Tab 3	**SB 80** by **Brodeur (CO-INTRODUCERS) Albritton**; Child Welfare

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Tab 4	**SB 92** by **Bean**; Department of Children and Families

Tab 5	**CS/SB 184** by **TR, Berman**; (Similar to H 00079) Purple Alert

Tab 6	**SB 590** by **Harrell**; (Identical to H 00383) Involuntary Examinations of Minors

Tab 7	**SB 626** by **Bracy**; (Compare to H 00303) Juvenile Justice

Tab 8	**SB 828** by **Book (CO-INTRODUCERS) Gainer**; (Similar to H 00405) Mental Health and Substance Abuse

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The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Book, Chair
Senator Albritton, Vice Chair

MEETING DATE: Tuesday, February 16, 2021
TIME: 9:00—11:30 a.m.
PLACE: *Mallory Horne Committee Room,* 37 Senate Building

MEMBERS: Senator Book, Chair; Senator Albritton, Vice Chair; Senators Brodeur, Garcia, Harrell, Rouson, Torres, and Wright

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	PUBLIC TESTIMONY WILL BE RECEIVED FROM ROOM A2 AT THE DONALD L. TUCKER CIVIC CENTER, 505 W PENSACOLA STREET, TALLAHASSEE, FL 32301		
1	Presentation on Child Welfare by Robert Latham, J.D.; Associate Director of the Children & Youth Law Clinic, University of Miami, School of Law		Presented
2	Presentation on Childhood Development by Dr. Mimi Graham, Ph.D; Director of the Center for Prevention and Early Intervention Policy, Florida State University		Presented
3	**SB 80** Brodeur	Child Welfare; Requiring the case record of every child under the supervision or in the custody of the Department of Children and Families, the department's agents, or providers contracting with the department to include a case record face sheet; revising criteria for the court to consider when determining whether a legal change of custody is in the best interests of the child; providing for priority placements for a child who must be placed in out-of-home care; requiring the department to make reasonable efforts to place siblings in the same foster, kinship, adoptive, or guardianship home when certain conditions are met, etc. CF 02/16/2021 Fav/CS JU RC	Fav/CS Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 92** Bean	Department of Children and Families; Requiring the department to establish community alliances in each community-based care lead agency service area; requiring the department to treat caregivers in a specified manner; requiring, rather than authorizing, each community-based care lead agency to establish a kinship navigator program; requiring a board member or an officer of a managing entity to disclose specified activity that may reasonably be construed as a conflict of interest; revising a limitation on salaries of community-based care lead agency employees, etc. CF 02/16/2021 Favorable AHS AP	Favorable Yeas 8 Nays 0
5	**CS/SB 184** Transportation / Berman (Similar H 79)	Purple Alert; Requiring the Department of Law Enforcement, in cooperation with the Department of Transportation, the Department of Highway Safety and Motor Vehicles, the Department of the Lottery, and local law enforcement agencies, to establish and implement the Purple Alert; requiring the local law enforcement agency having jurisdiction to notify media and alert subscribers if a Purple Alert is determined to be necessary and appropriate; providing that the Department of Law Enforcement, as the Purple Alert coordinator, and certain agencies, employees, individuals, and entities are immune from civil liability for damages when performing certain actions in good faith, etc. TR 02/02/2021 Fav/CS CF 02/16/2021 Favorable AP	Favorable Yeas 8 Nays 0
6	**SB 590** Harrell (Identical H 383)	Involuntary Examinations of Minors; Revising parent, guardian, or caregiver notification requirements that must be met before an involuntary examination of a minor; revising parent and guardian notification requirements that must be met before conducting an involuntary examination of a minor who is removed from school, school transportation, or a school-sponsored activity; creating reporting requirements for schools relating to involuntary examinations of minors; requiring that certain plans include procedures to assist certain mental and behavioral health providers in attempts to verbally deescalate certain crisis situations before initiating an involuntary examination, etc. CF 02/16/2021 Favorable ED AP	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 626** Bracy (Compare H 303)	Juvenile Justice; Creating the "Kaia Rolle Act"; prohibiting a child younger than a certain age from being adjudicated delinquent, arrested, or charged with a violation of law or a delinquent act; authorizing children of at least a specified age, rather than of any age, to be taken into custody under certain circumstances; requiring that children who are taken into custody pursuant to certain circuit court orders be treated in a specified manner and be detained only pursuant to specified findings, etc. CF 02/16/2021 Temporarily Postponed CJ AP	Temporarily Postponed
8	**SB 828** Book (Similar H 405, Compare H 955)	Mental Health and Substance Abuse; Requiring facilities to inform respondents with a serious mental illness of the essential elements of recovery and provide them assistance in accessing a continuum of care regimen; authorizing the state to establish that a transfer evaluation was performed by providing the court with a copy of the evaluation before the close of the state's case in chief; revising the requirements for when a person may be taken to a receiving facility for involuntary examination; revising the requirements for when a person may be ordered for involuntary inpatient placement; requiring the clerk of the court to notify the state attorney's office upon the receipt of a petition filed for involuntary treatment services, etc. CF 02/16/2021 Fav/CS JU AP	Fav/CS Yeas 8 Nays 0

Other Related Meeting Documents

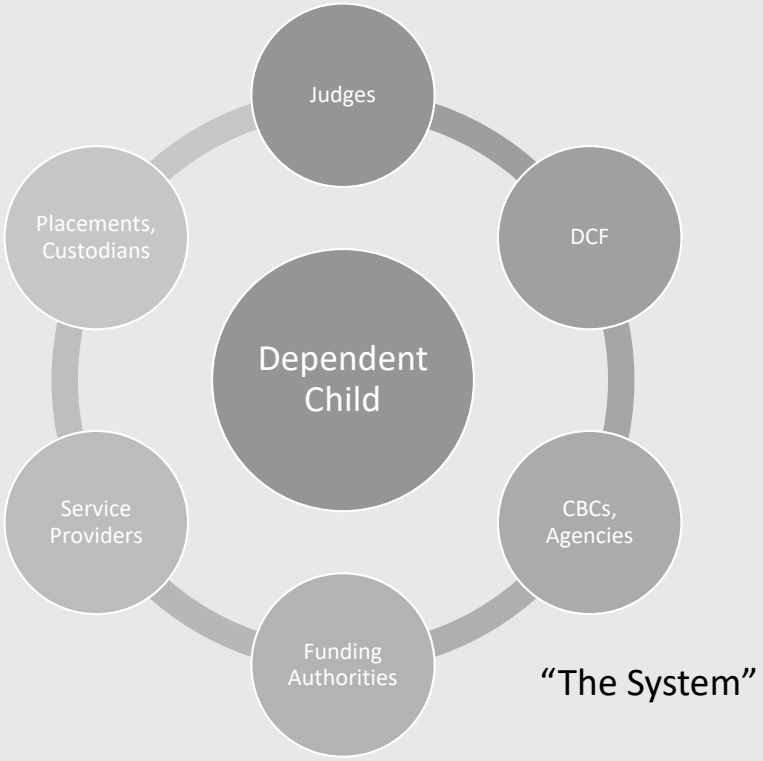
Child Representation in the Foster Care System

Robert Latham, J.D.
Associate Director
Children & Youth Law Clinic

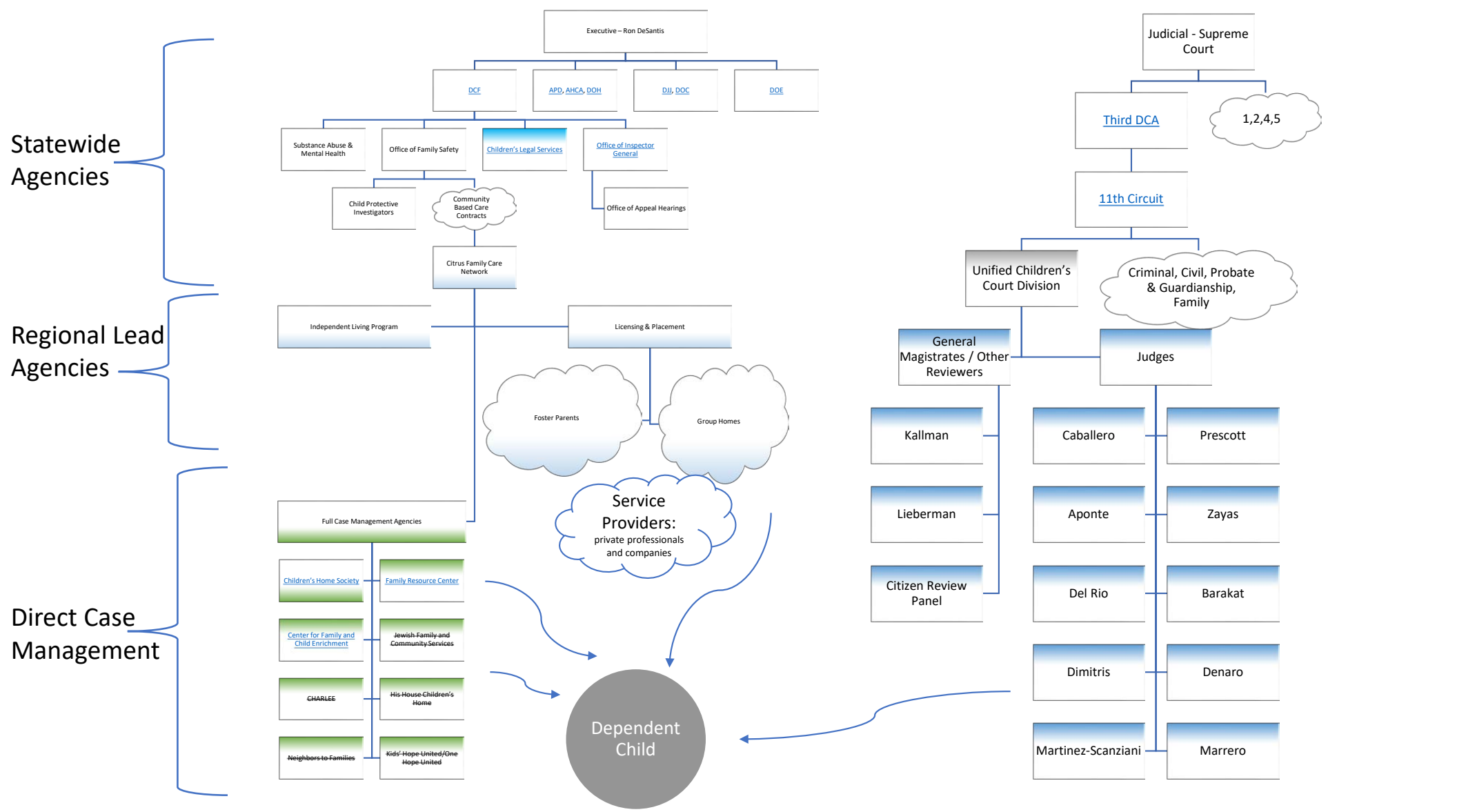
When a child enters foster care, they lose…

- Home, bedroom, toys & games, pets
- Neighbors, friends, backyard, favorite tree
- School, classmates, teachers
- Daily routine, favorite food, clothes, pictures, music
- Stability, predictability, routine, attachment, trust
- A single person or group of known people who are responsible for their needs

Dependent children are overseen by a complex group of competing decisionmakers



"The System"


Statewide Agencies
Regional Lead Agencies
Direct Case Management
Executive – Ron DeSantis
DCF
APD, AHCA, DOH
DJJ, DOC
DOE
Substance Abuse & Mental Health
Office of Family Safety
Children's Legal Services
Office of Inspector General
Child Protective Investigators
Community Based Care Contracts
Office of Appeal Hearings
Citrus Family Care Network
Independent Living Program
Licensing & Placement
Foster Parents
Group Homes
Service Providers:
private professionals and companies
Full Case Management Agencies
Children's Home Society
Family Resource Center
Center for Family and Child Enrichment
Jewish Family and Community Services
CHARLEE
His House Children's Home
Neighbors to Families
Kids' Hope United/One Hope United
Dependent Child
Judicial - Supreme Court
Third DCA
1,2,4,5
11th Circuit
Unified Children's Court Division
Criminal, Civil, Probate & Guardianship, Family
General Magistrates / Other Reviewers
Judges
Kallman
Lieberman
Citizen Review Panel
Caballero
Prescott
Aponte
Zayas
Del Rio
Barakat
Dimitris
Denaro
Martinez-Scanziani
Marrero

A foster child needs an advocate

1. Someone who can promote the child's individual interests
2. Someone who can understand and explain what's happening
3. Someone the child can trust and who believes them
4. Someone who can navigate the system and get things done

OPPAGA: 56% of children had no advocate or time-limited advocacy

- 33% of children were not appointed to the GAL Program
  - Ranged from 0 to 44% in circuits
- GAL withdrew before case closure on 34% of appointments (23% of all children)

Exhibit 6
Closure Reasons Reported by GAL Program Remained Stable From Fiscal Year 2016-17 Through the First Half of Fiscal Year 2019-20[1]

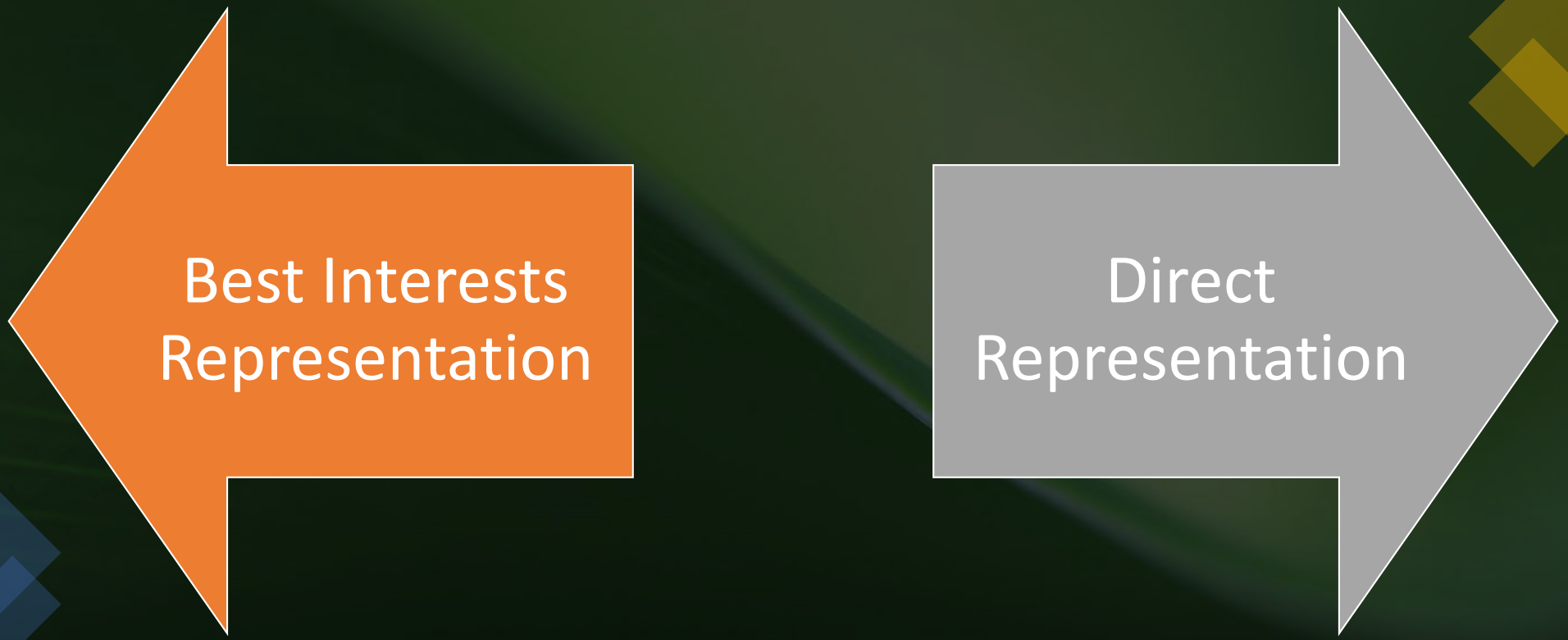
GAL Program Closure Reason for GAL Program Closures	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20[1]	Four-Year Total
Reunification	29%	31%	29%	31%	30%
Adoption	18%	18%	20%	19%	19%
Permanency Goal Established[2]	18%	19%	23%	22%	21%
Permanent Guardianship	17%	15%	13%	12%	15%
Other[3]	9%	9%	6%	6%	8%
Insufficient Program Resources[4]	5%	4%	4%	4%	5%
Aged Out of Care	3%	4%	4%	4%	4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

[1] To control for differences between GAL Program closures and DCF discharges, we limited the Fiscal Year 2019-20 data to the first six months (July 1, 2019–December 31, 2019).
[2] Closure reasons of APPLA are included here.
[3] Other includes children who ran away, were transferred to or placed in another circuit, and cases that were either consolidated or bifurcated by the courts.
[4] This includes cases to which the GAL Program was appointed where the program was either unable to staff the case at all or had to discharge from a case before it concluded. Closure reasons of APPLA are included here.
Source: OPPAGA analysis of Florida Guardian ad Litem Program data representing 80% of GAL children with a closed case.

An opportunity

- Federal law has required a child advocate (lay or professional) for 100% of foster children since 1974
- Federal funding will now support that mandate with 50% FFP on IV-E eligible cases
  - Lawyer & legal costs
  - Administrative costs
  - Investigators, social workers, peer partners
  - Training (75% FFP already available)
- Must be “independent legal representation”

Child representation debate:
What is the proper role for a lawyer?



The Discussion

- The standard models
  - Attorney-Guardian ad Litem
  - Direct Representation Attorney
  - Court Appointed Special Advocate
- Florida’s Guardian ad Litem Program

How do the models function?
What values are promoted by each?

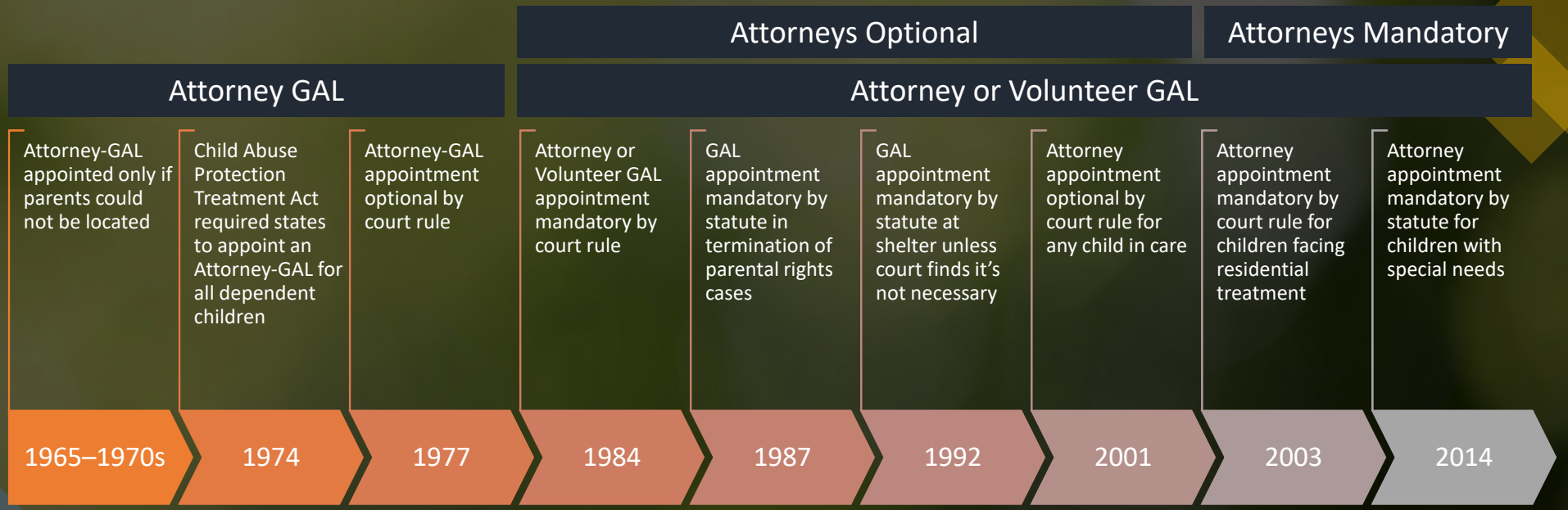
The Models

States use a variety of models & structures

Exhibit C-2
Other States' CASA/GAL State Associations Vary on Numerous Factors[1]

State CASA Association[1]	Representation Model	CASA/GAL Asso. Structure	Total Funding	State Funding	Number of Children Served	Number of Active Volunteers
Delaware	Best interest (attorney)	Publically administered, direct service	$2.6 million	$2.4 million	464	240
Florida	Multidisciplinary team	Publically administered, direct service	60.7 million	51.4 million	37,947	9,938
Georgia	Hybrid	Nonprofit, no direct service	16 million	3.2 million	11,000	2,700
Illinois[2]	Best interest (lay volunteer)	Nonprofit, no direct service	11.5 million	1.4 million[3]	6,447	2,436
Iowa	Hybrid	Publically administered, direct service	2.8 million	2.8 million	1,376	505
Kentucky	Best interest (attorney)	Nonprofit, no direct service	1.5 million	1.4 million	3,818	1,313
Nebraska	Best interest (attorney)	Nonprofit, no direct service	4.7 million	500,000	2,031	912
North Carolina	Multidisciplinary team	Publically administered, direct service	17.8 million	15.5 million	18,036	5,539
Ohio	Best interest (lay volunteer)	Nonprofit, no direct service	14.1 million	226,361	10,189	2,491
South Dakota	Best interest (attorney)	Publically administered, no direct service	1.8 million	760,596[4]	1,628	348
Texas	Hybrid	Nonprofit, no direct service	33.5 million	13.6 million	30,432	10,874
Utah	Best interest (attorney)	Publically administered, direct service	8.7 million	8.7 million	1,659	736
Median values			**$10.1 million**	**$2.6 million**	**5,133**	**1,875**

Child Representation in Florida Dependency Cases



Ethical Duties of Attorney to Client

- Competence
- Diligence
- Counsel
- Communication
- Confidentiality
- Loyalty
- Zealous Advocacy

Scope of Legal Representation

Duties to client

1. The **client sets the goals**.
2. The **lawyer determines the means** in consultation with the client.

Limits

- A lawyer cannot counsel or assist a client to engage in **criminal or fraudulent conduct**.
- A lawyer owes the court a duty of **candor and meritorious claims**.
- If a client insists on taking action that the attorney fundamentally disagrees with, **the attorney may withdraw**.

Direct Representation Advocacy Process

Start with what the client wants, investigate, counsel them on what is possible.

Move the client to a legally and factually supportable position.

In dependency law, the process moves the child away from harm and towards the child's best interests.

Example: Psychotropic Medication

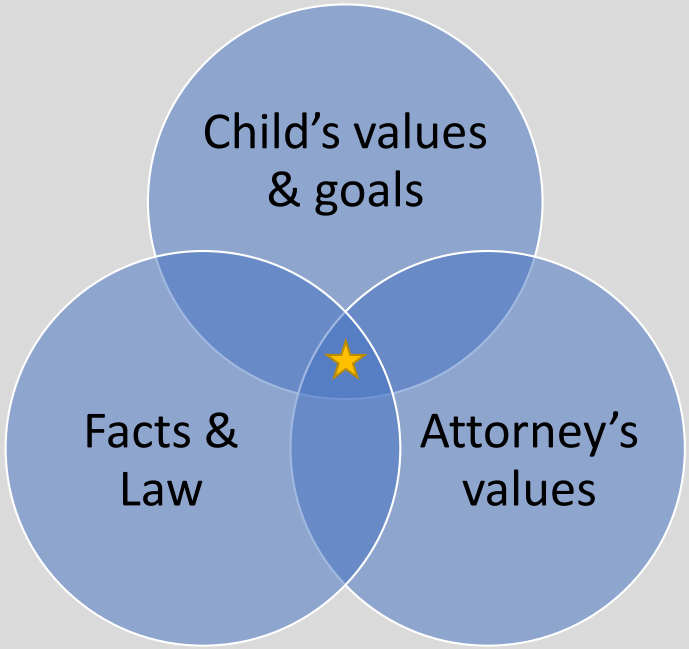
- The youth is 14 years old and prescribed psychotropic medication. The youth is willing to take the meds if it will help him, but he's nervous about the potential side effects.
- A court order is required for DCF to provide the medication.
- Legal standard: medically recommended and in child's best interest
- How should the child's attorney advocate?

Direct Representation Position Formation

- **Initial Position:** The client is reluctantly willing to take the meds but is worried about the side effects.
- **Investigation:** Talk to doctor, therapist, placement
  - Is the medication necessary or just recommended?
  - Are there alternative treatments?
  - Are there ways to minimize the side effects?
  - What's happening at home?
- **Counseling:** Inform client of investigation and possible options
- **Counseled position:** With new information, the client would rather:
  - Try the meds and stop them if the side effects are bad
  - Try a different medication
  - Try therapy or another intervention first
- **Legal advocacy:** It's in the child's best interest to…

Direct representation seeks to find an overlap

- Pros
  - The child has their concerns voiced, heard, and accounted for.
  - The representation moves the client's values and goals toward the legal standards (best interests or no harm)
  - The attorney is not required to make any argument she is not comfortable with.
- Cons
  - Most lawyers have no special training in communication with children, child development, or trauma.
  - Litigation and legalistic approaches can disrupt relationships. Lawyers can promote legal principles over other needs.



★ = potential positions

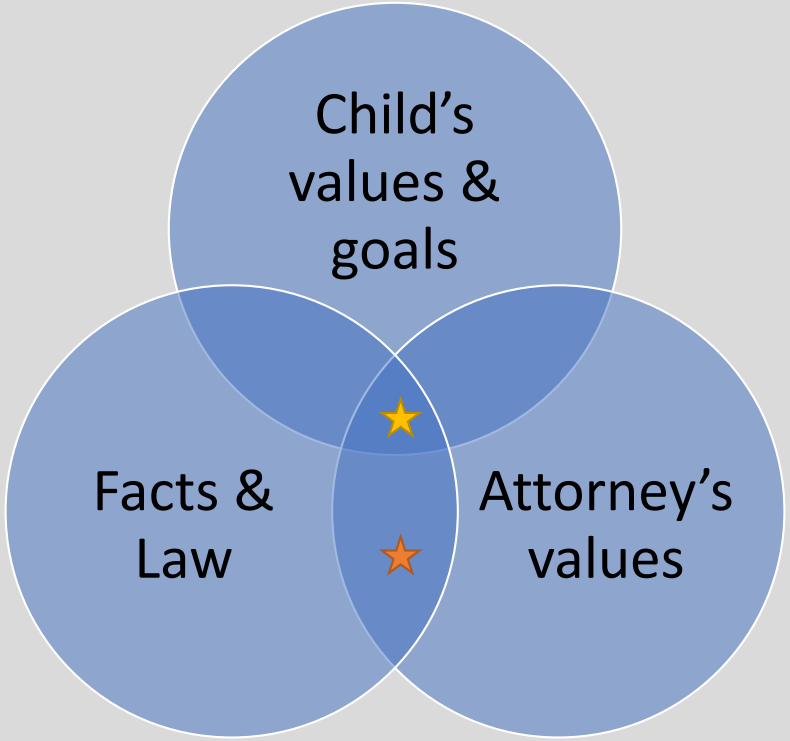
Best Interest Representation
Position Formation

- **Initial Position:**
  - I don't think kids should ever be on psychotropic medication.
  - I don't think I should second-guess a doctor.
  - I don't think I should second-guess the child.
  - I need more information.
  - I think psychotropic medications can really help a child succeed.
  - I think this child really needs medications.
- **Investigation**
- **Updated position: _____**
- **Legal advocacy:** It's in the child's best interests to…

Best Interests Representation

- Pros
  - Provides legal advocacy.
  - The attorney is bound by duties of candor and meritorious claims.
  - The attorney is not bound to advocate for something she believes is not in child's best interest.
- Cons
  - The representation elevates the attorney's values. The child can feel unheard or betrayed. The disconnect can lead to bad outcomes.
  - The attorney can forego fact investigation or analysis for gut instinct.
  - Most lawyers have no training in child wellbeing. Socioeconomic gap between attorney and child.
  - The direction and intensity of advocacy can vary greatly depending on the advocate.
  - The model does not square easily with the Rules of Professional Conduct.

☆ = potential positions

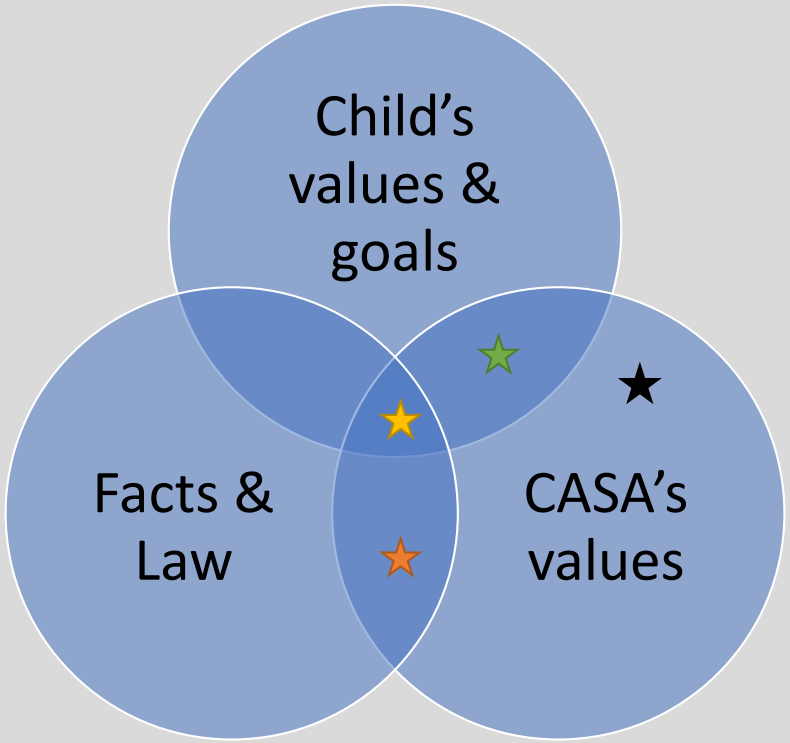


Court Appointed Special Advocate Model (CASA)

- **Created in 1977:** before ASFA, case plans, permanency goals, counsel for parties, and most modern oversight mechanisms
- **Volunteers**
  - recruited from the community
  - trained on foster care system
  - conduct investigations & issue reports
- Typically run as **court program**
- **Not legal representation**
- "**Expert witness on the child**"

CASA Representation

- Pros
  - Independent investigation
  - Very low caseload
  - Many volunteers function as mentors and champions for reform
- Cons
  - Cannot provide legal representation (which was reasonable in 1977)
  - Not bound by legal ethics or evidence-based advocacy.
  - Socioeconomic gap between CASA and child.
  - The advocacy can diverge significantly from the child's position, the facts and law, and can vary greatly depending on the advocate.



☆ = potential positions

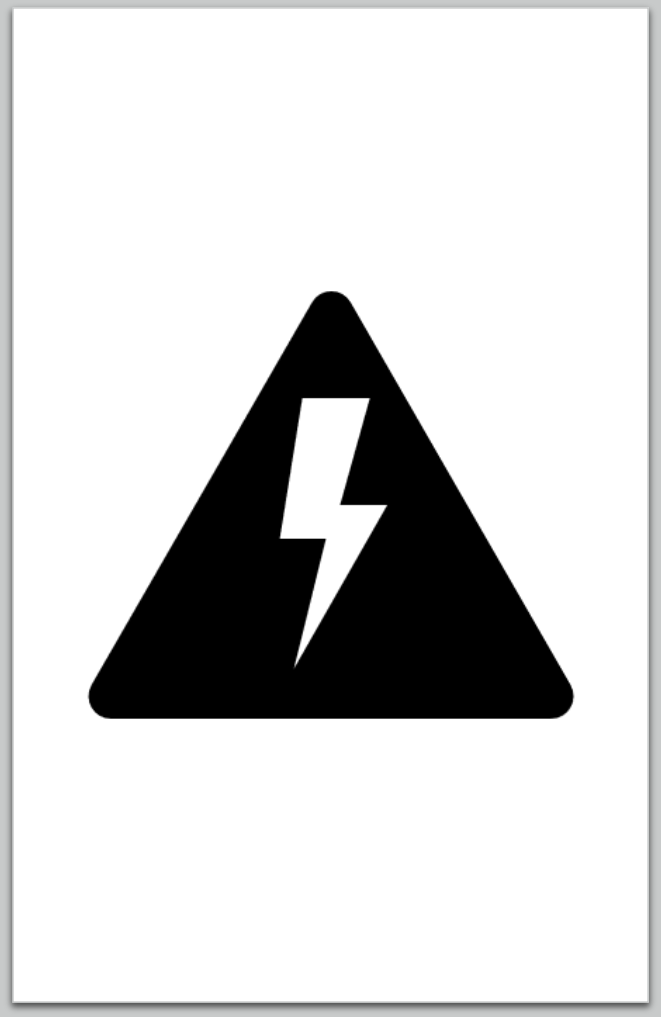
Attorney representation is crucial for the best interest of children.

Chapter 39 Hearings

- Shelter Hearing
- Adjudicatory Hearing for Dependency
- Modification of Placement Hearings
- Hearing to Place Child in Residential Treatment Center
- Case Plan Amendment Hearings
- Change of Visitation Hearings
- Termination of Parental Rights Trials

Ancillary Hearings

- Medicaid, APD, SSI Denial Appeals
- School Due Process Hearings
- Independent Living Program Appeals
- Licensing and Adoption Appeals
- Marchman Act Proceedings
- Appeals



What if the child wants to do something harmful? Run away, go to an unsafe home, stop treatment?

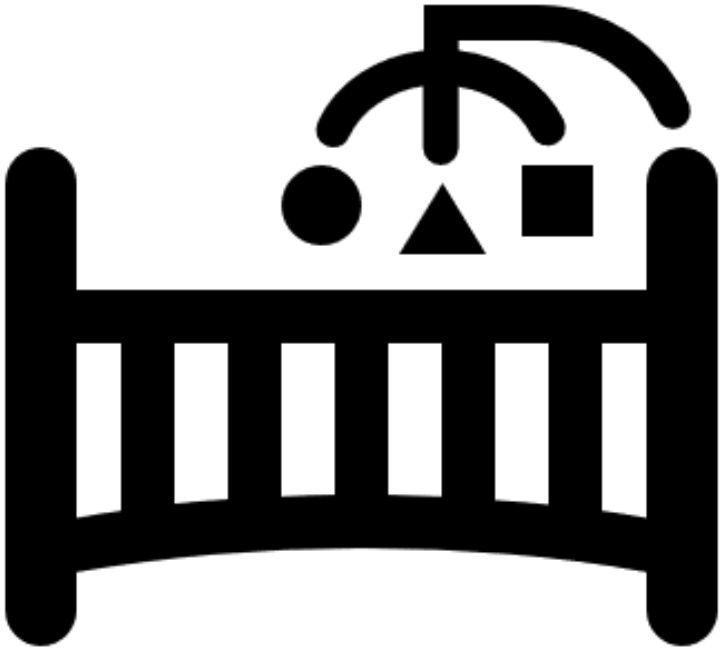
Most children are not trying to hurt themselves. They are often responding to a situation they can't control.

The direct representation attorney:

- Must determine the motivation and goals of the child
- Must try to find a solution that is both legal and acceptable to the child
- Must be honest with the child about the consequences
- May take action, decline to take action, or withdraw

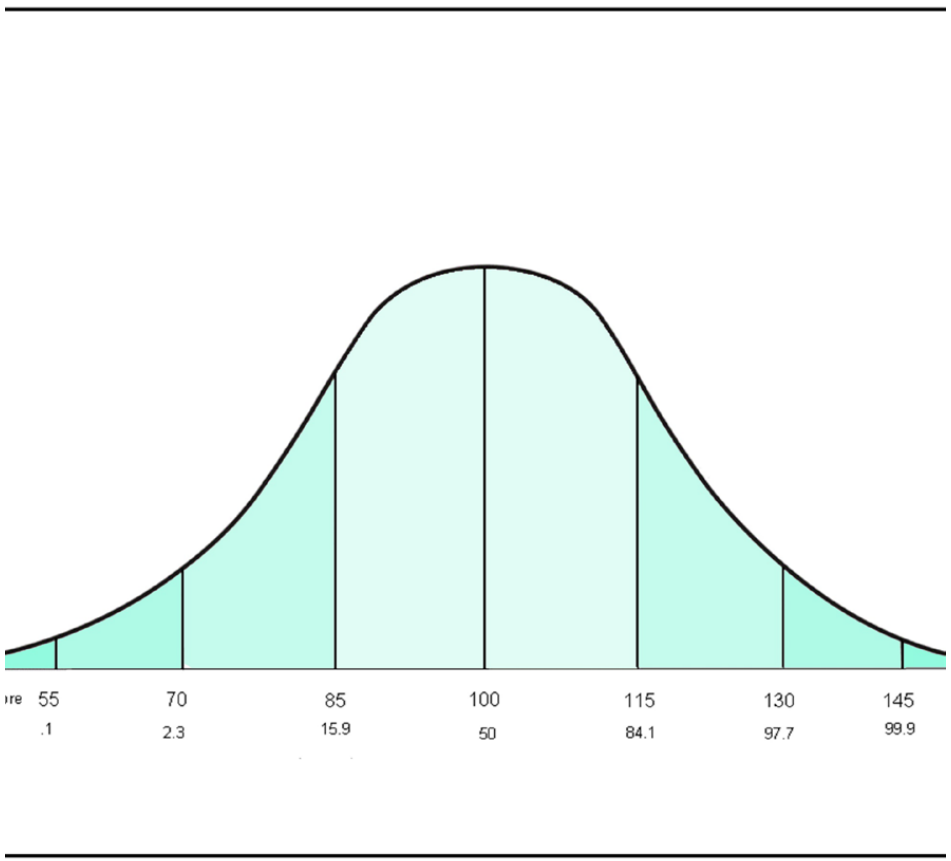
Judges can deny the motion.

How can an attorney represent a baby?



Legal ethics rules have provisions for incapacitated clients

- The rules require the attorney to
  - Maintain **as normal a relationship as possible** with the client
  - Take "**protective action**" when the client cannot act in their own interests
  - Can seek appointment of **guardian**
- Capacity can vary depending on the issue
- What are a baby's "own interests"?



Alternatives to pure discretion model

- **Expert deference** – work with psycho-therapeutic experts or multidisciplinary teams
- **Attachment and family system** – promote primary and family attachments
- **Legal rights model** – maximally assert legal rights (and other "values" models)
- **Substituted judgment** – construct the client's position from objective indicia (probate model)
- **Advocacy guidelines** – factors or standards set by statute or court rule

The system needs to hear the child's views to make better decisions. The child needs to be heard to feel and be safe.

- How often should a child visit his siblings if they're very far away?
- Should a female child live with her aunt or her uncle?
- Should a child live with a wealthy foster parent or a poor relative?
- How should a child's race, religion, and identity factor into placement decisions?
- How much extra time should a parent get on their case plan before ending services and moving to termination of parental rights?
- Should a child who could be safely reunified finish the school year in the foster home or change schools to go home?
- Should a child with disabilities be in a residential program or a community home with support?
- Should a grandmother adopt or take permanent guardianship?
- Should a child who discloses that a foster parent abused her be believed?

Best Practice

- **All children need high quality legal representation in dependency proceedings.**
  - The attorney must provide **counsel** and **advocacy;** be **competent, zealous, independent**; and have a **workable caseload**.
  - The attorney should receive **training and support** from experts on effective communication and counseling of children with **trauma**.
- **The role of the attorney should match the child's developmental needs.**
  - When the child has capacity, an attorney should be appointed to directly represent the child.
  - When the child has limited capacity, the attorney should try to maintain as normal a relationship as possible but be candid with the court and parties about the client's limits.
  - When the child is pre-capacitated, there are many options but there is ongoing debate about the best approach.
- **A best interest advocate or fact investigator should be appointed when available and necessary.** The advocate can be an independent witness or part of the legal team. The role should be clearly defined.

IV-E funding is available for Attorney-GAL model, too

Question: May the title IV-E agency claim independent legal representation costs by a Guardian Ad Litem (GAL) for a child who is a candidate for title IV-E foster care or is in title IV-E foster care, and his/her parent in foster care legal proceedings?

Answer: A title IV-E agency may claim title IV-E administrative costs for a GAL if he or she is an attorney providing independent legal representation to a title IV-E eligible child in all stages of foster care proceedings.

The Florida Guardian ad Litem Program

Statutory definition of guardian ad litem includes:

A guardian ad litem is…

- The Statewide Guardian Ad Litem Office, which includes circuit guardian ad litem programs;
- a duly certified volunteer, a staff member, a staff attorney, a contract attorney, or a pro bono attorney working on behalf of a guardian ad litem;
- a court-appointed attorney; or
- a responsible adult

Who is…

- appointed by the court to represent the best interests of a child in a proceeding as provided for by law [],
- a party to any judicial proceeding as a representative of the child, and
- serves until discharged by the court.

Chapter 39 duties of a GAL in Florida

The legislature did not mandate a particular model or structure.

Maintain the confidential status of records

Review all dispositional recommendations and changes in placement, file a dispositional report, and be present at all critical stages or submit written report

Advocate in certain situations:

- Investigate and be present at all TPR hearings, submit a written report of recommendations, including child's wishes
- Be appointed for children in residential treatment centers and participate in treatment plan preparation
- Be appointed in Keeping Children Safe Act hearings
- Submit a list of recommended services for APPLA and Fit & Willing Relative Cases
- Participate in case plan development face-to-face

"To represent the best interests of the child until the jurisdiction over the child terminates or unless excused by the court."

Does the GAL Program Attorney provide independent legal representation to the child?

1. The Guardian ad Litem Program and the child are both parties to the case.
2. An attorney **cannot represent two parties** to the same case if it will require asserting **adverse positions**. (Cannot be waived.)
3. An attorney cannot represent a client if they owe **an obligation to a third party that materially limits the representation**.

Who does the Program attorney represent?

PROGRAM ATTORNEY

8700

DISTINGUISHING CHARACTERISTICS OF WORK

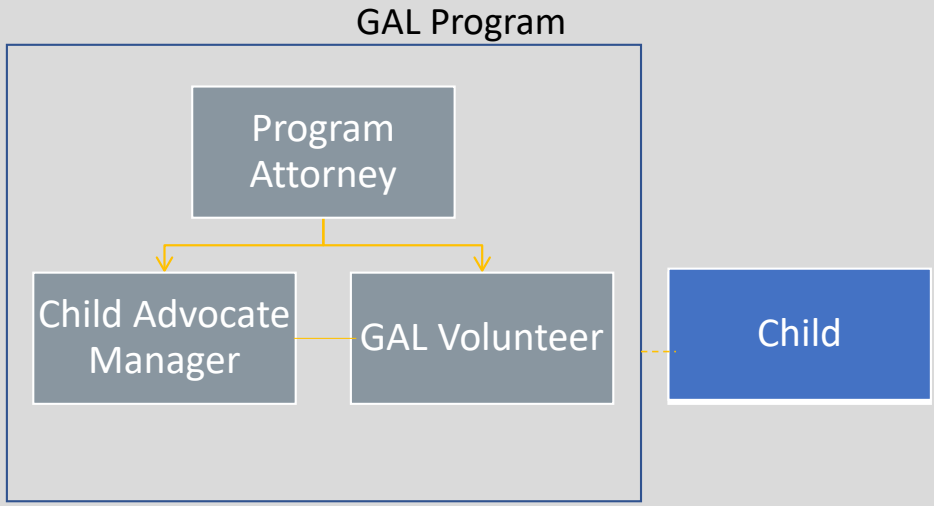
This is highly responsible entry level work in a developing capacity, providing legal counsel and representation to a circuit Guardian ad Litem (GAL) Program which advocates for the best interests of abused, neglected and abandoned children involved in dependency proceedings. The Program Attorney provides legal representation in court on behalf of the GAL Program, files pleadings and motions, and attends depositions, mediations and staffings with social service agencies, GAL employees and volunteers concerning children represented by the GAL Program. The Program Attorney reviews case files to identify legal issues, and participates in the development and implementation of case strategies. The Program Attorney works cooperatively with staff and volunteers to implement a plan that will further the child's best interests. The Program Attorney must exercise discretion in dealing with confidential and extremely sensitive issues before the court.

The GAL Program Attorney will identify and manage the legal issues in the case. The Program Attorney provides advice and counsel to the team and to the child giving consideration to the child's age, cognitive ability, maturity, trauma history, and therapeutic needs. The GAL Program Attorney represents the GAL Program and while there is no attorney-client relationship between the GAL Attorney and the child, the GAL Attorney has a fiduciary duty to the child as the beneficiary of the Program's representation. Representation of the child's best interests is the sole purpose of the advocacy.

Above: GAL Program Pay Plan
Below: GAL Program Employee Manual

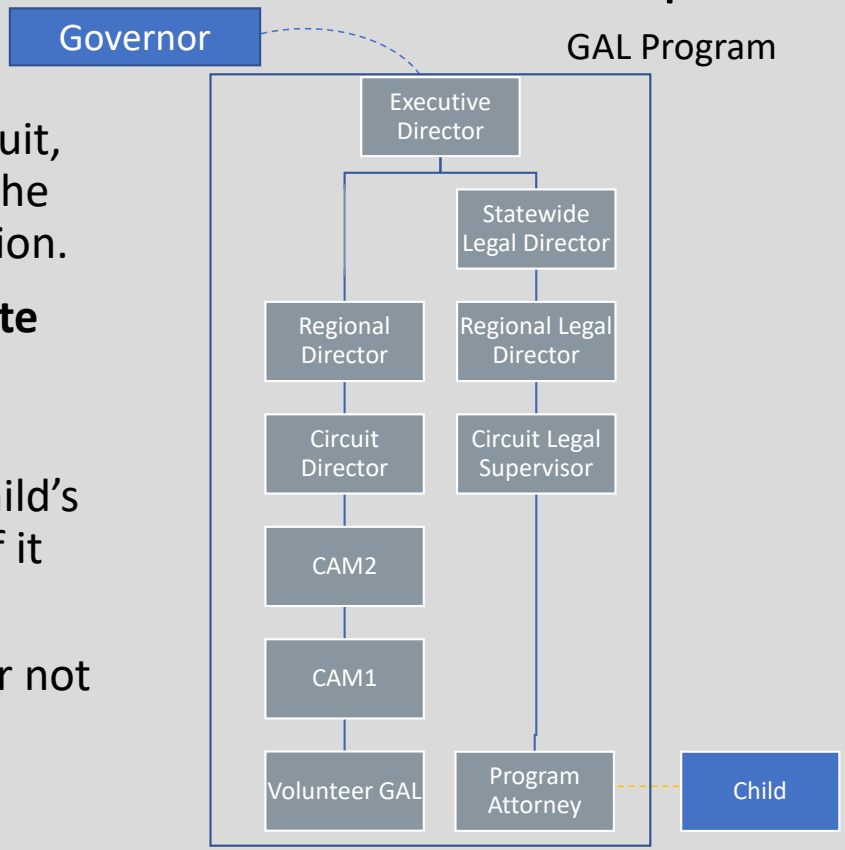
The GAL Program Team Model

- The GAL Program is appointed as the guardian ad litem.
- The GAL Program
  - Recruits **volunteers** or staff to do fact investigations
  - Hires **Child Advocate Managers** to supervise volunteers
  - Hires **attorneys** to provide legal advice and representation
- Manual states: The team seeks **consensus**. Defer to volunteer on facts, defer to attorney on the law.
- Court rule and statute: The GAL must report the child's wishes to the court.



The GAL Program conflict resolution process

- Disputes can be **escalated** to the circuit, regional, and statewide leadership. The team is "**informed**" of the final decision.
- The Program can **remove or terminate** team members.
- **The Program decides** if it wishes to disclose internal conflicts over the child's best interest. **The Program decides** if it has conflicts of interest.
- Governor can remove ED for cause or not re-appoint at end of 3-year term.

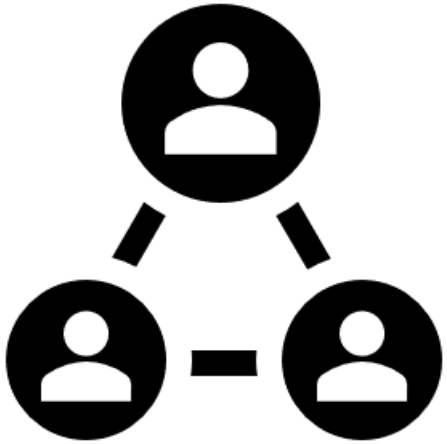


An attorney for an organization owes ethical duties to the organization

(Ethics Rule 4-1.13)

1. If a lawyer knows the organization is engaging in misconduct or violating a legal duty, the lawyer shall proceed as is reasonably necessary in the best interest of the organization.
2. If the organization will not change its conduct, the attorney may resign.
3. The requirement of maintaining confidentiality of information relating to representation applies to government lawyers who may disagree with the policy goals that their representation is designed to advance.
4. Ethical obligations of a government lawyer can be prescribed by statute.

The Program attorney **cannot** "independently represent" a child and owe ethical obligations to the Program and third parties.



The attorney owes obligations to the volunteers and the CAMs.

Scenarios:

- The volunteer and CAM want the attorney to take a legal position the attorney believes is not in child's best interest and the child objects to.
- A volunteer has not seen a child in months, despite reporting to the Program that the child is well. The volunteer only spoke to the custodian. The CAM asks the attorney not to report this to the court.
- A volunteer recommends that a child be evaluated for a residential program because of a recent incident. The attorney doubts the reliability of the volunteer's information, but the volunteer insists on the evaluation.
- A volunteer has been called as a witness against the child in a delinquency trial.
- A volunteer develops a personal relationship with a foster parent and objects to reunification despite it being legally required.
- A volunteer recommends a child move to a foster home because it will be closer to the volunteer's house and require less travel.
- The child requests the volunteer be replaced because he wants someone who understands him better. The CAM refuses.
- The attorney disagrees with a volunteer who is a powerful member of the GAL community. The volunteer recruits and fundraises for the Program.

The attorney owes obligations to the Program.

Scenarios:

- The Program instructs the attorney to take a position that the attorney does not believe is in the child's best interest and the child objects to.
- The Program does not authorize litigation funds to pursue a motion the attorney believes in the child's best interest.
- The Program limits the attorney from handling an administrative appeal that would further the best interests of the child.
- The Program does not authorize a motion seeking contempt against DCF despite clear evidence of it violating a court order.
- The Program does not authorize a constitutional argument out of concern that the legislature will cut its funding for seeking to strike down a statute.

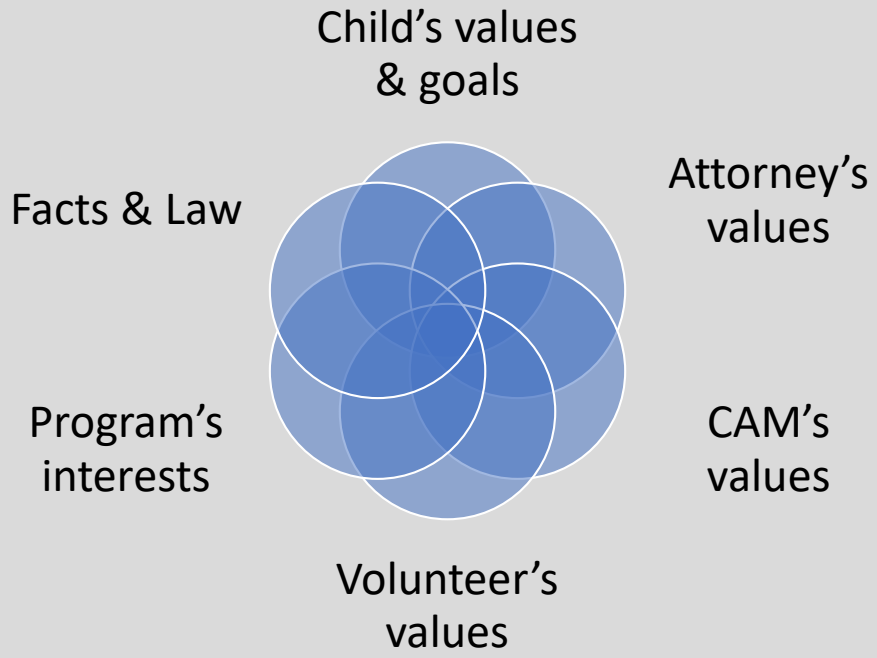
The attorney can owe obligations to third parties.

Scenarios:

- The Program is assigned to two children who desperately need placement in a therapeutic home. Only one bed is available.
- The Program is assigned to a sibling group. The Program recommends that one child return home and the other stay in foster care. Arguing conflicting positions will result in weakening the argument for both children.
- The Program recommends a person for an adoptive placement. The person has a close personal and business relationship with the Program.
- The Program does not authorize an appeal against a judge who is a strong public supporter of the Program.
- The Program receives a donation through its direct support organization from a service provider it makes recommendations regarding.

GAL Program

- Pros
  - Multidisciplinary team model
  - An attorney is involved in the Program's advocacy
  - Benefits of CASA volunteers
- Cons
  - Creates layers of separation between child and attorney.
  - Elevates Program's interests.
  - Advocacy can significantly diverge from child's values and best interest.
  - Not independent legal representation.



We can have a strong child advocacy system in Florida.

- We can get to 100% representation
- We can empower youth
- We can have strong community involvement
- We can promote best interests and system reform from within

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Data Addendum

System Demographics for January 1, 2019 and Exits in 2019.

Reasons in Care

- Physical or sexual abuse 14%
- Drugs or alcohol 48%
- Everything else 38%

Demographics in Care

- **Race**
  - White 60%
  - Black 30%
  - Multiracial 9%
  - Other 1%
- **Gender**
  - 51% male, 49% female
- **Age quartiles**
  - 0-2
  - 3-5
  - 6-10
  - 11-17

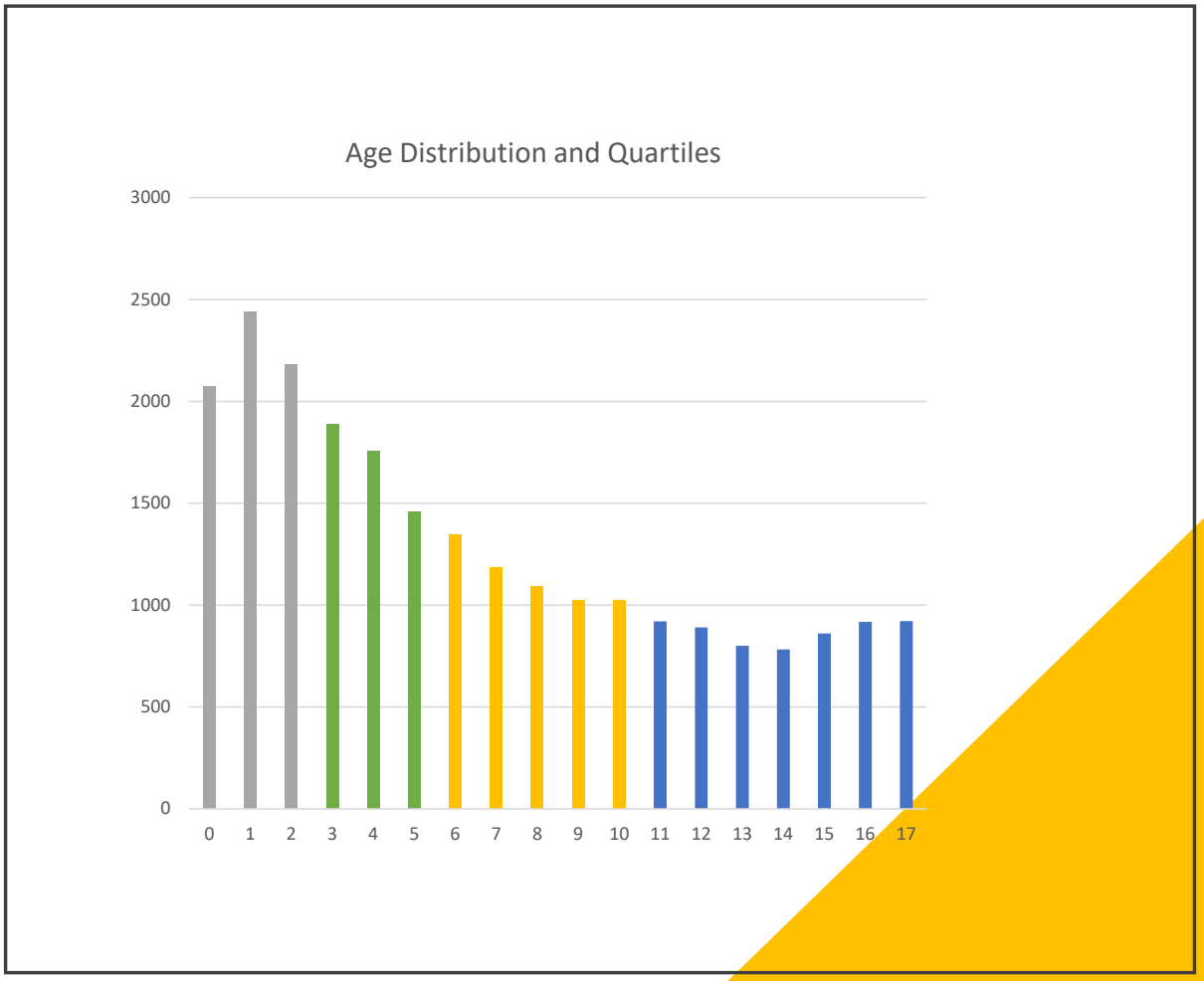
Placements

- **Relative 44.2%**
- **Foster/Non-Relative 43.1%**
- **Group Care 8.9%**
- **Institutional 1.3%**
  - Correctional 0.8%
  - Residential Treatment Center 0.2%
  - Medical Hospitalization 0.2%
  - Mental Hospitalization 0.1%
- **Other 2.5%**
  - Visitation 0.7%
  - Runaway 0.6%
  - Respite 0.1%
  - Unknown 1.1%

Exited Care in 2019 to _____

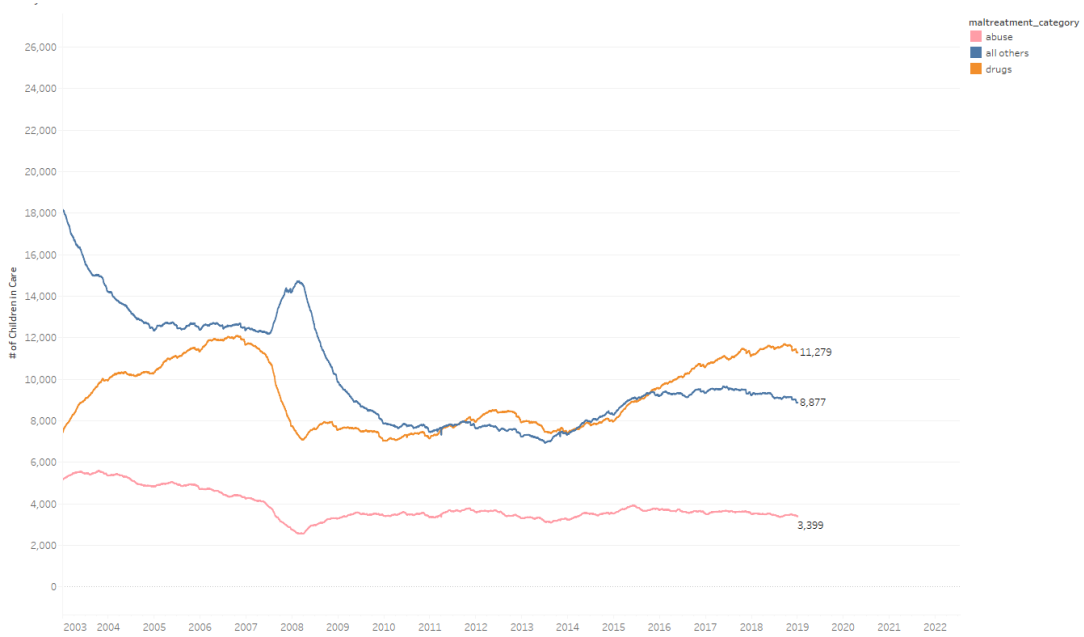
- **Parent or relative 75%**
  - 46% reunification
  - 14% guardianship
  - 14% adoption
  - 1% aged out
- **Non-relative or foster 18%**
  - 13% adoption
  - 3% guardianship
  - 2% aged out
- **Unlabeled in data 7%**
  - 3% adoption
  - 4% aged out

Age of Children in Care on Jan. 1, 2019



Data: Public FSFN Database (July 2020)

Children in care partitioned by maltreatment category



FSFN has maltreatment type variables with either Y or N as the value. The maltreatment categories used here were generated as follows:

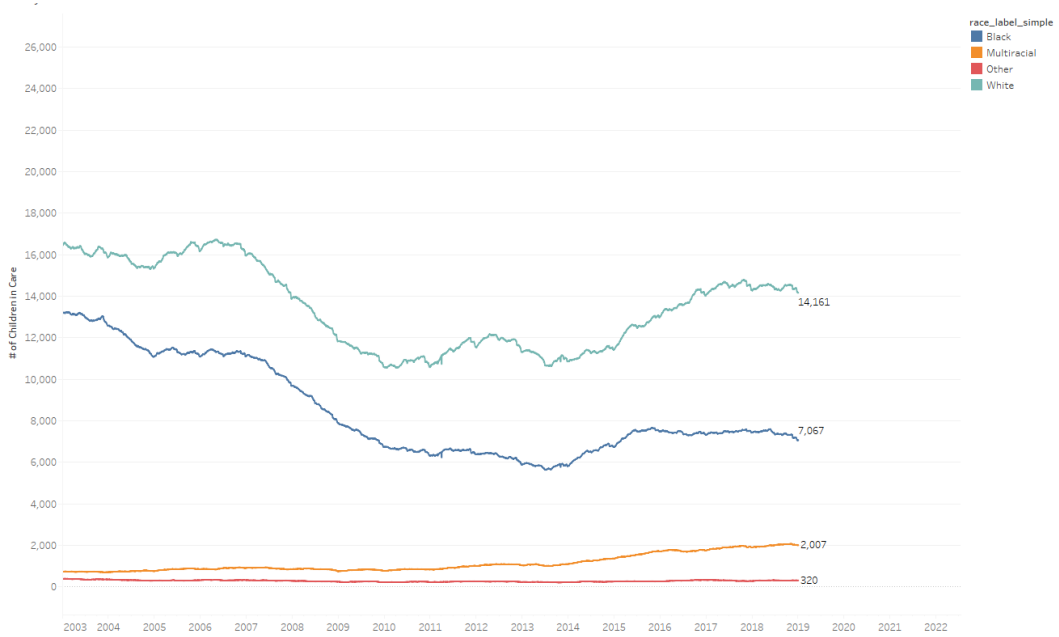
Abuse = physical or sexual abuse, irrespective of any other category

Drugs = substance or alcohol abuse, if not already counted as physical or sexual abuse

All Others = any other maltreatment type

Data: Public FSFN Database (July 2020)

Children in care partitioned by race label



FSFN has variables for race labels (e.g., "race_white") with either Y or N as the values. The categories here were created from those variables as follows:

- **White** = only race_white = "Y"
- **Black** = only race_black = "Y"
- **Multiracial** = race_white = "Y" and race_black = "Y", or race_multiracial = "Y"
- **Other** = all other children

Data: Public FSFN Database (July 2020)

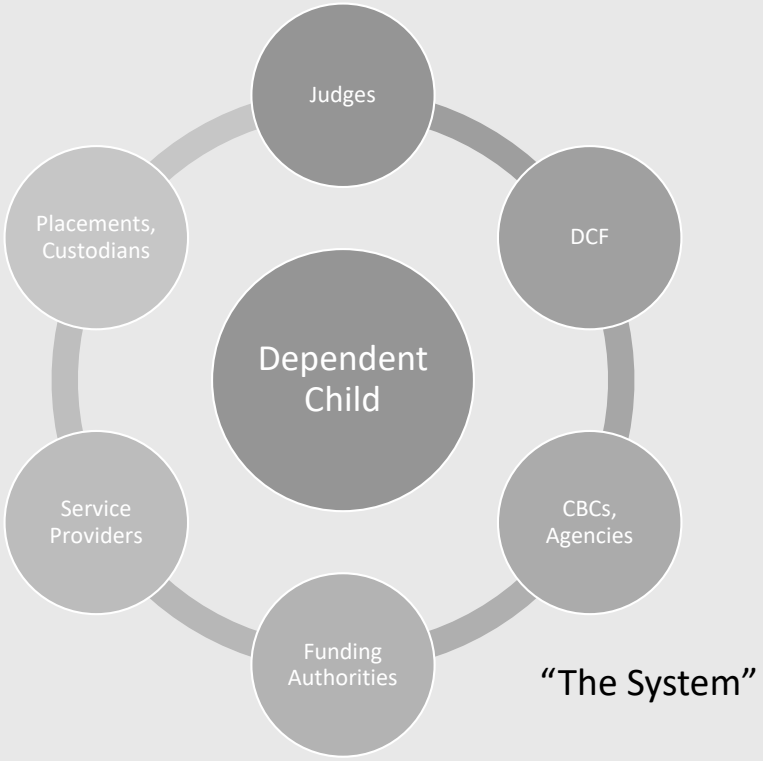
Child Representation in the Foster Care System

Robert Latham, J.D.
Associate Director
Children & Youth Law Clinic

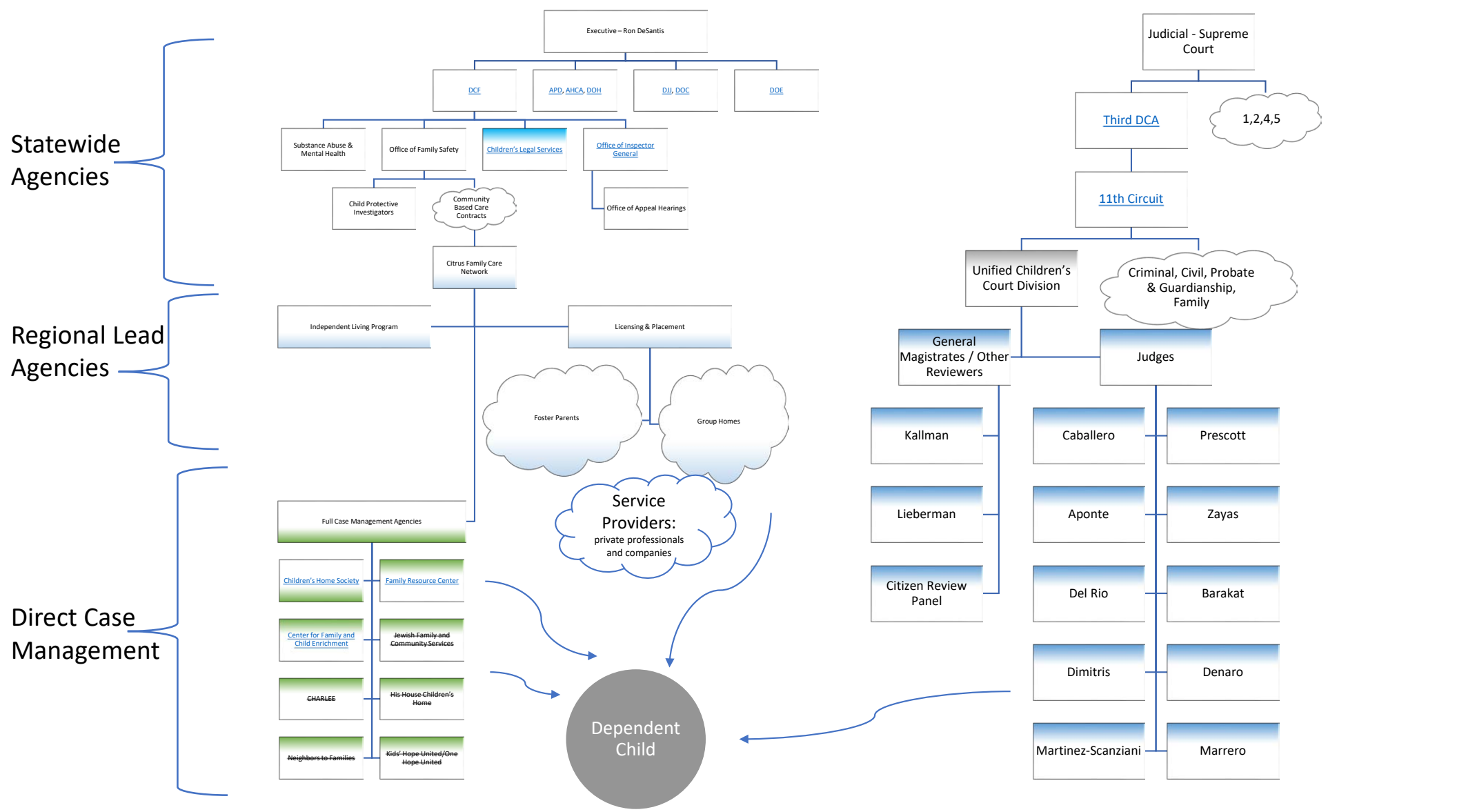
When a child enters foster care, they lose…

- Home, bedroom, toys & games, pets
- Neighbors, friends, backyard, favorite tree
- School, classmates, teachers
- Daily routine, favorite food, clothes, pictures, music
- Stability, predictability, routine, attachment, trust
- A single person or group of known people who are responsible for their needs

Dependent children are overseen by a complex group of competing decisionmakers



"The System"


Statewide Agencies
Regional Lead Agencies
Direct Case Management
Executive – Ron DeSantis
DCF
APD, AHCA, DOH
DJJ, DOC
DOE
Substance Abuse & Mental Health
Office of Family Safety
Children's Legal Services
Office of Inspector General
Child Protective Investigators
Community Based Care Contracts
Office of Appeal Hearings
Citrus Family Care Network
Independent Living Program
Licensing & Placement
Foster Parents
Group Homes
Service Providers:
private professionals and companies
Full Case Management Agencies
Children's Home Society
Family Resource Center
Center for Family and Child Enrichment
Jewish Family and Community Services
CHARLEE
His House Children's Home
Neighbors to Families
Kids' Hope United/One Hope United
Dependent Child
Judicial - Supreme Court
Third DCA
1,2,4,5
11th Circuit
Unified Children's Court Division
Criminal, Civil, Probate & Guardianship, Family
General Magistrates / Other Reviewers
Judges
Kallman
Lieberman
Citizen Review Panel
Caballero
Prescott
Aponte
Zayas
Del Rio
Barakat
Dimitris
Denaro
Martinez-Scanziani
Marrero

A foster child needs an advocate

1. Someone who can promote the child's individual interests
2. Someone who can understand and explain what's happening
3. Someone the child can trust and who believes them
4. Someone who can navigate the system and get things done

OPPAGA: 56% of children had no advocate or time-limited advocacy

- 33% of children were not appointed to the GAL Program
  - Ranged from 0 to 44% in circuits
- GAL withdrew before case closure on 34% of appointments (23% of all children)

Exhibit 6
Closure Reasons Reported by GAL Program Remained Stable From Fiscal Year 2016-17 Through the First Half of Fiscal Year 2019-20[1]

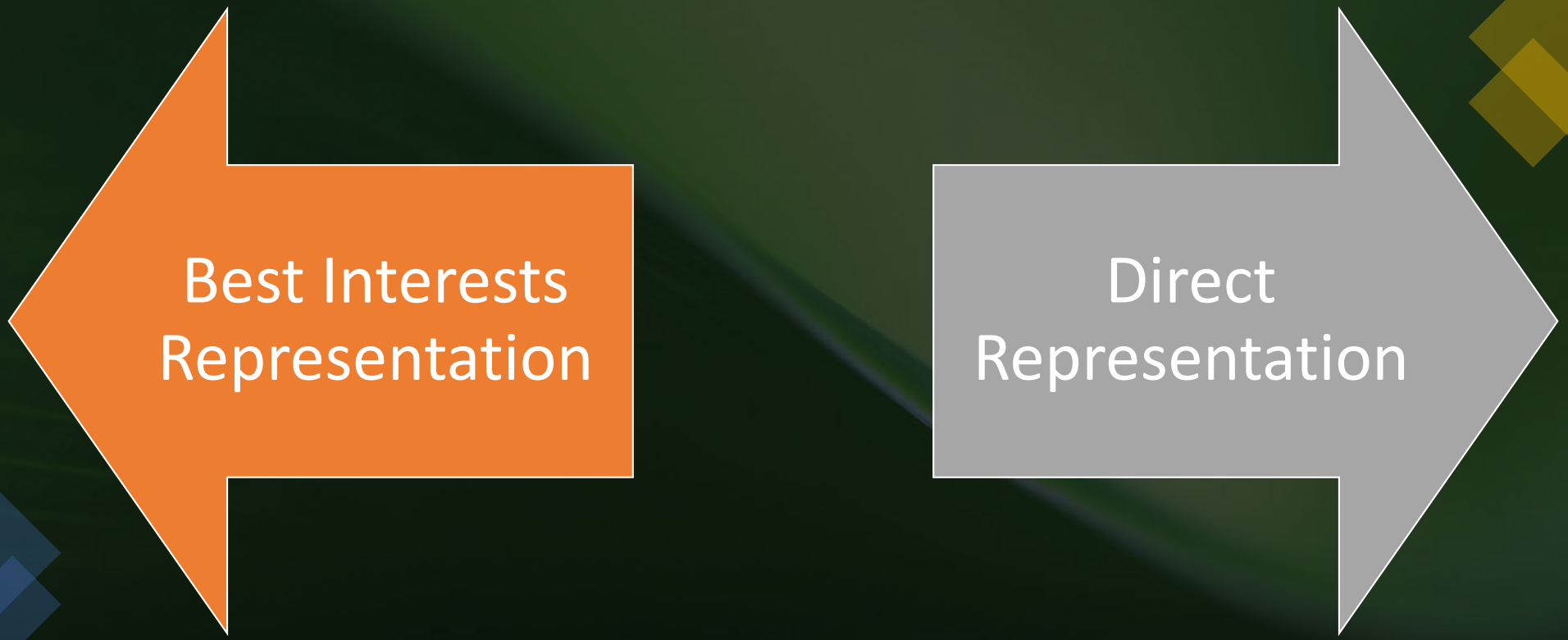
GAL Program Closure Reason for GAL Program Closures	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20[1]	Four-Year Total
Reunification	29%	31%	29%	31%	30%
Adoption	18%	18%	20%	19%	19%
Permanency Goal Established[2]	18%	19%	23%	22%	21%
Permanent Guardianship	17%	15%	13%	12%	15%
Other[3]	9%	9%	6%	6%	8%
Insufficient Program Resources[4]	5%	4%	4%	4%	5%
Aged Out of Care	3%	4%	4%	4%	4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

[1] To control for differences between GAL Program closures and DCF discharges, we limited the Fiscal Year 2019-20 data to the first six months (July 1, 2019–December 31, 2019).
[2] Closure reasons of APPLA are included here.
[3] Other includes children who ran away, were transferred to or placed in another circuit, and cases that were either consolidated or bifurcated by the courts.
[4] This includes cases to which the GAL Program was appointed where the program was either unable to staff the case at all or had to discharge from a case before it concluded. Closure reasons of APPLA are included here.
Source: OPPAGA analysis of Florida Guardian ad Litem Program data representing 80% of GAL children with a closed case.

An opportunity

- Federal law has required a child advocate (lay or professional) for 100% of foster children since 1974
- Federal funding will now support that mandate with 50% FFP on IV-E eligible cases
  - Lawyer & legal costs
  - Administrative costs
  - Investigators, social workers, peer partners
  - Training (75% FFP already available)
- Must be “independent legal representation”

Child representation debate:
What is the proper role for a lawyer?



The Discussion

- The standard models
  - Attorney-Guardian ad Litem
  - Direct Representation Attorney
  - Court Appointed Special Advocate
- Florida’s Guardian ad Litem Program

How do the models function?
What values are promoted by each?

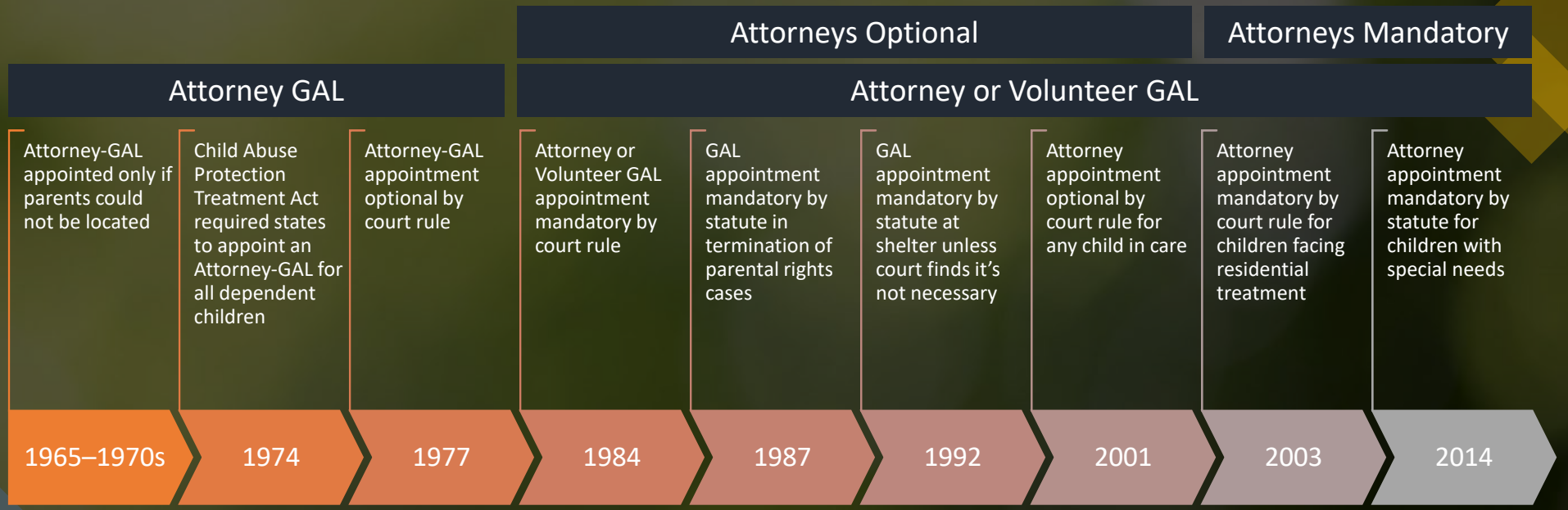
The Models

States use a variety of models & structures

Exhibit C-2
Other States' CASA/GAL State Associations Vary on Numerous Factors[1]

State CASA Association[1]	Representation Model	CASA/GAL Asso. Structure	Total Funding	State Funding	Number of Children Served	Number of Active Volunteers
Delaware	Best interest (attorney)	Publically administered, direct service	$2.6 million	$2.4 million	464	240
Florida	Multidisciplinary team	Publically administered, direct service	60.7 million	51.4 million	37,947	9,938
Georgia	Hybrid	Nonprofit, no direct service	16 million	3.2 million	11,000	2,700
Illinois[2]	Best interest (lay volunteer)	Nonprofit, no direct service	11.5 million	1.4 million[3]	6,447	2,436
Iowa	Hybrid	Publically administered, direct service	2.8 million	2.8 million	1,376	505
Kentucky	Best interest (attorney)	Nonprofit, no direct service	1.5 million	1.4 million	3,818	1,313
Nebraska	Best interest (attorney)	Nonprofit, no direct service	4.7 million	500,000	2,031	912
North Carolina	Multidisciplinary team	Publically administered, direct service	17.8 million	15.5 million	18,036	5,539
Ohio	Best interest (lay volunteer)	Nonprofit, no direct service	14.1 million	226,361	10,189	2,491
South Dakota	Best interest (attorney)	Publically administered, no direct service	1.8 million	760,596[4]	1,628	348
Texas	Hybrid	Nonprofit, no direct service	33.5 million	13.6 million	30,432	10,874
Utah	Best interest (attorney)	Publically administered, direct service	8.7 million	8.7 million	1,659	736
Median values			**$10.1 million**	**$2.6 million**	**5,133**	**1,875**

Child Representation in Florida Dependency Cases



Ethical Duties of Attorney to Client

- Competence
- Diligence
- Counsel
- Communication
- Confidentiality
- Loyalty
- Zealous Advocacy

Scope of Legal Representation

Duties to client

1. The **client sets the goals**.
2. The **lawyer determines the means** in consultation with the client.

Limits

- A lawyer cannot counsel or assist a client to engage in **criminal or fraudulent conduct**.
- A lawyer owes the court a duty of **candor and meritorious claims**.
- If a client insists on taking action that the attorney fundamentally disagrees with, **the attorney may withdraw**.

Direct Representation Advocacy Process

Start with what the client wants, investigate, counsel them on what is possible.

Move the client to a legally and factually supportable position.

In dependency law, the process moves the child away from harm and towards the child's best interests.

Example: Psychotropic Medication

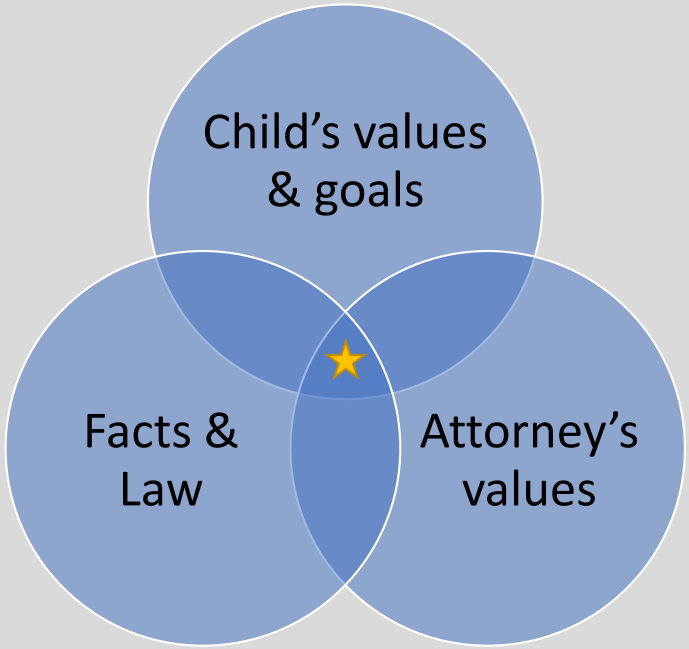
- The youth is 14 years old and prescribed psychotropic medication. The youth is willing to take the meds if it will help him, but he's nervous about the potential side effects.
- A court order is required for DCF to provide the medication.
- Legal standard: medically recommended and in child's best interest
- How should the child's attorney advocate?

Direct Representation Position Formation

- **Initial Position:** The client is reluctantly willing to take the meds but is worried about the side effects.
- **Investigation:** Talk to doctor, therapist, placement
  - Is the medication necessary or just recommended?
  - Are there alternative treatments?
  - Are there ways to minimize the side effects?
  - What's happening at home?
- **Counseling:** Inform client of investigation and possible options
- **Counseled position:** With new information, the client would rather:
  - Try the meds and stop them if the side effects are bad
  - Try a different medication
  - Try therapy or another intervention first
- **Legal advocacy:** It's in the child's best interest to…

Direct representation seeks to find an overlap

- Pros
  - The child has their concerns voiced, heard, and accounted for.
  - The representation moves the client's values and goals toward the legal standards (best interests or no harm)
  - The attorney is not required to make any argument she is not comfortable with.
- Cons
  - Most lawyers have no special training in communication with children, child development, or trauma.
  - Litigation and legalistic approaches can disrupt relationships. Lawyers can promote legal principles over other needs.



★ = potential positions

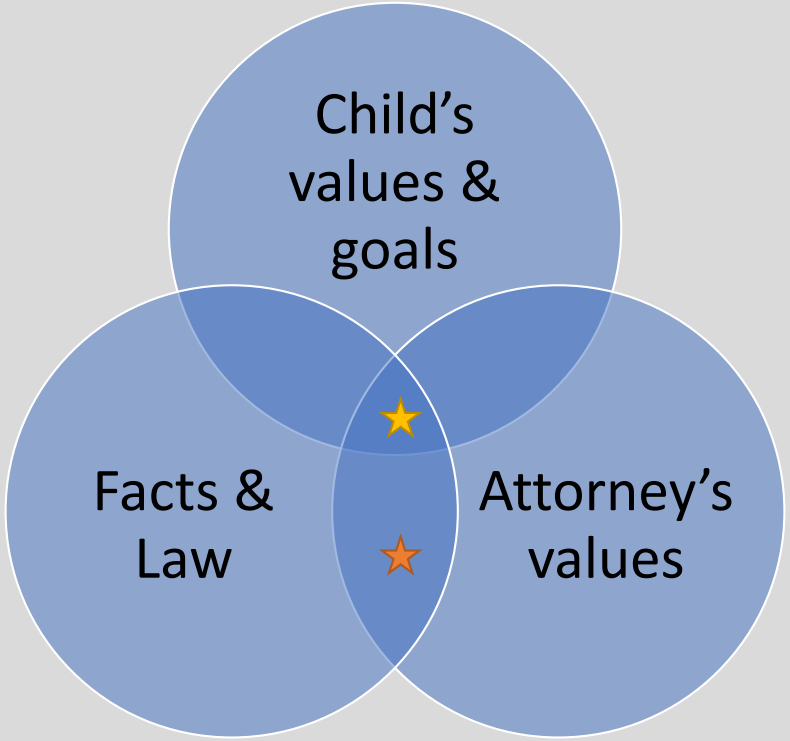
Best Interest Representation
Position Formation

- **Initial Position:**
  - I don't think kids should ever be on psychotropic medication.
  - I don't think I should second-guess a doctor.
  - I don't think I should second-guess the child.
  - I need more information.
  - I think psychotropic medications can really help a child succeed.
  - I think this child really needs medications.
- **Investigation**
- **Updated position: _____**
- **Legal advocacy:** It's in the child's best interests to…

Best Interests Representation

- Pros
  - Provides legal advocacy.
  - The attorney is bound by duties of candor and meritorious claims.
  - The attorney is not bound to advocate for something she believes is not in child's best interest.
- Cons
  - The representation elevates the attorney's values. The child can feel unheard or betrayed. The disconnect can lead to bad outcomes.
  - The attorney can forego fact investigation or analysis for gut instinct.
  - Most lawyers have no training in child wellbeing. Socioeconomic gap between attorney and child.
  - The direction and intensity of advocacy can vary greatly depending on the advocate.
  - The model does not square easily with the Rules of Professional Conduct.

☆ = potential positions

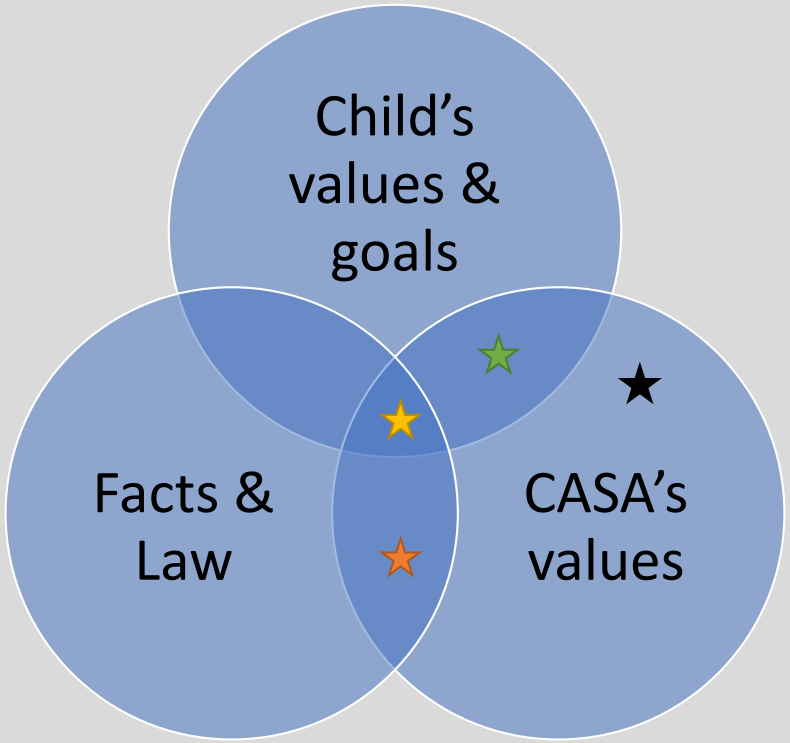


Court Appointed Special Advocate Model (CASA)

- **Created in 1977:** before ASFA, case plans, permanency goals, counsel for parties, and most modern oversight mechanisms
- **Volunteers**
  - recruited from the community
  - trained on foster care system
  - conduct investigations & issue reports
- Typically run as **court program**
- **Not legal representation**
- "**Expert witness on the child**"

CASA Representation

- Pros
  - Independent investigation
  - Very low caseload
  - Many volunteers function as mentors and champions for reform
- Cons
  - Cannot provide legal representation (which was reasonable in 1977)
  - Not bound by legal ethics or evidence-based advocacy.
  - Socioeconomic gap between CASA and child.
  - The advocacy can diverge significantly from the child's position, the facts and law, and can vary greatly depending on the advocate.



☆ = potential positions

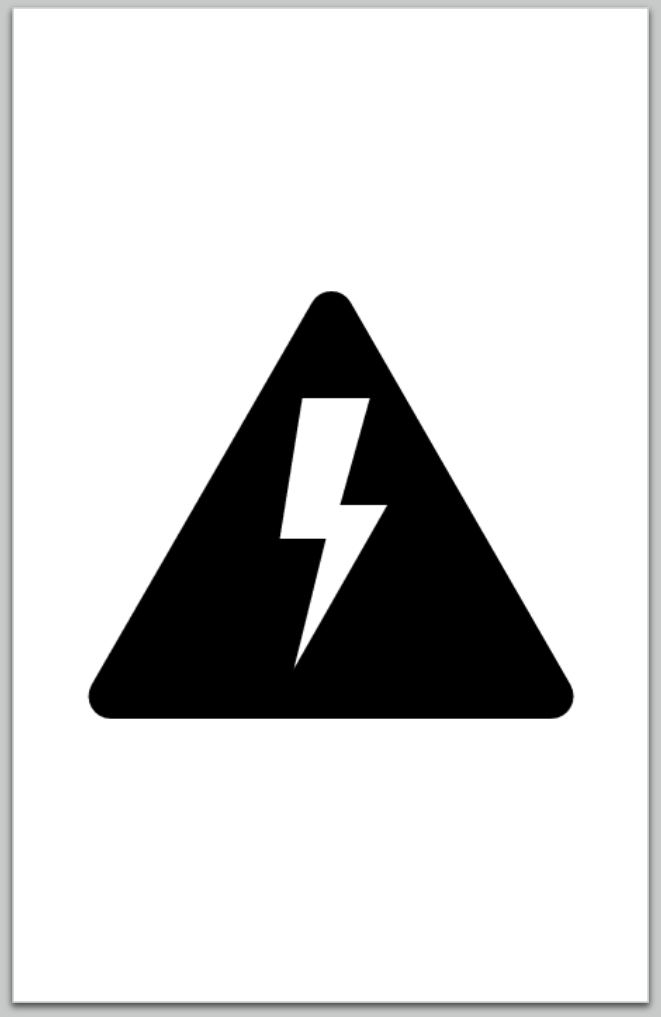
Attorney representation is crucial for the best interest of children.

Chapter 39 Hearings

- Shelter Hearing
- Adjudicatory Hearing for Dependency
- Modification of Placement Hearings
- Hearing to Place Child in Residential Treatment Center
- Case Plan Amendment Hearings
- Change of Visitation Hearings
- Termination of Parental Rights Trials

Ancillary Hearings

- Medicaid, APD, SSI Denial Appeals
- School Due Process Hearings
- Independent Living Program Appeals
- Licensing and Adoption Appeals
- Marchman Act Proceedings
- Appeals



What if the child wants to do something harmful? Run away, go to an unsafe home, stop treatment?

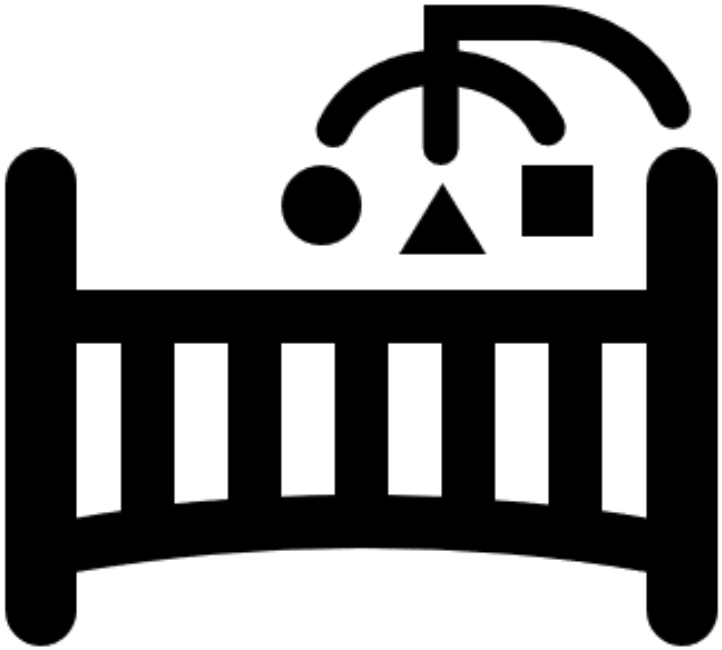
Most children are not trying to hurt themselves. They are often responding to a situation they can't control.

The direct representation attorney:

- Must determine the motivation and goals of the child
- Must try to find a solution that is both legal and acceptable to the child
- Must be honest with the child about the consequences
- May take action, decline to take action, or withdraw

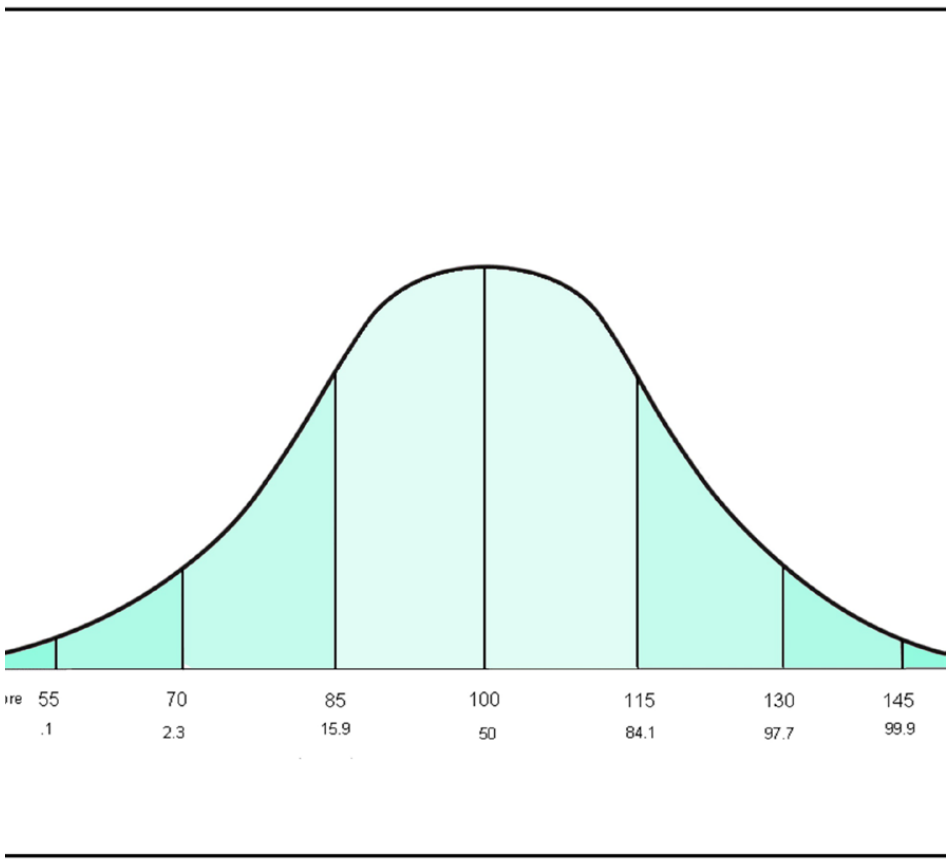
Judges can deny the motion.

How can an attorney represent a baby?



Legal ethics rules have provisions for incapacitated clients

- The rules require the attorney to
  - Maintain **as normal a relationship as possible** with the client
  - Take "**protective action**" when the client cannot act in their own interests
  - Can seek appointment of **guardian**
- Capacity can vary depending on the issue
- What are a baby's "own interests"?



Alternatives to pure discretion model

- **Expert deference** – work with psycho-therapeutic experts or multidisciplinary teams
- **Attachment and family system** – promote primary and family attachments
- **Legal rights model** – maximally assert legal rights (and other "values" models)
- **Substituted judgment** – construct the client's position from objective indicia (probate model)
- **Advocacy guidelines** – factors or standards set by statute or court rule

The system needs to hear the child's views to make better decisions. The child needs to be heard to feel and be safe.

