. *Id.*

98. Dr. Monahan homes in on (1) the prevalence of violence in individuals with mental illness among mental patients and members of the community and (2) the prevalence of mental illness in violent individuals who are criminals and among community samples. *Id.*

99. *Id.* at 511. Dr. Monahan describes in detail the epidemiological data and evidence supporting his new findings. *Id.* at 514–519.

100. *The Social-Environmental Context of Violent Behavior in Persons Treated for Severe Mental Illness*, 92 Am. J. Pub. Health 1523, 1523 (2002) (available at http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.92.9.1523).

severely mentally ill patients in four states, Dr. Swanson found that the prevalence of violent behavior among them over a one-year period was thirteen percent.[101] Through a statistical analysis, Dr. Swanson concluded that violence among the severely mentally ill is related to multiple risk factors, including homelessness, substance abuse, a history of being subjected to violence, and poor medical health.[102] Although Dr. Swanson found that violence among the severely mentally ill is independently associated with homelessness,[103] the one-year rate of violence for those mentally ill subjects who exhibit only one risk factor (e.g., homelessness, substance abuse, a history of being subjected to violence, or poor medical health) is just two percent, indicating that violent behavior is contingent on possessing more than one risk factor.[104] Homelessness and poor medical health, however, often coexist,[105] a fact that may place the severely mentally ill who are homeless at a higher risk for violence.

A few years after Dr. Swanson's report, Jason C. Matejkowski and his colleagues at the University of Pennsylvania conducted further research into the relationship between severe mental illness and violence,[106] in the largest study of its kind in the United States.[107] Mr. Matejkowski reviewed the records of 723 people convicted of homicide in Indiana between 1990 and 2002.[108] Within that timeframe, he found that the severely mentally ill were responsible for approximately ten percent of all the homicides in Indiana—a number that equates to about 1,700 of the 17,034 total homicides in the United States in 2006.[109] Of those convicted murderers who were severely mentally ill, nearly twelve percent were classified as homeless or unknown.[110] In two smaller but similar studies that preceded Mr. Matejkowski's study,

101. *Id.* at 1523, 1528.
102. *Id.* at 1528–1529.
103. *Id.* at 1528.
104. *Id.* at 1529.
105. *See e.g.* James D. Wright, *Poor People, Poor Health: The Health Status of the Homeless*, 46 J. Soc. Issues 49, 49, 60–63 (1990) (finding that based on clinical data from the National Health Care for the Homeless program, physical and mental illnesses are consequences of homelessness).
106. Matejkowski et al., *supra* n. 37, at 74.
107. Torrey, *supra* n. 16.
108. Matejkowski et al., *supra* n. 37, at 76.
109. Torrey, *supra* n. 16.
110. Matejkowski et al., *supra* n. 37, at 78–79.

researchers arrived at comparable results, finding that severely mentally ill individuals committed ten percent of all homicides within Contra Costa County, California, and twenty-nine percent of homicides within Albany County, New York.[111]

While peers have given Mr. Matejkowski's study high praise and attention,[112] Annette Friend, M.D., proposes that readers should exercise caution when assessing the study's findings, citing selection bias as a possible concern.[113] Simply put, selection bias is the distortion of statistics that results from the way a researcher chooses a sample.[114] For example, in Mr. Matejkowski's research, selection bias limits the study because individuals who are "arrested, incarcerated, or hospitalized are by definition more likely to be violent or very ill and thus are not representative of psychiatric patients in the general population."[115] A similar selection bias might also have limited Dr. Swanson's study, in which he used patients who had been previously hospitalized as his participants.[116]

According to Richard A. Friedman, M.D., a less biased study of the relationship between mental illness and violence comes from epidemiological data,[117] samples derived from individuals in the community—the type of data that Dr. Monahan used in *Mental Disorder and Violent Behavior*.[118] Dr. Monahan, however, believes that the effects of statistical bias are inconsequential when defining the relationship between mental illness and violence:

> Whether the measure is the prevalence of violence among the disordered or . . . disorder among the violent, whether

111. Torrey, *supra* n. 16 (briefly describing these two smaller studies).

112. *See e.g.* Annette Friend, *Commentary: Describing Differences—Possibilities and Pitfalls*, 36 J. Am. Acad. Psych. & L. 87, 87 (2008) (available at http://www.jaapl.org/cgi/reprint/36/1/87) (describing Mr. Matejkowski's study as "creative" and "descriptive"); Torrey, *supra* n. 16 (discussing the results of Mr. Matejkowski's study in the context of deinstitutionalization and the costs that deinstitutionalization imposes on society).

113. Friend, *supra* n. 112, at 88–89.

114. Matejkowski et al., *supra* n. 37, at 74.

115. Richard A. Friedman, *Violence and Mental Illness—How Strong Is the Link?* 355 New Eng. J. Med. 2064, 2065 (2006) (available at http://www.nejm.org/doi/pdf/10.1056/NEJMp068229).

116. Swanson et al., *supra* n. 100, at 1523.

117. Friedman, *supra* n. 115, at 2065 (noting that community samples are the most accurate type of sampling for assessing the severely mentally ill's risk of violence).

118. *Supra* n. 98.

> the sample is . . . inmates or patients . . . or . . . the . . . community, and no matter how many . . . factors are statistically taken into account, there appears to be a relationship between mental disorder and violent behavior.[119]

If a relationship between severe mental illness and violence does in fact exist, the risk of violent behavior by the mentally ill is likely small,[120] increasing the overall rate of violence in the general population by approximately three to five percent.[121]

C. The Prevalence of Severe Mental Illness among the Homeless and the Cost of Recidivism

While Dr. Swanson and Mr. Matejkowski both identify homelessness as one factor that increases the risk of violent behavior among the severely mentally ill, the weight of that risk factor can only depend on the prevalence of severely mentally ill individuals among the homeless—a prevalence to which numerical data provides significant credence. Severely mentally ill individuals, for example, comprise at least one-third of the nationwide homeless population.[122] Florida, which ranks third among all states in homeless inhabitants, is a haven to a homeless population of more than fifty-six thousand, behind only California and New York, respectively.[123] Of those fifty-six thousand, about twenty-five percent—a number that comprises over fourteen thousand—have a severe mental illness, and more than fifty percent have spent time in Florida's jails or prisons.[124] Moreover, of the one hundred twenty-five thousand mentally ill individuals who are arrested and booked annually in Florida, most are homeless.[125] The large majority of them are charged with "minor misdemeanors and

119. Monahan, *supra* n. 38, at 519.

120. *See id.* at 511 (stating that a relationship between mental disorder and violence likely exists but "probably is not large").

121. *See* Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, in *Violence and Mental Disorder: Developments in Risk Assessment* 101, 119 (John Monahan & Henry J. Steadman eds., U. Chi. Press 1994) (stating "[s]ince serious mental illness by itself is quite rare, the attributable risk for violence associated with it is not very high—in the range of about 3.0% to 5.3%").