- How often should a child visit his siblings if they're very far away?
- Should a female child live with her aunt or her uncle?
- Should a child live with a wealthy foster parent or a poor relative?
- How should a child's race, religion, and identity factor into placement decisions?
- How much extra time should a parent get on their case plan before ending services and moving to termination of parental rights?
- Should a child who could be safely reunified finish the school year in the foster home or change schools to go home?
- Should a child with disabilities be in a residential program or a community home with support?
- Should a grandmother adopt or take permanent guardianship?
- Should a child who discloses that a foster parent abused her be believed?

Best Practice

- **All children need high quality legal representation in dependency proceedings.**
  - The attorney must provide **counsel** and **advocacy;** be **competent, zealous, independent**; and have a **workable caseload**.
  - The attorney should receive **training and support** from experts on effective communication and counseling of children with **trauma**.
- **The role of the attorney should match the child's developmental needs.**
  - When the child has capacity, an attorney should be appointed to directly represent the child.
  - When the child has limited capacity, the attorney should try to maintain as normal a relationship as possible but be candid with the court and parties about the client's limits.
  - When the child is pre-capacitated, there are many options but there is ongoing debate about the best approach.
- **A best interest advocate or fact investigator should be appointed when available and necessary.** The advocate can be an independent witness or part of the legal team. The role should be clearly defined.

IV-E funding is available for Attorney-GAL model, too

Question: May the title IV-E agency claim independent legal representation costs by a Guardian Ad Litem (GAL) for a child who is a candidate for title IV-E foster care or is in title IV-E foster care, and his/her parent in foster care legal proceedings?

Answer: A title IV-E agency may claim title IV-E administrative costs for a GAL if he or she is an attorney providing independent legal representation to a title IV-E eligible child in all stages of foster care proceedings.

The Florida Guardian ad Litem Program

Statutory definition of guardian ad litem includes:

A guardian ad litem is…

- The Statewide Guardian Ad Litem Office, which includes circuit guardian ad litem programs;
- a duly certified volunteer, a staff member, a staff attorney, a contract attorney, or a pro bono attorney working on behalf of a guardian ad litem;
- a court-appointed attorney; or
- a responsible adult

Who is…

- appointed by the court to represent the best interests of a child in a proceeding as provided for by law [],
- a party to any judicial proceeding as a representative of the child, and
- serves until discharged by the court.

Chapter 39 duties of a GAL in Florida

The legislature did not mandate a particular model or structure.

Maintain the confidential status of records

Review all dispositional recommendations and changes in placement, file a dispositional report, and be present at all critical stages or submit written report

Advocate in certain situations:

- Investigate and be present at all TPR hearings, submit a written report of recommendations, including child's wishes
- Be appointed for children in residential treatment centers and participate in treatment plan preparation
- Be appointed in Keeping Children Safe Act hearings
- Submit a list of recommended services for APPLA and Fit & Willing Relative Cases
- Participate in case plan development face-to-face

"To represent the best interests of the child until the jurisdiction over the child terminates or unless excused by the court."

Does the GAL Program Attorney provide independent legal representation to the child?

1. The Guardian ad Litem Program and the child are both parties to the case.
2. An attorney **cannot represent two parties** to the same case if it will require asserting **adverse positions**. (Cannot be waived.)
3. An attorney cannot represent a client if they owe **an obligation to a third party that materially limits the representation**.

Who does the Program attorney represent?

PROGRAM ATTORNEY

8700

DISTINGUISHING CHARACTERISTICS OF WORK

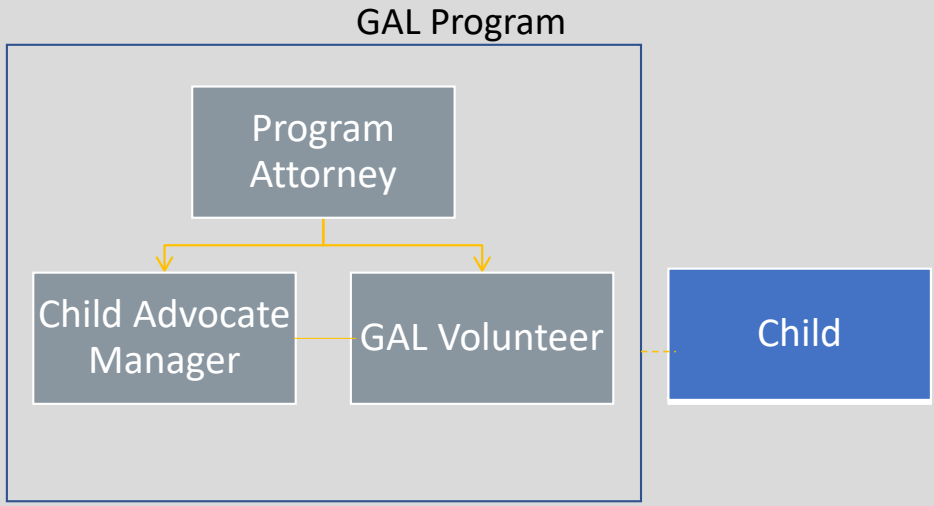
This is highly responsible entry level work in a developing capacity, providing legal counsel and representation to a circuit Guardian ad Litem (GAL) Program which advocates for the best interests of abused, neglected and abandoned children involved in dependency proceedings. The Program Attorney provides legal representation in court on behalf of the GAL Program, files pleadings and motions, and attends depositions, mediations and staffings with social service agencies, GAL employees and volunteers concerning children represented by the GAL Program. The Program Attorney reviews case files to identify legal issues, and participates in the development and implementation of case strategies. The Program Attorney works cooperatively with staff and volunteers to implement a plan that will further the child's best interests. The Program Attorney must exercise discretion in dealing with confidential and extremely sensitive issues before the court.

The GAL Program Attorney will identify and manage the legal issues in the case. The Program Attorney provides advice and counsel to the team and to the child giving consideration to the child's age, cognitive ability, maturity, trauma history, and therapeutic needs. The GAL Program Attorney represents the GAL Program and while there is no attorney-client relationship between the GAL Attorney and the child, the GAL Attorney has a fiduciary duty to the child as the beneficiary of the Program's representation. Representation of the child's best interests is the sole purpose of the advocacy.

Above: GAL Program Pay Plan
Below: GAL Program Employee Manual

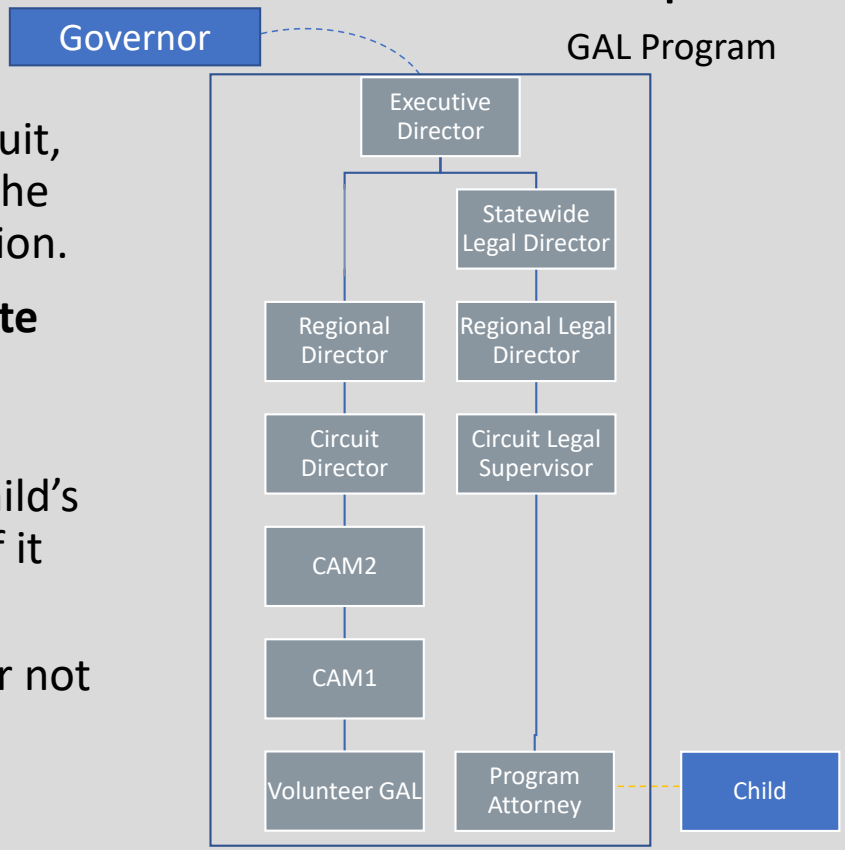
The GAL Program Team Model

- The GAL Program is appointed as the guardian ad litem.
- The GAL Program
  - Recruits **volunteers** or staff to do fact investigations
  - Hires **Child Advocate Managers** to supervise volunteers
  - Hires **attorneys** to provide legal advice and representation
- Manual states: The team seeks **consensus**. Defer to volunteer on facts, defer to attorney on the law.
- Court rule and statute: The GAL must report the child's wishes to the court.



The GAL Program conflict resolution process

- Disputes can be **escalated** to the circuit, regional, and statewide leadership. The team is "**informed**" of the final decision.
- The Program can **remove or terminate** team members.
- **The Program decides** if it wishes to disclose internal conflicts over the child's best interest. **The Program decides** if it has conflicts of interest.
- Governor can remove ED for cause or not re-appoint at end of 3-year term.

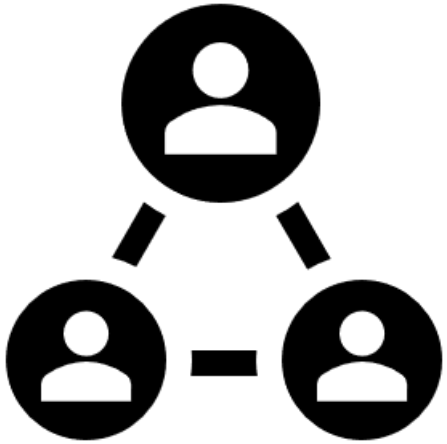


An attorney for an organization owes ethical duties to the organization

(Ethics Rule 4-1.13)

1. If a lawyer knows the organization is engaging in misconduct or violating a legal duty, the lawyer shall proceed as is reasonably necessary in the best interest of the organization.
2. If the organization will not change its conduct, the attorney may resign.
3. The requirement of maintaining confidentiality of information relating to representation applies to government lawyers who may disagree with the policy goals that their representation is designed to advance.
4. Ethical obligations of a government lawyer can be prescribed by statute.

The Program attorney **cannot** "independently represent" a child and owe ethical obligations to the Program and third parties.



The attorney owes obligations to the volunteers and the CAMs.

Scenarios:

- The volunteer and CAM want the attorney to take a legal position the attorney believes is not in child's best interest and the child objects to.
- A volunteer has not seen a child in months, despite reporting to the Program that the child is well. The volunteer only spoke to the custodian. The CAM asks the attorney not to report this to the court.
- A volunteer recommends that a child be evaluated for a residential program because of a recent incident. The attorney doubts the reliability of the volunteer's information, but the volunteer insists on the evaluation.
- A volunteer has been called as a witness against the child in a delinquency trial.
- A volunteer develops a personal relationship with a foster parent and objects to reunification despite it being legally required.
- A volunteer recommends a child move to a foster home because it will be closer to the volunteer's house and require less travel.
- The child requests the volunteer be replaced because he wants someone who understands him better. The CAM refuses.
- The attorney disagrees with a volunteer who is a powerful member of the GAL community. The volunteer recruits and fundraises for the Program.

The attorney owes obligations to the Program.

Scenarios:

- The Program instructs the attorney to take a position that the attorney does not believe is in the child's best interest and the child objects to.
- The Program does not authorize litigation funds to pursue a motion the attorney believes in the child's best interest.
- The Program limits the attorney from handling an administrative appeal that would further the best interests of the child.
- The Program does not authorize a motion seeking contempt against DCF despite clear evidence of it violating a court order.
- The Program does not authorize a constitutional argument out of concern that the legislature will cut its funding for seeking to strike down a statute.

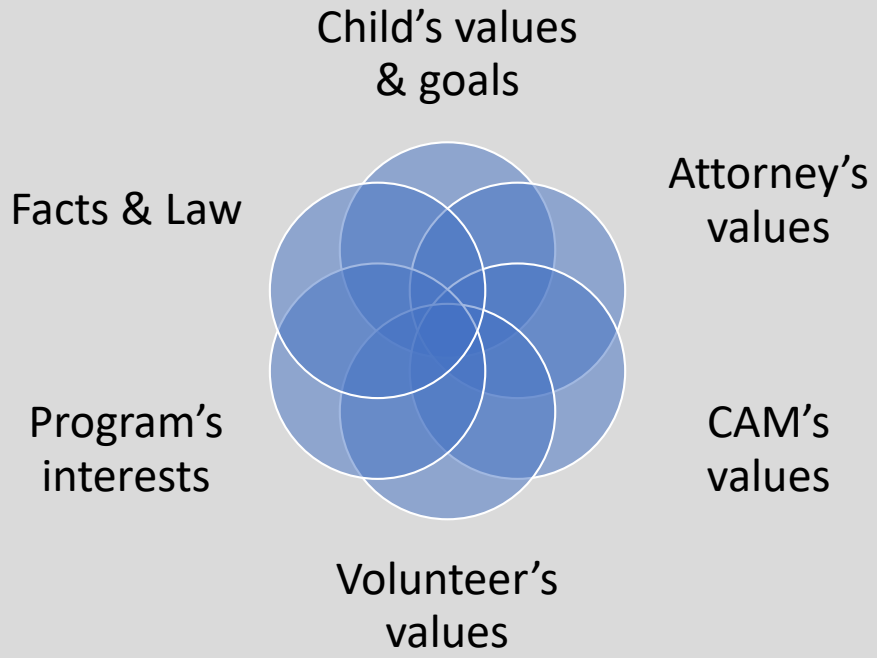
The attorney can owe obligations to third parties.

Scenarios:

- The Program is assigned to two children who desperately need placement in a therapeutic home. Only one bed is available.
- The Program is assigned to a sibling group. The Program recommends that one child return home and the other stay in foster care. Arguing conflicting positions will result in weakening the argument for both children.
- The Program recommends a person for an adoptive placement. The person has a close personal and business relationship with the Program.
- The Program does not authorize an appeal against a judge who is a strong public supporter of the Program.
- The Program receives a donation through its direct support organization from a service provider it makes recommendations regarding.

GAL Program

- Pros
  - Multidisciplinary team model
  - An attorney is involved in the Program's advocacy
  - Benefits of CASA volunteers
- Cons
  - Creates layers of separation between child and attorney.
  - Elevates Program's interests.
  - Advocacy can significantly diverge from child's values and best interest.
  - Not independent legal representation.



We can have a strong child advocacy system in Florida.

- We can get to 100% representation
- We can empower youth
- We can have strong community involvement
- We can promote best interests and system reform from within

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Data Addendum

System Demographics for January 1, 2019 and Exits in 2019.

Reasons in Care

- Physical or sexual abuse 14%
- Drugs or alcohol 48%
- Everything else 38%

Demographics in Care

- **Race**
  - White 60%
  - Black 30%
  - Multiracial 9%
  - Other 1%
- **Gender**
  - 51% male, 49% female
- **Age quartiles**
  - 0-2
  - 3-5
  - 6-10
  - 11-17

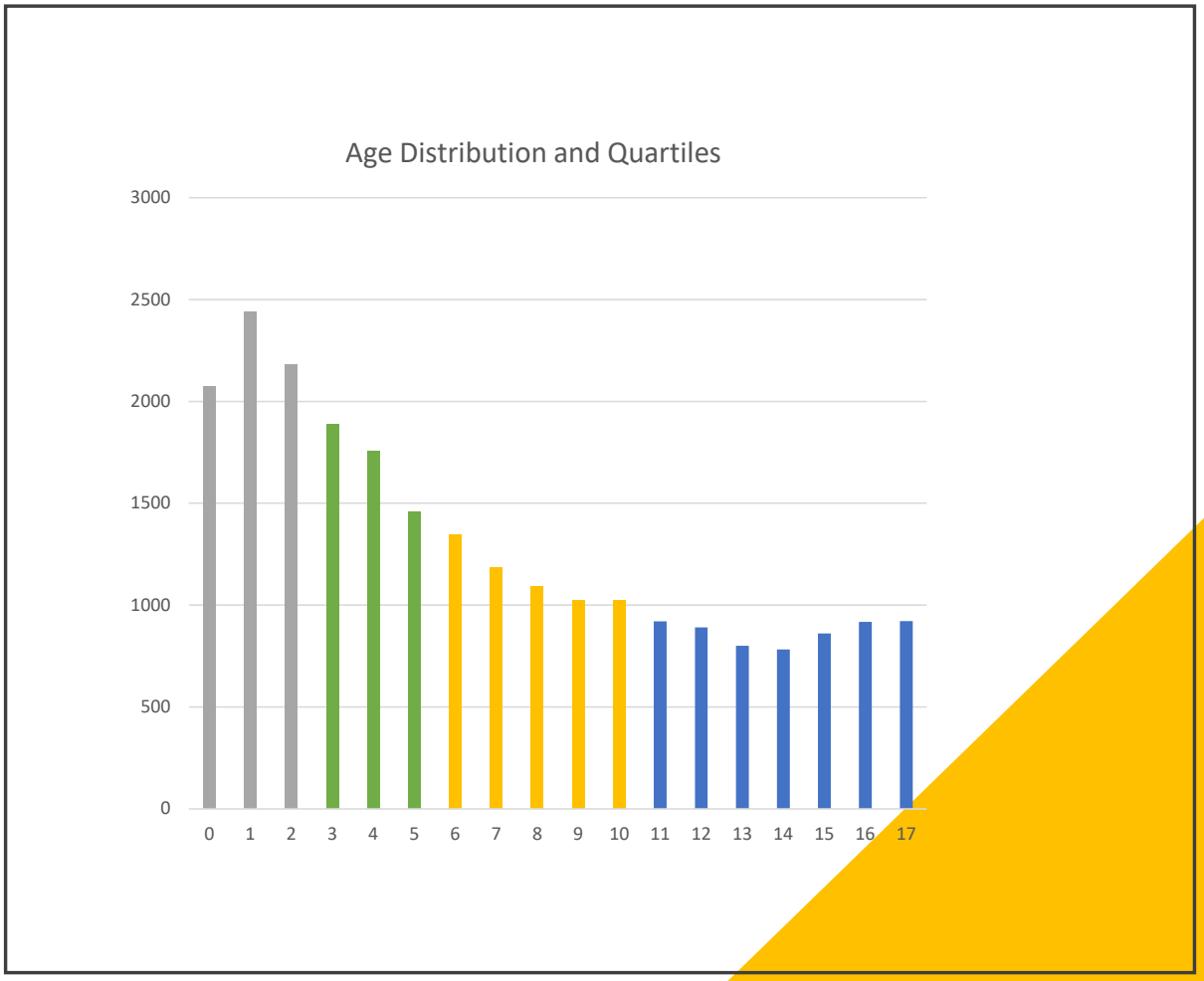
Placements

- **Relative 44.2%**
- **Foster/Non-Relative 43.1%**
- **Group Care 8.9%**
- **Institutional 1.3%**
  - Correctional 0.8%
  - Residential Treatment Center 0.2%
  - Medical Hospitalization 0.2%
  - Mental Hospitalization 0.1%
- **Other 2.5%**
  - Visitation 0.7%
  - Runaway 0.6%
  - Respite 0.1%
  - Unknown 1.1%

Exited Care in 2019 to _____

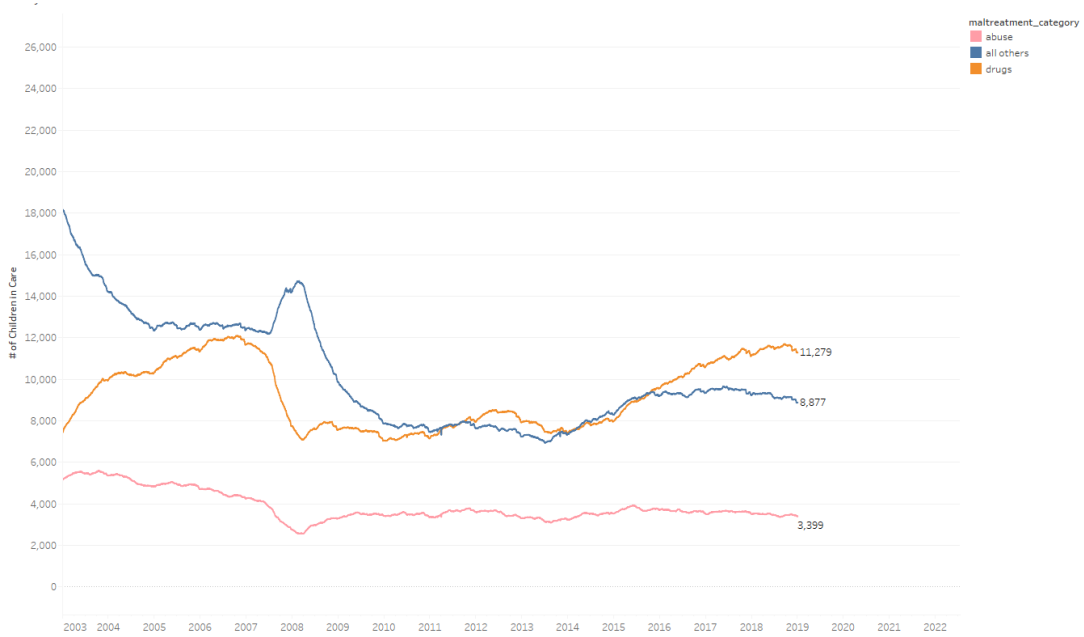
- **Parent or relative 75%**
  - 46% reunification
  - 14% guardianship
  - 14% adoption
  - 1% aged out
- **Non-relative or foster 18%**
  - 13% adoption
  - 3% guardianship
  - 2% aged out
- **Unlabeled in data 7%**
  - 3% adoption
  - 4% aged out

Age of Children in Care on Jan. 1, 2019



Data: Public FSFN Database (July 2020)

Children in care partitioned by maltreatment category



FSFN has maltreatment type variables with either Y or N as the value. The maltreatment categories used here were generated as follows:

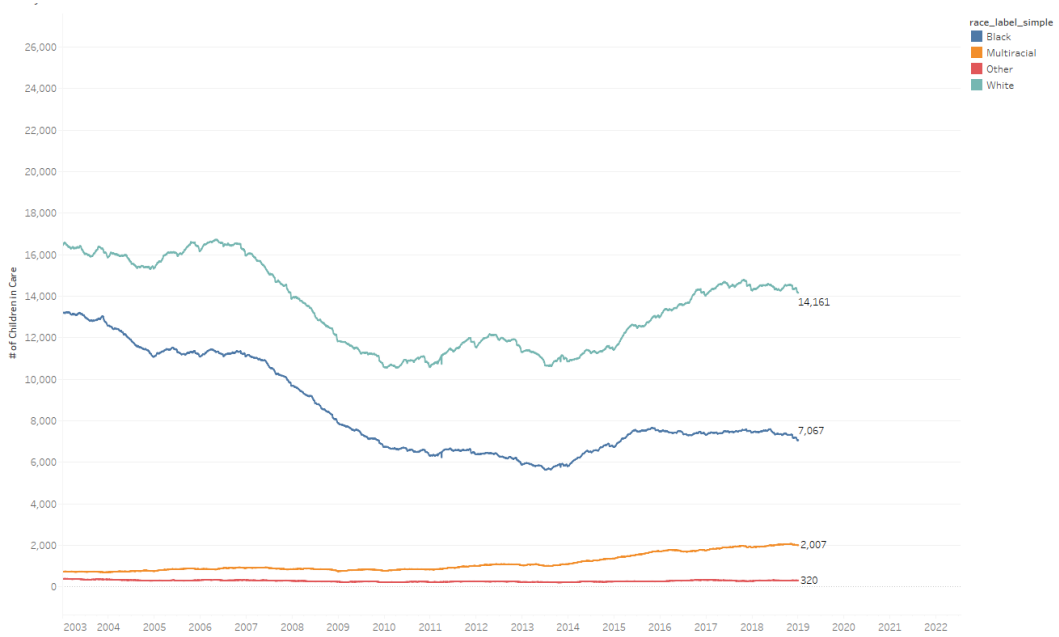
Abuse = physical or sexual abuse, irrespective of any other category

Drugs = substance or alcohol abuse, if not already counted as physical or sexual abuse

All Others = any other maltreatment type

Data: Public FSFN Database (July 2020)

Children in care partitioned by race label



FSFN has variables for race labels (e.g., "race_white") with either Y or N as the values. The categories here were created from those variables as follows:

- **White** = only race_white = "Y"
- **Black** = only race_black = "Y"
- **Multiracial** = race_white = "Y" and race_black = "Y", or race_multiracial = "Y"
- **Other** = all other children

Data: Public FSFN Database (July 2020)

How Science & Lessons Learned from Early Childhood Court Can Transform Child Welfare

Dr. Mimi A. Graham, Director
FSU Center for Prevention & Early Intervention Policy
mgraham@fsu.edu

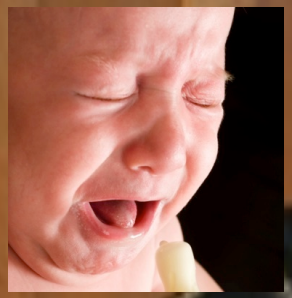
Florida's Early Childhood Courts

Trauma Informed Judges

Coordinator & Multidisciplinary Team

Child/Parent Therapy

Multigenerational Cycle of Trauma & Court Involvement



Dependency Court

Juvenile Court

Adult Courts:
Criminal Court
Drug Court
DV Court
Divorce Court
Veteran's Court

Today's victims become tomorrow's defendants

Simply removing maltreated kids out of their home is not sufficient to repairing the damage and the lifelong repercussions of early trauma.

Early Childhood Court can change the tragedy that brings families into child welfare into an opportunity to heal.

Florida's Early Childhood Courts

Trauma Informed Judges

Coordinator & Team

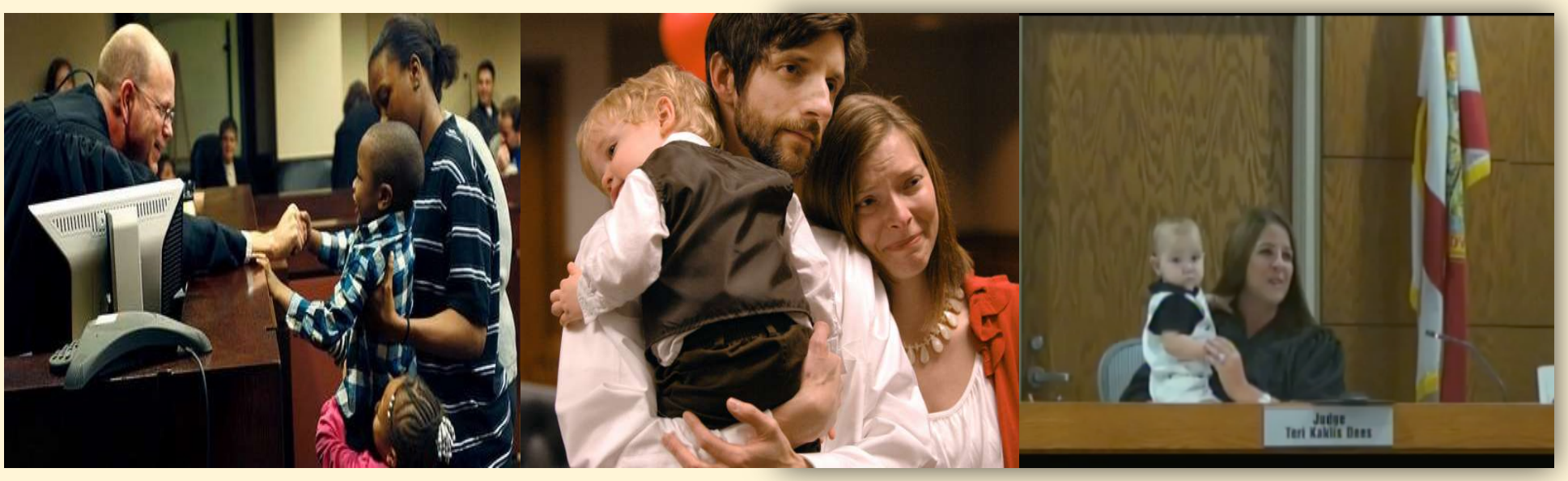
Child/Parent Therapy

Accelerates Permanency

Reduces Re-Abuse

Enhances Well-Being

Florida has embraced the science, mobilized our child welfare systems and built capacity for evidence-based trauma treatment to create the only statewide baby court in the nation.



Early Childhood Court: Grounded in The Science

1 Science of Brain & Child Development

2 Attachment Science

Florida's Early Childhood Courts

3 Trauma Science

4 Resiliency Science

1

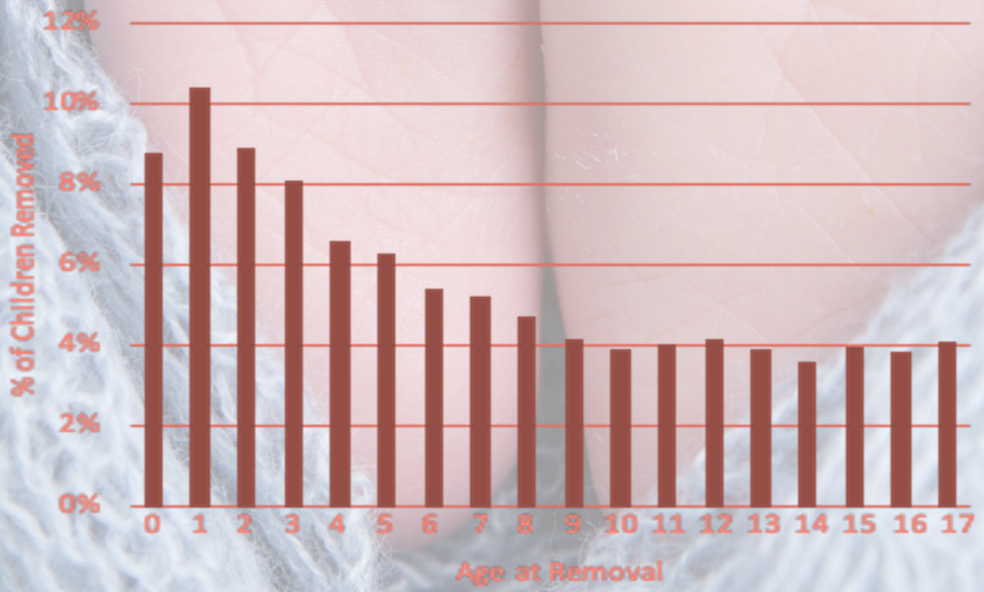
Early Childhood Court is Guided by

The Science of Brain & Child Development

The brain is not fully developed at birth.
80% brain developed by age 3. 90% by age 5.

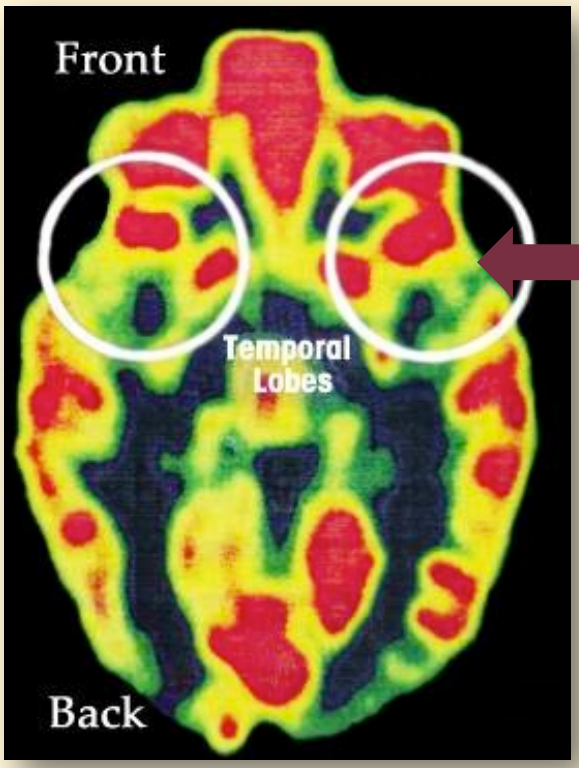
Infants are the Largest Age Group Coming into Child Welfare.

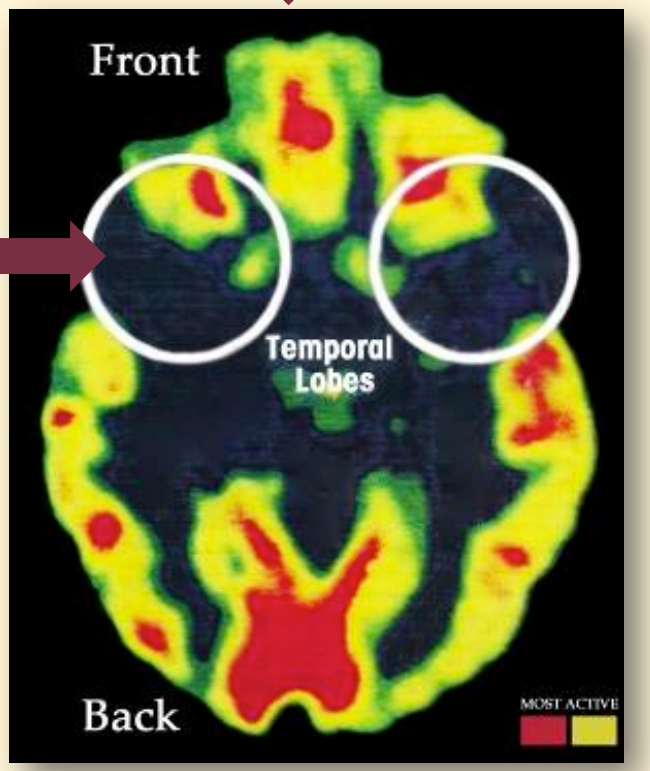
50% age 5 and under



Source: Florida DCF, June 2020. Retrived from:
https://www.myflfamilies.com/programs/childwelfare/dashboard/c-in-ooh.shtml

Abuse & Neglect is Harmful to the Developing Brain





Healthy Child

Neglected Child

PET Scan image courtesy of Dr. H.T. Chugani, Children's Hospital of Michigan, Wayne State University

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Brain Science Guides Early Childhood Court

Judges Give Out Books to Promote Early Learning

Stable, Nurturing Caregivers

Quality Child Care & Early Learning Environments

Timely Developmental Screening and Early Intervention Services

2

Early Childhood Court is Guided by

Attachment Science

Abundant research shows that healthy attachment is the cornerstone for all development and future relationships.

The Fundamental Task in Early Childhood is Formation of Attachment

0-8 Months

Physical connections **produce oxytocin, the bonding hormone** which builds attachment.
The accumulation of daily routines creates **attachment**.

8-12 Months

As the brain's emerging capacity for memory and emotions mature**,** babies become **fearful of strangers**, **seek comfort** when unfamiliar situations, and **protest loudly when attachment figure leaves**.

12-24 Months

Attachment figure becomes **secure base** helping baby to feel safe & tolerate stress.

When distressed, toddler **returns to attachment figure**.

Stress is tolerable for the child with the attachment figure but becomes toxic without their secure base caregiver.

Attachment Science Guides Early Childhood Court Decisions

Placement Stability with Nurturing Caregiver

Early Concurrent Planning

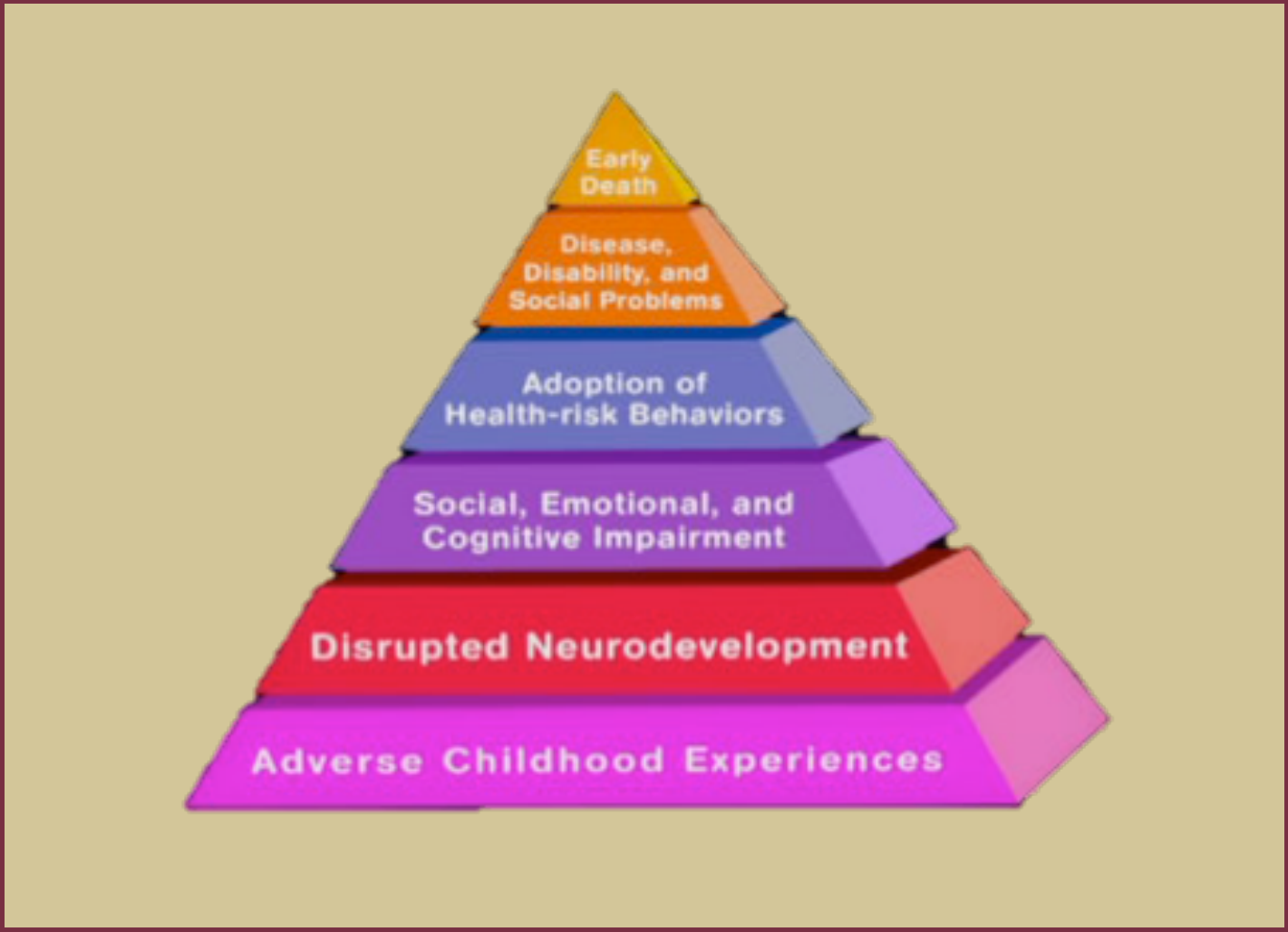
Frequent Family Time Visitation

Planned Transitions

3

Early Childhood Court is Guided by

Adverse Childhood Experiences (ACEs) & Trauma Science



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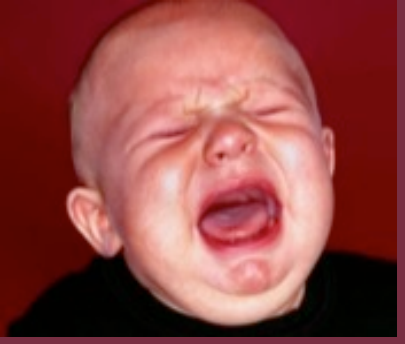
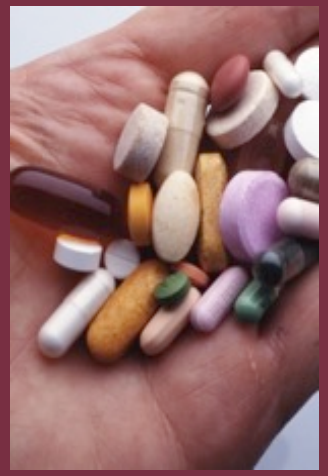
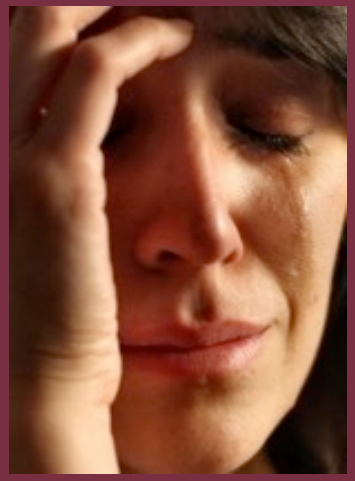


40 Years of Trauma Research Shows that Adverse Childhood Experiences Increase the Risk of…



Substance Abuse



Mental Health

Delinquency

Domestic Violence

Child Welfare

Obesity

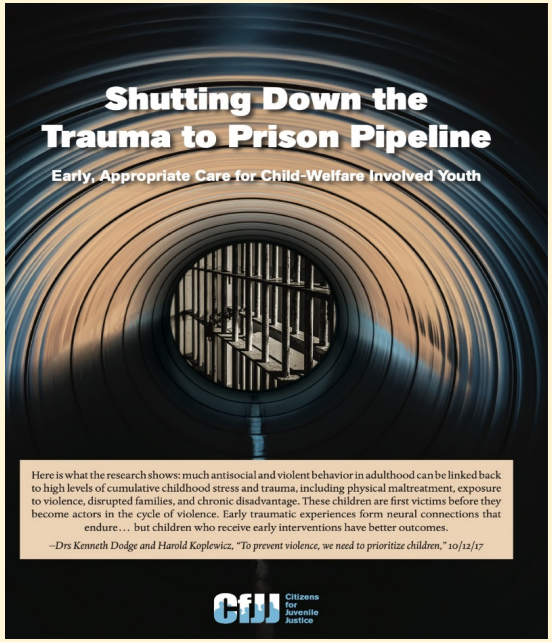
Smoking

Alcoholism

Poor Health

Court Involvement

Accumulated Trauma in the Child Welfare System is the Pipeline to Delinquency System



Florida's Criminal Justice System

Study of 64,329 Florida DJJ youth

97%
at least 1 ACE

50%
4+ ACEs

Baglivio, M., Epps, N., Swartz, K., Huq, M. S., Sheer, A. & Hardt, N. (2014). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. Journal of Juvenile Justice, (3)2.

Systemic Trauma

Although well meaning, the systems meant to protect children often compound trauma with:

- abrupt removals
- stressful separations from home and siblings and schools
- retraumatization and
- multiple placements
- Untreated trauma and mental health problems

…despite substantial evidence of long-term harm from these practices.

Early Childhood Court Teams Use the Trauma Science to Break the Multigenerational Cycle of Maltreatment

Approach the Case with a Trauma Lens

27-year-old female
Long history of drug related charges, thefts, burglaries
ACE score: 8
Suffered significant **sexual abuse starting at age 6**, severe physical abuse from mother and many of her mother's boyfriends
Mother went to prison when she was 7-14 years old. She was left in the care of her abuser.
Began **using drugs at age 14 to cope with the abuse** and her Bipolar Disorder.
Completed Jail Diversion Program and therapy for 4 months.
Last update: she bought her own trailer, had two jobs and was in the process of **getting custody of her son back**.

Trauma-informed judge, lawyers and court team

Child Parent Therapy offers simultaneous healing to address two-generational trauma & promotes healthy relationships

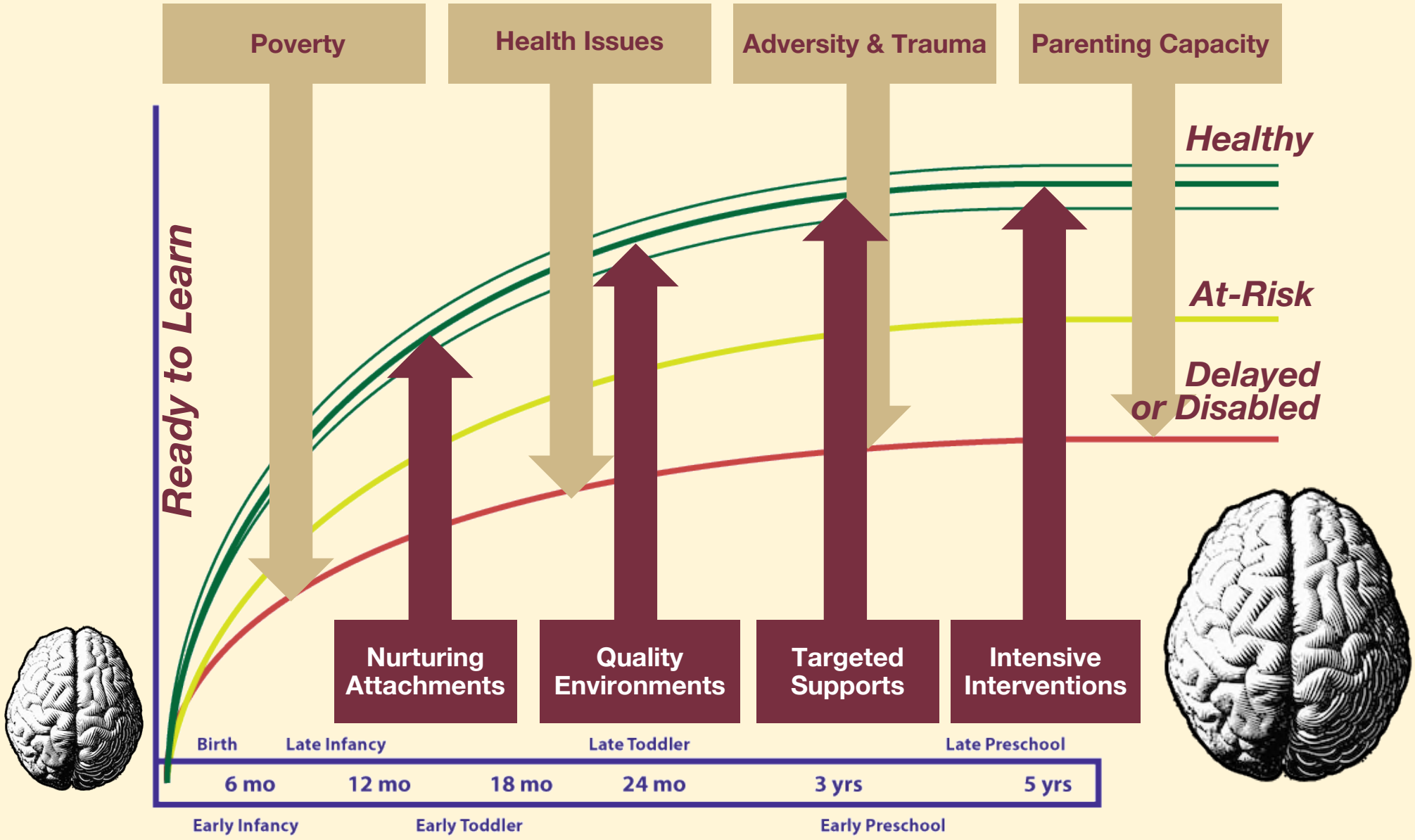
4

Early Childhood Court is Guided by

Resiliency Science

Capacity to recover “bounce back” from adversity

Early Childhood Court Changes the ACEs Trajectory



Early Childhood Courts Promote Connections

Single most important factor for a child to **build resilience:** the support of at least one stable, committed **relationship** with a parent, caregiver, or other trusted adult.

Early Childhood Court Successful Outcomes

Reunification with parents is significantly **more likely** AND 8.5 months **faster.**

Faster time to ALL permanency options (adoption, guardianship, reunification) 4.7 months faster on average

40% **less likely for recurrence** of maltreatment.

Mental health & other services **enhance well-being**.

Comparative analysis by Florida's Office of Court Improvement. Data from the Florida Dependency Court Information System 2014-2018. https://www.flcourts.org/ content/download/426426/4628486/file/early-childhood-court-data-analysis-report.pdf

Florida's Early Childhood Courts

Improving outcomes for infants and toddlers in Florida's dependency court

Florida's Early Childhood Courts: Return on Investment

SAVING Labor Costs NOW!

Average Cost per Child*

Traditional Court:	$22,561
Early Childhood Courts:	$18,422

SAVINGS PER CHILD **$4,139**

+

SAVING Out-of-Home Costs NOW!

Average Cost per Child**

Traditional Court:	$10,640
Early Childhood Courts:	$8,493

SAVINGS PER CHILD **$2,147**

=

Total Saving Per Child NOW!

	Traditional Courts	Early Childhood Courts
Labor Costs:	$22,561	$18,422
Out-of-Home Costs:	$10,640	$8,493
Total Costs:	$33,201	$26,915

SAVINGS PER CHILD **$6,286**

Potential Savings Per Year

If the ECC model was used for all children ages 0-3 in dependency court

$82.2 million***
Labor & Out-of-Home Potential Savings Per Year

+

$30.8 million****
Recidivism Potential Savings per Year

$113 million*****
Total Potential Savings per Year
Labor + Out-of-Home + Recidivism

Florida Tax Watch Productivity Award for Early Childhood Court

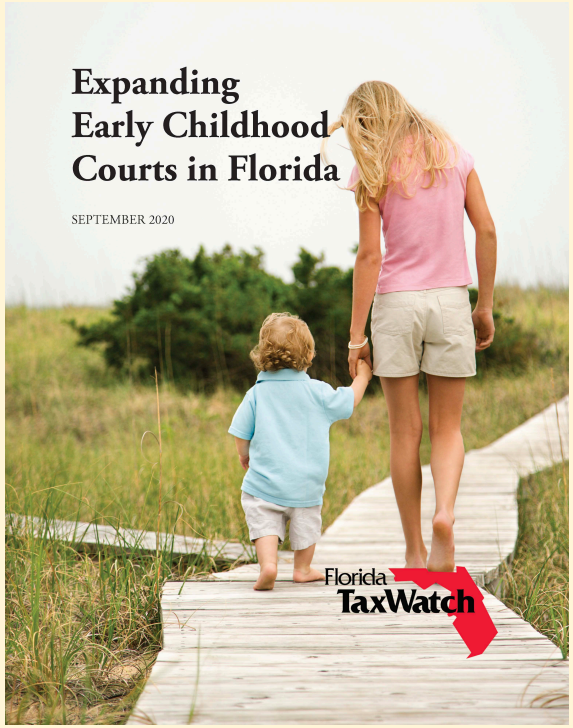
Florida's
Early Childhood
Courts

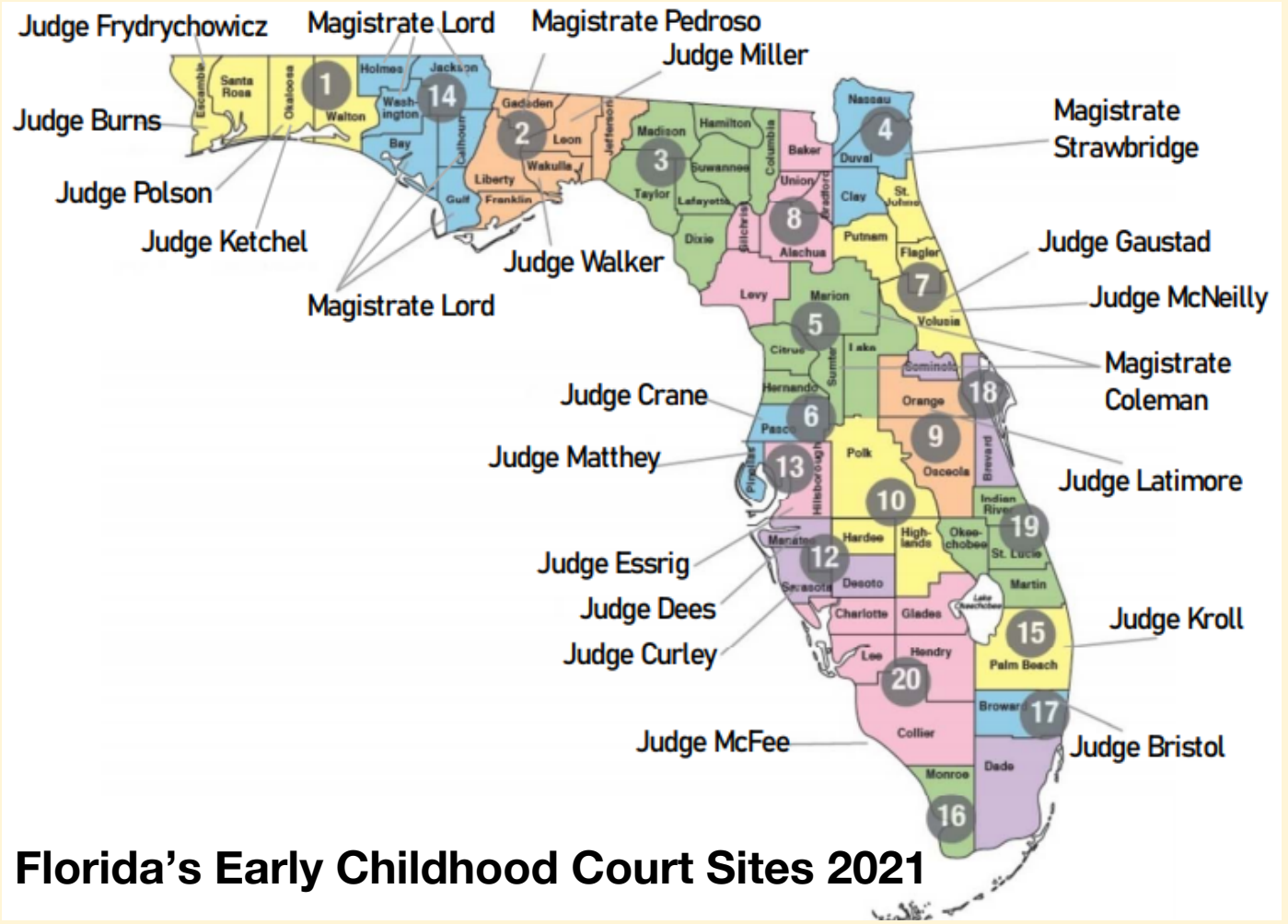
Based on the Science and What We've Learned through Early Childhood Court, How Can We Target Our Investments in Child Welfare to Get Better Results?

Note: These are my recommendations and do not reflect the courts or other agencies.

#1 Expand home visiting to PREVENT child abuse.

#2 Expand Early Childhood Court and dedicate a revenue source.





Strengthening America's Families Act

H.R. 7868, Bilirakis, DeLauro, Suozzi, Rutherford, Soto, and Steube Lead Bipartisan Effort to Protect Children

H.R. 7868 expands the reach of proven successful programs to transform how communities and the child welfare system support the wellbeing of infants, toddlers, and families.

#3 Broaden best practices from ECC to ALL child welfare.

Trauma science informs decisions at every level

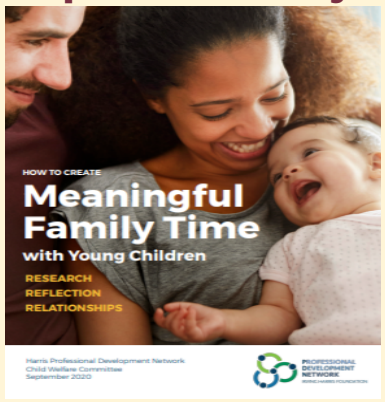
Multidisciplinary team decision-making

Two-generational, evidence-based interventions

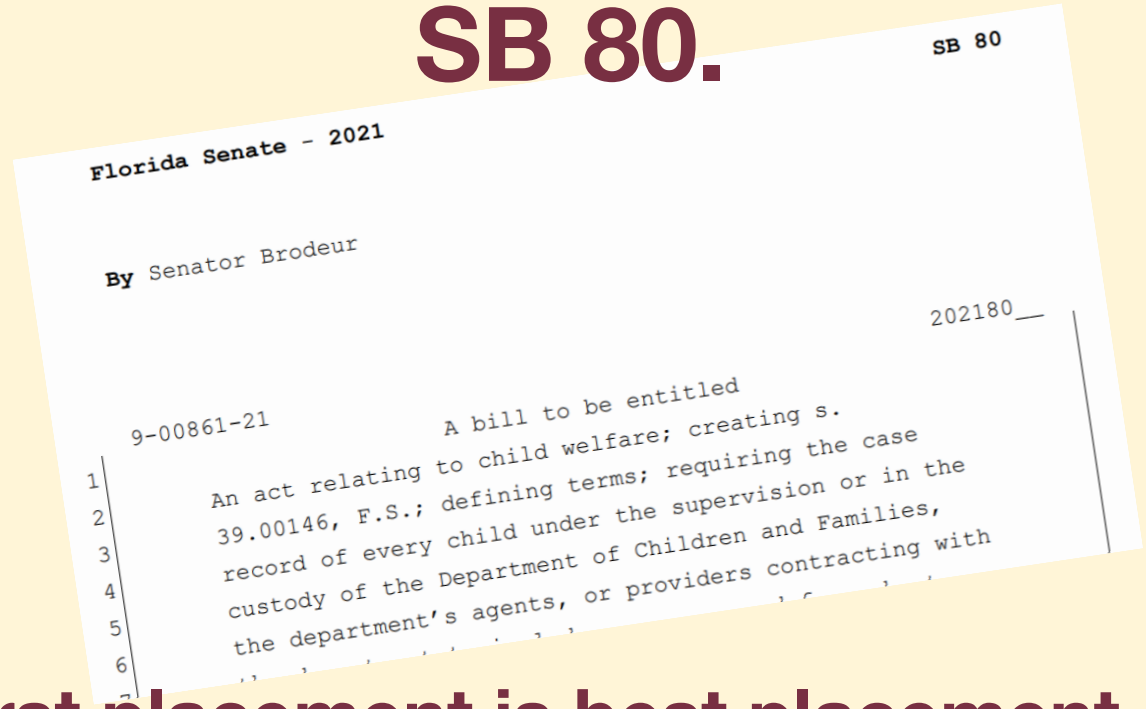
First placement is the last placement

Attachment science guides transitions are thoughtful, planned, and based on developmental needs

Visitation is frequent, meaningful & promotes permanency



#4 Promote legislation with SB 80.



Florida Senate - 2021 SB 80

By Senator Brodeur

9-00861-21 202180__

A bill to be entitled

An act relating to child welfare; creating s. 39.00146, F.S.; defining terms; requiring the case record of every child under the supervision or in the custody of the Department of Children and Families, the department's agents, or providers contracting with

First placement is best placement.

Attachment informs changes in placement.

Transitions from one placement to another are thoughtful, planned, and based on developmental needs.

#5 Fund quality child care for all young children in out-of-home care to promote brain development & prevent re-abuse.

Child welfare children often in poor quality licensed childcare

Foster parents often must pay difference for quality childcare out-of-pocket.

www.myflfamilies.com/service-programs/childcare

#6 Improve residential maternity homes.

WHAT WE KNOW:

- Exceptionally **high rates of teen pregnancy** among girls **in foster care.** Many are **victims of trafficking**.
- Placements are often made to Residential Maternity Homes contracted through DCF.
- Babies are at **high risk** for coming into the system.

WHAT WE CAN DO:

- Strengthen DCF **standards** of quality.
- Focus on the intergenerational impact of trauma.
- Provide on-site infant **mental health and trafficking services** to support safe and healthy relationships.
- Develop a network of **program support** to improve quality.

#7 Promote recovery while parenting by providing pathways for addiction treatment and attachment.

Adult Drug Courts that provided parenting classes had 65% greater reductions in criminal recidivism (Carey, Mackin & Finigan,2012).

Strategies for Better Outcomes

#1 Expand home visiting to PREVENT abuse.

#2 Expand Early Childhood Court and dedicate a revenue source.

#3 Broaden best practices beyond Early Childhood Court.

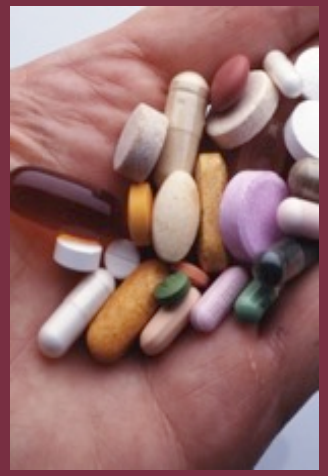
#4 Create legislation & oversight.

#5 Fund quality child care for all young children in out-of-home care to promote brain development & protect from re-abuse.

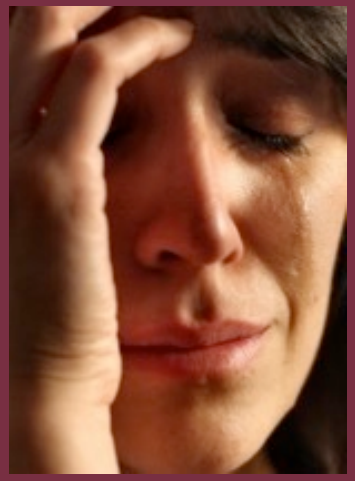
#6 Improve quality of residential maternity homes.

#7 Promote addiction recovery while parenting.

Addressing Adverse Childhood Experiences is the Greatest Opportunity for Preventing Our Intractable Problems



Substance Abuse



Mental Health

Delinquency

Domestic Violence

Child Welfare

Obesity

Smoking

Alcoholism

Poor Health

Court Involvement

Long-Term Benefits to Florida

Priceless

Thank you!

Dr. Mimi A. Graham, Director

FSU Center for Prevention & Early Intervention Policy, Tallahassee, Florida

mgraham@fsu.edu

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/16/2021	.	
	.	
	.	
	.	

The Committee on Children, Families, and Elder Affairs (Brodeur) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 39.00146, Florida Statutes, is created to read:

39.00146 Case record face sheet.—

(1) As used in this section, the term:

(a) "Multidisciplinary team" has the same meaning as provided in s. 39.4022(2).

(b) "Placement change" has the same meaning as in s. 39.4023(2).

(c) "School" has the same meaning as in s. 39.4023(2).

(d) "Sibling" has the same meaning as in s. 39.4024(2).

(2) The case record of every child under the supervision or in the custody of the department or the department's authorized agents, including community-based care lead agencies and their subcontracted providers, must include a face sheet containing relevant information about the child and his or her case, including at least all of the following:

(a) General case information, including, but not limited to:

1. The child's name and date of birth;

2. The current county of residence and the county of residence at the time of the referral;

3. The reason for the referral and any family safety concerns;

4. The personal identifying information of the parents or legal custodians who had custody of the child at the time of the referral, including name, date of birth, and county of residence;

5. The date of removal from the home; and

6. The name and contact information of the attorney or attorneys assigned to the case in all capacities, including the attorney or attorneys that represent the department and the parents, and the guardian ad litem, if one has been appointed.

(b) The name and contact information for any employees of the department, the department's authorized agents, or providers contracting with the department, including community-based care

lead agencies and their subcontracted service providers, who have worked with the child, including the child's current and previous case managers, and the supervisor information for such employees.

(c) The personal information of relevant family members and other fictive kin, including, but not limited to, the name and contact information of:

1. The child's parents;

2. The child's siblings, including the location of their current out-of-home placement, if applicable;

3. The child's current caregivers and any previous out-of-home placements;

4. Any other caretaking adults; and

5. All children in the out-of-home placement, if applicable.

(d) A description of any threats of danger placing the child at imminent risk of removal.

(e) A description of individual parent or caregiver concerns for the child.

(f) Any concerns that exist regarding the parent or the current caregiver's ability to:

1. Maintain a safe home;

2. Engage or bond with the child if the child is an infant;

3. Structure daily activities that stimulate the child;

4. Manage the child's behavior; or

5. Make good health decisions for the child.

(g) Any transitions in placement the child has experienced since the child's initial placement and a description of how such transitions were accomplished in accordance with s.

713212

39.4023.

(h) If the child has any siblings and they are not placed in the same out-of-home placement, the reasons the children are not in joint placement and the reasonable efforts that the department or appropriate lead agency will make to provide frequent visitation or other ongoing interaction between the siblings, unless the court determines that the interaction would be contrary to a sibling's safety or well-being in accordance s. 39.4024.

(i) Information pertaining to recent and upcoming court hearings, including, but not limited to, the date, subject matter, and county of court jurisdiction of the most recent and next scheduled court hearing.

(j) Any other information the department, the department's authorized agents, or providers contracting with the department, including community-based care lead agencies deem relevant.

(3) The department, the department's authorized agents, or providers contracting with the department, including community-based care lead agencies, must ensure that the face sheet for each case is updated at least once per month. This requirement includes ensuring that the department, its authorized agents, or providers contracting with the department gather any relevant information from any subcontracted providers who provide services for the case record information required to be included under this section.

(4) The department shall adopt rules to implement this section.

Section 2. Subsection (3) of section 39.401, Florida Statutes, is amended to read:

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39.401 Taking a child alleged to be dependent into custody; law enforcement officers and authorized agents of the department.—

(3) If the child is taken into custody by, or is delivered to, an authorized agent of the department, the agent shall review the facts supporting the removal with an attorney representing the department. The purpose of the review is to determine whether there is probable cause for the filing of a shelter petition.

(a) If the facts are not sufficient, the child shall immediately be returned to the custody of the parent or legal custodian.

(b) If the facts are sufficient and the child has not been returned to the custody of the parent or legal custodian, the department shall file the petition and schedule a hearing, and the attorney representing the department shall request that a shelter hearing be held within 24 hours after the removal of the child.

(c) While awaiting the shelter hearing, the authorized agent of the department may place the child in out-of-home care, and placement shall be determined based on priority of placements as provided in s. 39.4021 and what is in the child's best interest based on the criteria and factors set out in s. 39.4022 ~~licensed shelter care or may release the child to a parent or legal custodian or responsible adult relative or the adoptive parent of the child's sibling who shall be given priority consideration over a licensed placement, or a responsible adult approved by the department if this is in the best interests of the child~~.

(d) Placement of a child which is not in a licensed shelter must be preceded by a criminal history records check as required under s. 39.0138.

(e) In addition, the department may authorize placement of a housekeeper/homemaker in the home of a child alleged to be dependent until the parent or legal custodian assumes care of the child.

Section 3. Paragraph (h) of subsection (8) of section 39.402, Florida Statutes, is amended to read:

39.402 Placement in a shelter.—

(8)

(h) The order for placement of a child in shelter care must identify the parties present at the hearing and must contain written findings:

1. That placement in shelter care is necessary based on the criteria in subsections (1) and (2).

2. That placement in shelter care is in the best interest of the child.

3. That continuation of the child in the home is contrary to the welfare of the child because the home situation presents a substantial and immediate danger to the child’s physical, mental, or emotional health or safety which cannot be mitigated by the provision of preventive services.

4. That based upon the allegations of the petition for placement in shelter care, there is probable cause to believe that the child is dependent or that the court needs additional time, which may not exceed 72 hours, in which to obtain and review documents pertaining to the family in order to appropriately determine the risk to the child.

5. That the department has made reasonable efforts to prevent or eliminate the need for removal of the child from the home. A finding of reasonable effort by the department to prevent or eliminate the need for removal may be made and the department is deemed to have made reasonable efforts to prevent or eliminate the need for removal if:

a. The first contact of the department with the family occurs during an emergency;

b. The appraisal of the home situation by the department indicates that the home situation presents a substantial and immediate danger to the child's physical, mental, or emotional health or safety which cannot be mitigated by the provision of preventive services;

c. The child cannot safely remain at home, either because there are no preventive services that can ensure the health and safety of the child or because, even with appropriate and available services being provided, the health and safety of the child cannot be ensured; or

d. The parent or legal custodian is alleged to have committed any of the acts listed as grounds for expedited termination of parental rights in s. 39.806(1)(f)-(i).

6. That the department has made reasonable efforts to place the child in order of priority as provided in s. 39.4021 unless such priority placement is not a placement option or in the best interest of the child based on the criteria and factors set out in s. 39.4022.

7. That the department has made reasonable efforts to keep siblings together if they are removed and placed in out-of-home care unless such placement is not in the best interest of each

child. It is preferred that siblings be kept together in a foster home, if available. Other reasonable efforts shall include short-term placement in a group home with the ability to accommodate sibling groups if such a placement is available. The department shall report to the court its efforts to place siblings together unless the court finds that such placement is not in the best interest of a child or his or her sibling.

8.~~7.~~ That the court notified the parents, relatives that are providing out-of-home care for the child, or legal custodians of the time, date, and location of the next dependency hearing and of the importance of the active participation of the parents, relatives that are providing out-of-home care for the child, or legal custodians in all proceedings and hearings.

9.~~8.~~ That the court notified the parents or legal custodians of their right to counsel to represent them at the shelter hearing and at each subsequent hearing or proceeding, and the right of the parents to appointed counsel, pursuant to the procedures set forth in s. 39.013.

10.~~9.~~ That the court notified relatives who are providing out-of-home care for a child as a result of the shelter petition being granted that they have the right to attend all subsequent hearings, to submit reports to the court, and to speak to the court regarding the child, if they so desire.

11.~~10.~~ That the department has placement and care responsibility for any child who is not placed in the care of a parent at the conclusion of the shelter hearing.

Section 4. Section 39.4021, Florida Statutes, is created to read:

39.4021 Priority placement for out-of-home placements.—

(1) LEGISLATIVE FINDINGS AND INTENT.—The Legislature finds that it is a basic tenet of child welfare practice and the law that a child be placed in the least restrictive, most family-like setting available in close proximity to the home of his or her parents which meets the needs of the child, and that a child be placed in a permanent home in a timely manner.

(2) PLACEMENT PRIORITY.—

(a) When a child cannot safely remain at home with a parent, out-of-home placement options must be considered in the following order:

1. Non-offending parent.

2. Relative caregiver.

3. Adoptive parent of the child's sibling.

4. Fictive kin, with a close existing relationship to the child.

5. Licensed foster care.

6. Group or congregate care.

(b) Sibling groups must be placed in the same placement whenever possible and if placement together is in the best interest of each of child in the sibling group. Placement decisions for sibling groups must be made pursuant to ss. 39.4022 and 39.4024.

(c) Except as otherwise provided for in this chapter, a change to a child's physical or legal placement after the child has been sheltered but before the child has achieved permanency must be made in compliance with this section.

Section 5. Section 39.4022, Florida Statutes, is created to read:

39.4022 Multidisciplinary teams; staffings; assessments; report.—

(1) LEGISLATIVE INTENT.—

(a) The Legislature finds that services for children and families are most effective when delivered in the context of a single integrated multidisciplinary team staffing that includes the child, his or her family, natural and community supports, and professionals who join together to empower, motivate, and strengthen a family and collaboratively develop a plan of care and protection to achieve child safety, child permanency, and child and family well-being.

(b) The Legislature also finds that effective assessment through an integrated multidisciplinary team is particularly important for children who are vulnerable due to existing histories of trauma which led to the child's entrance into the child welfare system. This assessment is especially important for young children who are 3 years of age or younger, as a result of the enhanced need for such children to have healthy and stable attachments to assist with necessary brain development. Stable and nurturing relationships in the first years of life, as well as the quality of such relationships, are integral to healthy brain development, providing a foundation for lifelong mental health and determining well-being as an adult.

(2) DEFINITIONS.—For purposes of this section, the term:

(a) "Change in physical custody" means a change by the department or the community-based care lead agency to the child's physical residential address, even when such change does not require a court order changing the legal custody of the

child.

(b) "Multidisciplinary team" means an integrated group of individuals which meets to collaboratively develop and attempt to reach a consensus decision on the most suitable out-of-home placement, educational placement, or other specified important life decision that is in the best interest of the child.

(3) CREATION AND GOALS.—

(a) Multidisciplinary teams must be established for the purpose of allowing better engagement with families and a shared commitment and accountability from the family and their circle of support.

(b) The multidisciplinary teams must adhere to the following goals:

1. Secure a child's safety in the least restrictive and intrusive placement that can meet his or her needs;

2. Minimize the trauma associated with separation from the child's family and help the child to maintain meaningful connections with family members and others who are important to him or her;

3. Provide input into the placement decision made by the community-based care lead agency and the services to be provided in order to support the child;

4. Provide input into the decision to preserve or maintain the placement, including necessary placement preservation strategies;

5. Contribute to an ongoing assessment of the child and the family's strengths and needs;

6. Ensure that plans are monitored for progress and that such plans are revised or updated as the child's or family's

circumstances change; and

7. Ensure that the child and family always remain the primary focus of each multidisciplinary team meeting.

(4) PARTICIPANTS.—

(a) Collaboration among diverse individuals who are part of the child's network is necessary to make the most informed decisions possible for the child. A diverse team is preferable to ensure that the necessary combination of technical skills, cultural knowledge, community resources, and personal relationships is developed and maintained for the child and family. The participants necessary to achieve an appropriately diverse team for a child may vary by child and may include extended family, friends, neighbors, coaches, clergy, coworkers, or others the family identifies as potential sources of support. Each multidisciplinary team staffing must consist of the following members:

1. The child, unless he or she is not of an age or capacity to participate in the team;

2. The child's family members and other individuals identified by the family as being important;

3. The current caregiver;

4. A representative from the department; and

5. The case manager for the child.

(b) Based on the particular goal the multidisciplinary team staffing identifies as the purpose of convening the staffing as provided under subsection (5), the department or lead agency may also invite to the meeting other professionals, including, but not limited to:

1. A representative from Children's Medical Services;

2. A guardian ad litem, if one is appointed;

3. A school personnel representative who has direct contact with the child;

4. A therapist or other behavioral health professional, if applicable.

5. A mental health professional with expertise in sibling bonding, if applicable; or

6. Other community providers of services to the child or stakeholders, when applicable.

(c) Each multidisciplinary team staffing must be led by a person who serves as a facilitator and whose main responsibility is to help team participants use the strengths within the family to develop a safe plan for the child. The person serving as the facilitator must be a trained professional who is otherwise required to attend the multidisciplinary team staffing under this section in his or her official capacity. Further, the trained professional serving as the facilitator does not need to be the same person for each meeting convened in a child's case under this section or in the service area of the designated lead agency handling a child's case.

(5) SCOPE OF MULTIDISCIPLINARY TEAM.—A multidisciplinary team staffing must be held when an important decision is required to be made about a child's life, including all of the following:

(a) Initial placement decisions for a child who is placed in out-of-home care.

(b) Changes in physical custody after the child is placed in out-of-home care by a court and, if necessary, determination of an appropriate mandatory transition plan in accordance with

s. 39.4023.

(c) Changes in a child's educational placement and, if necessary, determination of an appropriate mandatory transition plan in accordance with s. 39.4023.

(d) Placement decisions for a child as required by paragraphs (a), (b), or (c) which involve sibling groups that require placement in accordance with s. 39.4024.

(e) Any other important decisions in the child's life which are so complex that the department or appropriate community-based lead agency determines convening a multidisciplinary team staffing is necessary to ensure the best interest of the child is maintained.

(6) ASSESSMENTS.—

(a)1. The multidisciplinary team staffing participants must, before formulating a decision under this section, gather and consider data and information on the child which is known at the time, including, but not limited to:

a. The child's age, maturity, and strengths;

b. Mental, medical, behavioral health, and medication history;

c. Community ties and school placement;

d. The stability and longevity of the child's current placement;

e. The established bonded relationship between the child and the current or proposed caregiver;

f. The child's previous and current relationship with a sibling, if the change in physical custody or placement will separate or reunite siblings, evaluated in accordance with s. 39.4024;

g. The physical, mental, and emotional health benefits to the child by remaining in his or her current placement or moving to the proposed placement;

h. The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference;

i. The recommendation of the child's current caregiver, if applicable;

j. The recommendation of the child's guardian ad litem, if one has been appointed;

k. The likelihood of the child attaining permanency in the current or proposed placement;

l. The likelihood that the child will have to change schools or day care placement, the impact of such a change, and the parties' recommendations as to the timing of the change including an education transition plan required under s. 39.4023;

m. The disruption of continuity of care with medical, mental health, behavioral health, dental, or other treatment services the child is receiving at the time of the change of custody decision;

n. The allegations of any abuse, abandonment, or neglect, including sexual abuse and trafficking history, which caused the child to be placed in out-of-home care and any history of additional allegations of abuse, abandonment, or neglect;

o. The impact on activities that are important to the child, including the ability of the child to continue in such activities;

p. The impact on the child's future access to education,

Medicaid, and independent living benefits; and

q. Any other relevant factors.

2. Multidisciplinary team staffings may not be delayed to accommodate pending behavioral health screenings or assessments or pending referrals for services.

(b) The assessment conducted by the multidisciplinary team may also use an evidence-based assessment instrument or tool that is best suited for determining the specific decision of the staffing and the needs of that individual child and family.

(c)1. To adequately prepare for a multidisciplinary staffing team meeting to consider a decision related to a child 3 years of age or younger, all of the following information on the child which is known at the time must be gathered and considered by the team:

a. Identified kin and relatives who express interest in caring for the child, including strategies to overcome potential delays in placing the child with such persons if they are suitable.

b. The likelihood that the child can remain with the prospective caregiver past the point of initial removal and placement with, or subsequent transition to, the caregiver and the willingness of the caregiver to provide care for any duration deemed necessary if placement is made.

c. The prospective caregiver’s ability and willingness to:

(I) Accept supports related to early childhood development and services addressing any possible developmental delays;

(II) Address the emotional needs of the child and accept infant mental health supports, if needed;

(III) Help nurture the child during the transition into

out-of-home care;

(IV) Work with the parent to build or maintain the attachment relationship between parent and child;

(V) Effectively co-parent with the parent; and

(VI) Ensure frequent family visits and sibling visits.

d. Placement decisions for each child in out-of-home placement which are made under this paragraph must be reviewed as often as necessary to ensure permanency for that child and to address special issues that may arise which are unique to younger children.

(d)1. If the participants of a multidisciplinary team staffing reach a consensus decision, it becomes the official position of the community-based care lead agency regarding the decision under subsection (5) for which the team convened. Such decision is binding upon all department and lead agency participants, who are obligated to support it.

2. If the participants of a multidisciplinary team staffing cannot reach a consensus decision, the trained professional acting as the facilitator must attempt to bring at least the lead agency’s staff to a decision that all participants can support. If there is disagreement even among lead agency staff, the multidisciplinary team may request a review of the decision from a designated, high level administrator within the community-based care lead agency and such person’s decision becomes the official position for the decision under subsection (5) for which the team was convened.

3. If the multidisciplinary team cannot agree on the placement, it is the responsibility of the placing lead agency to determine the most appropriate placement for the child in

order to achieve the goals of child safety, permanency, and well-being.

(7) CONVENING A TEAM UPON REMOVAL.—The formation of a multidisciplinary team staffing must begin as soon as possible when a child is removed from a home. The multidisciplinary team must convene a staffing no later than 72 hours from the date of a subsequent removal in an emergency situation as that term is defined in s. 39.4023(2) and in accordance with s. 39.4023.

(8) REPORT.—If a multidisciplinary team staffing fails to reach a consensus decision, the facilitator must prepare and submit a written report to the court within 5 business days after the conclusion of the staffing which details the decision made at the conclusion of the multidisciplinary team staffing under subsection (6) and the positions of the staffing's participants.

(9) CONFIDENTIALITY.—Notwithstanding any other provision of law, participants representing the department and the community-based care lead agency may discuss confidential information during a multidisciplinary team staffing in the presence of individuals who participate in the staffing. Information collected by any agency or entity that participates in the multidisciplinary team staffing which is confidential and exempt upon collection remains confidential and exempt when discussed in a staffing required under this section. All individuals who participate in the staffing shall maintain the confidentiality of any information shared during the staffing.

(10) CONSTRUCTION.—This section may not be construed to mean that multidisciplinary team staffings coordinated by the department or the appropriate lead agency for purposes other

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than those provided for in subsection (5) before October 1, 2021, are no longer required to be conducted or are required to be conducted in accordance with this section.

(11) RULEMAKING.—The department shall adopt rules to implement this section.

Section 6. Section 39.4023, Florida Statutes, is created to read:

39.4023 Placement and education transitions; transition plans.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that many children in out-of-home care experience multiple changes in placement, and those transitions often result in trauma not only for the child but also for caregivers, families, siblings, and all professionals involved.

(b) The Legislature further finds that poorly planned and executed or improperly timed transitions may adversely impact a child's healthy development as well as the child's continuing capacity to trust, attach to others, and build relationships in the future.

(c) The Legislature finds that the best child welfare practices recognize the need to prioritize the minimization of the number of placements for every child in out-of-home care. Further, the Legislature finds that efforts must be made to support caregivers in order to promote stability. When placement changes are necessary, they must be thoughtfully planned.

(d) The Legislature finds that transition plans are critical when moving all children, including infants, toddlers, school-age children, adolescents, and young adults.

(e) It is the intent of the Legislature that a placement change or an educational change for a child in out-of-home care be achieved ideally through a period of transition that is unique to each child, provides support for all individuals affected by the change, and has flexible planning to allow for changes necessary to meet the needs of the child.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Educational change" means any time a child is moved between schools when such move is not the result of the natural transition from elementary school to middle school or middle school to high school. The term also includes changes in child care or early education programs for infants and toddlers.

(b) "Emergency situation" means that there is an imminent risk to the health or safety of the child, other children, or others in the home or facility if the child remains in the placement.

(c) "Placement change" means any time a child is moved from one caregiver to another, including moves to a foster home, a group home, relatives, prospective guardians, prospective adoptive parents, and reunification with parents. The term also includes moves between rooms and buildings operated by a group home provider.

(d) "School" means any child care, early education, elementary, secondary, or postsecondary educational setting.

(3) PLACEMENT TRANSITIONS.—

(a) *Mandatory transition plans*.—Except as otherwise provided, the department or the community-based lead agency shall create and implement an individualized transition plan before each placement change experienced by a child.

(b) *Minimizing placement transitions.*—Once a caregiver accepts the responsibility of caring for a child, the child may be removed from the home of the caregiver only if:

1. The caregiver is unwilling or unable to safely or legally care for the child;

2. The child and the birth or legal parent are reunified;

3. The child is being placed in a legally permanent home in accordance with a case plan or court order; or

4. The removal is demonstrably in the best interest of the child.

(c) *Services to prevent disruption.*—The community-based care lead agency shall provide any supportive services deemed necessary to a caregiver and a child if the child's current out-of-home placement with the caregiver is in danger of needing modification. The supportive services must be offered in an effort to remedy the factors contributing to the placement being considered unsuitable and therefore contributing to the need for a change in placement.

(d) *Transition planning.*—

1. If the supportive services provided pursuant to paragraph (c) have not been successful to make the maintenance of the placement suitable or if there are other circumstances that require the child to be moved, the department or the community-based care lead agency must convene a multidisciplinary team staffing as required under s. 39.4022 before the child's placement is changed, or within 72 hours of moving the child in an emergency situation, for the purpose of developing an appropriate transition plan.

2. A placement change may occur immediately in an emergency

situation without a convening a multidisciplinary team staffing. However, a multidisciplinary team staffing must be held within 72 hours after the emergency situation arises.

3. At least 14 days before moving a child from one out-of-home placement to another or within 72 hours after an emergency situation, the department or the community-based care lead agency must provide written notice of the planned move and must include in the notice the reason a placement change is necessary. A copy of the notice must be filed with the court and be provided to:

a. The child, unless he or she, due to age or capacity, is unable to comprehend the written notice, which will necessitate the department or lead agency to provide notice in an age- and capacity-appropriate alternative manner;

b. The child's parents, unless prohibited by court order;

c. The child's out-of-home caregiver;

d. The guardian ad litem, if one is appointed; and

e. The attorney for the department.

4. The transition plan must be developed through cooperation among the persons included in subparagraph 3., and such persons must share any relevant information necessary to ensure that the transition plan does all of the following:

a. Respects the child's developmental stage and psychological needs.

b. Ensures the child has all of his or her belongings and is allowed to help pack those belongings when appropriate.

c. Allows for a gradual transition from the current caregiver's home with substantial overlap between the two caregivers and provides time for the child to have a final

visitation with everyone important to the child from the current placement, including pets.

d. Allows, when possible, for continued contact with the previous caregiver and others in the home after the child leaves.

e. Prohibits a placement change which occurs between 7 p.m. and 8 a.m.

5. The department or the community-based care lead agency shall file the transition plan with the court within 48 hours after the creation of such plan and provide a copy of the plan to the persons included in subparagraph 3.

(e) *Additional considerations for transitions of infants and children under school age.*—Relationship patterns over the first year of life are important predictors of future relationships. Research demonstrates that babies begin to form a strong attachment to a caregiver at approximately 7 months of age. From that period of time through age 2, moving a child from a caregiver who is the psychological parent is considerably more damaging. Placement decisions must focus on promoting security and continuity for infants and children under 5 years of age in out-of-home care. Transition plans for infants and young children must describe the facts that were considered when each of the following were discussed and must specify what decision was made as to how each of the following applies to the child:

1. The age of the child and the child's current ability to accomplish developmental tasks, with consideration made for whether the child is:

a. Six months of age or younger, thereby indicating that it may be in the child's best interest to move the child sooner

rather than later; or

b. One year to 2 years of age, thereby indicating it may not be a healthy time to move the child.

2. The length of time the child has lived with the current caregiver, the strength of attachment to the current caregiver, and the harm of disrupting a healthy attachment compared to the possible advantage of a change in placement.

3. The relationship, if any, the child has with the new caregiver and whether a reciprocal agreement exists between the current caregiver and the prospective caregiver to maintain the child's relationship with both caregivers.

4. The pace of the transition and whether flexibility exists to accelerate or slow down the transition based on the child's needs and reactions.

(f) *Preparation of prospective caregivers before placement.*—

1. Prospective caregivers must be fully informed of the child's needs and circumstances and be willing and able to accept responsibility for providing high-quality care for such needs and circumstances before placement.

2. The community-based care lead agency shall review with the prospective caregiver the caregiver's roles and responsibilities according to the parenting partnerships plan for children in out-of-home care pursuant to s. 409.1415. The case manager shall sign a copy of the parenting partnerships plan and obtain the signature of the prospective caregiver acknowledging explanation of the requirements before placement.

(4) EDUCATION TRANSITIONS.—

(a) *Findings.*—Children in out-of-home care frequently

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change child care, early education programs, and schools. These changes can occur when the child first enters out-of-home care, when the child must move from one caregiver to another, or when the child returns home upon reunification. Research shows that children who change schools frequently make less academic progress than their peers and fall further behind with each school change. Additionally, educational instability at any level makes it difficult for children to develop supportive relationships with teachers or peers. State and federal law contain requirements that must be adhered to in order to ensure educational stability for a child in out-of-home care. A child's educational setting should only be changed when maintaining the educational setting is not in the best interest of the child.

(b) *Mandatory educational transition plans.*—The department or the community-based care lead agency shall create and implement an individualized transition plan each time a child experiences a school change.

(c) *Minimizing school changes.*—

1. Every effort must be made to keep a child in the school of origin. Any placement decision must include thoughtful consideration of which school a child will attend if a school change is necessary.

2. A determination that it is not the child's best interest to remain in the school of origin and which school the child will attend in the future must be made in consultation with the child; the parents; the caregiver; the child welfare professional; the guardian ad litem, the educational surrogate child care and educational staff, including teachers and guidance counselors; and the school district representative or

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foster care liaison.

3. If a determination is made that remaining in the school or program of origin is not in the child's best interest, selection of a new school or program must consider relevant factors, including, but not limited to:

a. The child's desire to remain in the school or program of origin.

b. The preference of the child's parents or legal guardians.

c. Whether the child has siblings, close friends, or mentors at the school or program of origin.

d. The child's cultural and community connections in the school or program of origin.

e. Whether the child is suspected of having a disability under the Individuals with Disabilities Education Act (IDEA) or s. 504 of the Rehabilitation Act of 1973, or has begun receiving interventions under this state's multitiered system of supports.

f. Whether the child has an evaluation pending for special education and related services under IDEA or s. 504 of the Rehabilitation Act of 1973.

g. Whether the child is a student with a disability under IDEA who is receiving special education and related services or a student with a disability under s. 504 of the Rehabilitation Act of 1973 who is receiving accommodations and services and, if so, whether those required services are available in a school or program other than the school or program of origin.

h. Whether the child is an English Language Learner student and is receiving language services, and if so, whether those required services are available in a school or program other

than the school or program of origin.

i. The impact a change to the school or program of origin would have on academic credits and progress toward promotion.

j. The availability of extracurricular activities important to the child.

k. The child's known individualized educational plan or other medical and behavioral health needs and whether such plan or needs are able to be met at a school or program other than the school or program of origin.

l. The child's permanency goal and timeframe for achieving permanency.

m. The child's history of school transfers and how such transfers have impacted the child academically, emotionally, and behaviorally.

n. The length of the commute to the school or program from the child's home or placement and how such commute would impact the child.

o. The length of time the child has attended the school or program of origin.

4. The cost of transportation cannot be a factor in making a best interest determination.

(d) *Transitions between child care and early education programs.*—When a child enters out-of-home care or undergoes a placement change, the child shall, if possible, remain with a familiar child care provider or early education program unless there is an opportunity to transition to a higher quality program. If it is not possible for the child to remain with the familiar child care provider or early education program or transition to a higher quality program, the child's transition

plan must be made with the participation of the child's current and future school or program. The plan must give the child an opportunity to say goodbye to important figures in the educational environment.

(e) *Transitions between K-12 schools*.—The transition plan for a transition between K-12 schools must include all of the following:

1. Documentation that the department or community-based care lead agency has made the decision to change the child's school in accordance with paragraph (c). The plan must include a detailed discussion of all factors considered in reaching the decision to change the child's school.

2. Documentation that the department or community-based care lead agency has coordinated with local educational agencies to provide immediate and appropriate enrollment in a new school, including transfer of educational records, any record of a school-entry health examination, and arrangements for transportation to the new school.

3. Discussion of the timing of the proposed school change which addresses the potential impact on the child's education and extracurricular activities. This section must include, at a minimum, grading periods, exam schedules, credit acquisitions, sports eligibility, and extracurricular participation.

4. Details concerning the transportation of the child to school.

(5) TRANSITION PLAN AND DOCUMENTATION.—

(a) The department, in collaboration with the Quality Parenting Initiative, shall develop a form to be completed and updated each time a child in out-of-home care is moved from one

placement to another.

(b) A completed form must be attached to the case record face sheet required to be included in the case file pursuant to s. 39.00146. The form must be used statewide and, at a minimum, must include all of the following information:

1. The membership of the multidisciplinary team staffing convened under s. 39.4022 to develop a transition plan for the change in placement and the dates on which the team met.

2. The name of the person who served as the facilitator in that specific multidisciplinary team staffing.

3. The topics considered by the multidisciplinary team staffing in order to ensure an appropriate transition.

4. The recommendations of the multidisciplinary team and the name of each individual or entity responsible for carrying out each recommendation.

(c) The department or the community-based care lead agency shall document all multidisciplinary team staffings and placement transition decisions in the Florida Safe Families Network and must include the information in the social study report for judicial review, as required under s. 39.701.

(6) RULEMAKING.—The department shall adopt rules to implement this section.

Section 7. Section 39.4024, Florida Statutes, is created to read:

39.4024 Placement of siblings; visitation; continuing contact.—

(1) LEGISLATIVE FINDINGS.—

(a) The Legislature finds that sibling relationships can provide a significant source of continuity throughout a child's

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life and are likely to be the longest relationships that most individuals experience. Further, the placement of siblings together can increase the likelihood of achieving permanency and is associated with a significantly higher rate of family reunification.

(b) The Legislature finds that it is beneficial for a child who is placed in out-of-home care to be able to continue existing relationships with his or her siblings, regardless of age, so that they may share their strengths and association in their everyday and often common experiences.

(c) The Legislature also finds that healthy connections with siblings can serve as a protective factor for children who have been placed in out-of-home care. The Legislature finds that child protective investigators and caseworkers should be aware of the variety of demographic and external situational factors that may present challenges to placement in order to identify such factors relevant to a particular group of siblings and ensure that these factors are not the sole reasons that siblings are not placed together.

(d) The Legislature also finds that it is the responsibility of all entities and adults involved in a child's life, including, but not limited to, the department, community-based lead agencies, parents, foster parents, guardians ad litem, next of kin, and other persons important to the child to seek opportunities to foster sibling relationships to promote continuity and help sustain family connections.

(e) While there is a presumption in law and policy that it is in the best interest of a child going into out-of-home care to be placed with any siblings, the Legislature finds that

overall well-being of the child and family improves when the person or team responsible for placement decisions evaluates the child's sibling and family bonds and prioritizes the bonds that are unique drivers of the child's ability to maintain and develop healthy relationships. The person or team with an understanding of the need to balance all attachment bonds of a child and the potential need to prioritize existing and healthy sibling relationships differently than a potential or unhealthy sibling relationship over a healthy existing bond with a caregiver will result in more stable and healthier placements for all children in out-of-home care.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Multidisciplinary team" has the same meaning as provided in s. 39.4022.

(b) "Lead agency" means a community-based care lead agency under contract with the department to provide care to children in foster care under chapter 409.

(c) "Sibling" means:

1. A child who shares a birth parent or legal parent with one or more other children; or

2. A child who has lived together in a family with one or more other children whom he or she identifies as siblings.

(3) PLACEMENT OF SIBLINGS IN OUT-OF-HOME CARE.—

(a) *General provisions.*—

1. The department or lead agency shall make reasonable efforts to place sibling groups that are removed from their home in the same foster, kinship, adoptive, or guardianship home when it is in the best interest of each sibling and when an appropriate, capable, and willing joint placement for the

sibling group is available.

2. If a child enters out-of-home care after his or her sibling, the department or lead agency and the multidisciplinary team shall make reasonable efforts to initially place the child who has entered out-of-home care with his or her siblings in the sibling's existing placement, provided it would not jeopardize the stability of such placement and it is in the best interest for each child.

3. When determining whether to move a child from a current placement to a new placement when such change is initiated by a sibling relationship, all relevant factors must be considered by the multidisciplinary team to ensure that the child is best served by the decision. A uniform policy that does not consider and apply a balancing test to ensure all existing attachment bonds for a child and his or her siblings are honored and evaluated holistically may result in placement decisions or changes of placement decisions that may result in additional trauma.

4. The department and the court are not required to make an initial placement or change in placement to develop a relationship between siblings which did not exist at the time a child is placed in out-of-home care.

(b) *Factors to consider when placing sibling groups.*—

1. At the time a child who is a part of a sibling group is removed from the home, the department or lead agency shall convene a multidisciplinary team staffing in accordance with s. 39.4022 to determine and assess the sibling relationships from the perspective of each child to ensure the best placement of each child in the sibling group. The multidisciplinary team

shall consider all relevant factors included in s. 39.4022 and this section, including, but not limited to, the existing emotional ties between and among the siblings, the degree of harm each child is likely to experience as a result of separation, and the standard protocols established by the Quality Parenting Initiative under paragraph (d).

2.a. If the department or the appropriate lead agency is able to locate a caregiver that will accept the sibling group and the multidisciplinary team determines that the placement is suitable for each child, the sibling group must be placed together.

b. If the department or appropriate lead agency is not able to locate a caregiver or placement option that allows the sibling group to be placed together in an initial placement, the department or lead agency must make all reasonable efforts to ensure contact and visitation between siblings placed in separate out-of-home care placements and provide reviews of the placements in accordance with this section.

3. If all the siblings are unable to be placed in an existing placement and the siblings do not have an existing relationship, when determining whether to move any child who is part of the sibling group from his or her current placement to a new placement that will unite the sibling group, the department or lead agency must consider all of the following additional factors:

a. The presence and quality of current attachment relationships, including:

(I) The quality and length of the attachment of the child to both the current and prospective caregiver;

(II) The age of the child at placement with the current caregiver and the child's current age as well as the ages of any siblings;

(III) The ease with which the child formed an attachment to the current family;

(IV) Any indications of attachment difficulty in the child's history; and

(V) The number of moves and number of caregivers the child has experienced.

b. The potential of the new caregiver to be a primary attachment figure to the sibling group by ensuring care for each child's physical needs and the willingness and availability to meet the each child's emotional needs.

c. The quality of existing sibling relationships and the potential quality of sibling relationships that can be formed between the children.

d. The consideration of any costs and benefits of disrupting existing emotional attachments to a primary caregiver to place children in a new placement with siblings, including:

(I) The length and quality of the established and current primary attachment relationships between the siblings and between the siblings and their current caregivers; and

(II) Relationships between any other siblings and whether such relationships appear adequate and not stressful or harmful.

e. The ability to establish and maintain sibling visitation and contact pursuant to this section in a manner and schedule that makes sense for an infant or young child if it is determined that the infant or young child is to remain with his or her primary caregivers rather than be placed with his or her

siblings.

f. The ability to establish and maintain contact with the sibling and new caregiver as part of a transition plan developed in accordance with paragraph (c) and s. 39.4023 before changing the child's placement to allow the child, his or her siblings, and new caregiver to adjust and form bonds.

(c) *Transitioning a child after a determination.*—If after considering the provisions and factors described in paragraphs (a) and (b) it is determined that the child would benefit from being placed with his or her siblings, the transition of the child to the new home must be carried out gradually in accordance with s. 39.4023.