122. Torrey, *supra* n. 16.

123. Alliance to End Homelessness, *The State of Homelessness in America 2012*, at 20 (Jan. 2012) (available at http://b.3cdn.net/naeh/9892745b6de8a5ef59_q2m6yc53b.pdf).

124. *Transforming Florida's Mental Health System*, *supra* n. 31, at 10.

125. *Id.*

low[-]level felony offenses that are a direct result of their psychiatric illnesses."[126]

These minor misdemeanors are likely violations of homeless ordinances, such as laws that outlaw panhandling, prohibit sleeping in or on the right-of-way, ban temporary shelters on public property, and outlaw the storage of personal property on public property.[127] Each of these laws is now on the books in the City of St. Petersburg,[128] for example, and violation of any one is punishable by up to sixty days' imprisonment.[129] Although St. Petersburg's panhandling ordinance went into effect in June 2010,[130] holdouts have remained in the city, and police have cited and arrested some of them several times.[131] A former member of the city council insists that panhandling will never go away: "'There is a group that is confrontational about this issue,'" and "'they make it their holy grail.'"[132] Other panhandlers have crossed the bridge into Tampa, but now officials there have approved their own panhandling ordinance.[133] Surrounding cities, like the City of Lakeland, have also instituted similar ordinances: in September 2010, Lakeland's city commission approved an anti-

126. *Id.*

127. *See generally* City of St. Petersburg, Fla., *Ordinances and Laws Regarding Homelessness*, http://www.stpete.org/socialservices/homelessness/ordinanceslaws.asp (last modified Nov. 28, 2011) (providing general information on these types of laws as they pertain to the City of St. Petersburg, Florida, and quoting pertinent parts of the ordinances themselves).

128. St. Petersburg City Code (Fla.) §§ 20-74, 20-76, 20-79 (current through Sept. 23, 2010) (available at http://search.municode.com/html/11602/level1/PTIISTPECO.html) (forbidding sleeping in or on the right-of-way, the placement and use of temporary shelters and the storage of personal property, and panhandling).

129. *Id.* at § 1-7.

130. *See generally* Andy Boyle, *St. Petersburg Ordinance Thins Ranks of Panhandlers, but There Are Desperate Holdouts*, St. Petersburg Times B3 (Aug. 13, 2010) (available at http:/www.tampabay.com/news/localgovernment/st-petersburg-ordinance-thins-ranks-of-panhandlers-but-there-are-desperate/1114954) (providing general information about St. Petersburg's panhandling ordinance, including the month and year it became effective and those whom the law affects).

131. *See generally id.* (discussing the struggles of the homeless in St. Petersburg). One homeless man, Michael Ivy, was arrested and incarcerated for a period of ten days in a Pinellas County jail after being charged with violating St. Petersburg's panhandling ordinance for the sixth time. *Id.* After his release, he will "walk back to Fourth Street and Gandy . . . . He'll probably have another sign. And he'll probably get charged again." *Id.*

132. *Id.* (quoting Jamie Bennett, former City Council member of St. Petersburg).

133. *See generally* Richard Danielson, *Tampa Council Gives Final Approval to Six-Day-a-Week Panhandling Ban*, St. Petersburg Times B1 (Oct. 21, 2011) (available at http://www.tampabay.com/news/localgovernment/tampa-council-gives-final-approval-to-six-day-a-week-panhandling-ban/1197711) (reporting on the ban on panhandling in Tampa).

camping ordinance that can carry a penalty of six months' imprisonment for homeless individuals found sleeping in streets and parks.[134]

But the recriminalization of the severely mentally ill for repeated violations "that are a direct result of their psychiatric illnesses"[135] is not without financial burden to the state. In Hillsborough County, which encompasses the City of Tampa, seventy-five homeless individuals are arrested and incarcerated for minor misdemeanor violations per day.[136] An estimated eighteen of those seventy-five individuals have a severe mental illness.[137] The daily cost of housing an inmate with a severe mental illness in Florida is likely about $125,[138] sixty percent higher than that of general inmates, though some variation in these figures may exist from county to county.

The cost of recidivism when these individuals are readmitted to hospitals instead of incarcerated in jails or prisons, however, is even higher. Andrew Goldstein, for example, in the two years prior to his murder of Kendra Webdale, received a total of 199 days of emergency treatment and inpatient services in six different hospitals on fifteen different occasions, costing taxpayers over $95,000 in one year.[139] These 199 days of treatment amount to an expense of roughly $477 per day. In 2002 in Florida, one patient alone received forty-one examinations in an inpatient setting,

134. *See generally* Ken Suarez, *Lakeland Approves Modified Homeless Ordinance*, http://www.myfoxtampabay.com/story/18027896/lakeland-approves-modified-homeless-ordinance (updated Sept. 7, 2010) (reporting on the enactment and objectives behind Lakeland's new ordinance).

135. *Transforming Florida's Mental Health System*, *supra* n. 31, at 10.

136. Homeless Coalition of Hillsborough Co., Inc. & City of Tampa Dep't of Bus. & Community Servs., *Places for People: A 10 Year Community Response Initiative to End Homelessness* 9 (Aug. 2, 2006) (available at http://www.endhomelessness.org/files/597_file_Tampa_HillsboroughCoFL.pdf).

137. This calculation is based on the numbers that make up Florida's homeless population and the number of severely mentally ill among that population. *See Transforming Florida's Mental Health System*, *supra* n. 31, at 10 (stating that approximately twenty-five percent of Florida's homeless population have a severe mental illness); Nat'l Alliance to End Homelessness, *supra* n. 123, at 20 (stating that Florida has a homeless population of over fifty-six thousand). About fourteen thousand of the fifty-six thousand among Florida's homeless population are severely mentally. In proportion to this ratio, eighteen out of seventy-five are severely mentally ill.

138. Ken Jenne & Donald F. Eslinger, *Without Reforms, Problems Mount*, S. Fla. Sun-Sentinel 25A (Apr. 21, 2003) (available at http://articles.sun-sentinel.com/2003-04-21/news/0304200146_1_mental-health-mental-illness-law-enforcement).

139. Bardey, *supra* n. 22.

treatment totaling approximately $81,000 for the State—not including the costs of long-term care, court costs, or law enforcement resources.[140] In that same year, more than nine hundred adults in Florida were readmitted to hospitals four times or more to receive examinations—a number that represents a fourteen-percent jump from the previous year and that increases every year.[141] Between July 2004 and June 2007, nearly forty-two thousand adults were admitted two or more times to receive examinations.[142]

Of those forty-two thousand readmitted adults, the number of them who are severely mentally ill and homeless is unclear, but studies indicate that the severely mentally who are homeless are much more likely to be hospitalized or readmitted to hospitals than the non-homeless.[143] One study, for example, shows that the rate of psychiatric hospitalization is a hundred times higher for mentally ill homeless individuals in Hawaii than the rate for non-homeless individuals.[144] The study estimates that the excess cost of inpatient treatment is $2,000 per mentally ill homeless individual.[145] According to national data from Veterans Affairs medical centers,[146] thirty-five percent of inpatients with mental illnesses are either homeless or have no stable residence.[147] In addition, homeless veterans are twice as likely as non-homeless veterans to be readmitted within thirty days after discharge.[148]

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140. *Id.* Based on these figures, the cost of an inpatient's psychiatric examination is roughly $2,000. This number is consistent with that found in another study. *See* text accompanying *infra* n. 145 (estimating the cost of inpatient treatment).