(d) *Standards for evaluating sibling placements.*—The department, in collaboration with the Quality Parenting Initiative, must develop standard protocols for the department and lead agency which incorporate the provisions and factors described in paragraphs (a), (b), and (c) and any other factors deemed relevant for use in making decisions about when placing siblings together would be contrary to a child's well-being or safety or decisions providing for frequent visitation and contact under subsection (4).

(4) MAINTAINING CONTACT WHEN SIBLINGS ARE SEPARATED.—

(a) Regular contact among a sibling group that cannot be placed together, especially among siblings with existing attachments to each other, is critical for the siblings to maintain their existing bonds and relationships or to develop such bonds and attachments, if appropriate. The following practices must be considered in helping to maintain or strengthen the relationships of separated siblings:

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1. Respect and support the child's ties to his or her birth or legal family, including parents, siblings, and extended family members, must be provided by the caregiver, and he or she must assist the child in maintaining allowable visitation and other forms of communication. The department and lead agency shall provide a caregiver with the information, guidance, training, and support necessary for fulfilling this responsibility.

2. Provide adequate support to address any caregiver concerns and to enhance the caregiver's ability to facilitate contact between siblings who are not in the same out-of-home placement and promote the benefits of sibling contact.

3. Prioritize placements with kinship caregivers who have an established personal relationship with each child so that even when siblings cannot be placed together in the same home, kinship caregivers are more likely to facilitate contact.

4. Prioritize placement of siblings geographically near each other, such as in the same neighborhood or school district, to make it easier for the siblings to see each other regularly.

5. Encourage frequent and regular visitation, if the siblings choose to do so, to allow the children to be actively involved in each other's lives and to participate in celebrations, including, but not limited to, birthdays, graduations, holidays, school and extracurricular activities, cultural customs, and other milestones.

6. Provide other forms of contact when regular in-person meetings are not possible or are not sufficient to meet the needs or desires of the siblings, such as maintaining frequent contact through letters, e-mail, social media, cards, or

telephone calls.

7. Coordinate, when possible, joint outings or summer or weekend camp experiences to facilitate time together, including, but not limited to, activities or camps specifically designed for siblings in out-of-home care.

8. Encourage joint respite care to assist the caregivers who are caring for separated siblings to have needed breaks while also facilitating contact among the siblings, including, but not limited to, providing babysitting or respite care for each other.

9. Prohibit the withholding communication or visitation among the siblings as a form of punishment.

(b) The court may limit or restrict communication or visitation under this subsection only upon a finding by clear and convincing evidence that the communication or visitation is harmful to the child. If the court makes such a finding, it must direct the department or lead agency to immediately provide services to ameliorate the harm so that communication and visitation may be restored as soon as possible.

(5) SUBSEQUENT REVIEWS.—

(a) The department and the lead agency shall periodically, but at least once every 6 months, reassess sibling placement, visitation, and other sibling contact decisions in cases where siblings are separated, not visiting, or not maintaining contact to determine if a change in placement is warranted unless the decision to not place a child with his or her sibling group was made due to such placement being inappropriate, unhealthy, or unsafe for the child.

(b) If a child in a sibling group who has been placed in an

out-of-home care placement with his or her siblings does not adjust to the placement, the lead agency must provide services to the caregiver and sibling group in accordance with s. 39.4023(3) to try to prevent the disruption of the placement. If after reasonable efforts are made under s. 39.4023(3), the child still has not adjusted to the out-of-home placement, a multidisciplinary team staffing must be convened to determine what is best for all of the children. The multidisciplinary team shall review the current placement of the sibling group and choose a plan that will be least detrimental to each child. If the team determines that the best decision is to move the child who has not adjusted to a new out-of-home placement, the team must develop a transition plan in accordance with ss. 39.4022 and 39.4023 which ensures the opportunity for the siblings to maintain contact in accordance with subsection (4) of this section.

(c) If it becomes known that a child in out-of-home care has a sibling of whom the child, department, or lead agency was previously unaware, the department or lead agency must convene a multidisciplinary team staffing within a reasonable amount of time after the discovery of such sibling to decide if the current placement or permanency plan requires modification.

(6) ADDITIONAL REQUIREMENTS AND CONSIDERATIONS.—

(a) The department shall promptly provide a child with the location of and contact information for his or her siblings. If the existence or location of or contact information for a child's siblings is not known, the department must make reasonable efforts to ascertain such information.

(b) If a child's sibling is also in out-of-home care and

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such sibling leaves out-of-home care for any reason, including, but not limited to, emancipation, adoption, or reunification with his or her parent or guardian, the child has a right to continued communication with his or her sibling as provided under subsection (4).

(c) The department or the lead agency must document in writing any decision to separate siblings in the case file as required in s. 39.00146 and document the decision in the Florida Safe Families Network. The documentation must include any efforts made to keep the siblings together, an assessment of the short-term and long-term effects of separation on each child and the sibling group as a whole, and a description of the plan for communication or contact between the children if separation is approved.

(7) RULEMAKING AUTHORITY.—The department shall adopt rules to implement this section.

Section 8. Section 39.522, Florida Statutes, is amended to read:

39.522 Postdisposition change of custody.—

(1) The court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing.

(2)(a) ~~(1)(a)~~ At any time before a child is residing in the permanent placement approved at the permanency hearing, a child who has been placed in the child's own home under the protective supervision of an authorized agent of the department, in the home of a relative, in the home of a legal custodian, or in some other place may be brought before the court by the department or by any other interested person, upon the filing of a motion

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alleging a need for a change in the conditions of protective supervision or the placement. If any party or the current caregiver denies ~~the parents or other legal custodians deny~~ the need for a change, the court shall hear all parties in person or by counsel, or both.

(b) Upon the admission of a need for a change or after such hearing, the court shall enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered. The standard for changing custody of the child shall be the best interests of the child. When determining whether a change of legal custody or placement is in the best interests of the child, the court shall consider the factors listed in s. 39.4022 and the report filed by the multidisciplinary team, if applicable. The court shall also consider the priority of placements established under s. 39.4021 when making a decision regarding the best interest of the child in out-of-home care.~~:~~

~~1. The child's age.~~

~~2. The physical, mental, and emotional health benefits to the child by remaining in his or her current placement or moving to the proposed placement.~~

~~3. The stability and longevity of the child's current placement.~~

~~4. The established bonded relationship between the child and the current or proposed caregiver.~~

~~5. The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference.~~

~~6. The recommendation of the child's current caregiver.~~

~~7. The recommendation of the child's guardian ad litem, if one has been appointed.~~

~~8. The child's previous and current relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings.~~

~~9. The likelihood of the child attaining permanency in the current or proposed placement.~~

~~10. Any other relevant factors.~~

(c) ~~(b)~~ If the child is not placed in foster care, the new placement for the child must meet the home study criteria and court approval under this chapter.

(3)(a) For purposes of this subsection, the term "change in physical custody" means a change by the department or community-based care lead agency to the child's physical residential address even when such change does not require a court order to change the legal custody of the child.

(b)1. In a hearing on the change of physical custody under this section, there shall be a rebuttable presumption that it is in the child's best interest to remain permanently in his or her current physical placement if:

a. The child has been in the same safe and stable placement for 9 consecutive months or more;

b. Reunification is not a permanency option for the child;

c. The caregiver is able, willing, and eligible for consideration as an adoptive parent or permanent custodian for the child;

d. The caregiver is not requesting the change in physical placement; and

e. The change in physical placement being sought is not to

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reunify the child with his or her parent or sibling or transition the child from a safe and stable nonrelative caregiver to a safe and stable relative caregiver.

2. In order to rebut the presumption established in this paragraph, the court shall hold an evidentiary hearing on the change in physical custody to determine if the change in placement is in the best interest of the child. As part of the evidentiary hearing, the court must consider competent and substantial evidence and testimony related to the factors enumerated in s. 39.4022 and any other evidence deemed relevant to a determination of placement, including evidence from a court-selected neutral and independent expert in the science and research of child-parent bonding and attachment.

3. This presumption may not be rebutted solely by the expressed wishes of a biological parent, a biological relative, or a caregiver of a sibling of the child.

(c)1. A current caregiver who has been the physical custody placement for at least 9 consecutive months and who meets all the established criteria in paragraph (b) shall be notified by the department or community-based care lead agency of an intent to change the physical custody of the child at least 21 days before the desired date for transitioning the child to the new physical custody placement.

2. A caregiver who objects to the change in physical custody must notify the court and the department or lead agency of his or her objection and the intent to request an evidentiary hearing in writing in accordance with this subsection as soon as possible after receiving notice under subparagraph 1., but no later than 5 days before the desired date for transitioning the

child to the new physical custody placement.

3. Upon the department or community-based care lead agency receiving written notice of the caregiver's objection, the change to the child's physical custody must be placed in abeyance and the child may not be transitioned to a new physical placement without a court order.

4. Within 7 days after receiving written notice from the caregiver, the court must conduct an initial case status hearing, at which time the court must:

a. Grant party status to the current caregiver who is seeking permanent custody and has maintained physical custody of that child for at least 9 continuous months;

b. Appoint a lawyer for the child who is the subject of the permanent custody proceeding;

c. Advise the caregiver of his or her right to retain counsel for purposes of the evidentiary hearing; and

d. Appoint a court-selected neutral and independent expert in the science and research of child-parent bonding and attachment.

(d) The court must conduct the evidentiary hearing and provide a written order of its findings regarding the placement that is in the best interest of the child no later than 90 days from the date the caregiver provided written notice to the court under this subsection. The court must provide its written order to the department or lead agency, the caregiver, and the prospective caregiver.

(e) If the court orders that the physical custody of the child change from the current caregiver after the evidentiary hearing, the department or lead agency must provide an

appropriate transition plan in accordance with s. 39.4023.

(4) ~~(2)~~ In cases where the issue before the court is whether a child should be reunited with a parent, the court shall review the conditions for return and determine whether the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home with an in-home safety plan prepared or approved by the department will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health.

(5) ~~(3)~~ In cases where the issue before the court is whether a child who is placed in the custody of a parent should be reunited with the other parent upon a finding that the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home of the other parent with an in-home safety plan prepared or approved by the department will not be detrimental to the child, the standard shall be that the safety, well-being, and physical, mental, and emotional health of the child would not be endangered by reunification and that reunification would be in the best interest of the child.

(6) ~~(4)~~ In cases in which the issue before the court is whether to place a child in out-of-home care after the child was placed in the child's own home with an in-home safety plan or the child was reunified with a parent or caregiver with an in-home safety plan, the court must consider, at a minimum, the following factors in making its determination whether to place the child in out-of-home care:

(a) The circumstances that caused the child's dependency

and other subsequently identified issues.

(b) The length of time the child has been placed in the home with an in-home safety plan.

(c) The parent's or caregiver's current level of protective capacities.

(d) The level of increase, if any, in the parent's or caregiver's protective capacities since the child's placement in the home based on the length of time the child has been placed in the home.

The court shall additionally evaluate the child's permanency goal and change the permanency goal as needed if doing so would be in the best interests of the child. If the court changes the permanency goal, the case plan must be amended pursuant to s. 39.6013(5).

Section 9. Subsections (2) and (5) of section 39.523, Florida Statutes, are amended to read:

39.523 Placement in out-of-home care.—

(2) ASSESSMENT AND PLACEMENT.—When any child is removed from a home and placed in ~~into~~ out-of-home care, a comprehensive placement assessment process shall be completed in accordance with s. 39.4022 to determine the level of care needed by the child and match the child with the most appropriate placement.

(a) The community-based care lead agency or subcontracted agency with the responsibility for assessment and placement must coordinate a multidisciplinary team staffing as established in s. 39.4022 with the necessary participants for the stated purpose of the staffing ~~with any available individual currently involved with the child including, but not limited to, a~~

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~~representative from the department and the case manager for the child; a therapist, attorney ad litem, guardian ad litem, teachers, coaches, Children's Medical Services; and other community providers of services to the child or stakeholders as applicable. The team may also include clergy, relatives, and fictive kin if appropriate. Team participants must gather data and information on the child which is known at the time including, but not limited to:~~

~~1. Mental, medical, behavioral health, and medication history;~~

~~2. Community ties and school placement;~~

~~3. Current placement decisions relating to any siblings;~~

~~4. Alleged type of abuse or neglect including sexual abuse and trafficking history; and~~

~~5. The child's age, maturity, strengths, hobbies or activities, and the child's preference for placement~~.

(b) The comprehensive placement assessment process may also include the use of an assessment instrument or tool that is best suited for the individual child.

(c) The most appropriate available out-of-home placement shall be chosen after consideration by all members of the multidisciplinary team of all of the information and data gathered, including the results and recommendations of any evaluations conducted.

(d) Placement decisions for each child in out-of-home placement shall be reviewed as often as necessary to ensure permanency for that child and address special issues related to this population of children.

(e) The department, a sheriff's office acting under s.

39.3065, a community-based care lead agency, or a case management organization must document all placement assessments and placement decisions in the Florida Safe Families Network.

(f) If it is determined during the comprehensive placement assessment process that residential treatment as defined in s. 39.407 would be suitable for the child, the procedures in that section must be followed.

(5) RULEMAKING.—The department shall ~~may~~ adopt rules to implement this section.

Section 10. Paragraph (e) of subsection (1) of section 39.806, Florida Statutes, is amended to read:

39.806 Grounds for termination of parental rights.—

(1) Grounds for the termination of parental rights may be established under any of the following circumstances:

(e) When a child has been adjudicated dependent, a case plan has been filed with the court, and:

1. The child continues to be abused, neglected, or abandoned by the parent or parents. The failure of the parent or parents to substantially comply with the case plan for a period of 12 months after an adjudication of the child as a dependent child or the child's placement into shelter care, whichever occurs first, constitutes evidence of continuing abuse, neglect, or abandonment unless the failure to substantially comply with the case plan was due to the parent's lack of financial resources or to the failure of the department to make reasonable efforts to reunify the parent and child. The 12-month period begins to run only after the child's placement into shelter care or the entry of a disposition order placing the custody of the child with the department or a person other than the parent and

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the court's approval of a case plan having the goal of reunification with the parent, whichever occurs first; or

2. The parent or parents have materially breached the case plan by their action or inaction. Time is of the essence for permanency of children in the dependency system. In order to prove the parent or parents have materially breached the case plan, the court must find by clear and convincing evidence that the parent or parents are unlikely or unable to substantially comply with the case plan before time to comply with the case plan expires.

3. The child has been in care for any 12 of the last 22 months and the parents have not substantially complied with the case plan so as to permit reunification under s. 39.522(4) ~~s. 39.522(2)~~ unless the failure to substantially comply with the case plan was due to the parent's lack of financial resources or to the failure of the department to make reasonable efforts to reunify the parent and child.

Section 11. This act shall take effect October 1, 2021.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to child welfare; creating s. 39.00146, F.S.; defining terms; requiring the case record of every child under the supervision or in the custody of the Department of Children and Families, the department's agents, or providers contracting with

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the department to include a case record face sheet; specifying information required to be included in the case record face sheet; requiring the department, the department's agents, and providers contracting with the department to update the case record face sheet monthly; requiring the department to adopt rules; amending s. 39.401, F.S.; requiring the department to determine out-of-home placement based on priority of placements and other factors; amending s. 39.402, F.S.; requiring the department to make reasonable efforts to place a child in out-of-home care based on priority of placements; providing exceptions and other criteria; creating s. 39.4021, F.S.; providing legislative findings; establishing certain placement priorities for out-of-home placements; requiring the department or lead agency to place sibling groups together when possible if in the best interest of each child after considering specified factors; providing construction; creating s. 39.4022, F.S.; providing legislative intent; defining terms; requiring that multidisciplinary teams be established for certain purposes; providing goals for such teams; providing for membership of multidisciplinary team staffings; authorizing the department or lead agency to invite other participants to attend a team staffing under certain circumstances; providing requirements for multidisciplinary team staffings; requiring that team staffings be held when specified decisions regarding a child must be made; requiring team staffing

participants to gather and consider data and information on the child before formulating a decision; providing for the use of an evidence-based assessment instrument or tool; requiring multidisciplinary teams to conduct supplemental assessments for certain children; requiring team participants to gather certain information related to the child for such supplemental assessments; requiring that a consensus decision reached by the team becomes the official position and that specified parties are bound by such consensus decision; providing procedures for when the team does not reach a consensus decision; requiring that the lead agency determine a suitable placement if the team cannot come to a consensus decision; requiring the formation of a team within specified timeframes; requiring the facilitator to file a report with the court within a specified timeframe if the team does not reach a consensus decision; providing requirements for the report; authorizing specified parties to discuss confidential information during a team staffing in the presence of participating individuals; providing that information collected by any agency or entity that participates in a staffing which is confidential and exempt upon collection remains confidential and exempt when discussed in staffings; requiring individuals who participate in a staffing to maintain the confidentiality of all information shared; providing construction; requiring the department to adopt rules;

creating s. 39.4023, F.S.; providing legislative findings and intent; defining terms; providing for the creation of transition plans for specified changes in placement; providing conditions under which a child may be removed from a caregiver's home; requiring community-based care lead agencies to provide services to prevent a change in placement; requiring the department and a community-based care lead agency to convene a multidisciplinary team staffing to develop a transition plan under certain circumstances; requiring the department or community-based care lead agency to provide written notice of a planned placement change; providing requirements for the notice; requiring additional considerations for placement changes for infants and young children; providing findings; providing for determinations to be made to minimize changes in school placements; specifying factors that must be considered when selecting a new school for a child; requiring children who enter out-of-home care or undergo changes in placement to remain with familiar child care providers or early education programs, if possible; providing requirements for transition plans for transitions between K-12 schools; requiring the department, in collaboration with the Quality Parenting Initiative, to develop a form for a specified purpose; specifying requirements for the form; requiring the department and community-based care lead agencies to document multidisciplinary team staffings and placement transition decisions in the

Florida Safe Families Network and include such information in the social study report for judicial review; requiring the department to adopt rules; creating s. 39.4024, F.S.; providing legislative findings; defining terms; requiring the department or lead agency to make reasonable efforts to place siblings in the same foster, kinship, adoptive, or guardianship home when certain conditions are met; requiring the department or lead agency and multidisciplinary team to take certain actions when siblings are not placed together; specifying that the department and court are not required to make a placement or change in placement to develop certain sibling relationships; requiring the department or the lead agency to convene a multidisciplinary team staffing to determine and assess sibling relationships when a child is removed from a home; providing for the placement of sibling groups in certain circumstances; specifying factors for the multidisciplinary team to consider when determining placement or change of placement for children in sibling groups who do not have an existing relationship with siblings; requiring that a child’s transition to a new home be carried out gradually when it is determined that the child would benefit from being placed with siblings; requiring the department, in collaboration with the Quality Parenting Initiative, to develop standard protocols for the department and lead agency for use in making specified decisions about child placement; providing

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considerations for maintaining contact between siblings when separated; providing duties for caregivers; authorizing the court to limit and restrict communication and visitation upon a finding of clear and convincing evidence that such communication or visitation is harmful to the child; requiring the department and community-based care lead agencies to periodically reassess certain sibling placements in certain instances; requiring the department to provide certain services to prevent disruption in a placement when a child does not adjust to such placement; requiring that a multidisciplinary team staffing is convened when one child does not adjust to placement as a sibling group under certain conditions; requiring the team to review such placement and choose a plan least detrimental to each child; requiring that a multidisciplinary team be convened in certain circumstances where the department or child subsequently identify a sibling; requiring the department to provide children with specified information relating to their siblings; requiring the department to make reasonable efforts to ascertain such information if it is not known; providing that a child has a right to continued communication with a sibling when the child’s sibling is also in out-of-home care and such sibling leaves out-of-home care for any reason; requiring the department and lead agencies to document in writing decisions to separate siblings in case files and the Florida Safe Families Network;

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specifying requirements for such documentation; requiring the department to adopt rules; amending s. 39.522, F.S.; deleting and relocating criteria for the court to consider when determining whether a legal change of custody is in the best interest of the child; defining the term "change in physical custody"; providing a rebuttable presumption that the best interest of a child is to remain in a current placement; providing applicability for such presumption; establishing the manner in which to rebut the presumption; requiring the department or lead agency to notify a caregiver within a specified timeframe of the intent to move a child; requiring the caregiver to provide written notice of objection to such move within a specified time frame; requiring the court to conduct an initial status hearing within a specified timeframe upon receiving specified written notice from a caregiver; prohibiting the department or lead agency from moving a child upon receiving specified written notice from a caregiver; providing for the appointment of an attorney for a child; providing for the appointment of an expert; providing deadlines for an evidentiary hearing; amending s. 39.523, F.S.; requiring the department or lead agency to coordinate a multidisciplinary team staffing for specified purposes; requiring, rather than authorizing, the department to create rules; amending s. 39.806, F.S.; conforming a cross-reference; providing an effective date.

By Senator Brodeur

9-00861-21 202180__

A bill to be entitled

An act relating to child welfare; creating s. 39.00146, F.S.; defining terms; requiring the case record of every child under the supervision or in the custody of the Department of Children and Families, the department's agents, or providers contracting with the department to include a case record face sheet; specifying information required to be included in the case record face sheet; requiring the department, the department's agents, and providers contracting with the department to update the case record face sheet monthly; requiring the department to adopt rules; amending s. 39.522, F.S.; revising criteria for the court to consider when determining whether a legal change of custody is in the best interests of the child; providing a rebuttable presumption that the best interest of the child is to remain in the current placement; providing for when the presumption is applicable; establishing the manner to rebut the presumption; amending s. 39.523, F.S.; providing legislative findings; providing for priority placements for a child who must be placed in out-of-home care; requiring that sibling groups be placed together under certain circumstances; requiring placement decisions for sibling groups be made pursuant to a specified provision; requiring that child and family team meetings be held when an important decision regarding the child must be made; providing the purpose of child and family team

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meetings; providing for the composition of child and family teams; providing requirements for child and family team meetings; requiring community-based care lead agencies and subcontracted agencies to coordinate a child and family team meeting as part of the comprehensive placement assessment process; requiring the formation of a team as soon as possible when the child is removed from the home; requiring the child and family teams to collaborate with services providers to ensure coordination of existing services; prohibiting the delay of team meetings under certain circumstances; requiring child and family teams to conduct supplemental assessments for certain children; requiring team participants to gather certain information related to the child for such supplemental assessments; authorizing the department to discuss confidential information during the child and family team meeting in the presence of individuals who participate in the meeting; providing that information collected by any agency or entity that participates in the child and family team meeting which is confidential and exempt upon collection remains confidential and exempt when discussed in meetings; providing that all individuals who participate in the meeting must maintain the confidentiality of all information shared during the meeting; requiring, rather than authorizing, the department to adopt rules; creating s. 39.5321, F.S.; providing legislative findings and intent; defining terms;

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providing for the creation of transition plans for changes in placement; providing conditions under which a child may be removed from a caregiver's home; requiring community-based care lead agencies to provide services to prevent a change in placement; requiring the department and community-based care lead agencies to coordinate a child and family team meeting to develop a transition plan under certain circumstances; requiring the department or community-based care lead agency to provide notice of a planned placement change; providing requirements for the notice; providing for transition planning in emergency situations; providing child and family meeting requirements in emergency situations; requiring the department or community-based care lead agency to provide notice of the emergency placement change to specified persons; providing requirements for the notice; providing requirements for transition plans made in emergency situations; requiring the department or community-based care lead agency to file such transition plans with the court within a specified timeframe; requiring that prospective caregivers be fully informed of certain information before placement; requiring community-based care lead agencies to review certain information with prospective caregivers; requiring additional considerations for placement changes for infants and young children; providing findings; providing for determinations to be made to minimize changes in

school placements; providing factors that must be considered when selecting a new school for a child; requiring children who enter out-of-home care or undergo changes in placement to remain with familiar child care providers or early education programs, if possible; providing requirements for transition plans for transitions between K-12 schools; requiring the department, in collaboration with the Quality Parenting Initiative, to develop a form for a specified purpose; specifying requirements for the form; requiring the department and community-based care lead agencies to document child and family team meetings and placement transition decisions in the Florida Safe Families Network and include such information in the social study report for judicial review; requiring the department to adopt rules; creating s. 39.5232, F.S.; providing legislative findings; defining terms; requiring the department to make reasonable efforts to place siblings in the same foster, kinship, adoptive, or guardianship home when certain conditions are met; requiring the department to take certain actions when siblings are not placed together; specifying that the department and court are not required to make a placement or change in placement to develop certain sibling relationships; requiring caseworkers to convene a child and family team meeting to determine and assess sibling relationships at the time a child is removed from a home; providing requirements for such child and family

teams and related meetings; requiring the department and community-based care lead agencies to document in writing decisions to separate siblings in case files and the Florida Safe Families Network; specifying requirements for such documentation; requiring caseworkers to convene a child and family team meeting when one child does not adjust to placement as a sibling group; requiring the child and family team to review such placement and choose a plan least detrimental to each child; requiring the department and community-based care lead agencies to periodically reassess certain sibling placements; requiring the department and community-based care lead agencies to determine specified factors when determining whether to move infants and young children to new placements under certain conditions; requiring that a child's transition to a new home be carried out gradually when it is determined that the child would benefit from being placed with siblings; requiring the department, in collaboration with the Quality Parenting Initiative, to develop standard protocols for caseworkers for use in making specified decisions about child placement; providing considerations for maintaining contact between siblings when separated; providing duties for caregivers; requiring the department to provide children with specified information relating to their siblings; requiring the department to make reasonable efforts to ascertain such information if it is not known; requiring the

department and community-based care lead agencies to convene a child and family team meeting under certain conditions; providing that a child has a right to continued communication with a sibling when the child's sibling is also in out-of-home care and such sibling leaves out-of-home care for any reason; authorizing the court to limit and restrict communication and visitation upon a finding of clear and convincing evidence that such communication or visitation is harmful to the child; requiring the court to direct the department to provide certain services; requiring the department to adopt rules; amending s. 39.806, F.S.; conforming a cross-reference; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 39.00146, Florida Statutes, is created to read:

39.00146 Case record face sheet.—

(1) As used in this section, the term:

(a) "Sibling" has the same meaning as in s. 39.5232(2).

(b) "Child and family team" means a team established as provided in s. 39.523(3).

(c) "Placement change" has the same meaning as in s. 39.5321(2).

(d) "School" has the same meaning as in s. 39.5321(2).

(2) The case record of every child under the supervision or in the custody of the department, the department's authorized

agents, or providers contracting with the department, including community-based care lead agencies and their subcontracted providers, must include a face sheet containing relevant information about the child and his or her case, including at least all of the following:

(a) General case information, including, but not limited to:

1. The child's name and date of birth;

2. The current county of residence and the county of residence at the time of the referral;

3. The reason for the referral and any family safety concerns;

4. The personal identifying information of the parents or legal custodians who had custody of the child at the time of the referral, including name, date of birth, and county of residence;

5. The date of removal from the home; and

6. The name and contact information of the attorneys assigned to the case in all capacities, including the attorney or attorneys that represent the department and the parents, and the guardian ad litem, if appointed to the child.

(b) The name and contact information for any employees of the department, the department's authorized agents, or providers contracting with the department, including community-based care lead agencies and their subcontracted providers, who have worked with the child, including the child's current and previous case managers, and the supervisor information for such employees.

(c) The personal information of relevant family members and other fictive kin, including, but not limited to, the name and

contact information of:

1. The child's parents;

2. Any siblings known at the time of the child's removal from the home, including the location of the current out-of-home placement, if applicable;

3. The child's current caregivers and any previous out-of-home placements;

4. Any other caretaking adults; and

5. All children in the out-of-home placement, if applicable.

(d) Information pertaining to recent and upcoming court hearings, including, but not limited to:

1. The date, subject matter, and county of court jurisdiction of the most recent court hearing; and

2. The date, subject matter, and county of court jurisdiction of the next scheduled court hearing.

(e) Contact information for persons and organizations currently providing services and support to the child.

(f) A description of any threats of danger placing the child at imminent risk of removal.

(g) A description of individual parent or caregiver concerns for the child.

(h) Any concerns that exist regarding the parent or the current caregiver's ability to:

1. Engage or bond with the child if the child is an infant;

2. Structure daily activities that stimulate the child;

3. Manage the child's behavior;

4. Maintain a safe home; or

5. Make good health decisions for the child.

(i) Any transitions in placement the child has experienced since the child's initial placement and a description of how such transitions were accomplished in accordance with s. 39.5321.

(j) Any other information the department, the department's authorized agents, or providers contracting with the department, including community-based care lead agencies and their subcontracted providers, deem relevant.

(3) The department, the department's authorized agents, or providers contracting with the department, including community-based care lead agencies and their subcontracted providers, must ensure that the face sheet for each case is updated at least once per month.

(4) The department shall adopt rules to implement this section.

Section 2. Section 39.522, Florida Statutes, is amended to read:

39.522 Postdisposition change of custody.—

(1) The court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing.

(2) ~~(1)~~ (a) At any time before a child is residing in the permanent placement approved at the permanency hearing, a child who has been placed in the child's own home under the protective supervision of an authorized agent of the department, in the home of a relative, in the home of a legal custodian, or in some other place may be brought before the court by the department or by any other interested person, upon the filing of a motion alleging a need for a change in the conditions of protective

supervision or the placement. If any party or the current caregiver denies ~~the parents or other legal custodians deny~~ the need for a change, the court shall hear all parties in person or by counsel, or both.

(b) Upon the admission of a need for a change or after such hearing, the court shall enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered. The standard for changing custody of the child shall be the best interests of the child. When determining whether a change of legal custody or placement is in the best interests of the child, the court shall consider:

1. The child's age.

2. The physical, mental, and emotional health benefits to the child by remaining in his or her current placement or moving to the proposed placement.

3. The stability and longevity of the child's current placement.

4. The established bonded relationship between the child and the current or proposed caregiver.

5. The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference.

6. The recommendation of the child's current caregiver.

7. The recommendation of the child's guardian ad litem, if one has been appointed.

8. The child's previous and current relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings, evaluated in accordance with s.

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39.5232.

9. The likelihood of the child attaining permanency in the current or proposed placement.

10. The likelihood that the child will have to change schools or day care placement, the impact of such a change, and the parties' recommendations as to the timing of the change.

11. The disruption of continuity of care with medical, mental health, dental, or other treatment services the child is receiving at the time of the change of custody decision.

12. The impact on activities that are important to the child, including the ability of the child to continue in such activities.

13. The impact on the child's future access to education, Medicaid, and independent living benefits.

14. The recommendations of the multidisciplinary team that developed a transition plan that is child-centered and created in accordance with s. 39.523.

15. Any other relevant factors.

(c) ~~(b)~~ If the child is not placed in foster care, the new placement for the child must meet the home study criteria and court approval under this chapter.

(3)(a) In a hearing on a change of legal custody conducted under subsection (2), there shall be a rebuttable presumption that it is in the child's best interest to remain permanently in the same safe and stable placement in which the child has been living continuously for the past 6 months if the court finds that:

1. Reunification is not a permanency option for the child;

2. The child has resided in the same out-of-home placement

for more than 6 months; and

3. The custodian of the child in the out-of-home placement requests and is eligible for consideration as an adoptive parent or a permanent custodian for the child.

(b) This presumption may not be rebutted solely by the expressed wishes of a biological parent, a biological relative, or a caregiver of a sibling of the child.

(c) In order to rebut the presumption established in paragraph (a), the court shall hold an evidentiary hearing and grant party status to the current caregiver who is seeking permanent custody and has maintained custody of that child for at least 6 continuous months. The court shall appoint a lawyer to represent the current caregiver, and the court shall appoint a lawyer for the child that is the subject of the permanent custody proceeding. As part of the evidentiary hearing, the court must consider competent and substantial evidence and testimony related to the factors enumerated in subsection (2) and any other evidence deemed relevant to a determination of placement, including evidence from a court-selected neutral and independent expert in the science and research of child-parent bonding and attachment.

(4) ~~(2)~~ In cases where the issue before the court is whether a child should be reunited with a parent, the court shall review the conditions for return and determine whether the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home with an in-home safety plan prepared or approved by the department will not be detrimental to the child's safety, well-being, and physical, mental, and

emotional health.

(5)~~(3)~~ In cases where the issue before the court is whether a child who is placed in the custody of a parent should be reunited with the other parent upon a finding that the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home of the other parent with an in-home safety plan prepared or approved by the department will not be detrimental to the child, the standard shall be that the safety, well-being, and physical, mental, and emotional health of the child would not be endangered by reunification and that reunification would be in the best interest of the child.

(6)~~(4)~~ In cases in which the issue before the court is whether to place a child in out-of-home care after the child was placed in the child's own home with an in-home safety plan or the child was reunified with a parent or caregiver with an in-home safety plan, the court must consider, at a minimum, the following factors in making its determination whether to place the child in out-of-home care:

(a) The circumstances that caused the child's dependency and other subsequently identified issues.

(b) The length of time the child has been placed in the home with an in-home safety plan.

(c) The parent's or caregiver's current level of protective capacities.

(d) The level of increase, if any, in the parent's or caregiver's protective capacities since the child's placement in the home based on the length of time the child has been placed in the home.

The court shall additionally evaluate the child's permanency goal and change the permanency goal as needed if doing so would be in the best interests of the child. If the court changes the permanency goal, the case plan must be amended pursuant to s. 39.6013(5).

Section 3. Section 39.523, Florida Statutes, is amended to read:

39.523 Placement in out-of-home care; child and family teams; child and family team meetings.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that it is a basic tenet of child welfare practice and the law that a child be placed in the least restrictive, most family-like setting available in close proximity to the home of his or her parents which meets the needs of the child, and that a child be placed in a permanent home in a timely manner.

(b) The Legislature ~~also~~ finds that there is an association between placements that do not meet the needs of the child and adverse outcomes for the child, that mismatching placements to children's needs has been identified as a factor that negatively impacts placement stability, and that identifying the right placement for each child requires effective assessment.

(c) The Legislature finds that effective assessment is particularly important for young children who are 3 years of age or younger as evidenced by research on the science of attachment and brain development. Such research shows that a stable and nurturing relationship in the first years of life, as well as the quality of such relationships, shape a person's brain

development, provide a foundation for lifelong mental health, and determine well-being as an adult.

(d) The Legislature also finds that there is an increasing body of evidence showing that services for children and families are most effective when delivered in the context of a single, integrated child and family team that includes the child, his or her family, natural and community supports, and professionals who join together to empower, motivate, and strengthen a family and collaboratively develop a plan of care and protection to achieve child safety, child permanency, and child and family well-being.

(e) It is the intent of the Legislature that whenever a child is unable to safely remain at home with a parent, the most appropriate available out-of-home placement shall be chosen after an assessment of the child's needs and the availability of caregivers qualified to meet the child's needs.

(2) PLACEMENT PRIORITY.—

(a) When a child cannot safely remain at home with a parent, out-of-home placement options must be considered in the following order:

1. Relative caregiver.

2. Non-relative caregivers with a close relationship to the child.

3. Licensed foster care.

4. Group or congregate care.

(b) Sibling groups must be placed in the same placement whenever possible and if placement together is in the best interest of each of the children. Placement decisions for sibling groups must be made pursuant to s. 39.5232.

(3) CHILD AND FAMILY TEAMS.—

(a) Child and family team meetings must be held when an important decision has to be made about the child's life. The purpose of the use of child and family team meetings is to allow better engagement with families and a shared commitment and accountability from the family and their circle of support. Effective team processes support and encourage family members to invite the participation of individuals who are part of the family's own network of informal support to collaborate with formal professionals who support the family. Such collaboration is necessary to make the most informed decision possible for the child.

(b) A diverse team is preferable to ensure that the necessary combination of technical skills, cultural knowledge, community resources, and personal relationships is developed and maintained for the child and family. The participants necessary to achieve an appropriately diverse team for a child may vary by child and may include extended family, friends, neighbors, coaches, clergy, coworkers, or others the family identifies as a potential source of support.

(c) To achieve a diverse team of informal and formal family supports for the child, the child and family teams:

1. Must always include:

a. The child;

b. The child's family members and other individuals identified by the family as being important;

c. The current caregiver;

d. A representative from the department;

e. The case manager for the child; and

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f. A therapist or other behavioral health professional, when applicable.

2. May also include other professionals, including, but not limited to:

a. A representative from Children's Medical Services;

b. A guardian ad litem, if appointed;

c. A school personnel representative who has direct contact with the child; or

d. Other community providers of services to the child or stakeholders, when applicable.

3. Must be led by a trained, skilled facilitator to maintain a safe environment by acting as a neutral team member. The facilitator's main responsibility is to help team members use the strengths within the family to develop a safe plan for the child. The plan must then be approved by the team members.

(d) 1. The child and family must always be the primary focus of each child and family team meeting.

2. Based on the particular goal of the child and family team meeting, the case manager may determine which individuals listed under subparagraph (c)2. are necessary for the particular meeting.

3. The case manager shall make every effort to engage extended family and community-based informal supports who are able to continue helping the family after the department is no longer involved.

(e) Child and family team meetings must be structured to accomplish the stated goal of the meeting and must always ensure that the goal:

1. Secures a child's safety in the least restrictive and

intrusive placement that can meet his or her needs;

2. Minimizes the trauma associated with separation from the child's family and helps the child to maintain meaningful connections with family members and others who are important to him or her;

3. Provides input into the placement decision made by the community-based care lead agency and the services to be provided in order to support the child;

4. Provides input into the decision to preserve or maintain the placement, including necessary placement preservation strategies;

5. Contributes to an ongoing assessment of the child and the family's strengths and needs;

6. Ensures that plans are monitored for progress and that such plans are revised or updated as the child's or family's circumstances change; and

7. Facilitates the timely achievement of permanency for the child.

(4) ASSESSMENT AND PLACEMENT.—When any child is removed from a home and placed in ~~into~~ out-of-home care, a comprehensive placement assessment process shall be completed to determine the level of care needed by the child and match the child with the most appropriate placement.

(a) The community-based care lead agency or subcontracted agency with the responsibility for assessment and placement must coordinate a child and family ~~multidisciplinary~~ team meeting ~~staffing~~ with any available individual currently involved with the child, including, but not limited to, persons enumerated in paragraph (3)(c) ~~a representative from the department and the~~

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~~case manager for the child; a therapist, attorney ad litem, guardian ad litem, teachers, coaches, Children's Medical Services; and other community providers of services to the child or stakeholders as applicable. The team may also include clergy, relatives, and fictive kin if appropriate~~. Team participants must gather data and information on the child which is known at the time including, but not limited to:

1. Mental, medical, behavioral health, and medication history;

2. Community ties and school placement;

3. Current placement decisions relating to any siblings;

4. Alleged type of abuse or neglect including sexual abuse and trafficking history; and

5. The child's age, maturity, strengths, hobbies or activities, and the child's preference for placement.

(b) The comprehensive placement assessment process may also include the use of an assessment instrument or tool that is best suited for the individual child.

(c) The formation of a child and family team must begin as soon as possible when the child is removed from the home. A child and family team must include collaboration with services providers to ensure that the appropriate services are well-coordinated upon removal and placement in out-of-home care. Team meetings may not be delayed to accommodate pending behavioral health screenings or assessments or pending referrals for services.

(d) The child and family team must conduct a supplemental assessment for children 3 years of age or younger. Team participants must gather data and information on the child which

is known at the time, including, but not limited, to:

1. Identified kin and relatives who express interest in caring for the child, including strategies to overcome potential delays in placing the child with such persons if they are suitable.

2. The likelihood that the child can remain with the prospective caregiver past the point of initial removal and the willingness of the caregiver to provide care for any duration deemed necessary.

3. The prospective caregiver's ability and willingness to:

a. Accept supports related to early childhood development and services addressing any possible developmental delays;

b. Address the emotional needs of the child and accept infant mental health supports, if needed;

c. Help nurture the child during the transition into out-of-home care;

d. Work with the parent to build or maintain the attachment relationship between parent and child;

e. Effectively co-parent with the parent; and

f. Ensure frequent family visits.

(e) The most appropriate available out-of-home placement shall be chosen after consideration by all members of the child and family ~~multidisciplinary~~ team of all of the information and data gathered, including the results and recommendations of any evaluations conducted.

(f) ~~(d)~~ Placement decisions for each child in out-of-home placement shall be reviewed as often as necessary to ensure permanency for that child and address special issues related to this population of children.

(g) ~~(e)~~ The department, a sheriff's office acting under s. 39.3065, a community-based care lead agency, or a case management organization must document all placement assessments and placement decisions in the Florida Safe Families Network.

(h) ~~(f)~~ If it is determined during the comprehensive placement assessment process that residential treatment as defined in s. 39.407 would be suitable for the child, the procedures in that section must be followed.

(i) Notwithstanding any other provision of law, the department may discuss confidential information during the child and family team meeting in the presence of individuals who participate in the meeting. Information collected by any agency or entity that participates in the child and family team meeting which is confidential and exempt upon collection remains confidential and exempt when discussed in meetings required under this section. All individuals who participate in the meeting shall maintain the confidentiality of all information shared during the meeting.

(5) ~~(3)~~ JUDICIAL REVIEW.—At each judicial review, the court shall consider the results of the assessment, the placement decision made for the child, and services provided to the child as required under s. 39.701.

(6) ~~(4)~~ DATA COLLECTION.—The department shall collect the following information by community-based care lead agencies and post it on the Department of Children and Families' website. The information is to be updated on January 1 and July 1 of each year.

(a) The number of children placed with relatives and nonrelatives, in family foster homes, and in residential group

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care.

(b) An inventory of available services that are necessary to maintain children in the least restrictive setting that meets the needs of the child and a plan for filling any identified gap in those services.

(c) The number of children who were placed based upon the assessment.

(d) An inventory of existing placements for children by type and by community-based care lead agency.

(e) The strategies being used by community-based care lead agencies to recruit, train, and support an adequate number of families to provide home-based family care.

(7) ~~(5)~~ RULEMAKING.—The department shall ~~may~~ adopt rules to implement this section.

Section 4. Section 39.5321, Florida Statutes, is created to read:

39.5321 Placement and education transitions.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that many children in out-of-home care have experienced multiple changes in placement, and those transitions often result in trauma not only for the child, but also for caregivers, families, siblings, and all professionals involved.

(b) The Legislature further finds that poorly planned and executed or improperly timed transitions may adversely impact a child's healthy development as well as the child's continuing capacity to trust, attach to others, and build relationships in the future.

(c) The Legislature finds that the best child welfare

practices recognize the need to prioritize the minimization of the number of placements for every child in out-of-home care. Further, the Legislature finds that efforts must be made to support caregivers in order to promote stability. When placement changes are necessary, they must be thoughtfully planned.

(d) The Legislature finds that transition plans are critical when moving all children, including infants, toddlers, school-age children, adolescents, and young adults.

(e) It is the intent of the Legislature that a placement change or an educational change for a child in out-of-home care be achieved ideally through a period of transition that is unique to each child, provides support for all individuals affected by the change, and has flexible planning to allow for changes necessary to meet the needs of the child.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Educational change" means any time a child is moved between schools which is not the result of the natural transition from elementary school to middle school or middle school to high school. The term also includes changes in child care or early education programs for infants and toddlers.

(b) "Emergency situation" means that there is an imminent risk to the health or safety of the child, other children, or others in the home or facility if the child remains in the placement.

(c) "Placement change" means any time a child is moved from one caregiver to another, including moves to a foster home, a group home, relatives, prospective guardians, prospective adoptive parents, and reunification with parents. The term also includes moves between rooms and buildings operated by a group

home provider.

(d) "School" means any child care, early education, elementary, secondary, or postsecondary educational setting.

(3) PLACEMENT TRANSITIONS.—

(a) *Mandatory transition plans.*—An individualized transition plan must be created and implemented for each placement change.

(b) *Minimizing placement transitions.*—Once a caregiver accepts the responsibility of caring for a child, the child may be removed from the home of the caregiver only if:

1. The caregiver is clearly unable to safely or legally care for the child;

2. The child and the birth or legal parent are reunified;

3. The child is being placed in a legally permanent home in accordance with a case plan or court order; or

4. The removal is demonstrably in the best interests of the child.

(c) *Services to prevent disruption.*—The community-based care lead agency shall provide any supportive services deemed necessary to a caregiver and a child if such child's current out-of-home placement with the caregiver is in danger of needing modification. The supportive services must be offered in an effort to remedy the factors contributing to the placement being considered unsuitable and therefore contributing to the need for a change in placement.

(d) *Transition planning when there is no emergency situation.*—

1. If the supportive services provided to the caregiver or child pursuant to paragraph (c) have not been successful to make

the maintenance of the placement suitable or if there are other circumstances that require the child to be moved, the department or the community-based care lead agency must coordinate a child and family team meeting as required under s. 39.523(3) for the specific purpose of developing an appropriate transition plan for the change in placement.

2. At least 14 days before moving a child from one out-of-home placement to another, the department or the community-based care lead agency must provide notice of the planned move and must include in the notice the reason a placement change is necessary. A copy of the notice must be filed with the court and be provided to the:

a. Child;

b. Child's parents, unless prohibited by court order;

c. Child's out-of-home caregivers;

d. Guardian ad litem, if appointed to the child; and

e. Attorney for the department.

3. The transition plan must be developed through cooperation among the persons included in subparagraph 2., and such persons must share any relevant information necessary to ensure that the transition plan does all of the following:

a. Respects the child's developmental stage and psychological needs.

b. Ensures the child has all of his or her belongings and is allowed to help pack those belongings when appropriate.

c. Allows for a gradual transition from the current caregiver's home with substantial overlap between the two caregivers and provides time for the child to have a final visitation with everyone important to the child from the current

placement, including pets.

d. Allows, when possible, for continued contact with the previous caregiver and others in the home after the child leaves.

e. Prohibits a change in placement that occurs between 7 p.m. and 8 a.m.

4. The department or the community-based care lead agency shall file the transition plan with the court within 48 hours after the creation of such plan and provide a copy of the plan to the persons included in subparagraph 2.

(e) *Transition planning in an emergency situation.*—

1. In an emergency situation, a placement change may be made immediately.

2. If a child and family team meeting required under s. 39.523(3) cannot be held before the child is moved, such meeting must be convened within 72 hours of the immediate change in placement for the specific purpose of developing a transition plan to minimize the impact of the placement change on the child.

3. Within 72 hours after a placement change due to an emergency situation, the department or the community-based care lead agency shall provide notice of the emergency placement change and shall include in the notice the reason the placement change was necessary. A copy of the notice must be filed with the court and be provided to the persons included in subparagraph (d)2.

4. The transition plan must involve cooperation and information sharing among the persons included in subparagraph (d)2., and such persons must share any relevant information that

ensures the transition plan does all of the following:

a. Respects the child's developmental stage and psychological needs.

b. Ensures the child has all of his or her belongings.

c. Provides the opportunity for the child to have a final visitation with everyone important to the child, including pets.

d. Allows, if possible, for continued contact with the previous caregiver and others in the home after the child leaves.

5. The department or the community-based care lead agency shall file the transition plan with the court within 48 hours after the creation of such plan and provide a copy of the plan to the persons included in subparagraph (d)2.

(f) *Preparation of prospective caregivers before placement.*—

1. Prospective caregivers must be fully informed of the child's needs and circumstances and be willing and able to accept responsibility for providing high-quality care for such needs and circumstances before placement.

2. The community-based care lead agency shall review with the prospective caregiver the caregivers' roles and responsibilities according to the parenting partnerships plan for children in out-of-home care pursuant to s. 409.1415. The case manager shall sign a copy of the parenting partnerships plan and obtain the signature of the prospective caregiver acknowledging explanation of the requirements before placement.

(g) *Additional considerations for transitions of infants and children under school age.*—Relationship patterns over the first year of life are important predictors of future

relationships. Research demonstrates that babies begin to form a strong attachment to a caregiver at approximately 7 months of age. From that period of time through age 2, moving a child from the caregiver who is the psychological parent is considerably more damaging. Placement decisions must focus on promoting security and continuity for infants and children under 5 years of age in out-of-home care. Transition plans for infants and young children must describe the facts that were considered when each of the following were discussed and must specify what decision was made as to how each of the following applies to the child:

1. The age of the child and the child's current ability to accomplish developmental tasks, with consideration made for whether the child is:

a. Six months of age or younger, thereby indicating that it may be in the child's best interest to move the child sooner rather than later; or

b. One year to 2 years of age, thereby indicating it may not be a healthy time to move the child.

2. The length of time the child has lived with the current caregiver, the strength of attachment to the current caregiver, and the harm of disrupting a healthy attachment compared to the possible advantage of a change in placement.

3. The relationship, if any, the child has with the new caregiver and whether a reciprocal agreement exists between the current caregiver and the prospective caregiver to maintain the relationship with both caregivers.

4. The pace of the transition and whether flexibility exists to accelerate or slow down the transition based on the

needs and reactions of the child.

(4) EDUCATION TRANSITIONS.—

(a) *Findings.*—Children in out-of-home care frequently change child care, early education programs, and schools. These changes can occur when the child first enters out-of-home care, when the child must move from one caregiver to another, or when the child returns home upon reunification. Research shows that children who change schools frequently make less academic progress than their peers and fall further behind with each school change. Additionally, educational instability at any level makes it difficult for children to develop supportive relationships with teachers or peers. State and federal law contain requirements that must be adhered to in order to ensure educational stability for a child in out-of-home care. A child's educational setting should only be changed when maintaining the educational setting is not in the best interest of the child. An individualized transition plan must be created and implemented for every school change.

(b) *Minimizing school changes.*—

1. Every effort must be made to keep a child in the school of origin. Any placement decision must include thoughtful consideration of which school a child will attend if a school change is necessary.

2. A determination that it is not the child's best interest to remain in the school of origin and which school the child will attend in the future must be made in consultation with the child, parents, caregivers, child welfare professional, guardian ad litem, educational surrogate, child care and educational staff, including teachers and guidance counselors, and school

district representative or foster care liaison.

3. If a determination is made that remaining in the school or program of origin is not in the child's best interest, selection of a new school must consider relevant factors, including, but not limited to:

a. The child's desire to remain in the school or program of origin.

b. The preference of any of the child's parents or legal guardians.

c. Whether the child has siblings, close friends, or mentors at the school or program of origin.

d. The child's cultural and community connections in the school or program of origin.

e. Whether the child is suspected of having a disability under the Individuals with Disabilities Education Act (IDEA) or s. 504 of the Rehabilitation Act of 1973, or has begun receiving interventions under this state's multitiered system of supports.

f. Whether the child has an evaluation pending for special education and related services under IDEA or s. 504 of the Rehabilitation Act of 1973.

g. Whether the child is a student with a disability under IDEA who is receiving special education and related services or a student with a disability under s. 504 of the Rehabilitation Act of 1973 who is receiving accommodations and services and, if so, whether those required services are available in a school or program other than the school or program of origin.

h. Whether the child is an English Language Learner student and is receiving language services, and, if so, whether those required services are available in a school or program other

than the school or program of origin.

i. The impact a change to the school or program of origin would have on academic credits and progress toward promotion.

j. The availability of extracurricular activities important to the child.

k. The child's known individualized educational plan or other medical and behavioral health needs and whether such plan or needs are able to be met at a school or program other than the school or program of origin.

l. The child's permanency goal and timeframe for achieving permanency.

m. The child's history of school transfers and how such transfers have impacted the child academically, emotionally, and behaviorally.

n. The length of the commute to the school or program and how it would impact the child.

o. The length of time the child has attended the school or program of origin.

4. The cost of transportation cannot be a factor in making the best interest determination.

(c) *Transitions between child care and early education programs.*—When a child enters out-of-home care or undergoes a change in placement, the child shall, if possible, remain with the familiar child care provider or early education program unless there is an opportunity to transition to a higher quality program. If it is not possible for the child to remain with the familiar child care provider or early education program or transition to a higher quality program, the child's transition plan must be made with the participation of the child's current

and future school or program. The plan must give the child an opportunity to say goodbye to important figures in the educational environment.

(d) *Transitions between K-12 schools.*—The transition plan for a transition between K-12 schools must include all of the following:

1. Documentation that the department or community-based care lead agency has made the decision to change the child's school in accordance with paragraph (3)(b). The plan must include a detailed discussion of all factors considered in reaching the decision to change the child's school.

2. Documentation that the department or community-based care lead agency has coordinated with local educational agencies to provide immediate and appropriate enrollment in a new school, including transfer of educational records, record of a school-entry health examination, and arrangements for transportation to the new school.

3. Discussion of the timing of the proposed school change which addresses the potential impact on the child's education and extracurricular activities. This section must include, at a minimum, grading periods, exam schedules, credit acquisitions, sports eligibility, and extracurricular participation.

4. Details concerning the transportation of the child to school.

(5) TRANSITION PLAN AND DOCUMENTATION.—

(a) The department, in collaboration with the Quality Parenting Initiative, shall develop a form to be completed and updated each time a child in out-of-home care is moved from one placement to another. The updated form must be attached to the

case record face sheet required to be included in the case file pursuant to s. 39.00146.

(b) The form must be used statewide and, at a minimum, must include all of the following information:

1. The membership of the child and family team convened to develop a transition plan for the change in placement and the dates the team met.

2. The name of the professional facilitator of the child and family team meeting.

3. The topics considered by the child and family team in order to ensure an appropriate transition.

4. The recommendations of the child and family team and the name of each individual or entity responsible for carrying out each recommendation.

(c) The department or the community-based care lead agency shall document all child and family team meetings and placement transition decisions in the Florida Safe Families Network and must include the information in the social study report for judicial review, as required under s. 39.701.

(6) RULEMAKING.—The department shall adopt rules to implement this section.

Section 5. Section 39.5232, Florida Statutes, is created to read:

39.5232 Placement of siblings; visitation; continuing contact.—

(1) LEGISLATIVE FINDINGS.—

(a) The Legislature finds that sibling relationships can provide a significant source of continuity throughout a child's life and are likely to be the longest relationships that most

individuals experience. Further, the Legislature finds that the placement of siblings together can increase the likelihood of achieving permanency and is associated with a significantly higher rate of family reunification.

(b) The Legislature also finds that healthy connections with siblings can serve as a protective factor for children who have been placed in out-of-home care, but for a variety of reasons, siblings may not be placed together or may not have regular contact.

(c) The Legislature finds that it is beneficial for a child who is placed in out-of-home care to be able to continue existing relationships with his or her siblings, regardless of age, so that they may share their strengths and association in their everyday and often common experiences.

(d) The Legislature also finds that it is the responsibility of all entities and adults involved in a child's life to seek opportunities to foster existing sibling relationships to promote continuity and help to sustain family connections, including, but not limited to, the department, community-based lead agencies, parents, foster parents, guardians ad litem, next of kin, and other persons important to the child.

(e) While there is a presumption in law and policy that it is in the best interest of a child going into foster care to be placed with any siblings, the Legislature finds that the importance of prioritizing placement decisions that continue healthy existing sibling relationships may be different than prioritizing a sibling relationship over a healthy existing bond with a caregiver when there is not an existing bond between the

siblings being evaluated for placement or in which the bond that exists between the siblings is not healthy for all children of that sibling group.

(f) The Legislature finds that demographic and situational factors may present challenges for agencies to place siblings together and that child protective investigators and caseworkers should be aware of such factors to ensure that these are not the sole reasons for siblings being unable to be placed together.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Child and family team" means the team established in s. 39.523(3).

(b) "Sibling" means:

1. A child who shares a birth parent or legal parent with one or more other children; or

2. A child who has lived together in a family with one or more other children whom he or she identifies as siblings.

(3) PLACEMENT OF SIBLINGS IN OUT-OF-HOME CARE.—

(a) *General provisions.*—

1. Notwithstanding any other provision of law, the department shall make reasonable efforts to place siblings who have an existing relationship and are removed from their home in the same foster, kinship, adoptive, or guardianship home, when it is in the best interest of each sibling and when an appropriate, capable, and willing joint placement for the sibling group is available.

2. If siblings are not placed together, the department must document in writing in the file and in the case record face sheet required to be included in the case file pursuant to s. 39.00146 the reasons joint placement was not able to occur and

the reasonable efforts the department will make to provide frequent visitation or other ongoing interaction between the siblings. Such interaction is not required if there is a determination that the interaction would be contrary to a sibling's safety or well-being. This determination must also be documented in the case file and the case record face sheet.

3. The department and the court are not required to make a placement or change in placement to develop a relationship between siblings which did not exist at the time a child is placed in out-of-home care.

(b) *Factors to consider when placing sibling groups.*—

1. At the time a child is removed from the home, the assigned caseworker shall convene a child and family team meeting to determine and assess the sibling relationships from the perspective of each child to ensure the best placement of each child in the sibling group. The child and family team shall consider the existing emotional ties between and among the siblings and the degree of harm each child is likely to experience as a result of separation. Mental health professionals with expertise in sibling bonding must be included in a child and family team meeting convened for the purpose of deciding the placement of a sibling group.

2. The department or the community-based care lead agency must document in writing any decision to separate siblings in the case file as required in paragraph (a) and document the decision in the Florida Safe Families Network. The documentation must include the efforts made to keep the siblings together, an assessment of the short-term and long-term effects of separation on each child and the sibling group as a whole, and a

description of the plan for communication or contact between the children if separation is approved.

3. If, after placement as a sibling group, one child does not adjust to the placement, the caseworker must convene a child and family team meeting to determine what is best for all of the children. The child and family team shall review the current placement of the sibling group and choose a plan that will be least detrimental to each child.

4. The department and the community-based care lead agencies shall periodically reassess sibling placement, visitation, and other sibling contact decisions in cases where siblings are separated, not visiting, or not maintaining contact to determine if a change in placement is warranted.

(c) *Additional factors to consider when placing sibling groups of infants and young children.*—The practice of placing siblings who are removed from the primary home and placed into out-of-home care together has been adopted as best practice by the child welfare system. In some instances, the placement of siblings together occurs at the time the children enter foster care. However, at other times, a child is born after his or her siblings are already in out-of-home care. A newborn infant may or may not enter care upon birth even when an older sibling is in out-of-home care. If the infant enters out-of-home care, he or she may be placed in a home separately from any siblings. The infant might begin life without developing a relationship with his or her siblings. Even if the newborn infant is not immediately placed into out-of-home care when his or her siblings are in such care, the young child may not develop a relationship with his or her siblings who are in out-of-home

care. If the infant or young child is then removed from the parent's care and placed in out-of-home care into a loving and nurturing home, the infant or young child will begin to develop a secure attachment relationship with his or her caregivers. If the policy of placing siblings together is uniformly followed without consideration of an existing attachment bond or the consideration of the individual infant's or young child's needs, disruption from the primary attachment figure might occur to place the infant or young child with siblings and a caregiver he or she does not know. Therefore, when consideration is being given to determine whether to move an infant or young child from the current placement to a new placement when such change is initiated by a sibling relationship that does not currently exist, the department or community-based lead agency must consider all of the following additional factors:

1. The presence and quality of current attachment relationships, including:

a. The quality and length of the attachment to the current and potential caregiver;

b. The age of the child at placement with the current caregiver and the child's current age;

c. The ease with which the child is attached to the current family;

d. Any indications of attachment difficulty in the child's history; and

e. The number of moves and number of caregivers the child has experienced.

2. The potential of the new caregiver to be a primary attachment figure to the infant by ensuring care for the child's

physical needs and being willing and available to meet the child's emotional needs.

3. The quality of sibling relationships between the child's other siblings and the potential quality of the sibling relationship that can be formed between the child and his or her siblings.

4. The consideration of any costs and benefits of disrupting existing emotional attachments to the primary caregiver to place a child in a new placement with his or her siblings, including the:

a. Length and quality of the established and current primary attachment relationships;

b. Relationships between the child's other siblings and whether such relationships appear adequate and not stressful or harmful; and

c. Length and quality of the established and current primary attachment relationships between the siblings and the sibling's current caregiver.

5. The ability to establish and maintain sibling visitation and contact in a manner and schedule that makes sense for the infant or young child if it is determined that the infant or young child is to remain with the primary caregivers rather than be placed with his or her siblings.

(d) *Transitioning a child after a determination.*—If after considering the provisions and factors described in paragraphs (a), (b), and (c) it is determined that the child would benefit from being placed with his or her siblings, it is essential that the transition to the new home be carried out gradually in accordance with s. 39.5321.

(e) *Standards for evaluating sibling placements.*—The department, in collaboration with the Quality Parenting Initiative, must develop standard protocols for caseworkers which incorporate the provisions and factors described in paragraphs (a), (b), and (c) and any other factors deemed relevant for use in making decisions about when it would be contrary to a child's well-being or safety to place siblings together or provide for frequent visitation.

(4) MAINTAINING CONTACT WHEN SIBLINGS ARE SEPARATED.—Regular contact among a sibling group that cannot be placed together, especially amongst sibling groups that have existing attachments to each other, is critical for the sibling group to maintain the existing bonds and relationships. Caregivers and professionals play an important role in facilitating contact between siblings and it is important for caseworkers to address any caregiver concerns and promote the benefits of sibling contact. The following practices must be considered to help maintain or strengthen relationships among separated siblings:

(a) Placement with kinship caregivers who have an established personal relationship with each child so that even when siblings cannot be placed together in the same home the relatives are more likely to facilitate contact.

(b) Placement of siblings geographically near each other, such as in the same neighborhood or school district, to make it easier for the siblings to see each other regularly.

(c) If the siblings choose to do so, frequent and regular visitation to be actively involved in each other's lives and to participate in celebrations, including, but not limited to, birthdays, graduations, holidays, school and extracurricular

activities, cultural customs, and other milestones.

(d) Utilization of other forms of contact when regular in-person meetings are not possible or are not sufficient to meet the needs or desires of the siblings, such as maintaining frequent contact through letters, e-mail, social media, cards, or telephone calls.

(e) Coordination of joint outings or summer or weekend camp experiences to facilitate time together, including, but not limited to, activities or camps specifically designed for siblings in out-of-home care.

(f) Utilization of joint respite care to assist the caregivers who are caring for separated siblings to have needed breaks while also facilitating contact among the siblings, including, but not limited to, providing babysitting or respite care for each other.

(g) Prohibition on withholding communication or visitation among the siblings as a form of punishment.

(5) ADDITIONAL REQUIREMENTS AND CONSIDERATIONS.—

(a) A caregiver shall respect and support the child's ties to his or her birth or legal family, including parents, siblings, and extended family members, and shall assist the child in maintaining allowable visitation and other forms of communication. The department and community-based care lead agency shall provide a caregiver with the information, guidance, training, and support necessary for fulfilling this responsibility.

(b) The department shall promptly provide a child as to the location of and contact information for his or her siblings. If the existence or location of or contact information for a

child's siblings is not known, the department must make reasonable efforts to ascertain such information.

(c) If it becomes known that a child in out-of-home care has a sibling of whom the child was previously unaware, the department or community-based care lead agency must convene a child and family team meeting within a reasonable amount of time of the discovery of such sibling to decide if the current placement or permanency plan requires modification.

(d) If a child's sibling is also in out-of-home care and such sibling leaves out-of-home care for any reason, including, but not limited to, emancipation, adoption, or reunification with his or her parent or guardian, the child has a right to continued communication with his or her sibling as provided under this subsection.

(e) The court may limit or restrict communication or visitation under this subsection only upon a finding by clear and convincing evidence that the communication or visitation is harmful to the child. If the court makes such a finding, it must direct the department to immediately provide services to ameliorate the harm so that communication and visitation may be restored as soon as possible.

(6) RULEMAKING AUTHORITY.—The department shall adopt rules to implement this section.

Section 6. Paragraph (e) of subsection (1) of section 39.806, Florida Statutes, is amended to read:

39.806 Grounds for termination of parental rights.—

(1) Grounds for the termination of parental rights may be established under any of the following circumstances:

(e) When a child has been adjudicated dependent, a case

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

plan has been filed with the court, and:

1. The child continues to be abused, neglected, or abandoned by the parent or parents. The failure of the parent or parents to substantially comply with the case plan for a period of 12 months after an adjudication of the child as a dependent child or the child's placement into shelter care, whichever occurs first, constitutes evidence of continuing abuse, neglect, or abandonment unless the failure to substantially comply with the case plan was due to the parent's lack of financial resources or to the failure of the department to make reasonable efforts to reunify the parent and child. The 12-month period begins to run only after the child's placement into shelter care or the entry of a disposition order placing the custody of the child with the department or a person other than the parent and the court's approval of a case plan having the goal of reunification with the parent, whichever occurs first; or

2. The parent or parents have materially breached the case plan by their action or inaction. Time is of the essence for permanency of children in the dependency system. In order to prove the parent or parents have materially breached the case plan, the court must find by clear and convincing evidence that the parent or parents are unlikely or unable to substantially comply with the case plan before time to comply with the case plan expires.

3. The child has been in care for any 12 of the last 22 months and the parents have not substantially complied with the case plan so as to permit reunification under s. 39.522(4) ~~s. 39.522(2)~~ unless the failure to substantially comply with the case plan was due to the parent's lack of financial resources or

to the failure of the department to make reasonable efforts to reunify the parent and child.

Section 7. This act shall take effect October 1, 2021.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SB 80
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Tuesday, February 16, 2021
TIME: 9:00—11:30 a.m.
PLACE: 37 Senate Building

FINAL VOTE			2/16/2021 1 Brodeur					
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Brodeur						
X		Garcia						
X		Harrell						
X		Rouson						
X		Torres						
X		Wright						
X		Albritton, VICE CHAIR						
X		Book, CHAIR						
8	0	**TOTALS**	RCS	-				
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

2021 AGENCY LEGISLATIVE BILL ANALYSIS
Department of Children and Families

BILL INFORMATION	
BILL NUMBER:	SB 80
BILL TITLE:	**Child Welfare**
BILL SPONSOR:	**Senator Brodeur**
EFFECTIVE DATE:	October 1, 2021

COMMITTEES OF REFERENCE
1) Children, Families, and Elder Affairs
2) Judiciary
3) Rules
4)
5)

CURRENT COMMITTEE
Children, Families, and Elder Affairs

SIMILAR BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

PREVIOUS LEGISLATION	
BILL NUMBER:	N/A
SPONSOR:	N/A
YEAR:	N/A
LAST ACTION:	N/A

IDENTICAL BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

Is this bill part of an agency package?
No.

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	February 2, 2021
LEAD AGENCY ANALYST:	Vanessa Snoddy, OCW Stephanie Zimmerman, CLS
ADDITIONAL ANALYST(S):	Jessica Johnson, OCW Courtney Smith, OCW
LEGAL ANALYST:	Stefanie Camfield, OGC
FISCAL ANALYST:	Sue Zwirz, Budget

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 80 requires the case record of every child under the supervision or in the custody of the Department of Children and Families (Department), the Department's agents, or providers contracting with the Department to include a case record face sheet. It revises criteria for the court to consider when determining whether a legal change of placement is in the best interests of the child, provides for priority placements for a child who must be placed in out-of-home care, and requires the Department to make reasonable efforts to place siblings in the same foster, kinship, adoptive, or guardianship home when certain conditions are met. Additionally, the bill requires the creation of a specified child and family team with certain composition and duties. It outlines new processes for placement transitions, provides the Department rulemaking authority, and other conforming changes.

2. SUBSTANTIVE BILL ANALYSIS

PRESENT SITUATION

Section 1 - s. 39.00146, F.S., - Case record face sheet. -

The Florida Safe Families Network (FSFN) application is designed and developed to meet the State of Florida's requirements for a child welfare system and meet Federal reporting requirements for child protection, foster care and adoption. The FSFN application automates casework practice and integrates client, service, financial, and provider data to provide child welfare professionals and administrators with information to protect children, help families, and manage child welfare programs.

There are many statutes and rules that detail the information that is required to be documented in the case record of every child:

- Section 39.00145, F.S., outlines the information that must be contained in the case record of every child under the supervision of or in the custody of the Department and outlines who may have access to the case record. The case record must contain, at a minimum, the child's case plan and the full name and street address of all shelters, foster parents, group homes, treatment facilities, or locations where the child has been placed. Records in the child case record must be made available upon request to the child who is the subject of the case record and to the child's caregiver, guardian ad litem, or attorney (at no cost). Caregivers are limited to parents, legal custodians, permanent guardians, or foster parents; employees of a residential home, institution, facility, or agency at which the child resides; and other individuals legally responsible for a child's welfare in a residential setting. If a court determines that sharing information in the child's case record is necessary to ensure access to appropriate services for the child or for the safety of the child, the court may approve the release of confidential records or information contained in them.
- Public records law, s. 119.10, F.S., outlines sanctions and penalties for a Department employee if he or she denies access to a child's case record after a request by a child or the child's caregiver, guardian ad litem, or attorney.
- Section 409.996(1)(c), F.S., requires the lead agency to furnish current and accurate information on its activities in all cases in client case records in the state's statewide automated child welfare information system, which in practice is the FSFN. In addition to lead agencies, their subcontracted providers, child protective investigators employed by the Department and by contracted sheriff's offices, and attorneys for the Department enter current and accurate information of their activities into children's records in FSFN.
- Rule 65C-28.003, F.A.C., requires the Department to document the child's medical care and treatment in the child's case record in FSFN and in the resource record that is provided to each caregiver at time of placement.
- Rule 65C-28.004, F.A.C., requires all licensed caregivers to be provided with the child's resource record, which must be maintained and updated by the licensed care giver. The following documents must be placed in the child's record.
    1. Medical, dental, psychological, psychiatric and behavioral history.
    2. Copies of documentation regarding all on-going medical, dental, psychological, psychiatric and behavioral services, including child health check-ups provided through Medicaid.
    3. Parental consent for treatment or court order.
    4. Copy of the Medicaid card.
    5. Copy of the Shelter Order.
    6. Copy of the court order or "Voluntary Placement Agreement" placing or accepting the child into out-of-home care.
    7. Copy of the Case Plan.

8. Copy of the most recent Judicial Review Social Study Report.
9. All available school records.
10. An envelope for storing pictures.
11. The most recent photograph available.
12. Copy of the child's birth certificate or birth verification certified by the Office of Vital Statistics, as appropriate.
13. Documentation of immigration status, including certificate of citizenship, if available.
14. The names and phone numbers of staff to be contacted in emergencies.

- Rule 65C-45.010, F.A.C., provides guidance for caregivers in maintaining the child resource record (CRR) and states it should be updated as events occur. The CRR shall be maintained by the licensed out-of-home caregiver. The CRR is a standardized record developed and maintained for every child entering out-of-home care that contains copies of the basic legal, demographic, available and accessible educational, and available and accessible medical and psychological information pertaining to a specific child, as well as any documents necessary for a child to receive medical treatment and educational services. Where medical or educational information is not available and accessible, written documentation of the efforts made to obtain the information must be in the file. The CRR shall be housed where the child is placed and shall accompany the child to every health encounter and shall be updated as events occur.
- Rule 65C-30.007, F.A.C., requires documentation in the case record that will be completed by the case manager to include:
    1. All contacts and attempted contacts shall be documented in the case file within two business days of the contact or attempted contact. The documentation shall provide evidence of the following:
        i. Sufficiency of current safety plan and whether it is the least intrusive;
        ii. Progress towards completion of case plan outcomes;
        iii. Effectiveness of current services and identification of additional services needed;
        iv. Observations of the child's development, physical condition and interaction with the parent or caregiver and household members;
        v. Assessment of progress in tasks and services aimed at ensuring the child's health, safety and well-being needs; and,
        vi. For children in an out-of-home placement:
            1. Age 13 and older, documentation shall include comments from the child and caregiver concerning progress in learning identified life skills,
            2. Frequency of visitation between the child, siblings and parents, any reason visitation is not occurring, and efforts to facilitate.

Section 2., s. 39.522, F.S., - Postdisposition change of custody. –

Section 39.552, F.S., permits courts to change the temporary legal custody or the conditions of the protective supervision at post-disposition hearings without the necessity of another adjudicatory hearing.

Section 39.522(1), F.S., permits the Department or any interested person to file a motion to modify the conditions of supervision or placement. Only parents or other legal custodians may object to the motion to change placement, upon which the court must conduct a hearing. The standard for changing custody of the child shall be the best interests of the child. The court must consider the following factors when determining whether a change of custody or placement is in the child's best interests:

- child's age;
- physical, mental, and emotional health benefits by remaining in the current placement or moving to the proposed placement;
- stability and longevity of the current placement;
- established bonded relationship between the child and the current or proposed caregiver;
- reasonable preference of the child;
- recommendation from current caregiver and guardian ad litem;
- child's previous and current relationship with siblings, if change of legal custody or placement will be to separate or reunify;
- child's likelihood of attaining permanency; and
- any other relevant factors.

Rule 65C-28.005, F.A.C., outlines requirements and factors to consider when there is a need for placement change for a child in out-of-home care. Child welfare professionals are required to provide supportive services to the current caregivers when a placement is in danger of disrupting and urge caregivers to wait to request removal of the child until efforts can be made to remedy the reasons. If efforts to stabilize a placement have not been

successful or other circumstances preclude the child's stay, the child welfare professional will work with the current caregivers to reach an agreement on a transition date that takes in the needs of the child. The following factors are considered when a child placement changes:

- breaks in the school year;
- location of an alternative placement;
- arraignments for the child's transition to the new setting can be made and implemented;
- preparation for the new caregiver and supports shall be given to assist the with the child's transition and stability;
- all relevant information about the child shall be given to the new caregiver while maintaining confidentially requirements;
- discussion of any training the caregiver may need, including special needs for the child and possible reactions to specific trauma the child has experienced;
- discussion of any services that are needed for the child, and discussion of the role of the out-of-home caregiver about transportation, participation in treatment sessions, communication with service providers, and implementation of treatment recommendations in the home;
- inform the out-of-home caregiver about available programs that may provide financial and medical assistance for the child;
- review with the licensed caregivers their roles and responsibility according to the Partnership Plan for Children in Licensed Out-of-Home incorporated in paragraph 65C-28.004(6)(c), F.A.C.; and
- provide to the out-of-home caregiver the CRR which must be reviewed upon the child's new placement. Discussion of maintaining and updating the record shall be conducted by the child welfare professional.

Rule 65C-28.004, F.A.C., requires the completion of a multidisciplinary staffing if the change of placement requires a change in the level of care. The following factors must be considered:

- medical needs;
- developmental needs;
- mental health needs;
- medication history, including psychotropic medications;
- behavioral health needs;
- alleged type of abuse or neglect and trafficking history;
- community ties and school placement, including educational needs;
- current placement decisions related to any siblings, including a sibling that has been previously adopted or is in an adoptive placement; foster and adoptive parents of a sibling shall be contacted and, if interested, considered for placement; and
- child's age, maturity, hobbies or activities and preference for placement.

Section 63.0425, F.S., outlines that if a child has lived with a grandparent for at least 6 months within the 24-month period immediately preceding the filing of the termination of parental rights petition, the grandparents must be noticed.

Rule 65C-16.002(2), F.A.C., outlines that adoptive placements must be made consistent with the best interest of the child and s. 63.045, F.S. Rule 65C-16.002(7), F.A.C., requires the assessment of the best interest of the child includes the current needs, projected needs, birth family's medical and mental health history, and strengths of the potential adoptive family. Pursuant to 65C-16.002, F.A.C., specific considerations need to be given to the following:

- Grandparents—a grandparent entitled to notice pursuant to s. 63.0425, must be afforded the opportunity to have a home study completed and to petition for adoption;
- Current caregivers—if the current caregiver applies to adopt, the application must be evaluated through an adoptive home study;
- Relatives and non-relatives with whom the child has a relationship—persons known to the child, but who do not have custody of the child, must have their application evaluated through a home study;
- Family new to the child—these families mut be provided information about children available for adoption and must be helped to determine if special needs adoption is appropriate for their family.

Section 3., s. 39.523, F.S., - Placement in out-of-home care; child and family teams; child and family team meetings. –

Chapter 39 prioritizes placement with a parent, adult relative, or the adoptive parent of the child's sibling, then in a licensed placement or with a responsible adult approved by the department. Sections 39.401(3)(b), and 39.521(3), F.S., and Rule 65C-28.004(2), F.A.C., requires placement with a relative or non-relative prior to

placement in licensed care. If licensed care is required, a multidisciplinary staffing must be held to determine the level of licensed care, to include medical foster care.

Section 39.523(1), F.S., outlines the legislative findings as to the importance of placing a child in the least restrictive, family-like setting and the most appropriate out-of-home placement shall be chosen after assessment of the child's needs and the availability of caregivers qualified to meet the child's needs.

Section 39.523(2), F.S., outlines the assessment process that must be completed to determine the level of care the child needs and to match the child with the most appropriate placement. This assessment process requires the community-based care (CBC) lead agency or subcontracted agency to coordinate a multidisciplinary team staffing with any individual involved with the child including, but not limited to, a representative from the Department, the case manager, a therapist, attorney ad litem, guardian ad litem, teachers, coaches, Children's Medical Services, and other providers of services. The assessment process must include use of an assessment tool. The placement decisions shall be reviewed as often as necessary to ensure permanency for the child.

Rule 65C-29.003(3)(a), F.A.C., requires the Department to use the least intrusive protective actions to ensure the child's safety:

a. Release of the child to the other parent shall be the first safety action considered.
b. When the other parent is unavailable or not an appropriate placement option, the next least intrusive action is placement of the child with a relative.
c. When a relative is unavailable or not an appropriate placement option, the next least intrusive action is placement of the child with a non-relative who is known to the family and who is able to provide for the health and safety of the child and has an established relationship with the child.
d. When non-relatives are not available or are not appropriate placement options, the child shall be placed in licensed care.

Rule 65C-28.004, F.A.C., requires the completion of a multidisciplinary staffing if the change of placement requires a change in the level of care. The following factors must be considered:

- medical needs;
- developmental needs;
- mental health needs;
- medication history, including psychotropic medications;
- behavioral health needs;
- alleged type of abuse or neglect and trafficking history;
- community ties and school placement, including educational needs;
- current placement decisions related to any siblings, including a sibling that has been previously adopted or is in an adoptive placement; foster and adoptive parents of a sibling shall be contacted and, if interested, considered for placement; and
- child's age, maturity, hobbies or activities and preference for placement.

Rule 65C-30.001(48), F.A.C., defines family team meeting as a process that allows families to create and utilize a team of persons and professionals to assist with safety and/or case planning. In addition, Rule 65C-28.006, F.A.C., outlines the use of a family team meeting for the purpose of determining the appropriateness of the current goal for the child.

Currently, the Department utilizes a multidisciplinary team staffing approach to accomplish the goals and requirements outlined in s. 39.523(4), F.S., for child and family team meetings.

Rule 65C-28.004, F.A.C., requires child welfare professionals to complete the assessment to determine the most appropriate out of home placement based on the child's needs and availability of caregivers qualified to meet the child's need. The assessment is required to be complete on all children in out of home care, regardless of age.

Under federal law, The Multiethnic Placement Act, 42 U.S.C.A. 671(a)(18), requires placement decision for children in the care and custody of the Department be made without regard to race.

Rule 65C-16.005(9), F.A.C., states that an Adoption Applicant Review Committee (AARC) must convene when multiple families who have approved home studies apply to adopt the same child, the prospective adoptive parent is experiencing some serious or chronic medical conditions that could compromise their ability to provide physical, emotional, social or economic support necessary for the child to thrive. Additionally, an AARC must occur when the applicant has a verified finding of abuse, neglect or abandonment, have one or more investigations with verified or not substantiated findings, or have criminal charges that warrant review. Lastly, an AARC must be

convened when a current or previous foster parent has been the subject of supervision concerns or violations. Members of the AARC must have completed the Department approved Adoption Competency Training and have a knowledge or experience in the area of adoption. The factors of attachment, siblings, kinship, permanence and post contact outlined in Rule 65C-16.002(5), F.A.C., must be considered when determining the best interest of the child when selecting an adoptive family.

Section 4., s. 39.5321, F.S., - Placement and education transitions. –

Section 39.01(66), F.S., defines present danger as a significant and clearly observable family condition that is occurring at the current moment and is already endangering or threatening to endanger the child. Present danger threats are conspicuous and require that an immediate protective action be taken to ensure the child's safety.

Federal reporting for Adoption and Foster Care Analysis and Reporting, identifies the following moves as services and not placements:

- Respite Placement
- Routine/Emergency Medical Services
- Routine/Emergency Mental Health Services
- Routine/Emergency Services
- Missing Child
- Visitation
- Hospitalization – Medical
- Hospitalization - Mental

Section 409.1415(2)(b)(6)(7), F.S., requiring the Department and CBC lead agency to provide a caregiver with the services and support they need to enable them to provide quality care for the child. Once a caregiver accepts the responsibility of caring for a child, the child may be removed from the home of the caregiver only if:

- the caregiver is clearly unable to safely or legally care for the child;
- the child and the birth or legal parent are reunified;
- the child is being placed in a legally permanent home in accordance with a case plan or court order; or
- the removal is demonstrably in the best interests of the child.

Rule 65C-28.005, F.A.C., requires that except in emergency situations, the child's parents, unless contrary to court order, licensed out-of-home caregivers and the guardian ad litem or attorney ad litem, if appointed, shall be given at least two weeks' notice prior to moving a child from one out-of-home placement to another and the reason a placement change is necessary.

Rule 65C-28.005(l), F.A.C., outlines in emergency situations, a change of placement can be made immediately. The child welfare professional shall within 72 hours inform the child's parents, unless contrary to court order, Children's Legal Services and guardian ad litem and child's attorney, if appointed, of the move and the reasons an emergency placement change was necessary.

The Federal, Every Student Succeeds Act (ESSA), reauthorizes the Elementary and Secondary Education Act of 1965, Pub.L. 89-10. ESSA strives to ensure equal opportunity for all students. The law requires that schools include educational outcomes for children known to the Department in the state report cards. Schools are also required to collaborate with child welfare agencies to ensure children can stay in their school of origin when it is in the child's best interest. This collaboration will require school districts and CBCs to share information pursuant to the requirements of the law.

Section 39.604, F.S., requires educational and child care stability to minimize disruptions unless it is not in the best interest of the child. If it is not in the best interest, parties must determine the best setting for the child.

Section 5., s. 39.5232, F.S., - Placement of siblings; visitation; continuing contact. –

Florida law requires the Department to make every possible effort to place siblings together in the same out-of-home placement or, if permanent, the same adoptive placement. When a child is removed from the home, law places a priority on placement with a parent or legal custodian, responsible adult relative, or the adoptive parent of the child's sibling, then in a licensed placement or with a responsible adult approved by the Department. State law also defines reasonable efforts to maintain sibling bonds at shelter to include the use of short-term group homes that can accommodate a sibling group. State law further prioritizes sibling bonds and reunification by requiring the Department to update the court on efforts to reunify siblings, or if it has been determined to be in the best interest of one of the children to remain in a separate placement, any and all efforts to encourage and facilitate sibling visitation. The Department is also required to place the expectation in all contracts with lead

agencies that sibling placement and reunification must be prioritized, and they must track sibling placement and reunification efforts in the Results Oriented Accountability program.

Section 39.01(80), F.S., defines “sibling” to mean:

(a) a child who shares a birth parent or legal parent with one or more other children; or
(b) a child who has lived together in a family with one or more other children whom he or she identifies as siblings.

Section 39.001(1)(k), F.S., requires the Department to make every possible effort, if two or more children who are in the care or under the supervision of the Department are siblings, to place the siblings in the same home; and in the event of permanent placement of the siblings, to place them in the same adoptive home or, if the siblings are separated while under the care or supervision of the Department or in a permanent placement, to keep them in contact with each other.

Section 39.4015, F.S., subject to available resources, permits the Department and CBC lead agencies to use family finding efforts to keep siblings together in care, when in the best interest of each child and when possible.

Section 39.401(3)(b), F.S., requires that if a child cannot be returned back to the custody of a parent, the Department may file a petition, and while awaiting a shelter hearing, the Department may place the child with an adoptive parent of the child’s siblings if a parent is unavailable. Rule 65C-16.002(3), F.A.C., states that, if the Department takes into custody a child who is a sibling or previously adopted child(ren), the Department or CBC shall advise the adoptive parents of this removal. If the child becomes available for adoption, the adoptive parents of the previously placed sibling(s) must be notified, given the opportunity to apply to adopt and given the same consideration as a relative.

Section 39.402(8)(h)6, F.S., requires the Department to make reasonable efforts to keep siblings together if it is in the best interest of the children, with preferred placement in a foster home if available, with group homes used as a short-term option.

Section 39.402(9)(b), F.S., requires the Department to provide the courts with recommendations for frequent visitation and interaction if siblings cannot be placed together.

Section 39.523, F.S., and 65C-28.004, F.A.C., require the child welfare professional to consider placement with the siblings through the comprehensive placement assessment.

Section 39.6012(3)(b), F.S., requires case plan documentation of visitation amongst siblings when separated.

Section 39.6221(2)(c), F.S., requires the Department to specify the frequency and nature of visitation or contact for children and their siblings when the case is closed permanent guardianship.

Rule 65C-28.002, F.A.C., requires family time among siblings. The child welfare professional responsible for the case shall ensure that separated siblings under supervision maintain family time unless the family time would be contrary to the safety or well-being of any of the children. Sibling family time shall only be limited or terminated by order of the court.

Section 39.701(2), F.S., requires court to determine the frequency, kind, and duration of contacts among siblings who have been separated during placement, as well as efforts taken to reunite them if doing so is in the best interests of the child.

Section 65C-16.002(3), F.A.C., requires that when considering the separation of siblings for the purpose of adoption who are in an open dependency case, a sibling separation staffing must be held. Members of the staffing must consider the emotional ties existing between the siblings and the degree of harm which each child is likely to experience because of a separation. Additionally, an assessment of both the short-term and long-term effects of separating the children. If the decision is to separate, a post adoption communication plan must be developed. In difficult cases, a professional who has expertise in sibling bonding and adoption may be consulted.

Section 6., s. 39.806, F.S., - Grounds for termination of parental rights. -

Section 39.806(1)(e), F.S., provides a ground for termination of parental rights after a court has adjudicated a child dependent and the Department files a case plan if one of three conditions is established. One of those conditions, s. 39.806(1)(e)(3), F.S., is when the child has been in care for 12 of the last 22 months and the parents have not substantially complied with the case plan so as to permit reunification under s. 39.522(2), F.S.,

unless the failure to substantially comply with the case plan was due to the parent's lack of financial resources or to the failure of the Department to make reasonable efforts to reunify the parent and child.

EFFECT OF THE BILL:

Section 1., s. 39.00146, F.S., - Case record face sheet:

The bill requires the Department to develop and include a "face sheet containing relevant information about the child and his or her case" in every child's case record. This face sheet is to include ten categories of information about the child and child's case. FSFN is Florida's official electronic system of record and it contains the entire history of the child and case. The casebook function in FSFN provides users a view of the child's more recent case information and case history and was designed for users to navigate to the information in FSFN easier and be used to work a case. It is not a single view of information and cannot be printed or electronically shared. Providing a face sheet would supplement the current FSFN casebook functionality and could pull together information from FSFN, as well as other Department and external data sources.

While the majority of the data requirements outlined in the bill are currently found in FSFN, there are five items which are not or required modification for the stated face sheet purposes:

- Name and contact info of attorneys assigned to case in all capacities *(Legal section only lists one attorney)*
- Name and contact info of all employees who have worked with the child (current or previous) and supervisor info for them – (Outside Providers)
- Contact info for persons/orgs currently providing services & support for child *(Information is in FSFN but not to the extent of answering this question*
- Concerns that exist regarding parent or caregiver ability to:
  - Engage or bond with (infant) child/ structure daily activities/ manage behavior/ maintain safe home/ make good health decisions *(Information is in FSFN but not to the extent of answering this question)*
- Transitions in placement the child has experienced since initial placement and descriptions *(Information is in FSFN but not to the extent of answering this question)*

The FSFN Technology impact estimate to pull together relevant FSFN data from across the system, provide a face sheet, and add new data elements/pages for face sheet, transition planning, and separate sibling process is included in the Technology Impact below. Pulling data from other Department and external sources is not included in the estimate.

The Department is currently analyzing various options in pursuit of the most effective and efficient means to support case managers. While the additional FSFN application functionality would need to be added to support data and pages for transition planning, separate siblings, meetings, file cabinet, judicial review worksheet, FFA-Ongoing and Progress Update, options to pull the data and provide the face sheet should be considered as part of a Comprehensive Child Welfare Information System (CCWIS) solution that supports the CBCs, but also all parties involved in a case.

FSFN is designed to grant access based on the user security profile for the entire system. To allow each parent or caregiver access to a specific child case, various profiles specific to the parent or caregiver would need to be created, as they are not currently given FSFN access. This will require changes to FSFN and cause an increase in workload for the security manager and team. It is imperative that information contained within FSFN remains confidential and parties granted access only have access to their specific case information. This work is not included in the estimate.

Section 2., s. 39.522, F.S., - Postdisposition change of custody. –

This section of the bill amends and renumbers s. 39.522, F.S., to incorporate new language to address placement changes when the child has been in a continuous, long-term placement.

Section s. 39.522(1)(a), F.S., is renumbered as subsection s. 39.522(2)(a), F.S., and is further amended to change who may challenge a motion to modify placement from "the parents or other legal custodian" to "any party or current caregiver." This allows any licensed foster parent or group home to object to any change of placement of a child in their care, regardless of how long the child is in their home. The expansion will result in more hearings on placement changes, which will cause an increase in workload for the judiciary, Department counsel, parents' counsel, guardian ad litem volunteers and their counsel, and child welfare workers.

This section also expands the list of factors that a court must consider to determine whether a change of placement is in the child's best interests by adding the following factors to those already in statute:

- The likelihood that the child will have to change schools or day care placement, the impact of such a change, and the parties' recommendations as to the timing of the change.
- The disruption of continuity of care with medical, mental health, dental, or other treatment services the child is receiving at the time of the change of custody decision.
- The impact on activities that are important to the child, including the ability of the child to continue in such activities.
- The impact on the child's future access to education, Medicaid, and independent living benefits.
- The recommendations of the multidisciplinary team (renamed as Child and Family Team) that developed a transition plan that is child-centered and created in accordance with s. 39.523, F.S.

Section 39.522(3)(a), F.S., establishes, for the first time, a rebuttable presumption that it is in the child's best interests to remain permanently in the same placement in which the child has been living continuously for the past 6 months if the court finds that:

1. Reunification is not a permanency option for the child;
2. The child has resided in the same out-of-home placement for more than 6 months; and
3. The custodian of the child in the out-of-home placement requests and is eligible for consideration as an adoptive parent or a permanent custodian for the child.

As written, the phrase "reunification is not a permanency option" is unclear. It is difficult to determine whether the phrase means that the goal must no longer be reunification or if the parent is not demonstrating behavior change to meet the conditions for return. If the first interpretation is used, a parent who has met the conditions for return after the court changed the goal to adoption would have to overcome the presumption before being reunified. This may be an unconstitutional restriction on the parent's rights.

Section 39.522(3)(b), F.S., explains that the presumption may not be rebutted solely by the expressed wishes of a biological parent, a biological relative, or a caregiver of a sibling.

Section 39.522(3)(c), F.S., requires the court to hold an evidentiary hearing to rebut this presumption and grants party status to the current caregiver who is seeking permanent custody and has maintained custody of the child for 6 months. This section places no time constraint on when the evidentiary hearing must be held. In context of intervention, the Legislature has determined in s. 63.082, F.S., that the modification hearing must be held in 30 days and order entered 15 days thereafter.

The court must also appoint a lawyer for the current caregiver and give the caregiver party status. The bill requires the appointment of counsel for the caregiver without a requirement of indigency, granting greater rights to a caregiver than a parent, since parents are only appointed counsel when indigent under s. 39.013(9)(a), F.S. Furthermore, the bill does not end the appointment of counsel or the caregiver's party status after the court rules on the placement motion.

Just as the new subsection requires appointment of an attorney for the caregiver, s. 39.522(3)(c), F.S., requires the appointment of counsel for the child who is the subject of the motion. Where a child has already been appointed a guardian ad litem, the guardian ad litem program already represents the child's best interest in modification of placements hearing through counsel. The language in this subsection would result in the child having two attorneys advocate for the child in the hearing, who could advance different positions depending on what is in the child's best interests and what the child directs. And, where the child is too young to direct his or her representation, the attorney ad litem would be duplicating the work of the guardian ad litem to make a recommendation that is in the child's best interests.

In addition to the factors that are in s. 39.522(2), F.S., where a rebuttable presumption applies, the court must also consider evidence from a court-selected neutral and independent expert in the science and research of child-parent bonding and attachment. There is no express requirement that the neutral expert meet with the child or study the family's dynamics before offering evidence to the court. The bill is also silent as to how the court should determine who can meet such qualifications consistent with the Daubert standard adopted by the Florida Supreme Court in In re Amendments to the Florida Evidence Code, 278 So. 3d 551 (Fla. 2019), that every expert must satisfy to offer testimony to a court.

Finally, the protections and policy surrounding the rebuttable presumption that it is the best interest of the child to remain permanently in the same continuous placement of at least 6 months would likely make the previously discussed expansion of s. 39.522(2)(a), F.S., to allow a current caregiver the ability to object to any change of

placement unnecessary. Furthermore, regardless of whether a caregiver can object, s. 39.522(2)(b)(6), F.S. requires the court to consider the recommendation of a caregiver when determining if the placement change is in the child's best interest.

Section 3., s. 39.523, F.S., - Placement in out-of-home care; child and family teams; child and family team meetings. –

This section of the bill provides legislative intent, creates a prioritized list of out-of-home placements, and renames and adds requirements for multidisciplinary teams.

Section 39.523(1), F.S., is amended to expand the legislative findings to include a finding that effective assessment is particularly important for children 3 years of age and younger and a finding that services are most efficient when delivered in an integrated child and family team that includes the child, the family, and community and professional supports.

Section 39.523(2)(a), F.S., is created to outline the following order of priority for placements in out-of-home care:

1. Relative;
2. Non-relative caregivers with close relationships with the child;
3. Licensed Foster Care; and
4. Group or Congregate Care.

The Department has existing Rule, 65C-29.003(3)(a), F.A.C., that replicates the above priority placement. Child Welfare professionals are required to conduct this level of practice at removal and any placement thereafter. The comprehensive placement assessment has the same listed priority placements.

Section 39.523(2)(b), F.S., mirrors s. 39.402(8)(h)6, F.S., outlining the requirement for the Department to make reasonable efforts to keep siblings together when placed in out-of-home care. Section 39.523(2)(b), F.S., also requires a decision for sibling placements to be made pursuant to new section 39.5232, F.S. Please see Section 5 of this bill analysis for additional information.

Section 39.523(3) and (4), F.S., renames the previously required multidisciplinary team responsible for assessment and placement as a "child and family team" and adds requirements for that team's operation and meetings:

- Requires the completion of child and family team meetings at each important decision made about the child's life but does not define what constitutes as important decision. "Important decision" is not defined and would need more specificity to be implemented consistent with the legislature's intent.
- Requires the inclusion of a diverse team of following participants; the child, the current caregivers, family members and other individuals identified by the family as being important, a representative of the Department, the case manager, and a therapist or other behavioral therapist if applicable. Additional participants may include children's medical services, the guardian ad litem, school personnel representative who has direct contact with the child, and community providers of services to the child. This section of law is drafted as "must include" which does not allow the meeting to be conducted in the absence of that individual, this could cause delay, particularly if domestic violence is involved. The inclusion of the child is required with no contemplation of age, maturity, or understanding. The bill does not provide for a trauma informed exception to attendance. Finally, parents' counsel and attorneys ad litem should be included in the list of those that may attend.
- Requires a trained skilled facilitator to facilitate teams as a neutral team member to maintain a safe environment for the child. Additional staff resources are likely necessary to support trainers to prepare skilled facilitators as well as other workload increases.

Section 39.523(4)(c), F.S., requires the creation of a child and family team meeting as soon as possible when the child is removed and s. 39.523(4)(d), F.S., requires a supplemental assessment for children 3 years of age or younger that is includes the following:

- Identification of kin and relatives who express interest in caring for the child, including strategies to overcome potential delays in placing the child with such persons if they are suitable.
- The likelihood that the child can remain with the prospective caregiver and the willingness of caregiver to be a long-term placement.
- The caregiver's willingness to accept services and supports for the child, and effectively maintain the attachment between the parent and child.

Section 39.523(4)(i), F.S., allows the Department to share confidential information with all parties in attendance of the child and family team meeting. This language would need to include case managers and other contracted

agents of the Department, to protect those individuals from violating s. 39.202, F.S., when information is shared with participants who are not entitled to the information under current confidentiality provisions in Chapter 39.

Section 39.523(7), F.S., requires the Department to adopt rules for new language in this section.

Section 4., s. 39.5321, F.S., - Placement and education transitions. –
This section of the bill provides legislative intent surrounding placement changes for children in the care of the Department, new definitions, and requirements for changes in placement and transition planning.

Section 39.5321(2)(b), F.S., creates a new definition of "emergency situation" that means an imminent risk to health or safety of the child or other children placed in the home. The bill is silent as to whether a foster parent who is no longer willing to keep a child but does not pose an imminent risk to health or safety would fall under this definition.

Section 39.5321(2)(c), F.S., creates a new definition for "placement change" to contemplate any time a child is moved to another caregiver, as opposed to a change of custody, and includes a move to a foster home, a group home, relatives, prospective guardians, prospective adoptive parents, and reunification with parents. It also includes moves between rooms and buildings operated by a group home provider.

Placement Transitions
Section 39.5321(3)(a), F.S., requires a transition plan be created and implemented for every placement move a child makes, to include the movement from one room to the next in a group home setting, emergency situations, and respite. Children can change bedrooms frequently within group homes and this new language would require a plan be created and implemented for each change. For room to room placement changes, case management will have an increased workload for creation of transition plans in these instances. Public Law 115-123, Family First Prevention Services Act (FFPSA), allows for children in settings that are not an FFPSA setting, or if the children are in a group home that transitions to an FFPSA setting, to remain in the placement without financial penalty. Due of the complexity in the transition process, group care providers will be required to ensure all children are in an environment that is safe for everyone's well-being. This includes having to revise current sleeping arrangements within the group home as additional children are admitted into their program and present with extreme behaviors. The new bill language will require each room change/sleeping arrangement to be staffed for a child and family team staffing.

Sections 39.5321(3)(b) and (c), F.S., mirror current law in sections 409.1415(2)(b)(6) and (7), F.S., creating duplicate language within statute. This language will have no new effect as it is currently law.

Section 39.5321(3)(d), F.S., requires a child and family team meeting be completed at every placement move for a child in out-of-home to include room to room moves for children in group care and respite. In addition, a 14-day notice before moving the child must be completed, filed with the court, and provided to the following participants:

- the child;
- child's parents, unless prohibited by court order;
- child's out-of-home caregivers;
- guardian ad litem, if appointed; and
- attorney for the Department.

The above listed participants are included in the transition planning and such persons must share any relevant information necessary to ensure a smooth transition.

The section prohibits a placement change that occurs between 7:00pm-8:00am. As written, it is difficult to determine whether the proposed language means the beginning of the placement change or transition, the end of the placement change or transition, or simply a bar on when a placement change may be requested. The language is also silent as to whether the time frame includes transportation time to perform a placement change.

Section 39.5321(3)(e), F.S., requires a child and family team meeting to discuss transition completed within 72 hours after an emergency situation. The Department already provides 72-hour notice to all parties.

Section 39.5321(3)(f), F.S., requires the prospective caregiver be fully informed of the child's needs and be willing to accept responsibility for high-quality care for such needs, a review of the roles and responsibilities listed on the Partnership Plan for children in out-of-home care pursuant to s. 409.1415, F.S., and requires a signature of both the child welfare professional and the prospective caregiver acknowledging an explanation of the requirements before placement.

Section 39.5231(3)(g), F.S., details the components that must be considered in the transition plan and factors considered in the assessment and decision:

- The age of the child and the child's current ability to accomplish developmental tasks, with consideration made for whether the child is:
  a. Six months of age or younger, thereby indicating that it may be in the child's best interest to move the child sooner rather than later; or
  b. One year to 2 years of age, thereby indicating it may not be a healthy time to move the child.
- The length of time the child has lived with the current caregiver, the strength of attachment to the current caregiver, and the harm of disrupting a healthy attachment compared to the possible advantage of a change in placement.
- The relationship, if any, the child has with the new caregiver and whether a reciprocal agreement exists between the current caregiver and the prospective caregiver to maintain the relationship with both caregivers.
- The pace of the transition and whether flexibility exists to accelerate or slow down the transition based on the needs and reactions of the child.

These new placement change requirements will increase workload for case management, Children's Legal Services, and clerk of courts due to the multiple placement transitions that must be filed with the court. According to FSFN data, there were 22,705 placement changes in FY 2019-2020 where a child moved from one caregiver to another, including moves to a relative, nonrelative, foster home, group home, and reunification with a parent. This number does not include placements made room-to-room in group home settings or to other buildings within the group home setting. The Department would be required to prepare a transition plan after a meeting for each of these placement changes. The requirement for a transition meeting will increase the work hours as to allow for everyone's voice to be heard. Additionally, there will be an increase in travel time to transport children and possibly their parents to the meetings. There will also be an increase in workload for the Department to facilitate the meetings.

Education Transitions

Section 39.5231(4)(a), F.S., contains legislative intent and findings language.

Section 39.5231(4)(b), F.S., requires every effort be made to keep a child in the school of origin, and a determination that it is not in the best interest of a child to remain in the school of origin must be made in consultation with the:

- child;
- parents;
- caregivers;
- child welfare professionals;
- guardian ad litem;
- educational surrogate;
- child care and educational staff; and
- school district representative or foster care liaison.

The bill requires consultation with parties that may not exist in all cases, such as an educational surrogate or guardian ad litem.

Section 39.5321(4)(b), F.S., has similar language to s. 39.0016(2)(b) and (3), F.S., for educational requirements. In addition, s. 39.5321(4)(b), F.S., mirrors Florida Administrative Code 65C-28.018.

If it is determined that remaining in the child's school of origin is not in the best interest of the child, s. 39.5231(4)(b)3., F.S., requires many relevant factors be considered in selecting a new school, including, but not limited to:

- the child's desire;
- the preference of the child's parents;
- siblings and mentors at the school of origin;
- cultural and community connections;
- disability status under federal law and interventions available;
- pending evaluations;
- language services and requirements;

- impact on academic credits;
- availability of extracurricular activities;
- IEP and other behavioral or medical health needs;
- permanency goal and timeframe for permanency;
- history of transfers and historical academic, emotional, and behavioral impact;
- length of commute; and
- length of time the child has attended current school of origin.

The bill states that cost of transportation cannot be a factor in whether it is the best interest of the child.

Section 39.5231(4)(d), F.S., requires educational transition plans for transitions between child care and early education programs as well as transitions between K-12 programs. K-12 transition plans are required to include documentation of:

- The Department or CBC has made the decision in accordance with the above listed consultation and requirements;
- The Department or CBC has coordinated the transition with local educational agencies to provide immediate and appropriate enrollment, including transfer or records, school-entry health examination, arranged transportation; and
- Discussion of the timing which addresses the potential impact on the child, to include at a minimum grading periods, exams, credit acquisition, sports eligibility, and extracurricular participation.

Section 39.5231(5), F.S., requires a form to be developed in conjunction with the Quality Parenting Initiative ("QPI") to be used statewide for documentation of transition plans. The form must include, at a minimum, the following:

- The membership of the child and family team convened to develop a transition plan for the change in placement and the dates the team met.
- The name of the professional facilitator of the child and family team meeting.
- The topics considered by the child and family team in order to ensure an appropriate transition.
- The recommendations of the child and family team and the name of each individual or entity responsible for carrying out each recommendation.

The Department or the CBC lead agency shall document all child and family team meetings and placement transition decisions in the FSFN and must include the information in the social study report for judicial review, as required under s. 39.701, F.S.

Section 39.5231(6), F.S., requires the Department to adopt rules to implement this section.

Section 5., s. 39.5232, F.S., - Placement of siblings; visitation; continuing contact. –

This section of the bill provides for legislative intent and findings in relation to sibling placement, visitation, and contact. The bill provides factors to consider when determining sibling placement, requirements for transition, and standards for evaluation.

Section 39.5232(2), F.S., creates definitions for the section and duplicates s. 39.01(80), F.S., which currently defines siblings. Therefore, there will be no new effects of this portion of the bill.

Section 39.5232(3), F.S., requires the Department to make reasonable efforts to place siblings who have an existing relationship and are removed from their home in the same foster, kinship, adoptive, or guardianship home, when it is in the best interest of each sibling and when an appropriate joint placement is available. If siblings are not placed together, this subsection requires the child welfare professional to document in the case record and newly created face sheet reasons why joint placement of siblings and reasonable efforts for visits could not occur when siblings are not placed together. Currently, all case information including placement and safety and well-being concerns must be documented in FSFN.

The documentation required by this section must include:

- Efforts made to keep the siblings together.
- An assessment of the short-term and long-term effects of separation on each child, and the sibling group as a whole.
- Description of the plan for communication or contact between the children if separation is approved.

New s. 39.5232(3)(a)3., F.S., explains the Department and the court are not required to make a sibling placement or change in placement to develop a relationship between siblings that did not exist at the time a child was placed in out-of-home care.

In addition, s. 39.5232(3)(b), F.S., requires the child welfare professional to conduct a sibling placement staffing to include a mental health professional with expertise in sibling bonding. The outcome of the assessment must be documented in the case file and FSFN. Currently, the child's case file is in FSFN and it is unclear what separate documentation is needed. There is an anticipated cost increase to the Department to address the participation of a mental health professional with an expertise in bonding at a sibling placement staffing.

The Department and CBCs are required to periodically reassess sibling placement, visitation, and other sibling contact decisions in cases where siblings are separated, not visiting, or not maintaining contact to determine if a change in placement is warranted.

Current Rule 65C-28.002, F.A.C., requires that family visitation occur in accordance with court orders and addresses mandating visitation when siblings are separated. When considering moving a child who is with an existing caregiver to be placed with their sibling who newly entered care, the factors that must be considered are as follows:

1. The presence and quality of current attachment relationships, including:
    a. The quality and length of the attachment to the current and potential caregiver;
    b. The age of the child at placement with the current caregiver and the child's current age;
    c. The ease with which the child is attached to the current family;
    d. Any indications of attachment difficulty in the child's history; and
    e. The number of moves and number of caregivers the child has experienced.
2. The potential of the new caregiver to be a primary attachment figure to the infant by ensuring care for the child's physical needs and being willing and available to meet the child's emotional needs.
3. The quality of sibling relationships between the child's other siblings and the potential quality of the sibling relationship that can be formed between the child and his or her siblings.
4. The consideration of any costs and benefits of disrupting existing emotional attachments to the primary caregiver to place a child in a new placement with his or her siblings, including the:
    a. Length and quality of the established and current primary attachment relationships;
    b. Relationships between the child's other siblings and whether such relationships appear adequate and not stressful or harmful; and
    c. Length and quality of the established and current primary attachment relationships between the siblings and the sibling's current caregiver.
5. The ability to establish and maintain sibling visitation and contact in a manner and schedule that makes sense for the infant or young child if it is determined that the infant or young child is to remain with the primary caregivers rather than be placed with his or her siblings.

Section 39.5232(3)(d), F.S., requires that when the Department decides to move a child's placement because the child would benefit from being placed with his or her siblings, the transition to the new home must be in accordance with section 39.5321, F.S.

Section 39.5232(3)(e), F.S., instructs the Department to work with QPI to develop standard protocols for caseworkers for standards for evaluation sibling placements. The Department may incur additional cost from contracted providers to achieve the above task.

Section 39.5232(4), F.S., outlines practices that must be considered to maintain or strengthen relationships among separated siblings, to include the following:

a. Placement with kinship caregivers who have an established personal relationship with each child so that even when siblings cannot be placed together in the same home the relatives are more likely to facilitate contact.
b. Placement of siblings geographically near each other, such as in the same neighborhood or school district, to make it easier for the siblings to see each other regularly.

c. If the siblings choose to do so, frequent and regular visitation to be actively involved in each other's lives and to participate in celebrations, including, but not limited to, birthdays, graduations, holidays, school and extracurricular activities, cultural customs, and other milestones.
d. Utilization of other forms of contact when regular in-person meetings are not possible or are not sufficient to meet the needs or desires of the siblings, such as maintaining frequent contact through letters, e-mail, social media, cards, or telephone calls.
e. Coordination of joint outings or summer or weekend camp experiences to facilitate time together, including, but not limited to, activities or camps specifically designed for siblings in out-of-home care.
f. Utilization of joint respite care to assist the caregivers who are caring for separated siblings to have needed breaks while also facilitating contact among the siblings, including, but not limited to, providing babysitting or respite care for each other.
g. Prohibition on withholding communication or visitation among the siblings as a form of punishment.

Section 39.5232(5), F.S., details additional requirements and considerations in relation to sibling placement and contact. The section requires caregivers to respect and support a child's ties to his or her birth family, siblings, and extended family are requires them to assist in maintaining allowable visitation and other forms of communication; the Department must provide a child with the location and contact information for his or her siblings and also make reasonable efforts to obtain that information if unknown; the Department must convene a child and family team if a sibling that the child was previously unaware is discovered to determine if the current placement or permanency plan requires modification; and the court may limit or restrict communication or visitation only upon a finding of clear and convincing evidence that contact would harm the child. If a court makes this determination, the court must direct the Department to provide services to ameliorate the harm so that contact may be restored as soon as possible.

From the above sections, it appears, at a minimum, a case manager may be required to complete three separate assessments to move a child's placement.

Section 6., s. 39.806, F.S., - Grounds for termination of parental rights. –
This section amends s. 39.806(1)(e)(3), F.S., to renumber a reference to a subsection changed in s. 39.522, F.S., (Section 2 of the bill). There are no substantive changes in this section**.**

Section 7.
This act takes effect on October 1, 2021.

1. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?

If yes, explain:	Yes, s. 39.00146, F.S., in Section 1; s. 39.523(7), F.S., in Section 3; s. 39.5231(6), F.S., in Section 4; and s. 39.5232(6), F.S. Section 5 require the Department to adopt rules.
What is the expected impact to the agency's core mission?	N/A
Rule(s) impacted (provide references to F.A.C., etc.):	65C-16, 65C-28, and 65C-30.

2. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

List any known proponents and opponents:	Unknown.
Provide a summary of the proponents' and opponents' positions:	Unknown.

3. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?

If yes, provide a description:	N/A
Date Due:	N/A

Bill Section Number(s):	N/A

4. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL?

Board:	N/A
Board Purpose:	N/A
Who Appoints:	N/A
Appointee Term:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Office of Administrative Services finds that there are no expenditures generated by this bill.
Does the legislation increase local taxes or fees?	The Department's Office of Administrative Services finds that this bill does not increase local taxes or fees.
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	The Department's Office of Administrative Services finds that this section is not applicable.

2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?

Revenues:	None
Expenditures:	**Section 3** To fulfill the requirements of this section of the bill, the Department anticipates a need of at least 174 statewide facilitators (FTEs) for child/family team meetings to conduct a meeting each time there is a placement change and on an annual basis in conjunction with the child's permanency hearing. Additional facilitators would be needed to conduct the team meetings for other "important decisions" that may arise in the cases. *The number of facilitators was calculated as follows:* According to FSFN data, there were 22,705 placement changes in FY 2019-2020, where a child moved from one caregiver to another, including moves to a relative, nonrelative, foster home, group home, and reunification with a parent. This number does not include moves between rooms or buildings operated by group homes. FSFN data also establishes that there are 17,525 cases active as of February 1, 2021. Each of those cases is anticipated to have at least one permanency staffing. To fulfill the goals of Section 3, a child family team meeting would be expected to take at least 8 hours which includes scheduling, planning and facilitating each meeting.

	22,705 placement changes + 17,525 permanency hearings = 40,230 family team meetings X 8 hours/meeting = 321,840 hours/1,854 hours per FTE = 174 FTEs needed. *Salaries and Benefits, Expenses and Human Resources for the 174 FTEs are calculated as follows:* The family team facilitator averages an annual salary with benefits of $57,706.94 a year. Total salary and benefits for 174 facilitators is **$10,041,008**. To determine expenses, 174 FTEs are multiplied by $10,422 ($5,974 recurring and $4,448 nonrecurring) for a total of $1,813,428, ($1,039,476 is recurring and $773,952 is nonrecurring). For additional travel, the 174 FTEs are multiplied by $13,802 (High travel) for a total of $2,401,548. The total annual need for expenses is **$4,214,976** ($3,441,024 in recurring and $773,952 in nonrecurring). Each FTE would have a Human Resources Service need of $330.22, totaling **$57,458** for all facilitators. *The total need for this section is **$14,313,442** ($13,539,490 in recurring and $773,952 in nonrecurring). **Section 5** This section of the bill requires that a mental health professional with expertise in sibling bonding must be included in a child and family team meeting convened to decide the placement of a sibling group. According to FSFN data as of December 31, 2020, there were 5,510 sibling groups in out-of-home care that would have been subject to a child and family team meeting at the time of removal for the purpose of deciding placement. To fulfill the goals of Section 5, those child and family team meetings would be expected to take at least 2 hours to conduct. A mental health professional with expertise in sibling bonding generally charges the Department or the CBCs $150/hour for staffings and $250/hour for court testimony. *The total cost to include experts at the sibling placement child and family team meeting was calculated as follows:* 5,510 sibling groups X 2 hours = 11,020 hours X $150 expert fee/hour = **$1,653,000** **Cost to Implement Sections 3 and 5** Total Annualized Need for 174 FTEs (Section 3) and expert fees (Section 5): **$15,966,442** ($15,192,490 in recurring and $773,952 in nonrecurring) Please see Technology Impact section for additional fiscal impact resulting from technology needs.
Does the legislation contain a State Government appropriation?	The Department's Office of Administrative Services finds that this bill does not contain a State Government Appropriation.
If yes, was this appropriated last year?	The Department's Office of Administrative Services finds that this section is not applicable.

3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	**Section 4** This section requires the Department to develop a transition plan for each placement change that occurs annually and will impact the CBC Lead Agencies. According to FSFN data, there were 22,705 placement changes in

	FY 2019-2020 where a child moved from one caregiver to another, including moves to a relative, nonrelative, foster home, group home, and reunification with a parent. This number does not include moves between rooms or buildings operated by group homes for which the Department would also be required to develop a transition plan. It requires a case manager on average 8 hours to develop a transition plan that includes the components and consultation with the interested persons outlined in the bill. The Department anticipates at least 98 new case management positions would be required to complete transition plans. *The number of case management positions was calculated as follows:* 22,705 placement changes X 8 hours to develop each transition plan = 181,640 hours/1,854 hours per FTE = 98 FTEs *Salaries and Benefits, Expenses and Human Resources for the 98 FTEs are calculated as follows:* The Case Managers average an annual salary with benefits of $58,362 a year. Total salary and benefits for 98 case managers is **$5,719,476**. To determine expenses 98 Case Managers are multiplied by $10,422 ($5,974 recurring and $4,448 nonrecurring) for a total of $1,021,356 ($585,452 is recurring and $435,904 is nonrecurring). For additional travel, the 98 FTEs are multiplied by $13,802 (High travel) for a total of $1,352,596. The total annual need for expenses is **$2,373,952** ($1,938,048 in recurring and $435,904 in nonrecurring). *The total need for this section is **$8,093,428** ($7,657,524 in recurring and $435,904 in nonrecurring).
Other:	The Department's Office of Administrative Services finds that this section is not applicable.

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?

Does the bill increase taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not increase taxes, fees, or fines.
Does the bill decrease taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not decrease taxes, fees, or fines.
What is the impact of the increase or decrease?	The Department's Office of Administrative Services finds that this section is not applicable.
Bill Section Number:	The Department's Office of Administrative Services finds that this section is not applicable.

TECHNOLOGY IMPACT

Does the legislation impact the agency's technology systems (i.e., IT	This legislation is expected to require significant changes to the FSFN system. This includes changes to support data currently not in FSFN and the development of web services to provide the data required for the case record face sheet to an external system. Detailed requirements necessary for detailed estimates have not yet been created, but high-level requirements and assumptions based on the bill were used to create a high-level estimate. The items identified as high-level requirements are:

<table>
<tr>
<td>support, licensing software, data storage, etc.)?</td>
<td>

New pages (2) to be developed in the FSFN application for (Transition Planning and Separate Sibling;
Pages (6) to be modified in FSFN for Maintain Case, Meetings, File Cabinet, Judicial Review Worksheet, FFA Ongoing, and Progress Update;
Existing templates (3) to be modified in FSFN for Judicial Review, FFA Ongoing, and Progress Update;
New template (1) to be developed in FSFN for Transition Planning;
Web Services (5-8) to be developed to pull FSFN data for the identified case record functional areas;
Security Web Service (1) to be developed for the external system to request data from FSFN using the existing FSFN role-based security; and
External Provider Solution Licensing and Services for a third-party solution that already has a Face Sheet.

This initial set of web services developed for the case record face sheet can be reused to support CCWIS requirements. This direction also supports the Governor’s Data Interoperability and Data Sharing initiatives.
It should be noted external provider solutions offer much more than just case record face sheet functionality. In fact, they have investigation, case management and care giver portal applications built into their mobile app solutions. Additional web services would be required to support this additionality functionality.
</td>
</tr>
<tr>
<td>If yes, describe the anticipated impact to the agency including any fiscal impact.</td>
<td>
The range of hours estimated (low spectrum level of effort, or LOE, to high spectrum level of effort) is shown in the table below. The hourly cost range is calculated using the current contracted programming vendor rate of $100/hour.
<table>
<tr><th></th><th colspan="2">Range of LOE</th></tr>
<tr><th>Title</th><th>Low Spectrum LOE</th><th>High Spectrum LOE</th></tr>
<tr><td>2 New pages to be developed in FSFN for Transition Planning and Separate sibling process</td><td>931</td><td>1870</td></tr>
<tr><td>6 pages to be modified in FSFN for Maintain case page, Meetings, File Cabinet, Judicial Review Worksheet, FFA Ongoing, and Progress update</td><td>680</td><td>1870</td></tr>
<tr><td>3 existing templates to be modified in FSFN for Judicial Review, FFA Ongoing, and Progress update</td><td>1622</td><td>2700</td></tr>
<tr><td>1 new template to be developed in FSFN for Transition Planning</td><td>872</td><td>1700</td></tr>
<tr><td>5-8 new web services to be developed to pull data from FSFN for the identified case record functional areas</td><td>4000</td><td>6400</td></tr>
<tr><td>1 new security web service to be developed for the external system to request data from FSFN using the existing FSFN role-based security</td><td>800</td><td>800</td></tr>
<tr><td>High-Level Estimated Hours:</td><td>8,905</td><td>15,340</td></tr>
</table>
The high-level services cost estimate is $410,500 to $814,000 for the FSFN Changes and $480,000 to $720,000 for the Web Services.
</td>
</tr>
</table>

	In addition to the FSFN changes and web services, the high-level cost estimate to license an external provider solution that already has a Face Sheet is $540K to $750K annually for all statewide stakeholders. This is a recurring annual cost that covers licensing and support. **The total high-level cost estimate for the FSFN changes, web services, and an external provider solution is $1,430,500 to $2,284,000.** There may also be implementation costs charged by the third party depending on the final requirements. If addition to the case record face sheet, if additional investigation, case management and care giver portal functionality is required, there will be additional costs to develop the web services.

FEDERAL IMPACT

Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)?	Yes
If yes, describe the anticipated impact including any fiscal impact.	Several components within Section 5 of this bill contradicts federal language with respect to sibling placements. The Department could be in federal violation of its state plan, which impacts the Department's ability to make Title IV-E claims for federal drawdown. There is also an impact to FFPSA Public Law 115-123 for group homes.

ADDITIONAL COMMENTS

Section 1: The Department is currently converting to a CCWIS model which may not be FSFN, therefore the term FSFN may become obsolete.

Section 2: The bill at lines 254-340 amends s. 39.522, F.S., to establish that a court must conduct an evidentiary hearing when a party or caregiver denies the need for a change of placement. Before the court may order a change of placement, the court must consider among other factors the recommendation of the multidisciplinary team that developed a transition plan consistent with s. 39.523, F.S., and, if a caregiver is entitled to rebuttable presumption under s. 39.522(3)(a), F.S., the court must receive evidence from a court-selected neutral and independent expert in the science and research of child-parent bonding and attachment. This process will ensure that the court has the best information available to it when making decisions when an emergency does not exist. However, where an emergency exists such as evidence that the caregiver has sexually abused the child, the language does not provide an emergency mechanism for the Department or the court to immediately remove the child from the unsafe home before the court has the opportunity to conduct the required evidentiary hearing or the required witnesses have the opportunity to perform the statutory assessments of the case.

Section 3: The bill at line 428 uses the term "non-relative placement." The term "Fictive Kin," as the definition of fictive kin includes non-relative caregivers who have a close relationship with the child and may be the more appropriate term to use.

At line 436, the bill creates s. 39.523(3), F.S., to establish child and family teams that will meet when important decisions have to be made about a child's life. Lines 456-466, detail individuals who must always be included in the team. Among others, the language contemplates the child, the child's family members (which would include the parents), and other individuals identified by the family as being important must always be included in the meetings. As written, this language would require a child, regardless of the age, to be in the same meeting with the abusive parent. This language would also require a parent who is a domestic violence victim to be in the meeting with the other parent who was the perpetrator of the abuse. Requiring victims, especially child victims of sexual abuse or domestic violence victims, to engage with their abusers would cause further trauma and be contrary to the express purpose of the child and family teams. Creating a trauma-informed exception to the participation of the child when it

is not in the child's best interests and an exception to the inclusion of any individual who has a no contact order or injunction against them would ensure the team could effectively collaborate.

If the Child and Family Team and meeting is to replace the AARC, the following should be considered:

- While all the individuals listed as members of the Child and Family Team meetings can provide input as to the final recommendation to the Department, they are not the decision makers in the current AARC process.
- The decision of the Child and Family Team would be a recommendation to the Department as the Department selects adoption applicants for cases requesting an AARC.
- Individuals who are members of the AARC have adoption specific training, familiarity with adoption laws and policies will be needed to ensure individuals are adoption competent.

Section 4: This portion of the bill creates s. 39.5321, F.S., to address placement and education transitions. The definition of "placement change" in s 39.5321(2)(c), F.S., at lines 663-668, means any time a child is moved from one caregiver to another. Because the definition is premised upon a move and not a change of custody, for every move to respite care the Department would be required to provide supportive services and develop a transition plan. This language undermines the Department's policy to immediately move a child to respite care when there are allegations that a caregiver has sexually abused a child. Also, the Department would be required to develop a transition plan when a caregiver requests immediate removal of a child based on safety concerns, sometimes to other children in the home. Creating an exception for moves for respite care or child safety would enable the Department to immediately protect a child when there are allegations against the caregiver. Further, the transition planning required to be used in emergency situations at lines 736-767 still requires the Department to share information with the caregiver, provide for the child to have a final visit, and allow continued contact with the caregiver if possible. An "in the best interest" exception to these requirements would ensure that the Department can properly conduct its investigation where there are allegations that the caregiver has abused the child without simultaneously subjecting the child to further abuse.

The definition of "placement change" to include moves between rooms and buildings and operated by a group home provider would be inconsistent with the concept of "normalcy" outlined in 409.415(2), F.S., that empowers each caregiver to use a reasonable and prudent parent standard of care in their interactions with children in out-of-home care. To reduce Department and court interference with such a parenting standard and to substantially reduce the work impact required to produce transitions plans for such moves, it is recommended that the second sentence in the definition of "placement change" be removed.

Section 5: Several components of this section are inconsistent with federal guidance in refence to sibling placement. Federal law has emphasized the importance of maintaining sibling relationships since the Fostering Connections to Success and Increasing Adoptions Act of 2008. This federal law set the stage to require states to make reasonable efforts to maintain sibling connections by either placing them in the same home or providing for frequent visitation, unless either would not be in the best interest of the child. More recently the Federal government has highlighted the importance of sibling contact in the Family First Prevention Services Act of 2018 by allowing a State to increase the number of children in a foster family home beyond federal numerical caps to allow a sibling group to stay together. In June of 2019, the Children's Bureau released a Bulletin for Professionals (Bulletin,) highlighting "Sibling Issues in Foster Care and Adoption" indicating a renewed push to take these bonds into consideration when making placement decisions. The Bulletin concludes by stating that "[m]aintaining and strengthening sibling bonds is a key component to child well-being and permanency outcomes" and further reiterates that it is "central to meeting the requirements of the Fostering Connections Act."

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	Lines 1022-1025 run counter to federal guidelines and law. There could be issues with the Department's Title IV-E state plan. Lines 1034-1036 require mental health professionals with "expertise" in sibling bonding on a child and family team. Florida uses the "Daubert" standard to determine expertise. This could be an issue in conducting the required team meetings. Lines 1198–1203 codify a "right" of a child to contact a previously adopted sibling. This is a constitutional issue that may violate the privacy rights of the adopted child and his or her parents.

2020 AGENCY LEGISLATIVE BILL ANALYSIS
Department of Children and Families

BILL INFORMATION	
BILL NUMBER:	SB 1548
BILL TITLE:	**Child Welfare**
BILL SPONSOR:	Senator Perry
EFFECTIVE DATE:	October 1, 2020

COMMITTEES OF REFERENCE
1) Children, Families, and Elder Affairs
2) Appropriations Subcommittee on Health and Human Services
3) Appropriations
4)
5)

CURRENT COMMITTEE
Children, Families, and Elder Affairs

SIMILAR BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

IDENTICAL BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

PREVIOUS LEGISLATION	
BILL NUMBER:	N/A
SPONSOR:	N/A
YEAR:	N/A
LAST ACTION:	N/A

Is this bill part of an agency package?
Yes

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	January 16, 2020
LEAD AGENCY ANALYST:	Stephanie Zimmerman, Children's Legal Services Javier Enriquez, Office of General Counsel Brandie McCabe, OCW John Harper, OCW Jessica Johnson, OCW Samantha Wass de Czege, Child Care
ADDITIONAL ANALYST(S):	Michael Lee, Office of General Counsel Yemi Quijada, Child Care
LEGAL ANALYST:	Kelly McGrath, OGC Stefanie Camfield, OGC
FISCAL ANALYST:	Sue Zwirz, Budget Sandra Smith, Budget

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

The bill accomplishes the following:

- Requires the Florida Court Educational Council to establish certain standards, consistent with the purposes of Chapter 39, F.S., for instruction of circuit court judges in dependency cases.
- Eliminates the requirement for the Department to submit an annual report to the Governor and Legislature on false reporting of abuse allegations made to the Florida Abuse Hotline, as well as the Independent Living Services Report and the Independent Living Services Advisory Council's Report.
- Provides the Department authority to adopt rules for the establishment of processes and procedures for qualified evaluators and implement Medicaid behavioral health utilization management programs for statewide in-patient psychiatric (SIPP) facilities with a contracted vendor.
- Provides authority for the Department to appoint all Qualified Evaluators who conduct suitability assessments for children in out-of-home care.
- Creates an emergency modification of placement process that uses a probable cause standard to ensure child safety when a child is either abandoned by or must be immediately removed from a relative, nonrelative, or licensed foster home followed by a review process that uses the current standard of child's best interest established by a preponderance of the evidence. This modification of placement process applies when a child must be removed from a parent in an open dependency case after reunification has occurred but before the Department's supervision has been terminated.
- Resolves a conflict in Chapter 39 concerning the timeframe for filing and serving a case plan by amending the provisions in s. 39.6011(7), F.S., to mirror the deadlines in s. 39.521(1)(a), F.S.
- Clarifies the process for terminating court jurisdiction and Department supervision in a dependency court action by relocating provisions concerning supervision and jurisdiction that are located throughout Chapter 39, F.S., into new s. 39.630, F.S.
- Clarifies the paternity establishment and disestablishment process by modifying provisions concerning paternity that are located throughout Chapter 39.
- Creates a new s. 39.8025, F.S., to create a lawful process to immediately protect children whose parents are deceased by committing them to the custody of the Department and making them eligible for adoption.
- Clarifies that the Department is not required to provide reasonable efforts to preserve and reunify the family if a court has found that the parent is convicted of an offense that requires the parent to register as a sexual predator under s. 775.21, F.S.
- Provides standing for an unsuccessful applicant to adopt a child who is permanently committed to the Department to have the opportunity to prove that the Department has unreasonably withheld its consent to the applicant. These amendments eliminate the need for an administrative appeal process for unsuccessful applicants and eliminates multiple competing adoption petitions by the approved and unsuccessful applicants.
- Requires a petition to adopt a child who is permanently committed to the Department to demonstrate that the Department has consented to the adoption or that the dependency court has entered an order waiving the Department's consent.
- Provides that a dependent child's placement with a prospective adoptive parent after a Chapter 39 intervention in a Chapter 39 dependency proceeding can only occur after the placement is subject to a preliminary home study that establishes the suitability of the home.
- Creates a new s. 742.0211, F.S., to address paternity proceedings concerning dependent children.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Judicial Training

Section 1

There is only one statute that contemplates specialized training for the judiciary—s. 28.385, F.S., titled "Standards for instruction of circuit and county court judges in handling domestic violence cases." Pursuant to s. 28.385(1), F.S., the Florida Court Educational Council is required to establish standards for instruction of circuit and county court judges who have responsibility for domestic violence cases and provide such instruction on a periodic and timely basis.

There is not currently a statutorily-mandated dependency training requirement for members of the judiciary that preside over Chapter 39, F.S., cases. Yet, the judiciary encounter complex issues in dependency cases while fulfilling the purposes of Chapter 39, F.S., including:

- To provide for the care, safety, and protection of children in an environment that fosters healthy social, emotional, intellectual, and physical development; to ensure secure and safe custody; to promote the health and well-being of all children under the state's care; and to prevent the occurrence of child abuse, neglect, and abandonment;
- To ensure that permanent placement with the biological or adoptive family is achieved as soon as possible for every child in foster care and that no child remains in foster care longer than 1 year; and
- To provide judicial and other procedures to assure due process through which children, parents, and guardians and other interested parties are assured fair hearings by a respectful and respected court or other tribunal and the recognition, protection, and enforcement of their constitutional and other legal rights, while ensuring that public safety interests and the authority and dignity of the courts are adequately protected. § 39.001, F.S.

When members of the judiciary are newly assigned to the dependency division, they must rely upon other dependency judges, the Department, the Guardian ad Litem program, and their own resources to quickly learn the nuances of the dependency system that impact permanency and trauma-informed care. The establishment of standards of instruction and the offering of periodic instruction for circuit court judges who sit in the dependency division would ensure statewide consistent understanding of the scope of the judge's authority in fulfilling the purposes of Chapter 39, F.S.

Paternity

As of November 22, 2019, data extracted from the Florida Safe Families Network (FSFN) established that there are currently 4,516 children with active judicial cases who have no father identified. The failure to establish a father for a child as early in the case as possible leads to delay in permanency when the father appears months after disposition because a new case plan must be established. This often extends the goal date by at least six months. The failure to establish the father of the child early also limits the scope of available relative placements for the child, which is contrary to the legislative intent in s. 39.4015(1), F.S., acknowledging that research has shown that relative placements lead to better results for children.

While FSFN does not have the ability to track how often a father is established postdisposition, it is reasonable to approximate that of 16,463 children whose cases closed in FY 2018-2019, at least 500 of them had fathers enter the case after the court had ordered the case plan for the other parent, with at least 200 fathers not appearing in the case until after the permanency hearing was held twelve months after the child was removed from the other parent's home.

While chapter 2017-151, Laws of Florida, incorporated statutory changes to identify a child's legal father earlier in a dependency case, additional changes are necessary to ensure that once identified, the court enters an order establishing paternity. Statutory revisions are also needed to establish that where the court has identified a legal father, the dependency proceeding need not be delayed in order to provide notice to or to conduct a diligent search for a prospective parent. Lastly, Florida's dependency courts need guidance on how to treat a Chapter 742 action when it concerns a dependent child.

Section 2

If an individual is a "parent" in a dependency action, the individual is entitled to due process and notice before any judicial action may be taken. Section 39.01(56) defines "parent" to mean a woman who gives birth to a child and a man whose consent to the adoption of the child would be required under s. 63.062(1). The term "parent" also means legal father. If a child has been legally adopted, the term "parent" means the adoptive mother or father of

the child. The term does not include an individual whose parental relationship to the child has been legally terminated, or an alleged or prospective parent, unless:

(a) The parental status falls within the terms of s. 39.503(1) or s. 63.062(1); or

(b) Parental status is applied for the purpose of determining whether the child has been abandoned.

There is presently a delay in court proceedings in cases in which there is already a legally established father because of the statutory requirement to treat an alleged or prospective father who is identified during the inquiry contemplated by s. 39.503(1), F.S., as a parent even if that person has not yet been located or, if located, fails to execute a sworn affidavit of parenthood. Such delays occur even in cases where it is not contemplated that the legal father will be disestablished and the prospective parent will be established. And, those delays are compounded where multiple individuals are identified as the prospective father for a single child. Those delays are outlined further in Section 8 below.

Section 5

Section 39.01(40), F.S., defines "legal father" to mean a man married to the mother at the time of conception or birth of their child, unless paternity has been otherwise determined by a court of competent jurisdiction. If the mother was not married to a man at the time of birth or conception of the child, the term means a man named on the birth certificate of the child pursuant to s. 382.013(2), F.S., a man determined by a court order to be the father of the child, or a man determined to be the father of the child by the Department of Revenue as provided in s. 409.256, F.S.

When the identity and location of the legal father is unknown, ss. 39.402(8)(c)(4), 39.503(1), 39.803(1), F.S., require the court to inquire under oath of those present at the shelter, dependency, or termination of parental rights hearing whether they have any of the following information:

a. Whether the mother of the child was married at the probable time of conception of the child or at the time of birth of the child.

b. Whether the mother was cohabiting with a male at the probable time of conception of the child.

c. Whether the mother has received payments or promises of support with respect to the child or because of her pregnancy from a man who claims to be the father.

d. Whether the mother has named any man as the father on the birth certificate of the child or in connection with applying for or receiving public assistance.

e. Whether any man has acknowledged or claimed paternity of the child in a jurisdiction in which the mother resided at the time of or since conception of the child or in which the child has resided or resides.

f. Whether a man is named on the birth certificate of the child pursuant to s. 382.013(2), F.S.

g. Whether a man has been determined by a court order to be the father of the child.

h. Whether a man has been determined to be the father of the child by the Department of Revenue as provided in s. 409.256, F.S.

While ss. 39.402(8)(c)(4), 39.503(1), 39.803(1), F.S., explain the inquiry that a court must conduct to identify the legal father, there is no requirement in those statutes that the court must enter an order establishing paternity when a legal father has been identified. Without the entry of an order establishing paternity, the legal father is under no obligation to begin services or provide child support. Also, if the child is or were to be placed with the legal father's relatives, that placement is treated as a nonrelative placement until the order establishing paternity is entered.

Just as there is no statutory requirement mandating that the court enter an order establishing paternity, there is also no statutory prohibition on the court *sua sponte* disrupting paternity when no one has sought to disestablish a legal father. As a result, dependency court judges will make prospective fathers parties to a dependency case, resulting in dual paternity for a child and the need to provide services to multiple "fathers" at the same time. Most recently, in Department of Children and Families v. D.A., 279 So. 3d 1268 (Fla. 5th DCA September 18, 2019), the Department had to seek certiorari relief when the trial court ordered the Department to pay for DNA testing of a putative father who did not wish to assert his rights and where there was a legal father. The Fifth District Court

of Appeal quashed the order, holding that it was a departure from the essential requirements of the law because no party had put the issue of paternity into controversy. Clarification in the law that paternity should not be disturbed in the absence of a successful Chapter 742 action would avoid this unnecessary use of resources.

Section 7
Section 39.503, F.S., presently requires the Department and the court to take action including providing notice of hearings where the court's inquiry identifies any person as a parent or a prospective parent and conducting a diligent search if that person's location is unknown. In practice, compliance with the language has resulted in the unintended consequence of delay in the proceedings when notice must be provided to a parent whose location is unknown or a diligent must be conducted to locate a prospective father even where there is a legally-established father. FSFN data establishes that in FY 2018-2019, the Department performed diligent searches for 2,968 children. On average, it takes case management approximately 60 days to perform a diligent search and provide the results of the search to the court and the Department. While a definitive count cannot be provided to distinguish the number of diligent searches that were performed to locate a parent as opposed to a prospective parent, based upon the escalation of cases delayed due to the need to conduct a search, the majority of these searches were conducted to locate a prospective parent.

Conducting a diligent search for a prospective parent where there is a legal father results in unnecessary delay because, even if the prospective parent were to be located, there is no assurance that individual will seek to disestablish the legal father's rights or that he could meet the standing threshold established in Simmonds v. Perkins, 247 So. 3d 397 (Fla. 2018), of manifesting a substantial and continuing concern for the welfare of his child in order to be permitted to pursue a paternity action. The court could achieve disposition pursuant to s. 39.521, F.S., earlier if a diligent search was not required to be conducted to locate a prospective father where there is a legally-established father.

If there is no legal father, then a diligent search for a prospective parent is appropriate to establish paternity and potentially increase the pool of relative placements for the child. Section 39.503(8), F.S., establishes that if the inquiry and diligent search performed at the dependency stage identifies a prospective parent, that person must be given the opportunity to become a party to the proceedings by completing a sworn affidavit of parenthood and filing it with the court or the Department. A prospective parent, who files a sworn affidavit of parenthood while the child is a dependent child but no later than at the time of or before the adjudicatory hearing in any termination of parental rights proceeding for the child, shall be considered a parent for all purposes under this section unless the other parent contests the determination of parenthood.

Section 39.503(8), F.S., does not currently provide guidance to the court if an individual seeks to file a sworn affidavit of parenthood or files a Chapter 742 paternity action after the legal father's rights have been terminated. In the past year, there have been at least 10 cases in which a prospective father sought to establish his rights after the Department offered services to the legal father for more than a year and terminated the legal father's rights. In these cases, the children at issue had their permanency delayed for months while the parties collected discovery and the court conducted an evidentiary hearing on the Chapter 742 complaint. None of these prospective fathers had any barriers to bringing their paternity actions sooner.

Section 12
Section 39.801(3)(a), F.S., outlines who must be served a petition to terminate parental rights before the court may take action on the petition. The statute provides any prospective parent who has been identified under s. 39.503, F.S., or s. 39.803, F.S., must be served unless a court order has been entered pursuant to s. 39.504(4) or (9), F.S., or s. 39.803(4) or (9), F.S. There is no qualification that the prospective parent must have also been located under the statutes. Consequently, termination proceedings are being delayed until the Department can complete service on a prospective parent who has been identified but not located. Based on self-reports, this delay averages approximately 60 days.

Section 14
Section 39.803(1), F.S., contemplates that the court conduct an inquiry under oath if the identity or location of a parent is unknown. There is no exception even where the court has previously entered an order relieving the petitioner of further notice or search. The requirement to conduct an inquiry in cases where an inquiry has already been conducted has resulted in duplicative efforts and a delay in termination proceedings.

Like s. 39.503, F.S., discussed in Section 8 above, s. 39.803, F.S., presently requires the Department and the court to take action including providing notice of hearings where the court's inquiry identifies any person as a parent or a prospective parent and conducting a diligent search if that person's location is unknown. The same unnecessary delays that occur at the adjudication stage to perform a diligent search to locate a prospective

parent where there is a legal father occur at the termination of parent rights stage of the case. Indeed, these delays occur for a second time because the court orders the diligent search process be repeated because s. 39.503 does not presently relieve the petitioner of further search. As explained in Section 8, these delays are often a minimum of 60 days and the court could get to the adjudicatory hearing on the dependency petition pursuant to s. 39.809, F.S., earlier if a diligent search was not required to be conducted to locate a prospective father where there is a legally-established father.

Like s. 39.503(8), F.S., s. 39.803(8) does not currently provide guidance to the court if an individual seeks to file a sworn affidavit of parenthood or files a Chapter 742 paternity action after the legal father's rights have been terminated. As stated previously, there have been at least 10 cases where the children at issue had their permanency delayed for months to conduct Chapter 742 when the prospective fathers had no barriers to bringing their paternity actions sooner.

Section 25

Chapter 742, F.S., concerns determination of parentage. Section 742.011, F.S., permits any woman who is pregnant or has a child, any man who has reason to believe that he is the father of a child, or any child may bring proceedings in the circuit court, in chancery, to determine the paternity of the child when paternity has not been established by law or otherwise. Section 742.021, F.S., provides for the filing of a complaint charging paternity in the circuit court where the plaintiff resides or where the defendant resides. Section 742.031, F.S., contemplates that the court will conduct a hearing on the complaint and that, if the court finds that the alleged father is the father of the child, it shall so order. Section 742.18, F.S., provides for a process under which a male may disestablish paternity or terminate a child support obligation when the male is not the biological father of the child.

Neither Chapter 742 nor ss 39.402(8)(c)(4), 39.503(1), 39.803(1), F.S., provide any guidance on the standards a court should use in a Chapter 39 proceeding to disestablish a legal father's rights when a Chapter 742 action has been filed concerning a dependent child. Instead, courts get their guidance on resolving a Chapter 742 disestablishment claim from case law. In Simmonds v. Perkins, 247 So. 3d 397 (Fla. 2018), the Florida Supreme Court established the test to determine whether a biological father has standing to bring a paternity action when a child is born of an intact marriage. The Court found that if a biological father manifests a substantial and continuing concern for the welfare of his child, he will not be precluded from bringing a paternity action even if the mother was married at the time of conception or birth. Thereafter, the biological father must show there is a clear and compelling reason based primarily on the child's best interests to overcome the presumption of legitimacy. Dep't of Health & Rehab. Servs. v. Privette, 617 So. 2d 305, 308 (Fla. 1993). Incorporating these standards into Florida law, which protect the child's best interests, would ensure uniform statewide resolution of paternity disputes in Chapter 39 proceedings.

Florida Rules of Juvenile Procedure 8.266 provides the court having jurisdiction over the dependency matter may conduct proceedings under Chapter 742, F.S., either as part of the Chapter 39, F.S., proceeding or in a separate action under Chapter 742, F.S. Yet, there is no provision in statutory law for a Chapter 39 court to exercise jurisdiction over a Chapter 742 proceeding.

Case Closure

According to FSFN data, the judicial dependency cases for 16,463 children were closed between July 1, 2018 and June 30, 2019.

Section 8

Chapter 39, F.S., does not have a case closure statute that provides when a court can terminate the Department's supervision or the court's jurisdiction. Instead, the only statute in Chapter 39, F.S., to describe when these events can occur is s. 39.521, F.S., which addresses disposition. Section 39.521(1)(c)3., F.S., provides that protective supervision shall be terminated by the court whenever the court determines that permanency has been achieved for the child, whether with a parent, another relative, or a legal custodian, and that protective supervision is no longer needed. The termination of supervision may be with or without retaining jurisdiction, at the court's discretion, and shall in either case be considered a permanency option for the child. The order terminating supervision by the Department must set forth the powers of the custodian of the child and include the powers ordinarily granted to a guardian of the person of a minor unless otherwise specified. Upon the court's termination of supervision by the Department, further judicial reviews are not required if permanency has been established for the child.

Section 39.521(3), F.S., provides that when any child is adjudicated by a court to be dependent, the court shall determine the appropriate placement for the child. If the court determines that the child can safely remain in the home with the parent with whom the child was residing at the time the court established jurisdiction and it is in the

child's best interest to remain in the home, then the court shall order conditions under which the child may remain or return to the home. If there is a parent with whom the child was not residing at the time the events occurred who desires to assume custody of the child, the court shall place the child with that parent upon completion of a home study, unless the court finds that such placement would endanger the safety, well-being, or physical, mental, or emotional health of the child, and terminate jurisdiction after ordering reasonable visitation by the noncustodial parent or order services for one or both parents. If no fit parent is available, the court must place the child in the legal custody of an adult relative or another adult under the supervision of the Department. If no fit parent is willing or available to assume care and custody of the child, the court shall place the child in the temporary legal custody of an adult relative, the adoptive parent of the child's sibling, or another adult approved by the court who is willing to care for the child, under the protective supervision of the Department. If the child cannot be safely placed in a nonlicensed placement, the court shall commit the child to the temporary legal custody of the Department.

Section 39.521(7), F.S., further states that the court may enter an order ending its jurisdiction over a child when a child has been returned to the parents, provided the court shall not terminate its jurisdiction or the Department's supervision over the child until 6 months after the child's return. The Department shall supervise the placement of the child after reunification for at least 6 months with each parent or legal custodian from whom the child was removed. Because this provision is located within the statute concerning disposition, parents' counsel have argued that the six-month postplacement supervision does not apply if the child is returned to the parent's custody prior to disposition.

Recently, courts have been presented with argument that the provisions regarding termination of jurisdiction and supervision in s. 39.521, F.S., apply only when the court is contemplating termination of jurisdiction and supervision at the time of disposition. While the language suggests that it is also applicable postdisposition, it is unclear what standards should be used before disposition. The creation of a stand-alone statute that outlines the process for case closure at any time in the case would clarify for the court and the parties the requirements that must be met to ensure child safety before jurisdiction and supervision is terminated.

Section 11

While many statutes in Chapter 39 concern a child remaining in or returning to the home or being placed in some other permanency placement, those statutes are silent on how and when supervision and jurisdiction should be terminated.

Section 39.402(7), F.S., regarding shelter hearings, states a child may not be removed from the home or continue out of the home pending disposition if, with the provision of appropriate and available early intervention or preventive services, including services provided in the home, the child could safely remain at home. If the child has been removed from the home and the reasons for his or her removal have been remedied, the child may be returned to the home. However, the statute does not explain when the court is permitted to terminate Department supervision or the court's jurisdiction.

Section 39.507(5), F.S., explains that if the court finds that the child named in the petition is dependent, but finds that no action other than supervision in the child's home is required, the court may enter an order briefly stating the facts upon which its finding is based, but withholding an order of adjudication and placing the child's home under the supervision of the Department. The statute does not provide when the Department's supervision may be terminated.

Section 39.621(10), F.S., provides that the permanency placement made by the court is intended to continue until the child reaches the age of majority and may not be disturbed absent a finding by the court that the circumstances of the permanency placement are no longer in the best interest of the child. However, this statute does not explain under what circumstances the court is permitted to terminate its jurisdiction or terminate the Department's supervision after placing the child in a permanent placement.

Section 39.6221(5), F.S., provides that the court shall retain jurisdiction over a case and the child shall remain in the custody of the permanent guardian unless the order creating the permanent guardianship is modified by the court. When the court establishes the permanent guardianship, the court shall relieve the Department of the responsibility for supervising the placement of the child. Notwithstanding the retention of jurisdiction, the placement shall be considered permanency for the child.

Section 39.6231(5), F.S., states that the Department shall continue to supervise a permanent placement with a fit and willing relative until further court order.

The creation of a stand-alone statute that outlines the process for case closure at any time in the case would clarify for the court and the parties the requirements that must be met to ensure child safety before jurisdiction and supervision is terminated in the above scenarios.

Emergency Post-Disposition Modification of Placement
Section 9

FSFN data reflects that during FY 2018-2019 a postdisposition change of custody was granted for 3,724 children. The process for granting changes of custody is controlled by s. 39.522, F.S. Section 39.522(1), F.S., states that a child who has been placed in the child's own home under the protective supervision of the Department, in the home of a relative, in the home of a legal custodian, or in some other place may be brought before the court by the Department or by any other interested person, upon the filing of a petition alleging a need for a change in the conditions of protective supervision or the placement. If the parents or other legal custodians deny the need for a change, the court must hear all parties. Upon the admission of a need for a change or after such hearing, the court shall enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered. The standard for changing custody of the child shall be the best interest of the child. When applying this standard, the court shall consider the continuity of the child's placement in the same out-of-home residence as a factor when determining the best interests of the child. If the child is not placed in foster care, then the new placement for the child must meet the home study criteria.

Importantly, s. 39.522(1), F.S., does not establish the legal burden of proof, nor does it provide as s. 39.402, F.S., for an emergency hearing when a child's placement must be immediately modified. Because there is no emergency process for modification of placement, when a child is at risk of abuse, abandonment, or neglect, the Department must exercise its shelter power to protect the child and the court conducts a shelter hearing. This leads to confusion as to the standard to be used to move the child—probable cause to shelter or best interests to modify placement. Moreover, the provisions in s. 39.402(8)(c)-(g) regarding how to conduct a shelter hearing are designed to address a family first entering the dependency system, not a child who has already been adjudicated dependent and whose parents already have appointed counsel to represent their interests.

Filing of Case Plan Before Disposition
Section 10

Section 39.6011(1), F.S., requires the Department to prepare a case plan for each child receiving services under Chapter 39, F.S. A case plan for a family must be developed in conformity with s. 39.6011, F.S. According to s. 39.6011(2), F.S., the case plan must be developed in a face-to-face conference with the parent, the Guardian ad Litem, and the child (if appropriate). But, where the parents are deceased, the case plan cannot describe pursuant to s. 39.6012, F.S., the services to be provided to facilitate the child's return to the home. The case plan must be written simply and contain a description of the identified problem being addressed, the permanency goal, the date the compliance period ends, and written notice to the parent that failure to substantially comply with the case plan may result in the termination of parental rights, and that a material breach of the case plan may result in the filing of a petition for termination of parental rights sooner than the compliance period set forth in the case plan.

During FY 2018-2019, the court ordered a case plan at disposition for 9,186 children. However, before the court could order these case plans, the Department was required to file the case plan and serve a copy on the other parties. There is currently a conflict in the law as to when the Department must perform this task.

Section 39.521(1)(a), F.S., requires the Department to file the case plan with the court and serve a copy on the parties:

1. Not less than 72 hours before the disposition hearing, if the disposition hearing occurs on or after the 60th day after the date the child was placed in out-of-home care. All such case plans must be approved by the court.

2. Not less than 72 hours before the case plan acceptance hearing, if the disposition hearing occurs before the 60th day after the date the child was placed in out-of-home care and a case plan has not been submitted pursuant to this paragraph, or if the court does not approve the case plan at the disposition hearing. The case plan acceptance hearing must occur within 30 days after the disposition hearing to review and approve the case plan.

Section 39.6011(7), F.S., requires that the case plan must be filed with the court and copies provided to all parties, not less than three business days before the disposition hearing, regardless of when the disposition hearing is held.

Permanent Commitment of Orphaned Children
Section 13
Presently, the Department can adjudicate a child dependent if both parents are deceased, but there is no legal mechanism to permanently commit the child to the Department for subsequent adoption.

The court in F.L.M. v. Department of Children and Families, 912 So. 2d 1264 (Fla. 4th DCA 2005), held that when the parents or guardians have died, they have not abandoned the child because the definition of abandonment contemplates the failure to provide a minor child with support and supervision while being able and the parents who died are no longer able to do anything. Instead, the court held that an orphaned child without a legal custodian can be properly adjudicated dependent based upon then s. 39.01(14)(e), F.S., which is currently numbered as s. 39.01(15)(e), F.S., in that the child has no parent or legal custodian capable of providing supervision and care. As such, the Department relies upon s. 39.01(15)(e), F.S., to adjudicate orphaned children dependent.

Section 39.811(2), F.S., permits a court to commit a child to the custody of the Department for the purpose of adoption if the court finds that the grounds for termination of parental rights have been established by clear and convincing evidence. Section 39.806(1), F.S., outlines the available grounds for termination of parental rights. Those grounds include: a written surrender voluntarily executed by the parent, abandonment, failure by the parent to substantially comply with a case plan, and egregious conduct on the part of the parent, among other grounds. All of the grounds available under s. 39.806(1), F.S., require that the parent engage in some kind of behavior that puts a child at risk. Because a deceased parent can no longer engage in any behavior, the Department cannot seek the termination of a deceased parent's rights. Moreover, even if there was a legal ground to seek the termination of a deceased parent's rights, there may be benefits that the child is receiving such as social security benefits or an inheritance as a result of the parent's death that the Department would not want to halt by seeking a termination of the deceased parent's rights. Because the Department cannot seek termination of parental rights when both parents are deceased, courts are permanently committing children to the Department's custody without meeting the requirements of s. 39.811(2), F.S. The dependency system is in need of a statute that permits an orphaned child to be permanently committed to the Department for subsequent adoption without terminating the deceased parent's rights so as to allow the child to continue to receive death benefits.

Reasonable Efforts for Registered Sexual Predators
Section 15
Section 39.806(1)(n), F.S., provides that a ground for termination of parental rights may be established when the parent is convicted of an offense that requires the parent to register as a sexual predator under s. 775.21, F.S.

Section 39.806(2), F.S., explains that the Department is not required to provide reasonable efforts to preserve and reunify families if a court of competent jurisdiction has determined that any of the events described in ss. 39.806(1)(b)-(d) or (1)(f)-(m), F.S., have occurred. These grounds are referred to as the expedited termination of parental rights grounds because the Department does not need to obtain an adjudication of dependency and offer the parents a case plan for reunification before seeking termination of the parents' rights. These grounds include where the parent has committed egregious conduct, aggravated child abuse, and aggravated sexual battery. Because s. 39.806(1)(n), F.S., is not listed in s. 39.806(2), F.S., the Department must provide a parent who is a convicted and registered sexual predator a case plan for reunification prior to seeking termination of that parent's rights pursuant to this particular ground for termination.

Department's Selection of Adoptive Placement and Court Review of Department's Consent
Sections 16, 17, and 18
The Department's ability to place a child in its custody for adoption and the court's review of the placement is controlled by s. 39.812, F.S. That statute provides the Department may place a child in a home and the Department's consent alone shall be sufficient. The dependency court retains jurisdiction over any child placed in the custody of the Department until the child is adopted pursuant to ss. 39.811(9), 39.812(4), and 39.813, F.S. After custody of a child for subsequent adoption has been given to the Department, the court has jurisdiction for the purpose of reviewing the status of the child and the progress being made toward permanent adoptive placement. As part of this continuing jurisdiction, s. 39.811(9), F.S., provides that for good cause shown by the Guardian ad Litem for the child, the court may review the appropriateness of the adoptive placement of the child.

Where a child is available for adoption, the Department through its contractors will receive applications to adopt the child. Some applicants are not selected because their adoption home study is denied. When there are two or more families with approved home studies, the Department's rules route these conflicting applications through the adoption applicant review committee (AARC) for resolution. The decision of the AARC is then reviewed and the Department issues its consent to one applicant while communicating its denial to the other applicants through

certified letter. These letters are considered final agency action. Unsuccessful applicants have a “point of entry” to seek review of Department action through the administrative hearing process under Chapter 120, F.S. These hearings are heard by designated hearing officers within the Department. The assignment of adoption disputes to the Chapter 120, F.S., process did not originate with nor was it inspired by legislative directive. Instead, this process arose due to the opinion in Department of Children & Family Services v. I.B. and D.B., 891 So. 2d 1168 (Fla. 1st DCA 2005). However, this process is inconsistent with the Legislature's clear intent of permanency and resolution of all disputes through the Chapter 39, F.S., process.

Florida law also permits individuals, who the Department has not approved to adopt a child, to initiate a new Chapter 63, F.S., legal action by filing a petition for adoption. Upon filing the petition, the petitioner must demonstrate pursuant to s. 63.062(7), F.S., that the Department unreasonably withheld its consent to be permitted to adopt the child. Because Chapter 63, F.S., permits anyone who meets the requirements of s. 63.042(2), F.S., to adopt and any petitioner may argue the Department's consent to the adoption should be waived because it was unreasonably withheld, multiple parties may file a petition to adopt the same child. Indeed, there can be at least three legal proceedings simultaneously addressing the adoption of the child: (1) the Chapter 39, F.S., dependency proceeding, (2) the Chapter 63, F.S., adoption proceeding filed by the family who has the Department's consent, and (3) the Chapter 63, F.S., adoption proceeding filed by the applicant who asserts the Department unreasonably withheld its consent. Multiple competing adoption petitions require additional court hearings to resolve the conflict and leads to a delay of the child's adoption. These court proceedings often occur concurrently with the administrative hearing process, which can lead to disparate results.

In 2017, the Department commenced and concluded 28 separate Chapter 120 cases involving a family's petition for administrative hearing for purposes of contesting a Chapter 39 adoption selection. This number rose by 35.7 percent in 2018 with the Department adjudicating 38 cases. In 2019, the Department is on pace to a review 57 cases—a 50 percent increase from 2018 and a 103 percent increase from 2017. It is further projected that this trend will continue to increase in 2020 and beyond.

Each of these cases involves Department attorneys serving as lead trial counsel as well as a separate attorney serving as a designated hearing officer pursuant to section 120.80(7), F.S. When serving as a hearing officer, each of these matters involves approximately 33 hours of assigned labor. Assigned counsel provides approximately 49 hours of labor. The agency clerk's office likewise provides an additional 17 hours of commitment per case. In total, each case involves, on average, 99 hours of Department resources. In addition to the hourly cost associated with staff time, there are fixed costs associated with each case. A standard appearance fee, necessary for each hearing by statute, is generally $500 with each case lasting, on average, two days. This $1,000 fee is compounded by the costs of transcripts which generally provide a $1,750 invoice. As outlined further in the fiscal analysis, the total costs associated with these administrative matters in 2019 equate to $512,715 with total hourly commitment by Department staff equating to 7,524 hours, or nearly four FTEs.

These numbers do not compute the hours, time, and monetary resources required by Department contracted staff, agency witnesses, or other individuals required to give/present testimony and resolve these matters. These cases routinely involve multiple individuals, many of whom have primary responsibilities as front-line investigators, case managers, nurses, or even psychologist and doctors. It is difficult to estimate the costs of these individuals' time due to the varied nature of their employment, but it likely equals or surpasses the dollar and time amounts from Department counsel, agency clerk, and agency representative.

Beyond the agency costs are the delays inherent in these procedures that encumber the Chapter 39 demand for permanency. Twenty-five Chapter 120 contested adoption matters were sampled between 2018 and 2019, and the average length of time between the receipt of a hearing request and entry of a final order was 213 days. Of note, this does not include any additional delays caused by appeal to the appropriate District Court which adds, on average, an additional 120 days of delay. It is estimated that approximately 153 days of delay will be removed if Chapter 120 proceedings are eliminated and a declined applicant seeks review in the dependency court. With an average of two children involved in each case, and at an average cost of care per day at $37.64, this will save the Department approximately $656,516.88 each year.

Relative Home Studies in Chapter 63 Intervention Proceedings
Section 19

For children in the custody of the Department, s. 63.082(6)(a), F.S., provides that if a parent executes a consent for placement of a minor with an adoption entity or qualified adoptive parents, but parental rights have not yet been terminated, the adoption consent is valid, binding, and enforceable by the court. After the parent executes the consent, s. 63.082(6)(b), F.S., permits the adoption entity to intervene in the dependency case as a party in interest and requires the adoption entity to provide the court with a copy of the preliminary home study of the

prospective adoptive parents and any other evidence of the suitability of the placement. Section 63.082(6)(b), F.S., further provides that the home study provided by the adoption entity shall be sufficient unless the court has concerns regarding the qualifications of the home study provider or concerns that the home study may not be adequate to determine the best interests of the child.

Although s. 63.082(6), F.S., provides no exception for the completion of a preliminary home study before the court may transfer custody of the child to the prospective adoptive parents, parties have been able to intervene and accomplish a modification of placement without presenting the court with a home study by relying upon s. 63.092(3), F.S. This section provides that a preliminary home study in a nondependency proceeding is not required when the petitioner for adoption is a stepparent or a relative. Section 63.032(16), F.S., defines a "relative" to mean a person related by blood to the person being adopted within the third degree of consanguinity. As a result of this interpretation of the law, a "relative" who did not pass a Department home study because of safety concerns in the home or disqualifying background offenses is permitted to intervene in a dependency action to obtain placement of the child. In one recent case, the relative failed 5 different Department home studies, yet the trial court held that she did not need to complete a home study to intervene in the proceeding pursuant to s. 63.082(6), F.S. The Department has no ability to ensure the safety of the child in these instances because the adoption entity upon the modification of placement takes over supervision of the child pursuant to s. 63.082(6)(f), F.S.

Statutorily Mandated Reports
Included in Chapters 39 and 409, F.S., are several legislatively mandated reports that the Department is required to complete each year and send to the President of the Senate, the Speaker of the House, and the Governor's Office. Some of these reports have been mandated for years despite changes in processes, and tracking and posting of data monthly. A review schedule of the relevancy of the reports is not required but the Department decided to review all of the required reports for child welfare to determine if any reports were outdated or if information was readily available from other sources. The below chart reflects two reports that the Department determined were no longer relevant.

Name of the Report	Statutory Reference	What does this report include	Due date of the report	Approximate employee manhours saved	Information accessibility if report is no longer required
Independent Living Services Advisory Council Annual Report	s. 409.1451(7), F.S.	Recommendations to the Legislature and the Department on the status of the services being provided, including successes and barriers to these services.	December 31	~562 (+ review & routing)	The oversight provided by the ILSAC Committee and annual report is a duplication of efforts of Results-Oriented Accountability (ROA) Program and the ROA annual performance report required to the legislature.
False Reporting	s. 39.205(7), F.S.	The number of false reports referred to law enforcement for consideration of a criminal investigation.	March 30	TBD	Information is partially captured in FSFN and partially manually tracked by the region program offices or legal.

Section 3
Section 39.205(7), F.S., currently requires the Department to submit an annual report to the Governor and the Florida Legislature detailing the number of false reports referred to law enforcement for consideration of a criminal investigation. Any person who knowingly and willingly files a false report with the Florida Abuse Hotline, or advises another individual to make such a report, is guilty of a felony of the third degree as provided in ss. 775.082 and 775.083, F.S. The first submission of this report was initially the responsibility of each respective state attorney (ref: s. 39.205(6), F.S.(1998)). Chapter 39, F.S., was subsequently amended in 1999 to direct the Department to submit the annual report from that point forward.

This report has consistently indicated that the vast majority of reports are made in good faith to the Florida Abuse Hotline. Since FY 2015-2016, the Department has averaged 172,500 child protective investigations per year with only 325 reports per year suspected as being initiated as a result of false reporting. Over the past four years that equates to only one suspected false report per approximately 500+ investigations. Low rates have repeatedly been reported to the Legislature since 2006.

Section 24

Section 409.1451(6), F.S., requires the Department to prepare a report on the outcome measures and the Department's oversight activities regarding independent living no later than January 31 of each year. The report is to be submitted to the President of the Senate, the Speaker of the House of Representatives, and the committees with jurisdiction over issues relating to children and families in the Senate and the House of Representatives.

The report must include:

(a) An analysis of performance on the outcome measures developed under the section reported for each community-based care lead agency (CBC) and compared with the performance of the Department on the same measures.

(b) A description of the Department's oversight of the program, including, by CBC, any programmatic or fiscal deficiencies found, corrective actions required, and current status of compliance.

(c) Any rules adopted or proposed under the section since the last report.

The Department is required to provide the Children's Bureau, an Office of the Administration for Children and Families, an Annual Progress and Services Report (APSR). A section of the federal APSR is dedicated to sharing outcome and oversight information regarding the Department's independent living services programs and services provided under s. 409.1451, F.S., that are linked to federal funding. The APSR is also provided to the Legislature each year for review. Striking the language in s. 409.1451, F.S., will eliminate the duplicate review currently required in the statutes.

In addition, the Department is required to develop a legislatively mandated Results Oriented Accountability - CBC Performance Report. The report monitors and measures the use of resources, the quality and amount of services provided, and the child and family outcomes. While this report does not currently capture specific outcomes related to independent living program, the content could be expanded to include this population if some level of duplication is needed for document context.

Since 2002, when the Independent Living Services Integration Workgroup [currently known as Independent Living Services Advisory Council (ILSAC)] was first established, the Department has made substantive changes to the law to ensure Florida's transitioning youth and young adults receive appropriate services, support, and supervision. The greatest legislative advancement was the "Nancy C. Detert Common Sense and Compassion Independent Living Act," which allowed for youth to remain in foster care until he or she turned 21 (22 with a disability). Since implementation in 2014, policies and practices regarding independent living programs have been refined. Most recently, Florida made significant legislative changes pursuant to Chapter 2018-103, Laws of Florida, allowing Florida's Extended Foster Care program to receive federal reimbursement through Title IV-E of the Social Security Act. This change not only brought about standardization of transition services but has invited additional federal oversight.

Additionally, legislation passed in 2014 updated s. 409.997, F.S., to require an integrated approach for the development and implementation of a Results-Oriented Accountability Program (ROA) to serve as the engine to instill a culture of transparency and accountability throughout the child welfare system of care and to drive system-wide improvements in decision-making about the use of resources, quality and amount of services provided, and policies and practices which influence child and family outcomes. A Technical Advisory Panel, which includes a broad stakeholder group, advises the Department on the program's implementation. Program oversight is provided by the ROA Governance Committee, which consists of representatives from the Department, the CBCs, the Florida Institute for Child Welfare, Children's Legal Services, sheriffs' offices that conduct child protective investigations, contracted providers, Office of the State Courts Administrator, and community partners.

Through the course of legislative changes impacting independent living services throughout the years, s. 409.1451(7), F.S., regarding the ILSAC's charge has remained unchanged except for incorporating Extended Foster Care. The law still requires the Secretary of the Department to appoint members to ILSAC for reviewing and making recommendations concerning the implementation and operation of independent living program services. The Department's Independent Living Specialist [currently titled Youth & Young Adult Transition Services Specialist] continues to provide administrative support and assists in preparing responses to the recommendations provided from the annual report. ILSAC remains as specified in the law "until the Legislature determines that the advisory council can no longer provide a valuable contribution to the Department's efforts to achieve the goals of the services designed to enable a young adult to live independently."

Licensing Requirements
Section 4
Section 39.302(7)(a), F.S., establishes the fact that a person named in some capacity in a report may not be used in any way to adversely affect the interests of that person after an investigation of institutional abuse, neglect, or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report. However, if a person is a licensee of the Department and is named in any capacity in three or more reports within a 5-year period, the Department may review the reports and determine if information contained is relevant to determine if said person's license should be renewed or revoked.

Qualified Evaluator
Section 6
Effective July 1, 2016, the statutes were changed and the Agency for Health Care Administration (AHCA) was required to assign all rights, obligations, and other interest in and under contract pertaining to Qualified Evaluator Network services to the Department. Section 39.407(6)(b), F.S., was not picked up in the 2016 changes and still requires AHCA to appoint the qualified evaluators. AHCA continues to have statutory authority to adopt rules for the registration of qualified evaluators and to establish a reasonable cost efficient fee schedule for qualified evaluators under s. 39.407, F.S.

Child Care
To protect the health and welfare of children, it is the intent of the Legislature to develop a regulatory framework that promotes the growth and stability of the child care industry and facilitates the safe physical, intellectual, motor, and social development of the child. To that end, the Child Care Regulation Program is responsible for regulating programs that provide services that meet the statutory definition of "child care." This is accomplished through the inspection of licensed child care programs to ensure the consistent statewide application of child care standards established in statute and rule, and the registration of child care providers not subject to inspection. The Department regulates licensed child care facilities, licensed family day care homes, licensed large family child care homes, and licensed mildly ill facilities in 62 of the 67 counties in Florida.

"Child care" is defined as "the care, protection, and supervision of a child, for a period of less than 24 hours a day on a regular basis, which supplements parental care, enrichment, and health supervision for the child, in accordance with his or her individual needs, and for which a payment, fee, or grant is made for care." If a child care program meets this statutory definition of "child care," it is subject to regulation by the Department/local licensing agencies, unless specifically excluded or exempted from regulation by statute. Every program determined to be subject to licensing must meet the applicable licensing standards established by ss. 402.301-402.319, F. S., and rules.

Section 20
The current definition in s. 402.302, F.S., allows the family day care operation to occur in any occupied residence, thus allowing for operators to utilize additional residences to operate the family day care home. Additionally, clarification is needed to ensure who is counted in the capacity; this is needed in reference to ratio allowances for dually licensed foster homes.

Section 21, 22 and 23
Current language in s. 402.305, F.S., allows for child care personnel to complete "training" in cardiopulmonary resuscitation. Training in this statute has always been interpreted and implemented as certification. Certification ensures that child care personnel have actually demonstrated an ability to implement cardiopulmonary resuscitation training. This section of statute is the primary issue at stake in a pending challenge on the rule development process.

Additionally, child care providers struggle with providing information at different times as required in ss. 402.305, 402.313, and 403.3131, F.S., each year for each recordkeeping requirement. Aligning the dates would make it easier for providers to comply.

2. EFFECT OF THE BILL:
Judicial Training
Section 1
This section establishes a periodic instruction for circuit court judges on the complex issues that are faced in the dependency system to ensure statewide uniform practices to fulfill the purposes of Chapter 39, F.S.

This section amends the title of s. 25.385, F.S., to "Standards for instruction of circuit and county court judges" in order to expand the scope of the statute beyond just training on domestic violence. Section 25.385, F.S., is further

amended to create a new subsection (2) that requires the Florida Court Educational Council to establish standards for instruction of circuit court judges who have responsibility for dependency cases. The standards for instruction must be consistent with and reinforce the purposes of Chapter 39, F.S., particularly the purpose of ensuring that a permanent placement is achieved as soon as possible for every child in foster care and that no child remains in foster care longer than 1 year. This instruction must be provided on a periodic and timely basis and may be provided by or in consultation with current or retired judiciary, the Department of Children and Families, or the Statewide Guardian ad Litem Office established by s. 39.8296, F.S.

Paternity
Section 2
This section amends the definition of "parent" in s. 39.01(56), F.S., to remove an alleged or prospective parent from the definition of parent. The remaining language ensures that the legal parents' rights are not modified and eliminates the need to provide rights to prospective parents who have not yet established their paternity. Should a prospective parent execute a sworn affidavit of parenthood pursuant to s. 39.503(8), that statute establishes that the individual would at that point in the case be a parent for all purposes, ensuring then their right to notice and participation.

Section 5
This section encourages early establishment of paternity through court order by amending s. 39.402(8)(c)5., F.S., to require the court to enter an order establishing the paternity of the child if the inquiry under s. 39.402(8)(c)4., F.S., identifies a person as a legal father, as defined in s. 39.01, F.S. This subsection further provides that once an order establishing paternity has been entered, the court shall not take any further action to disestablish this paternity in the absence of an action filed pursuant to Chapter 742, F.S. The statute explains that if an action is filed pursuant to Chapter 742 for a dependent child, the action must comply with new s. 742.0211, which is addressed in Section 25 of the bill.

Section 7
This section amends s. 39.503, F.S., which establishes a process for cases in which the identity or location of the parent or prospective parent is unknown, to address instances in which there is a legal father.

Specifically, this section amends subsection (3) to provide if the inquiry under subsection (1) identifies any person as a parent or a prospective parent and that person's location is known, the court shall require notice of the hearing to be provided to that person, except that notice shall not be required to be provided to a prospective parent if there is an identified legal father, as defined in s. 39.01(40), for the child.

This section creates a new subsection (4) to address what should occur when a legal father is identified. If the inquiry under subsection (1) identifies a person as a legal father, as defined in s. 39.01, F.S., the court shall enter an order establishing the paternity of the child. This subsection further provides that once an order establishing paternity has been entered, the court shall not take any further action to disestablish this paternity in the absence of an action filed pursuant to Chapter 742, F.S. The statute explains that if an action is filed pursuant to Chapter 742 for a dependent child, the action must comply with new s. 742.0211, which is addressed in Section 25 of the bill.

Previously numbered subsections (4) through (9) of section 39.503, F.S., are renumbered.

Newly-renumbered s. 39.503(5), F.S., is amended to provide that the petitioner is relieved from further search in addition to being relieved of further notice when an inquiry does not identify a parent or a prospective parent.

Newly-renumbered s. 39.503(6), F.S., is amended to provide that a diligent search shall not be required to be conducted for a prospective parent if there is an identified legal father, as defined in s. 39.01(40), F.S., for the child.

New section 39.503(9), F.S., provides that if the inquiry and diligent search identifies and locates a parent, the individual shall be considered a parent for all purposes under this chapter and the court shall require notice of all hearings to be provided to that person.

Newly-renumbered s. 39.503(10), F.S., which was previously subsection (8), is amended to provide If the inquiry and diligent search identifies and locates a prospective parent and there is no legal father, that person must be given the opportunity to become a party to the proceedings by completing a sworn affidavit of parenthood and filing it with the court or the Department. The subsection still provides that a prospective parent who files a sworn affidavit of parenthood while the child is a dependent child, but no later than at the time of or before the

adjudicatory hearing in any termination of parental rights proceeding for the child, shall be considered a parent for all purposes under this chapter unless the other parent contests the determination of parenthood. The subsection adds that no person shall have standing to file a sworn affidavit of parenthood or otherwise establish parenthood except through adoption after entry of a judgment terminating the parental rights of the legal father of the child. If the known parent contests the recognition of the prospective parent as a parent, the court having jurisdiction over the dependency matter shall conduct paternity proceedings under Chapter 742, F.S. The prospective parent may not be recognized as a parent until proceedings to determine maternity or paternity have been concluded. However, the prospective parent shall continue to receive notice of hearings as a participant pending results of the proceedings to determine maternity or paternity.

Newly-renumbered s. 39.503(11), F.S., which was previously subsection (9), is amended to state if the diligent search under subsection (6) fails to identify and locate a parent or a prospective parent who was identified during the inquiry under s. 39.503(1), F.S., the court shall so find and may proceed without further notice and the petitioner is relieved of further search.

The revisions in this section promote judicial efficiency and timeliness, as well as ensure a child's permanency is not subsequently undermined by an individual who attempts to assert his paternity for the first time after the legal parents' rights have been terminated.

Section 12
This section amends s. 39.801(3)(a)(6), F.S., to renumber subsections changed in ss. 39.503 and s. 39.803, F.S., (Sections 7 and 14 of the bill) and to clarify that personal service of a termination of parental rights petition is required only on a prospective parent who has been both identified and located. This revision ensures termination proceedings are not delayed by requiring services on a prospective parent who cannot be located.

Section 14
This section amends s. 39.803, F.S., to make all of the amendments that were made in Section 7 of the bill to s. 39.503, F.S. This section further amends s. 39.803(1), F.S., to clarify that the court needs to conduct an inquiry to determine the identity or location of a parent where an inquiry has not previously been performed under s. 39.503, F.S.

Section 25
This section creates a new s. 742.0211, F.S., to clarify the process for paternity proceedings concerning a dependent child.

Section 742.0211(1), F.S., provides that the term "dependent child" as used in the section means a child who is subject to any proceeding under Chapter 39.

Section 742.0211(2), F.S., provides that, in addition to satisfying the other requirements of this chapter, any paternity proceeding filed under Chapter 742 concerning a dependent child must comply with the requirements of this section.

Section 742.0211(3), F.S., provides that, notwithstanding s. 742.021(1), F.S., a paternity proceeding filed under Chapter 742 concerning a dependent child may be filed in the circuit court of the county that is exercising jurisdiction over the Chapter 39 proceeding even if the plaintiff or the defendant do not reside in the county.

Section 742.0211(4), F.S., provides that the court having jurisdiction over the dependency matter may conduct proceedings under this chapter either as part of the Chapter 39 proceeding or as a separate action under Chapter 742. When read together, subsections (3) and (4) ensure that there are no barriers to the Chapter 39 adjudicating a paternity complaint concerning a dependent child.

Section 742.0211(5), F.S., provides that no person shall have standing to file a paternity complaint under this chapter regarding a dependent child after entry in the Chapter 39 proceeding of a judgment terminating the parental rights of the legal father, as defined in s. 39.01(40), for the dependent child.

Section 742.0211(6), F.S., establishes that a hearing held pursuant to s. 742.031, F.S., concerning a dependent child must be held within 30 days after the complaint is filed.

Section 742.0211(7), F.S., addresses paternity proceedings concerning a dependent child who already has an established legal father under Chapter 39. Where the dependent child has a legal father, as defined in s. 39.01(40), F.S., and a different man who has reason to believe that he is the father of the dependent child has

filed a complaint under this chapter to establish his paternity, subsection (7) clarifies that before the court may determine the issue of whether the alleged father is the father of the dependent child, the alleged father must prove at the hearing held pursuant to s. 742.031, F.S., that he has acted with diligence in seeking the establishment of paternity and has manifested a substantial and continuing concern for the welfare of the dependent child. If the alleged father establishes these facts, in addition to establishing that he is the father of the dependent child, the alleged father must prove by clear and convincing evidence that there is a clear and compelling reason to establish paternity and disestablish the legal father's paternity based primarily on the dependent child's best interest. Where the alleged father files his complaint under this chapter twelve months or more after the dependent child became the subject of the Chapter 39 proceeding or the alleged father cannot pass a home study to be a placement for the dependent child, there is a rebuttable presumption that it is not in the dependent child's best interest to disestablish the dependent child's legal father to establish the legal status of the alleged father.

Section 742.0211(8), F.S., mandates that the court shall enter a written order on the paternity complaint within 30 days after conclusion of the hearing held pursuant to s. 742.031, F.S.

Section 742.0211(9), F.S., provides that if the court enters an order finding the alleged father is the father of the dependent child, that individual will be considered a parent as defined in s. 39.01(56), F.S., for all purposes of the Chapter 39 proceeding.

Case Closure

Section 8

This section of the bill amends s. 39.521(1)(c)3., (3)(d), and (7), F.S., to eliminate the description of how long protective supervision can continue and under what circumstances the court can terminate protective supervision. Instead, protective supervision will now be fully addressed in new s. 39.63, F.S., described in Section 11 of this analysis.

Section 11

This section creates new s. 39.63, F.S., to outline the circumstances under which the court shall close the judicial case except those cases in which the youth is in extended foster care by terminating protective supervision and its jurisdiction in a Chapter 39, F.S., proceeding. This statute clarifies for the court and the parties the requirements that must be met to ensure child safety before jurisdiction and supervision is terminated at any stage of the case.

Section 39.63(1), F.S., provides that, where a child has been placed under the protective supervision of the Department, protective supervision continues until the court terminates it or until the child reaches the age of 18, whichever date is first. Protective supervision shall be terminated by the court whenever the court determines that: permanency has been achieved for the child, whether with a parent, another relative, or a legal custodian; and protective supervision is no longer needed except that the Department must supervise the placement of the child after reunification for at least 6 months with each parent or legal custodian from whom the child was removed. The termination of supervision may be with or without retaining jurisdiction, at the court's discretion. The language in this subsection is taken from current s. 39.521(1)(c)3. and (3)(d), F.S., except that the language requiring supervision for at least 6 months after reunification is taken from current s. 39.521(7), F.S.

Section 39.63(2), F.S., provides that the order terminating supervision by the Department must set forth the powers of the custodian of the child and include the powers ordinarily granted to a guardian of the person of a minor unless otherwise specified. The language in this subsection is taken from current s. 39.521(1)(c)3. and (3)(d), F.S.

Section 39.63(3), F.S., provides that upon the court's termination of supervision by the Department, further judicial reviews are not required. The language in this subsection is taken from current s. 39.521(1)(c)3. and (3)(d), F.S.

Section 39.63(4), F.S., requires the court to enter a written order ending its jurisdiction when a child has been returned to a parent, provided the court shall not terminate its jurisdiction over the child for at least 6 months after the child's return to the home and not until protective supervision is no longer need. The language in this subsection is modified from current s. 39.521(7), F.S. by adding the language "and not until protective supervision is no longer needed" to ensure supervision is not terminated before the child is determined to be safe.

Section 39.63(5), F.S., provides that, where a child has not been removed from the home, the court must enter a written order ending its jurisdiction when the court determines that permanency has been achieved for the child.

The language in this subsection is new as there is currently no statute explaining when a court should terminate jurisdiction under these circumstances.

Section 39.63(6), F.S., states that, where a child is placed in the custody of a parent and the court determines that reasonable efforts to reunify the child with the other parent are not required, the court may at any time order that the custodial parent assume sole custodial responsibilities for the child, may provide for reasonable visitation by the noncustodial parent, and may then terminate its jurisdiction over the child. If the court has previously approved a case plan that requires that services be provided to the noncustodial parent, the court may not terminate its jurisdiction prior to the expiration of the case plan unless the court finds by a preponderance of the evidence that it is not likely that the child will be reunified with the noncustodial parent within 12 months after the child was removed from the home. The first portion of this subsection is language modified from current s. 39.521(3)(b)1., F.S. The second portion of the subsection is new language intended to provide the courts with a mechanism to use after disposition and acceptance of the case plan, but prior to the permanency hearing held 12 months after the child was removed from the home, to terminate jurisdiction over a child who is safely placed with a parent and there is strong evidence that the other parent has either refused or is not capable of building the protective capacities to be reunified timely.

Section 39.63(7), F.S., establishes that where a child has been adopted pursuant to a Chapter 63, F.S., proceeding, the court must enter a written order terminating its jurisdiction over the child in the Chapter 39, F.S., proceeding. This language is not currently found in Chapter 39 but is intended to ensure timely closure of the Chapter 39 case after adoption.

Section 39.63(8), F.S., explains that the court shall determine whether its jurisdiction should be continued or terminated based on a report of the Department or agency or the child's Guardian ad Litem. The language in this subsection is taken from current s. 39.521(7), F.S.

Emergency Post-Disposition Modification of Placement
Section 9

This section creates an emergency modification of placement that will enable the Department and the judiciary to take immediate action to protect children at risk of abuse, abandonment, or neglect who have already been subject to disposition.

Section 39.522, F.S., is amended to clarify that the statute applies to a modification of placement if a child must be removed from the parent's custody while the Department is supervising the placement of the child after the child is returned to the parent. This fills a gap in the law as there is no statute that describes the standard the court is to use when a child must re-enter care after being reunified with a parent.

Section 39.522(1), F.S., is amended to state that at any time, an authorized agent of the Department or a law enforcement officer may remove a child from a court-ordered placement and take the child into custody if the child's current caregiver requests immediate removal of the child from the home or if the circumstances meet the criteria of s. 39.401(b), F.S. The Department shall file a motion to modify placement within one business day of the child being taken into custody. Unless all parties stipulate to the change of placement, the court shall set a hearing within 24 hours of the filing of the motion. At the hearing, the court shall determine whether the Department has established probable cause that reasonable grounds exist to immediately remove the child from the current placement. The court may base its determination on a sworn motion or affidavit and may hear all relevant and material evidence, including oral and written reports to the extent of its probative value even though it would not be competent evidence at an adjudicatory hearing. If probable cause is not established to support the removal from the placement, the court shall enter an order to return the child to the placement. If the caregiver admits to a need for a change of placement or probable cause is established to support the removal from the placement, the court shall enter an order changing the placement. If the child is not placed in foster care, then the new placement for the child must meet the home study criteria in Chapter 39, F.S. Where the court modifies a child's placement based upon a probable cause standard, the court shall conduct a subsequent evidentiary hearing on the motion unless all parties waive the hearing, at which point the court shall determine whether the Department has established by a preponderance of the evidence that continuing the child in the new placement is in the child's best interest. When applying this standard, the court shall consider the continuity of the child's placement in the same out-of-home residence as a factor when determining the best interests of the child.

Previously-numbered s. 39.522(1), F.S., is renumbered as s. 39.522(2), F.S., and states that, at any time before a child is residing in the permanent placement approved at a permanency hearing, a child, who has been placed in the child's own home under the protective supervision of an authorized agent of the Department, in the home of a relative, in the home of a legal custodian, or in some other place, may be brought before the court by the

Department or by any other party interested person, upon the filing of a petition motion alleging a need for a change in the conditions of protective supervision or the placement. If the parents or other legal custodians deny the need for a change, the court shall hear all parties in person or by counsel, or both. Upon the admission of a need for a change or after such hearing, the court shall enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered. The standard for changing custody of the child shall be whether a preponderance of the evidence establishes that a change is in the best interest of the child. When applying this standard, the court shall consider the continuity of the child's placement in the same out-of-home residence as a factor when determining the best interests of the child. If the child is not placed in foster care, then the new placement for the child must meet the home study criteria and court approval pursuant to this chapter.

Previously-numbered ss. 39.522(2) and (3), F.S., have been renumbered as subsection (3) and (4), respectively.

Filing of Case Plan Before Disposition
Section 10
This section resolves a conflict in the law.

Section 39.6011(7), F.S., is amended to state that the Department is required to file the case plan with the court and serve a copy on the parties:

1. Not less than 72 hours before the disposition hearing, if the disposition hearing occurs on or after the 60th day after the date the child was placed in out-of-home care. All such case plans must be approved by the court.

2. Not less than 72 hours before the case plan acceptance hearing, if the disposition hearing occurs before the 60th day after the date the child was placed in out-of-home care and a case plan has not been submitted pursuant to this paragraph, or if the court does not approve the case plan at the disposition hearing. The case plan acceptance hearing must occur within 30 days after the disposition hearing to review and approve the case plan.

Permanent Commitment of Orphaned Children
Section 13
Section 39.8025, F.S., is created to provide a process for the permanent commitment of a child to the Department for the purpose of adoption when both parents are deceased. This new statute fills a gap in Chapter 39, F.S., to permit an orphaned child to be permanently committed to the Department for subsequent adoption without terminating the deceased parent's rights, so as to allow the child to continue to receive death benefits.

Section 39.8025(1), F.S., provides that, where both parents of a child are deceased and the child does not have a legal custodian through a probate or guardianship proceeding, an attorney for the Department, or any other person who has knowledge of the facts alleged or is informed of them and believes that they are true, may initiate a proceeding seeking an adjudication of dependency and permanent commitment of the child to the custody of the Department, for the purpose of adoption, by filing a petition for adjudication and permanent commitment. If after a child has been adjudicated dependent both parents become deceased or the last living parent becomes deceased, an attorney for the Department, or any other person who has knowledge of the facts alleged or is informed of them and believes that they are true, may file a petition for permanent commitment. The petition shall be in writing, identify the deceased parents, and allege the facts that establish both parents are deceased and the child does not have a legal custodian through a probate or guardianship proceeding. The petition must be signed by the petitioner under oath stating the petitioner's good faith in filing the petition.

Section 39.8025(2), F.S., provides that, when a child has been placed in shelter status by order of the court and not yet adjudicated, a petition for adjudication and permanent commitment must be filed within 21 days after the shelter hearing. In all other cases, the petition must be filed within a reasonable time after the date the child was referred to protective investigation or after the petitioner becomes aware of the facts supporting the petition.

Section 39.8025(3), F.S., provides that, when a petition for adjudication and permanent commitment or a petition for permanent commitment has been filed, the clerk of court shall set the case before the court for an adjudicatory hearing to be held as soon as possible, but no later than 30 days after the petition is filed.

Section 39.8025(4), F.S., provides notice of the date, time, and place of the adjudicatory hearing for the petition for adjudication and permanent commitment or the petition for permanent commitment. A copy of the petition must be served upon the following persons, specifically notifying them that a petition has been filed:

(a) Any person who has physical custody of the child.
(b) A living relative of each parent of the child, unless upon diligent search and inquiry no such relative can be found.
(c) The Guardian ad Litem for the child or the representative of the Guardian ad Litem program, if the program has been appointed.

Section 39.8025(5), F.S., provides that adjudicatory hearings shall be conducted by the judge without a jury, applying the rules of evidence in use in civil cases and adjourning the hearings from time to time as necessary. In a hearing on a petition for adjudication and permanent commitment or a petition for permanent commitment, the court shall consider whether the petitioner has established by clear and convincing evidence that both parents of the child are deceased, and that the child does not have a legal custodian through a probate or guardianship proceeding. The presentation of a certified copy of the death certificate for each parent shall constitute evidence of the parents' deaths and no further evidence is required to establish that element.

Section 39.8025(6), F.S., provides when the adjudicatory hearing is on a petition for adjudication and permanent commitment, within 30 days after conclusion of the adjudicatory hearing, the court shall enter a written order as follows:

(a) If the court finds that a petition for adjudication and permanent commitment has been establish by clear and convincing evidence, the court shall enter a written order adjudicating the child dependent and permanently committing the child to the custody of the Department for the purpose of adoption. The order shall provide for a disposition hearing, to be scheduled no later than 30 days after entry of the order, in which the Department shall provide to the court a case plan that identifies the permanency goal for the child. Reasonable efforts must be made to place the child in a timely manner in accordance with the permanency plan and to complete whatever steps are necessary to finalize the permanent placement of the child. Thereafter, until the adoption of the child is finalized or the child reaches the age of 18 years, whichever occurs first, the court shall hold hearings at 6-month intervals to review the progress being made toward permanency for the child.
(b) If the court finds at the adjudicatory hearing on a petition for adjudication and permanent commitment that the petition has not been established by clear and convincing evidence but that a preponderance of the evidence establishes the child has no parent or legal custodian capable of providing supervision or care, the court shall enter a written order adjudicating the child dependent. The order shall provide for a disposition hearing, to be scheduled no later than 30 days after entry of the order, pursuant to s. 39.521, F.S.
(c) If the court finds at the adjudicatory hearing on a petition for adjudication and permanent commitment that the petition is not established by clear and convincing evidence and that a preponderance of the evidence does not establish the child has no parent or legal custodian capable of providing supervision or care, the court shall enter a written order so finding and dismissing the case.

Section 39.8025(7), F.S., provides when the adjudicatory hearing is on a petition for permanent commitment, within 30 days after conclusion of the adjudicatory hearing, the court shall enter a written order as follows:

(a) If the court finds that a petition for permanent commitment has been established by clear and convincing evidence, the court shall enter a written order permanently committing the child to the custody of the Department for the purpose of adoption. The order shall provide for a disposition hearing, to be scheduled no later than 30 days after entry of the order, in which the Department shall provide to the court an amended case plan that identifies the permanency goal for the child. Reasonable efforts must be made to place the child in a timely manner in accordance with the permanency plan and to complete whatever steps are necessary to finalize the permanent placement of the child. Thereafter, until the adoption of the child is finalized or the child reaches the age of 18 years, whichever occurs first, the court shall hold hearings at 6-month intervals to review the progress being made toward permanency for the child.
(b) If the court finds at the adjudicatory hearing on a petition for permanent commitment that the petition has not been established by clear and convincing evidence the court shall enter a written order so denying the petition. The order has no effect on the child's prior adjudication. Such an order does not bar the petitioner from filing a subsequent petition for permanent commitment based on newly discovered evidence that establishes both parents of a child are deceased and the child does not have a legal custodian through a probate or guardianship proceeding.

Reasonable Efforts for Registered Sexual Predators

Section 15

Section 39.806(2), F.S., is amended to provide that reasonable efforts to preserve and reunify families are not required if a court of competent jurisdiction has determined that any of the events described in ss. 39.806(1)(b)-(d) and (1)(f)-(n), F.S., have occurred. Consequently, the Department will no longer need to make reasonable efforts if a parent has been convicted of an offense that requires the parent to register as a sexual predator.

Department's Selection of Adoptive Placement and Court Review of Department's Consent

Sections 16, 17, and 18 reduce the number of simultaneous adoption actions that can be filed by multiple parties to adopt the same child by requiring that a denied applicant seek trial court review of the Department's determination to deny consent in the Chapter 39 proceeding and permitting the filing of a Chapter 63 petition to adopt only upon a court's determination that the Department unreasonably withheld its consent. That trial court determination would be subject to appeal to the applicable district court of appeal and Chapter 120 proceedings would no longer be needed.

Section 16

Section 39.811(9), F.S., is amended to provide the court shall retain jurisdiction over any child for whom custody is given to a social service agency until the child is adopted after termination of parental rights or permanent commitment pursuant to new s. 39.8025, F.S. The subsection is further amended to provide that the Department's decision to deny an application to adopt a specific child who is under the court's jurisdiction is reviewable only through the process established in s. 39.812(4), F.S., and is not subject to the provisions of Chapter 120, F.S.

Section 17

Section 39.812(1), F.S., is amended to provide that the Department may place a child in the Department's custody with an agency as defined in s. 63.032, F.S., with a child-caring agency registered under s. 409.176, F.S., or in a family home for prospective subsequent adoption without the need for a court order unless as otherwise provided in this section. Subsection (1) is also amended to authorize the Department, without the need for a court order, to allow prospective adoptive parents to visit with the child to determine whether adoptive placement would be appropriate.

Section 39.812(4), F.S., is amended to provide that if the Department has denied an individual's application to adopt a child, within 30 days of issuance of the Department's written notification of the decision to deny the application that denied applicant may file a motion to file a Chapter 63, F.S., petition to adopt a child without the Department's consent, wherein the denied applicant must allege that the Department unreasonably withheld its consent to the adoption, and the court as part of its continuing jurisdiction may review and rule upon the motion. The denied applicant shall have standing in the Chapter 39, F.S., proceeding only to file such a motion and to present evidence in support of the motion at a hearing, which must be held within 30 days of the filing of the motion. When reviewing whether the Department unreasonably withheld its consent, the court shall only consider whether the Department's review of the application was consistent with the agency's policies and made in an expeditious manner, using an abuse of discretion review. The court may not weigh the denied applicant against another applicant to determine which placement is in the child's best interest. If the denied applicant establishes by a preponderance of the evidence that the Department unreasonably withheld its consent, the court shall enter an order that finds the denied applicant may file a petition to adopt the child pursuant to Chapter 63, F.S., and the Department's consent is waived. If the denied applicant does not prove by a preponderance of the evidence that the Department unreasonably withheld its consent, the court shall enter an order so finding. The denied applicant's standing in the Chapter 39, F.S., proceeding is terminated upon the entry of a court order on the motion. Section 39.812(4), F.S., is further amended to provide that the Department may remove the child from a foster home or court-ordered custodian whose application to adopt has been denied if: the Department has selected another prospective adoptive applicant to adopt the child, and either, the foster parent or custodian has not filed a motion to file a Chapter 63, F.S., petition to adopt a child without the Department's consent pursuant to subsection (4) or the court has denied such a motion.

Section 39.812(5), F.S., is amended to clarify that a copy of the consent executed by the Department must be attached to the petition to adopt, unless waived pursuant to s. 39.812(4), F.S.

Section 18

Section 63.062(7), F.S., is amended to provide that if parental rights to the minor have previously been terminated, the adoption entity with which the minor has been placed for subsequent adoption must provide consent to the adoption. When the minor has been permanently committed to the Department for subsequent adoption, the Department must consent to the adoption or the petitioner must attach to the petition to adopt: a

court order entered pursuant to s. 39.812(4), F.S., that finds the Department unreasonably withheld its consent, and a favorable preliminary adoptive home study as required under s. 63.092, F.S.