141. Bardey, *supra* n. 22.

142. Petrila & Christy, *supra* n. 26, at 21.

143. *See generally* Haw. H. Test., *What Is the Cost of Homelessness?* 26th Legis., Reg. Sess. (Feb. 9, 2011) (available at http://www.capitol.hawaii.gov/session2011/testimony/HB753_TESTIMONY_HSG_02-09-11_LATE_.PDF) (providing statistics on the cost of homelessness in Hawaii); Robert Rosenheck & Kenneth W. Kizer, Ltr. to the Ed., *Hospitalizations and the Homeless*, 339 New Eng. J. Med. 1161, 1166 (Oct. 15, 1998) (available at http://www.nejm.org/doi/pdf/10.1056/NEJM199810153391616) (discussing a national survey of Veterans Affairs medical centers).

144. Haw. H. Test., *supra* n. 143.

145. *Id.*

146. The Department of Veterans Affairs is the country's "largest direct provider of services" to the homeless, including healthcare services to over sixty-five thousand homeless veterans per year. Rosenheck & Kizer, *supra* n. 143, at 1166.

147. *Id.*

148. *Id.*

D. The Shortcomings of Florida's Outpatient Treatment Law

The care of the mentally ill is the responsibility of the state,[149] and outpatient treatment laws are a product of that responsibility.[150] Upon the enactment of Florida's outpatient treatment law in 2004, proponents of the law lauded it as "the first important step in halting the relentless revolving door of repeated arrests, short-term hospitalizations, and homelessness for thousands of people in Florida with severe untreated mental illnesses, like schizophrenia and bipolar disorder."[151] The law, however, has not lived up to these expectations according to John Petrila, J.D., LL.M., and Annette Christy, Ph.D., who point out that a "chasm" has developed "between [the law's] enactment and use."[152] During the law's first three years in existence, for example, courts issued outpatient treatment orders for just 71 of 41,997 people who were potentially eligible for outpatient treatment because they had been committed to inpatient settings twice within a three-year span—a statutory prerequisite for outpatient treatment.[153] The lack of orders has become the status quo in Florida even though its outpatient treatment law is molded from the same cast as New

149. 18 U.S.C. § 4246(d)(1) (2006) (requiring that the Attorney General take responsibility for the patient until "such a State will assume such responsibility"). *See also e.g. United States v. Shawar*, 865 F.2d 856, 859 (7th Cir. 1989) (stating that the responsibility for the care of the mentally ill is a function of the states); *United States v. Ecker*, 489 F. Supp. 2d 130, 135–136 (D. Mass. 2007) (declaring that the states' responsibility for the care of the mentally ill is "clearly outlined" in 18 U.S.C. Section 4246(d)(1)); E. Fuller Torrey & Mary Zdanowicz, *Why Deinstitutionalization Turned Deadly*, Wall St. J. A18 (Aug. 4, 1998) (available at http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=593&Itemid=194) (noting that the care of the severely disabled and mentally ill has been a responsibility of the states for 150 years).

150. *See e.g.* Memo. from Kathy A. Bennett, *supra* n. 15, at 1 (stating that "[t]he core principle behind [Kendra's Law] is that true compassion for the mentally ill requires us to acknowledge that some [of the severely mentally ill] have great difficulty taking responsibility for their own care").

151. Mary Zdanowicz, *Landmark Legislation for Florida's Mentally Ill, Statement by Treatment Advocacy Center Executive Director, Mary Zdanowicz, Esq.*, http://www.treatmentadvocacycenter.org/index2.php?option=com_content&do_pdf=1&id=142 (June 30, 2004).

152. Petrila & Christy, *supra* n. 26, at 21.

153. *Id.* As a criterion for outpatient treatment, the statute requires that a person be involuntarily admitted at a receiving or treatment facility for a seventy-two-hour examination at least twice within a thirty-six-month span, or that the person has received mental health services in a correctional facility. Fla. Stat. § 394.4655(1)(e)1.

York's Kendra's Law,[154] under which, in its first five years, healthcare professionals filed petitions for over four thousand patients and received court-granted orders in ninety-three percent of those cases.[155]

Because tens of thousands of Florida's mentally ill inpatients have proven to be potentially eligible for outpatient treatment, the paucity of court-granted orders likely does not indicate reluctance on the courts' part to issue those orders but instead reluctance of healthcare professionals to use the law.[156] Mr. Petrila and Dr. Christy attribute this reluctance to (1) difficulty in filing a petition under the statutory criteria; (2) a lack of community treatment resources; and (3) a lack of enforcement mechanisms.[157] Only an administrator of one of Florida's 103 receiving facilities—facilities where the mentally ill can receive inpatient treatment—may file a petition for outpatient treatment.[158] Under Kendra's Law, however, almost anyone who is familiar with the patient may file a petition for outpatient treatment on the patient's behalf.[159] Florida's law also creates logistical problems during the petition-filing process by placing high demands on psychiatrists, petitioners, and outpatient treatment providers—all of whom must perform the following tasks within seventy-two hours[160] of a

154. Petrila & Christy, *supra* n. 26, at 21 (stating that in creating Florida's outpatient treatment law, the Florida legislature drew "primarily from [Kendra's Law]"); *see also supra* nn. 15, 17 and accompanying text (citing parts of Kendra's Law).

155. Petrila & Christy, *supra* n. 26, at 21 (contrasting Kendra's Law with Florida's outpatient treatment law).

156. *Id.* at 21–22 (mentioning data regarding the scarce use of Florida's outpatient treatment law; asking, "Why . . . has the law been used so sparingly?"; and going on to answer that question by suggesting that the law is difficult for healthcare professionals to use).

157. *Id.* at 22.

158. Fla. Stat. § 394.4655(3)(a)(1)–(2). Under the statute, the term "*receiving facility* means any public or private facility designated by the department to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail." Fla. Stat. § 394.455(26).

159. *Supra* n. 17 (describing those whom Kendra's Law permits to file a petition for outpatient treatment).

160. *See* Fla. Stat. § 394.4655(2)(b) (providing the seventy-two-hour window); *see also* Petrila & Christy, *supra* n. 26, at 21 (discussing the seventy-two-hour period during which a petitioner and an outpatient treatment provider must complete detailed steps before a court can grant a petition).

patient's admission to an inpatient setting, or the petition will fail before a court:[161]

> (1) a psychiatrist must examine the patient and recommend the patient for outpatient treatment, and a second psychiatrist, or a clinical psychologist, must support that recommendation;[162]
>
> (2) the administrator of the receiving facility must identify the outpatient treatment provider;[163]
>
> (3) the outpatient treatment provider must prepare a treatment plan with the patient or his or her guardian; the provider must give a copy of the treatment plan to the patient and the administrator of the receiving facility; the treatment plan must be detailed, specifying the nature of the patient's mental illness, the need for reduction of the patient's symptoms, and the goals of outpatient treatment;[164] and
>
> (4) the outpatient treatment provider must verify to the court that services for outpatient treatment, such as the necessary community treatment resources, are available in the patient's local community.[165]

In addition to the seventy-two-hour timeframe that psychiatrists, administrators, and outpatient treatment providers have to prepare the petition, the law also mandates that the petitioner—that is, the administrator of a receiving facility—must file the petition in the county where the patient resides,[166] regardless of the distance between the receiving facility and that county.[167]

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161. Petrila & Christy, *supra* n. 26, at 22 (discussing the steps that psychiatrists, petitioners, and outpatient treatment providers must complete to file a successful petition for outpatient treatment).

162. Fla. Stat. § 394.4655(2)(a)(1).

163. *Id.* at § 394.4655(2)(a)(2).

164. *Id.* at § 394.4655(2)(a)(3).

165. *Id.* at § 394.4655(2)(a)(3), (c)(2) (stating that if a proposed community treatment plan is not available in the patient's local community, the petitioner may not file the petition).

166. *Id.* at § 394.4655(2)(c)(1).

167. Petrila & Christy, *supra* n. 26, at 22 (noting the impracticalities of this scenario, "given the large geographic catchment areas served by each state hospital and the distance from the hospitals to many of the counties they serve").

In contrast, under Kendra's Law, the patient need only receive an examination from one physician,[168] not two as required by Florida's law,[169] and although the physician must conduct an examination of the patient in seventy-two hours under either law,[170] Kendra's Law affords the petitioner up to ten days to prepare the petition from the time of that examination.[171] In addition, the written treatment plan under Kendra's Law requires less information than that under Florida's law because Kendra's Law requires neither the details about the patient's illness nor the mention of reduction of the patient's symptoms.[172] Also, under Kendra's law, although a petitioner may have to file a petition in a county far from the receiving facility at which the patient received treatment,[173] someone other than the administrator of the hospital or the receiving facility may file that petition;[174] that is, because Kendra's Law permits a sibling over the age of eighteen, a parent, a spouse, or a social worker to act as a petitioner,[175] any one of them, in lieu of a busy administrator, could bring a petition in the county where the patient resides (provided the other statutory criteria are met).[176]

Like the logistical problems with the statutory criteria under Florida's outpatient treatment law, a lack of community treatment resources and enforcement mechanisms also limit the law's

168. N.Y. Mental Hygiene Law § 9.60(e)(3) (stating that the petition must have an affidavit from a physician).

169. Fla. Stat. § 394.4655(2)(a)(1).

170. *Id.* at § 394.4655(2)(b) (noting the seventy-two-hour timeframe during which a psychiatrist may examine the patient and recommend that the patient receive outpatient treatment); N.Y. Mental Hygiene Law § 9.60(n)(iii) (mentioning that a physician has to determine whether a patient is mentally ill and requires outpatient treatment).

171. *See* N.Y. Mental Hygiene Law § 9.60(h)(2) (stating that "[t]he court shall not order assisted outpatient treatment unless an examining physician . . . has personally examined the subject of the petition no more than ten days before the filing of the petition"). *Compare* N.Y. Mental Hygiene Law § 9.60(h)(2) *with* Fla. Stat. § 394.4655(2)(b) (providing the periods of time during which a petitioner may file a petition).

172. *Compare* N.Y. Mental Hygiene Law § 9.60(i) *with* Fla. Stat. § 394.4655(2)(a)(3) (noting the details that must be included in the patient's outpatient treatment plan).

173. Under Kendra's Law, the petitioner must file the petition in the county where the patient is present or is reasonably believed to be present. N.Y. Mental Hygiene Law § 9.60(e)(2)(iii).

174. *Id.* at § 9.60(e)(2).

175. *Id.*

176. For example, the petitioner must have an affidavit showing that a physician has examined the patient and recommended that the patient receive outpatient treatment. *Id.* at § 9.60(e)(3).

utility.[177] Section (3)(b)(2), for example, precludes the filing of a petition for outpatient treatment without the proper community treatment resources in place in the location where the patient resides.[178] Mr. Petrila and Dr. Christy note that community treatment resources are scarce for the mentally ill in Florida because of the impoverished condition of the state's mental health system.[179] Florida, in fact, ranks "near dead last"[180] among all states in spending on community treatment resources[181] and in per capita spending on mental health.[182] The State has directed no new funding into the implementation of its outpatient treatment law, whereas New York backed Kendra's Law with substantial funds.[183] Even if community treatment resources are in place, however, Mr. Petrila and Dr. Christy acknowledge that some patients still may not comply with their outpatient treatment plans because no real enforcement mechanisms exist under the law to compel their compliance.[184] In cases of noncompliance, a patient may be returned to a receiving facility for a seventy-two-hour evaluation, but if the patient proves to be stable, little can be done other than modification of the patient's outpatient treatment plan.[185]

177. Petrila & Christy, *supra* n. 26, at 22 (stating, "Providers may also ignore the Florida statute because of a lack of community treatment resources").

178. Fla. Stat. § 394.4655. "If the necessary [community treatment] services are not available in the patient's local community to respond to the person's individual needs, the petition may not be filed." *Id.* at § 394.4655(3)(b).

179. Petrila & Christy, *supra* n. 26, at 22 (discussing the impoverished state of Florida's mental health system in comparison to New York's and other states').

180. *Transforming Florida's Mental Health System*, *supra* n. 31, at 11.

181. *Id*.

182. Petrila & Christy, *supra* n. 26, at 22.

183. *Id.*

184. *Id.* Mr. Petrila and Dr. Christy note that one physician, Paul S. Appelbaum, M.D., believes "that the lack of practical alternatives to inpatient care as an enforcement mechanism" is a major barrier to the use of Florida's outpatient treatment law. *Id.* (citing *Ambivalence Codified: California's New Outpatient Commitment Statute*, 54 L. & Psych. 26, 26–28 (Jan. 2003)) (available at http://psychiatryonline.org/data/Journals/PSS/3596/26.pdf).

185. *Id.* The statute permits the outpatient treatment provider and the patient to modify the outpatient treatment plan, but the provider must notify the court of any modifications. Fla. Stat. § 394.4655(6)(b)(2).