Relative Home Studies in Chapter 63 Intervention Proceedings
Section 19
This section closes the gap in Chapter 63, F.S., that permits certain relatives who have not passed a Department home study from being able to use an intervention proceeding to obtain placement of the child.

Section 63.082(6)(b), F.S., is amended to provide that a preliminary home study is required for all prospective parents regardless of whether that individual is a stepparent or a relative, and that the exemption in s. 63.092(3), F.S., does not apply when a minor child is under the supervision of the Department or otherwise subject to the jurisdiction of the dependency court as a result of the filing of a shelter petition, a dependency petition, or a petition for termination of parental rights pursuant to Chapter 39, F.S.

Statutorily Mandated Reports
Section 3
This section amends s. 39.205(7), F.S., by deleting the requirement to submit an annual report on false reports made to the Florida Abuse Hotline. Deletion of the annual report does not change the Department's statutorily mandated handling of suspected false reports (i.e., submitting the report to law enforcement for consideration of a criminal investigation or levying an administrative fine against the individual responsible for filing a false report).

Section 24
This section amends s. 409.1451(6), F.S., by striking the requirement for a legislative report regarding independent living oversight and outcomes.

This section repeals the language in s. 409.1451(7), F.S., pertaining to the Department's requirement to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Eliminating the language requiring the annual legislatively mandated ILSAC report will relieve member representatives from the Department, the CBC, the Department of Juvenile Justice, the Department of Economic Opportunity, the Department of Education, AHCA, the State Youth Advisory Board, CareerSource Florida, Inc., and the Statewide Guardian Ad Litem Office from the collective responsibility of having to reduce recommendations into a formal written document to be reviewed by the Department's Secretary.

Licensing Requirements
Section 4
This section amends s. 39.302(7)(a), F.S., to require the Department to review any and all reports within a 5-year period, if a person is a licensee of the Department and is named in any capacity within the report.

Qualified Evaluator
Section 6
Section 39.407(6), F.S., authorizes the Department to adopt rules for qualified evaluators and implement Medicaid behavioral health utilization Department management programs for statewide in-patient psychiatric (SIPP) facilities with a contracted vendor. This section makes a technical change to agree with the law that was changed in 2016 to move responsibility for the appointment of Qualified Evaluators to the Department from AHCA.

Child Care
Section 20
This section amends s. 402.302(8), F.S., to specify that family day care home operations must occur in the operator's primary residence and that the capacity is limited to children present in the home during operations.

Section 21
This section amends s. 402.305(7)(a), F.S., to clarify that at least one child care facility staff person must receive a certification for completion of a cardiopulmonary resuscitation course.

Sections 402.305(9)(b) and (c), F.S., are amended to align the dates for providers on when information is to be shared with parents or guardians.

Section 402.305(10), F.S., is amended to specify that, prior to providing transportation services, a child care facility, family day care home or large family child care home is required to notify the Department for approval to

begin the service to ensure that all standards have been verified as compliant. Currently, providers are not required to notify the Department when they begin offering transportation services. The amendment further specifies that family or large family child care homes are not responsible for children being transported by a parent or guardian.

Section 22
Sections 402.313 (14) and (15), F.S., are amended to align the dates for providers on when information is to be shared with parents or guardians.

Section 23
Sections 402.3131(9) and (10), F.S., are amended to align the dates for providers on when information is to be shared with parents or guardians.

Effective Date
Section 26
This section provides that the bill will take effect on October 1, 2020.

3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? YES

If yes, explain:	Section 6 moves rulemaking authority for qualified evaluators from AHCA to the Department. Changes to Chapter 402, F.S., change statutory language for clarification purposes, adopts additional minimum safety standards for procedures and systems to ensure accountability for children being transported.
What is the expected impact to the agency's core mission?	N/A
Rule(s) impacted (provide references to F.A.C., etc.):	The Department will have to adopt new rules (number to be assigned) for qualified evaluators. Changes to Chapter 402, F.S., will require rule changes to the following rules: 65C-22.001 – 65C-22.010 F.A.C 65C-22.008 – 65C-20.014 F.A.C.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

List any known proponents and opponents:	Unknown
Provide a summary of the proponents' and opponents' positions:	N/A

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?

If yes, provide a description:	No
Date Due:	N/A
Bill Section Number(s):	N/A

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL?

Board:	No

Board Purpose:	N/A
Who Appoints:	N/A
Appointee Term:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	Pinellas, Hillsborough, and Sarasota counties would be required to adopt standards that address the minimum standards in the changes to Chapter 402, F.S. N/A for the rest of the bill.
Does the legislation increase local taxes or fees?	The Department's Office of Administrative Services finds that this bill does not increase local taxes of fees.
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	The Department's Office of Administrative Services finds that this section is not applicable.

2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?

Revenues:	There is a potential cost avoidance of $1,169,231.88 if the changes in Sections 16, 17, and 18 are implemented. In 2019, the Department is on pace to review 57 Chapter 120 cases, concerning a family petition for administrative hearing, for purposes of contesting a Chapter 39 adoption selection. <u>Each case requires the following labor:</u> Hearing Officer: 33 hours at $52/hour=$1,716 Assigned Counsel: 49 hours at $52/hour=$2,548 Agency Clerk:17 hours at $52/hour=$884 Designated Rep: 35 hours at $48/hour=$1,680 Total: 134 hours and $6,828/case <u>Fixed costs:</u> Court Reporter Appearance Fee: $1,000 Transcript: $1,167 Total: $2,167/case Total labor and fixed cost per case: 8,995

	Total labor and fixed cost for the 57 cases in 2019: $512,715 In addition to the agency costs, it is estimated that approximately 153 days of delay in out-of-home care while the Chapter 120 proceeding is pending will be eliminated by Sections 16, 17, and 18. Out of Home Care Costs: Average daily cost of Child in out of home care: $37.64 Average Number of Children involved in each case: 2 Estimated days of care eliminated through review per case: 153 Total Cost Avoidance per case in out of home care: $11,517.84 Total Cost Avoidance per fiscal year: $656,516.88 Total Annual Cost Avoidance on all costs: $512,715 + $646,516.88= $1,169,231.88
Expenditures:	There is a cost in adopting rule changes impacted by this bill, but this can be covered by existing resources.
Does the legislation contain a State Government appropriation?	The Department's Office of Administrative Services finds that this bill does not contain a State Government Appropriation.
If yes, was this appropriated last year?	The Department's Office of Administrative Services finds that this section is not applicable.

3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Office of Administrative Services finds that there are no expenditures generated by this bill.
Other:	The Department's Office of Administrative Services finds that this section is not applicable.

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?

Does the bill increase taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not increase taxes, fees, or fines.
Does the bill decrease taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not decrease taxes, fees, or fines.
What is the impact of the increase or decrease?	The Department's Office of Administrative Services finds that this section is not applicable.
Bill Section Number:	The Department's Office of Administrative Services finds that this section is not applicable.

TECHNOLOGY IMPACT

Does the legislation impact the agency's technology systems (i.e., IT support, licensing software, data storage, etc.)?	The Department's Office of Information Technology Services finds that this bill does not impact the agency's technology systems.
If yes, describe the anticipated impact to the agency including any fiscal impact.	The Department's Office of Information Technology Services finds that this section is not applicable.

FEDERAL IMPACT

Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)?	No
If yes, describe the anticipated impact including any fiscal impact.	N/A

ADDITIONAL COMMENTS

None

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	The Department's Office of the General Counsel has no issues, concerns, or comments on this bill.

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

2/10/21
Meeting Date

80
Bill Number (if applicable)

713212
Amendment Barcode (if applicable)

Topic Child welfare

Name Sara Clements

Job Title Vice President, McGuireWoods Consulting

Address 115 E. Park Ave
Street

Phone 850-727-5000

Tallahassee FL 32301
City *State* *Zip*

Email sclements@mwcllc.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Foster and Adoptive Parent Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

02/16/2021
Meeting Date

SB 0080
Bill Number (if applicable)

Amendment 713212
Amendment Barcode (if applicable)

Topic Child Welfare

Name Victoria Vangalis Zepp

Job Title Chief Policy and Research Officer

Address 317 East Park Avenue
Street

Phone 8502416309

Tallahassee FL 32301
City *State* *Zip*

Email victoria@flchildren.org

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Coalition for Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

02/16/2021
Meeting Date

SB 0080
Bill Number (if applicable)

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Topic Child Welfare

Name Victoria Vangalis Zepp

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Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Coalition for Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 80
INTRODUCER:	Children, Families, and Elder Affairs and Senator Brodeur
SUBJECT:	Child Welfare
DATE:	February 18, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Cox	CF	**Fav/CS**
2.			JU	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 80 amends and creates a number of sections of law related to the child welfare system, which make substantial changes to the process of, in part, provisions related to placement decisions and transitions of children in out-of-home care, including specific provisions addressing such complex decisions involving young children and sibling groups. Specifically the bill:

- Require the Department of Children and Families (the DCF) and community-based care lead agencies (lead agency) to develop a "FACE sheet", which must include minimum information related to the child's case to be kept in the dependency case file as a quick reference resource and require the FACE sheet to be updated at least once a month.
- Provide legislative findings and intent related to priority placements for children in out-of-home care.
- Expand and relocate the list of persons that should be considered as priority placements for these children and ensure this priority list applies to initial and for all subsequent removals.
- Relocate and expand existing multidisciplinary teams (MDT) to ensure better decisions for the child through engaging with families and other important individuals.
- Provide legislative intent for MDT, staffings, and assessments and provide a definition for the term "multidisciplinary team".
- Enumerate circumstances when the MDT must be convened within specified timeframes, including to consider placement decisions, transitions and transition plans, and sibling placements.

- Specify the participants that must be invited and provide authority for the DCF or lead agency to invite other relevant participants and require the MDT staffing to be led by a facilitator who is a person otherwise required to attend the staffing.
- Require MDT staffing participants to gather and consider data and information on the child before formulating a decision.
- Require MDTs to conduct supplemental assessments for children under age 3, including specified additional data to collect and factors to consider when making decision relating to such children.
- Require that a consensus decision reached by the MDT becomes the official position and that specified parties are bound by such consensus decision, provide procedures for when the MDT does not reach a consensus decision, and require the facilitator to file a report with the court providing specified information within a certain time frame.
- Require the lead agency to determine a suitable placement if the MDT cannot come to a consensus decision.
- Authorize specified parties to discuss confidential information during a team staffing in the presence of participating individuals and provide that information collected by any agency or entity that participates in a MDT staffing which is confidential and exempt upon collection remains confidential and exempt when discussed in staffings.
- Provide legislative findings and intent related to changes in placement and define the terms "educational change", "emergency situation", "placement change", and "school".
- Require the DCF and lead agency to convene the MDT to develop transition plans for placement changes and education transitions that focus minimizing the impact on the child within specified time frames for emergency versus nonemergency circumstances.
- Require the lead agencies to provide services to a caregiver intended to try and prevent a placement disruption prior to convening the MDT to develop a transition plan.
- Ensuring clarity that a child may be removed from his or her home in an emergency without convening the MDT for transition plan development prior to removal.
- Ensure the transition plans address specialized concerns, including additional specified factors, which include consideration of additional specified factors for children that are younger than 3 years of age.
- Require the DCF and lead agency to consider certain factors when determining the best education placement for a child and provide additional considerations for transitions of early education or programs versus K-12 education schools.
- Require that prospective caregivers are prepared for accepting the child who is being transitioned to their home, including providing information on the child and the transition plan.
- Require the DCF to develop a form related to transition plans in collaboration with the Quality Parenting Initiative to be attached to the FACE sheet.
- Provide legislative findings related to siblings in out-of-home care and define the terms "multidisciplinary team", "lead agency", and "sibling".
- Specify how the DCF and the lead agencies must handle changes in placement and educational settings and transitions of sibling groups throughout the dependency process.
- Require that the DCF must make reasonable efforts to place sibling groups together when they are removed at the same time from the same home and on an initial placement of a child who enters out-of-home care later than his or her siblings if it won't disrupt the placement

and provide that the DCF and the court are not required to make an initial placement or change of placement to develop a sibling bond that does not exist.
- Require the DCF or lead agency to convene a MDT staffing to make a decision regarding placements of sibling groups and establish specified criteria for the DCF or lead agency to consider when determining initial placement and for the court to consider when a change of placement is sought for sibling groups that have certain existing relationships as well as additional factors for consideration when the siblings may not have an existing relationship.
- Provide specified factors to consider when determining placement of a child who is part of a sibling group and is younger than 3 years of age.
- Require the DCF, in collaboration with the Quality Parenting Initiative, to develop standard protocols for the DCF and lead agency for use in making specified decisions about child placement;
- Provide for the contact and visitation between siblings who are not placed together in out-of-home care that will assist the siblings with continuing established relationships or possibly developing a relationship.
- Require subsequent reviews by the MDT for sibling groups when a child does not adjust to a placement with his or her siblings after certain services are offered or in the event a sibling group is not placed together.
- Create a rebuttable presumption that in specified cases the best interest of the child is to continue the current placement and require the court to conduct an evidentiary hearing to determine the best placement.
- Require the caregiver to, in response to receiving written notice of the DCF or lead agency's intent to change a placement, file written notice to the court and the DCF requesting the evidentiary hearing.
- Require the court to hold the initial status hearing and conduct the evidentiary hearing within specified timeframes and prohibit the DCF from moving the child until a court order states to do so.
- Require the court to appoint an attorney for the child and an expert in attachment and bonding and authorize the caregiver to retain counsel.

The DCF stated in the agency analysis dated February 2, 2021, that SB 80, as filed, will have a negative significant fiscal impact on state government and the private sector related to the child and family teams and transition plans. However, CS/SB 80 substantially amended the provisions that were attributed by the DCF to result in the significant fiscal impact, including, in part, to clarify that the MDTs provided for in CS/SB 80 are intended to operate in a substantially similar manner as is under current law. To the extent that these changes reduced the need for additional FTEs, the CS/SB 80 will likely have a positive indeterminate fiscal impact on state government and the private sector. See Section V. Fiscal Impact Statement.

The bill is effective October 1, 2021.

II. Present Situation:

Dependency Case Process - Overview

The Department of Children and Families (DCF) operates the Florida central abuse hotline (hotline), which accepts reports 24 hours a day, seven days a week, of known or suspected child

abuse,[1] abandonment,[2] or neglect.[3, 4] Current law requires any person who knows or suspects that a child has been abused, abandoned, or neglected to report such knowledge or suspicion to the hotline.[5] A child protective investigation begins if the hotline determines the allegations meet the statutory definition of abuse, abandonment, or neglect.[6] A child protective investigator investigates the situation either immediately or within 24 hours after the report is received, depending on the nature of the allegation.[7]

If, after conducting an investigation in response to receiving a call to the hotline, the child protective investigator determines that the child is in need of protection and supervision that necessitates removal, the investigator may initiate formal proceedings to remove the child from his or her home. The proceeding, known as a shelter hearing, results in a court determining if probable cause exists to keep a child in shelter[8] status pending further investigation of the circumstances leading to the detention of a child.[9]

When the DCF removes a child from the home, a series of dependency court proceedings must occur before a child may be adjudicated dependent.[10] Within 28 days after a child has been

[1] Section 39.01(2), F.S., defines "abuse" to mean any willful act or threatened act that results in any physical, mental, or sexual abuse, injury, or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes the birth of a new child into a family during the course of an open dependency case when the parent or caregiver has been determined to lack the protective capacity to safely care for the children in the home and has not substantially complied with the case plan towards successful reunification or met the conditions for return of the children into the home. Abuse of a child also includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.

[2] *See* s. 39.01(1), F.S., which defines "abandonment", in part, to mean a situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child, or both. It further defines, "establish or maintain a substantial and positive relationship" to include, but not be limited to, frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the child, and the exercise of parental rights and responsibilities. The definition specifically provides that marginal efforts and incidental or token visits or communications are not sufficient to establish or maintain a substantial and positive relationship with a child.

[3] Section 39.01(50), F.S., defines "neglect" to mean when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired. Circumstances are not to be considered neglect if caused primarily by financial inability unless actual services for relief have been offered to and rejected. Further, a parent or legal custodian legitimately practicing religious beliefs in accordance with a recognized church or religious organization who thereby does not provide specific medical treatment for a child may not, for that reason alone, be considered a negligent parent or legal custodian, unless a court orders the following services to be provided, when the health of the child so requires: medical services from a licensed physician, dentist, optometrist, podiatric physician, or other qualified health care provider; or treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization. The definition further provides that neglect of a child includes acts or omissions.

[4] Section 39.201(5), F.S.

[5] Section 39.201(a), F.S.

[6] Section 39.201(2)(a), F.S.

[7] Section 39.201(5), F.S.

[8] Section 39.01(78), F.S., defines "shelter" means a placement with a relative or a nonrelative, or in a licensed home or facility, for the temporary care of a child who is alleged to be or who has been found to be dependent, pending court disposition before or after adjudication.

[9] Section 39.01(79), F.S.

[10] *See* s. 39.01(15), F.S., for the definition of "child who is found to be dependent".

sheltered, the court must hold an arraignment hearing on the petition for dependency.[11] If a parent or legal guardian denies an allegation in the petition, the court must hold an adjudicatory hearing within 30 days.[12]

Subsequent to a child being found dependent, a court must hold a disposition hearing to determine a course of treatment and services and placement of the child under protective supervision.[13] The court must first consider placement of the child with relatives.[14] If a child cannot remain safely in the original home and no adult relative is available for temporary, legal custody, the child may be placed with an adult willing to care for the child under the protective supervision of the DCF.[15] Placement of the child to the temporary, legal custody of the DCF invests the DCF with the rights and responsibilities of a legal custodian.[16]

The DCF must develop and refine a case plan[17] for each child receiving services throughout the dependency process with input from all parties to the child's dependency case. The case plan details are required to be tailored to address the abuse, abandonment, or neglect that gave rise to the abuse report, any other issues which would support family preservation if appropriate, and services to address the child's needs that are identified during the child protective investigation and throughout the case.[18] Case plan services must focus on clearly defined objectives with the intent of improving conditions in the home and facilitating the child's safe return to the home when reunification is an appropriate goal, ensuring proper care of the child, or advancing the child's permanent placement.[19]

Once the court approves a case plan, the dependency case continues with judicial review hearings,[20] custody or placement changes, and permanency planning. The goal is for the dependency court and all parties involved in the child's case to ensure the child remains safe.[21]

In determining the specific permanency goal for the child and whether requirements for its achievement have been met, or if other actions need to be taken to protect the child, the court considers information about the parent's behavior and other relevant details provided by parties to the case, such as through written reports submitted to the court and witness testimony at hearings. If an attorney for the DCF decides that a termination of parental rights is appropriate, the DCF must allege in a petition for a termination of parental rights that one of a specified

[11] The purpose of an arraignment hearing is for a parent to admit, deny, or consent to findings of dependency that are alleged in the petition for dependency. If any party has requested a demand for early filing, the court must hold the arraignment hearing within 7 days after the date of filing of the petition. Section 39.506(1), F.S.
[12] Section 39.506(1), F.S.
[13] Section 39.521(1), F.S.
[14] Section 39.507(7)(c), F.S.
[15] Section 39.521(3)(c), F.S.
[16] Section 39.521(3)(d), F.S.
[17] Section 39.01(11), F.S., defines "case plan" to mean a document, as described in s. 39.6011, F.S., related to case plan development, prepared by the DCF with input from all parties. The case plan follows the child from the provision of voluntary services through any dependency, foster care, or termination of parental rights proceeding or related activity or process.
[18] Sections 39.6011 and 39.6012, F.S. Case plans must be developed in a face-to-face conference with the child's parent, any court-appointed Guardian ad Litem, and the child's temporary custodian and, if appropriate, the child.
[19] Section 39.6012(1)(a), F.S.
[20] These hearings are in accordance with s. 39.701, F.S.
[21] Section 39.001(1)(a), F.S.

grounds is in support of the petition.[22] The DCF must file a petition to terminate parental rights within 60 days after any of the specified factors has occurred.[23]

The dependency court process is summarized in the table below.[24]

The Dependency Court Process

Dependency Proceeding	Description of Process	Controlling Statute
Removal	A child protective investigation determines the child's home is unsafe, and the child is removed.	s. 39.401, F.S.
Shelter Hearing	A shelter hearing occurs within 24 hours after removal. The judge determines whether to keep the child out-of-home.	s. 39.401, F.S.
Petition for Dependency	A petition for dependency occurs within 21 days of the shelter hearing. This petition seeks to find the child dependent.	s. 39.501, F.S.
Arraignment Hearing and Shelter Review	An arraignment and shelter review occurs within 28 days of the shelter hearing. This allows the parent to admit, deny, or consent to the allegations within the petition for dependency and allows the court to review any shelter placement.	s. 39.506, F.S.
Adjudicatory Trial	An adjudicatory trial is held within 30 days of arraignment. The judge determines whether a child is dependent during trial.	s. 39.507, F.S.
Disposition Hearing	If the child is found dependent, disposition occurs within 15 days of arraignment or 30 days of adjudication. The judge reviews the case plan and placement of the child. The judge orders the case plan for the family and the appropriate placement of the child.	s. 39.506, F.S. s. 39.521, F.S.
Postdisposition hearing	The court may change temporary placement at a postdisposition hearing any time after disposition but before the child is residing in the permanent placement approved at a permanency hearing.	s. 39.522, F.S.
Judicial Review Hearings	The court must review the case plan and placement every 6 months, or upon motion of a party.	s. 39.701, F.S.

[22] Section 39.806(1), F.S. A few examples in support of a termination of parental rights petition include that the parent or parents voluntarily executed a written surrender of the child to the DCF for adoption; the parent or parents have abandoned the child; or the parent or parents through their conduct demonstrate that continuing involvement threatens the child's life, safety, or well-being irrespective of the provision of services.

[23] Section 39.8055(1), F.S. Exceptions to the requirement to file a termination of parental rights include the following: the child is being cared for by a qualifying relative or that the DCF provides a compelling reason that filing such a petition is not in the best interests of the child. Compelling reasons include that: adoption is not the appropriate permanency goal for the child; no grounds to file a petition to terminate parental rights exist; the child is an unaccompanied refugee minor; international legal obligations or compelling foreign-policy reasons preclude terminating parental rights; or the DCF has not provided to the family, consistent with the time period in the case plan, services that the DCF deems necessary for the safe return of the child to the home. Section 39.8055(2), F.S.

[24] For example, a social study report is submitted prior to judicial review hearings and it includes information on the child's placement, the child's safety in the placement, efforts of the parents to comply with case plan tasks, services provided to the foster family or legal custodian to address the child's needs, information on the visitation between the parent and child, and other information related to the child and the parent.

Petition for Termination of Parental Rights	Once the child has been out-of-home for 12 months, if DCF determines that reunification is no longer a viable goal, termination of parental rights is in the best interest of the child, and other requirements are met, a petition for termination of parental rights is filed.	s. 39.802, F.S. s. 39.8055, F.S. s. 39.806, F.S. s. 39.810, F.S.
Advisory Hearing	This hearing is set as soon as possible after all parties have been served with the petition for termination of parental rights. The hearing allows the parent to admit, deny, or consent to the allegations within the petition for termination of parental rights.	s. 39.808, F.S.
Adjudicatory Hearing	An adjudicatory trial shall be set within 45 days after the advisory hearing. The judge determines whether to terminate parental rights to the child at this trial.	s. 39.809, F.S.

Initial Removal and Placement in Out-of-Home Care

Detention or Shelter Determination of a Child

A shelter hearing is a proceeding in which a court determines whether probable cause exists to keep a child in shelter status pending further investigation of the circumstances leading to the detention of a child.[25] The circumstances in which a child may be detained or taken into custody by the DCF are limited.

A hospital administrator or licensed health care professional may detain a child without parental consent if returning the child to the parent or caregiver presents an imminent danger to the child. If the child is detained, the medical provider must immediately notify the DCF. Upon receiving notification, the DCF must immediately notify the parents or legal custodians that their child is being detained and begin a child protective investigation.[26]

Additionally, a law enforcement officer may take a child into custody, if probable cause exists that:

- The child has been abused, neglected, or abandoned, or suffers from or is in imminent danger of illness or injury due to abuse, neglect, or abandonment;
- The parent or legal custodian of the child has materially violated a condition of placement ordered by the court; or
- The child has no parent, legal custodian, or responsible adult relative immediately known and able to provide care.[27]

If a child is taken into custody, the attorney representing the DCF must request a hearing within 24 hours after the removal of the child.[28] A child may not be held in a shelter for more than 24

[25] Section 39.01(79), F.S.
[26] Section 39.395, F.S.
[27] Section 39.401(1)(b), F.S.
[28] Section 39.401(3)(b), F.S.

hours unless a court orders the child to remain in the shelter after a shelter hearing.[29] Prior to the shelter hearing, the parents or legal custodians must be given written notice that:

- They will be given an opportunity to be heard and to present evidence at the shelter hearing; and
- They have the right to be represented by counsel, and, if indigent, have counsel appointed at the shelter hearing and at each subsequent hearing or proceeding.[30]

Further, the shelter hearing can be continued for specified period of time under certain circumstances and, if granted by the court, the child shall be continued in shelter care for the length of the continuance.[31]

A child may not be removed from the home or continued out of the home pending disposition if he or she could safely remain at home with the provision of appropriate and available early intervention or preventive services. However, if the child's safety and well-being are in danger, the child must be removed and continue to be removed until the danger has been eliminated. If the child has been removed from the home and the reasons for his or her removal have been remedied, the child may be returned to the home. If the court finds that the prevention or reunification efforts of the DCF will allow the child to remain safely at home, the court shall allow the child to remain in the home.[32]

Placement in Out-of-Home Care

In 2001 and 2002, the Florida Legislature expanded the ability of community-based care lead agencies to place children in residential group care until additional foster homes could be recruited.[33] The 2001 legislation made it easier to put children in group care by requiring that any child 11 years of age or older who has been in licensed family foster care for 6 months or longer and who is then moved more than once must be assessed for placement in licensed residential group care. It also created s. 409.1676, F.S., which allowed comprehensive residential services, including residential care, case management, and other services, to be provided to children in the child protection system who have extraordinary needs, such as serious behavioral problems or having been determined to be without the options of either reunification with family or adoption. The 2002 legislation moved the language in 39.521, F.S., enacted in 2001 to newly created s. 39.523, F.S., and also provided that children in the custody of the DCF may be placed without prior approval of the court in certain residential settings.

At the same time, national research was showing an association between frequent placement disruptions and outcomes that are adverse to the child.[34] Some of the adverse outcomes included are poor academic performance and social or emotional adjustment difficulties such as aggression, withdrawal, and poor social interaction with peers and teachers. Despite this

[29] Section 39.402(8)(a), F.S.
[30] Section 39.402(5)(b), F.S. The appointment of counsel is made pursuant s. 39.013, F.S.
[31] *Id*.
[32] Section 39.402(7), F.S.
[33] Chapter 2001-68, ss. 3, 5, and 6, L.O.F. (creating s. 39.521(5), 409.1676, and 409.1677, F.S.; effective July 1, 2001); and ch. 2002-219, ss. 1, 2, 3, and 5, L.O.F (repealing s.39.521(5), F.S., creating s. 39.523, F.S., and amending s. 39.407(5) and 409.1676, F.S.; effective July 1, 2002).
[34] *See* The Imprint, A Look Back at the Impact of Research on Child Welfare Policy, available at https://imprintnews.org/analysis/look-back-impact-research-child-welfare-policy/28350 (last visited February 17, 2021).

evidence, child welfare systems made limited efforts to intervene and reduce placement instability as a mechanism for improving outcomes for children.[35] Mismatching placements to children's needs has been identified as a factor that negatively impacts placement stability. Identifying the right placement requires effective assessment.[36]

In response to trends in research, the Fostering Connections to Success and Increasing Adoptions Act (Fostering Connections Act) was enacted in 2008, which shifted policies to increase federal support to states so they can place more children permanently with relative guardians or adoptive parents, and enhance aid to foster youth.[37] The Fostering Connections Act, in part, increased kinship guardianship assistance payments and increased grants to specified entities who included kinship navigator programs. These reflected the changes that:

- A child must be placed in the least restrictive, most family-like setting available in close proximity to the home of his or her parents;
- The placement must meet the needs of the child; and
- A child must be placed in a permanent home in a timely manner.[38]

In 2017, the Florida Legislature recognized the above-mentioned shift in federal policy by amending s. 39.523, F.S., to require a comprehensive placement assessment process to be conducted when any child is removed from a home and placed into out-of-home care to determine the level of care needed by the child and match the child with the most appropriate placement.[39] Section 39.523(2), F.S., currently provides that when any child is removed from a home and placed into out-of-home care, a comprehensive placement assessment process must be completed to determine the level of care needed by the child, and match the child with the most appropriate placement.[40] The lead agency or subcontracted agency must coordinate a multidisciplinary team (MDT) staffing, described in detail below, with any individual who is available to attend the staffing and is currently involved with the child.[41] The participants for the MDT assessments include, but are not limited to:

- A representative from the DCF and the case manager for the child;
- A therapist;
- Attorney ad litem;
- Guardian ad litem;
- Teachers;
- Coaches;
- Children's Medical Services; and

[35] Noonan, K. and Rubin, D., et al., The Children's Hospital of Philadelphia Research Institute, *Securing Child Safety, Well-being, and Permanency Through Placement Stability in Foster Care*, Fall 2009, p. 2, available at https://policylab.chop.edu/sites/default/files/pdf/publications/PolicyLab_EtoA_CSAW_Fall_2009.pdf (last visited February 17, 2021).
[36] Teija Sudol, *Placement Stability Information Packet*, National Resource Center for Permanency and Family Connections, December 2009, available at http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/Placement_Stability_Info_Pack.htm (last visited February 17, 2021).
[37] *See* Fostering Connections to Success and Increasing Adoptions Act; Pub. L. 110-351; *See also* the National Conference of State Legislatures, Fostering Connections to Success and Increasing Adoptions Act of 2008, available at https://www.ncsl.org/documents/cyf/FosteringConnectionsSummary.pdf (last visited February 17, 2021).
[38] *See* Adoption Assistance and Child Welfare Act of 1980; Pub.L. 96-272.
[39] Chapter 2017-151, L.O.F.
[40] Section 39.523(2), F.S.
[41] Section 39.523(2)(a), F.S

- Other community providers of services to the child or stakeholders as applicable.
- Clergy, relatives, and fictive kin if appropriate.[42]

Further, team participants must gather and consider data and information on the child which is known at the time of the staffing including, but not limited, to:

- Mental, medical, behavioral health, and medication history.
- Community ties and school placement.
- Current placement decisions relating to any siblings.
- Alleged type of abuse or neglect including sexual abuse and trafficking history.
- The child's age, maturity, strengths, hobbies or activities, and the child's preference for placement.[43]

The most appropriate available out-of-home placement must be chosen after consideration by all members of the MDT of all of the information and data gathered, including the results and recommendations of any evaluations conducted.[44] Placement decisions for each child in out-of-home placement must be reviewed as often as necessary to ensure permanency for that child and to address special issues related to this population of children.[45] The DCF, a sheriff's office acting under s. 39.3065, F.S., a lead agency, or a case management organization must document all placement assessments and placement decisions in the Florida Safe Families Network (FSFN).[46, 47]

At each judicial review required under s. 39.701, F.S., the court is required to consider the results of the assessment, the placement decision made for the child, and services provided to the child.

Special Considerations for Placement of Siblings

An important consideration in the placement of children into out-of-home care involves the placement of sibling groups. Children may experience anxiety or pain when they are separated from their siblings. However, child welfare agencies experience a number of obstacles in trying to place siblings together when they enter out of home care including, in part:

- Children in sibling groups often have diverse and special needs some of whom may require one-on-one attention;

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[42] *Id.*

[43] *Id.* The comprehensive placement assessment process may also include the use of an assessment instrument or tool that is best suited for the individual child.

[44] Section 39.523(2)(c), F.S.

[45] Section 39.523(2)(d), F.S. Further, s. 39.523(2)(f), F.S., provides that if it is determined during the comprehensive placement assessment process that residential treatment as defined in s. 39.407, F.S., would be suitable for the child, the procedures in that section must be followed.

[46] Section 39.523(2)(e), F.S.

[47] The FSFN system is Florida's implementation of the Statewide and Tribal Automated Child Welfare Information Systems (SACWIS/TACWIS), which is a federally funded data collection system. All states were required to collect and report particular information to the federal government. States had the option of creating a SACWIS model in order to comply with these federal reporting requirements or they may implement an alternative data collection model. This information was then compiled into the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS). Both systems are made publicly available on the Children's Bureau's Child Welfare Outcomes Report Data website. *See* the National Conference of State Legislatures, *Child Welfare Information Systems*, June 25, 2020, available at https://www.ncsl.org/research/human-services/child-welfare-information-systems.aspx (last visited February 17, 2021).

- Foster and adoptive parents are often unwilling to take in sibling groups;
- Resources to find and maintain placements for sibling groups are often challenged by agencies with excessive caseloads and limited resources; and
- Children may enter care through different agencies, possibly in different jurisdictions.[48]

There is limited research on the importance of the sibling bond which has only recently been accepted by research scientists and policymakers that has sparked a flurry of attention to research, policy making, litigation, and development of innovative programs.[49]

Child welfare laws have evolved in many states to address this issue. The Fostering Connections Act makes funding contingent on complying with the law, which requires:

- Reasonable efforts to place siblings together in out of home care unless the state documents that it would be contrary to their safety or well-being; and
- Frequent visitation if they are not placed together, unless the state documents that it would be contrary to the children's safety or well-being.[50]

In general, child protection agencies understand the importance of maintaining sibling connections and have embraced approaches that support sibling placements. Thirty-seven states and the District of Columbia have statutes requiring agencies to make reasonable efforts to place siblings together unless a joint placement would not be in the best interests of one of the siblings, such as when one sibling poses a risk to the other. Additionally, 35 states and Puerto Rico have statutes requiring agencies to make provisions for siblings who cannot be placed together, including opportunities for visits and/or other forms of contact or communication.[51]

A number of strategies can be encouraged to mitigate the barriers to joint placements for siblings, including:

- Prioritizing placement with kin.
- Establishing clear policies and training for caseworkers and foster or adoptive parents about the importance of preserving sibling connections, and ensure siblings are assigned to the same caseworker, regardless of when they enter care.
- Involving children in placement decisions for the sibling group.
- Utilizing targeted foster or adoptive parent recruitment and retention strategies that aim to recruit foster and adoptive homes specifically for sibling groups, and homes that are reflective of the racial and ethnic diversity of children in care.[52]

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[48] The National Center for Youth Law, *Keeping Siblings together: Past, Present, and Future*, available at https://youthlaw.org/publication/keeping-siblings-together-past-present-and-future/ (last visited February 17, 2021).
[49] *Id*.
[50] The Children's Bureau, Child Welfare Information Gateway, *Sibling Issues in Foster Care and Adoption*, available at https://www.childwelfare.gov/pubPDFs/siblingissues.pdf; the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Child and Family Services Reviews, available at https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews (all sites last visited February 17, 2021).
[51] The Casey Family Programs, *How are child protection agencies promoting and supporting joint sibling placements and adoptions?*, available at https://www.casey.org/joint-sibling-placements/ (last visited February 17, 2021).
[52] *Id*.

Florida law currently addresses sibling placement and visitation in a number of sections of statute, but there is no single consolidated section specifically dealing with sibling related issues. For example:

- Section 409.996(19)(b), F.S., requires that the DCF and each lead agency to monitor and document any reasons that siblings are not placed together in out-of-home care and sibling placement information must be incorporated into the results-oriented accountability system and into the evaluation of the outcome and made available to the Florida Institute for Child Welfare for use in assessing the performance of child welfare services.
- Section 39.522(1)(a)8., F.S., requires the court, when determining whether a change of placement is in the best interests of the child, to consider the child's previous and current relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings.
- Section 39.6012(3)(b), F.S., requires that the case plan include a description of the parent's visitation rights and obligations and the plan for sibling visitation if the child has siblings with whom he or she is separated.

Postdisposition Change of Custody

Currently, the court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing when a child is already under the jurisdiction of the court, without the necessity of another adjudicatory hearing.

At any time before a child is residing in the permanent placement approved at the permanency hearing, a motion alleging a need for a change in the conditions of protective supervision or the placement may be filed by the DCF or by any other interested person in the case of a child who has been placed in:

- The child's own home under the protective supervision of an authorized agent of the DCF;
- The home of a relative;
- The home of a legal custodian; or
- Some other place.[53]

If the parents or other legal custodians deny the need for a change, the court must hear all parties in person or by counsel, or both. Upon the admission of a need for a change or after the hearing, the court must enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered.[54]

The standard for changing custody of the child must be the best interests of the child.[55] In making a determination whether a change of legal custody or placement is in the best interests of the child, the court must consider:

[53] Section 39.522(1)(a), F.S.
[54] *Id*.
[55] United Nations, Office of the High Commissioner for Human Rights, Convention on the Rights of the Child, available at https://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx (last visited February 2, 2021). The term "best interests" or "best interests of the child" is a child rights principle, which derives from Article 3 of the UN Convention on the Rights of the Child, which says that all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. The Convention on the Rights of the Child is the most rapidly and widely ratified human rights treaty in history—with 196 countries as "states parties." The United States is the only country that has not ratified the Convention.

- The child's age.
- The physical, mental, and emotional health benefits to the child by remaining in his or her current placement or moving to the proposed placement.
- The stability and longevity of the child's current placement.
- The established bonded relationship between the child and the current or proposed caregiver.
- The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference.
- The recommendation of the child's current caregiver.
- The recommendation of the child's guardian ad litem, if one has been appointed.
- The child's previous and current relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings.
- The likelihood of the child attaining permanency in the current or proposed placement.
- Any other relevant factors.[56]

If the child is not placed in foster care, the new placement for the child must meet the home study criteria and court approval under ch. 39, F.S.[57]

When the court is determining reunification, the court is required to review the conditions for return and determine whether the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home with an in-home safety plan prepared. Alternatively, if the reunification is approved by the DCF, the court must determine that reunification will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health.[58]

A court considering is whether a child who is placed in the custody of a non-offending parent should be reunited with the other parent, upon a finding that the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home of the other parent with an in-home safety plan prepared or approved by the DCF will not be detrimental to the child, must find that the safety, well-being, and physical, mental, and emotional health of the child would not be endangered by reunification and that reunification would be in the best interest of the child.[59]

A court must consider additional factors when deciding whether to place a child in out-of-home care after the child was placed in the child's own home with an in-home safety plan or the child was reunified with a parent or caregiver with an in-home safety plan to determine whether to place the child in out-of-home care. The factors include, at a minimum:

- The circumstances that caused the child's dependency and other subsequently identified issues.
- The length of time the child has been placed in the home with an in-home safety plan.
- The parent's or caregiver's current level of protective capacities.

[56] Section 39.522(1)(a), F.S.
[57] Section 39.522(1)(b), F.S.
[58] Section 39.522(2), F.S.
[59] Section 39.522(3), F.S.

- The level of increase, if any, in the parent's or caregiver's protective capacities since the child's placement in the home based on the length of time the child has been placed in the home.[60]

In addition, the court is required to evaluate the child's permanency goal and change the permanency goal as needed if doing so would be in the best interests of the child. If the court changes the permanency goal, the case plan must be amended pursuant to s. 39.6013(5), F.S.[61]

Transitions

Placement Transitions

Transition planning and practice may be used for any move of any child from one caregiver to another caregiver, including to or from a biological parent. It is important to minimize the number of out-of-home care placements in every child's case. However, in some situations, a change in out-of-home care placement might be considered necessary.[62]

Once the child establishes a bond with a caregiver who becomes the psychological parent, transition planning from one caregiver's home to another must be as emotionally protective as possible.[63] Poorly executed or improperly timed transitions may adversely affect a child's healthy development and capacity to attach to others.[64]

Any change in primary caregiver may be very traumatic and this trauma can be minimized by implementing a caring transition plan. Visitation with a future caregiver does not establish the same bond that develops when a child bonds with a caregiver who provides day-to-day care. This includes visitation with a biological parent relative who has been visiting consistently and appropriately, which suggests there will inevitably be trauma when the child is moved to a different day-to-day caregiver when the child has formed an attachment to a current caregiver.[65]

Transition planning and visiting must be tailored to the individual child's circumstances and consideration must be given to certain factors such as the child's age and attachment to his or her current caregiver. Special consideration should be given to transitioning infants and toddlers who are removed from their placement during developmental phases that may be adverse to such change, given they may lack verbal skills or developmental ability and maturity to understand what is happening to them.[66]

The fundamental task in early childhood is the formation of attachment. Attachment is an emotional bond with another person. It is believed that the earliest bonds formed by children

[60] Section 39.522(4), F.S.
[61] Section 39.522, F.S.
[62] Advokids, *Transition Planning*, available at https://advokids.org/childhood-mental-health/transitions/ (last visited February 17, 2021).
[63] *Id.*
[64] *Id*.
[65] Advokids, *Transition Planning*, available at https://advokids.org/childhood-mental-health/transitions/ (last visited February 17, 2021).
[66] Child Advocates, *Smooth Transitions for Young Children in Foster Care*, available at https://www.childadvocates.net/smooth-transitions-young-children-foster-care/ (last visited February 17, 2021).

with their caregivers have a tremendous impact that continues throughout life. Typical attachment stages are:

- At 0-8 weeks of age, the stage for developing secure attachment is being set. During this pre-attachment period the mother will 'warm up' the emotional bond with her sensitive and consistent responses. The infant may distinguish between caregivers but in general displays little preference. Baby separation anxiety in relation to the mother has not kicked in yet.
- At 2-6 months, the child starts to distinguish more clearly between known and unknown figures. The child starts to get a sense of how his or her mother will react when they are anxious or distressed.
- At 6-11 months and stage of child development, the baby has developed a clear understanding as to who his or her primary caregiver is (typically the mother). This awareness often makes the mother the preferred caregiver.
- At 18-24 months, the child's attachment behavior is very clear. The child is very conscious of good strategies for reaching the desired proximity of his or her mother.[67]

Infants and toddlers who are removed from their home and placed in out-of-home care need special consideration and guidance through the grieving process, in their relationships, and through transitions from one caregiver to another. Because they may be non-verbal or lack the developmental ability and maturity to understand what is happening to them, let alone articulate it, their feelings are easily overlooked or misinterpreted. Young children in out-of-home care suffer the same grief and loss and doubts that older children do, without the ability to express what the child is feeling.[68]

Florida law addresses out-of-home care transitions and educational stability in a number of circumstances, including, but not limited to:

- Section 39.6035(1), F.S., requires, within 180 days after a child reaches 17 years old, the DCF and lead agency to collaborate with the caregiver and other individuals identified by the child to assist the child with developing a transition plan to prepare for when the child ages out of care.69
- Section 39.604(5), F.S., provides for transition plans when it is not in a child's best interest to remain in the child care or early education setting that he or she attended prior to being placed into out-of-home care and requires the caregiver to collaborate with specified individuals to determine the best setting for the child.
- Section 39.701(3)(d), F.S., which provides at the last review hearing before the child reaches 18 years of age, the court must:
    - Address whether the child plans to remain in foster care, and, if so, ensure that the child's transition plan includes a plan for meeting one or more of the criteria and a supervised living arrangement under s. 39.6251, F.S.;
    - Ensure the child has been informed of the:
        - Right to continued support and services from the DCF and the lead agency;

[67] Positive Parenting Ally, Psychology Attachment Behavior, available at https://www.positive-parenting-ally.com/psychology-attachment.html (last visited February 17, 2021).
[68] Child Advocates, *Smooth Transitions for Young Children in Foster Care*, available at: https://www.childadvocates.net/smooth-transitions-young-children-foster-care/ (last visited February 17, 2021).
[69] Section 39.6035(1), F.S. The plan must address housing, health insurance, education, and workforce support and employment services.

- Right to request termination of dependency jurisdiction and be discharged from foster care;
- Opportunity to reenter foster care pursuant to s. 39.6251, F.S.;

- Ensure that the young adult, if he or she requests termination of dependency jurisdiction and discharge from foster care, has been informed of:
  - Services or benefits for which the young adult may be eligible based on his or her former placement in foster care;
  - Services or benefits that may be lost through termination of dependency jurisdiction;
  - Other federal, state, local, or community-based services or supports available to him or her.

Florida rules require two weeks' notice prior to a change of placement except in emergency situation, and requires a transition plan to a new placement if the child's current placement is unable to be stabilized and is not in the child's best interest.[70] The DCF also has operating procedures for transition planning for youth to ensure that children develop necessary life skills and to prepare children to transition to adulthood.[71]

Education Transitions

State and federal law contain requirements that must be adhered to in order to ensure educational stability for a child in out-of-home care. A child's educational setting should only be changed when maintaining the educational setting is not in the best interest of the child.

The Every Student Succeeds Act (ESSA)[72] was signed into law on December 10, 2015. ESSA reauthorized the Elementary and Secondary Education Act and includes new provisions that promote educational stability for children in foster care so they can continue their education without disruption, maintain important relationships, and have the opportunity to achieve college and career readiness. The law also emphasizes the importance of collaboration and joint decision-making between child welfare agencies and educational agencies.

Specific protections related to children in out-of-home care include:

- Being able to remain in the same school when in the child's best interest;
- Immediate enrollment in school and transfer of school records;
- School transportation when changing schools;
- Point of contact designated within state educational agency;
- Local educational agency point of contact;
- Required data collection and reporting. For the first time, state educational agencies will be required to report annually on student achievement and graduation rates for students in out-of-home care.[73]

[70] Rule 65C-28.005, F.A.C.
[71] The DCF, *CFOP 170-17 Transitioning Youth and Young Adult*, ch. 2, July 29, 2019, available at https://myflfamilies.com/admin/publications/cfops/CFOP%20170-xx%20Child%20Welfare/CFOP%20170-17%20Services%20for%20Transitioning%20Youth%20and%20Young%20Adults/CFOP%20170-17,%20%20Chapter%2002,%20Transition%20Planning%20for%20Youth.pdf (last visited February 17, 2021).
[72] The Every Student Succeeds Act, Public Law 114-95.
[73] *Id*.

The Fostering Connections Act also places requirements on child welfare agencies to work with schools to support the education needs of children in foster care. Since its passage in 2008, the Fostering Connections Act has brought much-needed attention to the critical importance of education stability for children in out-of-home care.[74] The Act helps children and in out-of-home care, guardianship and adoption achieve their educational goals by requiring that states ensure that they attend school and, when placed in out-of-home care, they remain in their same school where appropriate, or, when a move is necessary, get help transferring promptly to a new school. It also provides increased federal support to assist with school-related transportation costs.

Florida law provides for transition plans when it is not in a child's best interest to remain in the child care or early education setting that he or she attended prior to being placed into out-of-home care and requires the caregiver to collaborate with specified individuals to determine the best setting for the child.[75]

Multidisciplinary Teams

The use of a MDT team in child welfare settings is a concept that has been an established practice for over the past 60 years through the use of hospital-based child protection teams[76] and, more recently, child advocacy centers.[77] Because of the complex nature of child abuse and neglect investigations and family assessments and interventions, MDT teams are often used to enhance and improve investigations and responses necessary for children and families to recover and succeed. The MDT teams are becoming more widely used today to include a variety of individuals, both professional and non-professional, that interact and coordinate their efforts to plan for children and families receiving child welfare services. The MDT may also be referred to as an "interdisciplinary team," or a "case consultation team."[78]

Utilizing a MDT approach builds upon existing family-centered approaches to care. The use of a strengths-based, family-centered multidisciplinary process is key to engaging children, youth and families in the development and implementation of their individual case or treatment plans or other related services designed to meet their needs. By sharing decision-making and working together, it is more likely that positive and lasting outcomes will be achieved.[79]

The MDTs can help eliminate, or at least reduce, many barriers to effective action, including a lack of understanding by the members of one profession of the objectives, standards, conceptual bases, and ethics of the others; lack of effective communication; confusion over roles and responsibilities; interagency competition; mutual distrust; and institutional relationships which

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[74] *See* Fostering Connections to Success and Increasing Adoptions Act, Pub.L. 110-351.
[75] Section 39.604, F.S.
[76] The Kempe Foundation, *Child Protection Team Celebrates 60 Years*, available at http://www.kempe.org/child-protection-team-celebrates-60-years/ (last visited February 17, 2021).
[77] The National Children's Alliance, *History of NCA*, available at https://www.nationalchildrensalliance.org/history-of-nca/#:~:text=The%20history%20of%20National%20Children's,system%20to%20help%20abused%20children (last visited February 17, 2021).
[78] The Child Welfare Information Gateway, *Multidisciplinary Teams*, available at https://www.childwelfare.gov/topics/responding/iia/investigation/multidisciplinary/ (last visited February 17, 2021).
[79] The Kinship Center, *The Importance of the Child and Family Team*, available at http://www.kinshipcenter.org/about-kinship-center/news-and-events/breaking-news/the-importance-of-the-child-and-family-team-cft.html (last visited February 17, 2021).

limit interprofessional contact.[80] As a result, a number of states[81] are using a MDT team model, also known as a "Child and Family Team", that is key to the well-being of children and families served by child welfare agencies and their partners. This model is premised on the notion that children and families have the capacity to resolve their problems if given sufficient support and resources to help them do so.[82]

In California, for example, the process begins when a child enters out-of-home, and a child welfare social worker engages with a child and his or her family, and then uses a variety of strategies to identify other team members and factors to develop a plan to help achieve positive outcomes for a child's safety, permanency, and well-being.[83] This strengths-based approach to child welfare recognizes that families are experts in their own lives, and they can achieve success when they have an active role in creating and implementing solutions.[84]

Currently, Florida law provides for the use of MDTs in a number of circumstances, including, in part:

- Child Protection Teams under s. 39.303, F.S.;
- Child advocacy center multidisciplinary case review teams under s. 39.3035, F.S.;
- MDT staffing's under s. 39.523, F.S.; and
- MDT staffings under ss. 39.524 and 409.1754, F.S.

Additionally, the DCF reports that it or lead agencies currently coordinate MDT staffings for a number of purposes, including, in part:

- Adoption related staffings;
- Baker Act staffings;
- Case plan conferences;
- Case staffings;
- Case transfer staffings;
- Close the loop staffings;
- Comprehensive Medical Assessment Team staffings;
- Comprehensive Placement Assessment Team staffings;
- Human Trafficking staffings;
- The Department of Juvenile Justice staffings;
- High risk staffing or critical case staffings;

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[80] National Center on Child Abuse and Neglect, U.S. Children's Bureau, Administration for Children, Youth and Families, Office of Human Development Services, U.S. Department of Health, Education, and Welfare, *Multidisciplinary Teams In Child Abuse And Neglect Programs*, 1978, available at https://www.ojp.gov/pdffiles1/Digitization/51625NCJRS.pdf (last visited February 17, 2021).

[81] *See* Clark County Department of Family Services, *Child and Family Team Meetings Nevada Case Planning and Assessment Policies*, available at https://www.childwelfare.gov/pubPDFs/NV_CaseManagementTrainingFacilitator.pdf; State of Tennessee Department of Children's Services, *Administrative Policies and Procedures: 31.7*, available at https://files.dcs.tn.gov/policies/chap31/31.7.pdf; Indiana Department of Child Services, *Child Welfare Policy*, January 1, 2020, available at https://www.in.gov/dcs/files/5.07%20Child%20and%20Family%20Team%20Meetings.pdf (all sites last visited February 17, 2021).

[82] California Department of Social Services, *About Child and Family Teams*, available at https://www.cdss.ca.gov/inforesources/foster-care/child-and-family-teams/about (last visited February 17, 2021).

[83] *Id.*

[84] *Id.*

- Independent living staffings;
- Institutional staffings;
- Legal, medical, or mental health staffings;
- New child staffings;
- Permanency staffing;
- Safety management staffing;
- Separated sibling staffings;
- Service staffings; and
- Transfer staffings.[85]

Case Record Face Sheet

A case record face sheet is generally defined as any cover sheet to a multipage document that contains the relevant points covered in the document itself. They are commonly used in the medical or healthcare arenas and typically provides a patient's information at a quick glance. Face sheets can include contact details, a brief medical history and the patient's level of functioning, along with patient preferences and wishes.[86]

A number of states also use similar face sheets to record pertinent information about a child welfare case, including most notably Iowa and Illinois.[87]

Currently, Florida law does not require a face sheet to be included in the case file for child welfare cases.

Rebuttable Presumptions

A rebuttable presumption is defined as meaning it is a legal assumption the court is required to make if certain facts are established and no contradictory evidence is produced. There are various rebuttable presumptions found in Florida law. Two examples found in ch. 39, F.S., include:

- Section 39.0139, F.S., relating to visitation and contact with children who have been sexually abused, provides for the creation of a rebuttable presumption of detriment to a child when specified conditions are met.
- Section 39.203, F.S., relating to immunity from liability in cases of child abuse, abandonment or neglect, provides a rebuttable presumption that specified actions are

[85] The DCF, Electronic mail from John Paul Fiore, Legislative Specialist, *RE: Follow up on data request from last week*, February 12, 2021 (on file with the Senate Committee on Children, Families, and Elder Affairs) (noting several other meetings and conferences that are held for other purposes throughout dependency cases) (hereinafter cited as "The DCF Supplemental Information").

[86] Caring.com, *What is a Face Sheet*, available at https://www.caring.com/articles/what-is-a-face-sheet/; the Medical Dictionary, available at https://medical-dictionary.thefreedictionary.com/face+sheet (all sites last visited February 17, 2021).

[87] Iowa Department of Human Services, *Child Welfare Services Referral Face Sheet*, available at https://dhs.iowa.gov/sites/default/files/470-5150.pdf?102920201715; State of Illinois, Department of Children and Family Service, *Help Unit Face Sheet*, available at https://www2.illinois.gov/dcfs/aboutus/notices/Documents/cfs399_2.pdf#search=face%20sheet (all sites last visited February 17, 2021).

retaliatory if the specified actions are committed within a prescribed period of time against a person who reports child abuse, abandonment, or neglect under ch. 39, F.S.

III. Effect of Proposed Changes:

The bill codifies, consolidates, and amends, in part, current law in new sections regarding priority placement under s. 39.4021, F.S., multidisciplinary team staffings to make placement, education and other important life decisions of the child under s. 39.4022, F.S., transition plans under s. 39.4023, F.S., and sibling placements under s. 39.4024, F.S. These new sections are created in Part V, titled Taking Children into Custody and Shelter Hearings, to ensure that these issues are addressed at the time a child is removed from his or her home due to abuse, abandonment, or neglect and applied throughout dependency proceedings as current law is silent on how to deal with placement issues between the time of shelter and the disposition hearing. Current law in other sections which relate to these placement or education issues have been amended to cross-reference the new sections.

The bill also amends ss. 39.522 and 39.523, F.S., relocating factors related to postdisposition changes and placement in out-of-home care into s. 39.4022, F.S., creating the new MDTs. Section 39.522, F.S., is also amended to create a rebuttable presumption in certain cases.

Placement in Out-of-Home Care

Section 39.4021, F.S., is created to set out the following list of priority placements of which the DCF must attempt to place a child when he or she is being placed in out-of-home care:

- Non-offending parent;
- Relative;
- Adoptive parent of a child's sibling;
- Fictive kin, with a close existing relationship to the child;
- Licensed foster care; and
- Group or congregate care.

This list slightly amends the list under current law in s. 39.401, F.S., by clarifying that the child may be released to a non-offending parent, fictive kin with a close existing relationship to the child, or group or congregate care, in the order of priority set out above.

Section 39.4021, F.S., also confirms the requirement under current law to place sibling groups together whenever possible unless it is not in the children's best interest when applying the criteria and factors as set out under s. 39.4022, F.S., and 39.4024, F.S. Placement decisions after shelter must be made in compliance with s. 39.4021, F.S., unless otherwise provide in ch. 39, F.S.

The bill also amends ss. 39.401 and 39.402, F.S., to cross-reference s. 39.4021, F.S., which codifies current law and clarifies the priority of placement which the DCF is required to apply when determining where to release a child who is removed due to abuse, abandonment, or neglect while awaiting a shelter hearing and to require the court to make written findings in shelter orders that the DCF has made reasonable efforts to place the child in order of priority unless it is not an option or in the best interest of the child, respectively.

Multidisciplinary Teams

The DCF reports that MDTs are presently being convened for many purposes throughout a dependency case, and current law makes reference to requirements to convene these staffings, for instance in s. 39.523, F.S., in relation to postdisposition change of placement decisions. Section 39.4022, however, codifies the creation of these teams, defines them, provide for stated goals, an expanded list of mandatory reasons when staffings must be convened, and specified factors which must be considered when making decisions about what is in the child's best interest.

The bill provides legislative findings including that:

- There is an increasing body of evidence showing that services for children and families are most effective when delivered in the context of a single, integrated child and family team that includes the child, his or her family, natural and community supports, and professionals who join together to empower, motivate, and strengthen a family and collaboratively develop a plan of care and protection to achieve child safety, child permanency, and child and family well-being.
- Effective assessment through an integrated MDT is particularly important for children who are vulnerable due to existing histories of trauma which led to the child's entrance into the child welfare system. This assessment is especially important for young children who are 3 years of age or younger, as a result of the enhanced need for such children to have healthy and stable attachments to assist with necessary brain development. Stable and nurturing relationships in the first years of life, as well as the quality of such relationships, are integral to healthy brain development, providing a foundation for lifelong mental health and determining well-being as an adult.

The bill provides definitions for the following terms:

- "Change in physical custody", which is defined to mean a change by the DCF or the lead agency to the child's physical residential address, even when such change does not require a court order changing the legal custody of the child.
- "Multidisciplinary team", which is defined to mean an integrated group of individuals which meets to collaboratively develop and attempt to reach a consensus decision on the most suitable out-of-home placement, educational placement, or other specified important life decision that is in the best interest of the child.

The bill sets out MDT goals which are child and family focused with an emphasis of having them involved in important life changing decisions, securing a child's safety, minimizing any potential trauma, and monitoring their strengths and needs throughout the case. The MDTs are required to adhere to the following goals:

- Secure a child's safety in the least restrictive and intrusive placement that can meet his or her needs;
- Minimize the trauma associated with separation from the child's family and help the child to maintain meaningful connections with family members and others who are important to him or her;

- Provide input into the placement decision made by the community-based care lead agency and the services to be provided in order to support the child;
- Provide input into the decision to preserve or maintain the placement, including necessary placement preservation strategies;
- Contribute to an ongoing assessment of the child and the family's strengths and needs;
- Ensure that plans are monitored for progress and that such plans are revised or updated as the child's or family's circumstances change; and
- Ensure that the child and family always remain the primary focus of each MDT staffing.

The bill provides for collaboration among diverse, qualified individuals who are part of the child's network to make the most informed decisions possible for a child. The MDT participants necessary to achieve an appropriately diverse team for a child may vary by child, but must consist of the following members:

- The child, unless he or she is not of an age or capacity not participate in the team;
- The child's family members and other individuals identified by the family as being important;
- The current caregiver;
- A representative from the DCF; and
- The case manager for the child.

The DCF or lead agency may invite additional participants depending on the stated purpose of the staffing, including, but not limited to:

- A representative from Children's Medical Services;
- A guardian ad litem, if one is appointed;
- A school personnel representative who has direct contact with the child;
- A therapist or other behavioral health professional, if applicable.
- A mental health professional with expertise in sibling bonding, if applicable; or
- Other community providers of services to the child or stakeholders, when applicable.

The bill provides that each MDT staffing must be led by a facilitator who is a trained professional who is otherwise required to attend the staffing in his or her official capacity and whose main responsibility is to help team participants use the strengths within the family to develop a safe plan for the child. The facilitator does not need to be the same person for each staffing convened in a child's case or in the service area of the designated lead agency handling a child's case.

The bill provides that the MDT staffings must be held as soon as possible before all of the following events occur or within 72 hours after an emergency situation arises defined in s. 39.4023(2) , F.S., and in accordance with s. 39.4023, F.S.:

- Initial out-of-home placement decisions;
- Changes in physical custody and appropriate mandatory transition plans in accordance with s. 39.4023, F.S.;
- Changes in a child's educational placement and mandatory transition plans in accordance with s. 39.4023, F.S.;
- Placement decisions for a child which involve sibling groups in accordance with s. 39.4024, F.S.; and

- Any other important decisions in the child's life which are so complex that the DCF or appropriate lead agency determines that it must be addressed by convening a MDT staffing to ensure the best interest of the child is maintained.

The bill codifies current law which provides that an assessment conducted by the MDT may also use an evidence-based assessment instrument or tool that is best suited for the child and clarifies that the instrument or tool used should be that which is best suited for determining the specific decision of the staffing and the needs of that individual child and family. The bill requires that MDT staffing participants must, before formulating a decision, gather and consider data and information on the child which is known at the time, including, but not limited to:

- The child's age, maturity, and strengths;
- Mental, medical, behavioral health, and medication history;
- Community ties and school placement;
- The stability and longevity of the child's current placement;
- The established bonded relationship between the child and the current or proposed caregiver;
- The child's previous and current relationship with a sibling, if the change in physical custody or placement will separate or reunite siblings, evaluated in accordance with s. 39.4024, F.S.;
- The physical, mental, and emotional health benefits to the child by remaining in his or her current placement or moving to the proposed placement;
- The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference;
- The recommendation of the child's current caregiver, if applicable;
- The recommendation of the child's guardian ad litem, if one has been appointed;
- The likelihood of the child attaining permanency in the current or proposed placement;
- The likelihood that the child will have to change schools or day care placement, the impact of such a change, and the parties' recommendations as to the timing of the change including an education transition plan required under s. 39.4023, F.S.;
- The disruption of continuity of care with medical, mental health, behavioral health, dental, or other treatment services the child is receiving at the time of the change of custody decision;
- The allegations of any abuse, abandonment, or neglect, including sexual abuse and trafficking history, which caused the child to be placed in out-of-home care and any history of additional allegations of abuse, abandonment, or neglect;
- The impact on activities that are important to the child, including the ability of the child to continue in such activities;
- The impact on the child's future access to education, Medicaid, and independent living benefits; and
- Any other relevant factors.[88]

These factors are a consolidation of factors that are set out in current law under ss. 39.522(1)(a) and 39.523(2)(a), F.S., with one new factor and amendments to two current factors as follows:

- The factor relating to the child's previous and current relationship with a sibling, if the change in physical custody or placement will separate or reunite siblings, is amended to

[88] Further, the bill requires that MDT staffings may not be delayed to accommodate pending behavioral health screenings or assessments or pending referrals for services.

require that any issues regarding siblings must be evaluated in accordance with s. 39.4024, F.S.;

- A new factor is added which states the team must consider the likelihood that the child will have to change schools or day care placement, the impact of such a change, and the parties' recommendations as to the timing of the change including an education transition plan required under s. 39.4023, F.S.; and
- The factor relating to allegations of any abuse, abandonment, or neglect, including sexual abuse and trafficking history, which caused the child to be placed in out-of-home care is amended to include consideration of any history of additional allegations of abuse, abandonment, or neglect.

The bill lists specified information that must be gathered and considered by the MDTs for a decision related to a child 3 years of age or younger, and reviewed as often as necessary to ensure permanency, including:

- Identified kin and relatives who express interest in caring for the child, including strategies to overcome potential delays in placing the child with such persons if they are suitable.
- The likelihood that the child can remain with the prospective caregiver past the point of initial removal and placement with, or subsequent transition to, the caregiver and the willingness of the caregiver to provide care for any duration deemed necessary if placement is made.
- The prospective caregiver's ability and willingness to:
  - Accept supports related to early childhood development and services addressing any possible developmental delays;
  - Address the emotional needs of the child and accept infant mental health supports, if needed;
  - Help nurture the child during the transition into out-of-home care;
  - Work with the parent to build or maintain the attachment relationship between parent and child;
  - Effectively co-parent with the parent; and
  - Ensure frequent family visits and sibling visits.

The bill provides that if the staffing participants reach a consensus decision, it becomes the official position of the lead agency regarding the decision for which the MDT convened and binds all DCF and lead agency participants, who are obligated to support it. If the participants cannot reach a consensus decision, the trained professional acting as the facilitator is required to attempt to bring at least the lead agency's staff to a decision that all participants can support.

However, if there is disagreement even among lead agency staff, the MDT may request a review of the decision from a designated, high level administrator within the lead agency and that decision becomes the official position for the decision for which the team was convened. If the MDT cannot agree on the placement, the lead agency must determine the most appropriate placement for the child in order to achieve the goals of child safety, permanency, and well-being.

The bill provides that if a MDT staffing fails to reach a consensus decision, the facilitator must prepare and submit a written report to the court within 5 business days after the conclusion of the staffing which details the decision made and the positions of the MDT's participants.

The bill permits the DCF to discuss confidential information during MDT staffings in the presence of those participating. The bill requires any individuals who participate in MDT staffings to maintain the confidentiality of all information shared during the staffing.

The bill also provides that these provisions may not be construed to mean that MDT staffings coordinated by the DCF or the appropriate lead agency for purposes other than those specifically enumerated in the bill before October 1, 2021, are no longer required to be conducted or are required to be conducted in accordance with the above-mentioned criteria. The bill also requires the DCF to adopt rules.

Transitions

The bill creates s. 39.4023, F.S., establishing specific provisions for transitioning a child who is in the dependency system and specifically addressing placement transitions and education transitions. The bill provides legislative findings and intent, including, specifically:

- The Legislature finds that many children in out-of-home care have experienced multiple changes in placement, and those transitions often result in trauma not only for the child, but also for caregivers, families, siblings, and all professionals involved.
- The Legislature further finds that poorly planned and executed or improperly timed transitions may adversely impact a child's healthy development as well as the child's continuing capacity to trust, attach to others, and build relationships in the future.
- The Legislature finds that the best child welfare practices recognize the need to prioritize the minimization of the number of placements for every child in out-of-home care. Further, the Legislature finds that efforts must be made to support caregivers in order to promote stability. When placement changes are necessary, they must be thoughtfully planned.
- The Legislature finds that transition plans are critical when moving all children, including infants, toddlers, school-age children, adolescents, and young adults.
- It is the intent of the Legislature that a placement change or an educational change for a child in out-of-home care be achieved ideally through a period of transition that is unique to each child, provides support for all individuals affected by the change, and has flexible planning to allow for changes necessary to meet the needs of the child.

The bill also provides definitions for the following terms:

- "Educational change", which is defined to mean any time a child is moved between schools which is not the result of the natural transition from elementary school to middle school or middle school to high school. The term also includes changes in child care or early education programs for infants and toddlers.
- "Emergency situation", which is defined to mean that there is an imminent risk to the health or safety of the child, other children, or others in the home or facility if the child remains in the placement.
- "Placement change", which is defined to mean any time a child is moved from one caregiver to another, including moves to a foster home, a group home, relatives, prospective guardians, prospective adoptive parents, and reunification with parents. The term also includes moves between rooms and buildings operated by a group home provider.
- "School", which is defined to mean any child care, early education, elementary, secondary, or postsecondary educational setting.

Placement Transitions

The bill requires the DCF or lead agency to create and implement an individualized transition plan for each child before each placement change. In order to minimize changes in placement, once a caregiver accepts responsibility of caring for a child, the child may be removed from the home of the caregiver only if:

- The caregiver is unwilling or unable to safely or legally care for the child;
- The child is reunified with the parent or legal guardian;
- The child is being placed in a legally permanent home in accordance with a case plan or court order; or
- The removal is demonstrably in the best interests of the child.

The bill requires the lead agency to provide a caregiver and a child with any necessary supportive services to stabilize the child's current out-of-home placement if there is in danger of it needing modification. If the child is required to be removed notwithstanding the preventative services provided, the DCF or the lead agency must convene a MDT staffing before the child's placement is changed or within 72 hours of moving the child in an emergency situation to develop an appropriate transition plan.

The bill requires the DCF or lead agency to provide notice at least 14 days before moving a child from one out-of- home placement to another, which must include the reason a placement change is necessary. It must be filed with the court, and a copy be provided to the:

- Child, unless he or she, due to age or capacity, is unable to comprehend the written notice, which will necessitate the DCF or lead agency to provide notice in an age- and capacity-appropriate alternative manner;
- Child's parents, unless prohibited by court order;
- Child's out-of-home caregivers;
- Guardian ad litem, if appointed to the child; and
- Attorney for the DCF.

The bill also provides that the transition plan must be developed by the individuals required to receive notice of intent to move a child, and any relevant information must be shared and considered to ensure that the transition plan does all of the following:

- Respects the child's developmental stage and psychological needs;
- Ensures the child has all of his or her belongings and is allowed to help pack those belongings when appropriate;
- Allows for a gradual transition from the current caregiver's home with substantial overlap between the two caregivers and provides time for the child to have a final visitation with everyone important to him or her;
- Allows, when possible, for continued contact with the previous caregiver and others in the home; and
- Prohibits a change in placement that occurs between 7 p.m. and 8 a.m.

The bill requires the DCF or the lead agency to file the transition plan with the court within 48 hours after the creation of the plan and provide a copy of the plan to the specified persons who receive not of intent to move the child.

The bill provides for additional considerations for transitions of infants and children under school age. Placement decisions for infants and children under 5 years of age in out-of-home care must focus on promoting security and continuity. Transition plans for infants and young children must describe the facts that were considered when each of the following were discussed and specify what decision was made as to how each of the following applies to the child:

- The age of the child and the child's current ability to accomplish developmental tasks, with consideration made for whether the child is:
  - Six months of age or younger; or
  - One year to 2 years of age.
- The length of time the child has lived with the current caregiver, the strength of attachment to the current caregiver, and the harm of disrupting a healthy attachment compared to the possible advantage of a change in placement.
- The relationship, if any, the child has with the new caregiver and whether a reciprocal agreement exists between the current caregiver and the prospective caregiver to maintain the relationship with both caregivers.
- The pace of the transition and whether flexibility exists to accelerate or slow down the transition based on the needs and reactions of the child.

The bill requires the lead agency to fully inform prospective caregivers of the child's needs and circumstances and ensure that he or she is willing and able to accept responsibility for providing high-quality care for such needs and circumstances before the child is placed. The bill requires the lead agency to review the caregivers' roles and responsibilities according to the parenting partnerships plan for children in out-of-home care pursuant to s. 409.1415, F.S., the case manager must sign a copy of it, and obtain the signature of the prospective caregiver acknowledging explanation of the requirements before placement of the child.

Education Transitions

In addition to placement changes, the bill also establishes a number of provisions related to education transitions, which often occur in conjunction with a placement change, but may also be considered independently. The bill provides legislative findings, including that:

- Children in out-of-home care frequently changing child care, early education programs, and schools. These changes can occur when the child first enters out-of-home care, when the child must move from one caregiver to another, or when the child returns home upon reunification. Research shows that children who change schools frequently make less academic progress than their peers and fall further behind with each school change. Additionally, educational instability at any level makes it difficult for children to develop supportive relationships with teachers or peers. State and federal law contain requirements that must be adhered to in order to ensure educational stability for a child in out-of-home care. A child's educational setting should only be changed when maintaining the educational setting is not in the best interest of the child.

The bill requires that the DCF and lead agency must make every effort to keep a child in his or her school of origin and that any placement decision must include thoughtful consideration of which school a child will attend if a school change is necessary. The DCF and lead agency must consult with the child, parents, caregiver, child welfare professional, guardian ad litem, and other

specified individual, including but not limited to, certain school staff, to determine which school is in the child's best interest to attend. The bill requires the DCF or the lead agency to create and implement an individualized education transition plan each time a child experiences a school change.

If it is not in the child's best interest to remain in the school or program of origin, the specified individuals must consider the following relevant factors when determining the school the child will attend, including, but not limited to:

- The child's desire to remain in the school or program of origin;
- The child's parents or legal guardians' school preference.
- The child's relationship with other students or mentors the school or program of origin;
- The child's cultural and community connections in the school or program of origin;
- Whether the child is suspected of having a disability under the Individuals with Disabilities Education Act (IDEA) or s. 504 of the Rehabilitation Act of 1973, or has begun receiving interventions under this state's multi-tiered system of supports;
- Whether the child has an evaluation pending for special education and related services under IDEA or s. 504 of the Rehabilitation Act of 1973;
- Whether the child is a student with a disability under IDEA who is receiving special education and related services or a student with a disability under s. 504 of the Rehabilitation Act of 1973 who is receiving accommodations and services and, if so, whether those required services are available in a school or program other than the school or program of origin;
- Whether the child is an English Language Learner student and is receiving language services, and, if so, whether those required services are available in the proposed new school or program;
- The impact a change to the school or program of origin would have on academic credits and progress toward promotion;
- The availability of extracurricular activities important to the child;
- The child's known individualized educational plan or other medical and behavioral health needs and whether such plan or needs are able to be met at the proposed new school or program;
- The child's permanency goal and timeframe for achieving permanency;
- The child's history of school transfers and how such transfers have impacted the child academically, emotionally, and behaviorally;
- The length of the commute to the school or program and how it would impact the child; and
- The length of time the child has attended the school or program of origin.

The bill specifically provides that the cost of transportation cannot be a factor in making the best interest determination.

Transitions between child care and early education programs.

The child must, if possible, remain with the familiar child care provider or early education program when their placement changes unless there is an opportunity to transition to a higher quality program. When this is not possible, however, the child's education transition plan must be made with the participation of the child's current and future school or program, and the plan

must give the child an opportunity to say goodbye to important figures in the educational environment.

Transitions between K-12 schools.

The bill requires that a transition plan for a school change between K-12 schools must include all of the following:

- The decision and any related details of all factors considered to change the child's school in accordance with reasons allowed for removal;
- Evidence that the DCF or lead agency has coordinated with local educational agencies to provide immediate and appropriate enrollment in a new school, including transfer of educational records, record of a school entry health examination, and arrangements for transportation to the new school;
- Discussion of the timing of the proposed school change which addresses the potential impact on the child's education and extracurricular activities;[89] and
- Information regarding transportation of the child to school.

Transition Plan Documentation

The bill requires the DCF, in collaboration with the Quality Parenting Initiative, to develop a form to be completed and updated each time a child experiences a change of placement covered under s. 39.4023, F.S. The updated form must be attached to the case record face sheet required to be included in the case file pursuant to s. 39.00146. (b), F.S. The form must be used statewide and, at a minimum, must include all of the following information:

- The membership of the MDT convened to develop a transition plan for the change in placement and the dates the team met;
- The identity of the MDT professional facilitator;
- The topics considered by the MDT; and
- The MDT's recommendations and the name of each individual or entity responsible for carrying out each recommendation.

The bill requires the DCF or the lead agency to document all MDT staffings and placement transition decisions in the FSFN. This information must be included in the social study report for judicial review.[90] The bill also provides the DCF with rulemaking authority to implement the provisions of the bill related to placement and education transitions.

Placement of Siblings

The bill creates s. 39.4024, F.S., relating to the placement of siblings and providing clarity to provisions that address placement decision of sibling groups. These provisions expand current law to highlight the importance provide clear guidance for these children that enter out-of-home care. The bill provides legislative findings related to sibling relationships including that:

- Sibling relationships can provide a significant source of continuity throughout a child's life, are likely to be the longest relationships that individuals experience, and that healthy

[89] The bill provides that education plans for this level must include, at a minimum, grading periods, exam schedules, credit acquisitions, sports eligibility, and extracurricular participation.
[90] The judicial review referenced is as required under s. 39.701, F.S.

connections with siblings can serve as a protective factor for children who have been placed in out-of-home care.

- It is beneficial for a child who is placed in out-of-home care to be able to continue existing relationships with his or her siblings, regardless of age, so that they may share their strengths and association in their everyday and often common experiences.
- Healthy connections with siblings can serve as a protective factor for children who have been placed in out-of-home care. The Legislature finds that child protective investigators and caseworkers should be aware of the variety of demographic and external situational factors that may present challenges to placement in order to identify such factors relevant to a particular group of siblings and ensure that these factors are not the sole reasons that siblings are not placed together.
- It is the responsibility of all entities and adults involved in a child's life to seek opportunities to foster existing sibling relationships to promote continuity and help to sustain family connections, including, but not limited to, the DCF, lead agencies, parents, foster parents, guardians ad litem, next of kin, and other persons important to the child.
- While there is a presumption in law and policy that it is in the best interest of a child going into foster care to be placed with any siblings the Legislature finds that overall well-being of the child and family improves when the person or team responsible for placement decisions evaluates the child's sibling and family bonds and prioritizes the bonds that are unique drivers of the child's ability to maintain and develop healthy relationships. The person or team with an understanding of the need to balance all attachment bonds of a child and the potential need to prioritize existing and healthy sibling relationships differently than a potential or unhealthy sibling relationship over a healthy existing bond with a caregiver will result in more stable and healthier placements for all children in out-of-home care

The bill provides the following definitions that apply to the provision related to the placement of siblings:

- "Lead agency" means a community-based care lead agency under contract with the DCF to provide care to children in foster care under chapter 409, F.S.
- "Multidisciplinary team" has the same meaning as provided in s. 39.4022, F.S.
- "Sibling", which is defined to mean:
  - A child who shares a birth parent or legal parent with one or more other children;
  - A child who has lived together in a family with one or more other children whom he or she identifies as siblings.

Placement Decisions

The bill provides that the DCF is required to make reasonable efforts to place siblings who have been removed from their home and have an existing relationship in the same foster, kinship, adoptive, or guardianship home, when it is in the best interest of each sibling and when an appropriate, capable, and willing joint placement for the sibling group is available. Further, the bill provides that if a child is removed from his or her home after his or her sibling, the DCF or lead agency and the MDT must make reasonable efforts to initially place the child who has entered out-of-home care with his or her siblings in the sibling's existing placement, provided it would not jeopardize the stability of such placement and it is in the best interest for each child.

When determining whether to move a child from a current placement to a new placement when such change is instigated by a sibling relationship, all relevant factors must be considered by the MDT to ensure that the child is best served by the decision.

The bill clarifies that the DCF and the court are not required to make an initial placement or change in placement to develop a relationship between siblings which did not exist at the time a child is placed in out-of-home care.

The bill provides a number of considerations when determining how to place a child who is a part of a sibling group. To ensure that the placement decision is appropriate as early as possible, the bill provides that the DCF or lead agency must convene a MDT staffing in accordance with s. 39.4022, F.S., at the time a child who is a part of a sibling group is removed from the home to determine and assess the sibling relationships from the perspective of each child to ensure the best placement of each child in the sibling group. The MDT must consider all relevant factors included in ss. 39.4022 and 39.4024, F.S., including, but not limited to, the existing emotional ties between and among the siblings, the degree of harm each child is likely to experience as a result of separation, and the standard protocols established by the Quality Parenting Initiative.

The bill provides provisions that detail how the DCF or lead agency must place a child in a sibling group that has an existing relationship, including:

- Requiring that if the DCF or the appropriate lead agency is able to locate a caregiver that will accept the sibling group and the MDT determines that the placement is suitable for each child, the sibling group must be placed together.
- Requiring the DCF or lead agency to make all reasonable efforts to ensure contact and visitation between siblings placed in separate out-of-home care placements and provide reviews of the placements when the DCF or appropriate lead agency is not able to locate a caregiver or placement option that allows the sibling group to be placed together in an initial placement.

Further, if all the siblings are unable to be placed in an existing placement and the siblings do not have an existing relationship, when determining whether to move any child who is part of the sibling group from his or her current placement to a new placement that will unite the sibling group, the DCF or lead agency must consider all of the following additional factors:

- The presence and quality of current attachment relationships, including:
  - The quality and length of the attachment of the child to both the current and prospective caregiver
  - The age of the child at placement with the current caregiver and the child's current age as well as the ages of any siblings;
  - The ease with which the child formed an attachment to the current family;
  - Any indications of attachment difficulty in the child's history; and
  - The number of moves and number of caregivers the child has experienced.
- The potential of the new caregiver to be a primary attachment figure to the sibling group by ensuring care for each child's physical needs and the willingness and availability to meet the each child's emotional needs.
- The quality of existing sibling relationships and the potential quality of sibling relationships that can be formed between the children.

- The consideration of any costs and benefits of disrupting existing emotional attachments to a primary caregiver to place children in a new placement with siblings, including:
  - The length and quality of the established and current primary attachment relationships between the siblings and between the siblings and their current caregivers; and
  - Relationships between any other siblings and whether such relationships appear adequate and not stressful or harmful.
- The ability to establish and maintain sibling visitation and contact pursuant to this section in a manner and schedule that makes sense for an infant or young child if it is determined that the infant or young child is to remain with his or her primary caregivers rather than be placed with his or her siblings.
- The ability to establish and maintain contact with the sibling and new caregiver as part of a transition plan developed in accordance with s. 39.4023, F.S., before changing the child's placement to allow the child, his or her siblings, and new caregiver to adjust and form bonds.

The bill requires that if, after considering the required provisions and factors described above, the determination is that the child would benefit from being placed with his or her siblings, the transition of the child to the new home must be carried out gradually in accordance with s. 39.4023, F.S.

The bill requires the DCF, in collaboration with the Quality Parenting Initiative, to develop standard protocols that incorporate the required provisions and factors and any other factors deemed relevant for use in making decisions about when placing siblings together would be contrary to a child's well-being or safety or decisions providing for frequent visitation and contact. These protocols will be used by the DCF and lead agency.

The Legislature finds that regular contact among a sibling group that cannot be placed together, especially among siblings with existing attachments to each other, is critical for the siblings to maintain their existing bonds and relationships or to develop such bonds and attachments, if appropriate. The bill requires the following practices to be considered in helping to maintain or strengthen the relationships of separated siblings:

- Respect and support the child's ties to his or her birth or legal family, including parents, siblings, and extended family members, must be provided by the caregiver, and he or she must assist the child in maintaining allowable visitation and other forms of communication. The DCF and lead agency must provide a caregiver with the information, guidance, training, and support necessary for fulfilling this responsibility.
- Provide adequate support to address any caregiver concerns and to enhance the caregiver's ability to facilitate contact between siblings who are not in the same out-of-home placement and promote the benefits of sibling contact.
- Prioritize placements with kinship caregivers who have an established personal relationship with each child so that even when siblings cannot be placed together in the same home, kinship caregivers are more likely to facilitate contact.
- Prioritize placement of siblings geographically near each other, such as in the same neighborhood or school district, to make it easier for the siblings to see each other regularly.
- Encourage frequent and regular visitation, if the siblings choose to do so, to allow the children to be actively involved in each other's lives and to participate in celebrations,

including, but not limited to, birthdays, graduations, holidays, school and extracurricular activities, cultural customs, and other milestones.
- Provide other forms of contact when regular in-person meetings are not possible or are not sufficient to meet the needs or desires of the siblings, such as maintaining frequent contact through letters, e-mail, social media, cards, or telephone calls.
- Coordinate, when possible, joint outings or summer or weekend camp experiences to facilitate time together, including, but not limited to, activities or camps specifically designed for siblings in out-of-home care.
- Encourage joint respite care to assist the caregivers who are caring for separated siblings to have needed breaks while also facilitating contact among the siblings, including, but not limited to, providing babysitting or respite care for each other.
- Prohibit the withholding communication or visitation among the siblings as a form of punishment.

The bill authorizes the court to limit or restrict communication or visitation upon a finding by clear and convincing evidence that the communication or visitation is harmful to the child. If the court makes such a finding, it must direct the DCF or lead agency to immediately provide services to ameliorate the harm so that communication and visitation may be restored as soon as possible.

The bill requires the DCF and the lead agency to periodically, but at least once every 6 months, reassess sibling placement, visitation, and other sibling contact decisions in cases where siblings are separated, not visiting, or not maintaining contact to determine if a change in placement is warranted unless the decision to not place a child with his or her sibling group was made due to such placement being inappropriate, unhealthy, or unsafe for the child.

Further, the bill requires the lead agency to provide services to the caregiver and sibling group in accordance with s. 39.4023(3), F.S., to try to prevent the disruption of a placement if a child in a sibling group who has been placed in an out-of-home care placement with his or her siblings does not adjust to the placement. However, if after reasonable efforts are made under s. 39.4023(3), F.S., the child still has not adjusted to the out-of-home placement, a MDT staffing must be convened to determine what is best for all of the children. The MDT is required to review the current placement of the sibling group and choose a plan that will be least detrimental to each child. The MDT must develop a transition plan in accordance with ss. 39.4022 and 39.4023, F.S., if the decision is to move the child to ensure the opportunity for the siblings to maintain contact.

The DCF or lead agency must convene a MDT staffing within a reasonable amount of time after the discovery of such sibling to decide if the current placement or permanency plan requires modification if it becomes known that a child in out-of-home care has a sibling of whom the child, DCF, or lead agency was previously unaware.

The bill provides a number of other provisions related to a child and his or her siblings including:
- Requiring the DCF to promptly provide a child with the location of and contact information for his or her siblings and must make reasonable efforts to ascertain such information if the existence or location of or contact information for a child's siblings is not known.

- Providing that a child has a right to continued communication with his or her sibling if the child's sibling is also in out-of-home care and such sibling leaves out-of-home care for any reason, including, but not limited to, emancipation, adoption, or reunification with his or her parent or guardian.
- Requiring the DCF or the lead agency to document in writing any decision to separate siblings in the case file as required in s. 39.00146, F.S., and document the decision in the FSFN, including any efforts made to keep the siblings together, an assessment of the short-term and long-term effects of separation on each child and the sibling group as a whole, and a description of the plan for communication or contact between the children if separation is approved.

The bill requires the DCF to adopt rules to implement this section of the bill.

Postdisposition Change of Custody

A MDT staffing must be convened to try to reach a consensus on a postdisposition change of placement under s. 39.522, F.S. If any party or the caregiver denies the change of physical custody, the court must have an evidentiary hearing and consider the factors listed in s. 39.4022, F.S.;[91] the report filed by the MDT team, if applicable; and the priority of placements established under s. 39.4021, F.S., discussed above.

The bill creates a rebuttable presumption that it is in the child's best interest to remain permanently in his or her current physical placement if:
- The child has been in the same safe and stable placement for 9 consecutive months or more;
- Reunification is not a permanency option for the child;
- The caregiver is able, willing, and eligible for consideration as an adoptive parent or permanent custodian for the child;
- The caregiver is not requesting the change in physical placement; and
- The change in physical placement being sought is not to reunify the child with his or her parent or sibling or transition the child from a safe and stable nonrelative caregiver to a safe and stable relative caregiver.

The bill defines "change of physical custody" to mean a change by the DCF or lead agency to the child's physical residential address even when such change does not require a court order to change the legal custody of the child.

The court must consider competent and substantial evidence and testimony at an evidentiary hearing, related to the factors enumerated in s. 39.4022, F.S., expert evidence in the science and research of child-parent bonding and attachment, and any other evidence deemed relevant to a determination of placement. The presumption may not be rebutted solely by the expressed wishes of a biological parent, a biological relative, or a caregiver of a sibling of the child.

The bill also provides that a current caregiver who has had physical custody of a child for at least 9 consecutive months and who meets all the required criteria in the section is required to be notified by the DCF or lead agency of an intent to change the physical custody of the child at

[91] This is an expanded list of factors that includes, in part, those currently listed in s. 39.523, F.S.

least 21 days before the desired date for transitioning the child to the new physical custody placement. A caregiver may notify the court and the DCF or lead agency of any objection to the change in physical custody and the intent to request an evidentiary hearing in writing as soon as possible after receiving notice from the DCF or the lead agency, but no later than 5 days before the desired date for transitioning the child to the new physical custody placement.

The child's placement must not be changed without a court order once the DCF or the lead agency receives written notice of the caregiver's objection.

The court must conduct an initial case status hearing within 7 days after receiving written notice from the caregiver, at which time the court must:

- Grant party status to the current caregiver who is seeking permanent custody and has maintained physical custody of that child for at least 9 continuous months;
- Appoint a lawyer for the child who is the subject of the permanent custody proceeding;
- Advise the caregiver of his or her right to retain counsel for purposes of the evidentiary hearing; and
- Appoint a court-selected neutral and independent expert in the science and research of child-parent bonding and attachment.

The bill requires, no later than 90 days from the date the caregiver provides written notice of objection to the court, it must conduct an evidentiary hearing and provide a written order of its findings regarding the placement that is in the best interest of the child. A copy of the order must be provided to all parties and the current caregiver and prospective caregiver. If the court decides that the child's placement will be modified from his or her current caregiver after an evidentiary hearing, the DCF or lead agency must provide an appropriate transition plan in accordance with s. 39.4023, F.S.

As noted above, the bill amends s. 39.523, F.S., removing the list of factors that the MDT must gather and consider at staffings to assess postdisposition change of placement, and cross-references s. 39.4022, F.S., which is one of the new sections which consolidated these factors with other factors in s. 39.522, F.S., to create one comprehensive list to consider when determining what is in a child's best interest.

Case Record Face Sheet

The bill creates s. 39.00146, F.S., implementing the use of a case record sheet with all child welfare cases in Florida. To achieve this goal, the bill provides definitions for the following terms "Multidisciplinary team", Placement change", "School", and "Sibling", and all have the same meanings as discussed above.

The bill requires that the case record of every child under the supervision or in the custody of the DCF, the DCF's agents, or providers contracting with the DCF, including lead agencies and their subcontracted providers, must include a face sheet containing relevant information about the child and his or her case, including at least all of the following:

- General case information, including, but not limited to:
  - The child's name and date of birth;
  - The current county of residence and the county of residence at the time of the referral;

  - The reason for the referral and any family safety concerns;
  - The personal identifying information of the parents or legal custodians who had custody of the child at the time of the referral, including name, date of birth, and county of residence;
  - The date of removal from the home; and
  - The name and contact information of the attorney or attorneys assigned to the case in all capacities, including the attorney or attorneys that represent the DCF and the parents, and the guardian ad litem, if appointed to the child.
- The name and contact information for any employees of the DCF, the DCF's authorized agents, or providers contracting with the DCF, including lead agencies and their subcontracted providers, who have worked with the child, including the child's current and previous case managers, and the supervisor information for such employees.
- The personal information of relevant family members and other fictive kin, including, but not limited to, the name and contact information of:
  - The child's parents;
  - The child's siblings, , including the location of the current out-of-home placement, if applicable;
  - The child's current caregivers and any previous out-of-home placements;
  - Any other caretaking adults; and
  - All children in the out-of-home placement, if applicable.
- A description of any threats of danger placing the child at imminent risk of removal.
- A description of individual parent or caregiver concerns for the child.
- Any concerns that exist regarding the parent or the current caregiver's ability to:
  - Engage or bond with the child if the child is an infant;
  - Structure daily activities that stimulate the child;
  - Manage the child's behavior;
  - Maintain a safe home; or
  - Make good health decisions for the child.
- Any transitions in placement the child has experienced since the child's initial placement and a description of how such transitions were accomplished in accordance with s. 39.4023
- If the child has any siblings and they are not placed in the same out-of-home placement, the reasons the children are not in joint placement and the reasonable efforts that the DCF or appropriate lead agency will make to provide frequent visitation or other ongoing interaction between the siblings, unless the court determines that the interaction would be contrary to a sibling's safety or well-being in accordance s. 39.4024, F.S.
- Information pertaining to recent and upcoming court hearings, including, but not limited to, the date, subject matter, and county of court jurisdiction of the most recent and next scheduled court hearing.
- Any other relevant information.

The bill requires the DCF, the DCF's authorized agents, or providers contracting with the DCF, including lead agencies and their subcontracted providers, to ensure that the face sheet for each case is updated at least once per month. The DCF must obtain updated information from any case service providers working on the case.

The bill provides the DCF with rulemaking authority to implement provisions relating to case record face sheets.

The bill is effective October 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires the DCF or lead agency to develop a transition plan for each placement change that occurs. The DCF states that this requirement will impact the lead agencies. The DCF states that, according to the Florida Safe Families Network (FSFN) data, there were 22,705 placement changes in FY 2019-2020 where a child moved from one caregiver to another, including moves to a relative, nonrelative, foster home, group home, and reunification with a parent. The data currently collected in FSFN does not include moves between rooms or buildings operated by group homes for which the DCF would also be required to develop a transition plan. The DCF states that it typically requires a case manager on average 8 hours to develop a transition plan that includes the components and consultation with the interested persons outlined in the bill. The DCF further provides that this provision will require at least 98 new case management

positions, with a total need for salary, expenses, and travel anticipated to be $8,093,428 ($7,657,524 in recurring and $435,904 in nonrecurring).[92]

C. Government Sector Impact:

The DCF states in the agency analysis dated February 2, 2021, that SB 80, as filed, will have a negative significant fiscal impact on state government and the private sector related to the child and family teams and transition plans. Specifically, the DCF states that the to fulfill the requirements of the teams it needs at least 174 FTEs for the statewide facilitators referenced to lead a meeting each time there is a placement change and on an annual basis in conjunction with the child's permanency hearing. The total need for the anticipated FTEs cited in that analysis is $14,313,442 ($13,539,490 in recurring and $773,952 in nonrecurring).[93] Further, the DCF stated that the fiscal impact of the requirement that a mental health professional with expertise in sibling bonding would result in additional expenditures to the DCF of additional $1,653,000 for staffings and court testimony.[94]

However, CS/SB 80 substantially amended the provisions that were attributed by the DCF to result in this significant fiscal impact, including, in part, to clarify that the MDTs provided for in CS/SB 80 are intended to operate in a substantially similar manner as is under current law. To the extent that these changes reduced the need for additional FTEs, the CS/SB 80 will likely have a positive indeterminate fiscal impact on state government and the private sector.

Further, it should be noted that the DCF has provided supplemental information to Senate professional staff that there are a number of MDT staffings currently being conducted by the DCF or lead agency that involve very similar structure for the participant members as well as purpose. As a result, in light of this supplemental information and the provions found in CS/SB 80, additional information will need to be gathered from the DCF to understand the expenditure and FTE needs of the bill.[95]

Lastly, the DCF provides that the bill is expected to require significant changes to the FSFN system to support data currently not in FSFN and the development of web services to provide the data required for the case record face sheet to an external system. In addition to the FSFN changes and web services, the DCF states that will be a cost estimate to license an external provider solution that already has a Face Sheet, which will be a recurring annual cost that covers licensing and support. The DCF provides that the total estimate for the FSFN changes, web services, and an external provider solution will range between $1,430,500 to $2,284,000, depending on a number of factors.[96]

[92] The DCF, *Agency Analysis for SB 80*, p. 17-18, February 2, 2021 (on file with the Senate Committee on Children, Families, and Elder Affairs)(hereinafter cited as "The DCF SB 80 Analysis").
[93] The DCF Analysis, p. 16.
[94] *Id*.
[95] *See* The DCF Supplemental Information.
[96] The DCF SB 80 Analysis, p. 18-20.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends ss. 39.401, 39.402, 39.522, 39.523 and 39.806 of the Florida Statutes.

This bill creates ss. 39.00146, 39.4021, 39.4022, 39.4023, and 39.4024, of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on February 16, 2021:
The committee substitute:

- Requires the DCF and lead agencies to develop a "FACE sheet", which must include minimum information related to the child's case to be kept in the dependency case file as a quick reference resource.
- Requires the DCF and the lead agencies to update the FACE sheet at least once a month.
- Provides legislative findings and intent related to priority placements for children in out-of-home care.
- Expands and relocates the list of persons that should be considered as priority placements for these children and ensure this priority list applies to initial and for all subsequent removals.
- Relocates and expands existing MDT teams to ensure better decisions for the child through engaging with families and other important individuals.
- Provides legislative intent for MDT, staffings, and assessments and provide a definition for the term "multidisciplinary team".
- Enumerates circumstances when the MDT must be convened within specified timeframes, including to consider placement decisions, transitions and transition plans, and sibling placements.
- Specifies the participants that must be invited and provide authority for the DCF or lead agency to invite other relevant participants and requires the MDT staffing to be led by a facilitator who is a person otherwise required to attend the staffing.
- Requires MDT staffing participants to gather and consider data and information on the child before formulating a decision.
- Requires MDTs to conduct supplemental assessments for children under age 3, including specified additional data to collect and factors to consider when making decision relating to such children.

- Requires that a consensus decision reached by the MDT becomes the official position and that specified parties are bound by such consensus decision, provides procedures for when the MDT does not reach a consensus decision, and requires the facilitator to file a report with the court providing specified information within a certain time frame.
- Requires the lead agency to determine a suitable placement if the MDT cannot come to a consensus decision.
- Authorizes specified parties to discuss confidential information during a team staffing in the presence of participating individuals and provides that information collected by any agency or entity that participates in a MDT staffing which is confidential and exempt upon collection remains confidential and exempt when discussed in staffings.
- Provides legislative findings and intent related to changes in placement and defines the terms "educational change", "emergency situation", "placement change", and "school".
- Requires the DCF and lead agency to convene the MDT to develop transition plans for placement changes and education transitions that focus minimizing the impact on the child within specified time frames for emergency versus nonemergency circumstances.
- Requires the lead agencies to provide services to a caregiver intended to try and prevents a placement disruption prior to convening the MDT to develop a transition plan.
- Clarifies that a child may be removed from his or her home in an emergency without convening the MDT for transition plan development prior to removal.
- Provides that the transition plans address specialized concerns, including additional specified factors, which include consideration of additional specified factors for children that are younger than 3 years of age.
- Requires the DCF and lead agency to consider certain factors when determining the best education placement for a child and provides additional considerations for transitions of early education or programs versus K-12 education schools.
- Requires that prospective caregivers are prepared for accepting the child who is being transitioned to their home, including providing information on the child and the transition plan.
- Requires the DCF to develop a form related to transition plans in collaboration with the Quality Parenting Initiative to be attached to the FACE sheet.
- Provides legislative findings related to siblings in out-of-home care and define the terms "multidisciplinary team", "lead agency", and "sibling".
- Specifies how the DCF and the lead agencies must handle changes in placement and educational settings and transitions of sibling groups throughout the dependency process.
- Requires that the DCF must make reasonable efforts to place sibling groups together when they are removed at the same time from the same home and on an initial placement of a child who enters out-of-home care later than his or her siblings if it won't disrupt the placement and provides that the DCF and the court are not required to make an initial placement or change of placement to develop a sibling bond that does not exist.