E. The Mental Health Subcommittee's Solution for Florida's Mental Health Crisis

In 2007, a State-appointed subcommittee on mental health[186] recognized the problems with Florida's mental health system, ascertained the reasons for the system's shortcomings, and offered a solution.[187] The subcommittee identified deinstitutionalization as the culprit behind the system's troubles: "The problems currently facing Florida's mental health [system] and, consequently, criminal justice systems relate to the fact that the community mental health infrastructure was developed . . . when most people with severe . . . mental illnesses resided in state hospitals."[188] Neither jails nor prisons, the subcommittee acknowledged, were intended to be a "safety net" for the deinstitutionalized, and neither jails nor prisons are equipped to do so.[189] To address the inadequacies with, and the needs of, Florida's mental health system, the subcommittee recommended that the State invent "innovative financing strategies" to "invest in a redesigned and transformed system of care,"[190] one that prevents the recriminalization of the mentally ill, institutes mechanisms to identify the mentally ill who are incarcerated in jails and prisons, and uses community treatment resources to care for them.[191]

III. FINANCING MENTAL HEALTHCARE: A BUDGET-SAVING PROPOSAL FOR RETHINKING AND REVITALIZING FLORIDA'S INVOLUNTARY ASSISTED OUTPATIENT TREATMENT LAW

"Like Andrew Goldstein, [the severely mentally ill in Florida] need real and immediate help. Like Goldstein, some are headed for tragedy. For Florida, the time for change is long overdue."[192] Although Dr. Bardey, the former Director of New York's Bellevue

186. The subcommittee comprised judges, attorneys, medical doctors, professors, and other members. *Transforming Florida's Mental Health System*, *supra* n. 31, at 1–5.

187. *Id.* at 1–11, 36 (discussing the history of, evolution of, and issues currently before Florida's mental health system).

188. *Id.* at 11.

189. *Id.*

190. *Id.* at 12.

191. *Id.* at 36.

192. Bardey, *supra* n. 22.

Hospital Assisted Outpatient Treatment Program, wrote these words before the enactment of Florida's outpatient treatment law, the law's inefficacy today heightens their significance. While the risk of tragedy may be small[193] (indeed, most violent individuals are not mentally ill, and most mentally ill individuals are not violent[194]), playing the odds against that risk does both the mentally ill and society an injustice—the care of the severely mentally ill is the responsibility of the State,[195] and the mentally ill become a danger to society when the State falters in its responsibility to care for them.[196] Florida must not abdicate this responsibility.

To commit to the care of the mentally ill, Florida must rethink and revitalize its outpatient treatment law so that it becomes an effective tool for treatment. This Part identifies ways through which the State can do just that. Florida should use its homeless ordinances and the healthcare services in its jails and prisons to revitalize its outpatient treatment law. The enforcement of homeless ordinances provides the State with an ideal method by which it can identify the severely mentally ill among the homeless. Although jails and prisons may not be the ideal place to treat these individuals on an inpatient basis, they are, as today's de facto mental health institutions, by far the most practical. This approach to rethinking and revitalizing Florida's outpatient treatment law will also reduce the costs of care associated with the State's mental health system.[197]

This Part first discusses how local homeless ordinances provide Florida's legal authorities with a method by which they can seek out and identify the mentally ill among the homeless. Second, this Part demonstrates how Florida's jails and prisons, as today's de facto mental health institutions, are practical locations for the treatment of these individuals on an inpatient basis. Third, this Part argues that streamlining the petition-filing process through statutory modification is integral to the efficacy of Florida's outpatient treatment law. Fourth, this Part shows

193. *See* Friedman, *supra* n. 115, at 2065 (stating that the severely mentally ill increase the overall rate of violence in the general population by three to five percent); *see also* Monahan, *supra* n. 38, at 511 (stating that if a relationship between mental illness and violence exists, it is "probably . . . not large").

194. Friedman, *supra* n. 115, at 2066.

195. *Supra* n. 149 (providing a long line of sources that support this principle).

196. Torrey, *supra* n. 16.

197. *See infra* pt. III(E) (discussing how this approach is cost effective).

how homeless ordinances can serve as enforcement mechanisms that compel patients to follow their outpatient treatment plans, and it also alleviates concerns regarding recriminalization. Fifth, this Part assesses the costs associated with rethinking and revitalizing Florida's outpatient treatment law, and it then compares them to the costs associated with Florida's current mental healthcare system.

A. Identifying the Severely Mentally Ill among Florida's Homeless Population: The Usefulness of Homeless Ordinances

The first step in employing an outpatient treatment law is, of course, identifying those in need of outpatient services. Although some may find this step to be too elementary to merit analysis, the fact remains that an inability to identify—or a willingness to ignore—the severely mentally ill will not lead to treatment but instead to possible tragedy.[198] In Florida's case, the State needs a method by which it can identify the severely mentally ill among its large homeless population, and its homeless ordinances provide it with this method. Through the enforcement of its homeless ordinances, Florida has an already-in-place system by which it seeks out problematic behavior among its homeless population—and a far-sweeping system at that. These ordinances, therefore, enable the State to come into contact with homeless individuals who may be severely mentally ill.

While police officers are, of course, responsible for enforcing homeless ordinances, they usually are not trained to identify people with mental illnesses.[199] But because they respond first to calls relating to psychiatric disturbances,[200] they are the State's initial line of defense for identifying and dealing with those in the community with severe mental illness. To train officers to recognize and understand the severely mentally ill in the community, police departments nationwide are adopting Crisis Intervention Teams.[201] These teams comprise officers specially trained to deal with the severely mentally ill and who have an "intimate

198. *See supra* pt. I (providing examples of tragedies).
199. Stephey, *supra* n. 59.
200. *Id.*
201. *Id.*

knowledge and understanding of psychosis."[202] The Miami Police Department, for example, currently has crisis intervention training in place.[203]

Police officers, on the other hand, who have not had training in crisis intervention should remember that 125,000 mentally ill individuals are arrested annually in Florida[204] and that the majority are charged with "minor misdemeanors . . . that are a direct result of their psychiatric illnesses."[205] That is, those who are prone to panhandling, sleeping in or on the right-of-way, building shelters on public property, and/or other prohibited activities, may be engaging in this behavior because of mental illness. When officers, therefore, encounter those who are violating a homeless ordinance and demonstrating erratic or dangerous behavior, the officers should take particular care, keeping in mind the prevalence of mental illness among the homeless.

Upon identifying violators of a homeless ordinance who are likely severely mentally ill, officers must apprehend them, as permitted by the ordinance,[206] because their arrests are necessary to ensure their treatment, reduce the risk of violence to the public, and cut long-term recidivism. This approach does *not* call for a witch hunt of the severely mentally ill at large in the community but only for added vigilance under the law, with the well-being of both the public and the mentally ill in mind. The point of apprehending these individuals, who generally may receive maximum imprisonment of no more than sixty days,[207] is not to recriminalize the mentally ill—not to punish them repeatedly for committing minor misdemeanors or to flood jails and prisons with patients who will remain confined over the long term.[208] Instead,

202. *Id.*

203. *Id.*

204. *Transforming Florida's Mental Health System*, *supra* n. 31, at 34.

205. *Id.* at 10.

206. *See e.g.* St. Petersburg Code Ordin. at § 1-7(c) (providing officers with the option of fining, imprisoning, or both fining and imprisoning those who violate St. Petersburg's panhandling ordinance).

207. *See e.g. id.* (stating that imprisonment cannot exceed sixty days).

208. One of California's prison psychiatrists states, "We are literally drowning in patients, running around trying to put our fingers in the bursting dikes, while hundreds of men [and women] continue to deteriorate psychiatrically before our eyes into serious psychoses . . . ." Treatment Advoc. Ctr., *Treatment Advocacy Center Briefing Paper: Criminalization of Individuals with Severe Psychiatric Disorders* 1 (2007) (available at http://www.treatmentadvocacycenter.org/storage/documents/criminalization_of_individuals_with

the purpose is to ensure that those in Florida who are homeless and severely mentally ill receive inpatient evaluation during brief incarcerations in what are today's de facto mental health institutions—so that they can become stable, be placed on outpatient treatment plans upon their release, and avoid future contact with jails, prisons, and the mental health system. Inpatient evaluation is, after all, necessary before a recommendation and a petition for outpatient treatment may follow.[209] Outpatient treatment must be the aim for these individuals because when the mentally ill receive outpatient treatment, they are much less likely to be high risks for recidivism than those who do not receive it;[210] that is, they are much less likely to continue to commit misdemeanors "that are a direct result of their psychiatric illnesses"[211] and return to jail or prison.[212]

B. Ensuring Inpatient Treatment: Jails and Prisons as Providers of Mental Healthcare

With the power that homeless ordinances give Florida to detain the severely mentally ill, the State, to breathe life into its outpatient treatment law, must next ensure that these individuals receive proper inpatient treatment once incarcerated. Without inpatient treatment through which they can receive examinations by two psychiatrists, or one psychiatrist and one clinical psychologist,[213] outpatient treatment is impossible.[214] Proper inpatient treatment is therefore a precursor to outpatient treatment and must be available to them while they are imprisoned.

_severe_psychiatric_disorders.pdf). Because of the short thirty- to sixty-day period of incarceration, Florida can avoid a long-term backlog of patients in its jails and prisons.

209. Fla. Stat. § 394.4655(2)(a)(1).

210. The Duke Studies found that among individuals with multiple hospital readmissions, arrests, and/or violent behavior in a prior year, long-term outpatient treatment reduced hospitalization by up to seventy-four percent, arrests by seventy-four percent, and violence by up to fifty percent. Bardey, *supra* n. 22 (citing the Duke Studies).

211. *Transforming Florida's Mental Health System*, *supra* n. 31, at 10 (stating, "The vast majority of these individuals are charged with minor misdemeanor and low[-]level felony offenses that are a direct result of their psychiatric illnesses").

212. In the words of Dr. Bardey, involuntary "[a]ssisted outpatient treatment works." Bardey, *supra* n. 22. See also Part III(E) for a discussion of the low rate of recidivism among those who participate in outpatient treatment programs.

213. Fla. Stat. § 394.4655(2)(a)(1).

214. *Supra* n. 160 (discussing the short seventy-two-hour period during which detailed steps must be completed in order for a court to grant the petition).

As de facto mental health institutions that house thousands of severely mentally ill inmates,[215] Florida's jails and prisons, while not ideal settings for inpatient treatment, are nevertheless practical settings. This practicality is a product of four factors: (1) more Americans receive mental health treatment in jails and prisons than any other location;[216] (2) the level of this care must be the same level of care available in the community;[217] (3) inpatient treatment in Florida's jails and prisons is not only an acceptable form of mental health treatment but is also less costly than readmissions to hospitals;[218] and (4) it is also less costly than broad renovations to Florida's mental health system.[219] Indeed, "the techniques of quality assurance created for hospitals and other community mental health settings can be applied successfully to prisons and jails with minor modifications."[220] Although Florida's mental health subcommittee maintains that jails and prisons are neither designed nor equipped to be refuges for the deinstitutionalized, deinstitutionalization has nevertheless transformed them into facilities that must take on, and are in fact, taking on that task today:[221]

> People with severe mental illnesses are sometimes jailed because their families find it is the most expedient means of getting the person into needed treatment. As the public psychiatric system in the United States has progressively deteriorated, it has become common practice to give priority for psychiatric services to persons with criminal charges pending against them. Thus, for a family seeking treatment for

215. *See e.g. Transforming Florida's Mental Health System*, *supra* n. 31, at 10, 34.

216. Stephey, *supra* n. 59.

217. Several cases stand for this proposition. *E.g. Ruiz*, 503 F. Supp. at 1338; *see also* Task Force on Psychiatric Servs. in Jails & Prisons, *Position Statement on Psychiatric Services in Jails and Prisons*, http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps1988_Jails.pdf (Dec. 1988) (stating that "mental health service should . . . provide the same level of care to patients in the criminal justice process that is available in the community").

218. See *supra* Part II(C) for a discussion of the cost of recidivism when the severely mentally ill are readmitted to hospitals versus the cost of recidivism when they are re-incarcerated in jails or prisons.

219. See *infra* Part III(E) for information about the costs associated with this renovation.

220. Eisler & Weinstein, *supra* n. 85, at 110.

221. See *supra* Part II(A) for a discussion of the role of jails and prisons as de facto mental health institutions.

> an ill family member, having the person arrested may be the most effective way to accomplish their goal.[222]

In addition to the effects of deinstitutionalization on jails and prisons, the courts have contributed to their transformation too—again, having mandated the quality, timeliness, and universality of treatment in all jails and prisons.[223]

Although at least some of Florida's jails and prisons do fall short of meeting these standards—like the state mental hospitals of old,[224] they too have their stories of abuse and neglect[225]—the federal government has been responsive to these inadequacies,[226] as have other groups.[227] The delinquency of these particular jails and prisons aside, other jails and prisons in Florida provide high-quality healthcare to their severely mentally ill inmates. Hillsborough County's jail, for example, not only satisfies the minimal standards of healthcare but also meets the standards established by the National Commission on Correctional Health Care,[228] an organization that sets national guidelines for the management of correctional healthcare.[229] In the words of one author, "those who find themselves behind bars in Hillsborough County, Florida, can rest easier knowing that their [healthcare] needs are well looked

222. Treatment Advoc. Ctr., *supra* n. 208, at 3–4.

223. *E.g. Estelle*, 429 U.S. at 290; *Inmates of Allegheny Co. Jail*, 612 F.2d at 762; *Coleman v. Wilson*, 912 F. Supp. 1282, 1297–1298 (E.D. Cal. 1995); *Ruiz*, 503 F. Supp. at 1338; *Wittenberg*, 509 F. Supp. at 684–685.

224. Steve Leifman refers to the state-run mental hospitals that preceded deinstitutionalization as "horror houses." Stephey, *supra* n. 59; *see also O'Connor*, 422 U.S. at 575–576 (addressing whether a Florida mental hospital had violated a patient's constitutional right to liberty when administrators and staff had hospitalized him for fifteen years).