- Requires the DCF or lead agency to convene a MDT staffing to make a decision regarding placements of sibling groups and establishes specified criteria for the DCF or lead agency to consider when determining initial placement and for the court to consider when a change of placement is sought for sibling groups that have certain existing relationships as well as additional factors for consideration when the siblings may not have an existing relationship.
- Provides specified factors to consider when determining placement of a child who is part of a sibling group and is younger than 3 years of age.
- Requires the DCF, in collaboration with the Quality Parenting Initiative, to develop standard protocols for the DCF and lead agency for use in making specified decisions about child placement.
- Provides for the contact and visitation between siblings who are not placed together in out-of-home care that will assist the siblings with continuing established relationships or possibly developing a relationship.
- Requires subsequent reviews by the MDT for sibling groups when a child does not adjust to a placement with his or her siblings after certain services are offered or in the event a sibling group is not placed together.
- Creates a rebuttable presumption that in specified cases the best interest of the child is to continue the current placement and require the court to conduct an evidentiary hearing to determine the best placement.
- Requires the caregiver, in response to receiving written notice of the DCF or lead agency's intent to change a placement, to file written notice to the court and the DCF requesting the evidentiary hearing.
- Requires the court to hold the initial status hearing and conduct the evidentiary hearing within specified timeframes and prohibits the DCF from moving the child until a court order states to do so.
- Requires the court to appoint an attorney for the child and an expert in attachment and bonding and authorizes the caregiver to retain counsel.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Bean

4-01356F-21 202192__

A bill to be entitled

An act relating to the Department of Children and Families; amending s. 20.19, F.S.; requiring the department to establish community alliances in each community-based care lead agency service area; requiring community alliances to adopt certain bylaws; revising the membership of community alliances; amending s. 39.4015, F.S.; requiring, rather than authorizing, the department to develop a family-finding program; removing the limitation that the development of family-finding programs is subject to available resources; requiring that family finding begin as soon as a child is taken into custody of the department; making technical changes; amending s. 39.4087, F.S.; requiring the department to treat caregivers in a specified manner; requiring the department to provide certain information to and training for caregivers of children in foster care; removing the requirement that such information be provided subject to available resources; expanding certain information that is required to be fully disclosed to the caregivers to include the child's issues related to behavioral health; making technical changes; amending s. 39.5086, F.S.; removing the limitation that the development of kinship navigator programs is subject to available resources; requiring, rather than authorizing, each community-based care lead agency to establish a kinship navigator program; amending s. 394.9082, F.S.; requiring the department

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

to collect and post specified information on its website for each managing entity under contract with the department; defining the term "employee"; providing a limitation on the managing entity employees' salaries; requiring that contracts and amendments to existing contracts between the department and managing entities include a specified provision; creating s. 394.90825, F.S.; defining terms; requiring a board member or an officer of a managing entity to disclose specified activity that may reasonably be construed as a conflict of interest; creating a rebuttable presumption of a conflict of interest if the activity was acted upon by the board without prior notice; establishing a process for the managing entity's board of directors to address the activity under certain timelines; providing for certain consequences for failure to obtain a board's approval or failure to properly disclose a contract as a conflict of interest; amending s. 409.987, F.S.; requiring the department to develop an alternative plan to contracting with a lead agency in a community under certain circumstances; providing requirements for the alternative plan; defining terms; requiring a board member or an officer of a lead agency to disclose activity that may reasonably be construed as a conflict of interest; creating a rebuttable presumption of a conflict of interest if the activity was acted upon by the board without prior notice; establishing a process for the lead agency's board of

directors to address the activity under certain timelines; providing for certain consequences for failure to obtain a board's approval or failure to properly disclose a contract as a conflict of interest; amending s. 409.988, F.S.; deleting a requirement that lead agencies post their current budgets on their websites; requiring a lead agency to demonstrate the ability to adhere to all best child welfare practices; amending s. 409.992, F.S.; defining the term "employee"; revising a limitation on salaries of community-based care lead agency employees; requiring that contracts and amendments to existing contracts between the department and lead agencies include a specified provision; amending s. 409.996, F.S.; requiring that contracts between the department and lead agencies provide information to the department which specifies how the lead agency will adhere to all best child welfare practices; requiring the department to collect and post on its website specified information relating to contracts between lead agencies and the department; creating s. 409.998, F.S.; providing legislative findings and intent; requiring the department to establish a program that consists of a child and family well-being system; requiring the designated lead agency to carry out programmatic functions; defining the term "child and family well-being system"; specifying program requirements; requiring the department, in collaboration with specified entities, to design,

implement, and evaluate the program requirements; requiring the Florida Institute for Child Welfare, by a specified date, to annually submit a report to the Governor and the Legislature; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraphs (a), (d), and (e) of subsection (5) of section 20.19, Florida Statutes, are amended to read:

20.19 Department of Children and Families.—There is created a Department of Children and Families.

(5) COMMUNITY ALLIANCES.—

(a) The department shall, in consultation with local communities, establish a community alliance ~~or similar group~~ of the stakeholders, community leaders, client representatives, and funders of human services in each community-based care lead agency service area ~~county~~ to provide a focal point for community participation and governance of community-based services. ~~An alliance may cover more than one county when such arrangement is determined to provide for more effective representation.~~ The community alliance shall represent the diversity of the community.

(d) Each community alliance shall adopt bylaws to determine the specific membership composition that best represents the local community served by that community alliance. The membership of a ~~the~~ community alliance must ~~in a county shall at a minimum~~ be composed of no more than 20 members selected from the following:

1. A representative from the department.

2. Representatives ~~A representative~~ from local ~~county~~ government.

3. Representatives ~~A representative~~ from the school district.

4. A representative from the ~~county~~ United Way.

5. Representatives ~~A representative~~ from ~~the~~ county sheriffs' offices ~~sheriff's office~~.

6. A representative from each ~~the~~ circuit court in the lead agency service area ~~corresponding to the county~~.

7. A representative from the ~~county~~ children's services council ~~board~~, if one exists.

8. A representative of a faith-based organization involved in efforts to prevent child maltreatment, strengthen families, or promote adoption.

(e) The community alliance shall adopt bylaws that allow for the ~~and may increase the~~ membership of the alliance to be increased to no more than 30 members if, in the judgment of the alliance, such change is necessary to adequately represent the diversity of the population within the community alliance service circuits. The additional membership may ~~to~~ include the state attorney for the judicial circuit in which the community alliance is located, or his or her designee;~~,~~ the public defender for the judicial circuit in which the community alliance is located, or his or her designee; or~~, and~~ other individuals and organizations who otherwise represent perspectives that will enable the community alliance to accomplish the duties specified in paragraph (b). Such individuals and organizations may include, but need not be

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limited to, ~~represent~~ funding organizations, ~~are~~ community leaders, and individuals who have knowledge of community-based service issues~~, or otherwise represent perspectives that will enable them to accomplish the duties listed in paragraph (b), if, in the judgment of the alliance, such change is necessary to adequately represent the diversity of the population within the community alliance service circuits~~.

Section 2. Subsection (3) of section 39.4015, Florida Statutes, is amended to read:

39.4015 Family finding.—

(3) FAMILY-FINDING PROGRAM.~~ Subject to available resources,~~ The department, in collaboration with sheriffs' offices that conduct child protective investigations and community-based care lead agencies, shall ~~may~~ develop a formal family-finding program to be implemented by child protective investigators and community-based care lead agencies ~~as resources permit~~.

(a) Family finding shall ~~may~~ begin as soon as a child is taken into custody of the department, pursuant to s. 39.401, and throughout the duration of the case as necessary, finding and engaging with as many family members and fictive kin as possible for each child who may help with care or support for the child. The department or community-based care lead agency must specifically document strategies taken to locate and engage relatives and fictive kin. Strategies of engagement may include, but are not limited to, asking the relatives and fictive kin to:

1. Participate in a family group decision-making ~~decisionmaking~~ conference, family team conferencing, or other family meetings aimed at developing or supporting the family service plan;

2. Attend visitations with the child;

3. Assist in transportation of the child;

4. Provide respite or child care services; or

5. Provide actual kinship care.

(b) The family-finding ~~family finding~~ program shall provide the department and the community-based care lead agencies with best practices for identifying family and fictive kin. The family-finding ~~family finding~~ program must use diligent efforts in family finding and~~,~~ must continue those efforts until multiple relatives and fictive kin are identified~~, and must go beyond basic searching tools by exploring alternative tools and methodologies~~. Family-finding ~~Family finding~~ efforts by the department and the community-based care lead agency may include, but are not limited to:

1. Searching for and locating adult relatives and fictive kin.

2. Identifying and building positive connections between the child and the child's relatives and fictive kin.

3. Supporting the engagement of relatives and fictive kin in social service planning and delivery of services and creating a network of extended family support to assist in remedying the concerns that led to the child becoming involved with the child welfare system, when appropriate.

4. Maintaining family connections, when possible.

5. Keeping siblings together in care, when in the best interest of each child and when possible.

(c) To be compliant with this section, family-finding efforts must go beyond basic searching tools by exploring alternative tools and methodologies. A basic computer search

using the Internet or attempts to contact known relatives at a last known address or telephone number do not constitute effective family finding.

Section 3. Section 39.4087, Florida Statutes, is amended to read:

39.4087 Department ~~goals and~~ requirements relating to caregivers; dispute resolution.—

(1) To provide the best care to children, the Legislature requires ~~establishes as goals for~~ the department to treat foster parents, kinship caregivers, and nonrelative caregivers with dignity, respect, and trust while ensuring delivery of child welfare services is focused on the best interest of the child. To that end, regarding foster parents, kinship caregivers, and nonrelative caregivers caring for dependent children in their home, to the extent not otherwise prohibited by state or federal law ~~and to the extent of current resources~~, the department is required to do all of the following ~~will strive to~~:

(a) Provide a clear explanation to a caregiver on the role of the department, the role of the child's biological family as it relates to the delivery of child welfare services, and the rights and responsibilities of the caregiver.

(b) Provide training and support to the caregiver to help meet the necessary requirements for the daily care of the child and any special needs the child may have.

(c)1. Fully disclose all relevant information regarding the child and the background of his or her biological family. ~~A caregiver must maintain the confidentiality of any information as required by law.~~ Such disclosure includes, but is not limited to:

a.~~1.~~ Any issues relative to the child that may jeopardize the health and safety of the caregiver or other individuals residing in the household or alter the manner in which the caregiver would normally provide care.

b.~~2.~~ Any delinquency or criminal record of the child, including, but not limited to, any pending petitions or adjudications of delinquency when the conduct constituting the delinquent act, if committed by an adult, would constitute murder in the first degree, murder in the second degree, rape, robbery, or kidnapping.

c.~~3.~~ Information about any physical or sexual abuse the child has experienced.

d.~~4.~~ Any behavioral issues that may affect the care and supervision of the child.

e.~~5.~~ With parental consent to the extent required by law, any known health history and medical, psychological, or behavioral ~~mental~~ health issues or needs of the child, including, but not limited to, current infectious diseases the child has or any episodes of hospitalization due to mental or physical illness.

2. A caregiver must maintain the confidentiality of any information as required by law.

(d) Allow caregivers to communicate with professionals who work with the child, including, but not limited to, therapists and other behavioral health professionals, physicians and other health care professionals, and teachers.

(e) Provide a means by which a caregiver may contact the community-based care lead agency 24 hours a day, 7 days a week, for the purpose of receiving assistance from the lead agency.

(f) Solicit and consider caregiver input on a child's case plan.

(g) Provide a clear, written explanation to a caregiver of any plan concerning the placement of a child in the caregiver's home. If a plan was not developed before the placement, the department must provide a clear, written explanation to the caregiver once the plan is developed.

(h) Provide information, when it becomes available, on any emergency situation that requires a child to be placed in the caregiver's home.

(i) Allow a caregiver to request the removal of a child from the home without retaliation. However, the caregiver must be open to receiving training or other support services that may mitigate the need for the child's removal. If removal occurs, the caregiver shall cooperate with any transition that is in the best interest of the child to the extent that doing so is safe for the caregiver and other individuals in the caregiver's home.

(j) Inform the caregiver as soon as possible of any decision made by a court or child-caring agency relating to a child who is placed with the caregiver.

(k) Give at least 7 days' notice to a caregiver, to the extent possible, of any meeting or court hearing related to a child in his or her care. The notice must ~~shall~~ include, at minimum, ~~but is not limited to,~~ the name of the judge or hearing officer, the docket number, and the purpose and location of the hearing or meeting. If the department is providing such information to a child's biological parent, the department shall provide notice to the caregiver at the same time as the biological parent.

(l) ~~If the caregiver agrees,~~ Consider the caregiver as a placement option for a child if such child, who was formerly placed with the caregiver, reenters out-of-home care and the caregiver agrees to the child being placed with the caregiver upon reentry ~~and reenters out-of-home care~~.

(m) Upon reasonable notice from a caregiver, allow him or her a period of respite.

(n) Upon request, provide a caregiver with copies of all information in the department's records relating to the caregiver.

(2)(a) If a caregiver believes that the department, an employee of the department, an agency under contract with the department, or an employee of such agency has violated this section, and that the violation has harmed or could harm a child who is or was in the custody of the department, or that the violation inhibited the caregiver's ability to meet the child's needs as set forth in the case plan, the caregiver may notify the liaison assigned to the caregiver or the child's case manager. The liaison or case manager must make every attempt to resolve the dispute.

(b) If a caregiver believes the dispute is not adequately resolved by the case manager, the caregiver or the liaison for the caregiver may contact the supervisor of the liaison or the supervisor of the case manager. If the caregiver or the liaison for the caregiver contacts a supervisor in writing, he or she may copy the department on the communication, and the department shall maintain a record of any such communication received.

(c) If a caregiver believes that the supervisor of the liaison or the supervisor of the case manager did not adequately

resolve the dispute, the caregiver may contact the department, and the department must conduct a review and respond to the caregiver in writing within 30 days after being contacted.

Section 4. Paragraph (b) of subsection (2) of section 39.5086, Florida Statutes, is amended to read:

39.5086 Kinship navigator programs.—

(2) PURPOSE AND SERVICES.—

(b) ~~Subject to available resources,~~ Each community-based care lead agency shall ~~may~~ establish a kinship navigator program that:

1. Coordinates with other state or local agencies that promote service coordination or provide information and referral services, including any entities that participate in the Florida 211 Network, to avoid duplication or fragmentation of services to kinship care families;

2. Is planned and operated in consultation with kinship caregivers and organizations representing them, youth raised by kinship caregivers, relevant governmental agencies, and relevant community-based or faith-based organizations;

3. Has a toll-free telephone hotline to provide information to link kinship caregivers, kinship support group facilitators, and kinship service providers to:

a. One another;

b. Eligibility and enrollment information for federal, state, and local benefits;

c. Relevant training to assist kinship caregivers in caregiving and in obtaining benefits and services; and

d. Relevant knowledge related to legal options available for child custody, other legal assistance, and help in obtaining

legal services.

4. Provides outreach to kinship care families, including by establishing, distributing, and updating a kinship care website, or other relevant guides or outreach materials; and

5. Promotes partnerships between public and private agencies, including schools, community-based or faith-based organizations, and relevant governmental agencies, to increase their knowledge of the needs of kinship care families to promote better services for those families.

Section 5. Present paragraphs (f) through (j) of subsection (4) of section 394.9082, Florida Statutes, are redesignated as paragraphs (h) through (l), respectively, paragraph (m) is added to subsection (3) and new paragraphs (f) and (g) are added to subsection (4) of that section, and paragraph (a) of subsection (6) of that section is amended, to read:

394.9082 Behavioral health managing entities.—

(3) DEPARTMENT DUTIES.—The department shall:

(m) Collect and post all of the following information on its website, updated annually, for each managing entity under contract with the department:

1. Current salaries, bonuses, and other compensation paid, by position, for any employee who receives a salary from state-appropriated funds, including state-appropriated federal funds, whether base pay or base pay combined with any bonus or incentive payments, in excess of 100 percent of the annual salary paid to the secretary of the Department of Children and Families. For purposes of this subparagraph, the term "employee" includes, but is not limited to, the chief executive officer, chief financial officer, and chief operating officer, or any

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other executive staff of the managing entity.

2. Annual expenses, reported as both a percentage of total managing entity funds and as a total dollar amount, as follows:

a. Program expenses, including, but not limited to, costs directly related to carrying out the managing entity's mission, which result in services being provided;

b. Administrative expenses, including, but not limited to, costs of board of director meetings, general legal services, accounting, insurance, office management, auditing, human resources, and other centralized services; and

c. Fundraising expenses, including, but not limited to, costs for publicizing and conducting fundraising campaigns, maintaining donor mailing lists, conducting special fundraising events, and any other activities that involve soliciting contributions.

(4) CONTRACT WITH MANAGING ENTITIES.—

(f)1. For purposes of this paragraph, the term "employee" includes, but is not limited to, the chief executive officer, chief financial officer, and chief operating officer, or any other executive staff of the managing entity.

2. Notwithstanding any other law, a managing entity employee may not receive a salary from state-appropriated funds, including state-appropriated federal funds, whether base pay or base pay combined with any bonus or incentive payments, including the base pay or base pay combined with any bonus or incentive payments received as a result of employment with more than one community-based care lead agency or managing entity, in excess of 100 percent of the annual salary paid to the secretary of the Department of Children and Families.

3. This paragraph does not prohibit any party from providing cash that is not from appropriated state funds to a managing entity employee.

(g) Upon the execution of a new contract or in any amendment to an existing contract, the department shall include a provision that includes the limitation on compensation specified in paragraph (f).

(6) NETWORK ACCREDITATION AND SYSTEMS COORDINATION AGREEMENTS.—

(a)1. The department shall identify acceptable accreditations which address coordination within a network and, if possible, between the network and major systems and programs with which the network interacts, such as the child welfare system, the courts system, and the Medicaid program. In identifying acceptable accreditations, the department shall consider whether the accreditation facilitates integrated strategic planning, resource coordination, technology integration, performance measurement, and increased value to consumers through choice of and access to services, improved coordination of services, and effectiveness and efficiency of service delivery.

2. All managing entities under contract with the state by July 1, 2016, shall earn accreditation deemed acceptable by the department pursuant to subparagraph 1. by June 30, 2019. Managing entities whose initial contract with the state is executed after July 1, 2016, shall earn network accreditation within 3 years after the contract execution date. Pursuant to paragraph (4)(l) ~~(4)(j)~~, the department may continue the contract of a managing entity under contract as of July 1, 2016,

that earns the network accreditation within the required timeframe and maintains it throughout the contract term.

Section 6. Section 394.90825, Florida Statutes, is created to read:

394.90825 Boards of managing entities; conflicts of interest.—

(1) As used in this section, the term:

(a) "Activity" includes, but is not limited to, a contract for goods and services, a contract for the purchase of any real or tangible property, or an agreement to engage with the managing entity for the benefit of a third party in exchange for an interest in real or tangible property, a monetary benefit, or an in-kind contribution.

(b) "Conflict of interest" means when a board member or an officer, or a relative of a board member or an officer, of the managing entity does any of the following:

1. Enters into a contract or other transaction for goods or services with the managing entity.

2. Holds a direct or indirect interest in a corporation, limited liability corporation, partnership, limited liability partnership, or other business entity that conducts business with the managing entity or proposes to enter into a contract or other transaction with the managing entity. For purposes of this paragraph, "indirect interest" has the same meaning as provided in s. 112.312.

3. Knowingly obtains a direct or indirect personal, financial, professional, or other benefit as a result of the relationship of such member or officer, or relative of the member or officer, with the managing entity. For purposes of

this paragraph, the term "benefit" does not include per diem and travel expenses paid or reimbursed to board members in connection with their service on the board.

(c) "Managing entity" has the same meaning as in s. 394.9082.

(d) "Relative" means a relative within the third degree of consanguinity by blood or marriage.

(2)(a) For any activity that is presented to the board of a managing entity for its initial consideration and approval after July 1, 2021, or any activity that involves a contract that is being considered for renewal on or after July 1, 2021, and before January 1, 2022, a board member or an officer of a managing entity shall disclose to the board any activity that may reasonably be construed to be a conflict of interest before such activity is initially considered and approved or renewed by the board. A rebuttable presumption of a conflict of interest exists if the activity was acted upon by the board without prior notice as required under subsection (3).

(b) For contracts with a managing entity which are in existence on July 1, 2021, and are not subject to renewal before January 1, 2022, a board member or an officer shall disclose to the board any activity that may reasonably be construed to be a conflict of interest under this section by December 31, 2021.

(3)(a) If a board member or an officer, or a relative of a member or an officer, proposes to engage in an activity as described in (2)(a), the proposed activity must be listed on the meeting agenda for the next general or special meeting of the members, and copies of all contracts and transactional documents related to the proposed activity must be included in the agenda.

The meeting agenda must clearly identify the existence of a potential conflict of interest for the proposed activity. Before a member or an officer, or a relative of a member or an officer, engages in the proposed activity, the activity and contract or other transaction documents must be approved by an affirmative vote of two-thirds of all other members present.

(b) If a member or an officer notifies the board of a potential conflict of interest with the member or officer, or a relative of the member or officer, under an existing contract as described in paragraph (2)(b), the board must notice the activity on a meeting agenda for the next general or special meeting of the members, and copies of all contracts and transactional documents related to the activity must be attached. The meeting agenda must clearly identify the existence of a potential conflict of interest. The board must be given the opportunity to approve or disapprove the conflict of interest by a vote of two-thirds of all other members present.

(4)(a) If the board votes against the proposed activity pursuant to paragraph (3)(a), the board member or officer, or the relative of the member or officer, must notify the board in writing of his or her intention, or his or her relative's intention, not to pursue the proposed activity, or the member or officer shall withdraw from office before the next scheduled board meeting. If the board finds that an officer or a member has violated this paragraph, the officer or member shall be deemed removed from office before the next scheduled board meeting.

(b) In the event that the board does not approve of a conflict of interest as required in paragraph (3)(b), the

parties to the activity may opt to cancel the activity or, in the alternative, the member or officer must resign from the board before the next scheduled board meeting. If the activity canceled is a contract, the managing entity is only liable for the reasonable value of the goods and services provided up to the time of cancellation and is not liable for any termination fee, liquidated damages, or other form of penalty for such cancellation.

(5) A board member or an officer, or a relative of a member or an officer, who is a party to, or has an interest in, an activity that is a possible conflict of interest may attend the meeting at which the activity is considered by the board and is authorized to make a presentation to the board regarding the activity. After the presentation, the member or officer, or the relative of the member or officer, shall leave the meeting during the discussion of, and the vote on, the activity. A member or an officer who is a party to, or has an interest in, the activity shall recuse himself or herself from the vote.

(6) A contract entered into between a board member or an officer, or a relative of a member or an officer, and the managing entity which has not been properly disclosed as a conflict of interest or potential conflict of interest under this section is voidable and terminates upon the filing of a written notice terminating the contract with the board of directors which contains the consent of at least 20 percent of the voting interests of the managing entity.

Section 7. Section 409.987, Florida Statutes, is amended to read:

409.987 Lead agency procurement; boards; conflicts of

interest.—

(1) Community-based care lead agencies shall be procured by the department through a competitive process as required under chapter 287.

(2) The department shall produce a schedule for the procurement of community-based care lead agencies and provide the schedule to the community alliances established pursuant to s. 20.19(5) and post the schedule on the department's website.

(3) Notwithstanding s. 287.057, the department shall use 5-year contracts with lead agencies.

(4) In order to serve as a lead agency, an entity must:

(a) Be organized as a Florida corporation or a governmental entity.

(b) Be governed by a board of directors or a board committee composed of board members. The membership of the board of directors or board committee must be described in the bylaws or articles of incorporation of each lead agency, which must provide that at least 75 percent of the membership of the board of directors or board committee must consist of persons residing in this state, and at least 51 percent of the state residents on the board of directors must reside within the service area of the lead agency. However, for procurements of lead agency contracts initiated on or after July 1, 2014:

1. At least 75 percent of the membership of the board of directors must consist of persons residing in this state, and at least 51 percent of the membership of the board of directors must consist of persons residing within the service area of the lead agency. If a board committee governs the lead agency, 100 percent of its membership must consist of persons residing

within the service area of the lead agency.

2. The powers of the board of directors or board committee include, but are not limited to, approving the lead agency's budget and setting the lead agency's operational policy and procedures. A board of directors must additionally have the power to hire the lead agency's executive director, unless a board committee governs the lead agency, in which case the board committee must have the power to confirm the selection of the lead agency's executive director.

(c) Demonstrate financial responsibility through an organized plan for regular fiscal audits and the posting of a performance bond.

(5) The department's procurement team procuring any lead agencies' contracts must include individuals from the community alliance in the area to be served under the contract. All meetings at which vendors make presentations to or negotiate with the procurement team shall be held in the area to be served by the contract.

(6) In communities where conditions make it impossible or not feasible to competitively contract with a lead agency, the department shall develop an alternative plan, in collaboration with the local community alliance, that may include establishing an innovative consortia of partners which may include, but is not limited to, private entities, local and county governmental entities, and the department. The plan must detail how the community will continue to implement community-based care through competitively procuring either the specific components of foster care and related services or comprehensive services for defined eligible populations of children and families from

qualified licensed agencies as part of the community's efforts to develop the local capacity for a community-based system of coordinated care. The plan must ensure local control over the management and administration of the service provision in accordance with the intent of this section and may adhere to recognized best business practices, including, but not limited to, the use of public or private partnerships.

(7)(a) As used in this subsection, the term:

1. "Activity" includes, but is not limited to, a contract for goods and services, a contract for the purchase of any real or tangible property, or an agreement to engage with the lead agency for the benefit of a third party in exchange for an interest in real or tangible property, a monetary benefit, or an in-kind contribution.

2. "Conflict of interest" means when a board member or an officer, or a relative of a member or an officer, of the lead agency does any of the following:

a. Enters into a contract or other transaction for goods or services with the lead agency.

b. Holds a direct or indirect interest in a corporation, limited liability corporation, partnership, limited liability partnership, or other business entity that conducts business with the lead agency or proposes to enter into a contract or other transaction with the lead agency. For purposes of this subparagraph, "indirect interest" has the same meaning as provided in s. 112.312.

c. Knowingly obtains a direct or indirect personal, financial, professional, or other benefit as a result of the relationship of such member or officer, or relative of the

member or officer, with the lead agency. For purposes of this subparagraph, the term "benefits" does not include per diem and travel expenses paid or reimbursed to board members in connection with their service on the board.

3. "Relative" means a relative within the third degree of consanguinity by blood or marriage.

(b)1. For any activity that is presented to the board for its initial consideration and approval on or after July 1, 2021, or any activity that involves a contract which is being considered for renewal on or after July 1, 2021, and before January 1, 2022, a board member or an officer of a lead agency must disclose to the board any activity that may reasonably be construed to be a conflict of interest before such activity is initially considered and approved or renewed by the board. A rebuttable presumption of a conflict of interest exists if the activity was acted upon by the board without prior notice, as required in paragraph (c).

2. For contracts with a lead agency which are in existence on July 1, 2021, and are not subject to renewal before January 1, 2022, a board member or officer shall disclose to the board any activity that may reasonably be construed to be a conflict of interest under this section by December 31, 2021.

(c)1. If a member or an officer, or a relative of a member or an officer, proposes to engage in an activity that is covered by subparagraph (b)1., the proposed activity must be listed on the meeting agenda for the next general or special meeting of the members, and copies of all contracts and transactional documents related to the proposed activity must be included in the agenda. The meeting agenda must clearly identify the

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existence of a potential conflict of interest for the proposed activity. Before a member or an officer, or a relative of a member or an officer, engages in the proposed activity, the activity and contract or other transaction documents must be approved by an affirmative vote of two-thirds of all other members present.

2. If a member or an officer notifies the board of a potential conflict of interest with the member or officer, or a relative of the member or officer, under an existing contract as described in subparagraph (b)2., the board must notice the activity on a meeting agenda for the next general or special meeting of the members, and copies of all contracts and transactional documents related to the activity must be attached. The meeting agenda must clearly identify the existence of a potential conflict of interest. The board must be given the opportunity to approve or disapprove of the conflict of interest by a vote of two-thirds of all other members present.

(d)1. If the board votes against the proposed activity pursuant to subparagraph (c)1., the member or officer, or the relative of the member or officer, must notify the board in writing of his or her intention, or his or her relative's intention, not to pursue the proposed activity, or the member or officer shall withdraw from office before the next scheduled board meeting. If the board finds that an officer or a member has violated this subparagraph, the officer or member shall be deemed removed from office before the next scheduled board meeting.

2. In the event that the board does not approve of a conflict as required in subparagraph (c)2., the parties to the

activity may opt to cancel the activity or, in the alternative, the member or officer must resign from the board before the next scheduled board meeting. If the activity canceled is a contract, the lead agency is only liable for the reasonable value of the goods and services provided up to the time of cancellation and is not liable for any termination fee, liquidated damages, or other form of penalty for such cancellation.

(e) A member or an officer, or a relative of a member or an officer, who is a party to, or has an interest in, an activity that is a possible conflict of interest may attend the meeting at which the activity is considered by the board and is authorized to make a presentation to the board regarding the activity. After the presentation, the member or officer, or the relative of the member or officer, must leave the meeting during the discussion of, and the vote on, the activity. A member or an officer who is a party to, or has an interest in, the activity must recuse himself or herself from the vote.

(f) A contract entered into between a member or an officer, or a relative of a member or an officer, and the lead agency which has not been properly disclosed as a conflict of interest or potential conflict of interest under this subsection is voidable and terminates upon the filing of a written notice terminating the contract with the board of directors which contains the consent of at least 20 percent of the voting interests of the lead agency.

Section 8. Subsection (1) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(a) Shall serve all children referred as a result of a report of abuse, neglect, or abandonment to the department's central abuse hotline, including, but not limited to, children who are the subject of verified reports and children who are not the subject of verified reports but who are at moderate to extremely high risk of abuse, neglect, or abandonment, as determined using the department's risk assessment instrument, regardless of the level of funding allocated to the lead agency by the state if all related funding is transferred. The lead agency may also serve children who have not been the subject of reports of abuse, neglect, or abandonment, but who are at risk of abuse, neglect, or abandonment, to prevent their entry into the child protection and child welfare system.

(b) Shall provide accurate and timely information necessary for oversight by the department pursuant to the child welfare results-oriented accountability system required by s. 409.997.

(c) Shall follow the financial guidelines developed by the department and provide for a regular independent auditing of its financial activities. Such financial information shall be provided to the community alliance established under s. 20.19(5).

(d) ~~Shall post on its website the current budget for the lead agency, including the salaries, bonuses, and other compensation paid, by position, for the agency's chief executive officer, chief financial officer, and chief operating officer, or their equivalents.~~

~~(e)~~ Shall prepare all judicial reviews, case plans, and other reports necessary for court hearings for dependent children, except those related to the investigation of a

referral from the department's child abuse hotline, and shall submit these documents timely to the department's attorneys for review, any necessary revision, and filing with the court. The lead agency shall make the necessary staff available to department attorneys for preparation for dependency proceedings, and shall provide testimony and other evidence required for dependency court proceedings in coordination with the department's attorneys. This duty does not include the preparation of legal pleadings or other legal documents, which remain the responsibility of the department.

(e) ~~(f)~~ Shall ensure that all individuals providing care for dependent children receive:

1. Appropriate training and meet the minimum employment standards established by the department. Appropriate training shall include, but is not limited to, training on the recognition of and responses to head trauma and brain injury in a child under 6 years of age developed by the Child Protection Team Program within the Department of Health.

2. Contact information for the local mobile response team established under s. 394.495.

(f) ~~(g)~~ Shall maintain eligibility to receive all available federal child welfare funds.

(g) Shall demonstrate the ability to adhere to all best child welfare practices pursuant to ss. 39.4087, 39.523, 409.1415, and 409.145.

(h) Shall maintain written agreements with Healthy Families Florida lead entities in its service area pursuant to s. 409.153 to promote cooperative planning for the provision of prevention and intervention services.

(i) Shall comply with federal and state statutory requirements and agency rules in the provision of contractual services.

(j) May subcontract for the provision of services required by the contract with the lead agency and the department; however, the subcontracts must specify how the provider will contribute to the lead agency meeting the performance standards established pursuant to the child welfare results-oriented accountability system required by s. 409.997. The lead agency shall directly provide no more than 35 percent of all child welfare services provided unless it can demonstrate a need, within the lead agency's geographic service area, to exceed this threshold. The local community alliance in the geographic service area in which the lead agency is seeking to exceed the threshold shall review the lead agency's justification for need and recommend to the department whether the department should approve or deny the lead agency's request for an exemption from the services threshold. If there is not a community alliance operating in the geographic service area in which the lead agency is seeking to exceed the threshold, such review and recommendation shall be made by representatives of local stakeholders, including at least one representative from each of the following:

1. The department.
2. The county government.
3. The school district.
4. The county United Way.
5. The county sheriff's office.
6. The circuit court corresponding to the county.

7. The county children's board, if one exists.

(k) Shall post on its website by the 15th day of each month at a minimum the information contained in subparagraphs 1.-4. for the preceding calendar month regarding its case management services. The following information shall be reported by each individual subcontracted case management provider, by the lead agency, if the lead agency provides case management services, and in total for all case management services subcontracted or directly provided by the lead agency:

1. The average caseload of case managers, including only filled positions;

2. The turnover rate for case managers and case management supervisors for the previous 12 months;

3. The percentage of required home visits completed; and

4. Performance on outcome measures required pursuant to s. 409.997 for the previous 12 months.

(l) Shall identify an employee to serve as a liaison with the community alliance and community-based and faith-based organizations interested in collaborating with the lead agency or offering services or other assistance on a volunteer basis to the children and families served by the lead agency. The lead agency shall ensure that appropriate lead agency staff and subcontractors, including, but not limited to, case managers, are informed of the specific services or assistance available from community-based and faith-based organizations.

Section 9. Subsection (3) of section 409.992, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

409.992 Lead agency expenditures.—

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(3)(a) For purposes of this subsection, the term "employee" includes, but is not limited to, the chief executive officer, chief financial officer, and chief operating officer, or any other executive staff of the community-based care lead agency.

(b) Notwithstanding any other ~~provision of~~ law, a community-based care lead agency ~~administrative~~ employee may not receive a salary from state-appropriated funds, including state-appropriated federal funds, whether base pay or base pay combined with any bonus or incentive payments, including the base pay or base pay combined with any bonus or incentive payments received as a result of employment with more than one community-based care lead agency or managing entity, in excess of 100 ~~150~~ percent of the annual salary paid to the secretary of the Department of Children and Families ~~from state-appropriated funds, including state-appropriated federal funds~~.

(c) This subsection does not prohibit any party from providing cash that is not from appropriated state funds to a community-based care lead agency ~~administrative~~ employee.

(5) Upon the execution of a new contract or in any amendment to an existing contract with a lead agency, the department shall include a provision that includes the limitation on compensation specified in subsection (3).

Section 10. Present subsections (3) through (25) of section 409.996, Florida Statutes, are redesignated as subsections (4) through (26), respectively, a new subsection (3) is added to that section, and subsections (1) and (2) and paragraph (d) of present subsection (25) are amended, to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration,

or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility for the quality of contracted services and programs and shall ensure that, at a minimum, services are delivered in accordance with applicable federal and state statutes and regulations and the performance standards and metrics specified in the strategic plan created under s. 20.19(1).

(1) The department shall enter into contracts with lead agencies for the performance of the duties by the lead agencies established in s. 409.988. At a minimum, the contracts must do all of the following:

(a) Provide for the services needed to accomplish the duties established in s. 409.988. ~~and~~

(b) Provide information to the department which specifies how the lead agency will adhere to all best child welfare practices pursuant to ss. 39.4087, 39.523, 409.1415, and 409.145.

(c) Provide information to the department which is necessary to meet the requirements for a quality assurance program under subsection (20) ~~(19)~~ and the child welfare results-oriented accountability system under s. 409.997.

(d) ~~(b)~~ Provide for tiered interventions and graduated penalties for failure to comply with contract terms or in the event of performance deficiencies. Such interventions and penalties shall include, but are not limited to:

1. Enhanced monitoring and reporting.

2. Corrective action plans.

3. Requirements to accept technical assistance and

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consultation from the department under subsection (5) ~~(4)~~.

4. Financial penalties, which shall require a lead agency to reallocate funds from administrative costs to direct care for children.

5. Early termination of contracts, as provided in s. 402.1705(3)(f).

(e)~~(c)~~ Ensure that the lead agency shall furnish current and accurate information on its activities in all cases in client case records in the state's statewide automated child welfare information system.

(f)~~(d)~~ Specify the procedures to be used by the parties to resolve differences in interpreting the contract or to resolve disputes as to the adequacy of the parties' compliance with their respective obligations under the contract.

(2) The department must adopt written policies and procedures for monitoring the contract for delivery of services by lead agencies which must be posted on the department's website. These policies and procedures must, at a minimum, address the evaluation of fiscal accountability and program operations, including provider achievement of performance standards, provider monitoring of subcontractors, and timely follow-up ~~followup~~ of corrective actions for significant monitoring findings related to providers and subcontractors. These policies and procedures must also include provisions for reducing the duplication of the department's program monitoring activities both internally and with other agencies, to the extent possible. The department's written procedures must ensure that the written findings, conclusions, and recommendations from monitoring the contract for services of lead agencies are

communicated to the director of the provider agency and the community alliance as expeditiously as possible.

(3) The department shall collect and post on its website, and annually update, all of the following information for each lead agency under contract with the department:

(a) Current salaries, bonuses, and other compensation paid, by position, for any employee who receives a salary from state-appropriated funds, including state-appropriated federal funds, whether base pay or base pay combined with any bonus or incentive payments, in excess of 100 percent of the annual salary paid to the secretary of the Department of Children and Families. For purposes of this paragraph, the term "employee" includes, but is not limited to, the chief executive officer, chief financial officer, and chief operating officer, or any other executive staff of the community-based care lead agency.

(b) Annual expenses, reported as both a percentage of total lead agency funds and as a total dollar amount, as follows:

1. Program expenses, including, but not limited to, costs directly related to carrying out the lead agency's mission and which result in services being provided;

2. Administrative expenses, including, but not limited to, costs of board of directors' meetings, general legal services, accounting, insurance, office management, auditing, human resources, and other centralized services; and

3. Fundraising expenses, including, but not limited to, costs for publicizing and conducting fundraising campaigns, maintaining donor mailing lists, conducting special fundraising events, and any other activities that involve soliciting contributions.

(26) ~~(25)~~ Subject to an appropriation, for the 2020-2021 and 2021-2022 fiscal years, the department shall implement a pilot project in the Sixth and Thirteenth Judicial Circuits, respectively, aimed at improving child welfare outcomes.

(d) The department shall include the results of the pilot projects in the report required in subsection (25) ~~(24)~~ of this section. The report must include the department's findings and recommendations relating to the pilot projects.

Section 11. Section 409.998, Florida Statutes, is created to read:

409.998 Child and family well-being.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that every child deserves a safe, stable, and permanent family and that all families deserve the opportunities and supports to raise their children safely and successfully in their own homes and communities.

(b) The Legislature also finds that families are our greatest asset in ensuring that all children are safe and have what they need to thrive and succeed, and there is evidence that, with appropriate support, many families can remain safely together without court involvement or traumatic separations.

(c) The Legislature further finds that the state's current child welfare system and practices do not always align with current research related to the needs of children and families.

(d) It is the intent of the Legislature that the state establish a child and family well-being system that shifts the focus from child welfare to child well-being by allowing all sectors of a community and the state to work together to reallocate resources into services and supports that reduce the

need for out-of-home care and that improve the well-being of children and families.

(2) ESTABLISHMENT OF PROGRAM.—The department shall establish a program that consists of a child and family well-being system to serve children and their families through a contract with a designated lead agency operating in accordance with s. 409.987. The lead agency shall carry out all programmatic functions necessary to fulfill the intent of this section. As used in this section, the term "child and family well-being system" means a system that recognizes the difference between poverty and neglect and that provides mentoring and supports to biological parents as they develop the skills and resources necessary to adequately care for their children.

(3) PROGRAM REQUIREMENTS.—The creation of a child and family well-being system requires a fundamental change that refocuses all aspects of child welfare on supporting the family's role in caring for children. Successful implementation will result in a community-based network of support where the trauma of child removal is prevented and children are thriving in their own safe, permanent, and nurturing families. The designated lead agency shall collaborate with national experts that specialize in child welfare systems change to create a program that is required to do all of the following:

(a) Designate lead agency leadership that will identify a core group of agency individuals to develop a plan for creating necessary change in the way the agency works.

(b) Recognize that change of this magnitude is difficult and time-consuming and determine steps necessary to attend to the well-being of individuals involved early on in the process

to reduce undesired staff turnover and burnout and increase staff satisfaction and well-being.

(c) Develop a plan for creating a change in the way all partners in the process think about how to best keep families and children safe and together.

(d) Build working relationships throughout the process of change, including some unexpected or unconventional partners, allies, and mentors in the community.

(e) Provide regular and ongoing opportunities for the workforce to interact to discuss new ideas and principles that are needed for change to become permanent.

(f) Redirect resources toward primary prevention and away from removing children from their families.

(4) IMPLEMENTATION.—The department shall, in collaboration with the designated lead agency, the community alliance, and the Florida Institute for Child Welfare, design, implement, and evaluate the program requirements specified in subsection (3).

(5) REPORTING REQUIREMENTS.—By October 1, 2021, and annually thereafter, the Florida Institute for Child Welfare shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which evaluates the child and family well-being program, including, but not limited to, whether the program is in compliance with this section and the outcomes of the children served by the child and family well-being program.

Section 12. This act shall take effect July 1, 2021.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SB 92
FINAL ACTION: Favorable
MEETING DATE: Tuesday, February 16, 2021
TIME: 9:00—11:30 a.m.
PLACE: 37 Senate Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Brodeur						
X		Garcia						
X		Harrell						
X		Rouson						
X		Torres						
X		Wright						
X		Albritton, VICE CHAIR						
X		Book, CHAIR						
8	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

2021 AGENCY LEGISLATIVE BILL ANALYSIS
Department of Children and Families

BILL INFORMATION	
BILL NUMBER:	SB 92
BILL TITLE:	**Department of Children and Families**
BILL SPONSOR:	Senator Bean
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1) Children, Families, and Elder Affairs
2) Appropriations Subcommittee on Health and Human Services
3) Appropriations
4)
5)

CURRENT COMMITTEE
Children, Families, and Elder Affairs

SIMILAR BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

IDENTICAL BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

PREVIOUS LEGISLATION	
BILL NUMBER:	N/A
SPONSOR:	N/A
YEAR:	N/A
LAST ACTION:	N/A

Is this bill part of an agency package?
No.

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	February 10, 2021 For further information, please contact John Paul Fiore at (850) 488-9410.
LEAD AGENCY ANALYST:	Vanessa Snoddy, OCW
ADDITIONAL ANALYST(S):	Jessica Johnson, OCW Monique McCaskill, OCW Judson Freeman, Procurement Jimmers Micallef, SAMH
LEGAL ANALYST:	Stefanie Camfield, OGC
FISCAL ANALYST:	Sue Zwirz, Budget

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

The bill requires the Department of Children and Families (Department) to establish community alliances in each community-based care lead agency service area and to treat caregivers in a specified manner. The bill requires each community-based care (CBC) lead agency to establish a kinship navigator program and requires a board member or officer of a Managing Entity or lead agency to disclose specified activity that may reasonably be construed as a conflict of interest. Additionally, the bill revises a limitation on salaries of managing entities and CBC lead agency employees. Finally, the bill requires the Department in collaboration with certain stakeholders to develop a child and family well-being program with certain program and reporting requirements.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Section 1., s. 20.19., F.S., - Department of Children and Families. –

Section 20.19, F.S., requires the Department in consultation with local communities to establish a community alliance or similar group with stakeholders, community leaders, client representatives, and funders of human services in each county. The alliance may cover more than one county when it has been determined to provide more effective representation. The section further outlines the duties of the Department and community alliances as well as requirements for membership on a community alliance and the ability to adopt bylaws to increase the membership of the alliance.

Section 2., s. 39.4015, F.S., - Family finding. –

Section 39.4015, F.S., outlines the legislative intent of family finding programs, defines key terms, details requirements of a family finding program, and grants rulemaking authority. However, the entire section is subject to available resources.

Section 39.01(23), F.S., defines “diligent efforts of social service agency” to mean reasonable efforts were taken to provide social services or reunification services made by any social service agency that is a party to a case plan.

Section 39.01(24), F.S., defines “diligent search” as any efforts of a social service agency to locate a parent, or prospective parent, whose identity or location is unknown and is initiated as soon as the social service agency is made aware of the existence of such parent. The search progress is reported at each court hearing until the parent is either identified and located, or the court excuses further search.

Section 39.503(6), F.S., outlines the Department’s requirements for a diligent search for a parent, which include, at a minimum: inquiries of all relatives of the parent or prospective parent made known to the petitioner, inquiries of all offices of program areas of the Department likely to have information about the parent or prospective parent, inquiries of other state and federal agencies likely to have information about the parent or prospective parent, inquiries of appropriate utility and postal providers, a thorough search of at least one electronic database specifically designed for locating persons, a search of the Florida Putative Father Registry, and inquiries of appropriate law enforcement agencies. The Department, as the state agency administering Titles IV-B and IV-E of the Social Security Act, is provided access to the federal and state parent locator service for diligent search activities.

Section 3., s. 39.4087, F.S., - Department goals and requirements relating to caregivers; dispute resolution. –

Section 39.4087, F.S., provides that the Legislature establishes as goals for the Department to treat foster parents, kinship caregivers, and nonrelative caregivers with dignity, respect and trust when delivering child welfare service for the best interest of the child. It further instructs the Department to strive to provide caregivers with a clear explanation of the Department’s role, training and support, and fully disclose relevant information about the child to the caregiver. This section further provides that the caregiver should be permitted to communicate with professionals working with the child, have the ability to contact the CBC 24 hours a day, 7 days a week, ability to receive written explanation on the plan for the child’s placement, ability to receive information during emergency situations, request removal of the child, be provided on the decisions made in court, receive 7-day advance notice of court hearings and meetings, be considered as a placement option when a child reenters out of home care, and the ability to contact a liaison when they feel the Department has violated the law.

Section 4., s. 39.5086, F.S., - Kinship navigator program. –
Section 39.5086, F.S., provides that each CBC, subject to available resources, may establish a kinship navigator program to help relative caregivers and fictive kin of children in the child welfare system navigate the broad range of services available to them and the children from public, private, community, and faith-based organizations. This section defines "fictive kin," "kinship care," "kinship navigator program," and "relative." Each CBC may establish a program that:

1. Coordinates with other state or local agencies that promote service coordination or provide information and referral services;
2. Is planned and operated in consultation with kinship caregivers and organizations representing them, youth raised by kinship caregivers, relevant governmental agencies, and relevant community-based or faith-based organizations;
3. Has a toll-free line to provide information to link kinship caregivers, kinship support group facilitators, and kinship service providers to:
    - One another;
    - Eligibility and enrollment information for federal, state, and local benefits and services;
    - Relevant training to assist kinship caregivers in caregiving and in obtaining benefits and services; and
    - Relevant knowledge related to legal options available.
4. Provides outreach to kinship care families including establishing, distributing, and updating a kinship care website; and
5. Promotes partnerships between public and private agencies.

The Department is authorized to adopt rules to implement this section.

Section 39.622, F.S., allows the Department to establish and operate the Guardianship Assistance Program to provide guardianship assistance payments to relatives and fictive kin who meet the eligibility requirements.

Section 409.175, F.S., allows a level I licensure type to be designated for relative and non-relative caregivers. Level I licensure provides benefits in the form of foster care board payments for relative and non-relative caregivers who meet licensure requirements.

Section 39.5085 F.S., establishes a Relative Caregiver Program (RCP) to provide support to relatives and nonrelatives while they care for children in the foster care system and relatives who assume permanent guardianship when a child leaves the foster care system. To be eligible for relative caregiver benefits, the relative or nonrelative must have an approved home study by the court; the child must be deemed a dependent child by the court due to child abuse, neglect, or abandonment; and the child must have subsequently been placed in out-of-home care with the relative or nonrelative. Relatives who are within the fifth degree of relation to the child and nonrelatives eligible to receive benefits through the RCP receive monthly caregiver benefits and Medicaid. The monthly caregiver benefits are based on the child's age.

For relatives, support is provided via the Temporary Cash Assistance (TCA) Program, funded by Temporary Assistance for Needy Families (TANF). For children who are in foster care and subsequently placed into permanent guardianship custody, assistance is provided through the RCP, which is also funded by TANF. For nonrelative caregivers, there is a state-funded program that can be accessed while children are in foster care and continues if a nonrelative enters a court-approved permanent guardianship.

Section 5., s. 394.9082, F.S., - Behavioral health managing entities. –
Section 394.9082, F.S., details the definitions related to, duties of, and contracting requirements for a Managing Entity. This section also details the Department's duties, network accreditation and systems coordination agreements, performance measurement, accountability requirements, data collection, and funding requirements.

Section 6., s. 394.90825, F.S., - Boards of managing entities; conflicts of interest. –
Currently there is no statutory requirements for the board of directors or conflicts of interest in relation to Managing Entities.

Section 7., s. 409.987, F.S., - Lead agency procurement. –
Section 409.987, F.S., requires the Department to procure CBC lead agencies through a competitive process, pursuant to Chapter 287, F.S., and contract with the lead agencies for 5-years years. Moreover, this section outlines the requirements a lead agency must meet in order to be considered to contract with the Department.

Section 8., s. 409.988, F.S., - Lead agency duties; general provisions. –
Section 409.988, F.S., outlines the duties and responsibilities of a lead agency and authorizes the Department to conduct regular independent auditing of lead agency activities. The community alliance is authorized to receive financial information. The lead agency is required to post their current budget, salaries, bonuses and compensation paid to its Chief Executive Officer, Chief Financial Officer, and Chief Operating Officer. This section authorizes lead agencies to subcontract for serves required by their contract and comply with federal and state statutory provisions.

Section 9., s. 409.992, F.S., - Lead agency expenditures. –
Section 409.992, F.S., authorizes the Department to develop financial guidelines regarding procurement and contractual services which each lead agency shall be governed by. This section prohibits a CBC lead agency employee from receiving a salary, including bonuses, in excess of 150 percent of the annual salary paid to the Secretary of the Department from state-appropriated funds.

Section 10., s. 409.996, F.S., - Duties of the Department of Children and Families. –
Section 409.996, F.S., outlines the duties of the Department in contracting for the delivery, administration, or management of care for children in the child protection and child welfare system.

Section 11., s. 409.998, F.S., - Child and family well-being. –
There is currently no section of statute that creates or contemplates a child and family well-being system.

Section 39.001(47), F.S., defines “Family Support Services” as services provided to children (and their families) who have been found to be safe and at high or very high risk of future maltreatment.

Section 409.986, F.S., provides that it is the goal of the Department to protect the best interest of children by achieving the following outcomes in conjunction with the CBC lead agency, community-based subcontractors, and the community alliance:

- Children are first and foremost protected from abuse and neglect.
- Children are safely maintained in their homes, if possible and appropriate.
- Services are provided to protect children and prevent their removal from their home.
- Children have permanency and stability in their living arrangements.
- Family relationships and connections are preserved for children.
- Families have enhanced capacity to provide for their children’s needs.
- Children receive appropriate services to meet their educational needs.
- Children receive services to meet their physical and mental health needs.
- Children develop the capacity for independent living and competence as an adult.

Section 409.986(3)(a), F.S., defines “care” as services of any kind which are designed to facilitate a child remaining safely in his or her own home, returning safely to his or her own home if he or she is removed from the home, or obtaining an alternative permanent home if he or she cannot remain at home or be returned home. The term includes, but is not limited to, prevention, diversion, and related services.

Section 409.165, F.S., outlines that funds appropriated for the alternate care of children as described in this section may be used to meet the needs of children in their own homes or those of relatives if the children can be safely served in such settings and the expenditure of funds in such manner is equal to or less than the cost of out-of-home placement.

1. **EFFECT OF THE BILL:**

Section 1., s. 20.19., F.S., - Department of Children and Families. –
This section requires the Department, in consultation with local communities, to establish a community alliance with stakeholders, community leaders, client representatives, and funders of human services in each CBC lead agency service area.

The proposed language removes the ability to form a “similar group” and requires the formation of a community alliance. Additionally, the proposed language removes the requirement for a community alliance to cover a county or “more than one county” when necessary; it instead replaces county with “community-based care lead agency service area.” Each community alliance will be required to adopt bylaws to determine specific membership that represents the local community. The community alliance must be composed of no more than twenty members; however, the bylaws must include the ability to increase the membership by no more than thirty members.

Section 2., s. 39.4015, F.S., - Family finding. –
This section requires the Department, in collaboration with sheriffs' offices that conduct child protective investigations and CBC lead agencies, to develop a formal family-finding program to be implemented by child protective investigators and CBC lead agencies. It is to begin as soon as a child is taken into custody of the Department.

Section 3., s. 39.4087, F.S., - Department goals and requirements relating to caregivers; dispute resolution. –
This section requires the Department to treat foster parents, kinship caregivers, and nonrelative caregivers with dignity, respect and trust when delivering child welfare service for the best interest of the child. It also requires the Department to share and provide relevant information on the child with the caregiver. This section further requires forms of communication between the caregiver and the Department and CBCs about the child's case, while maintaining the confidentiality of any information as required by law. The caregiver shall be considered for placement when a child re-enters out of home care and the caregiver agrees to the child being placed in their care.

Section 4., s. 39.5086, F.S., - Kinship navigator program. –
This section requires each CBC lead agency to establish a kinship navigator program. Currently, all but one CBC lead agency offers kinship services. The kinship services provided by the CBC does not align with the current statute requirements for a kinship navigator program. In order to require every CBC lead agency to develop a kinship navigator program, they must meet the federal and state requirements.

The Family First Prevention Services Act (FFPSA), enacted as part of Public Law 115-123, authorizes Title IV-E agencies to claim 50 percent of federal financial participation for allowable kinship navigator program costs. In order to claim, the CBC must use an evidenced-based kinship navigation program rated in the Title IV-E prevention services clearinghouse. Programs must operate in accordance with "promising," "supported," or "well-supported" evidence requirements. While the CBC will be encouraged to use a rated kinship navigation program on the clearinghouse, they may continue to use their own kinship services without claiming for financial participation.

Section 5., s. 394.9082, F.S., - Behavioral health managing entities. –
This section amends s. 394.9082, F.S., to require the Department to annually collect and publish two new categories of Managing Entity financial information as follows:

1. Per position details regarding any "salaries, bonuses, and other compensation paid" to any Managing Entity employee, including executive staff, "in excess of 100 percent" of the Secretary's annual salary; and
2. Agency expense details, by dollar amount and percentage of Managing Entity funds, for annual expenses, program expenses, and administrative expenses.

This section prohibits a Managing Entity employee, including executive staff, from receiving a salary from state or federal funds appropriated by the state "in excess of 100 percent" of the Secretary's annual salary. The definition of "salary" for this purpose includes base pay, base pay combined with any bonus or incentive payments, and any combination of base pay, bonus or incentive payments "received as a result of employment with more than one community-based care lead agency or managing entity." Cash payments from non state-appropriated funds are exempt.

This section requires the Department to incorporate these standards into any new or amended Managing Entity contracts. It should be noted that, if adopted, these statutory terms would apply to the contracts on July 1, 2021, even if not amended by that date.

To implement the requirements of amended s. 394.9082(3), F.S., the Department will need to:

1. Develop new reporting templates for standardized collection of the mandated Managing Entity financial information.
2. Modify current year-end fiscal analysis tools to incorporate the elements required by this bill and modify its public-facing webpage to publish the elements required by this bill. The Department conducts a year-end fiscal analysis and reconciliation of Managing Entity expenditures beginning with final invoice submission on August 15 with final reconciliation reports completed late September or early October. It is likely website publication of the details mandated by this bill would be possible no earlier than November of the following fiscal year.

3. Modify current administrative monitoring tools and approaches to validate salary and expenditure information reported in Managing Entity budgets, contract reports and Florida Single Audit Act submissions.
4. Amend Managing Entity contracts to incorporate new reporting templates and to comply with the amendment requirements limiting compensation.

To implement the requirements of amended s. 394.9082(4), F.S., Managing Entities currently under contract will need to analyze all existing employee compensation packages, including those of executive staff, and determine if an individual's compensation must be reduced to comply with the maximum amount, or if other non state-appropriated funds are available to compensate persons in excess of the amount. The Department cannot estimate the number of Managing Entities or the number of current managing entity employees that may be affected by this bill.

Section 6., s. 394.90825, F.S., - Boards of managing entities; conflicts of interest. –
This section creates s. 394.90825, F.S., establishing standards applicable to conflicts of interest for board members or officers of a Managing Entity.

The definitions which collectively establish a conflict of interest when the following scenarios arise for a board member, or an officer, or a relative (to the third degree of consanguinity). A conflict arises when a party:

1. Enters into a contract or other transaction for goods or services with the Managing Entity.
2. Holds a direct or indirect interest in a business entity that conducts business with the Managing Entity or proposes to enter into a contract or other transaction with the Managing Entity.
3. Knowingly obtains a direct or indirect personal, financial, professional, or other benefit as a result of the relationship of such member or officer, or relative with the Managing Entity.

This section further requires a board member or officer to disclose "any activity that may reasonably be construed to be a conflict of interest" and requires board action in the event of disclosure. This section also addresses the consequences of board action.

The timing of a disclosure, the standard for board approval, and the consequences of board action are treated differently for matters pending board activity at the time this statute becomes effective than matters pending future board activity.

1. Regarding matters presented "for board Initial consideration and approval after July 1, 2021" or in cases of "a contract that is being considered for renewal on or after July 1, 2021, and before January 1, 2022," the party with a conflict must disclose "before such activity is initially considered and approved or renewed by the board." In these cases, the matter generating the conflict must be on the agenda for the next general or special meeting of the board. At that meeting, two-thirds of the other members present must affirmatively vote to approve "the activity and contract or other transaction documents." If the board disapproves, the person with a conflict is required to:
    a. Submit written notification of their intent to withdraw from the activity creating the conflict; or
    b. Withdraw from office before the next board meeting.
    c. If the board finds the person violated these requirements, "the officer or member shall be deemed removed from office before the next scheduled board meeting."

2. Regarding contracts "in existence on July 1, 2021, and … not subject to renewal before January 1, 2022," the party with a conflict must disclose by December 31, 2021. In these cases, the matter is required to be on the agenda for the next general or special meeting of the board, as above. However, no affirmative vote is required to approve the matter. Rather, the standard is merely that "[T]he board must be given the opportunity to approve or disapprove the conflict of interest by a vote of two-thirds of all other members present. If the board disapproves, the bill lists alternatives for those with a conflict but give no options to the Managing Entity. "[T]he parties to the activity may opt to cancel" or the individual with the conflict must resign from the board before the next meeting and limit Managing Entity liability for contract cancellation to the "reasonable value of the goods and services provided up to the time of cancellation."

This section allows a person with a conflict to attend a board meeting during which the matter is discussed and allows them to present on the matter. After presentation, they are required to "absent" themselves and, if a voting member, are required to recuse themselves from voting on the matter.

This section also addresses instances where a conflict or a "potential" conflict affecting a Managing Entity contract has not been disclosed. Such a contract becomes "voidable" and is terminated "upon the filing of a written notice

with the board of directors which contains the consent of at least 20 percent of the voting interests of the managing entity."

To implement the requirements of amended s. 394.9082(4), F.S., all Managing Entities will need to revise their by-laws or articles of incorporation to incorporate the new requirements into existing "conflict of interest" standards in place.

Section 7., s. 409.987, F.S., - Lead agency procurement; boards; conflicts of interest. –
This section provides that when conditions make it impossible or not feasible to competitively contract with a lead agency, the Department shall develop an alternative plan, in collaboration with the local community alliance. This alternative plan may include establishing an innovative consortium of partners which may include, but is not limited to, private entities, local and county governmental entities, and the Department. Further, this section specifies details of the Department's plan. Additionally, it details conflict of interest requirements for CBC lead agency boards. Upon becoming law, the Department would amend existing contracts and may require addendums to active Invitations to Negotiate. Additionally, the Department would edit the Supplemental Contract associated with future Invitations to Negotiate.

Section 8., s. 409.988, F.S., - Lead agency duties; general provisions. –
This section removes the requirement for lead agencies to post salary and other information on their websites, and shifts that requirement to the Department. Additionally, this section requires a lead agency to demonstrate the ability to adhere to all best child welfare practices pursuant to ss. 39.4087, 39.523, 409.1415, and 409.145, F.S. Upon becoming law, the Department would amend existing contracts and may require addendums to active Invitations to Negotiate. Additionally, the Department would edit the Supplemental Contract associated with future Invitations to Negotiate.

Section 9., s. 409.992, F.S., - Lead agency expenditures. –
This section defines "employee" for the purposes of lead agency expenditures and contracts to include the CEO, CFO, COO, or any other executive staff of the lead agency. It provides that a CBC lead agency employee may not receive a salary from state-appropriated funds, including state-appropriated federal funds, whether base pay or base pay combined with any bonus or incentive payments, including those received as a result of employment with more than one CBC lead agency or Managing Entity, in excess of 100 percent of the annual salary paid to the Secretary of the Department. The language does not prohibit any party from providing cash that is not from appropriated state funds to a Managing Entity employee. Upon becoming law, the Department would amend existing contracts and may require addendums to active Invitations to Negotiate. Additionally, the Department would edit the Supplemental Contract associated with future Invitations to Negotiate.

Section 10., s. 409.996, F.S., - Duties of the Department of Children and Families. –
This section requires the Department to post salary and other information on the Department's website. Additionally, this section requires a lead agency to demonstrate the ability to adhere to all best child welfare practices pursuant to ss. 39.4087, 39.523, 409.1415, and 409.145, F.S. These changes would require amendments to existing contracts and may require addendums to active Invitations to Negotiate. Upon becoming law, the Department would amend existing contracts and may require addendums to active Invitations to Negotiate. Additionally, the Department would edit the Supplemental Contract associated with future Invitations to Negotiate.

Section 11., s. 409.998, F.S., - Child and family well-being. –
This section creates s. 409.998, F.S., requiring the state to shift its focus from "child welfare" to "child well-being" by allowing sectors of the community and state to work together to reallocate resources in services and supports to reduce out-of-home care.

This section requires the Department to establish a program through a contract with the lead agency in accordance with s. 409.987, F.S., to carry out all programmatic functions. It requires the lead agency to collaborate with national experts in child welfare to create the program. This may require the CBC contract to be amended to incorporate the program.

This section defines "child and family well-being system" as a system that recognizes the difference between poverty and neglect and provider supports to biological parent as they develop skills to care for their children.

This section requires collaboration between the Department, the lead agency, community alliance, and Florida Institute for Child Welfare (FICW) to design, implement, and evaluate the program requirements. FICW will be required to report on the compliance of the program beginning October 1, 2021, and annually thereafter.

The Department has already begun the transition to a prevention focused child and family well-being system in response to the Family First Prevention Services Act (FFPSA), which authorizes new optional title IV-E funding for time-limited (one year) prevention services for mental health/substance abuse and in-home parent skill-based programs for: 1) a child who is a candidate for foster care (as defined in section 475(13) of the Act), 2) pregnant/parenting foster youth, and 3) the parents/kin caregivers of those children and youth (sections 471(e), 474(a)(6), and 475(13) of the Act).

Section 12.
The act shall take effect July 1, 2021.

2. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?

If yes, explain:	The Department may adopt rules that implement a formal family-finding program and the kinship navigator program.
What is the expected impact to the agency's core mission?	None.
Rule(s) impacted (provide references to F.A.C., etc.):	65c-30.003 Diligent Search, CFOP 170-1 Ch. 14 Diligent Search

3. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

List any known proponents and opponents:	Unknown
Provide a summary of the proponents' and opponents' positions:	Unknown

4. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?

If yes, provide a description:	Yes, FICW will submit a report to Governor, the President of the Senate and the Speaker of the House, which evaluates the child and family well-being program.
Date Due:	October 1, 2021
Bill Section Number(s):	Section 11

5. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL?

Board:	Community Alliances
Board Purpose:	To provide a focal point for community participation and governance of community-based services.
Who Appoints:	The Department shall, in consultation with local communities.
Appointee Term:	N/A
Changes:	Limits the number of members on the community alliance.
Bill Section Number(s):	Section 1

FISCAL ANALYSIS

1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The potential fiscal impact to the sheriff's offices may include the need to hire additional staff to implement family finding program. The Department projects that one position per sheriff's office (7) could support the family finding program. *Salaries and Benefits, Expenses for the 7 FTEs are calculated as follows:* The Operations Review Specialists average an annual salary with benefits of $62,890.71 a year. Total salary and benefits for 7 Operation Review Specialists is **$440,235**. To determine expenses, 7 Operations Review Specialists are multiplied by $10,422 ($5,974 recurring and $4,448 nonrecurring) for a total of **$72,954** ($41,818 is recurring and $31,136 is nonrecurring). *The total need for this section is **$513,189** ($482,053 in recurring and $31,136 in nonrecurring).
Does the legislation increase local taxes or fees?	The Department's Office of Administrative Services finds that this bill does not increase local taxes or fees.
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	The Department's Office of Administrative Services finds that this section is not applicable.

2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department estimates the need for 1 FTE at each Child Protective Investigator (CPI) service center (64) to complete the family finding program efforts for the 40+ CPI staffed at each location. *Salaries and Benefits, Expenses and Human Resources for the 64 FTEs are calculated as follows:* The Operations Review Specialists average an annual salary with benefits of $62,890.71 a year. Total salary and benefits for 64 Operations Review Specialists is **$4,025,005**. To determine expenses, 64 Operations Review Specialists are multiplied by $10,422 ($5,974 recurring and $4,448 nonrecurring) for a total of $667,008 ($382,336 is recurring and $284,672 is nonrecurring). To determine Human Resources expenses, 64 FTEs are multiplied by $330.22 for a total of $21,134. The total amount for expenses and human resources costs are **$688,142** ($403,470 is recurring and $284,672 is nonrecurring). The total need for this section is **$4,713,147** ($4,428,475 in recurring and $284,672 in nonrecurring). The Department will require minimal use of existing resources to adapt websites and contract documents.

Does the legislation contain a State Government appropriation?	The Department's Office of Administrative Services finds that this bill does not contain a State Government Appropriation.
If yes, was this appropriated last year?	The Department's Office of Administrative Services finds that this section is not applicable.

3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The CBC Lead Agencies will require a minimum of one staff for the family finder program. The Department currently has 19 contracts with the CBC Lead Agencies and anticipates that one staff person for each of the 19 contracts would be sufficient to implement the program. Five CBC lead agencies currently have an active family finder program; therefore, it is anticipated that 14 positions will be required to implement the program. *Salaries and Benefits, Expenses for the 14 positions are calculated as follows:* The Operations Review Specialists average an annual salary with benefits of $62,890.71 a year. Total salary and benefits for 14 Operations Review Specialists is **$880,470.** To determine expenses, 14 CBC positions are multiplied by $10,422 ($5,974 recurring and $4,448 nonrecurring) for a total of **$145,908** ($83,636 is recurring and $62,272 is nonrecurring). The total need for these 14 positions is **$1,026,378** ($964,106 in recurring and $62,272 in nonrecurring). The CBC lead agencies will use current resources to support the technology requirements of the kinship navigator program but will need additional staff to implement the kinship navigator program. The Department currently has 19 contracts with the CBC lead agencies and anticipates that 19 positions would be sufficient for the implementation of the program for each CBC, requiring a total of $10,061,982 (19 positions x $529,578) to fund these positions. It should be noted that Children's Home Network is an agency that has an existing kinship navigator program that is recognized by the Children's Bureau and is working with the Department to become rated in the clearinghouse for future utilization for all CBCs. The agency is staffed with the following positions to operate the program and these positions dedicate a portion of their time, notated in parentheses, towards the kinship navigator program. As such, the below amounts are prorated. Salaries: Chief of Prevention & Intervention (25%): $18,570 Director (100%): $47,500 Manager X 2 (20%): $9,900 Intake Coordinator (100%): $22,500 Peer Navigator X 5 (100%): $99,750 Family Support Navigator X 5 (100%): $122,514 Program Manager X 2 (100%): $67,500 Support Group Assistant, Part Time x 5 (50%): $35,428 Total Salaries: **$423,662** Benefits at 25 percent: **$105,916** Total Personnel Costs: **$529,578** The total costs for the 19 positions: **$10,061,982**

	The total need for this section is: **$11,088,360**
Other:	Section 5 is expected to have an indeterminate effect on any Managing Entity which currently has any employee, including executive staff, earning more in total compensation (including bonuses, etc.) than 100% of the Department's Secretary's salary. Any such Managing Entity will need to reduce salary or find alternative non state-appropriated funding for excess compensation. The Department's Office of Substance Abuse and Mental Health does not have data estimating the exact number or dollar amounts that may be impacted.

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?

Does the bill increase taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not increase taxes, fees, or fines.
Does the bill decrease taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not decrease taxes, fees, or fines.
What is the impact of the increase or decrease?	The Department's Office of Administrative Services finds that this section is not applicable.
Bill Section Number:	The Department's Office of Administrative Services finds that this section is not applicable.

TECHNOLOGY IMPACT

Does the legislation impact the agency's technology systems (i.e., IT support, licensing software, data storage, etc.)?	The Department's Office of Information Technology Service finds that there are no technology impacts.
If yes, describe the anticipated impact to the agency including any fiscal impact.	The Department's Office of Information Technology Services finds that this section is not applicable.

FEDERAL IMPACT

Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)?	The Office of Child Welfare finds this bill does not have a federal impact.
If yes, describe the anticipated impact including any fiscal impact.	The Office of Child Welfare finds section is not applicable.

ADDITIONAL COMMENTS

Section 2
There are currently five CBCs operating a Family Finder program in Florida. They are Safe Children Coalition, Eckerd Connects, Heartland for Children, Kids Central, and Embrace Families. The Department, in partnership with the Child Welfare Training Consortium of USF, is currently offering a 2-day Family Finder Train the Trainer to improve efforts in achieving and expediting permanency for our children and youth in care. The Department implemented this training in an effort to reduce the number of children in licensed care and specifically in congregate care as the Department aligns its placement for FFPSA. The training kicked off in December of 2020 and will conclude in March of 2021. The training is mandatory for selected trainers with the CBC lead agency, Children's Legal Services, Department's Regional Program staff and Child Protection Investigators, and Sheriff's Offices. The attendees are required to provide instruction to current and new staff as needed on the Family Finder Program to ensure ongoing efforts to connect foster children with family members for support and possible placement. Those completing the course will be eligible and offered opportunities for case specific technical assistance, upon completion of the 2-day course.

Section 4
In September of 2019, the FICW published a research report on the inventory of kinship care services in Florida. The report aimed to provide an inventory of the kinship care services throughout the state of Florida. Using 18 lead CBC lead agencies, the FICW examined the kinship supports in each agency. While there are currently no formal kinship navigator programs (as imagined by FFPSA) operating or implemented in Florida, according to the data, approximately 39 percent of agencies offer more than 31 of 41 best practice services. Additionally, half of the agencies offer more than 65 percent of services for kinship caregivers and more than half of the agencies offer 85 percent of services for programmatic support indicating kinship care families and caregivers are provided essential support to care for children placed in their home.

The study identified the available kinship care services based on the 42 best practice kinship care services available however the study does not provide an evaluation of the effectiveness of any of the kinship programs. While most CBC's provide kinship services across the state, their programs are not aligned with FFPSA criteria including operating in accordance with "promising," "supported," or "well-supported" evidence requirements through the federal clearinghouse. As described in section 427(a)(1) of the Social Security Act, kinship navigator programs are required to assist caregivers in learning about, finding, and using programs and services to meet the needs of the children they are raising. In addition, they shall coordinate and promote information referral services including entities that provide 2-1-1 or 3-1-1, and a host of other activities that may develop, enhance or evaluate their program. The Department's first objective is currently working with the Children's Home Network on continuing the focus to contribute to the evidence of their program to develop a third manuscript focusing on child-related outcomes per the Title IV- E Prevention Services Clearinghouse. This current provider was previously under review; however, it did not meet the rating criteria. March 2020, the Department was afforded the opportunity to receive a continued Kinship grant in which we included a second provider. The Department's objective includes an implementation of an evaluation plan for Kid's, Inc. which includes components of process evaluation and process outcome evaluation. The Department utilized the opportunity to have one or more of its own models meeting the criteria of the FFPSA clearinghouse. This is especially relevant given there have not been any kinship navigator programs that have achieved the FFPSA standards.

The full report can be located at the following link:
http://centerforchildwelfare.fmhi.usf.edu/kb/RelCaregivers/FL_Kinship%20Care%20Services_Inventory_FICW_09302019.pdf

Section 5
As written, lines 398 through 406 appear to prohibit using any state-appropriated funds to pay any employee whose total compensation exceeds the maximum amount. The language used is "a managing entity employee may not receive a salary from state-appropriated funds, including state-appropriated federal funds," but does not clearly address cases where a portion of an employee's salary is paid with the designated funds up to the maximum and any compensation over the maximum is paid with non state-appropriated funds. Lines 407 through 409 may be interpreted as an attempt to address such cases.

Section 6
The language in lines 541 through 548 appears to invest a minority of the board voting members with termination rights without any board action. The termination arises automatically when 20 percent of voting members filing a notice. It should be noted the termination arises in areas of potential conflict of interest, whether or not the alleged conflict has been investigated or validated. This may create a risk of behavioral health service disruption if the result is automatic termination of a contract for systemically necessary levels of care in communities where provider capacity is already

limited. An alternative would be to adopt a board vote to remove the person from the board, without the option for the party with a conflict to cancel their services.

The language of the bill does not clearly address the timing of disclosures or any actions to be taken regarding conflicts that arise after December 31, 2021.

The language of the bill does not address the requirement for disclosures on any new activity. As written, the terms apply only to existing matters before the board or existing Managing Entity contracts.

Section 11
The Department, in collaboration with the Florida Coalition for Children and community stakeholders, continue to meet to develop policy, risk assessments, technology interface, and the selection of evidence-based prevention services as the state prepares to implement FFPSA. In addition, the Department and CBCs continue to serve, through prevention services and supports, families who are safe but at high or very high risk of entering out-of-home care.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	Section 3 creates legal liability for the Department in relation to caregivers' rights that change from goals to requirements.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/21
Meeting Date

SB 92
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic DEPARTMENT OF CHILDREN AND FAMILIES

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA ASSOCIATION OF MANAGING ENTITIES

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

02/16/2021
Meeting Date

SB 0092
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Department of Children and Families

Name Victoria Vangalis Zepp

Job Title Chief Policy and Research Officer

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Street

Phone 8502416309

Tallahassee FL 32301
City *State* *Zip*

Email victoria@flchildren.org

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Coalition for Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 92
INTRODUCER:	Senator Bean
SUBJECT:	Department of Children and Families
DATE:	February 15, 2021 REVISED: 02/17/211

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Cox	CF	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 92 makes a number of changes to various provisions related the Department of Children and Families (DCF) and entities under contract with the DCF, including community-based care lead agencies and managing entities, who operate and provide services in the child welfare and behavioral health systems in accordance with chs. 394 and 409, F.S., respectively.

The bill amends several statutes within ch. 39, F.S., relating to programs and best practices of the child welfare system, to make such programs and practices mandatory, rather than permissive. Section 39.4015, F.S., is amended to require, rather than authorize, the DCF, sheriffs' offices, and community-based lead agencies to develop a formal family-finding program which must begin as soon as the child is taken into custody. Section 39.5086(2)(b), F.S., is also amended to require, rather than authorize, each community-based care lead agency to establish a kinship navigator program. Further, the bill removes the limitation for these two programs that tie the development of such programs to available resources. The bill also amends s. 39.4087, F.S., requiring the DCF to treat foster parents and other caregivers with dignity, respect, and trust while ensuring delivery of services is focused on the best interest of the child. The DCF is also required, rather than encouraged, to provide information, training, and support to foster parents and other designated caregivers except as otherwise provided by state or federal law.

The bill amends the DCF's duties to collect and post information regarding the managing entities and lead agencies' compensation, and program, administrative, and fundraising expenses. The bill also provides that the DCF's contracts with managing entities and lead agencies must limit employees' salary from state-appropriated funds to not exceed 100 percent of the annual salary paid to the Secretary of the DCF.

The bill amends s. 409.988, F.S., removing a requirement that lead agencies post their current budgets on their websites and relocating it to the above-mentioned provision. Section 409.988, F.S., is also amended to require, through contract execution, that the lead agencies demonstrate the ability to adhere to best child welfare practices enumerated in specified sections of chs. 39

and 409, F.S. Further, the contracts with the DCF must require the lead agencies to provide information which specifies how they will adhere to such best practices.

Further, the bill creates provisions that the boards for the managing entities and lead agencies must comply with related to disclosure of activity that may be reasonably construed to be considered a conflict of interest. Section 394.90825, F.S., is created, and s. 409.987, F.S., is amended, to require a board member or officer of a managing entity or lead agency to disclose specified activity that may reasonably be construed as a conflict of interest. The bill also provides procedures that must be followed to address the potential conflict of interest.

The bill amends s. 20.19, F.S., in part, requiring the DCF to create a community alliance in each service area of the lead agency, rather than county, which will align these bodies with the current service model in Florida. The bill also modifies the representative members of the community alliance and allows for the number of representatives to be increased from 20 to 30 members as necessary to adequately represent the diverse population within the community alliance service area. The bill also amends s. 409.987, F.S., providing for an alternative plan that establishes an innovative consortia of partners in communities where conditions make it infeasible to competitively contract with a lead agency and requirements that the plan must meet. This provision directs the DCF to work in collaboration with the local community alliance to achieve community-focused delivery of child welfare services.

Lastly, the bill creates a program that allows Florida to partner with national experts to establish a program that will implement a new child and family well-being system. The bill also provides for the program scope and requirements and requires the Florida Institute of Child Welfare to submit an annual report by a specified date to specified parties which evaluates and the program and the outcomes of the children served by the program.

The DCF estimates there will be a potential fiscal impact to local government of $513,189, state government of $4,713,147, and private sector of $11,088,360 resulting from the implementation of the family-finding and kinship navigator programs required under the bill. See Section V. Fiscal Impact Statement.

This bill is effective July 1, 2021.

II. Present Situation:

The DCF was created to support and promote stable and safe families.[1] The DCF is required to work with local partners to provide services by contract through private providers to the extent allowed by law and within specified appropriations.[2] The DCF is responsible for providing services relating, amongst other services, to:

- Child care regulation;
- Child welfare;
- Domestic violence;
- Economic self-sufficiency;

[1] *See* s. 20.19, F.S.
[2] Section 20.19(1)(c), F.S.

- Homelessness;
- Mental health and substance abuse;
- Refugee services; and
- Human trafficking.[3]

Some of these services, which are affected by the bill, are explained in more detail below.

Community-based Care Lead Agency

The DCF operates a community-based care child welfare system that outsources foster care and related services to agencies with an increased local community ownership to enhance accountability, resource development, and system performance.[4] The DCF contracts with community-based care lead agencies (lead agency) to provide direct or indirect child welfare services.[5]

The DCF Duties

Notwithstanding that services are contracted with local lead agencies, the DCF remains responsible for providing child welfare and support services in accordance with federal and state law.[6] The Legislature has articulated several duties with which DCF must comply, including, in part:

- Ensuring the DCF's contracts with the lead agencies contain specified terms, including to:
  - Provide for the services which must be provided as required under s. 409.988, F.S., and provide relevant information to the DCF related to the quality assurance program and the child welfare results-oriented accountability system;
  - Provide for tiered interventions and graduated penalties for failure to comply with the contract or performance deficiencies;
  - Require the lead agencies to provide current and accurate information of its activities related to case records in the statewide automated child welfare information system; and
  - Specify the procedures to resolve differences in interpreting the contract or to resolve a disagreement amongst the parties regarding compliance with the contract;
- Developing and maintaining written policies and procedures for monitoring compliance with the services that must be provided by lead agencies under their contracts and posted on the DCF website;
- Developing and implementing statewide and local interagency agreements to coordinate services that need to be provided to children and parents; and
- Establishing a quality assurance program for contracted services to dependent children; and
- Evaluating lead agencies under contract at least once annually.[7]

[3] Section 20.19(4), F.S.
[4] The DCF, *Community-Based Care*, available at https://www.myflfamilies.com/service-programs/community-based-care/overview.shtml (last visited February 16, 2021).
[5] *Id.*
[6] Section 409.996, F.S.
[7] *Id.*

Contracted Lead Agencies

A lead agency is a single entity with which the DCF has a contract for the provision of care in the child protection and welfare system.[8] The DCF enters into 5-year contracts with lead agencies for the procurement of services.[9] There are minimum requirements with which lead agencies must comply to be eligible to contract with the DCF, including, but not limited to;

- The lead agency must be organized as a Florida corporation or a governmental entity;[10]
- The board of directors or board committee must have the authority to approve the lead agency's budget and to hire the lead agency's executive director;[11] and
- The lead agency must also demonstrate financial responsibility by having a plan for regular fiscal audits and securing a performance bond.[12]

The lead agencies are obligated to perform several duties including, in part, to:

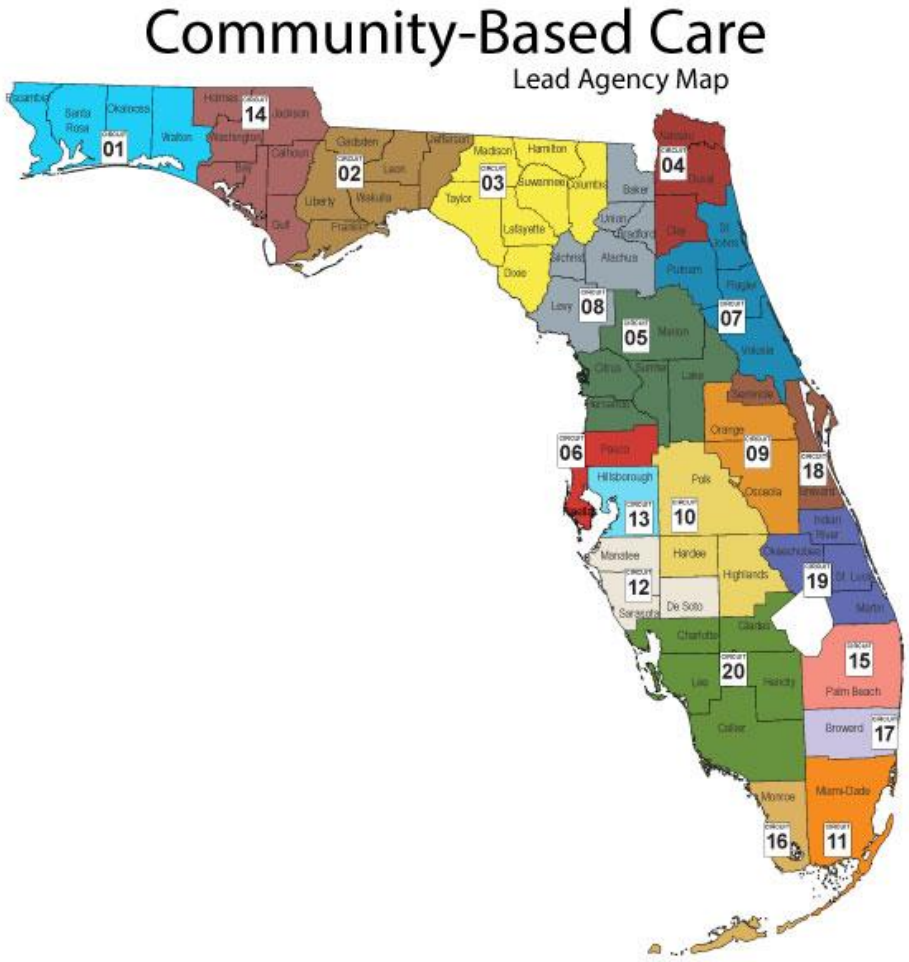
- Serve the children referred as a result of abuse, abandonment, or neglect reports;
- Provide accurate and timely information to the DCF as specified in s. 409.997, F.S.;
- Follow financial guidelines developed by the DCF and provide for a regular independent audits;
- Post its current budget, including the salaries, bonuses and other compensation paid to the agency's chief executive officer, chief financial officer, and chief operating officer, or their equivalents, on the lead agency's website;
- Prepare and file all necessary court documents, and attend dependency court proceedings to give evidence;
- Ensure all individuals providing care to dependent children receive training and specified information and meet employment requirements;
- Maintain eligibility to receive all available federal child welfare funds;
- Maintain written agreements with Health Families Florida lead entities;
- Comply with federal and statute statutory requirements and agency rules in the provision of contractual rules;
- Use authority to subcontract for the provision of services provided the lead agency contribute to services and meet specified criteria; and
- Post information regarding case management services on its website by a specified date.[13]

The DCF contracts with the following lead agencies as illustrated in the table and map below:[14]

Lead Agency	**Circuit(s)**
Lakeview Center, Families First Network	1

[8] Section 409.986(3)(d), F.S.
[9] Section 409.987(3), F.S.
[10] Section 409.987(4)(a), F.S.
[11] Section 409.987(4)(b), F.S.
[12] Section 409.987(4)(c), F.S.
[13] Section 409.988(1), F.S. Further, s. 409.988(1)(k), F.S., provides that lead agencies and subcontracted case management providers must disclose the average caseload of case managers for filled positions, the turnover rate for case managers and their supervisors for the previous 12 months, the percentage of required home visits completed, and performance on outcome measures required under s. 409.997, F.S., for the previous 12 months.
[14] The DCF, *Lead Agency Map, Community-Based Care*, available at: https://www.myflfamilies.com/service-programs/community-based-care/lead-agency-map.shtml (last visited Feb. 16, 2021).

Big Bend Community Based Care, Inc.	2 & 14
Partnership for Strong Families	3 & 8
Family Support Services of North Florida, Inc.	4 (Duval and Nassau)
Kids First of Florida, Inc.	4 (Clay)
Kids Central, Inc.	5
Eckerd Community Alternatives	6 and 13
St Johns County Board of County Commissioners	7 (St Johns)
Community Partnership for Children, Inc.	7 (Flagler, Volusia, Putnam)
Embrace Families	9 and 18 (Seminole)
Heartland for Children	10
Citrus Family Care Network	11 and 16
Safe Children Coalition	12
ChildNet Inc.	15 and 17
Brevard Family Partnership	18 (Brevard)
Communities Connected for Kids	19
Children's Network of SW Florida	20



Funding

Section 409.990, F.S., requires that a contract between the DCF and a lead agency be funded through General Revenue, other applicable state funds, or applicable federal funding sources.[15] Lead agencies must allocate their funding as provided under Florida law based on a proportion of child population, child abuse hotline workload, and children in care.[16]

Compensation

Lead agency expenditures must comply with financial guidelines developed by the DCF, comply with federal and state law, and follow good business practices.[17] The Internal Revenue Code sets the rules governing compensation at public nonprofits, including those known as 501(c)(3) organizations, and specifies that no part of the net earnings of a section 501(c)(3) organization may insure to the benefit of any private shareholder or individual.[18] However, the Internal Revenue Service (IRS) gives each nonprofit's board of directors latitude in determining how much to pay top employees. The IRS requires a nonprofit board to have an objective process for setting executives' salaries, including use of comparisons with salaries paid by similar organizations for similar service. However, a nonprofit that normally pays no taxes may be taxed for paying excess benefits to an insider.[19]

In 2015, during an operational audit of the lead agencies, the Florida Auditor General found instances where salary payments, including bonuses, and leave balances did not appear to be properly supported or calculated in accordance with established community-based care policy or state law.[20] During the 2017 Legislative Session, CS/CS/HB 1121 passed and was signed into law, which, in part, limited the lead agencies' administrative employees' salaries to 150 percent of the annual salary paid to the Secretary of the DCF from state-appropriated funds.[21] Administrative employees is not defined in s. 409.992(3), F.S.

In a January 2019 operational audit, the Florida Auditor General conducted a new independent audit and also followed up on the findings noted in the 2015 report related to lead agencies mentioned above. The 2019 report stated that as of March 31, 2017, which is prior to the implementation of CS/CS/HB 1121 (2017), the lead agencies' chief executive officer annual

[15] Section 409.990, F.S.
[16] Section 409.991(2), F.S., provides that core services funds are calculated based on the proportion of the (a) child population weighted as 5 percent of the total; (b) child abuse hotline workload weighted as 35 percent of the total; and (c) children in care weighted as 60 percent of the total. Section 409.991(3), F.S., provides that beginning in the 2015-2016 FY, 100 percent of the recurring core services funding must be based on the prior year recurring base core services funds, and any new funding be allocated as: (a) seventy percent of new funding amongst all lead agencies; and (b) thirty percent of new funding to lead agencies that are funded below their equitable share.
[17] Section 409.992(1), F.S.
[18] 26 U.S.C. §501. Exemption from tax on corporations, certain trusts, etc. Subject to some exemptions, corporations and other eligible entities that are organized and operate exclusively for religious, charitable, scientific and other specified purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise conducting exempted activities, are exempt from taxation.
[19] *Id.*
[20] The Office of the Auditor General, *Department of Children and Families and Selected Community-Based Care Lead Agencies Oversight of Foster Care and Related Service*, Report No. 2015-156, p. 1, March 2015, available at https://flauditor.gov/pages/pdf_files/2015-156.pdf (last visited February 16, 2021).
[21] Chapter 2017-151, L.O.F.; codified in s. 409.992(3), F.S.

salaries, before bonuses, averaged $210,863, and the average allocated to the DCF contracts with the lead agencies was $160,000.[22] The only finding related to the lead agencies on compensation benefits stated that two of the DCF's subcontracted entities did not require salaried employees to record annual leave used in increments of less than 8 hours.[23] The Florida Auditor General recommended the DCF amend the ME contracts to require compliance with statutory provisions restricting of state-funded bonus payments under the contract.[24]

Quality Assurance

The DCF shares responsibility with lead agencies and subcontractors to maintain a result-oriented accountability program that monitors and measures the use of resources, services provided, and outcomes achieved.[25] Reports must be produced quarterly, at a minimum, and published on the DCF's website.[26] The DCF reports the results in a quarterly scorecard which summarizes key issues, namely safety, permanency, and well-being metrics.[27]

Community Alliances

The DCF is required to establish community alliances[28] which shall be made up of local stakeholders and representatives in each county to encourage and maintain community participation, and governance of community based services.[29] Each community alliance may encompass more than one county when such arrangement is determined to provide for more effective representation.[30] Community alliances have a duty, amongst other obligations, to serve as a catalyst for community resource development, and promote prevention and early intervention.[31]

Community alliances are composed of a representative from the DCF, county government, the school district, the county United Way, the county sheriff's office, the circuit court corresponding to the county, the county children's board, if one exists, and a faith-based organization involved in efforts to prevent child maltreatment, strengthen families, and promote adoptions.[32] The community alliances shall adopt bylaws and may increase the membership of the alliance if such increase is necessary to adequately represent the diversity of the population.[33] The additional members may include states attorneys, public defenders, their designees, or

[22] The Office of the Auditor General, *Department of Children and Families Oversight and Administration of Community-Based Care Lead Agencies and Behavioral Health Managing Entities and Selected Department Administrative Activities*, Report No. 2019-111, p. 6 and 54-55, January 2019, available at https://flauditor.gov/pages/pdf_files/2019-111.pdf (last visited February 16, 2021) (hereinafter cited as "2019 Audit Report").
[23] *Id*. at p. 3.
[24] *Id*. at p. 28.
[25] Section 409.997(2), F.S.
[26] Section 409.997(2)(g), F.S.
[27] The DCF, *CBC Scorecard*, available at https://www.myflfamilies.com/programs/childwelfare/dashboard/cbc-scorecard.shtml (last visited February 16, 2021).
[28] Section 409.986(2)(c), FS., states a "community alliance" means the group of stakeholders, community leaders, client representatives, and funders of human services established pursuant to s. 20.19(5) to provide a focal point for community participation and oversight of community-based services.
[29] Section 20.19(5)(a), F.S.
[30] *Id*.
[31] Section 20.19(5)(b), F.S.
[32] Section 20.19(5)(d), F.S.
[33] Section 20.19 (5)(e), F.S.

individuals from funding organizations, community leaders or individuals who have knowledge of community-based service issues.[34]

Prior to 2014, s. 409.1671(1)(d), F.S.,, in part, provided that the DCF could develop an alternative plan to outsource services in an area if it was impossible or not feasible to competitively contract with a lead agency.[35] The DCF was required to develop a plan in collaboration with the local community alliance.[36] It was required to detail how the community would implement community-based care through local providers, and to ensure control over management and administration of services.[37] A plan developed under this former provision had to include best business practices, including some form of public and private partnerships.[38]

Managing Entities

The DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[39]

In 2001, the Legislature authorized the DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.[40] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[41] Full implementation of the statewide managing entity system occurred in 2013 and all geographic regions are now served by a managing entity.[42]

The DCF Duties

The DCF must also comply with duties with respect to the MEs, including, in part, to:

- Contract and conduct readiness reviews;
- Specify data reporting requirements and use of shared data systems;
- Define the priority populations that will receive care coordination;
- Support the development and implementation of a coordinated system of care;
- Contract to support efficient and effective administration and ensure accountability for performance; and[43]

[34] *Id.*
[35] Section 46, ch. 2014-224, L.O.F.
[36] *Id.*
[37] *Id.*
[38] Section 46, ch. 2014-224, L.O.F.
[39] *See* chs. 394 and 397, F.S.
[40] Chapter 2001-191, L.O.F.
[41] Chapter 2008-243, L.O.F.
[42] Florida Tax Watch, *Analysis of Florida's Behavioral Health Managing Entity Models*, p. 4, March 2015, available at https://floridataxwatch.org/Research/Full-Library/ArtMID/34407/ArticleID/15758/Analysis-of-Floridas-Behavioral-Health-Managing-Entities-Model (last visited February 16, 2021).
[43] Section 394.9082(7), F.S., details the performance measurements and accountability requirements of MEs.

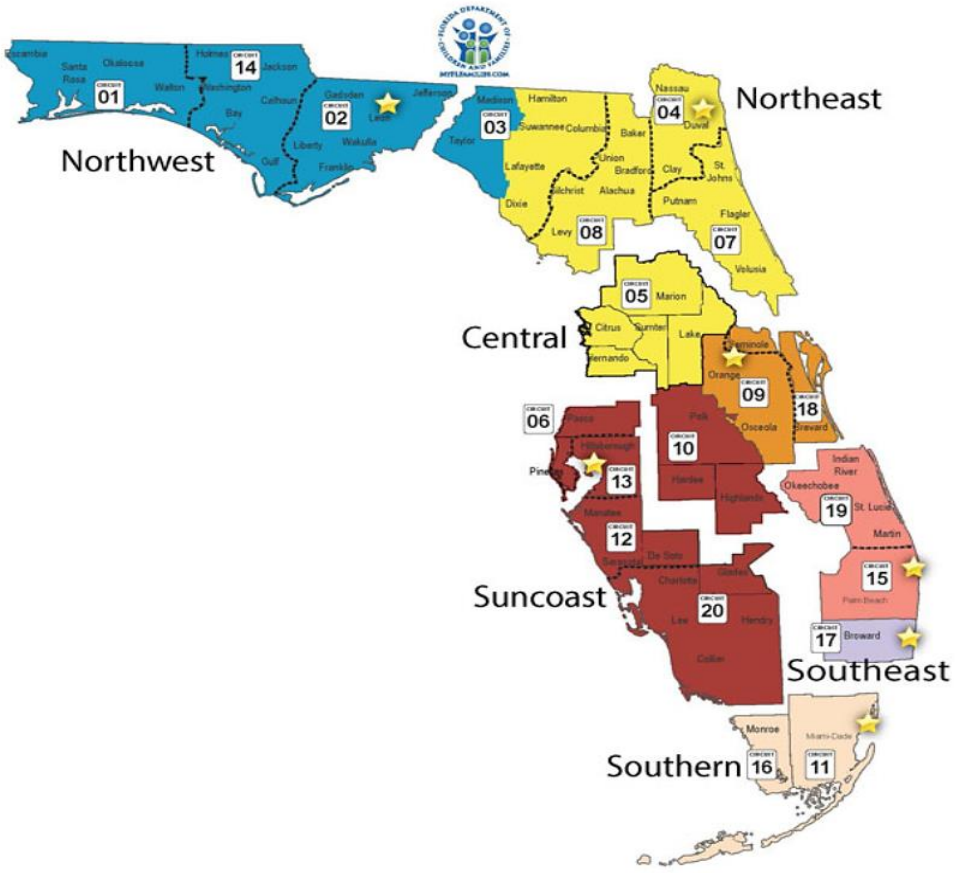
- Periodically review contract and reporting requirements and reduce costly, duplicative, and unnecessary administrative requirements.[44]

Contracted MEs

The MEs are required to comply with various statutory duties, including, in part, to:
- Maintain a governing board;
- Promote and support care coordination;[45]
- Develop a comprehensive list of qualified providers;
- Monitor network providers' performances;
- Manage and allocate funds for services in accordance with federal and state laws, rules, regulations and grant requirements; and
- Operate in a transparent manner, providing access to information, notice of meetings, and opportunities for public participation in ME decision making.[46]

The DCF contracts with seven MEs as shown in the map below and summarized as follows:
- Big Bend Community Based Care (blue);
- Lutheran Services Florida (yellow);
- Central Florida Cares Health System (orange);
- Central Florida Behavioral Health Network, Inc. (red);
- Southeast Florida Behavioral Health (pink);
- Broward Behavioral Health Network, Inc. (purple); and
- South Florida Behavioral Health Network, Inc. (beige).[47]

[44] Section 394.9082(3), F.S.
[45] Section 394.9082(6), F.S., sets out the network accreditation and systems coordination agreement requirements.
[46] Section 394.9082(5), F.S.
[47] The DCF, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited February 16, 2021).



The MEs in turn contract with local service providers for the delivery of mental health and substance abuse services.[48] In FY 2018-2019, the network service providers under contract with the MEs served 339,093 individuals.[49]

Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.[50] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[51] A community or region provides a coordinated system of care for those suffering from mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.[52] MEs must submit detailed plans to enhance

[48] Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
[49] The DCF, *Substance Abuse and Mental Health Triennial Plan Update for Fiscal Year,* (Dec. 6, 2019) https://www.myflfamilies.com/service-programs/samh/publications/docs/SAMH%20Services%20Plan%202018%20Update.pdf (last visited February 16, 2021).
[50] Section 394.9082(5)(d), F.S.
[51] Section 394.4573(1)(c), F.S.
[52] Section 394.4573(3), F.S. The Legislature has not funded system improvement grants.

crisis services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.[53] The DCF must use performance-based contracts to award grants.[54] There are several essential elements which make up a coordinated system of care, including:

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.[55]

A coordinated system of care must include, but is not limited to, the following array of services:

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.[56]

Current law requires the DCF to define the priority populations which would benefit from receiving care coordination, including considerations when defining such population.[57] Considerations include the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

[53] *Id.*
[54] *Id.*
[55] Section 394.4573(2), F.S.
[56] Section 394.495(4), F.S.
[57] Section 394.9082(3)(c), F.S.

Funding and Expenses

Contracts with MEs are funded with general revenue, other qualifying state funds, or applicable federal funding.[58] The MEs are required to develop and implement standards for collecting and reporting data related to crisis stabilization and detoxification and addictions receiving services.[59] The data is collected from entities who have received funds and operate under s. 394.875, F.S.[60] MEs are required to reconcile the data on a monthly basis, submit the data to the DCF on a monthly and annual basis, and the DCF is required to post data on its website regarding the utilization of funds these entities have received.[61]

In 2015, during an operational audit of the MEs, the Florida Auditor General found instances where salary payments for leave used and ME employee leave balances did not appear to be supported or calculated accurately.[62]

In the January 2019 operational audit by the Florida Auditor General described above, as of March 31, 2017, the MEs' chief executive officer annual salaries, before bonuses, averaged $226,216, and the average allocated to the DCF contracts with the MEs was $170,905.[63] The 2019 report also found that bonus payments of one ME did not appear clearly reasonable and necessary to the performance of the ME's duties.[64] The Florida Auditor General recommended the DCF amend the ME contracts to require compliance with statutory provisions restricting of state-funded bonus payments under the contract.[65]

Florida law is currently silent regarding a salary cap for administrative employees of MEs.

Kinship Navigator Programs

Section 39.5086(2)(b), F.S., permits each lead agency to establish a kinship navigator program subject to available resources. A kinship navigator program is defined as a program designed to ensure that kinship caregivers are provided with the necessary resources for the preservation of the family.[66] The purpose of such program is to provide support and services to kinship caregivers, specifically to:

- Coordinate with other state and local agencies that promote service coordination or provide information and referral services;
- Plan and operate in consultation with kinship caregivers and organizations representing them, youth raised by kinship caregivers, relevant governmental agencies, and relevant community-based or faith-based organizations;

[58] Section 394.9082(9), F.S.
[59] Section 394.9082(10), F.S.
[60] *Id.*
[61] Section 394.9082(10)(e) and (f), F.S.
[62] The Office of the Auditor General, *Department of Children and Families and Selected Behavioral Health Managing Entities*, Report No. 2015-155, p. 1-2, March 2015, available at https://flauditor.gov/pages/pdf_files/2015-155.pdf (last visited February 16, 2021).
[63] 2019 Audit Report, at p. 6 and 57.
[64] *Id.* at p. 3.
[65] *Id.* at 28.
[66] Section 39.5086(1)(c), F.S.

- Provide toll-free telephone hotline services with information to link kinship caregivers, kinship support facilitators, and kinship service providers;
- Provide outreach to kinship care families, including by establishing, distributing, and updating a kinship care website, or other relevant guides or outreach materials; and
- Promote partnerships between public and private agencies, including schools, community-based or faith-based organizations, and relevant governmental agencies, to increase their knowledge of the needs of kinship care families to promote better services for those families.[67]

Several provisions of law provide for financial support to relative and non-relative caregivers of children who are in out-of-home care who meet specified criteria, including the:

- Guardianship Assistance Program;[68]
- Level I family foster care homes licensure if qualifications are met;[69]
- Relative Caregiver Program (RCP);[70] and
- Temporary Cash Assistance (TCA) Program.[71]

The DCF operating procedures require case workers to provide information to relative caregivers about the kinship navigation program, including referrals, and guidelines about the program.[72] All lead agencies except for one offer kinship services,[73] but the services provided do not meet the current statutory requirements for such a program.[74] The DCF reports that approximately 39 percent of lead agencies offer more than 31 of 41 best practice services. Fifty percent of lead agencies offer more than 65 percent of services for kinship caregivers and offer 85 percent of services for programmatic support.[75]

The Family First Prevention Act allows Title IV-E agencies to claim 50 percent of kinship navigator program costs if specified criteria are met.[76] The DCF has been working with the

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[67] Section 39.5086(2)(b), F.S.
[68] Section 39.6225, F.S.
[69] Section 409.175, F.S.
[70] Section 39.5085, F.S.
[71] RCP and TCA are funded by Temporary Assistance for Needy Families. State funds are also available for children who were placed in foster care and change placement to a nonrelative in a permanent guardianship. *See* The DCF, *Temporary Cash Assistance (TCA)*, available at https://www.myflfamilies.com/service-programs/access/temporary-cash-assistance.shtml (last visited February 16, 2021).
[72] The DCF, *CFOP 170-10*, Chapter 8, p. 2, available at https://www.myflfamilies.com/admin/publications/policies.asp?path=CFOP%20170-xx%20Child%20Welfare/CFOP%20170-10%20%20Providing%20Services%20and%20Support%20for%20Children%20in%20Care%20and%20for%20Caregivers (last visited February 16, 2021) (hereinafter referred to as "CFOP 170-10")
[73] The DCF, *Agency Analysis for SB 92*, p. 5, February 10, 2021 (on file with the Senate Committee on Children, Families, and Elder Affairs) (hereinafter cited as "The DCF Analysis").
[74] *Id.*
[75] The DCF Analysis, p. 12.
[76] *Id.* The DCF Analysis explains that lead agencies must use evidenced-based kinship navigation program to be eligible for funds. Also, under Title IV-E of the Social Security Act, states, territories, and tribes are entitled to claim partial federal reimbursement for the cost of providing foster care, adoption assistance, and kinship guardianship assistance to children who meet federal eligibility criteria. The Title IV-E program is administered by the Children's Bureau, an agency within the U.S. Department of Health and Human Services. The DCF is Florida's Title IV-E agency. *See* Congressional Research Service, *Child Welfare: A Detailed Overview of Program Eligibility and Funding for Foster Care, Adoption Assistance and Kinship*

Children's Home Network to contribute to the evidence of their program.[77] The DCF received a one year grant and has been given the opportunity to received continued Kinship grant to include a second provider.[78] One of the DCF's objectives is to implement a plan for Kid's, Inc. to have one or more of its own models meeting the federal reimbursement standards.[79]

Family-Finding Program

The DCF may establish a formal family-finding program subject to available resources.[80] The family-finding program may begin as soon as the child is taken into custody and throughout the duration of the case as necessary, locating and engaging as many family members as possible who may assist with support and care of the child.[81] Florida law defines diligent search efforts,[82] but requires the DCF to make efforts beyond basic search tools by exploring alternative tools and methodology.[83]

The DCF has rule making authority to implement this discretionary program,[84] and must coordinate with the lead agencies to document strategies used to locate and engage the family to, in part:

- Attend visitation with the child;
- Assist with transportation of the child;
- Provide respite or child care services; or
- Provide actual kinship care.[85]

Between FY 2001-02 to 2008-09, the DCF implemented or expanded family finding tools in 67 counties to test the effectiveness of flexibly using Title IV-E funding provided under a waiver program to expanded child welfare services and supports available to increase the availability of family connections and to reduce the number of children in out-of-home care.[86] The six-step approach adopted includes discovery, engagement, planning, decision making, evaluation, and

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Guardianship Assistance under Title IV-E of the Social Security Act, available at https://www.everycrsreport.com/reports/R42792.html; the DCF, CFOP 170-15, available at https://www.myflfamilies.com/admin/publications/cfops/CFOP%20170-xx%20Child%20Welfare/CFOP%20170-15%20%20Federal%20and%20State%20Funding%20Eligibility/CFOP%20170-15,%20%20Chapter%2004,%20Title%20IV-E%20Foster%20Care.pdf (all sites last visited February 16, 2021).

[77] *Id.*

[78] The DCF Analysis, p. 12.

[79] *Id.*

[80] Section 39.4015(3), F.S.

[81] Section 39.4015(3)(a), F.S.

[82] Section 39.01(23), F.S., defines "diligent efforts of social service agency" as reasonable efforts were taken to provide social services or reunification services made by any social service agency that is a party to a case plan. Section 39.01(24), F.S., defines "diligent search" to mean the efforts of a social service agency to locate a parent, or prospective parent whose identity or location is unknown, is initiated as soon as the social service agency is made aware of the existence of such parent. When a parent's identity or location are unknown, s. 39.503, F.S., sets out efforts that must be made by the DCF to identify and locate him or her.

[83] Section 39.4015(3)(b), F.S.

[84] Section 39.4015(4), F.S.

[85] *Id.*

[86] Louis de la Parte, Florida Mental Health Institute, *Evaluation Brief 2, Florida's IV-E Waiver Demonstration Project*, pp. 1-2, 4, (Jan. 2010), available at https://www.myflfamilies.com/general-information/publications-forms/docs/APSR/S10-008463_Title%20IV-E%20Brief%202%20January2010.pdf (last visited February 16, 2021).

follow-up support.[87] The overall conclusion was that flexible use of Title IV-E funds will result in expanded services which reduce the number of children in out-of-home care, and that more children were reunified or were placed with caregivers.[88]

Child and Family Well-being Programs

Florida law does not presently provide for a child and family well-being system. There are, however, goals which the DCF in conjunction with lead agencies, community-based subcontractors, and the community alliance must aspire to achieve are to protect the best interest of the children including, in part, to:

- Protect children from abuse and neglect;
- Ensure that children remain safely in their home, if possible and appropriate;
- Preserve family relationships; and
- Provide services to families[89] and children to meet the children's needs, including their educational and mental health needs, and skills for independent living.[90]

There are innovative child and family well-being programs being developed throughout the United States which focus on family well-being and implementing creative preventative measures to keep families intact.[91] The U.S. Department of Health & Human Services Children's Bureau (Children's Bureau) provides information, training assistance, and grants focused on strengthening families, protecting children, and ensuring children have permanent families with a goal of improving safety, permanency, and well-being.[92]

Casey Family Programs (CFP) is an organization that focuses on these key objectives of child-welling. It was founded in 1966 and works in all 50 states.[93] The program provides consulting, research and analysis, and services free of charge to advance these goals.[94]

Alia is another program that is transforming child welfare systems by conducting research, providing strategy sessions, leadership coaching, and other workshops and events.[95] Alia promotes building an "unsystem" with five phases for implementing change to shift child welfare systems' primary focus to prevention. The five stages consist of:

- Preparing to Lead Change: Co-creating your Vision;
- Building the Foundation: Workforce Resilience;
- Shifting Agency Mindset: *Why* Change is Needed;

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[87] *Id*. at p. 4.
[88] *Id*. at p. 4-5.
[89] Section 39.001(47), F.S., states that "family support services" means services provided to children (and their families) who have been found to be safe and at high or very high risk of future maltreatment.
[90] Section 409.986, F.S.
[91] Casey Family Programs, *Who We Are*, available at https://www.casey.org/who-we-are/; Children's Bureau Express, *Transforming South Carolina's Approach to Child Welfare*, available at https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=219&sectionid=2&articleid=5652; Alia, *Get to Know Us*, available at https://www.aliainnovations.org/who-we-are (all sites last visited February 16, 2021).
[92] Children's Bureau, *What We Do*, available at https://www.acf.hhs.gov/cb/about/what-we-do (last visited February 16, 2021).
[93] Casey Family Programs, *Who We Are*, available at https://www.casey.org/who-we-are/ (last visited February 16, 2021).
[94] *Id*.
[95] Alia, *Project Work*, available at https://www.aliainnovations.org/project-work (last visited February 16, 2021).

- Aligning Practice with your *Why*; and
- Reaching a Tipping Point Toward Primary Prevention.[96]

South Carolina has adopted a child welfare system with similar goals and objectives as these programs and allocates resources with a primary focus on a preventative system.[97] Key elements of the system include, in part:

- Partnering with nonprofit and community-based organizations;
- Removing the stigma parents receive when receiving assistance;
- Engaging parents;
- Establishing family resource centers in local communities;
- Providing more services to meet families in locations convenient to them; and
- Fostering a greater understanding of trauma.[98]

Out–of-Home Placement

Section 39.4087, F.S., establishes goals for the DCF to achieve and requirements to meet with respect to caregivers. Specifically, one goal of the DCF is to treat caregivers, including foster parents, with dignity, respect, and trust while ensuring services are aimed at achieving what is in the child's best interest.[99] Subject to available resources and any state or federal law to the contrary, the DCF is required to provide to caregivers an open exchange of information and supportive services as specified in the statute.[100] For example, the DCF should, amongst other things:

- Provide training and support to the caregiver to help meet necessary requirements for the daily care and any special needs of the child.
- Fully disclose all relevant information regarding the child and the background of his or her biological family, including but not limited to:
  - Any delinquency or criminal record of the child; and
  - With parental consent to the extent required by law, any known health history and medical, psychological, or behavioral health issues or needs of the child.[101]

A caregiver must maintain the confidentiality of any information as required by law.[102]

The Florida Administrative Code requires community-based care lead agencies to provide support for all licensed out-of-home caregivers,[103] including:

- Access to foster parent support groups;
- Service resources for children placed in the home;
- Foster parent mentors; and

[96] *Id.*
[97] Children's Bureau Express, *Transforming South Carolina's Approach to Child Welfare*, available at https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=219&sectionid=2&articleid=5652 (last visited February 16, 2021).
[98] *Id.*
[99] Section 39.4087(1), F.S.
[100] *Id.*
[101] *Id.*
[102] Section 39.4087(1)(c), F.S.
[103] Rule 65C-45.011, F.A.C.

- Service resources for caregivers.[104]

The community-based care lead agencies must also make contact with the licensed caregiver at least quarterly.[105] Several other rules address efforts required by the child protective investigator or case manager to assist or provide information to caregivers.[106] Licensure rules address caregivers obligations to maintain confidentiality.[107]

The DCF has also established operating procedures for providing services and support for children in care and for caregivers,[108] including supporting relatives caring for children who are placed in out-of-home care,[109] and nonrelative caregiver financial assistance.[110] Additional subsidies are available depending on the permanency status of the child.[111] The DCF procedures also list information with which the child welfare professional must provide to the relative caregiver for completing the home study.[112]

Conflicts of Interest

There are several Florida statutes which address transactions or other situations in which a conflict of interest exists or may exist,[113] and define the term "conflict of interest" in context of the statute with which it relates.[114]

Corporations

Florida laws on corporations define "director's conflict of interest transaction" as a transaction between a corporation and one or more of its directors, or another entity in which one or more of the corporation's directors is directly or indirectly a party to the transaction, other than being an indirect party as a result of being a shareholder of the corporation, and has a direct or indirect material financial interest or other material interest.[115] If a director's conflict of interest transaction is fair to the corporation at the time it is authorized, approved, effectuated, or ratified:

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[104] Rule 65C-45.011(1), F.A.C.
[105] Rule 65C-45.011(2), F.A.C.
[106] *See* Rule 65C-35.004, F.A.C. (assisting the caregiver with attending appointments with a child if the caregiver is unavailable); Rule 65C-35.011(10), F.A.C. (informing the caregiver about the importance of communicating regarding a child's psychotropic medication and recommending they exchange contact details); and Rule 65C-28.005(4), F.A.C. (regarding services and information relating to the child upon a change of placement).
[107] *See* Rule 65C-45.003, F.A.C. (requiring an assessment of how, amongst other things, the caregiver will maintain confidentiality as required by law);
[108] Chapter 8, CFOP 170-10.
[109] Chapter 8, CFOP 170-10, p. 2-5. Several programs exist to provide relative caregiver support, including, but not limited to, the kinship navigator program, medical insurance, "at-risk child care subsidy, local flexible funds, "child-only" temporary cash assistance, and relative caregiver program.
[110] Chapter 9, CFOP 170-10.
[111] *Id.*
[112] *Id.* at pp. 5-7.
[113] *See* ss. 112.312, 605.04092, 607.0832, and 617.0832, F.S.
[114] *See* ss. 112.312, and 605.0492, F.S.
[115] Section 607.0832, F.S. *See also* s. 605.0492(1)(g), F.S., with respect to limited liability companies which defines "member's conflict of interest" as a transaction between a limited liability company and one or more of its members, or another entity in which one or more of the limited liability company's members is directly or indirectly a party to the transaction, other than being an indirect party as a result of being a member of the limited liability company, and has a direct or indirect material financial interest or other material interest.

- Such transaction is not void or voidable; and
- The fact that the transaction is a director's conflict of interest transaction is not grounds for any equitable relief, an award, or other sanctions.[116]

If proceedings challenging the validity of a director's conflict of interest transaction or proceedings seeking equitable relief, damages, or other sanction are brought, the person challenging the director's conflict of interest transaction has the burden to prove the lack of fairness of the transaction in specified situations.[117]

Nonprofit Organizations

Chapter 617, F.S., governs corporations not for profit and does not define conflict of interest. It provides, however, that no contract or other transaction between a corporation and one of its directors or other corporation in which one or more directors have an interest shall be void or voidable because of the relationship or interest, or because the interested director is present at the meeting which authorizes or ratifies such contract if:

- The relationship is disclosed or known to the other directors which authorizes or ratifies the transaction by a vote which is sufficient to approve the transaction without the interested director's vote.[118]
- The relationship is known or disclosed and the members entitled to vote authorize or ratify it by vote or written consent;[119] or
- The contract or transaction is fair and reasonable to the operation at the time is it authorized by the board, a committee, or the members.[120]

The transactions are required to be approved by a majority vote of the members who are entitled to vote.[121]

Public Officer and Employee

Public officers and employees must comply with standards of conduct provided for in s. 112.313, F.S. Ch. 112, F.S., restricts the type of business transactions that public officers and employees of an agency may have with a business entity in which the officer, employee, or the officer's or employee's specified family has a material interest.[122] Public officers and employees of agencies are also prohibited from having conflicting employment or contractual relationships with any business entity or regulation.[123] Section 112.312(8), F.S., defines "conflict" or "conflict of interest" as a situation in which regard for a private interest tends to lead to disregard of a public duty or interest.

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[116] Section 607.0832(2), F.S. This is the case when because of the relationship or interest, because such director is present at the meeting in which the transaction was authorized, or because his or her votes are counted for such purpose.
[117] Section 607.0832(3), F.S. The presence of or a vote cast by a director with an interest does not affect the validity of an action if specified conditions are met.
[118] Section 617.0832(1)(a), F.S. The presence of a vote cast by a director having a relationship or interest does not affect the validity of any action taken under paragraph (1)(a) if the transaction is otherwise authorized or ratified in this paragraph.
[119] Section 617.0832(1)(b), F.S.
[120] Section 617.0832(1)(c), F.S.
[121] Section 617.0832(2) and (3), F.S.
[122] Section 112.313(3), F.S.
[123] Section 112.313(7), F.S.

III. Effect of Proposed Changes:

Lead agencies and MEs

Duties

The bill amends s. 409.988, F.S., requiring the lead agencies to demonstrate the ability to adhere to all best child welfare practices under ss. 39.4087, 39.523, 409.1415, and 409.145, F.S. Further, the bill amends s. 409.996, F.S., providing the DCF must include a provision in its contracts with the lead agencies that requires them to provide information which specifies how the lead agency will adhere to this requirement.

Salary Provisions

The bill amends s. 409.988, F.S., removing the requirement for the individual lead agency to post specified budget information on its website. Sections 394.9082 and 409.996, F.S., are amended to add a similar provision; however, the bill requires the DCF, rather than each entity, to collect and post on its website compensation benefits for employees, annual expenses, administrative expenses, and fundraising expenses of MEs and lead agencies. The term "employee" is defined as their Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, or any other executive staff of the managing entity. The requirement to post this information in one centralized location will provide more consistency with the information posted for lead agencies statewide.

The bill amends s. 394.9082, F.S., requiring any new or amended contracts the DCF executes with lead agencies and MEs to limit employees' salaries[124] from state appropriated funds to no more than 100 percent of the annual salary paid to the secretary of the DCF. This provision is new in application to the MEs. Additionally, s. 409.992, F.S., is amended to reduce the limit on lead agencies salaries from state-appropriated funds to no more than 100 percent, from 150 percent, of the annual salary paid to the secretary of the DCF. These provisions explicitly state that this does not prevent the entity from paying more for salary, bonuses, etc. from other sources.

The DCF will need to develop new reporting templates, modify current year-end fiscal analysis tools, and modify ME contracts to implement these amendments.[125] MEs will have to assess employee compensation and determine whether any compensation requires an adjustment to comply with the new requirement, and the DCF is unable to estimate the number of employees which may be affected by this bill.[126]

Conflicts of Interest

The bill creates s. 394.90825 and 409.987(7), F.S., establishing a process for disclosing and eliminating any transaction or activity that could reasonably be construed to be a conflict of

[124] "Salary" means base pay or base pay combined with any bonus or incentive payments, including the base pay or the base pay combined with any bonus or incentive payments received as a result of employment with one or more than one community-based care lead agency or managing entity. If the bill is passed, the terms employee and salary would apply to the contracts on July 1, 2021 even if not amended by that date.
[125] The DCF Analysis at p. 5.
[126] *Id.* at p. 6.

interest for a member, officer, or relative of a lead agency or ME. The terms activity, conflict of interest, managing entity and relative are defined as follows:

- "Activity" includes, but is not limited to, a contract for goods and services, a contract for the purchase of any real or tangible property, or an agreement to engage with the managing entity for the benefit of a third party in exchange for an interest in real or tangible property, a monetary benefit, or an in-kind contribution;[127]
- "Conflict of interest" means when a board member or an officer, or a relative of a board member or an officer, of the managing entity/lead agency does any of the following:
  - Enters into a contract or other transaction for goods or services with the managing entity/lead agency;
  - Holds a direct or indirect interest in a corporation, limited liability corporation, partnership, limited liability partnership, or other business entity that conducts business with the managing entity/lead agency or proposes to enter into a contract or other transaction with the managing entity/lead agency;[128]
  - Knowingly obtains a direct or indirect personal, financial, professional, or other benefit as a result of the relationship of such member or officer, or relative of the member or officer, with the managing entity/lead agency;[129]
- "Managing entity" has the same meaning as in s. 394.9082, F.S.;[130] and
- "Relative" means a relative within the third degree of consanguinity by blood or marriage.[131]

For any activity that is presented to the board of these entities for initial consideration and approval after July 1, 2021, or any contract which is being considered for renewal between July 1, 2021 and December 31, 2021, a board member or officer must make a disclosure of such potential conflict of interest. A rebuttable presumption of a conflict of interest exists if the activity was acted upon by the board without prior notice.

If a contract is not subject to renewal before January 1, 2022, the board member or officer must disclose any that could reasonably be construed to be a conflict of interest by December 31, 2021.

Any proposed activity or existing contract which does give rise to a disclosure obligation must be listed on the meeting agenda for the next general or special meeting of the members, and copies of all contracts and relevant documents related to the transaction must be included. The meeting agenda must clearly state the potential conflict of interest. The board must be given an opportunity to approve or disapprove the conflict of interest by a vote of two-thirds of all other members present.

If the board votes against the proposed activity, the board member or officer must notify the board in writing of his or her intention, or his or her relative's intention, not to pursue the proposed activity or the board member or officer must resign. If the board finds that an officer or

[127] Sections 394.90825(1)(a) and 409.987(7)(a)1., F.S.
[128] Sections 349.90825(1)(b) and 409.987(7)(b)2., F.S. The bill provides that for purposes of this provision, 'indirect interest' has the same meaning as provided in s. 112.312, F.S.
[129] For purposes of this provision, the bill provides that the term 'benefit' does not include per diem and travel expenses paid or reimbursed to board members in connection with their service on the board.
[130] Section 394.90825(1)(c), F.S.
[131] Sections 394.90825(1)(d) and 409.987(7)3., F.S.

member has violated this provision, he or she will be deemed removed from office before the next scheduled board meeting. If the board votes against the renewal of an existing contract which gives rise to a conflict of interest, the parties to the activity may opt to cancel the activity, or in the alternative, the member or officer must resign from the board before the next scheduled meeting. The bill provides for limitations on damages under any existing contracts.

A board member, officer, or relative who has an interest in an activity that is a possible conflict of interest may attend the meeting at which the activity is considered by the board, make a presentation, and then leave the meeting during any relevant discussion by the other board members. A member or officer who is a party to, or has an interest in, the activity shall recuse himself or herself from the vote.

A contract entered into between a board member, officer, or relative of a member or an officer in which there is a conflict of interest or potential conflict of interest is void or voidable and terminates upon the filing of a written notice to the board which contains at least 20 percent of the voting interests of the managing entity.

MEs will need to amend their by-laws or articles of incorporation to ensure that the new requirements for potential conflict of interest transactions are incorporated.[132] The DCF would need to amend existing contracts with lead agencies and may need addendums to active Invitations to Negotiate in relation to several amendments proposed by the bill.[133] The DCF also would need to edit the Supplemental Contract related to the future Invitations to Negotiate.[134]

Community Alliances

The bill amends s. 20.19, F.S., modifying the requirement for the DCF's to form a community alliance to cover a county or "more than one county," to cover a "community-based care lead agency service area" instead.

It also requires each community alliance to adopt bylaws to determine the specific membership composition that best represents the local area being services by the alliance, and redefines the membership to a minimum of 20 members from a specified list of representatives, including:

- A representative from the DCF;
- Representatives from local government;
- Representatives from the school district;
- A representative from the United Way;
- Representatives from county sheriffs' offices;
- A representative from each circuit court in the lead agency service area;
- A representative from the children's services council, if one exists; and
- A representative of a faith-based organization involved in efforts to prevent child maltreatment, strengthen families, or promote adoption.

[132] The DCF Analysis at p. 7.
[133] *Id.*
[134] *Id.*

This section also requires community alliances to adopt bylaws which allow for increased membership to no more than 30 members if the change is necessary to adequately represent the diversity within the population within the area serviced by the community alliance.

The bill also amends s. 409.997, F.S., requiring the DCF to develop, in collaboration with the local community alliance, an alternative plan with specified details to use local community entities to implement community-based care services if conditions make it impossible or not feasible to competitively contract with a lead agency. This provision allows for the DCF and community alliance to work with partners that may include, but not be limited to, private entities, local and county governmental entities. The plan created must detail how the community will continue to implement community-based care through competitively procuring either the specific components of foster care and related services or comprehensive services for defined eligible populations of children and families. The bill requires the plan to ensure local control over the management and administration of the service provision and to adhere to recognized best business practices, including, but not limited to, the use of public or private partnerships. This amendment creates legislation that is substantially similar to former legislation under s. 409.1671(1)(d) that existed prior to July 2014.

Family-Finding and Kinship Navigator Programs

Sections 39.4015 and 39.5086, F.S., are amended to require, rather than permit if resources are available, the establishment of a formal family-finding program and kinship navigator program. The amendments clarify that family-finding efforts must go beyond basic search tools to comply with each of efforts required by the DCF and lead agencies' to search for children's families. The DCF may adopt rules to implement these programs.

Lead agencies would be encouraged to meet federal standards for the kinship program to claim 50 percent of the applicable costs.[135]

Children's Home Network that has an existing kinship navigator program that is recognized by the Children's Bureau and is collaborating with the DCF to become rated in the clearinghouse for future utilization in all lead agencies.[136]

Child and Family Well-Being

The bill requires DCF to establish a program that consists of a child and family well-being, system[137] to provide services through contracts with lead agencies in accordance with s. 409.987, F.S. The bill provides program requirements, including:

- Creating a system that requires fundamental change;
- Designating lead agency leadership that will identify a core group of agency individuals to develop a plan for creating the change;

[135] The DCF Analysis at p. 5.
[136] The DCF Analysis at p. 10.
[137] Section 409.998(2), F.S., defines "child and family well-being system" as a system that recognizes the difference between poverty and neglect and that provides mentoring and supports to biological parents as they develop the skills and resources necessary to adequately care for their children.

- Recognizing that change of this magnitude is difficult and time-consuming, and determine steps to determine well-being of individuals involved at an early stage of the process;
- Developing a plan for creating a change in the way partners view the process;
- Building relationships throughout the process of change;
- Providing regular interaction amongst the workforce to discuss changes that are needed; and
- Redirecting resources toward primary prevention and away from removing children from their homes.

The DCF must implement the program in collaboration with the designated lead agency, community alliance, and Florida Institute for Child Welfare. By October 1, 2021, and annually thereafter, the Florida Institute for Child Welfare must report to the Governor, President of the Senate, and the Speaker of the House of Representatives regarding program compliance and outcomes of the program.

The DCF has begun transitioning to a prevention focused child and family well-being system in accordance with the Family First Prevention Services Act (FFPSA) which authorizes new Title IV-E funding for a limited time period and in limited circumstances.[138]

Caregivers

The bill provides that the DCF is required to treat caregiver in a certain manner and provide specified support and information that used to be discretionary, depending on resources and subject to any laws to the contrary. Specifically, the DCF must treat caregivers with dignity, respect and trust while providing services that are in the best interest of the child. Also, the DCF now must provide specified support and information set out in s. 39.4087(1), F.S., including:

- Provide an explanation to the caregiver regarding the roles of the persons involved;
- Provide training and support to the caregiver;
- Disclose all relevant information regarding the child and the background of his or her biological family;
- Allow caregivers to communicate with professionals who work with the child;
- Provide a means by which a caregiver may contact the lead agency 24 hours a day, 7 days a week;
- Solicit and consider caregiver input on a child's case plan;
- Provide a clear, written explanation to a caregiver of any plan concerning the placement of a child;
- Provide information on any emergency situation which arises;
- Allow a caregiver to request removal of the child without retaliation;
- Inform the caregiver as soon as possible of any decision made by the court or child-caring agency relating to a child who is placed with the caregiver;
- Give at least 7 days' notice to a caregiver of any meeting or court hearing;
- Consider the caregiver as placement for the child if the child reenters out-of-home care;
- Allow a caregiver a period of respite upon reasonable notice; and
- Provide the caregiver, upon request, with copies of all information in the department's records regarding the caregiver.

[138] The DCF Analysis at p. 8.

The amendments to this subsection clarify that a caregiver must maintain confidentiality of any information as required by law, rather than this requirement being stated in relation only to the information the caregiver receives related to the child and the background of his or her biological family.

The bill is effective July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The DCF's Office of Administrative Services finds that this bill does not increase or decrease taxes, fees, or fines.[139]

B. Private Sector Impact:

Family-Finding Programs

The DCF's Office of Administrative Services finds that the potential fiscal impact to the private sector is $11,088,360 (including nonrecurring of $62,272) expenses to cover the positions for the family-finding and kinship navigator programs.

The DCF states that 14 lead agencies do not currently have a program and each will need one position to operate the program statewide. The DCF states that it anticipates the need

[139] The DCF Analysis at p. 11.

for one position at each of the remaining 14 lead agency locations that are not operating a family-finding program. The positions expected to be necessary are for Operations Review Specialist to implement the family-finding program.[140]

The DCF reports the average annual salary for an Operations Review Specialist with benefits is $62,890.71 a year with a total salary and benefits for the 14 positions of $880,470.[141] Administrative costs to determine expenses for 14 positions are multiplied by $10,422 for a total of $145,908.[142] The total funds required for the 14 positions to staff the family-finding program is $1,026,378 ($964,106 in recurring and $62,272 in nonrecurring) expenses.[143]

It should be noted that the DCF states that there are currently five lead agencies that are operating family finder programs even though the operation of such programs is permissive. These lead agencies are operating the family finder programs within existing resources and existing FTEs. As a result, additional information will need to be gathered from the DCF to understand the expenditure and FTE needs that are stated in the DCF's analysis dated February 10, 2021.

Kinship Navigator Programs

The DCF's Office of Administrative Services also finds there would be a potential fiscal impact to the private sector to fund the salaries of staff that is required to operate the kinship program.[144] The lead agencies will use current resources to support the technology requirements that will be necessary to operate the kinship navigator program.[145] The DCF currently has 19 contracts with lead agencies and anticipates that these positions would be sufficient to implement the program.[146] The 19 positions require funding of $10,061,982 (19 positions x $529,578).

As is stated with the family finder programs, the DCF provides that kinship services are being provided in Florida. Additional information needs to be obtained from the DCF to understand whether the services being provided meet the criteria for kinship navigator programs required under s. 39.5086(2)(b), F.S.

C. Government Sector Impact:

The DCF's Office of Administrative Services finds that the potential fiscal impact to local government is $513,189 (including $482,053 in recurring and $31,136 in nonrecurring) expenses to cover the salary of 7 positions one at each sheriff's office for an Operations Review Specialists to implement the family-finding program.[147] Total

[140] The DCF Analysis at p. 10.
[141] *Id.*
[142] *Id.*
[143] The DCF Analysis at p. 10.
[144] *Id.*
[145] *Id.*
[146] The DCF Analysis at p. 10.
[147] The DCF Analysis at p. 9.

salary and benefits for 7 Operation Review Specialists is $440,235.[148] To determine expenses, 7 Operations Review Specialists are multiplied by $10,422 ($5,974 recurring and $4,448 nonrecurring) for a total of $72,954 ($41,818 is recurring and $31,136 is nonrecurring).[149]

The DCF's Office of Administrative Services finds that the potential fiscal impact to state government is $4,713.147 (including $4,428,475 in recurring and $284,672 in nonrecurring) expenses to cover the salary of 64 positons one at each Child Protective Investigator service center for an Operations Review Specialist to implement the family-finding program.[150] Total salary and benefits for 64 employees is $4,025,005.[151] To determine expenses, 64 Operations Review Specialists are multiplied by $10,422 ($5,974 recurring and $4,448 nonrecurring) for a total of $667,008 ($382,336 is recurring and $284,672 is nonrecurring).[152] Human resources expenses have been determined by multiplying 64 full time employee positions by $330.22 for a total of $21,134.[153] The total amount of expenses and human resource costs are $688,142 ($403,470 is recurring and $284,672 is nonrecurring).[154]

As stated in the private sector impact statement, additional information will need to be gathered from the DCF to understand the expenditure and FTE needs that are provided in the government sector impact section in the DCF's analysis dated February 10, 2021.

The DCF will need minimal use of existing resources to adapt websites and contracts.[155]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 20.19, 30.4015, 39.4087, 39.5086, 394.9082, 409.987, 409.988, 409.992, and 409.996 of the Florida Statutes.

This bill creates sections 394.90825 and 409.998 of the Florida Statutes.

[148] *Id.*
[149] *Id.*
[150] The DCF Analysis at p. 9.
[151] *Id.*
[152] *Id.*
[153] The DCF Analysis at p. 9.
[154] *Id.*
[155] *Id.*

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By the Committee on Transportation; and Senator Berman

596-01961-21 2021184c1

A bill to be entitled

An act relating to the Purple Alert; amending s. 252.35, F.S.; requiring the Division of Emergency Management to identify and maintain an inventory of certain digitally displayed automatic changeable facing signs; amending s. 937.0201, F.S.; redefining the term "missing endangered person"; creating s. 937.0205, F.S.; providing legislative findings and intent; requiring the Department of Law Enforcement, in cooperation with the Department of Transportation, the Department of Highway Safety and Motor Vehicles, the Department of the Lottery, and local law enforcement agencies, to establish and implement the Purple Alert; specifying minimum requirements for the Purple Alert; authorizing local law enforcement agencies to broadcast information concerning certain missing adults; requiring the local law enforcement agency having jurisdiction to notify media and alert subscribers if a Purple Alert is determined to be necessary and appropriate; authorizing the local law enforcement agency having jurisdiction to request that a case be opened with the Department of Law Enforcement's Missing Endangered Persons Information Clearinghouse; requiring the clearinghouse to coordinate with the Department of Transportation and the Department of Highway Safety and Motor Vehicles in the activation of dynamic message signs on state highways and the immediate distribution of certain critical information under certain circumstances;

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

requiring the Purple Alert process to include certain procedures and an information and education strategy; authorizing the Department of Law Enforcement to adopt rules; amending s. 937.021, F.S.; providing that the Department of Law Enforcement, as the Purple Alert coordinator, and certain agencies, employees, individuals, and entities are immune from civil liability for damages when performing certain actions in good faith; providing that the presumption of good faith is not overcome under certain circumstances; providing construction; amending s. 937.022, F.S.; authorizing only the law enforcement agency having jurisdiction over a case to make a request to the clearinghouse for the activation of a Purple Alert involving a missing adult under certain circumstances; amending s. 429.918, F.S.; conforming provisions to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (z) is added to subsection (2) of section 252.35, Florida Statutes, to read:

252.35 Emergency management powers; Division of Emergency Management.—

(2) The division is responsible for carrying out the provisions of ss. 252.31-252.90. In performing its duties, the division shall:

(z) Identify and maintain an inventory of available digitally displayed automatic changeable facing signs capable of

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providing the immediate distribution of critical information to the public in times of declared emergency and regarding missing endangered persons.

Section 2. Subsection (4) of section 937.0201, Florida Statutes, is amended to read:

937.0201 Definitions.—As used in this chapter, the term:

(4) "Missing endangered person" means any of the following:

(a) A missing child.~~;~~

(b) A missing adult younger than 26 years of age.~~;~~

(c) A missing adult 26 years of age or older who is suspected by a law enforcement agency of being endangered or the victim of criminal activity.~~; or~~

(d) A missing adult who meets the criteria for activation of the Silver Alert Plan of the Department of Law Enforcement.

(e) A missing adult who meets the criteria for activation of the Purple Alert of the Department of Law Enforcement pursuant to s. 937.0205.

Section 3. Section 937.0205, Florida Statutes, is created to read:

937.0205 Purple Alert.—

(1) The Legislature finds that a standardized state system is necessary to aid in the search for a missing adult identified in paragraph (4)(a). The Legislature also finds that a coordinated local law enforcement and state agency response with prompt and widespread sharing of information will improve the chances of finding the person.

(2) It is the intent of the Legislature to establish the Purple Alert, to be implemented in a manner that, to the extent practicable, safeguards the privacy rights and related health

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and diagnostic information of such missing adults.

(3) The Department of Law Enforcement, in cooperation with the Department of Transportation, the Department of Highway Safety and Motor Vehicles, the Department of the Lottery, and local law enforcement agencies, shall establish and implement the Purple Alert. At a minimum, the Purple Alert must:

(a) Be the only viable means by which the missing adult is likely to be returned to safety;

(b) Provide, to the greatest extent possible, for the protection of the privacy, dignity, and independence of the missing adult by including standards aimed at safeguarding these civil liberties by preventing the inadvertent or unnecessary broadcasting or dissemination of sensitive health and diagnostic information;

(c) Limit the broadcasting and dissemination of alerts and related information to the geographic areas where the missing adult could reasonably be, considering his or her circumstances and physical and mental condition, the potential modes of transportation available to him or her or suspected to be involved, and the known or suspected circumstances of his or her disappearance; and

(d) Be activated only when there is sufficient descriptive information about the missing adult and the circumstances surrounding his or her disappearance to indicate that activating the alert is likely to help locate the missing adult.

(4)(a) Under a Purple Alert, a local law enforcement agency may broadcast to the media and to persons who subscribe to receive alert notifications under this section information concerning a missing adult:

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1. Who has a mental or cognitive disability; an intellectual disability or a developmental disability, as those terms are defined in s. 393.063; a brain injury; another physical, mental, or emotional disability that is not related to substance abuse; or a combination of any of these;

2. Whose disappearance indicates a credible threat of immediate danger or serious bodily harm to himself or herself, as determined by the local law enforcement agency;

3. Who cannot be returned to safety without law enforcement intervention; and

4. Who does not meet the criteria for activation of a local Silver Alert or the Silver Alert Plan of the Department of Law Enforcement.

(b) If a Purple Alert is determined to be necessary and appropriate, the local law enforcement agency having jurisdiction must notify the media and subscribers in the jurisdiction or jurisdictions where the missing adult is believed to or may be located. The local law enforcement agency having jurisdiction may also request that the Purple Alert notification be broadcast on lottery terminals within the geographic regions where the missing adult may reasonably be, including, but not limited to, lottery terminals in gas stations, convenience stores, and supermarkets.

(c) Under the Purple Alert, the local law enforcement agency having jurisdiction may also request that a case be opened with the Department of Law Enforcement’s Missing Endangered Persons Information Clearinghouse. To enhance local or regional efforts when the investigation indicates that an identifiable vehicle is involved, the clearinghouse must

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coordinate with the Department of Transportation and the Department of Highway Safety and Motor Vehicles for the activation of dynamic message signs on state highways and the immediate distribution of critical information to the public regarding the missing adult in accordance with the alert.

(5) The Purple Alert process must include procedures to monitor the use, activation, and results of alerts and a strategy for informing and educating law enforcement, the media, and other stakeholders concerning the alert.

(6) The Department of Law Enforcement may adopt rules to implement and administer this section.

Section 4. Paragraphs (c), (d), and (e) of subsection (5) of section 937.021, Florida Statutes, are amended to read:

937.021 Missing child and missing adult reports.—

(5)

(c) Upon receiving a request to record, report, transmit, display, or release Silver Alert or Purple Alert information from the law enforcement agency having jurisdiction over the missing adult, the Department of Law Enforcement as the state Silver Alert and Purple Alert coordinator, any state or local law enforcement agency, and the personnel of these agencies; any radio or television network, broadcaster, or other media representative; any dealer of communications services as defined in s. 202.11; or any agency, employee, individual, or entity is immune from civil liability for damages for complying in good faith with the request and is presumed to have acted in good faith in recording, reporting, transmitting, displaying, or releasing Silver Alert or Purple Alert information pertaining to the missing adult.

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(d) The presumption of good faith is not overcome if a technical or clerical error is made by any agency, employee, individual, or entity acting at the request of the local law enforcement agency having jurisdiction, or if the Amber Alert, Missing Child Alert, missing child information, missing adult information, or Silver Alert or Purple Alert information is incomplete or incorrect because the information received from the local law enforcement agency was incomplete or incorrect.

(e) Neither this subsection nor any other ~~provision of~~ law creates a duty of the agency, employee, individual, or entity to record, report, transmit, display, or release the Amber Alert, Missing Child Alert, missing child information, missing adult information, or Silver Alert or Purple Alert information received from the local law enforcement agency having jurisdiction. The decision to record, report, transmit, display, or release information is discretionary with the agency, employee, individual, or entity receiving the information.

Section 5. Paragraph (b) of subsection (3) of section 937.022, Florida Statutes, is amended to read:

937.022 Missing Endangered Persons Information Clearinghouse.—

(3) The clearinghouse shall:

(b) Provide a centralized file for the exchange of information on missing endangered persons.

1. Every state, county, or municipal law enforcement agency shall submit to the clearinghouse information concerning missing endangered persons.

2. Any person having knowledge may submit a missing endangered person report to the clearinghouse concerning a child

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or adult younger than 26 years of age whose whereabouts is unknown, regardless of the circumstances, subsequent to reporting such child or adult missing to the appropriate law enforcement agency within the county in which the child or adult became missing, and subsequent to entry by the law enforcement agency of the child or person into the Florida Crime Information Center and the National Crime Information Center databases. The missing endangered person report shall be included in the clearinghouse database.

3. Only the law enforcement agency having jurisdiction over the case may submit a missing endangered person report to the clearinghouse involving a missing adult age 26 years or older who is suspected by a law enforcement agency of being endangered or the victim of criminal activity.

4. Only the law enforcement agency having jurisdiction over the case may make a request to the clearinghouse for the activation of a state Silver Alert <u>or a Purple Alert</u> involving a missing adult if circumstances regarding the disappearance have met the criteria for activation of the Silver Alert Plan <u>or the Purple Alert</u>.

Section 6. Paragraph (d) of subsection (6) and subsection (9) of section 429.918, Florida Statutes, are amended to read:

429.918 Licensure designation as a specialized Alzheimer's services adult day care center.—

(6)

(d) Each employee hired on or after July 1, 2012, who provides direct care to ADRD participants, must receive and review an orientation plan that includes, at a minimum:

1. Procedures to locate an ADRD participant who has

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wandered from the center. These procedures shall be reviewed regularly with all direct care staff.

2. Information on the Silver Alert program and the Purple Alert in this state.

3. Information regarding available products or programs used to identify ADRD participants or prevent them from wandering away from the center, their home, or other locations.

(9) An adult day care center having a license designated under this section must give to each person who enrolls as an ADRD participant in the center, or the caregiver, a copy of the ADRD participant's plan of care, as well as information regarding resources to assist in ensuring the safety and security of the ADRD participant, which must include, but need not be limited to, information pertaining to driving for those persons affected by dementia, available technology on wandering-prevention devices and identification devices, the Silver Alert program and the Purple Alert in this state, and dementia-specific safety interventions and strategies that can be used in the home setting.

Section 7. This act shall take effect July 1, 2022.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: CS/SB 184
FINAL ACTION: Favorable
MEETING DATE: Tuesday, February 16, 2021
TIME: 9:00—11:30 a.m.
PLACE: 37 Senate Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Brodeur						
X		Garcia						
X		Harrell						
X		Rouson						
X		Torres						
X		Wright						
X		Albritton, VICE CHAIR						
X		Book, CHAIR						
8	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 184
INTRODUCER:	Transportation Committee and Senator Berman
SUBJECT:	Purple Alert
DATE:	February 15, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Proctor	Vickers	TR	**Fav/CS**
2.	Delia	Cox	CF	**Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 184 requires the Division of Emergency Management to identify and maintain an inventory of available digitally displayed automatic changeable facing signs capable of providing the immediate distribution of critical information to the public in times of declared emergency and regarding missing endangered persons.

It also establishes criteria and processes for issuing Purple Alerts to assist in finding missing adults with developmental disabilities, brain injuries, or other disabilities not related to substance abuse.

The fiscal impact to state and local governments is indeterminate. Please see Section V Fiscal Impact Statement for additional information.

The bill has an effective date of July 1, 2022.

II. Present Situation:

Florida Statutory Alerts

Section 937.021, F.S., requires law enforcement agencies (LEAs) in this state to adopt written policies that specify the procedures to be used to investigate reports of missing children and missing adults. Section 937.022, F.S., creates the Missing Endangered Persons Information

Clearinghouse (MEPIC) within the Florida Department of Law Enforcement (FDLE) "to serve as a central repository of information regarding missing endangered persons." Every state, county, or municipal LEA to submit to the clearinghouse information on missing endangered persons, which information must be "collected and disseminated to assist in the location of missing endangered persons."[1]

A Missing Child Alert is intended to enable law enforcement to quickly disseminate information when a child is missing and believed to be in life-threatening danger, but there is no indication that the child has been abducted.[2] A Missing Child Alert may result in an AMBER Alert if investigation produces an indication that the child has been abducted.[3] A state Silver Alert is intended to aid law enforcement in the rescue or recovery of a missing elderly person who suffers from irreversible deterioration of intellectual faculties[4] and becomes lost while driving a vehicle.[5]

Generally, in each case, the local LEA with jurisdiction contacts the FDLE's MEPIC. The FDLE works with the local LEA to determine whether information will be broadcast on a regional or statewide basis and prepares information for public distribution through the Emergency Alert System, wireless emergency alerts, the Department of Transportation's (FDOT) 511 traveler information system[6] and dynamic message signs, lottery machines, and email, as appropriate.[7]

With respect to use of the FDOT's dynamic message signs, after contact from the FDLE, the appropriate FDOT Regional Transportation Management Center is ultimately responsible for displaying alert messages on those signs. If the alert message is:

- A Missing Child Alert or a Silver Alert, the message is displayed for a maximum of six hours and is re-activated if the FDLE requests it, but only in the specific area the law enforcement believes the child may be located.
- An AMBER Alert, the message is displayed until the child is recovered or for a maximum of 24 hours, again re-activated upon the FDLE's request only in the specific area law enforcement believes the child may be located.[8]

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[1] Section 937.022(3)(b), F.S.
[2] The Florida Department of Law Enforcement (the FDLE) Missing Endangered Persons Information Clearinghouse, *Florida's Missing Child Alert*, available at http://www.fdle.state.fl.us/mcicsearch/MCApage.asp (last visited February 10, 2021).
[3] The FDLE Missing Endangered Persons Information Clearinghouse, *AMBER Alerts*, available at http://www.fdle.state.fl.us/mcicsearch/Amber.asp (last visited February 10, 2021).
[4] The FDLE Missing Endangered Persons Information Clearinghouse, *Florida's Silver Alert Plan,* available at http://www.fdle.state.fl.us/mcicsearch/SilverAlerts.asp (last visited February 10, 2021).
[5] *See Florida Missing Persons and Blue Alert Plans*, The FDLE and The Florida Department of Transportation, p. 1. (On file in the Senate Committee on Transportation)(hereinafter cited as "Missing Persons and Blue Alert Plans"). *See also* FDLE, *Florida's Silver Alert Plan*, available at http://www.fdle.state.fl.us/Silver-Alert-Plan/Silver-Alert-Plan (last visited February 10, 2021).
[6] *See* s. 334.044(31) and s. 334.60, F.S. The 511 System is used only while dynamic message signs are displayed. *See also* Missing Persons and Blue Alert Plans, p. 4.
[7] Missing Persons and Blue Alert Plans, pp. 1-5.
[8] Missing Persons and Blue Alert Plans, pp. 4-5.

Section 937.021(5), F.S., provides immunity from civil liability for complying in good faith with a request to record, report, transmit, display, or release Missing Child, AMBER, and Silver Alert information.

Section 784.071, F.S., authorizes Blue Alerts and the FDLE will issue a Blue Alert if a law enforcement officer has been killed, suffered serious bodily injury, or been assaulted with a deadly weapon; or is missing while in the line of duty or under circumstances indicating concern for an officer's safety; and the suspect has fled the scene and poses an imminent threat to the public or to other law enforcement officers.

The FDLE, in conjunction with the Florida Highway Patrol, the FDOT, and the Department of Lottery, broadcasts information to the public through the Emergency Alert System on television and radio when information about an offender would help avert further harm or assist in apprehending a suspect in connection with killing or harming a law enforcement officer.[9] In such cases, dynamic message signs are also used to display Blue Alerts.[10] These alerts use the technologies employed for Amber Alerts.[11] At the request of a local LEA, the FDLE Intelligence Watch and Warning Regional Special Agency Supervisor works with the investigating agency to prepare information for public release, include suspect and/or vehicle information. The FDLE works with the FDOT's Regional Transportation Management Center, which is ultimately responsible for displaying Blue Alert messages on the dynamic message signs. Again, the alert is displayed for a maximum of six hours, with re-activation upon FDLE request in the specific area that law enforcement believes the person may be located.[12]

The FDOT observes the following orders of priority with respect to these alert messages on dynamic message signs:

- If there are multiple alerts activated during the same time: AMBER, Missing Child, Blue, and Silver.
- If there are multiple AMBER, Missing Child, or Blue Alerts activated during the same time, each one is displayed on every other dynamic message sign.[13]

Missing Endangered Persons

Section 937.0201(4), F.S., defines the term "missing endangered person" for purposes of missing person investigations to mean:

- A missing child;
- A missing adult younger than 26 years of age;
- A missing adult 26 years of age or older who is suspected by an LEA of being endangered or the victim of criminal activity; or
- A missing adult who meets the criteria for activation of the Silver Alert Plan[14] of the FDLE.

[9] Missing Persons and Blue Alert Plans.
[10] Section 784.071(2)(a), F.S.
[11] FDLE, *Florida Blue Alert Notification System*, available at http://floridabluealert.com/ (last visited February 10, 2021).
[12] Missing Persons and Blue Alert Plans, pp. 4-5.
[13] *Id.* at p. 5.
[14] Both local (missing on foot) and state (missing in vehicle) Silver Alerts are currently used to locate missing persons suffering from an irreversible deterioration of intellectual faculties. *See* FDLE, *Silver Activation Steps*, available at

Alzheimer's Participants

Section 429.918, F.S., relating to licensure designation as a specialized Alzheimer's services adult day care center, requires a number of requirements for such day centers to operate, including, among other requirements that:

- Employees hired to provide direct care to ADRD participants[15] must receive and review an orientation plan that includes information on the Silver Alert Plan; and
- ADRD participants (or caregivers) must be provided a copy of the participant's plan of care and information regarding resources to assist in ensuring the safety and security of a participant, which must include (among other items) information on the Silver Alert Plan.

Civil Immunity

Florida law provides civil immunity to certain individuals in specified circumstances who, acting in good faith, attempt to render aid to others.[16] Section 937.021, F.S., currently provides civil immunity for specified entities requested by law enforcement to record, report, transmit, display, or release information pertaining to a missing person if such entity complied with the request in good faith.[17] These entities include:

- The FDLE, a state or local law enforcement agency, and agency personnel;
- A radio or television network, broadcaster, or other media representative; or
- A dealer of communications services as defined in s. 202.11, F.S.[18]

Entities who report, transmit, display, or release information pertaining to a missing person are presumed to have acted in good faith.[19] The presumption of good faith is not overcome if a technical or clerical error is made by an agency, employee, individual, or entity acting at the request of the local law enforcement agency having jurisdiction or if the missing person information is incomplete or incorrect because the information received from the local law enforcement agency was incomplete or incorrect.[20]

III. Effect of Proposed Changes:

The bill establishes criteria and processes for Purple Alerts.

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http://www.fdle.state.fl.us/Silver-Alert-Plan/Activation-Steps (last visited February 11, 2021)(hereinafter cited as "Silver Activation Steps"). This site lists the criteria for both local and state Silver Alerts.

[15] Section 429.918, F.S., defines the term "ADRD participant" to mean a participant who has a documented diagnosis of Alzheimer's disease or a dementia-related disorder (ADRD) from a licensed physician, licensed physician assistant, or a licensed advanced practice registered nurse.

[16] For example, Section 768.13, F.S. (also known as Florida's Good Samaritan Act (GSA)) provides immunity from civil liability for persons acting in good faith who render emergency care and treatment to individuals in need of assistance. Under the GSA, immunity from civil liability is available to any person who gratuitously and in good faith renders emergency assistance without the objection of a victim, if the person acts as a reasonably prudent person would act under similar circumstances.

[17] Section 937.021(5)(a), F.S.

[18] Examples of a dealer of communications services include a cable or satellite television service provider, a telephone service provider, or a mobile communication service provider. s. 937.021, F.S.

[19] Section 937.021(5)(c), F.S.

[20] *Id.*

Section 1 amends s. 252.35, F.S., relating to duties of the Division of Emergency Management, to add a requirement that the division identify and maintain an inventory of available digitally displayed automatic changeable facing signs capable of providing the immediate distribution of critical information to the public in times of declared emergency and regarding missing endangered persons.

Section 2 amends s. 937.0201, F.S., relating definitions for purposes of missing person investigations. The bill includes in the definition of "missing endangered person" a missing adult who meets the criteria for activation of the Purple Alert of the FDLE pursuant to s. 937.0205, F.S., created by the bill.

Section 3 creates s. 937.0205, entitled *Purple Alert.* The bill expresses the following Legislative findings:

- A standardized state system is necessary to aid in the search of certain missing adults (identified and discussed below).
- A coordinated local law enforcement and state agency response with prompt and widespread sharing of information will improve the chances of finding the person.

The bill also recites the Legislature's intent to establish the Purple Alert, implemented in a manner that, to the extent practicable, safeguards the privacy rights and related health diagnostic information of such missing adults.

The bill directs the FDLE, in cooperation with the FDOT, the Department of Highway Safety and Motor Vehicles (DHSMV), the Department of the Lottery, and local LEAs, to establish and implement the Purple Alert. At a minimum, the Purple Alert must:

- Be the only viable means by which the missing adult is likely to be returned to safety;
- Provide, to the greatest extent possible, for the protection of the privacy, dignity, and independence of the missing adult by including standards aimed at safeguarding these civil liberties by preventing the inadvertent or unnecessary broadcasting or dissemination of sensitive health and diagnostic information;
- Provide that the broadcasting and dissemination of alerts and related information be limited to the geographic areas where the missing adult could reasonably be, considering his or her circumstances and physical and mental condition, the potential modes of transportation available to him or her or suspected to be involved, and the known or suspected circumstances of his or her disappearance; and
- Be activated only when there is sufficient descriptive information about the missing adult and the circumstances surrounding his or her disappearance to indicate that activating the alert is likely to help locate the missing adult.

The bill authorizes (but does not require) a local LEA, under a Purple Alert, to broadcast to the media and to persons who subscribe to receive alert notifications information concerning a missing adult:

- Who has a mental or cognitive disability; an intellectual disability or a development disability, as those terms are defined in s. 393.063;[21] a brain injury; another physical, mental,

[21] That section defines "intellectual disability" to mean significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior which manifests before the age of 18 and can reasonably be expected to

or emotional disability that is not related to substance abuse; or a combination of any of these;
- Whose disappearance indicates a credible threat of immediate danger or serious bodily harm to himself or herself, as determined by the local LEA;
- Who cannot be returned to safety without law enforcement intervention; and
- Who does not meet the criteria for activation of a local Silver Alert or the Silver Alert Plan of the FDLE.[22]

If a Purple Alert is determined to be necessary and appropriate, the local law enforcement agency having jurisdiction must notify the media and subscribers in the jurisdiction or jurisdictions where the missing adult is believed to or may be located. The local law enforcement agency having jurisdiction may also request that the Purple Alert notification be broadcast on lottery terminals within the geographic regions where the missing adult may reasonably be, including, but not limited to, lottery terminals in gas stations, convenience stores, and supermarkets.

The local jurisdictional LEA is also authorized to request that a case be opened with the FDLE's MEPIC. To enhance local or regional efforts when the investigation indicates that an identifiable vehicle is involved, the MEPIC is required to coordinate with the FDOT and the DHSMV for the activation of dynamic message signs on state highways and the immediate distribution of critical information to the public regarding the missing adult in accordance with the alert.

The bill requires the Purple Alert process to include procedures to monitor the use, activation, and results of alerts and a strategy for informing and educating law enforcement, the media, and other stakeholders concerning the alert. Lastly, this section of the bill authorizes the FDLE to adopt rules to implement and administer the new section of law.

Missing adults who meet the criteria for activation of a Purple Alert, their caregivers and families, as well as the general public may benefit from improved communication of emergency information through Purple Alerts. However, to receive Purple Alerts, individuals must be subscribers in the jurisdiction or jurisdictions where the missing adult is believed to or may be located, see the alerts on lottery terminals in gas stations, convenience stores, or supermarkets or on dynamic message signs along the State Highway System, or otherwise gain knowledge of a Purple Alert following notification of the media by the local jurisdictional LEA.

Section 4 amends s. 937.021, F.S., relating to missing child and missing adult reports, to include Purple Alerts in the existing provisions relating to immunity from civil liability for law enforcement agencies, broadcasters, and other entities acting in good faith when involved in issuing Missing Child Alerts, AMBER Alerts, and Silver Alerts.

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continue indefinitely. For the purposes of this definition, the term: (a) "Adaptive behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community. (b) "Significantly subaverage general intellectual functioning" means performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in the rules of the agency. "Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

[22] *See* Silver Activation Steps. *See also* FDLE Missing Endangered Persons Information Clearinghouse, *Florida's Silver Alert Plan*, available at http://www.fdle.state.fl.us/mcicsearch/SilverAlerts.asp (last visited February 11, 2021).

Section 5 amends s. 937.022, F.S., relating to the MEPIC, to include Purple Alerts in this provision. This will limit the activation of the Purple Alerts to only the LEA having jurisdiction over a case may make a request to the MEPIC for the activation for activation of a Purple Alert if the criteria for issuance are met. This is the same limitation for the activation of Silver Alert Plan discussed above.

Section 6 amends s. 429.918, F.S., requiring ADRD participants to receive and review similar information on the Purple Alert as is provided related to the Silver Alert Plan.

Section 8 provides an effective date of July 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The FDLE estimates that to implement the bill, it will need three Crime Intelligence Analyst I FTE positions totaling $165,735 ($155,262 recurring). Additionally, the FDLE indicates that the cost of necessary modifications to existing information technology will

total $170,000 and take approximately 12 months to complete. The FDLE will be required to create policies and procedures on how to activate and cancel Purple Alerts but the department did not estimate the cost of such activities.[23]

The fiscal impact to the FDOT relating to display of Purple Alerts on dynamic message signs is indeterminate, as the potential increase in volume of alerts cannot be determined.

The DHSMV notes the bill will result in a significant workload increase for the Florida Highway Patrol, especially the regional communications center ultimately assigned to coordinate Purple Alerts. At this time, the workload increase is expected to be absorbed within existing resources at this time. However, the DHSMV states that it will monitor the workload increase to determine if additional staff may be necessary at a future time to address the workload.[24]

Local jurisdictional LEAs will incur indeterminate expenses associated with notifying the media and subscribers as authorized under the bill, and with developing any necessary policies and training and establishing or enhancing necessary infrastructure and systems.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 252.35, 937.0201, 937.021, 937.022, and 429.918.

This bill creates section 937.0205 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Committee on Transportation on February 2, 2021:

- Removes the appropriation of $152,836 in recurring funds and $170,000 in nonrecurring funds from the General Revenue Fund, and the three full-time equivalent positions.

[23] *See* the FDLE 2021 Legislative Bill Analysis for SB 184 on file with the Senate Committee on Transportation.
[24] *See* the DHSMV 2021 Legislative Bill Analysis for SB 184 on file with the Senate Committee on Transportation.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Harrell

25-00632-21 2021590__

A bill to be entitled

An act relating to involuntary examinations of minors; amending s. 381.0056, F.S.; revising parent, guardian, or caregiver notification requirements that must be met before an involuntary examination of a minor; amending s. 394.463, F.S.; revising data reporting requirements for the Department of Children and Families; amending s. 1001.212, F.S.; revising data reporting requirements for the Office of Safe Schools; amending s. 1002.20, F.S.; revising parent and guardian notification requirements that must be met before conducting an involuntary examination of a minor who is removed from school, school transportation, or a school-sponsored activity; providing an exception; amending s. 1002.33, F.S.; revising parent and guardian notification requirements that must be met before an involuntary examination of a minor who is removed from a charter school, charter school transportation, or a charter school-sponsored activity; providing an exception; amending s. 1006.07, F.S.; creating reporting requirements for schools relating to involuntary examinations of minors; amending s. 1006.12, F.S.; revising training requirements for school safety officers; amending s. 1011.62, F.S.; requiring that certain plans include procedures to assist certain mental and behavioral health providers in attempts to verbally deescalate certain crisis situations before initiating an involuntary examination; requiring the procedures to

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include certain strategies; creating requirements for memoranda of understanding between schools and local mobile crisis response services; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (4) of section 381.0056, Florida Statutes, is amended to read:

381.0056 School health services program.—

(4)(a) Each county health department shall develop, jointly with the district school board and the local school health advisory committee, a school health services plan. The plan must include, at a minimum, provisions for all of the following:

1. Health appraisal;
2. Records review;
3. Nurse assessment;
4. Nutrition assessment;
5. A preventive dental program;
6. Vision screening;
7. Hearing screening;
8. Scoliosis screening;
9. Growth and development screening;
10. Health counseling;
11. Referral and followup of suspected or confirmed health problems by the local county health department;
12. Meeting emergency health needs in each school;
13. County health department personnel to assist school personnel in health education curriculum development;

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

14. Referral of students to appropriate health treatment, in cooperation with the private health community whenever possible;

15. Consultation with a student's parent or guardian regarding the need for health attention by the family physician, dentist, or other specialist when definitive diagnosis or treatment is indicated;

16. Maintenance of records on incidents of health problems, corrective measures taken, and such other information as may be needed to plan and evaluate health programs; except, however, that provisions in the plan for maintenance of health records of individual students must be in accordance with s. 1002.22;

17. Health information which will be provided by the school health nurses, when necessary, regarding the placement of students in exceptional student programs and the reevaluation at periodic intervals of students placed in such programs;

18. Notification to the local nonpublic schools of the school health services program and the opportunity for representatives of the local nonpublic schools to participate in the development of the cooperative health services plan; and

19. ~~Immediate~~ Notification to a student's parent, guardian, or caregiver before ~~if~~ the student is removed from school, school transportation, or a school-sponsored activity to be ~~and~~ taken to a receiving facility for an involuntary examination pursuant to s. 394.463, including and subject to the requirements and exceptions established under ss. 1002.20(3) and 1002.33(9), as applicable.

Section 2. Subsection (4) of section 394.463, Florida Statutes, is amended to read:

394.463 Involuntary examination.—

(4) DATA ANALYSIS.—Using data collected under paragraph (2)(a), the department shall, at a minimum, analyze data on both the initiation of involuntary examinations of children and the initiation of involuntary examinations of students who are removed from a school, identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child or student, study root causes for such patterns, trends, or repeated involuntary examinations, and make recommendations to encourage the use of ~~for encouraging~~ alternatives to eliminate ~~and eliminating~~ inappropriate initiations of such examinations. The department shall submit a report on its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1 of each odd-numbered ~~odd numbered~~ year.

Section 3. Subsection (7) of section 1001.212, Florida Statutes, is amended to read:

1001.212 Office of Safe Schools.—There is created in the Department of Education the Office of Safe Schools. The office is fully accountable to the Commissioner of Education. The office shall serve as a central repository for best practices, training standards, and compliance oversight in all matters regarding school safety and security, including prevention efforts, intervention efforts, and emergency preparedness planning. The office shall:

(7) Provide data to support the evaluation of mental health services pursuant to s. 1004.44. Such data must include, for each school, the number of involuntary examinations as defined

in s. 394.455 which are initiated at the school, on school transportation, or at a school-sponsored activity and the number of children for whom an examination is initiated.

Section 4. Paragraph (l) of subsection (3) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(3) HEALTH ISSUES.—

(l) *Notification of involuntary examinations.*—

1. Except as provided in subparagraph 2., the public school principal or the principal's designee shall ~~immediately~~ notify the parent of a student before the student ~~who~~ is removed from school, school transportation, or a school-sponsored activity to be ~~and~~ taken to a receiving facility for an involuntary examination pursuant to s. 394.463.

2. The principal or the principal's designee may delay the required notification for no more than 24 hours after the student is removed if:

a. The principal or the principal's designee deems the delay to be in the student's best interest and ~~if~~ a report has been submitted to the central abuse hotline, pursuant to s. 39.201, based upon knowledge or suspicion of abuse, abandonment, or neglect; or

b. The principal or principal's designee reasonably believes that such delay is necessary to avoid jeopardizing the

health and safety of the student.

3. Before a principal or his or her designee contacts a law enforcement officer, he or she must verify that deescalation ~~de-escalation~~ strategies have been utilized and outreach to a mobile response team has been initiated unless the principal or the principal's designee reasonably believes that any delay in removing the student will increase the likelihood of harm to the student or others. This requirement does not supersede the authority of a law enforcement officer to act under s. 394.463.

Each district school board shall develop a policy and procedures for notification under this paragraph.

Section 5. Paragraph (q) of subsection (9) of section 1002.33, Florida Statutes, is amended to read:

1002.33 Charter schools.—

(9) CHARTER SCHOOL REQUIREMENTS.—

(q)1. The charter school principal or the principal's designee shall ~~immediately~~ notify the parent of a student before the student ~~who~~ is removed from school, school transportation, or a school-sponsored activity to be ~~and~~ taken to a receiving facility for an involuntary examination pursuant to s. 394.463.

2. The principal or the principal's designee may delay notification for no more than 24 hours after the student is removed if:

a. The principal or the principal's designee deems the delay to be in the student's best interest and ~~if~~ a report has been submitted to the central abuse hotline, pursuant to s. 39.201, based upon knowledge or suspicion of abuse, abandonment, or neglect; or

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

b. The principal or principal's designee reasonably believes that such delay is necessary to avoid jeopardizing the health and safety of the student.

3. Before a principal or his or her designee contacts a law enforcement officer, he or she must verify that deescalation ~~de-escalation~~ strategies have been utilized and outreach to a mobile response team has been initiated unless the principal or the principal's designee reasonably believes that any delay in removing the student will increase the likelihood of harm to the student or others. This requirement does not supersede the authority of a law enforcement officer to act under s. 394.463.

Each charter school governing board shall develop a policy and procedures for notification under this paragraph.

Section 6. Subsection (10) is added to section 1006.07, Florida Statutes, to read:

1006.07 District school board duties relating to student discipline and school safety.—The district school board shall provide for the proper accounting for all students, for the attendance and control of students at school, and for proper attention to health, safety, and other matters relating to the welfare of students, including:

(10) REPORTING OF INVOLUNTARY EXAMINATIONS.—Each district school board shall adopt a policy to require the district superintendent to annually report to the department the number of involuntary examinations, as defined in s. 394.455, which are initiated at a school, on school transportation, or at a school-sponsored activity.

Section 7. Present paragraph (c) of subsection (2) of

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

section 1006.12, Florida Statutes, is redesignated as paragraph (d), and a new paragraph (c) is added to that subsection, to read:

1006.12 Safe-school officers at each public school.—For the protection and safety of school personnel, property, students, and visitors, each district school board and school district superintendent shall partner with law enforcement agencies or security agencies to establish or assign one or more safe-school officers at each school facility within the district, including charter schools. A district school board must collaborate with charter school governing boards to facilitate charter school access to all safe-school officer options available under this section. The school district may implement any combination of the options in subsections (1)-(4) to best meet the needs of the school district and charter schools.

(2) SCHOOL SAFETY OFFICER.—A school district may commission one or more school safety officers for the protection and safety of school personnel, property, and students within the school district. The district school superintendent may recommend, and the district school board may appoint, one or more school safety officers.

(c) School safety officers must complete mental health crisis intervention training using a curriculum developed by a national organization with expertise in mental health crisis intervention. The training shall improve officers' knowledge and skills as first responders to incidents involving students with emotional disturbance or mental illness, including deescalation skills to ensure student and officer safety.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

If a district school board, through its adopted policies, procedures, or actions, denies a charter school access to any safe-school officer options pursuant to this section, the school district must assign a school resource officer or school safety officer to the charter school. Under such circumstances, the charter school's share of the costs of the school resource officer or school safety officer may not exceed the safe school allocation funds provided to the charter school pursuant to s. 1011.62(15) and shall be retained by the school district.

Section 8. Paragraph (b) of subsection (16) of section 1011.62, Florida Statutes, is amended to read:

1011.62 Funds for operation of schools.—If the annual allocation from the Florida Education Finance Program to each district for operation of schools is not determined in the annual appropriations act or the substantive bill implementing the annual appropriations act, it shall be determined as follows:

(16) MENTAL HEALTH ASSISTANCE ALLOCATION.—The mental health assistance allocation is created to provide funding to assist school districts in establishing or expanding school-based mental health care; train educators and other school staff in detecting and responding to mental health issues; and connect children, youth, and families who may experience behavioral health issues with appropriate services. These funds shall be allocated annually in the General Appropriations Act or other law to each eligible school district. Each school district shall receive a minimum of $100,000, with the remaining balance allocated based on each school district's proportionate share of the state's total unweighted full-time equivalent student

enrollment. Charter schools that submit a plan separate from the school district are entitled to a proportionate share of district funding. The allocated funds may not supplant funds that are provided for this purpose from other operating funds and may not be used to increase salaries or provide bonuses. School districts are encouraged to maximize third-party health insurance benefits and Medicaid claiming for services, where appropriate.

(b) The plans required under paragraph (a) must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care. At a minimum, the plans must include the following elements:

1. Direct employment of school-based mental health services providers to expand and enhance school-based student services and to reduce the ratio of students to staff in order to better align with nationally recommended ratio models. These providers include, but are not limited to, certified school counselors, school psychologists, school social workers, and other licensed mental health professionals. The plan also must identify strategies to increase the amount of time that school-based student services personnel spend providing direct services to students, which may include the review and revision of district staffing resource allocations based on school or student mental

health assistance needs.

2. Contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Team services to provide a behavioral health staff presence and services at district schools. Services may include, but are not limited to, mental health screenings and assessments, individual counseling, family counseling, group counseling, psychiatric or psychological services, trauma-informed care, mobile crisis services, and behavior modification. These behavioral health services may be provided on or off the school campus and may be supplemented by telehealth.

3. Policies and procedures, including contracts with service providers, which will ensure that students who are referred to a school-based or community-based mental health service provider for mental health screening for the identification of mental health concerns and ensure that the assessment of students at risk for mental health disorders occurs within 15 days of referral. School-based mental health services must be initiated within 15 days after identification and assessment, and support by community-based mental health service providers for students who are referred for community-based mental health services must be initiated within 30 days after the school or district makes a referral.

4. Strategies or programs to reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems, depression, anxiety disorders, suicidal tendencies, or substance use disorders.

5. Strategies to improve the early identification of

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social, emotional, or behavioral problems or substance use disorders, to improve the provision of early intervention services, and to assist students in dealing with trauma and violence.

6. Procedures to assist a mental health services provider or a behavioral health provider as described in subparagraph 1. or subparagraph 2., respectively, or a school resource officer or school safety officer who has completed mental health crisis intervention training in attempting to verbally deescalate a student's crisis situation before initiating an involuntary examination pursuant to s. 394.463. Such procedures must include strategies to deescalate a crisis situation for a student with a developmental disability as that term is defined in s. 393.063.

7. A memorandum of understanding with a local mobile crisis response service. Policies of the school district and the terms of the memorandum of understanding must require that, in a student crisis situation, school or law enforcement personnel must contact the local mobile crisis response service before initiating an involuntary examination pursuant to s. 394.463. Such contact may be in person or by using telehealth as defined in s. 456.47. School districts shall provide all school resource officers and school safety officers with training on protocols established under the memorandum of understanding developed pursuant to this subparagraph.

Section 9. This act shall take effect July 1, 2021.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SB 590
FINAL ACTION: Favorable
MEETING DATE: Tuesday, February 16, 2021
TIME: 9:00—11:30 a.m.
PLACE: 37 Senate Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Brodeur						
X		Garcia						
X		Harrell						
X		Rouson						
X		Torres						
X		Wright						
X		Albritton, VICE CHAIR						
X		Book, CHAIR						
8	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

2021 AGENCY LEGISLATIVE BILL ANALYSIS
Department of Children and Families

BILL INFORMATION	
BILL NUMBER:	SB 590
BILL TITLE:	**Involuntary Examinations of Minors**
BILL SPONSOR:	Senator Harrell
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1) Children, Families, and Elder Affairs
2) Education
3) Appropriations
4)
5)

CURRENT COMMITTEE
Children, Families, and Elder Affairs

SIMILAR BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

IDENTICAL BILLS	
BILL NUMBER:	HB 383
SPONSOR:	Representative Plasencia

PREVIOUS LEGISLATION	
BILL NUMBER:	2020: SB 1062 2019: HB 685 / SB 1084 2018: HB 947
SPONSOR:	2020: Senate Children, Families, and Elder Affairs Committee; Sen. Harrell & Sen. Perry 2019: Rep. Silvers / Sen. Albritton 2018: House Children, Families & Seniors Subcommittee
YEAR:	2020, 2019, 2018
LAST ACTION:	2020 HB 1062: Died in Education on March 14, 2020 2019 HB 685: Died in PreK-12 Quality Subcommittee on May 3, 2019. SB 1084: Died in Senate Education Committee - Indefinitely postponed and withdrawn from consideration on May 3, 2019. 2018 HB 947: Died in Senate Messages on March 10, 2018.

Is this bill part of an agency package?
No.

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	January 19, 2021 For further information, please contact John Paul Fiore at (850) 488-9410.
LEAD AGENCY ANALYST:	Heather Allman, DCF, SAMH
ADDITIONAL ANALYST(S):	Devon Tran, DCF, SAMH Twila Jowers, DCF, SAMH
LEGAL ANALYST:	Ivory Avant, DCF, OGC
FISCAL ANALYST:	Julie Mayo, DCF, SAMH

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill 590 revises requirements for parental notification prior to removing a student for involuntary examination under certain circumstances. The bill also requires school resource officers to complete mental health crisis intervention training. It also requires school mental health assistance plans to include procedures to assist certain mental and behavioral health providers in attempts to verbally de-escalate certain crisis situations before initiating an involuntary examination. The bill requires the Department of Children and Families (Department) to collect certain data regarding the involuntary examination of students who are removed from school. This data must be analyzed and included in a report to the Governor and Legislature every odd-numbered year.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

The Department is the single state authority for mental health services in Florida. As authorized under s. 394.457, F.S., the Department and the Agency for Health Care Administration exercise executive and administrative supervision over all mental health facilities, programs, and services, including all Baker Act receiving facilities in Florida.

Section 1

Section 381.0056(4)(a), F.S., requires each Florida county health department, district school board, and local school health advisory committee to jointly develop and maintain a school health services plan. Currently, the requirements for the school health services plan mandate that schools immediately notify parents when a student is taken to a receiving facility for an involuntary examination.

In addition to the requirements for notification specified in ss. 1002.20, F. and 1002.33, F.S., s. 394.4599(2)(c), F.S., also requires that a receiving facility give notice of the whereabouts of a minor who is being involuntarily held for examination. Specifically, a receiving facility shall give notice of the whereabouts of a minor who is being involuntarily held for examination to the minor's parent, guardian, caregiver, or guardian advocate in person, by telephone, or other form of electronic communication immediately after the minor's arrival at the facility. The facility may delay notification for no more than 24 hours after the minor's arrival if the facility has submitted a report to the central abuse hotline, pursuant to s. 39.201, F.S., based upon knowledge or suspicion of abuse, abandonment, or neglect and if the facility deems a delay in notification to be in the minor's best interest.

Section 394.4599(2)(c), F.S., also requires that the receiving facility attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until the receiving facility receives confirmation from the parent, guardian, caregiver, or guardian advocate verbally by telephone, or other form of electronic communication, or by recorded message that notification has been received. Attempts to notify the parent, guardian, caregiver, or guardian advocate must be repeated at least once every hour during the first 12 hours after the minor's arrival and once every 24 hours thereafter and must continue until such confirmation is received, unless the minor is released at the end of the 72-hour examination period, or until a petition for involuntary services is filed with the court. The receiving facility may seek assistance from a law enforcement agency to notify the minor's parent, guardian, caregiver, or guardian advocate if the facility has not received, within the first 24 hours after the minor's arrival, a confirmation by the parent, guardian, caregiver, or guardian advocate that notification has been received. The receiving facility must document notification attempts in the minor's clinical record.

Section 2
Section 394.463(4), F.S., establishes requirements for the Department to collect and report Baker Act-related data on the initiation of involuntary examinations of children. The Department shall submit a report on its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1 of each odd-numbered year.

Section 3
Section 1001.212, F.S., creates the Office of Safe Schools and establishes the requirements and responsibilities of this office, including the evaluation of mental health services provided pursuant to s. 1004.44, F.S.

Section 4
Section 1002.20, F.S., contains provisions addressing K-12 student and parent rights to timely information. Currently, s. 1002.2(3)(l), F.S., requires a public-school principal or their designee to immediately notify the parent of a student who is removed from school, school transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination pursuant to s. 394.463, F.S. The principal or the principal's designee may delay notification for no more than 24 hours after the student is removed if the principal or designee deems the delay to be in the student's best interest and if a report has been submitted to the central abuse hotline, pursuant to s. 39.201, F.S., based upon knowledge or suspicion of abuse, abandonment, or neglect. Each district school board shall develop a policy and procedures for notification.

Section 5
Section 1002.33, F.S., establishes requirements for the formation, operation, and administration of a charter school. Currently, s. 1002.33(9)(q), F.S., requires a charter school principal or the principal's designee to immediately notify the parent of a student who is removed from school, school transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination pursuant to s. 394.463, F.S. The principal or the principal's designee may delay notification for no more than 24 hours after the student is removed if the principal or designee deems the delay to be in the student's best interest and if a report has been submitted to the central abuse hotline, pursuant to s. 39.201, F.S., based upon knowledge or suspicion of abuse, abandonment, or neglect. Each charter school governing board shall develop a policy and procedures for notification.

Section 6
Section 1006.07, F.S., establishes the duties for district school boards, which directs the school boards to provide the proper accounting for all students, for the attendance and control of students at school, and for proper attention to health, safety, and other matters relating to the welfare of students.

Section 7
Section 1006.12, F.S., establishes the requirements for school-safety officers at each public school.

Section 8
Section 1011.62, F.S., establishes the requirements for each school district to receive funding from the mental health assistance allocation and includes a requirement for the development and submission of plan to receive funding.

2. EFFECT OF THE BILL:

Section 1
This section amends s. 381.0056(4)(a)(19), F.S., to require public K-12 and charter schools to notify a student's parent, guardian, or caregiver prior to the removal of a student for involuntary examination. However, the principal or their designee may delay the required notification for no more than 24 hours if they reasonable determine it to be in the best interest of the student and a report has been submitted to the central abuse hotline, pursuant to s. 39.201, F.S., based upon knowledge or suspicion of abuse, abandonment, or neglect; or if such notification does not cause a delay that jeopardizes the student's health or safety.

As written, this section does not have an impact on the Department.

Section 2
This section revises s. 394.463, F.S., to require that data collected on the initiation of involuntary examination of children includes data on those initiations that result in the removal of a students from a school. This information will be used in the analysis of the patterns or trends and cases that involve the repeated use of involuntary examination of the same child or student and to study the root causes for those patterns and trends. This

information will be compiled into a report with recommendations and submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1, of each odd-numbered year.

The Department completed the first report required by this section November 1, 2019. Most of the data analyzed for the report was obtained through medical records reviews and was challenging for the Department to produce utilizing existing resources. The required Cover Sheet that accompanies the Baker Act forms sent to the Baker Act Reporting Center (BARC) at the University of South Florida, asks if the child was in school prior to the exam. According to the BARC, Baker Act receiving facilities frequently leave these items blank (do not answer the yes/no question). Efforts are under way to review the data elements included in the Cover Sheet and Baker Act forms in order to improve the quality of data collected and reported by the BARC. This will require the revision of forms through rule development to amend Rule 65E-5 of the Florida Administrative Code.

The Department also continues its work with the Agency for Health Care Administration to jointly carry out the requirements outlined in House bill 945 (2020). This bill required the agencies to identify children and adolescents who are the highest utilizers of crisis stabilization services and list the actions taken to meet their behavioral health needs quarterly until Fiscal Year 2022. The agencies meet weekly to discuss establishing a system by which these children are identified and linked to the appropriate care coordination process. Once established, this system will aid the Department with the analysis and collection of data used to complete the report required by this section.

Section 3
The bill amends s. 1001.212, F.S., requiring the Office of Safe Schools to include within their data for each school the number of involuntary examinations that are initiated at the school, on school transportation, or at a school sponsored activity. This does not have any direct impact on the Department.

Section 4
The bill amends s. 1002.20, F.S., to require the public school principal or the principal's designee to notify the parent prior to the removal of a student for involuntary examination. However, the principal or their designee may delay the required notification for no more than 24 hours if they reasonable determine it to be in the best interest of the student and a report has been submitted to the central abuse hotline, pursuant to s. 39.201, F.S., based upon knowledge or suspicion of abuse, abandonment, or neglect; or if such notification does not cause a delay that jeopardizes the student's health or safety

As written, the bill does not have an impact on the Department.

Section 5
This section amends s. 1002.33, F.S., to add the same requirements for parental notification for charter schools as those added to s. 1002.20, F.S., for public K-12 schools.

As written, the bill does not have an impact on the Department.

Section 6
This section of the bill revises s. 1006.07, F.S., to require each district school board to adopt a policy to require the district superintendent to report the number of involuntary examinations that are initiated at the school, on school transportation, or at a school sponsored activity to the Department. This information can be used to provide more accurate information about the rate of school initiated involuntary examinations and provide targeted technical assistance to those schools.

Section 7
This section of the bill revises s. 1006.12, F.S., to require that school safety officers must complete mental health crisis intervention training using a curriculum developed by a national organization with expertise in mental health crisis intervention. This revision does not have any direct impact on the Department.

Section 8
This section of the bill revises s. 1011.62. F.S., to add that schools must establish procedures to assist behavioral health providers or school resource officers trained in mental health crisis intervention to verbally de-escalate a student in crisis before initiating an involuntary examination pursuant to s. 394.463, F.S. This must include strategies to de-escalate students with developmental disabilities as defined in s. 393.063, F.S.

The bill adds a requirement to establish a memorandum of understanding (MOU) with local mobile crisis response services. School district policies and terms of the MOU must require that in a crisis the school or law enforcement

personnel must contact the mobile crisis response service provider before initiating an involuntary examination pursuant s. 394.463, F.S. The school district must provide training on the protocols established by the MOU to all school safety officers.

The Department requires that mobile response teams under contract with behavioral health Managing Entities work with schools and law enforcement agencies to establish written agreements. While this has been largely successful, there are a limited number of schools and law enforcement agencies that do not contact the mobile response team prior to initiating an involuntary examination. The Department anticipates that this could lead to an increase in the number of calls to mobile response teams. Additional funding may be required to support the need to increase team capacity. It should be noted that individuals with developmental disabilities as defined in s. 393.063, F.S., are not eligible for involuntary examination unless a co-occurring mental illness is present.

Section 9
The bill is effective July 1, 2021.

3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?

If yes, explain:	No.
What is the expected impact to the agency's core mission?	None.
Rule(s) impacted (provide references to F.A.C., etc.):	None.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

List any known proponents and opponents:	Unknown.
Provide a summary of the proponents' and opponents' positions:	Unknown.

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?

If yes, provide a description:	No new reports are required, however, there is a requirement to include an additional data element to an existing report required under s. 394.463(4), F.S. This requires the Department to include information about the initiation of involuntary examination for children removed from school.
Date Due:	November 1, 2021.
Bill Section Number(s):	Section 2

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL?

Board:	No.
Board Purpose:	N/A
Who Appoints:	N/A
Appointee Term:	N/A

Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Office of Administrative Services finds that there are no expenditures generated by this bill.
Does the legislation increase local taxes or fees?	The Department's Office of Administrative Services finds that this bill does not increase local taxes or fees.
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	The Department's Office of Administrative Services finds that this section is not applicable.

2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Office of Administrative Services finds that there may be expenditures generated by this bill. Section 8 requires Mobile Response Teams under contract with Managing Entities to establish written agreements that require school personnel or law enforcement to contact the mobile crisis response teams before initiating an involuntary examination. There are a limited number of school and law enforcement agencies that do not contact mobile response teams before initiating an involuntary examination and this may increase the number of calls to mobile response teams in those areas requiring additional support to increase service capacity. The fiscal impact is indeterminate.
Does the legislation contain a State Government appropriation?	The Department's Office of Administrative Services finds that there is no State Government appropriation provided by this bill.
If yes, was this appropriated last year?	The Department's Office of Administrative Services finds that this section is not applicable.

3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Office of Administrative Services finds that there are no expenditures generated by this bill.
Other:	The Department's Office of Administrative Services finds that this section is not applicable.

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?

Does the bill increase taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not increase taxes, fees, or fines.

Does the bill decrease taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not decrease taxes, fees, or fines.
What is the impact of the increase or decrease?	The Department's Office of Administrative Services finds that this section is not applicable.
Bill Section Number:	The Department's Office of Administrative Services finds that this section is not applicable.

TECHNOLOGY IMPACT

Does the legislation impact the agency's technology systems (i.e., IT support, licensing software, data storage, etc.)?	The Department's Office of Information Technology Services finds that this bill does not impact the Department's technology systems.
If yes, describe the anticipated impact to the agency including any fiscal impact.	The Department's Office of Information Technology Services finds that this section is not applicable.

FEDERAL IMPACT

Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)?	The Department's Office of Substance Abuse and Mental Health does not find that there will a federal impact due to the provisions of this bill.
If yes, describe the anticipated impact including any fiscal impact.	The Department's Office of Substance Abuse and Mental Health finds that this section is not applicable.

ADDITIONAL COMMENTS

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	The Department's Office of the General Counsel has no issues, concerns, or comments on this bill.

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

2/16/2021
Meeting Date

590
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Involuntary Examination of Minors

Name Karen Woodall

Job Title Executive Director

Address 579 E. Call St.
Street

TAllahassee FI
City *State* *Zip*

Phone 850-321-9386

Email fcfep@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Center for Fiscal & Economic Policy

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

2/16/21
Meeting Date

THE FLORIDA SENATE

APPEARANCE RECORD

590
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Baker Act of Minors

Name Sara Mollo

Job Title Public Defender 6th Judicial Circuit

Address 14250 49th Street N
Street

Phone 727-464-6506

Clearwater — *City* | Florida — *State* | 33762 — *Zip*

Email saramollo@wearethehope.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Public Defender Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/14/2021
Meeting Date

SB 590
Bill Number (if applicable)

Topic Involuntary Examinations

Amendment Barcode (if applicable)

Name Angie Gallo

Job Title Advocate

Address _____ Phone _____
Street

City *State* *Zip*

Email angie@alliance4schools.org

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The Alliance for Public Schools

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2.16.2021
Meeting Date

SB0590
Bill Number (if applicable)

Children, Family & Elder Affairs

Topic Involuntary Examination of Minors

Amendment Barcode (if applicable)

Name Damaris Allen

Job Title Legislation Committee Member

Address 1747 Orlando Central Parkway
Street

Phone 407.855.7604

Orlando, FL. 32809
City *State* *Zip*

Email legislation@floridapta.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida PTA

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/10/21
Meeting Date

SB 590
Bill Number (if applicable)

Topic INVOLUNTARY EXAMINATION OF MINORS

Amendment Barcode (if applicable)

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Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA ASSOCIATION OF MANAGED ENTITIES

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 590
INTRODUCER:	Senator Harrell
SUBJECT:	Involuntary Examinations of Minors
DATE:	February 15, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Cox	CF	**Favorable**
2.			ED	
3.			AP	

I. Summary:

SB 590 requires public and charter schools to contact the parents of a minor student before the student is removed from school, school transportation, or a school-sponsored activity for an involuntary mental health examination. The bill provides that a principal or their designee may delay notification if they believe it is necessary for the health and safety of the student or others.

The bill requires schools to contact a mobile response service prior to initiating a student removal and requires all school safety officers to undergo crisis intervention training. The bill also requires school to generate and enter into a memorandum of understanding (MOU) with a local mobile crisis response team, and that the MOU mandate that school and law enforcement personnel contact the crisis response team, either in person or via telehealth, prior to initiating a Baker Act of a student. The bill mandates the collection of data by school districts and the Department of Children and Families (the DCF) relating to the number and frequency of involuntary examinations of minors initiated by schools.

The bill will have a fiscal impact on public and charter schools and has an effective date of July 1, 2021.

II. Present Situation:

Baker Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[1] The Act includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[2]

[1] Sections 394.451-394.47891, F.S.
[2] Section 394.459, F.S.

Involuntary Examination and Receiving Facilities

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[3] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:[4]

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; and
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Involuntary patients must be taken to either a public or a private facility that has been designated by the DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[5] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.[6] Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and who are the least able to pay.[7]

Crisis Stabilization Units (CSUs) are specialized public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[8] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[9] The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[10] Individuals often enter the public mental health system through CSUs.[11] For this reason, crisis services are a part of the comprehensive, integrated, community mental health and

[3] *See* Sections 394.4625 and 394.463, F.S.
[4] Section 394.463(1), F.S.
[5] Section 394.455(40), F.S. This term does not include a county jail.
[6] Section 394.455(38), F.S
[7] Rule 65E-5.400(2), F.A.C.
[8] Section 394.875(1)(a), F.S.
[9] *Id*.
[10] Section 394.875(1)(b) and (c)
[11] Florida Senate, Budget Subcommittee on Health and Human Services Appropriations, *Crisis Stabilization Units*, (Interim Report 2012-109), p. 2 (Sept. 2011), available at https://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-109bha.pdf (last visited Jan 30, 2020).

substance abuse services established by the Legislature in the 1970s to ensure continuity of care for individuals.[12]

As of February 2, 2021, there are 122 Baker Act receiving facilities in this state, including 54 public receiving facilities and 68 private receiving facilities.[13] Of the 54 public receiving facilities, 40 are CSU's.[14]

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[15] During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met.[16] If the patient is a minor, the examination must be initiated within 12 hours.[17]

Within that 72-hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next business day, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to a placement as a voluntary patient and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.[18]

Mental Health Services for Students

The Florida Department of Education (DOE), through the Bureau of Exceptional Education and Student Services and the Office of Safe Schools, promotes a system of support, policies, and practices that focus on prevention and early intervention to improve student mental health and school safety. Florida law requires instructional personnel to teach comprehensive health education that addresses concepts of mental and emotional health as well as substance use and abuse.[19] Student Services personnel, which includes school psychologists, school social workers, and school counselors, are classified as instructional personnel responsible for advising students regarding personal and social adjustments, and provide direct and indirect services at the district and school level.[20]

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[12] *Id*. Sections 394.451-394.47891, F.S.
[13] The Department of Children and Families (The DCF), *Designated Baker Act Receiving Facilities*, (February 2, 2021), available at https://www.myflfamilies.com/service-programs/samh/crisis-services/docs/baker/Baker%20Act%20Receiving%20Faciliites.pdf (last visited February 10, 2021). Hospitals can also be designated as public receiving facilities.
[14] *Id*.
[15] Section 394.463(2)(g), F.S.
[16] Section 394.463(2)(f), F.S.
[17] Section 394.463(2)(g), F.S.
[18] *Id*.
[19] Section 1003.42(2)(n), F.S.
[20] Section 1012.01(2)(b), F.S.