225. For example, guards in a Pensacola jail subdued two mentally ill inmates to death, and in a Clearwater jail, a mentally ill inmate gouged out his eye after waiting weeks for a bed. Stephey, *supra* n. 59.

226. *See e.g.* Charles Rabin & Amy Driscoll, *Miami-Dade Jails under Federal Investigation*, http://www.correctionsone.com/treatment/articles/1842639-Miami-Dade-jails-under-federal-investigation/ (Apr. 5, 2008) (reporting that the United States Department of Justice is investigating possible civil rights violations, including improper treatment of mentally ill inmates, in Miami–Dade County jails).

227. The Advocacy Center for Persons with Disabilities filed a federal lawsuit against the state of Florida, claiming that it violated the civil rights of hundreds of mentally ill convicts by not providing them with treatment while they awaited trial. Stephey, *supra* n. 59.

228. Jaime Shimkus, *Facility Profile: Florida Jail Takes Creative Approaches to Nursing Care, Discharge Planning*, 22 CorrectCare 26, 26 (Winter 2008) (available at http://www.ncchc.org/filebin/images/Website_PDFs/22-1.pdf).

229. Nat'l Comm'n on Correctional Health Care, *About Us*, http://www.ncchc.org/about/index.html (accessed Feb. 8, 2013).

after."[230] Because of the quality of its inpatient treatment, the Hillsborough County Jail "has had measurable success in reducing recidivism" after medical discharge.[231] Mentally ill inmates also receive exemplary treatment in Broward County's jails, which won the National Commission on Correctional Healthcare's Facility of the Year Award in 2009: "Mental [healthcare in Broward County's jails] is . . . handled smoothly . . . . One team takes care of the initial assessment, medication management[,] and crisis intervention, while another provides individual and group counseling and continuing therapy."[232] These results are a testament to the practicality and efficacy of Florida's jails and prisons as facilities that can revitalize the State's outpatient treatment law.

C. Streamlining the Petition-Filing Process: The Need for Modification of Florida's Outpatient Treatment Law

As providers of quality inpatient treatment for their mentally ill inmates, Florida's jails and prisons need a less complicated and more favorable petition-filing process, one that enables them to facilitate their inmates' transitions from inpatient to outpatient treatment. Personnel in these jails or prisons—that is, psychiatrists and clinical psychologists—are unable to file petitions for outpatient treatment because jails and prisons are not defined as receiving facilities under the statute. Instead, personnel in jails and prisons—after receiving, examining, and then recommending an inmate for outpatient treatment[233]—must contact those who do in fact have petition-filing authority: the administrator of an actual receiving facility.[234] They must do so before the seventy-two

230. Shimkus, *supra* n. 228. In June 2011, James Richard Verone robbed a bank in North Carolina, demanding one dollar from the teller. Afflicted with physical ailments and unable to afford proper healthcare, Verone, fifty-nine years old, robbed the bank so that he could receive proper medical treatment in prison. Zachary Roth, *Man Robs Bank to Get Medical Care in Jail*, http://news.yahoo.com/blogs/lookout/man-robs-bank-medical-care-jail-143625999.html (June 21, 2011).

231. Shimkus, *supra* n. 228.

232. Nat'l Comm'n. on Correctional Health Care, *Outstanding Honorees Celebrated at NCCHC's 2009 National Conference*, 23 Correct Care 4, 5 (Fall 2009) (available at http://www.ncchc.org/filebin/images/Website_PDFs/23-4.pdf).

233. *See* Fla. Stat. § 394.4655(2)(a)(1) (describing psychiatrists and clinical psychologists' role in the petition-filing process).

234. *See id.* (providing no other way for the filing of a petition other than through an administrator of a hospital or receiving facility).

hour window for petition-filing closes.[235] This circuitous process stands in the way of hundreds, if not thousands, of outpatient treatment orders in Florida because it prevents psychiatrists in jails and prisons from initiating the petition-filing process.[236] This reality is unacceptable considering that these mentally ill inmates—who, as violators of homeless ordinances, will be incarcerated for only a matter of weeks—will return to their communities in the short-term and are therefore prime candidates for outpatient treatment.

To increase the likelihood that these inmates will receive petitions for outpatient treatment, the Florida legislature should make an important modification to its outpatient treatment law: it should acknowledge jails and prisons as receiving facilities. Personnel in jails and prisons then could file petitions under their own authority, without reaching out to an administrator of a receiving facility—interaction that amounts to the wasting of time during the critical seventy-two-hour window. In addition, the legislature's acknowledgement of jails and prisons as receiving facilities would not alter the meaning of the statute itself; in harmony with the current definition of the term *receiving facility* in the statute,[237] jails and prisons would (1) receive the mentally (those who violated homeless ordinances); (2) many of them will need emergency psychiatric treatment; and (3) their treatment will be over a relatively short term, sixty days or less.[238]

D. Rounding Out Florida's Outpatient Treatment Law: Effective Community Treatment Resources and Enforcement Mechanisms

With a modified and streamlined petition-filing process in place, the final remedial measure for Florida's outpatient treatment law is the creation of effective community treatment resources and enforcement mechanisms. Community treatment resources and enforcement mechanisms make outpatient treatment successful because they are the sources of support and treatment for the mentally ill during the outpatient process and

235. *See supra* n. 160 (discussing the seventy-two-hour window).
236. Petrila & Christy, *supra* n. 26, at 21–22.
237. Fla. Stat. § 394.455(26).
238. *Id.*

compel them to comply with their treatment plans, respectively.[239] Although community treatment resources do exist in Florida, including the Agency for Community Treatment Services in Tampa,[240] some have no surety of prosperity and longevity other than funding from the state.[241] Because of Florida's underfunded mental health system, "innovative financing strategies,"[242] as recommended by the mental health subcommittee, may be the only way to secure additional funding.

The development of effective enforcement mechanisms under Florida's outpatient treatment law, however, does not require innovative funding. Homeless ordinances in and of themselves will be effective enforcement mechanisms because they carry the penalty of re-incarceration for those who do not comply with their outpatient treatment plans.[243] That is, mentally ill homeless individuals who refuse to follow their outpatient treatment plans upon their release from jail or prison are likely to deteriorate[244] and revert to the same behavior that prompted their arrests—namely violations of "minor misdemeanor[s] . . . that are a direct result of their psychiatric illnesses."[245] Compliance with outpatient treatment plans, then, is likely the only way they can remain stable in the community and avoid re-incarceration. Many of the mentally ill would likely be aware of the consequences should they stray from their treatment plans. Julio Perez, for example, who was homeless, knew he was in a serious bind when he lost his Medicaid card;[246] he knew he had to have his medication and would unravel without it;[247] and he knew the consequences that could follow if he did not find help.[248]

239. *See* Agency for Community Treatment Servs., Inc., *supra* n. 34 (providing examples of the services offered by treatment agencies). See also *supra* Part II(D) for a discussion of the significance of community treatment resources and enforcement mechanisms in the context of outpatient treatment).

240. Agency for Community Treatment Servs., Inc., *supra* n. 34.

241. The Agency for Community Treatment Services is a non-profit organization. *Id.*

242. *Transforming Florida's Mental Health System*, *supra* n. 31, at 12.

243. *Supra* n. 210.

244. Julio Perez, for example, after having his Medicaid card cancelled, was unable to get his medications, and his condition inevitably deteriorated. Bernstein, *supra* n. 2.

245. *Transforming Florida's Mental Health System*, *supra* n. 31, at 10.

246. Bernstein, *supra* n. 2.

247. *Id.*

248. *Id.*

Although re-incarceration translates to recriminalization, a costly expense for the State,[249] re-incarceration for the repeat violation of a homeless ordinance generally amounts to no more than an extended hospitalization, sixty days or less.[250] Again, re-incarceration of the severely mentally ill, as a form of treatment, is a more cost-effective option for Florida than re-hospitalization.[251] The purpose of re-incarceration for those who deteriorate and become repeat violators of homeless ordinances is not to give them "'a criminal record.'"[252] Instead, the purpose is to protect them and the public—a priority that should transcend concerns over the negative stigma of recriminalization—through their placement in today's de facto mental health institutions for abbreviated periods of time, during which they can receive mental healthcare and reevaluation of their outpatient treatment plans.

E. Assessing the Expenses Associated with Rethinking and Revitalizing Florida's Outpatient Treatment Law: A Cost Analysis

These recommendations for rethinking and revitalizing Florida's outpatient treatment law are cost-effective; they neither call for nor require taking a wrecking ball to the current system but instead rely on resources that the State presently has in place. Over time, the current mental health system's problems may prove pervasive enough to require the State to dismantle it and build from scratch, as recommended by the mental health subcommittee.[253] Florida, however, impoverished and near dead last among all states in mental health funding, likely cannot afford what will be a multi-billion-dollar redesign.[254] These recommendations for rethinking and revitalizing Florida's outpatient treatment law provide hope for the redesign of the current system

249. See *supra* Part II(C) for a discussion of the financial burdens associated with recriminalization.

250. *See e.g.* St. Petersburg Code of Ordin. at § 1-7(c) (stating that imprisonment for the violation of a homeless ordinance cannot exceed sixty days).

251. See *supra* Part II(C) and *infra* Part III(E) for a discussion and comparison of these costs, respectively.

252. Stephey, *supra* n. 59.

253. *Transforming Florida's Mental Health System*, *supra* n. 31, at 12.

254. *Id.* at 11.

without an all-out reliance on "innovative financing strategies" and investment.[255]

The basis for this hope lies in a cost analysis, which shows that the expenses associated with these recommendations are less than those associated with maintaining Florida's current mental healthcare system. The primary expenses associated with these recommendations would be the daily cost of housing a mentally ill individual in a jail or prison; the cost of inpatient mental healthcare, such as examinations; and the cost of some state funding for community treatment resources. For the purposes of this Article, a prediction of these costs over one year is based on the following estimates: one quarter—3,500—of Florida's severely mentally ill homeless population will be arrested in one year for violating homeless ordinances and spend thirty days in prison, half the maximum penalty under St. Petersburg's ordinance.[256] With the daily cost of housing a mentally ill inmate amounting to roughly $125 per day,[257] the price of housing for those 3,500 inmates for one month will come to about $13 million.[258] If each of these inmates also receives inpatient treatment while incarcerated, an expense of $2,000 per inmate,[259] then the cost for inpatient treatment for that month will amount to $7 million.[260] After that month, these inmates will be released and begin outpatient treatment programs. If the State increases its funding to $10 million per year for community treatment resources that support these programs, the one-year expense associated with rethinking and revitalizing Florida's outpatient treatment law is roughly $30 million.[261] According to the Duke Studies, after receiving outpatient treatment, seventy-four percent of these former inmates will not deteriorate and be arrested again.[262] If just twenty-six percent, then, are re-arrested and re-incarcerated, the State will

255. *Id.* at 12.

256. St. Petersburg Code of Ordin. at § 1-7(c).

257. Jenne & Eslinger, *supra* n. 138.

258. This figure is the product of multiplying 3,500 severely mentally ill inmates by the cost of daily housing by thirty days in a month.

259. *Supra* n. 140.

260. This figure is the product of multiplying 3,500 severely mentally ill inmates by the cost of an examination.

261. This figure is the sum of adding the cost of housing with the cost of examinations with the cost of funding community treatment resources.

262. Bardey, *supra* n. 22 (citing the Duke Studies).

incur a cost of recidivism of only about $5 million.[263] Under Florida's current mental health system, readmissions to hospitals for the mentally ill cost the State a minimum of $168 million per year,[264] and that number increases annually.[265] Because the severely mentally who are homeless account for probably at least half of that cost,[266] Florida could save about $50 million[267] by implementing this Article's proposals.

IV. CONCLUSION

With outpatient treatment almost nonexistent for the severely mentally ill who are homeless in Florida, the State must rethink and revitalize its outpatient treatment law—both for the well-being of the mentally ill and the security of the public. Florida's homeless ordinances provide the State with an unchampioned but cost-effective method by which it can do just that, enabling the State to seek out and identify the severely mentally ill among its homeless population. Florida's homeless ordinances also carry short-term penalties that would act as enforcement mechanisms under the outpatient treatment law, increasing compliance with outpatient treatment plans. During brief incarcerations for the violation of homeless ordinances, the severely mentally ill would receive necessary inpatient treatment in what are today's de facto mental hospitals. Slight modifications to Florida's outpatient treatment law will facilitate the petition-filing process for jails and prisons that do receive these individuals, increasing the likelihood that a petition will reach a court. With

263. If twenty-six percent, or 910, of these severely mentally ill former inmates are re-arrested, then the product of multiplying 910 by the cost of daily housing by thirty days in one month is about $3.4 million. And the product of multiplying 910 by the cost of an examination is about $1.8 million. Those two products added together equal $5.2 million.

264. From July 2004 through June 2007, nearly 42,000 severely mentally ill adults were readmitted to hospitals two or more times to receive examinations. Petrila & Christy, *supra* n. 26, at 21. With the cost of an examination amounting to $2,000 per patient, the product of multiplying 42,000 readmitted patients by two visits per year by the cost of an examination is $168 million.

265. Bardey, *supra* n. 22.

266. *See generally supra* nn. 143–148 and accompanying text (stating that the homeless are a hundred times more likely to be hospitalized or readmitted to hospitals than the non-homeless).

267. This figure is the difference between $84 million (half of $168 million) and $35 million (the one-year expense associated with rethinking and revitalizing Florida's outpatient treatment law plus the cost of recidivism).

these recommendations for rethinking and revitalizing Florida's outpatient treatment law, Florida may make headway in shoring up its mental health system—and save millions in mental health costs in the process.