State funding for school districts' mental health services is provided primarily by legislative appropriations, the majority of which is distributed through an allocation through the Florida Education Finance Program (FEFP) to each district. In addition to the basic amount for current operations for the FEFP, the Legislature may appropriate categorical funding for specified programs, activities, or purposes.[21] Each district school board must include the amount of categorical funds as a part of the district annual financial report to the DOE and The DOE must submit a report to the Legislature that identifies by district and by categorical fund the amount transferred and the specific academic classroom activity for which the funds were spent.[22]

The law allows district school boards and state agencies administering children's mental health funds to form a multiagency network to provide support for students with severe emotional disturbance.[23] The program goals for each component of the multiagency network are to:

- Enable students with severe emotional disturbance to learn appropriate behaviors, reduce dependency, and fully participate in all aspects of school and community living;
- Develop individual programs for students with severe emotional disturbance, including necessary educational, residential, and mental health treatment services;
- Provide programs and services as close as possible to the student's home in the least restrictive manner consistent with the student's needs; and
- Integrate a wide range of services necessary to support students with severe emotional disturbances and their families.[24]

The DOE awards grants to district school boards for statewide planning and development of the multiagency Network for Students with Emotional or Behavioral Disabilities.[25] SEDNET is a network of 19 regional projects that are composed of major child-serving agencies, community-based service providers, and students and their families. Local school districts serve as fiscal agents for each local regional project.[26] SEDNET focuses on developing interagency collaboration and sustaining partnerships among professionals and families in the education, mental health, substance abuse, child welfare, and juvenile justice systems serving children and youth with and at risk of emotional and behavioral disabilities.[27]

Mental Health Allocation

The mental health assistance allocation was established in 2018[28] to provide funding to assist school districts in establishing or expanding school-based mental health care. These funds must be allocated annually in the General Appropriations Act or other law to each eligible school district. Each school district must receive a minimum of $100,000 with the remaining balance

[21] Section 1011.62(6), F.S.
[22] *Id*.
[23] *See* s. 1006.04(1)(a), F.S.
[24] Section 1006.04(1)(b), F.S.
[25] Section 1006.04(2), F.S.
[26] Fiscal agencies include the Brevard, Broward, Clay, Columbia, Miami-Dade, Escambia, Hendry, Hernando, Hillsborough, Levy, Liberty, Orange, Palm Beach, Pinellas, Polk, St. Lucie, Volusia, and Washington school districts. Florida Department of Education (DOE), Bureau of Exceptional Education and Student Services, *BEESS Discretionary Projects*, January 2017, at p. 11, available at http://www.fldoe.org/core/fileparse.php/7567/urlt/projectslisting.pdf (last visited February 10, 2021).
[27] The DOE, Bureau of Exceptional Education and Student Services, *BEESS Discretionary Projects*, January 2017, p. 11, available at http://www.fldoe.org/core/fileparse.php/7567/urlt/projectslisting.pdf (last visited February 10, 2021).
[28] Section 29, ch. 2018-4, L.O.F. In 2018, $69,237,286 was appropriated to fund the mental health assistance allocation.

allocated based on each school district's proportionate share of the state's total unweighted full-time equivalent student enrollment. Eligible charter schools are entitled to a proportionate share of district funding. At least 90 percent of a district's allocation must be expended on the elements specified in law. The allocated funds may not replace funds that are provided for this purpose from other operating funds or be used to increase salaries or provide bonuses. School districts are encouraged to maximize third party health insurance benefits and Medicaid claiming for services, where appropriate.[29]

Before the distribution of the allocation:

- The school district must develop and submit a detailed plan outlining the local program and planned expenditures to the district school board for approval.
- A charter school must develop and submit a detailed plan outlining the local program and planned expenditures to its governing body for approval and it must be provided to the charter school's sponsor after the plan is approved by the governing body.
- The required plans must be focused on delivering evidence-based mental health care treatment to children and include the following elements:
    - Provision of mental health assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and students at high risk of such diagnoses.
    - Coordination of such services with a student's primary care provider and with other mental health providers involved in the student's care.
    - Direct employment of such service providers, or a contract-based collaborative effort or partnership with one or more local community mental health programs, agencies, or providers.[30]

School districts must submit approved plans, including approved plans of each charter school in the district, to the commissioner by August 1 of each fiscal year.[31]

Beginning September 30, 2019, and annually by September 30, each school district must submit to the DOE a report on its program outcomes and expenditures for the previous fiscal year that, at a minimum, must include the number of each of the following:

- Students who receive screenings or assessments.
- Students who are referred for services or assistance.
- Students who receive services or assistance.
- Direct employment service providers employed by each school district.
- Contract-based collaborative efforts or partnerships with community mental health programs, agencies, or providers.[32]

Office of Safe Schools

The Office of Safe Schools (OSS) in the DOE serves as a central repository for best practices, training standards, and compliance oversight in all matters regarding school safety and security,

[29] Section 1011.62(16), F.S.
[30] Section 1011.62(16)(b), F.S.
[31] Section 1011.62(16)(c), F.S.
[32] Section 1011.62(16)(d), F.S.

including prevention efforts, intervention efforts, and emergency preparedness planning.[33] The OSS requirements include:

- Establishing and updating as necessary a school security risk assessment tool[34] for use by school districts and charter schools.
- Providing ongoing professional development opportunities to school district personnel.
- Providing a coordinated and interdisciplinary approach to providing technical assistance and guidance to school districts on safety and security and recommendations to address findings identified in the school security risk assessment.[35]
- Developing and implementing a School Safety Specialist Training Program for school safety specialists. The office must develop the training program based on national and state best practices on school safety and security and must include active shooter training.[36]
- Reviewing and providing recommendations on the security risk assessments.

Safe-School Officers

Florida law requires each district school board and school district superintendent to partner with law enforcement agencies to establish or assign one or more safe-school officers at each school facility within the district by implementing one or more safe-school officer options which best meet the needs of the school district.[37] These options include:

- Establishing a school resource officer program, through a cooperative agreement with law enforcement agencies.[38]
- Commissioning one or more school safety officers. The district school superintendent may recommend, and the district school board may appoint, one or more school safety officers.[39]
- Participating in the Coach Aaron Feis Guardian Program if such program is established by the sheriff.[40]

Coach Aaron Feis Guardian Program

The Coach Aaron Feis Guardian Program (guardian program) was established in 2018[41] as an option for school districts to meet the safe-school officer requirements in law.[42] Each sheriff has the discretion to establish a guardian program to aid in the prevention or abatement of active assailant incidents on school premises. School employees, except individuals who exclusively perform classroom duties as classroom teachers as defined in law,[43] may participate in the guardian program. The sheriff who chooses to establish a guardian program shall appoint as

[33] Section 1001.212, F.S. *See also* The DOE, *Office of Safe Schools*, available at http://www.fldoe.org/safe-schools/ (last visited February 12, 2021).
[34] Section 1006.1493, F.S., provides for the Florida Safe Schools Assessment Tool (FSSAT).
[35] Section 1006.07(6)(a)4., F.S., requires a school security risk assessment at each public school using the school security risk assessment tool (FSSAT) developed by the OSS.
[36] Section 1006.07(6)(a), F.S., requires each district school superintendent to designate a school administrator as a school safety specialist for the district.
[37] Section 1006.12, F.S.
[38] Section 1006.12(1), F.S.
[39] Section 1006.12(2), F.S
[40] Section 1006.12(3), F.S
[41] Section 26, ch. 2018-3, L.O.F.
[42] Section 1006.12, F.S.
[43] Section 1012.01(2)(a), F.S.

school guardians, without the power of arrest, school employees who volunteer and who comply with all of the following:

- Hold a valid license issued under s. 790.06, F.S. (license to carry a concealed firearm).
- Complete 132 total hours of comprehensive firearm safety and proficiency training conducted by Criminal Justice Standards and Training Commission-certified instructors, which must include:
  - Eighty hours of firearms instruction based on the Criminal Justice Standards and Training Commission's Law Enforcement Academy training model, which must include at least 10 percent but no more than 20 percent more rounds fired than associated with academy training. Program participants must achieve an 85 percent pass rate on the firearms training.
  - Sixteen hours of instruction in precision pistol.
  - Eight hours of discretionary shooting instruction using state-of-the-art simulator exercises.
  - Eight hours of instruction in active shooter or assailant scenarios.
  - Eight hours of instruction in defensive tactics.
  - Twelve hours of instruction in legal issues.
- Pass a psychological evaluation administered by a psychologist licensed under ch. 490, F.S., and designated by the Florida Department of Law Enforcement (FDLE) and submit the results of the evaluation to the sheriff's office. The FDLE may provide the sheriff's office with mental health and substance abuse data for compliance with this requirement.
- Submit to and pass an initial drug test and subsequent random drug tests in accordance with the requirements of s. 112.0455, F.S.,[44] and the sheriff's office.
- Successfully complete ongoing training, weapon inspection, and firearm qualification on at least an annual basis.
- Successfully complete at least 12 hours of a certified nationally recognized diversity training program.[45]

A sheriff must issue a school guardian certificate to individuals who meet the requirements specified in law.[46] The sheriff must maintain documentation of weapon and equipment inspections, as well as the training, certification, inspection, and qualification records of each school guardian appointed by the sheriff.[47]

In ch. 2018-3, L.O.F.., the Legislature appropriated $500,000 in recurring funds and $67 million in nonrecurring funds to the DOE to allocate to sheriffs' offices that establish a guardian program. These funds were appropriated for screening-related and training-related costs and providing a one-time stipend of $500 to school guardians who participate in the guardian program. As of January 2019, the department had received $9.3 million in funding requests and $2.6 million had been paid out to sheriff's offices for authorized expenses.[48]

[44] Section 112.0455, F.S., relates to the Drug-Free Workplace Act.
[45] Section 30.15(1)(k), F.S.
[46] Section 30.15(1)(k)2., F.S.
[47] *Id*.
[48] *Id*.

Children and the Baker Act

Over a 15-year period, the number of children subject to involuntary commitments under the Baker Act have increased at a faster pace than any other age group.[49] Children are incapable of legally consenting to medical intervention needed to gauge whether an involuntary examination under the Baker Act is necessary.[50] School officials and mental health professionals have stressed the need for additional mobile response teams, greater access to telehealth technology in accessing the teams, and more school psychologists as methods of addressing the growing number of children subjected to the Baker Act.[51] Over 130 law enforcement agencies across the state have policies in place requiring a parent or family member of a minor to be contacted prior to initiating a Baker Act, however there is no currently no statewide statutory requirement for parental or family notification.[52]

Report on Involuntary Examinations of Minors

In 2017, the Legislature created a task force within the DCF[53] to address the issue of involuntary examination of minors age 17 years or younger, specifically by:[54]

- Analyzing data on the initiation of involuntary examinations of minors;
- Researching the root causes of and trends in such involuntary examinations;
- Identifying and evaluating options for expediting the examination process; and
- Identifying recommendations for encouraging alternatives to or eliminating inappropriate initiations of such examinations.

The task force found that specific causes of increases in involuntary examinations of children are unknown. Possible factors cited in the task force report include:

- Increase in mental health concerns:
  - In 2017, 31.5% of high school students experienced periods of persistent feelings of sadness or hopelessness within the past year, an increase from 2007 (28.5%).
  - In 2017, 17.2% of high school students seriously considered attempting suicide in the past year, increasing from 14.5% in 2007.[55]
- Social stressors such as parental substance use, poverty and economic insecurity, mass shootings, and social media and cyber bullying.[56]

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[49] Lynn Hatter, WFSU Public Media, *Committed: Improving Florida's Baker Act for Children a Challenge*, December 17, 2020, available at https://news.wfsu.org/2020-12-17/committed-improving-floridas-baker-act-for-children-a-challenge (last visited February 11, 2021).
[50] *Id*.
[51] *Id*.
[52] *Id*.
[53] Ch. 2017-151, LO.F.
[54] The DCF, *Task Force Report on Involuntary Examination of Minors,* (Nov. 2017), p. 1, available at https://www.myflfamilies.com/service-programs/samh/publications/docs/S17-005766-TASK%20FORCE%20ON%20INVOLUNTARY%20EXAMINATION%20OF%20MINORS.pdf (last visited February 11, 2021) (hereinafter cited as "The 2017 Task Force Report").
[55] The DCF, *Task Force Report on Involuntary Examination of Minors,* (Nov. 2019), p. 6, available at https://www.myflfamilies.com/service-programs/samh/publications/docs/Report%20on%20Involuntary%20Examination%20of%20Minors.pdf (last visited February 11, 2021) (hereinafter cited as "The 2019 Task Force Report").
[56] *Id*. at p. 3.

- Lack of availability of mental health services, due to wait lists for services, limitations on coverage or approval, lack of funding for prevention and diversion, and shortage of psychiatrists and other mental health professionals.
    - Among children ages 12-17 in Florida, approximately 13.0% experienced a major depressive episode in the past year, but only about 33% of children experiencing a major depressive episode in the past year receive treatment.[57]

As a follow up to the 2017 task force report, in 2019, the Legislature instructed the DCF to prepare a report on the initiation of involuntary examinations of minors age 17 years and younger and submit it by November 1 of each odd numbered year.[58] As part of the report (2019 report), the DCF was required to:

- Analyze data on the initiation of involuntary examinations of minors;
- Identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child;
- Study root causes for such patterns, trends, or repeated involuntary examinations; and
- Make recommendations for encouraging alternatives to and eliminating inappropriate initiations of such examinations.[59]

Task Force Recommendations

Among the 2017 task force report recommendations were to:

- Amend statute to increase the number of days that the receiving facility has to submit required forms to the DCF to capture additional data;
- Expedite involuntary exams by expanding the list of mental health professionals who can conduct the clinical exam to include physician assistants, psychiatric advanced registered nurse practitioners, licensed clinical social workers, licensed mental health counselors, and licensed marriage and family therapist;
- Increase funding for mobile crisis teams;
- Fund an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis;
- Expand access to outpatient crisis intervention services and treatment especially for children under 13;
- Create the "Invest in the Mental Health of our Children" grant program to provide matching funds to counties to enhance their systems of care serving these children;
- Encourage school districts to adopt a standardized suicide risk assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination;
- Revise statutes to include school psychologists licensed under ch. 490, F.S., to the list of mental health professionals who are qualified to initiate a Baker Act;
- Require Youth Mental Health First Aid and/or CIT training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools;
- Require AHCA to post quarterly Medicaid health plans' EPSDT compliance reports on its website; and

[57] *Id*. at p. 5.
[58] Chapter 2019-134, LO.F.
[59] *Id*.

- Supporting Baker Act training and technical assistance by funding a position in the DCF to train and provide technical assistance to providers, clinicians, and other professionals who are responsible for implementing the Baker Act.[60]

Several of these recommendations have been implemented through statutory change or legislative appropriations.

The 2019 report recommended:
- Increasing care coordination for minors with multiple involuntary examinations;
- Utilizing the wraparound care coordination approach for children with complex behavioral health needs and multi-system involvement to ensure one point of accountability and individualized care planning;
- Utilizing existing local review teams;
- Revising administrative rules to gather more information about actions taken after the initiation of exams, require electronic submission of forms, and improve care coordination and discharge planning;
- Funding an additional FTE at the DCF to provide technical assistance; and
- Ensuring that parents receive information about mobile crisis response teams and other community resources and supports upon child's discharge.[61]

Mobile Response Teams

A mental health crisis can be can be caused by a variety of factors at any hour of the day.[62] Family members and caregivers of an individual experiencing a mental health crisis are often ill-equipped to handle these situations and need the advice and support of professionals.[63] All too frequently, law enforcement or EMTs are called to respond to mental health crises and they often lack the training and experience to effectively handle the situation.[64] Mobile response teams can be beneficial in such instances.

Mobile response teams provide readily available crisis care in a community-based setting and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for jail or hospital/emergency department utilization.[65] Early intervention services are critical to reducing involuntary examinations in minors and there are areas across the state where options short of involuntary examination via the Baker Act are limited or nonexistent.[66] Response teams are available to individuals 25 years of age and under, regardless of their ability to pay, and must be ready to respond to any mental health emergency.[67] Telehealth can be used to provide direct

[60] The 2017 Task Force Report, p. 1.
[61] The 2019 Task Force Report, p. 17-18.
[62] The DCF, *Mobile Response Teams Framework*, (August 29, 2018), p. 4, available at https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf (last visited February 11, 2021)(hereinafter cited as "MRT Framework").
[63] *Id*.
[64] *Id*.
[65] *Id*. at 2
[66] MRT Framework, p. 4.
[67] *Id*.

services to individuals via video-conferencing systems, mobile phones, and remote monitoring.[68] It can also be used to provide assessments and follow-up consultation as well as initial triage to determine if an in-person visit is needed to respond to the crisis call.[69]

SB 7026 (2018) funded additional mobile response teams to serve areas of the state that were not being served by such teams at a total of $18.3 million. There are 40 MRTs serving all 67 counties in Florida, targeting services to individuals under the age of 25.[70] Recent MRT monthly reports showed an 80% statewide average of diverting individuals from involuntary examination.[71]

The DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:

- Be conducted with the collaboration of local Sherriff's Offices and public schools in the procurement planning, development, evaluation, and selection process;
- Be designed to ensure reasonable access to services among all counties in the Managing Entity's service region, taking into consideration the geographic location of existing mobile crisis teams;
- Require services be available 24 hours per day, seven days per week with on-site response time to the location of referred crises within 60 minutes of the request for services;
- Require the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents;
- Require access to a board-certified or board-eligible Psychiatrist or Psychiatric Nurse Practitioner; and
- Provide for an array of crisis response services that are responsive to the individual and family needs, including screening, standardized assessments, early identification, or linkage to community services as necessary to address the immediate crisis event.[72]

III. Effect of Proposed Changes:

Notification Requirements to Parents

The bill amends s. 381.0056, F.S., related to the school health services program, requiring school health services plans to mandate that a parent or guardian be notified before a student is removed from school or a school-sponsored activity for an involuntary examination except for when a principal or principal's designee believes that a delay in removal would jeopardize the health and safety of the student.

The bill amends ss. 1002.20 and 1002.33, F.S., related to K-12 student and parent rights and charter schools, respectively, requiring the appropriate principal or principal's designee to notify a parent before a student is removed from school, school transportation, or a school-sponsored activity to be taken to a receiving facility for an involuntary examination. The bill allows the

[68] MRT Framework, p. 7.
[69] *Id*.
[70] The 2019 Task Force Report, p. 4
[71] *Id*.
[72] MDT Framework, p. 2-3.

principal or principal's designee to delay notification, for no more than 24 hours, if the principal or designee believes that such a delay is necessary to avoid jeopardizing the health and safety of the student.

Reporting Requirements

The bill amends s. 394.463, F.S., related to involuntary examinations, adding the initiation of involuntary examinations of students who are removed from school, school transportation, or a school-sponsored activity to the elements that must be included in data collected by the DCF, and requiring the DCF to submit a report on findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House by November 1 of each odd-numbered year.

The bill amends s. 1001.212, F.S., related to the Office of Safe Schools, requiring that both the number of involuntary examinations initiated at each school or school-sponsored activity and the number of students for whom an involuntary examination was initiated be included in the data provided by the Office of Safe Schools to support the evaluation of mental health services.

The bill amends s. 1006.07, F.S., related to district school board duties relating to student discipline and school safety, requiring each district school board to adopt a policy requiring that the superintendent annually report to the DOE the number of involuntary examinations initiated at a school, on school transportation, or at a school-sponsored activity.

Training Requirements

The bill amends s. 1006.12, F.S., related to safe school officers at each public school, requiring that school safety officers complete mental health crisis intervention training using a curriculum developed by a national organization with expertise in mental health crisis intervention to improve skills in responding to students with emotional behavioral disability or mental illness, including de-escalation techniques.

Mental Health Assistance Allocation Memorandum of Understanding

The bill requires school districts to develop a memorandum of understanding with a local crisis response service and requires that school or law enforcement personnel contact the mobile crisis response service, in person or through telehealth, before initiating an involuntary examination. The bill requires school districts to provide all school resource officers and school safety officers with training on protocols established in the memorandum of understanding.

The bill provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

There will be an indeterminate impact to providers of crisis intervention training for school safety officers and school resource officers.

C. Government Sector Impact:

The DCF anticipates an indeterminate, negative fiscal impact generated by additional calls from schools to mobile response teams in instances where schools do not already contact teams prior to initiating a Baker Act.[73]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 381.0056, 394.463, 1001.212, 1002.20, 1002.33, 1006.07, 1006.12, and 1011.62 of the Florida Statutes.

[73] The DCF Analysis of SB 590 (January 19, 2021), p. 6. (on file with the Senate Children, Families, and Elder Affairs Committee).

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Bracy

11-00505-21 2021626__

A bill to be entitled

An act relating to juvenile justice; amending s. 985.03, F.S.; redefining the terms "child," "juvenile," and "youth"; creating s. 985.031, F.S.; providing a short title; prohibiting a child younger than a certain age from being adjudicated delinquent, arrested, or charged with a violation of law or a delinquent act; providing an exception; amending s. 985.101, F.S.; authorizing children of at least a specified age, rather than of any age, to be taken into custody under certain circumstances; authorizing children of specified ages to be taken into custody or arrested only under certain circumstances; providing construction; authorizing a child enrolled in a primary or secondary school to be taken into custody or arrested at the school he or she attends only under certain circumstances; providing construction; amending s. 985.24, F.S.; requiring that children who are taken into custody pursuant to certain circuit court orders be treated in a specified manner and be detained only pursuant to specified findings; reenacting s. 316.003(11), F.S., relating to the definition of the term "child," to incorporate the amendment made to s. 985.03, F.S., in a reference thereto; reenacting ss. 960.001(1)(b) and 985.439(2), F.S., both relating to children being taken into custody, to incorporate the amendment made to s. 985.101, F.S., in references thereto; reenacting s. 985.25(1), F.S., relating to a detention intake, to

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incorporate the amendment made to s. 985.24, F.S., in a reference thereto; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (7) of section 985.03, Florida Statutes, is amended to read:

985.03 Definitions.—As used in this chapter, the term:

(7) "Child," ~~or~~ "juvenile," or "youth" means any person 7 years of age or older but younger than 18 years of age ~~under the age of 18~~ or any person who is alleged to have committed a violation of law occurring after the person reached 7 years of age or older and before ~~prior to the time~~ that person reached ~~the age of~~ 18 years of age.

Section 2. Section 985.031, Florida Statutes, is created to read:

985.031 Age limitation; exception.—

(1) This section may be cited as the "Kaia Rolle Act."

(2) A child younger than 7 years of age may not be adjudicated delinquent, arrested, or charged with a violation of law or a delinquent act on the basis of acts occurring before he or she reaches 7 years of age.

(3) This section does not apply to a child who commits a forcible felony as defined in s. 776.08.

Section 3. Subsection (1) of section 985.101, Florida Statutes, is amended, and subsections (5) and (6) are added to that section, to read:

985.101 Taking a child into custody.—

(1) A child 15 years of age or older may be taken into

custody under any of the following circumstances:

(a) Pursuant to an order of the circuit court issued under this chapter, based upon sworn testimony, either before or after a petition is filed.

(b) For a delinquent act or violation of law, pursuant to Florida law pertaining to a lawful arrest. If such delinquent act or violation of law would be a felony if committed by an adult or involves a crime of violence, the arresting authority shall immediately notify the district school superintendent, or the superintendent's designee, of the school district with educational jurisdiction of the child. Such notification must ~~shall~~ include other education providers, such as the Florida School for the Deaf and the Blind, university developmental research schools, and private elementary and secondary schools. The information obtained by the superintendent of schools pursuant to this section must be released within 48 hours after receipt to appropriate school personnel, including the principal of the child's school, or as otherwise provided by law. The principal must immediately notify the child's immediate classroom teachers. Information provided by an arresting authority under this paragraph may not be placed in the student's permanent record and must ~~shall~~ be removed from all school records no later than 9 months after the date of the arrest.

(c) By a law enforcement officer for failing to appear at a court hearing after being properly noticed.

(d) By a law enforcement officer who has probable cause to believe that the child is in violation of the conditions of the child's probation, supervised release detention, postcommitment

probation, or conditional release supervision; has absconded from nonresidential commitment; or has escaped from residential commitment.

This ~~Nothing in this~~ subsection may not ~~shall~~ be construed to allow the detention of a child who does not meet the detention criteria in part V of this chapter.

(5) A child 7 years of age or older but younger than 15 years of age may be taken into custody or arrested only under any of the following circumstances:

(a) By a law enforcement officer for failing to appear at a court hearing after being properly noticed.

(b) By a law enforcement officer who has probable cause to believe that the child has absconded from nonresidential commitment or has escaped from residential commitment.

(c) By a law enforcement officer who has probable cause to believe that detention is necessary to prevent an imminent threat of serious bodily harm to another individual.

This subsection may not be construed to allow the detention of a child who does not meet the detention criteria in part V of this chapter.

(6) A child enrolled in a primary or secondary school may be taken into custody or arrested at the school he or she attends only under any the following circumstances:

(a) By a law enforcement officer for failing to appear at a court hearing after being properly noticed.

(b) By a law enforcement officer who has probable cause to believe that detention is necessary to prevent an imminent

threat of serious bodily harm to another individual.

This subsection may not be construed to allow the detention of a child who does not meet the detention criteria in part V of this chapter.

Section 4. Present subsection (4) of section 985.24, Florida Statutes, is redesignated as subsection (5), and a new subsection (4) is added to that section, to read:

985.24 Use of detention; prohibitions.—

(4) A child who is taken into custody pursuant to a summons, an arrest warrant, or any other circuit court order that does not explicitly require detention must be treated in the same manner as a child taken into custody under s. 985.101(1)(b) and may be detained only pursuant to a finding under subsection (1).

Section 5. For the purpose of incorporating the amendment made by this act to section 985.03, Florida Statutes, in a reference thereto, subsection (11) of section 316.003, Florida Statutes, is reenacted to read:

316.003 Definitions.—The following words and phrases, when used in this chapter, shall have the meanings respectively ascribed to them in this section, except where the context otherwise requires:

(11) CHILD.—A child as defined in s. 39.01, s. 984.03, or s. 985.03.

Section 6. For the purpose of incorporating the amendment made by this act to section 985.101, Florida Statutes, in a reference thereto, paragraph (b) of subsection (1) of section 960.001, Florida Statutes, is reenacted to read:

960.001 Guidelines for fair treatment of victims and witnesses in the criminal justice and juvenile justice systems.—

(1) The Department of Legal Affairs, the state attorneys, the Department of Corrections, the Department of Juvenile Justice, the Florida Commission on Offender Review, the State Courts Administrator and circuit court administrators, the Department of Law Enforcement, and every sheriff's department, police department, or other law enforcement agency as defined in s. 943.10(4) shall develop and implement guidelines for the use of their respective agencies, which guidelines are consistent with the purposes of this act and s. 16(b), Art. I of the State Constitution and are designed to implement s. 16(b), Art. I of the State Constitution and to achieve the following objectives:

(b) *Information for purposes of notifying victim or appropriate next of kin of victim or other designated contact of victim.*—In the case of a homicide, pursuant to chapter 782; or a sexual offense, pursuant to chapter 794; or an attempted murder or sexual offense, pursuant to chapter 777; or stalking, pursuant to s. 784.048; or domestic violence, pursuant to s. 25.385:

1. The arresting law enforcement officer or personnel of an organization that provides assistance to a victim or to the appropriate next of kin of the victim or other designated contact must request that the victim or appropriate next of kin of the victim or other designated contact complete a victim notification card. However, the victim or appropriate next of kin of the victim or other designated contact may choose not to complete the victim notification card.

2. Unless the victim or the appropriate next of kin of the

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victim or other designated contact waives the option to complete the victim notification card, a copy of the victim notification card must be filed with the incident report or warrant in the sheriff's office of the jurisdiction in which the incident report or warrant originated. The notification card shall, at a minimum, consist of:

a. The name, address, and phone number of the victim; or

b. The name, address, and phone number of the appropriate next of kin of the victim; or

c. The name, address, and telephone number of a designated contact other than the victim or appropriate next of kin of the victim; and

d. Any relevant identification or case numbers assigned to the case.

3. The chief administrator, or a person designated by the chief administrator, of a county jail, municipal jail, juvenile detention facility, or residential commitment facility shall make a reasonable attempt to notify the alleged victim or appropriate next of kin of the alleged victim or other designated contact within 4 hours following the release of the defendant on bail or, in the case of a juvenile offender, upon the release from residential detention or commitment. If the chief administrator, or designee, is unable to contact the alleged victim or appropriate next of kin of the alleged victim or other designated contact by telephone, the chief administrator, or designee, must send to the alleged victim or appropriate next of kin of the alleged victim or other designated contact a written notification of the defendant's release.

4. Unless otherwise requested by the victim or the appropriate next of kin of the victim or other designated contact, the information contained on the victim notification card must be sent by the chief administrator, or designee, of the appropriate facility to the subsequent correctional or residential commitment facility following the sentencing and incarceration of the defendant, and unless otherwise requested by the victim or the appropriate next of kin of the victim or other designated contact, he or she must be notified of the release of the defendant from incarceration as provided by law.

5. If the defendant was arrested pursuant to a warrant issued or taken into custody pursuant to s. 985.101 in a jurisdiction other than the jurisdiction in which the defendant is being released, and the alleged victim or appropriate next of kin of the alleged victim or other designated contact does not waive the option for notification of release, the chief correctional officer or chief administrator of the facility releasing the defendant shall make a reasonable attempt to immediately notify the chief correctional officer of the jurisdiction in which the warrant was issued or the juvenile was taken into custody pursuant to s. 985.101, and the chief correctional officer of that jurisdiction shall make a reasonable attempt to notify the alleged victim or appropriate next of kin of the alleged victim or other designated contact, as provided in this paragraph, that the defendant has been or will be released.

Section 7. For the purpose of incorporating the amendment made by this act to section 985.101, Florida Statutes, in a reference thereto, subsection (2) of section 985.439, Florida

Statutes, is reenacted to read:

985.439 Violation of probation or postcommitment probation.—

(2) A child taken into custody under s. 985.101 for violating the conditions of probation shall be screened and detained or released based on his or her risk assessment instrument score.

Section 8. For the purpose of incorporating the amendment made by this act to section 985.24, Florida Statutes, in a reference thereto, subsection (1) of section 985.25, Florida Statutes, is reenacted to read:

985.25 Detention intake.—

(1) The department shall receive custody of a child who has been taken into custody from the law enforcement agency or court and shall review the facts in the law enforcement report or probable cause affidavit and make such further inquiry as may be necessary to determine whether detention care is appropriate.

(a) During the period of time from the taking of the child into custody to the date of the detention hearing, the initial decision as to the child's placement into detention care shall be made by the department under ss. 985.24 and 985.245(1).

(b) The department shall base the decision whether to place the child into detention care on an assessment of risk in accordance with the risk assessment instrument and procedures developed by the department under s. 985.245, except that a child shall be placed in secure detention care until the child's detention hearing if the child meets the criteria specified in s. 985.255(1)(f) or is charged with possessing or discharging a firearm on school property in violation of s. 790.115.

(c) If the final score on the child's risk assessment instrument indicates detention care is appropriate, but the department otherwise determines the child should be released, the department shall contact the state attorney, who may authorize release.

(d) If the final score on the risk assessment instrument indicates detention is not appropriate, the child may be released by the department in accordance with ss. 985.115 and 985.13.

Under no circumstances shall the department or the state attorney or law enforcement officer authorize the detention of any child in a jail or other facility intended or used for the detention of adults, without an order of the court.

Section 9. This act shall take effect July 1, 2021.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

2021 FDLE LEGISLATIVE BILL ANALYSIS

BILL INFORMATION	
BILL NUMBER:	SB 626
BILL TITLE:	Juvenile Justice
BILL SPONSOR:	Senator Bracy
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1)
2)
3)
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	HB 303
SPONSOR:	Williams

PREVIOUS LEGISLATION	
BILL NUMBER:	SB 578
SPONSOR:	Senator Bracy
YEAR:	2020
LAST ACTION:	Died in committee

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	January 20, 2021
LEAD AGENCY ANALYST:	Chris Bufano
ADDITIONAL ANALYST(S):	Becky Bezemek, Ashley Pennington
LEGAL ANALYST:	Jim Martin
FISCAL ANALYST:	Cynthia Barr

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

The bill revises definitions, requirements and limitations related to persons under the age of 18 charged with criminal offense; prohibiting children younger the age of 7 from being adjudicated delinquent, arrested or charged with any crime with the exception of a Forceable Felony under Section 776.08, FS; authorizing children of at least a specified age, rather than of any age, to be taken into custody under certain circumstances; requiring that children who are taken into custody pursuant to certain circuit court orders be treated in a specified manner and be detained only pursuant to specified findings.

2. SUBSTANTIVE BILL ANALYSIS

1. **PRESENT SITUATION:** Currently child, juvenile or youth means any person under the age of 18 or any person who is alleged to have committed a violation of law occurring prior to the time that person reached 18 years of age. There is currently no statutory threshold age of mental culpability for criminal intent and no threshold age minimum for taking a child into custody.

2. **EFFECT OF THE BILL:** Defines child, juvenile or youth to be any person 7 years of age or older but younger than 18 years of age; establishes that no person under the age of 7 possesses the mental culpability required to commit criminal offenses; prohibits arresting, charging or adjudicating any person under the age of 7 for any crime; amends s. 985.101(1), FS, requiring that a child 15 years of age or older may only be taken into custody under certain circumstances; creates s. 985.101(5), FS, limiting the arrest of a child 7 years of age or older but less than 14 years of age only under the follow circumstances: (a) by a law enforcement officer for failing to appear at a court hearing after being properly noticed, (b) by a law enforcement officer who has probable cause to believe that the child has absconded from a nonresidential commitment or has escaped from a residential commitment or (c) by a law enforcement officer who has probable cause to believe that detention is necessary to prevent an imminent threat of serious bodily harm to another individual; limiting the circumstances in which a child (as defined in the current bill) enrolled at a primary or secondary school may be taken into custody at the school to: (a) by a law enforcement officer for failing to appear at a court hearing after being properly noticed or (b) by a law enforcement officer who has probable cause to believe that detention is necessary to prevent an imminent threat of serious bodily harm to another individual; requires that any child taken into custody that does not explicitly require detention, must be treated in the same manner as a child taken into custody under s. 985.101(1)(b), FS, and may be detained only pursuant to a finding under subsection (1).

3. **DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES OR PROCEDURES? Y ☐ N ☒**

If yes, explain:	
What is the expected impact to the agency's core mission?	**Y ☐ N ☐**
Rule(s) impacted (provide references to F.A.C., etc.):	

4. **WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?**

List any known proponents and opponents:	
Provide a summary of the proponents' and opponents' positions:	

5. **ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ☐ N ☒**

If yes, provide a description:	
Date Due:	

Bill Section Number:	

6. ARE THERE ANY NEW GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL? Y ☐ N ☒

Board:	
Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ☐ N ☒

Revenues:	
Expenditures:	
Does the legislation increase local taxes or fees?	
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y ☐ N ☒

Revenues:	
Expenditures:	
Does the legislation contain a State Government appropriation?	
If yes, was this appropriated last year?	

3. DOES THE BILL HAVE A FISCAL IMPACT TO THE PRIVATE SECTOR? Y ☐ N ☒

Revenues:	
Expenditures:	

Other:	

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ☐ N ☒

Does the bill increase taxes, fees or fines?	
Does the bill decrease taxes, fees or fines?	
What is the impact of the increase or decrease?	
Bill Section Number:	

TECHNOLOGY IMPACT

1. DOES THE LEGISLATION IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E., IT SUPPORT, LICENSING, SOFTWARE, DATA STORAGE, ETC.)? Y ☐ N ☒

If yes, describe the anticipated impact to the agency including any fiscal impact.	

FEDERAL IMPACT

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If yes, describe the anticipated impact including any fiscal impact.	

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	

ADDITIONAL COMMENTS

- The bill will protect all children under the age of 7 from being arrested, charged or sentenced for any crime they commit. This bill effectively provides immunity from prosecution to all those under the age of 7, except in the case of a Forceable Felony under s. 776.08, FS.

- The bill will restrict law enforcement from arresting any child between the ages of 7 to 14 for any new crime committed absent an imminent threat of serious bodily harm to another individual.

- Under this bill, a minor will be also be immune from arrest while on his or her primary or secondary school grounds, absent belief that the child is a current imminent threat of serious bodily harm to another individual.

- The bill will require the Criminal Justice Standards and Training Commission to amend basic recruit and advanced training course curriculums as they relate to juvenile arrest and detainment procedures. This could be implemented as part annual curriculum updates.

2021 FDLE LEGISLATIVE BILL ANALYSIS

BILL INFORMATION	
BILL NUMBER:	SB 626
BILL TITLE:	Juvenile Justice
BILL SPONSOR:	Senator Bracy
EFFECTIVE DATE:	July 1, 2021

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2)
3)
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SPONSOR:	Williams

PREVIOUS LEGISLATION	
BILL NUMBER:	SB 578
SPONSOR:	Senator Bracy
YEAR:	2020
LAST ACTION:	Died in committee

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

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3. **DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES OR PROCEDURES? Y ☐ N ☒**

If yes, explain:	
What is the expected impact to the agency's core mission?	**Y ☐ N ☐**
Rule(s) impacted (provide references to F.A.C., etc.):	

4. **WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?**

List any known proponents and opponents:	
Provide a summary of the proponents' and opponents' positions:	

5. **ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ☐ N ☒**

If yes, provide a description:	
Date Due:	

Bill Section Number:	

6. ARE THERE ANY NEW GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL? Y ☐ N ☒

Board:	
Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ☐ N ☒

Revenues:	
Expenditures:	
Does the legislation increase local taxes or fees?	
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y ☐ N ☒

Revenues:	
Expenditures:	
Does the legislation contain a State Government appropriation?	
If yes, was this appropriated last year?	

3. DOES THE BILL HAVE A FISCAL IMPACT TO THE PRIVATE SECTOR? Y ☐ N ☒

Revenues:	
Expenditures:	

Other:	

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ☐ N ☒

Does the bill increase taxes, fees or fines?	
Does the bill decrease taxes, fees or fines?	
What is the impact of the increase or decrease?	
Bill Section Number:	

TECHNOLOGY IMPACT

1. DOES THE LEGISLATION IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E., IT SUPPORT, LICENSING, SOFTWARE, DATA STORAGE, ETC.)? Y ☐ N ☒

If yes, describe the anticipated impact to the agency including any fiscal impact.	

FEDERAL IMPACT

1. DOES THE LEGISLATION HAVE A FEDERAL IMPACT (I.E., FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGECY INVOLVEMENT, ETC.)? Y ☐ N ☒

If yes, describe the anticipated impact including any fiscal impact.	

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	

ADDITIONAL COMMENTS

- The bill will protect all children under the age of 7 from being arrested, charged or sentenced for any crime they commit. This bill effectively provides immunity from prosecution to all those under the age of 7, except in the case of a Forceable Felony under s. 776.08, FS.

- The bill will restrict law enforcement from arresting any child between the ages of 7 to 14 for any new crime committed absent an imminent threat of serious bodily harm to another individual.

- Under this bill, a minor will be also be immune from arrest while on his or her primary or secondary school grounds, absent belief that the child is a current imminent threat of serious bodily harm to another individual.

- The bill will require the Criminal Justice Standards and Training Commission to amend basic recruit and advanced training course curriculums as they relate to juvenile arrest and detainment procedures. This could be implemented as part annual curriculum updates.

THE STATE OF FLORIDA
JUSTICE ADMINISTRATIVE COMMISSION

227 North Bronough Street, Suite 2100
Tallahassee, Florida 32301

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Executive Director

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FAX (850) 488-8944

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Public Defender, 20th Circuit
Brian Haas
State Attorney, 10th Circuit
Jack Campbell
State Attorney, 2nd Circuit

MEMORANDUM NO. 13-21, EXEC

TO: The Florida Senate

FROM: Alton L. "Rip" Colvin, Jr.

SUBJECT: Bill Analysis Response for Senate Bill 0626

DATE: February 8, 2021

Thank you for the opportunity to respond to your recent bill analysis request for Senate Bill 0626 on behalf of the Justice Administrative Commission (JAC).

Senate Bill 0626, filed by Senator Randolph Bracy on January 13, 2021, is an "act relating to juvenile justice." This act takes effect July 1, 2021.

Upon review, JAC finds that Senate Bill 0626 will have no policy, workload, or fiscal impacts to our agency. Please consider this reply as responsive to your request on behalf of JAC "proper" and not the judicial-related offices (JROs) administratively served by JAC. JROs include the offices of State Attorney, Public Defender, Criminal Conflict and Civil Regional Counsel, Capital Collateral Regional Counsel, and the Statewide Guardian ad Litem Program. Please note that the JROs will be provided a copy of this analysis as a courtesy.

2021 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Department of Juvenile Justice

BILL INFORMATION	
BILL NUMBER:	SB 626
BILL TITLE:	Juvenile Justice
BILL SPONSOR:	Senator Bracy
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1) Children, Families, and Elder Affairs
2) Criminal Justice
3) Appropriations
4) Click or tap here to enter text.
5) Click or tap here to enter text.

CURRENT COMMITTEE
Children, Families, and Elder Affairs

SIMILAR BILLS	
BILL NUMBER:	HB 303
SPONSOR:	Representative Williams

PREVIOUS LEGISLATION	
BILL NUMBER:	SB 578
SPONSOR:	Senator Bracy
YEAR:	2020
LAST ACTION:	Died in committee

IDENTICAL BILLS	
BILL NUMBER:	Click or tap here to enter text.
SPONSOR:	Click or tap here to enter text.

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	2/8/2021
LEAD AGENCY ANALYST:	Sam Kerce, Deputy Legislative Affairs Director, 850-717-2717
ADDITIONAL ANALYST(S):	Dr. Sherry Jackson, Director of Research and Data Integrity
LEGAL ANALYST:	John Mila, Asst. General Counsel
FISCAL ANALYST:	Click or tap here to enter text.

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

The bill creates the “Kaia Rolle Act” which prohibits the arrest, adjudication, or charge of a youth who is younger than 7 years of age. The bill also limits the circumstances where a youth under 15 may be taken into custody. In addition, the bill limits when a youth may be taken into custody while at school.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Definition of a Child

Section 985.03, Florida Statutes, defines a child, juvenile, or youth as any person under the age of 18 or any person who is alleged to have committed a violation of law occurring prior the time that person reached the age of 18 years. The Department does not arrest nor charge youth with a crime, but instead interacts with youth once law enforcement, the state courts, and statute provides. Services that the Department provides for youth span the full continuum of care including prevention, diversion, detention, probation, and residential commitment.

For many first time offenders, law enforcement officers will offer a civil citation. Since 2011 over 76,000 youth have been diverted from arrest through the use of civil citation and other similar prearrest diversion programs. These programs allow first-time misdemeanors to be diverted from entering the criminal justice system and instead the youth is assessed and assigned alternatives to arrest such as community service, anger management, or mental health counseling. If a youth is not eligible for a civil citation then the youth may be taken into custody.

Taking Custody of a Child

Currently, when a law enforcement officer decides to arrest a youth, they can either provide a youth a Notice to Appear or book them and take them to be screened. There is no state law limiting the age or location a child can be arrested. A youth may be arrested and taken into custody in the community or at school. However, some individual law enforcement agencies have local policies on how to handle the arrest of a younger youth, such as calling to receive permission from a supervising officer.

Notice to Appear is a process where a law enforcement officer gives a youth a formal ticket in the field that requires them to appear in court to handle their charges. These are normally given to youth that do not present a harm to public safety and who are likely attend their court hearing without having to be detained.

A law enforcement officer may also formally arrest and book a youth which will result in a screening being completed known as the Detention Risk Assessment Instrument (DRAI). The DRAI is used to assess if a youth should be held in secure detention after they are arrested or if they should be released back into the community. The main rational used when deciding whether to release a youth back into the community is whether they pose a risk to public safety. The DRAI takes into consideration a youth who is under the age of 12 when assigning a score to determine whether they should be released.

Once a trained DRAI screener completes their analysis and the score is totaled, one of the three options will be recommended for the youth:

- **Secure Detention** as defined in s. 985.03(18), F.S., a youth will be held in a juvenile secure detention center that serves that county.
- **Supervised Release** as defined in s. 985.03(18), F.S., would allow for a youth to be released on home detention pending their adjudicatory hearing. However, additional supervision overlays such as electronic monitoring, day and evening reporting, and nonsecure shelters can be added. Additional requirements may be imposed by the court.
- **Release** is the least restrictive option and would allow for a youth to be released back to their parent or guardian while they await their court proceedings.

During FY 2019-20, 2 youth who were under the age of seven when referred to the Department. The offenses included one misdemeanor assault/battery and one felony vandalism; neither youth was admitted to secure detention.

In FY 2019-2020, there were 12,114 referrals for youth age 7 years or older but younger than 15 years of age to the Department for charges ranging from murder and kidnapping to armed robbery and sexual battery. The most common new law offenses were Misdemeanor Assault and Battery (19%), Burglary (14%), Felony Aggravated Assault/Battery (11%), and Petit Theft (5%). A total of 2,200 youth ages 7 years or older but younger than 15 years of age were admitted to secure detention.

In FY 2019-20, a total of 5,298 school related offenses were committed by juveniles and charged as felonies or misdemeanors. Some of the most common offenses were for misdemeanor assault/battery (1,199), felony aggravated assault/battery (936), misdemeanor disorderly conduct (796), and felony drug offenses (465).

2. EFFECT OF THE BILL:

Section 1.

The bill amends s. 985.03, F.S., to change the definition of a child, juvenile, or youth, for use of Chapter 985 – Juvenile Justice, to any person 7 years of age or older but younger than 18 years of age who is alleged to have committed a violation of law occurring after the person reached 7 years of age or older and before that person reached 18 years of age.

Section 2.

Section 985.031, F.S., is created to state that a person who is under the age of 7 is not to be adjudicated delinquent, arrested, or charged with a violation of law or a delinquent act. An exception is made if the child commits a forcible felony as defined in s. 776.08, F.S.

Section 3

Section 985.101(1), F.S., is amended to put new limitations on when a youth under the age of 15 years old may be taken into custody. This is done through the creation of subsection 985.101(5), F.S., which allows for a youth between the ages of 7 and 14 to be taken into custody or arrested only if:

(1) they failed to appear at a court hearing after being properly notified, or
(2) law enforcement has probable cause to believe the child has absconded from a nonresidential commitment or escaped from a residential commitment program, or
(3) law enforcement has probable cause to believe that detention is necessary to prevent an imminent threat of seriously bodily harm to another individual.

The limitations on taking a youth into custody outlined in section 3 of the bill, could be problematic. For instance, a 14-year-old who commits a felony robbery may not be considered an ***imminent threat*** and not be able to be taken into custody. The bill does not give law enforcement the authority to take custody of a youth who may currently be on probation for a previous crime and then commits a new law violation or violates the conditions of their probation.

The bill also places limitations on when a child enrolled in primary or secondary school may be arrested or taken into custody while they are at school to youth who meet at least one of the following:

(1) they failed to appear at a court hearing after being properly notified, or
(2) law enforcement has probable cause to believe that detention is necessary to prevent an imminent threat of seriously bodily harm to another individual.

Section 4.

Section 985.24(4), F.S., requires that a child who is taken into custody pursuant to a summons, arrest warrant, or circuit court order that does not explicitly require detention, must be treated in the same manner as stated in the newly created statute s. 985.101(1)(b) as explained in section 2 of the bill.

Section 5.

The bill reenacts s. 316.003(11), F.S.

Section 6

The bill reenacts s. 960.001(1)(b), F.S.

Section 7

The bill reenacts s. 985.439(2), F.S.

Section 8
The bill reenacts s. 985.25(1), F.S.

Section 9
The bill provides for an effective date of July 1, 2021.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y☐ N☒

If yes, explain:	Click or tap here to enter text.
Is the change consistent with the agency's core mission?	Y☐ N☐
Rule(s) impacted (provide references to F.A.C., etc.):	Click or tap here to enter text.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	Unknown.
Opponents and summary of position:	Unknown.

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y☐ N☒

If yes, provide a description:	Click or tap here to enter text.
Date Due:	Click or tap here to enter text.
Bill Section Number(s):	Click or tap here to enter text.

6. ARE THERE ANY NEW GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSIONS, ETC. REQUIRED BY THIS BILL? Y☐ N☒

Board:	Click or tap here to enter text.
Board Purpose:	Click or tap here to enter text.
Who Appoints:	Click or tap here to enter text.
Changes:	Click or tap here to enter text.
Bill Section Number(s):	Click or tap here to enter text.

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y☐ N☒

Revenues:	Click or tap here to enter text.
Expenditures:	Unknown, while this bill would divert youth from the criminal justice system, it is not clear what services a youth may receive in place.
Does the legislation increase local taxes or fees? If yes, explain.	Click or tap here to enter text.
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	Click or tap here to enter text.

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y☐ N☒

Revenues:	Click or tap here to enter text.
Expenditures:	Unknown, while this bill would divert youth from the criminal justice system, it is not clear what services a youth may receive in place.
Does the legislation contain a State Government appropriation?	Click or tap here to enter text.
If yes, was this appropriated last year?	Click or tap here to enter text.

3. DOES THE BILL HAVE A FISCAL IMPACT TO THE PRIVATE SECTOR? Y☐ N☒

Revenues:	Click or tap here to enter text.
Expenditures:	Unknown, while this bill would divert youth from the criminal justice system, it is not clear what services a youth may receive in place.
Other:	Click or tap here to enter text.

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y☐ N☒

If yes, explain impact.	Click or tap here to enter text.
Bill Section Number:	Click or tap here to enter text.

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y☐ N☒

If yes, describe the anticipated impact to the agency including any fiscal impact.	Click or tap here to enter text.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y☐ N☒

If yes, describe the anticipated impact including any fiscal impact.	Click or tap here to enter text.

ADDITIONAL COMMENTS

Click or tap here to enter text.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	
Lines 48 and 52	The term "child" is misused. A person under age 7 is, by definition, not a child (see lines 38-43). The word "child" on line 48 should be replaced with "person." The word "child" on line 52 should be replaced with the phrase "person younger than 7 years of age."
Lines 103-05	The provision allowing law enforcement to arrest a 7-14 year-old in or out of a school setting upon "*probable cause to believe that detention is necessary to prevent an imminent threat of serious bodily harm to another individual."* The standard for probable cause is well articulated through legal interpretation, however probable cause as it relates to an "imminent threat or serious bodily harm to another individual" will be difficult to interpret.
Lines 115-17	Additionally, a different standard is placed upon those under 7 years of age and those 7 years of age to 14 years of age in regard to forcible felonies. A person under 7 is able to be arrested for a forcible felony as there is no reference to forcible felonies for youth 7-14 years of age.
Line 110	Primary or secondary school is not defined in statute.

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THE FLORIDA SENATE

APPEARANCE RECORD

2/16/21
Meeting Date

626
Bill Number (if applicable)

Topic Adult Treatment of Children

Amendment Barcode (if applicable)

Name Sara Mollo

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Public Defender Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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2/16/2021
Meeting Date

THE FLORIDA SENATE

APPEARANCE RECORD

626
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Juvenile Justice

Name Karen Woodall

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Center for Fiscal & Economic Policy

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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2/16/21
Meeting Date

THE FLORIDA SENATE

APPEARANCE RECORD

SB 626
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Juvenile Justice (Min. Age of Arrest)

Name Kara Gross

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing ACLU of Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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Reset Form

THE FLORIDA SENATE

APPEARANCE RECORD

February 16, 2021
Meeting Date

626
Bill Number (if applicable)

Topic Juvenile Justice

Amendment Barcode (if applicable)

Name Pamela Burch Fort

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing NAACP Florida State Conference

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/21
Meeting Date

626
Bill Number (if applicable)

Topic Kara Rolle Act

Amendment Barcode (if applicable)

Name Ida V. Eskamani

Job Title

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Phone

City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Rising

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/21
Meeting Date

608
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Juvenile justice

Name Lauren Gallo

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing League of Women Voters Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

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02/16/21
Meeting Date

THE FLORIDA SENATE

APPEARANCE RECORD

626
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Juvenile Justice

Name Ingrid Delgado

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Conference of Catholic Bishops

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

02/16/21
Meeting Date

626
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Juvenile Justice

Name Pamela Burch Fort

Job Title

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Tallahassee — *City* | Fl — *State* | 32301 — *Zip*

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing NAACP Florida State Conference

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 626
INTRODUCER:	Senator Bracy
SUBJECT:	Juvenile Justice
DATE:	February 15, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Cox	CF	**Pre-meeting**
2.			CJ	
3.			AP	

I. Summary:

The bill amends the definition of child, juvenile or youth to mean any person 7 years of age or older but younger than 18 years of age or any person who is alleged to have committed a violation of law during that age range.

The Kaia Rolle Act is created to prohibit children under the age of 7 from being arrested, charged with a violation of law, or adjudicated delinquent for any acts that occur before he or she reaches 7 years of age except for any child who commits a forcible felony as defined in s. 776.08, F.S.

The bill specifies at what age and circumstances a child may be taken into custody, including when a child may be taken into custody at his or her primary or secondary school. Section 985.24, F.S., is amended to place restrictions on when a child may be detained.

The bill reenacts ss. 316.003(11), 960.001(1), 985.439(2), F.S, and 985.25(1), F.S.

The bill does not appear to have a fiscal impact on state or local governments. See Section V. Fiscal Impact Statement.

The bill is effective July 1, 2021.

II. Present Situation:

Juvenile Capability

There are various age limitations on criminal liability throughout the United States. A recent United Nations study suggests that all member states should set a minimum age of criminal

responsibility no younger than age 14.[1] Several states have enacted legislation to establish a minimum age at which children may be held criminally liable.[2] Of the states that have passed this legislation, the minimum age ranges from 6 to 12 years of age.[3] For instance, Massachusetts law protects children 12 years of age or younger from criminal liability[4] whereas the age limit in North Carolina is 6 years of age or younger.[5] Fifteen jurisdictions set the minimum age at 10.[6] Some states have adopted exceptions to the minimum age requirement, such as Nevada which exempts children who are 10 years of age or younger from criminal liability unless the child between 8 to 10 years old is charged with murder or a sexual offense.[7]

Model Penal Code (MPC) sets out four mens rea that may be required to show culpability for any valid criminal conviction,[8] namely purposely,[9] knowingly,[10] recklessly,[11] and negligently.[12] Mens rea is not required for a person to be convicted of a crime that provides for strict liability.[13] Some studies suggest and precedents from the U.S. Supreme Court have held that adolescents have a diminished capacity to make consistent choices, engage in self-management, assess risk perception, and calculate future consequences,[14] in other words, to formulate a mens rea.

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[1] *Id.*
[2] NJDC Article; *See also* Interstate Commission for Juveniles, *Age Matrix*, available at https://www.juvenilecompact.org/age-matrix (last visited February 11, 2021).
[3] National Juvenile Defender Center, *Minimum Age for Delinquency Adjudication – Multi-jurisdiction Survey*, available at https://njdc.info/practice-policy-resources/state-profiles/multi-jurisdiction-data/minimum-age-for-delinquency-adjudication-multi-jurisdiction-survey/ (last visited February 11, 2021) (hereinafter cited as "NJDC Article").
[4] Section 119.52, Mass. Gen. Laws Ann. Ch.
[5] Section 7B-1501(7), N.C. Gen. Stat. Ann.
[6] NJDC Article (citing American Samoa, Arkansas, Arizona, Colorado, Kansas, Louisiana, Minnesota, Mississippi, Nevada, North Dakota, Pennsylvania, South Dakota, Texas, Vermont, and Wisconsin).
[7] Section 194.010, N.R.S.
[8] Section 2.02(1), MPC.
[9] Section 2.02(2)(a), MPC. If the material element of an offense involves the nature of a person's conduct or a result thereof, a person acts purposely when it is his conscious object to engage in conduct of that nature or to cause such a result, and, if a material element involves the attendant circumstances, he is aware of them or he believes or hopes that they exist. Material element means issues relating to the harm or evil sought to be prevented by the law. MPC § 1.13(10).
[10] Section 2.02(2)(b), MPC. If a material element of an offense involves the nature of a person's conduct or the attendant circumstances, a person acts knowingly when he is aware that his conduct is of that nature or that such circumstances exist, and, if the material element involves the result of his conduct, he is aware that it is practically certain that his conduct will cause such a result.
[11] Section 2.02(2)(c), MPC. A person acts recklessly with respect to a material element of an offense when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of the actor's conduct and the circumstances known to him, his conduct involves a gross deviation from the standard that a law-abiding person would observe in the actor's situation.
[12] Section 2.02(2)(d). A person acts negligently with respect to a material element of an offense when he should be aware of a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that the actor's failure to perceive it, considering the nature and purpose of his conduct and the circumstances known to him, involves a gross deviation from the standard of care that a reasonable person would observe in the actor's situation.
[13] Section 2.02, MPC.
[14] Jenny E. Carroll, *Brain Science and the Theory of Juvenile Mens Rea*, 94 N.C. L. REV. 539, 582 (2016). *See also Roper v. Simmons*, 543 U.S. 551 (2005); *Graham v. Florida*, 560 U.S. 48 (2010); *Miller v. Alabama*, 567 U.S. 460 (2012).

Offenses Committed by Children

A person may not be tried for a capital crime without presentment or indictment by a grand jury, or for other felony without such presentment or indictment or an information under oath filed by the prosecuting officer of the court, except persons on active duties in the militia when tried by courts martial.[15]

However, a child may be charged with a violation of law as an act of delinquency instead of a crime and tried without a jury or other requirements applicable to criminal cases.[16] If a child is found to be delinquent, he or she must be disciplined as provided by law.[17]

Under ch. 985, F.S., the terms child, juvenile or youth currently mean any person under the age of 18 or any person who is alleged to have committed a violation of law occurring prior to the time that person reached the age of 18 years.[18] However, Florida law does not presently restrict the age in which a child, juvenile, or youth may be arrested, charged with a violation of the law, or adjudicated dependent.

Florida's Juvenile Justice System

The Department of Juvenile Justice (DJJ) is tasked with providing a full continuum of care to youth, including but not limited to, prevention,[19] diversion,[20] and detention,[21] probation,[22] residential commitment.[23, 24]

Prevention services

The purpose of prevention services mandated under ch. 985, F.S., is to reduce recidivism, protect public safety, and assist with at-risk youth's reentry into the community.[25] As a condition of state funds, the DJJ is required, in part, to design programs providing services to further one or more of the following strategies:

- Design the programs providing such services to further one or more of the following strategies:
  - Encouraging youth to attend and succeed in school.
  - Engaging youth in productive and wholesome activities during non-school hours that build positive character, instill positive values, and enhance educational experiences.
  - Encouraging youth to avoid the use of violence.

[15] FLA. CONST. art. I, s. 15(a).
[16] FLA. CONST. art. I, s. 15(b).
[17] *Id.*
[18] Section 985.03(7), F.S.
[19] *See* s. 985.17, F.S.
[20] Section 985.12, F.S. (providing for civil citation or similar arrest diversion programs).
[21] Chapter 985, Part V, F.S.
[22] Section 985.435, F.S.
[23] Section 985.441, F.S. The DJJ is also responsible for probation services (s. 985.435, F.S.) and residential commitment (s. 985.441, F.S.). Sections 985.435(1) and 985.441(1), F.S., provide the court with jurisdiction to sanction children who are adjudicated delinquent to probation or residential commitment.
[24] The DJJ, *Agency Analysis for SB 626*, p. 2, February 8, 2021 (On file with the Senate Committee on Children, Families, and Elder Affairs) (hereinafter cited as "DJJ Analysis").
[25] Section 985.17(1), F.S.

- Assisting youth in acquiring the skills needed to find meaningful employment, which may include assisting the youth in finding a suitable employer.
- Provide demographic information, dates of services, and types of interventions received by each youth.[26]

For FY 2019-2020, the DJJ reports that 990 children under the age of 7 were admitted to a prevention program.[27] The DJJ partners with several agencies and other organizations to provide these services to the children, including, in part, the:

- Department of Children and Families;
- Department of Juvenile Justice; and
- Prevention Partnership.

Civil Citations

Each judicial circuit must establish a civil citation or similar diversion program.[28] These programs are designed to divert children who have committed misdemeanor offenses from the juvenile delinquency system.[29]

Each circuit must determine which misdemeanor offenses qualify and other eligibility of the program.[30] Examples of program requirements include community service, restitution, family counseling, substance abuse and mental health treatment.[31] A civil citation or similar diversion program has been implemented in 65 counties in Florida.[32] Bradford and Hardee counties have not established such a program.[33]

Since 2011, over 76,000 eligible first-time youth offenders who have committed a misdemeanor offense have been offered a civil citation pre-arrest to participate in a division program.[34]

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[26] Section 985.17(4)(a), F.S.
[27] The DJJ, Electronic mail from Rachel Moscoso, Legislative Affairs Director, RE: Agency Bill Analysis for SB 626, February 8, 2021 (on file with the Senate Committee on Children, Families, and Elder Affairs) (noting that prevention services serve at-risk youth but the 990 children who participated in the prevention services were not due to a delinquent act or charge).
[28] Section 985.12(1), F.S.
[29] *Id.*
[30] Section 985.12(2)(b)1. and 2., F.S.
[31] Section 985.12(2)(b)4., F.S. The DJJ, *Overview Look Here to Locate the Civil Citation Provider in your Area*, available at http://www.djj.state.fl.us/partners/our-approach/florida-civil-citation (last visited February 11, 2021) (listing the civil citation and similar prearrest diversion programs in Florida, and depicting the process for civil citation and similar prearrest diversion programs in a flow chart).
[32] Florida Department of Juvenile Justice, *Civil Citation Implementation by County as of October 2019*, available at http://www.djj.state.fl.us/docs/probation-policy-memos/civil-citation-implementation-map-10-2020.pdf?sfvrsn=4 (last visited February 11, 2021).
[33] *Id.*
[34] DJJ Analysis at p. 2. *See also* The DJJ, *Civil Citation and Similar Diversion Program Best Practices Guide*, (2020), available at http://www.djj.state.fl.us/docs/probation-policy-memos/civil-citation-and-similar-diversion-program-best-practices-guide-2020.pdf?sfvrsn=2 (last visited February 11, 2021) (explaining statewide utilization for the fiscal year 2019-20 was 59 percent).

Notice to Appear

When a child violates the law, the arresting officer may elect to release the child as provided by law to a parent, responsible adult relative, or legal guardian, and issue a notice of appear at a designated court or government office at a specified date and time provided conditions articulated under the rules are met.[35]

Taking a child into custody

Art. 1, s. 14 of the Florida Constitution states that unless charged with a capital offense or an offense punishable by life imprisonment and the proof of guilt is evident or the presumption is great, every person charged with a crime or violation of law shall be entitled to pretrial release on reasonable conditions. If no conditions of release can reasonably protect the community from risk of physical harm to persons, assure the presence of the accused at trial, or assure the integrity of the judicial process, the accused may be detained.

The Florida Statutes does not presently distinguish the circumstances under which a child may be taken into custody based on the age of the youth. Section 985.101(1), F.S., provides, in part, that any child may be taken into custody in the following circumstances:

- Pursuant to an order of the circuit court, based upon sworn testimony, either before or after a petition is filed;
- For a delinquent act or violation of law, pursuant to Florida law pertaining to a lawful arrest;
- By a law enforcement officer for failing to appear at a court hearing after being properly noticed; or
- By a law enforcement officer who has probable cause to believe that:
  - The child is in violation of the conditions of the child's probation, supervised release detention, postcommitment probation;
  - Conditional release supervision;
  - Has absconded from nonresidential commitment; or
  - Has escaped from residential commitment.[36]

Intake and Assessment

Every child under the age of 18 charged with a crime in Florida is referred to the DJJ.[37] Intake and screening services for youth referred to the DJJ are performed at a Juvenile Assessment Center (JAC),[38] but must be performed by a the DJJ employee.[39] Once brought into intake, the DJJ assigns the child a juvenile probation officer (JPO) to determine what, if any, detention care

[35] *See* Rule 8.045(b), Fla. R. Juv. P. An officer may issue a notice to appear unless: (1) the child fails or refuses to sufficiently identify himself or herself or supply the required information; (2) the child refuses to sign the notice to appear; (3) the officer has reason to believe that the continued liberty of the child constitutes an unreasonable risk of bodily injury to the child or others; (4) the child has no ties with the jurisdiction reasonably sufficient to ensure an appearance or there is substantial risk that the child will refuse to respond to the notice; (5) the officer has any suspicion that the child may be wanted in any jurisdiction; or (6) it appears that the child has previously failed to respond to a notice or a summons or has violated the conditions of any pretrial release program.
[36] Section 985.101(1)(a), F.S.
[37] A referral is similar to an arrest in the adult criminal justice system. *See* the DJJ, *Probation and Community Intervention, Overview*, available at http://www.djj.state.fl.us/services/probation (last visited February 11, 2021).
[38] Section 985.135(4), F.S.
[39] Section 985.14(2), F.S.

is necessary.[40] The JPO makes an initial decision regarding detention care placement using the "Detention Risk Assessment Instrument."[41] In certain instances, the JPO does not have discretion and must place a child in secure detention (e.g., when a child is charged with possessing or discharging a firearm on school property).[42] The JPO serves as the primary case manager responsible for managing, coordinating, and monitoring services provided to the child.[43]

Detention Care System

Detention care is the temporary care of children pursuant to an adjudication or order of the court.[44] Children may be detained in either secure[45] or supervised release detention.[46]

Section 985.24(1), F.S., provides guidelines for the court to use in ordering detention care that address the child's prior history with the juvenile justice system, and other risk factors.[47]

A child may not be held in detention for more than 24 hours without a detention hearing.[48] A detention hearing is conducted by a circuit judge who reviews the assessment instrument to determine if there is probable cause that the child committed the offense and the need for continued detention.[49] A court's detention order must include specific instructions for release of the child from detention.[50]

Probation or Postcommitment Probation (Probation)

A child's probation program must include both a penalty and a rehabilitative component.[51] Each child is assigned a juvenile probation officer who monitors the child's compliance and helps the child connect with service providers.

If the child does not comply with terms of probation, the child may be brought before the court on a violation of probation. The violation may be a substantive violation for committing a new

[40] Section 985.25(1), F.S.
[41] Sections 985.25(1)(b) and 985.245, F.S. Section 985.245, F.S., outlines with whom the Detention Risk Assessment Instrument must be developed, when and how it must be updated, and what factors the assessment instrument should identify when evaluating a child to determine whether detention placement is appropriate.
[42] Section 985.25(1)(b), F.S.
[43] Section 985.145(1), F.S.
[44] Section 985.03(18), F.S.
[45] Section 985.03(18)(a), F.S., defines "secure detention" as temporary custody of the child while the child is under the physical restriction of a detention center or facility pending adjudication, disposition, or placement.
[46] Section 985.03(18)(b), F.S., defines "supervised release detention" as temporary, nonsecure custody of the child while the child is released to the custody of the parent, guardian, or custodian in a physically nonrestrictive environment under the supervision of the department staff pending adjudication or disposition, through programs that include, but are not limited to, electronic monitoring, day reporting centers, and nonsecure shelters. Supervised release detention may include other requirements imposed by court.
[47] Section 985.24(1), F.S., Factors including but not limited to not appearing at a hearing and requests protection from imminent bodily harm.
[48] Section 985.26(1), F.S. The child has the right to be represented at this hearing or can waive the right under S. 985.033, F.S.
[49] Section 985.255(3), F.S.
[50] *Id.* Under s. 985.26(2), F.S., a 21-day limit applies to a detention order but may be held up to 30 days if the child is charged with what would be, if committed by an adult, a capital felony, a life felony, a first degree felony, or a second degree felony offense.
[51] Section 985.435(2) and (3), F.S., give examples of what these components include.

criminal offense or a technical violation for failure to comply with a condition of probation.[52] If a child admits to the violation or is found by the court to have violated probation, the court must enter an order revoking, modifying, or continuing probation.[53] Specifically, the court may:

- Place the child into an alternative consequence program;
- Place the child on home detention with electronic monitoring;
- Modify or continue the child's probation; or
- Revoke probation and commit the child to the DJJ.[54]

Residential Commitment

The court may commit the child to a nonresidential or residential facility.[55] Commitment programs vary by "restrictiveness level," defined in s. 985.03(44), F.S., as "the level of programming and security provided by programs that service the supervision, custody, care, and treatment needs of committed children." Levels of commitment are:

- Minimum-risk nonresidential where children remain in their community and participate at least 5 days a week in day treatment;
- Nonsecure residential where children are in a residential program and have supervised access to their community;
- High-risk residential where children are not allowed access to their community with limited exception; and
- Maximum-risk residential including juvenile correctional facilities or juvenile prisons that do not allow the children to have any access to their community.[56]

If the court determines the child should be adjudicated delinquent and committed to the DJJ through court order, [57] the DJJ must recommend the restrictiveness level for the child. The court may commit the child at a different restrictiveness level but must set out findings for departure in the record based on a preponderance of the evidence.[58]

Data on Offenses Committed by Juveniles

The DJJ reports that in FY 2019-20 12,224 youth between the ages of 7 and 14 years of age were referred to the DJJ for charges ranging from murder and kidnapping to armed robbery and sexual battery.[59] The most common of these offenses were misdemeanor assault/battery (19%), burglary (14%), felony aggravated assault/battery (11%), and petit theft (5%).[60] A total of 2,200 youth ages 7 years or older but younger than 15 years of age were admitted to secure detention.[61]

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[52] *See Meeks v. State*, 754 So.2d 101, 103-104 (Fla. 1st DCA 2000); *Johnson v. State*, 678 So.2d 934, 934-935 (Fla. 3d DCA 1996).
[53] Section 985.439(4), F.S.
[54] Section 985.439(4)(d), F.S.
[55] Section 985.441, F.S.
[56] Section 985.03(44), F.S. Florida law caps the number of beds at maximum-risk residential facilities at 90 beds.
[57] Section 985.441(1), F.S.
[58] Section 985.441(2), F.S.
[59] DJJ Analysis at p. 3.
[60] *Id*.
[61] *Id.*

In FY 2019-2020, 5,298 school related offenses were committed by juveniles and charged as felony or misdemeanor offenses, including but not limited to, misdemeanor assault/battery (1,199), felony aggravated assault/battery (936), misdemeanor disorderly conduct (796), and felony drug offenses (465).[62]

Interstate Compact on Juveniles

The Interstate Compact for Juveniles is an agreement amongst compacting states to be responsible for the safe return of juveniles who are on probation or parole and who have absconded, escaped, or run away from supervision and control.[63] The Governor must execute an interstate compact for juveniles on behalf of Florida with any other state who joins the compact.[64] The compact does not limit the Legislature's ability to determine policy regarding juvenile offenders and non-offenders within Florida,[65] or restrict the definition of juvenile by age limit.[66]

III. Effect of Proposed Changes:

The bill amends s. 985.03, F.S., modifying the definition of a child, juvenile or youth to any person who is 7 years of age or older but younger than 18 years old who is alleged to have violated the law after the person has reached age 7, but before the person has reached 18 years of age.

The bill also amends s. 985.031, F.S., prohibiting a person who is under the age of 7 from being arrested, charged, or adjudicated delinquent except if the child commits a forcible felony as defined in s. 776.08, F.S.[67]

Section 985.10(1), F.S., limiting the current proscribed circumstances in which a child may be taken into custody to a youth who is 15 years of age and older. The bill also provides circumstances under which a child who is between ages 7 and 14 may be taken into custody by law enforcement, specifically any of the following:

- Youth who have failed to appear at a court hearing after being properly noticed.
- By a law enforcement officer who has probable cause to believe that the child has absconded from nonresidential commitment or has escaped from residential commitment.
- By a law enforcement officer who has probable cause to believe that detention is necessary to prevent an imminent threat of serious bodily harm to another individual.

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[62] DJJ Analysis at p. 3.
[63] Interstate Commission for Juveniles (ICJ), *The Interstate Compact for Juveniles*, p. 1, available at https://www.juvenilecompact.org/sites/default/files/ICJRevisedLanguage.pdf (last visited February 10, 2021).
[64] *See* s. 985.802, F.S.
[65] *Id.*
[66] ICJ, *ICJ Rules, Interstate Commission for Juveniles, Serving Juveniles While Protecting Communities*, p. 6, (April 23, 2020), available at https://www.juvenilecompact.org/sites/default/files/ICJ%20Rules_Final.pdf (last visited February 9, 2021).
[67] Section 776.08, F.S., defines "forcible felony" to mean treason; murder; manslaughter; sexual battery; carjacking; home-invasion robbery; robbery; burglary; arson; kidnapping; aggravated assault; aggravated battery; aggravated stalking; aircraft piracy; unlawful throwing, placing, or discharging of a destructive device or bomb; and any other felony which involves the use or threat of physical force or violence against any individual.

The bill also limits the circumstances for when a child who is enrolled in primary or secondary school may be taken into custody while they are at school, including:

- By a law enforcement officer for failing to appear at a court hearing after being properly noticed; or
- By a law enforcement officer who has probable cause to believe that detention is necessary to prevent an imminent threat of serious bodily harm to another individual.

The bill also amends s, 985.24(4), F.S., requiring any child who is taken into custody but does not explicitly require detention to be treated in the same manner as a child taken into custody under s. 985.101(1)(b), F.S., and may be detained only when:

- Presents a substantial risk of not appearing at a hearing;
- Presents a substantial risk of inflicting bodily harm on others as evidenced by recent behavior;
- Presents a history of committing a property offense prior to adjudication, disposition, or placement;
- Has committed contempt of court; or
- Requests protection from imminent bodily harm.

The bill reenacts ss. 316.003(11), 960.001(1)(b), 985.439(2), and 985.25(1), F.S., for the purpose of incorporating changes made by the act.

The bill provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The bill prohibits a child under the age of 7 from being arrested, charged with a violation of the law, or adjudicated delinquent except in specified circumstances which may result in indeterminate reduction of local fund expenditures for costs relating to criminal prosecution and confinement if such child would have otherwise been detained or charged with a crime. However, these provisions relate to the defense, prosecution, or punishment of criminal offenses, and criminal law and are therefore exempt from the requirements of Art. VII, s. 18(d) of the Florida Constitution, relating to unfunded mandates.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill does not appear to have a fiscal impact on state or local governments.

The Florida Department of Law Enforcement (FDLE) will be required to amend basic recruit and advanced training course curriculums in relation to the new custody and detention laws which may be incorporated in annual training review courses.[68]

The Justice Administrative Commission (JAC) reports that the bill will have no policy, workload, or fiscal impacts on the agency.[69]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 985.03, 985.101, and 985.24 of the Florida Statutes. This bill creates section 985.031, and subsections 985.101(5) and (6) of the Florida Statutes. This bill reenacts sections 316.003(11), 960.001, 985.436, and 985.25 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

[68] The FDLE, *Agency Analysis for 626*, p. 5, January 20, 2021 (on file with the Senate Committee on Children, Families, and Elder Affairs).
[69] The JAC, *Memorandum No. 13-21, Exec*, p.1, February 8, 2021 (on file with the Senate Committee on Children, Families, and Elder Affairs).

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

755868

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/16/2021	.	
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The Committee on Children, Families, and Elder Affairs (Book) recommended the following:

Senate Amendment (with directory and title amendments)

Between lines 971 and 972
insert:

(7) PROCEDURE FOR CONTINUED INVOLUNTARY INPATIENT PLACEMENT.—

(d) If at a hearing it is shown that the patient continues to meet the criteria for involuntary inpatient placement, the administrative law judge shall sign the order for continued involuntary inpatient placement for up to ~~90 days. However, any~~

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~~order for involuntary mental health services in a treatment facility may be for up to~~ 6 months. The same procedure shall be repeated before the expiration of each additional period the patient is retained.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======

And the directory clause is amended as follows:

Delete line 828

and insert:

(b), and (c) of subsection (6), and paragraph (d) of subsection (7) of section 394.467, Florida

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete line 71

and insert:

provisions to changes made by the act; revising the amount of time a court may require a patient to receive services; amending ss.

By Senator Book

32-00424A-21 2021828__

A bill to be entitled

An act relating to mental health and substance abuse; amending s. 394.455, F.S.; conforming a cross-reference; defining the terms "neglect or refuse to care for himself or herself" and "real and present threat of substantial harm"; amending s. 394.459, F.S.; requiring facilities to inform respondents with a serious mental illness of the essential elements of recovery and provide them assistance in accessing a continuum of care regimen; authorizing the Department of Children and Families to adopt certain rules; amending s. 394.4598, F.S.; conforming a cross-reference; amending s. 394.4599, F.S.; conforming provisions to changes made by the act; amending s. 394.461, F.S.; authorizing the state to establish that a transfer evaluation was performed by providing the court with a copy of the evaluation before the close of the state's case in chief; prohibiting the court from considering substantive information in the transfer evaluation unless the evaluator testifies at the hearing; amending s. 394.4615, F.S.; conforming provisions to changes made by the act; amending s. 394.462, F.S.; conforming provisions to changes made by the act; amending s. 394.4625, F.S.; providing requirements relating to the voluntariness of admissions to a facility for examination and treatment; providing requirements for verifying the assent of a minor admitted to a facility; requiring the appointment of a public defender to review the

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voluntariness of a minor's admission to a facility; requiring the filing of a petition for involuntary placement or release of a minor to his or her parent or legal guardian under certain circumstances; requiring minor patients' assent to voluntary care to be verified in a specified manner before a transfer to voluntary status may occur; conforming provisions to changes made by the act; amending s. 394.463, F.S.; revising the requirements for when a person may be taken to a receiving facility for involuntary examination; requiring a facility to inform the department of certain persons who have been examined or committed under certain circumstances; conforming provisions to changes made by the act; providing criminal and civil penalties; amending s. 394.4655, F.S.; revising the requirements for involuntary outpatient treatment; amending s. 394.467, F.S.; revising the requirements for when a person may be ordered for involuntary inpatient placement; revising requirements for continuances of hearings; revising the conditions under which a court may waive the requirement for a patient to be present at an involuntary inpatient placement hearing; authorizing the court to permit all witnesses to attend and testify remotely at the hearing through certain means; requiring facilities to make certain clinical records available to a state attorney within a specified timeframe; specifying that such records remain confidential and may not be used for certain purposes;

revising when the court may appoint a magistrate; requiring the court to allow certain testimony from individuals; revising the amount of time a court may require a patient to receive services; requiring facilities to discharge patients after the patient no longer meets the criteria for involuntary treatment; prohibiting courts from ordering that individuals with developmental disabilities be involuntary placed in a state treatment facility; requiring such individuals to be referred to certain agencies for evaluation and services; authorizing facilities to hold such individuals under certain circumstances; conforming provisions to changes made by the act; amending ss. 394.495 and 394.496, F.S.; conforming provisions to changes made by the act; amending s. 394.499, F.S.; making technical and conforming changes; amending s. 394.9085, F.S.; conforming cross-references; amending s. 397.305, F.S.; revising the purposes of ch. 397, F.S.; amending s. 397.311, F.S.; revising the definition of the terms "impaired" and "substance abuse impaired"; defining the terms "involuntary treatment services," "neglect or refuse to care for himself or herself," and "real and present threat of substantial harm"; amending s. 397.416, F.S.; conforming a cross-reference; amending s. 397.501, F.S.; requiring that respondents with serious substance use disorders be informed of the essential elements of recovery and provide them assistance with accessing a continuum of care regimen; authorizing the

department to adopt certain rules; amending s. 397.675, F.S.; revising the criteria for involuntary admissions; amending s. 397.6751, F.S.; revising the responsibilities of a service provider; amending s. 397.681, F.S.; revising where involuntary treatment petitions for substance abuse impaired persons may be filed; revising what part of such proceedings a general or special magistrate may preside over; requiring that the state attorney represent the state as the real party of interest in an involuntary proceeding, subject to legislative appropriation; providing that the petitioner has the right to be heard; specifying that certain records obtained by a state attorney must remain confidential and may not be used for certain purposes; conforming provisions to changes made by the act; repealing s. 397.6811, F.S., relating to involuntary assessment and stabilization; repealing s. 397.6814, F.S., relating to petitions for involuntary assessment and stabilization; repealing s. 397.6815, F.S., relating to involuntary assessment and stabilization procedures; repealing s. 397.6818, F.S., relating to court determinations for petitions for involuntary assessment and stabilization; repealing s. 397.6819, F.S., relating to the responsibilities of licensed service providers with regard to involuntary assessment and stabilization; repealing s. 397.6821, F.S., relating to extensions of time for completion of involuntary assessment and stabilization; repealing s. 397.6822, F.S., relating to the disposition of

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individuals after involuntary assessments; amending s. 397.693, F.S.; revising the circumstances under which a person is eligible for court-ordered involuntary treatment; amending s. 397.695, F.S.; authorizing the court or clerk of the court to waive or prohibit any service of process fees for an indigent petitioner; amending s. 397.6951, F.S.; revising the requirements for the contents of a petition for involuntary treatment services; authorizing a petitioner to include with the petition a certificate or report of a qualified professional; requiring the certificate or report to contain certain information; requiring that certain additional information be included if an emergency exists; amending s. 397.6955, F.S.; requiring the clerk of the court to notify the state attorney's office upon the receipt of a petition filed for involuntary treatment services; revising when the office of criminal conflict and civil regional counsel represents a person; revising when a hearing must be held on the petition; requiring law enforcement agencies to effect service for initial treatment hearings unless certain requirements are met; providing requirements for when a petitioner asserts that emergency circumstances exist or the court determines that an emergency exists; conforming provisions to changes made by the act; amending s. 397.6957, F.S.; expanding the exemption from the requirement that a respondent be present at a hearing on a petition for involuntary treatment services;

authorizing the court to order drug tests and permit all witnesses to remotely attend and testify at the hearing through certain means; deleting a provision requiring the court to appoint a guardian advocate under certain circumstances; prohibiting a respondent from being involuntarily ordered into treatment unless certain requirements are met; providing requirements relating to involuntary assessment and stabilization orders; providing requirements relating to involuntary treatment hearings; requiring that the assessment of a respondent occur before a specified time unless certain requirements are met; requiring the service provider to discharge the respondent after a specified time unless certain requirements are met; requiring a qualified professional to provide copies of his or her report to the court and all relevant parties and counsel; providing requirements for the report; authorizing a court to order certain persons to take a respondent into custody and transport him or her to or from certain service providers and the court; revising the petitioner’s burden of proof in the hearing; authorizing the court to initiate involuntary proceedings under certain circumstances; requiring that, if a treatment order is issued, it must include certain findings; amending s. 397.697, F.S.; requiring that an individual meet certain requirements to qualify for involuntary outpatient treatment; specifying that certain hearings may be set by the motion of a party or under the court’s own authority;

specifying that a service provider's authority is separate and distinct from the court's jurisdiction; amending s. 397.6971, F.S.; revising when an individual receiving involuntary treatment services may be determined eligible for discharge; conforming provisions to changes made by the act; amending s. 397.6975, F.S.; authorizing certain entities to file a petition for renewal of involuntary treatment; revising the timeframe during which the court is required to schedule a hearing; conforming provisions to changes made by the act; amending s. 397.6977, F.S.; conforming provisions to changes made by the act; repealing s. 397.6978, F.S., relating to the appointment of guardian advocates; amending ss. 409.972, 464.012, 744.2007, and 790.065, F.S.; conforming cross-references; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present subsections (32) through (39) and (40) through (49) of section 394.455, Florida Statutes, are redesignated as subsections (33) through (40) and (42) through (51), respectively, new subsections (32) and (41) are added to that section, and subsection (23) of that section is amended, to read:

394.455 Definitions.—As used in this part, the term:

(23) "Involuntary examination" means an examination performed under s. 394.463, s. 397.6772, s. 397.679, s.

397.6798, or s. 397.6957 ~~s. 397.6811~~ to determine whether a person qualifies for involuntary services.

(32) "Neglect or refuse to care for himself or herself" includes, but is not limited to, evidence that a person:

(a) Is unable to satisfy basic needs for nourishment, clothing, medical care, shelter, or safety in a manner that creates a substantial probability of imminent death, serious physical debilitation, or disease; or

(b) Is substantially unable to make an informed treatment choice and needs care or treatment to prevent deterioration.

(41) "Real and present threat of substantial harm" includes, but is not limited to, evidence of a substantial probability that the untreated person will:

(a) Lack, refuse, or not receive services for health and safety which are actually available in the community; or

(b) Suffer severe mental, emotional, or physical harm that will result in the loss of his or her ability to function in the community or the loss of cognitive or volitional control over thoughts or actions.

Section 2. Subsection (13) is added to section 394.459, Florida Statutes, to read:

394.459 Rights of patients.—

(13) POST-DISCHARGE CONTINUUM OF CARE.—Upon discharge, the facility must inform a respondent with a serious mental illness of the essential elements of recovery and provide assistance with accessing a continuum of care regimen. The department may adopt rules specifying the services that may be provided to such respondents.

Section 3. Subsection (1) of section 394.4598, Florida

Statutes, is amended to read:

394.4598 Guardian advocate.—

(1) The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist that the patient is incompetent to consent to treatment. If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and a guardian with the authority to consent to mental health treatment appointed, it shall appoint a guardian advocate. The patient has the right to have an attorney represent him or her at the hearing. If the person is indigent, the court shall appoint the office of the public defender to represent him or her at the hearing. The patient has the right to testify, cross-examine witnesses, and present witnesses. The proceeding shall be recorded either electronically or stenographically, and testimony shall be provided under oath. One of the professionals authorized to give an opinion in support of a petition for involuntary placement, as described in ~~s. 394.4655 or~~ s. 394.467, must testify. A guardian advocate must meet the qualifications of a guardian contained in part IV of chapter 744, except that a professional referred to in this part, an employee of the facility providing direct services to the patient under this part, a departmental employee, a facility administrator, or member of the Florida local advocacy council shall not be appointed. A person who is appointed as a guardian advocate must agree to the appointment.

Section 4. Paragraph (d) of subsection (2) of section 394.4599, Florida Statutes, is amended to read:

394.4599 Notice.—

(2) INVOLUNTARY ADMISSION.—

(d) The written notice of the filing of the petition for involuntary services for an individual being held must contain the following:

1. Notice that the petition for:

a. Involuntary inpatient treatment pursuant to s. 394.467 has been filed with the circuit court in the county in which the individual is hospitalized and the address of such court; or

b. Involuntary outpatient services pursuant to s. 394.4655 has been filed with the criminal county court~~, as defined in s. 394.4655(1),~~ or the circuit court, as applicable, in the county in which the individual is hospitalized and the address of such court.

2. Notice that the office of the public defender has been appointed to represent the individual in the proceeding, if the individual is not otherwise represented by counsel.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.

4. Notice that the individual, the individual's guardian, guardian advocate, health care surrogate or proxy, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the individual.

5. Notice that the individual is entitled to an independent expert examination and, if the individual cannot afford such an examination, that the court will provide for one.

Section 5. Subsection (2) of section 394.461, Florida Statutes, is amended to read:

394.461 Designation of receiving and treatment facilities and receiving systems.—The department is authorized to designate and monitor receiving facilities, treatment facilities, and receiving systems and may suspend or withdraw such designation for failure to comply with this part and rules adopted under this part. Unless designated by the department, facilities are not permitted to hold or treat involuntary patients under this part.

(2) TREATMENT FACILITY.—The department may designate any state-owned, state-operated, or state-supported facility as a state treatment facility. A civil patient shall not be admitted to a state treatment facility without previously undergoing a transfer evaluation. Before the close of the state's case in chief in a ~~court~~ hearing for involuntary placement ~~in a state treatment facility~~, the state may establish that the transfer evaluation was performed and the document properly executed by providing the court with a copy of the transfer evaluation. The court may not ~~shall receive and~~ consider the substantive information ~~documented~~ in the transfer evaluation unless the evaluator testifies at the hearing. Any other facility, including a private facility or a federal facility, may be designated as a treatment facility by the department, provided that such designation is agreed to by the appropriate governing body or authority of the facility.

Section 6. Subsection (3) of section 394.4615, Florida Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(3) Information from the clinical record may be released in the following circumstances:

(a) When a patient has communicated to a service provider a specific threat to cause serious bodily injury or death to an identified or a readily available person, if the service provider reasonably believes, or should reasonably believe according to the standards of his or her profession, that the patient has the apparent intent and ability to imminently or immediately carry out such threat. When such communication has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.

(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

For the purpose of determining whether a person meets the criteria for involuntary outpatient placement ~~or for preparing the proposed treatment plan~~ pursuant to s. 394.4655, the clinical record may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals~~, including the service provider identified in s. 394.4655(7)(b)2.,~~ in accordance with state and federal law.

Section 7. Section 394.462, Florida Statutes, is amended to read:

394.462 Transportation.—A transportation plan shall be

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developed and implemented by each county in collaboration with the managing entity in accordance with this section. A county may enter into a memorandum of understanding with the governing boards of nearby counties to establish a shared transportation plan. When multiple counties enter into a memorandum of understanding for this purpose, the counties shall notify the managing entity and provide it with a copy of the agreement. The transportation plan shall describe methods of transport to a facility within the designated receiving system for individuals subject to involuntary examination under s. 394.463 or involuntary admission under s. 397.6772, s. 397.679, s. 397.6798, or s. 397.6957 ~~s. 397.6811,~~ and may identify responsibility for other transportation to a participating facility when necessary and agreed to by the facility. The plan may rely on emergency medical transport services or private transport companies, as appropriate. The plan shall comply with the transportation provisions of this section and ss. 397.6772, 397.6795, ~~397.6822,~~ and 397.697.

(1) TRANSPORTATION TO A RECEIVING FACILITY.—

(a) Each county shall designate a single law enforcement agency within the county, or portions thereof, to take a person into custody upon the entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the appropriate facility within the designated receiving system pursuant to a transportation plan.

(b)1. The designated law enforcement agency may decline to transport the person to a receiving facility only if:

a. The jurisdiction designated by the county has contracted

on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities pursuant to this section at the sole cost of the county; and

b. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.

2. The entity providing transportation may seek reimbursement for transportation expenses. The party responsible for payment for such transportation is the person receiving the transportation. The county shall seek reimbursement from the following sources in the following order:

a. From a private or public third-party payor, if the person receiving the transportation has applicable coverage.

b. From the person receiving the transportation.

c. From a financial settlement for medical care, treatment, hospitalization, or transportation payable or accruing to the injured party.

(c) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transport of the patient. Such company must be insured and provide no less than $100,000 in liability insurance with respect to the transport of patients.

(d) Any company that contracts with a governing board of a county to transport patients shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(e) When a law enforcement officer takes custody of a

person pursuant to this part, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.

(f) When a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination pursuant to s. 394.463 or s. 397.675 and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.

(g) When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination pursuant to s. 394.463, the law enforcement officer shall transport the person to the appropriate facility within the designated receiving system pursuant to a transportation plan. Persons who meet the statutory guidelines for involuntary admission pursuant to s. 397.675 may also be transported by law enforcement officers to the extent resources are available and as otherwise provided by law. Such persons shall be transported to an appropriate facility within the designated receiving system pursuant to a transportation plan.

(h) When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person must first be processed in the same manner as any other criminal suspect. The law enforcement agency shall

thereafter immediately notify the appropriate facility within the designated receiving system pursuant to a transportation plan. The receiving facility shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide examination and treatment to the person where he or she is held.

(i) If the appropriate law enforcement officer believes that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

(j) The costs of transportation, evaluation, hospitalization, and treatment incurred under this subsection by persons who have been arrested for violations of any state law or county or municipal ordinance may be recovered as provided in s. 901.35.

(k) The appropriate facility within the designated receiving system pursuant to a transportation plan must accept persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, for involuntary examination pursuant to s. 394.463.

(l) The appropriate facility within the designated receiving system pursuant to a transportation plan must provide persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, pursuant to s. 397.675, a basic

screening or triage sufficient to refer the person to the appropriate services.

(m) Each law enforcement agency designated pursuant to paragraph (a) shall establish a policy that reflects a single set of protocols for the safe and secure transportation and transfer of custody of the person. Each law enforcement agency shall provide a copy of the protocols to the managing entity.

(n) When a jurisdiction has entered into a contract with an emergency medical transport service or a private transport company for transportation of persons to facilities within the designated receiving system, such service or company shall be given preference for transportation of persons from nursing homes, assisted living facilities, adult day care centers, or adult family-care homes, unless the behavior of the person being transported is such that transportation by a law enforcement officer is necessary.

(o) This section may not be construed to limit emergency examination and treatment of incapacitated persons provided in accordance with s. 401.445.

(2) TRANSPORTATION TO A TREATMENT FACILITY.—

(a) If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting a voluntary or involuntary patient to a treatment facility, the transportation plan established by the governing board of the county or counties must specify how the hospitalized patient will be transported to, from, and between facilities in a safe and dignified manner.

(b) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely

liable for the safe and dignified transportation of the patient. Such company must be insured and provide no less than $100,000 in liability insurance with respect to the transport of patients.

(c) A company that contracts with one or more counties to transport patients in accordance with this section shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(d) County or municipal law enforcement and correctional personnel and equipment may not be used to transport patients adjudicated incapacitated or found by the court to meet the criteria for involuntary placement pursuant to s. 394.467, except in small rural counties where there are no cost-efficient alternatives.

(3) TRANSFER OF CUSTODY.—Custody of a person who is transported pursuant to this part, along with related documentation, shall be relinquished to a responsible individual at the appropriate receiving or treatment facility.

Section 8. Subsections (1) and (4) of section 394.4625, Florida Statutes, are amended to read:

394.4625 Voluntary admissions.—

(1) EXAMINATION AND TREATMENT ~~AUTHORITY TO RECEIVE PATIENTS~~.—

(a) In order to be admitted to a facility on a voluntary basis, a person must show evidence of a mental illness and be suitable for treatment by the facility.

1. If the person is an adult, he or she must be competent to provide his or her express and informed consent in writing to the facility.

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2. A minor may be admitted to a facility only on the basis of the express and informed consent of the minor's parent or legal guardian in conjunction with the minor's assent.

a. The minor's assent is an affirmative agreement by the minor to remain at the facility for examination and treatment. The minor's failure to object is not assent for purposes of this subparagraph.

b. The minor's assent must be verified through a clinical assessment that is documented in the minor's clinical record and conducted within 12 hours after arrival at the facility by a licensed professional authorized to initiate an involuntary examination under s. 394.463.

c. In verifying the minor's assent, the examining professional must first provide the minor with an explanation as to why the minor will be examined and treated, what the minor can expect while in the facility, and when the minor may expect to be released, using language that is appropriate to the minor's age, experience, maturity, and condition. The examining professional must determine and document that the minor is able to understand this information.

d. The facility must advise the minor of his or her right to request and have access to legal counsel.

e. The facility administrator must file with the court a notice of a minor's voluntary placement within 1 court working day after the minor's admission to the facility.

f. The court shall appoint a public defender who may review the voluntariness of the minor's admission to the facility and further verify his or her assent. The public defender may interview and represent the minor and shall have access to all

relevant witnesses and records. If the public defender does not review the voluntariness of the admission, the clinical assessment of the minor's assent shall serve as verification of assent.

g. Unless the minor's assent is verified pursuant to this subparagraph, a petition for involuntary placement must be filed with the court or the minor must be released to his or her parent or legal guardian within 24 hours after arriving at the facility ~~A facility may receive for observation, diagnosis, or treatment any person 18 years of age or older making application by express and informed consent for admission or any person age 17 or under for whom such application is made by his or her guardian. If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility. A person age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent~~.

(b) A mental health overlay program or a mobile crisis response service or a licensed professional who is authorized to initiate an involuntary examination pursuant to s. 394.463 and is employed by a community mental health center or clinic must, pursuant to district procedure approved by the respective district administrator, conduct an initial assessment of the ability of the following persons to give express and informed consent to treatment before such persons may be admitted voluntarily:

1. A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility,

adult day care center, or adult family-care home, when such person has been diagnosed as suffering from dementia.

2. A person 60 years of age or older for whom transfer is being sought from a nursing home pursuant to s. 400.0255(12).

3. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under chapter 765.

(c) When an initial assessment of the ability of a person to give express and informed consent to treatment is required under this section, and a mobile crisis response service does not respond to the request for an assessment within 2 hours after the request is made or informs the requesting facility that it will not be able to respond within 2 hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.

(d) A facility may not admit as a voluntary patient a person who has been adjudicated incapacitated, unless the condition of incapacity has been judicially removed. If a facility admits as a voluntary patient a person who is later determined to have been adjudicated incapacitated, and the condition of incapacity had not been removed by the time of the admission, the facility must either discharge the patient or transfer the patient to involuntary status.

(e) The health care surrogate or proxy of a voluntary

patient may not consent to the provision of mental health treatment for the patient. A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.

(f) Within 24 hours after admission of a voluntary patient, the admitting physician shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

(4) TRANSFER TO VOLUNTARY STATUS.—An involuntary patient who applies to be transferred to voluntary status shall be transferred to voluntary status immediately, unless the patient has been charged with a crime, or has been involuntarily placed for treatment by a court pursuant to s. 394.467 and continues to meet the criteria for involuntary placement. When transfer to voluntary status occurs, notice shall be given as provided in s. 394.4599, and if the patient is a minor, the minor's assent to voluntary care must be verified through the procedures under subparagraph (1)(a)2. before the transfer to voluntary status may occur.

Section 9. Subsection (1) and paragraphs (a), (g), and (h) of subsection (2) of section 394.463, Florida Statutes, are amended, and subsection (5) is added to that section, to read:

394.463 Involuntary examination.—

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that

the person has a mental illness and because of his or her mental illness:

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

2. The person is unable to determine for himself or herself whether examination is necessary; and

(b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services; or

2. There is a substantial likelihood that in the near future and without care or treatment, the person will inflict serious ~~cause serious bodily~~ harm to self ~~himself or herself~~ or others ~~in the near future~~, as evidenced by recent acts, omissions, or behavior causing, attempting, or threatening such harm, which includes, but is not limited to, significant property damage.

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony

that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a time limit is not specified in the order, the order is valid for 7 days after the date that the order was signed.

2. A law enforcement officer may ~~shall~~ take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse registered under s.

464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

(g) The examination period must be for up to 72 hours. For a minor, the examination shall be initiated within 12 hours after the patient's arrival at the facility. The facility must inform the department of any person who has been examined or

committed three or more times under this chapter within a 12-month period. Within the examination period or, if the examination period ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to subparagraph 1., for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary services shall be filed in the circuit court ~~if inpatient treatment is deemed necessary~~ or with the criminal county court, as described in s. 394.4655 ~~defined in s. 394.4655(1)~~, as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. The petition ~~When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(4)(a). A petition for involuntary inpatient placement~~ shall be filed by the facility administrator.

(h) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a facility within the examination period specified

in paragraph (g). The examination period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient services pursuant to s. 394.4655 ~~s. 394.4655(2)~~ or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary services or placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient services or involuntary outpatient placement must be entered into the patient's clinical record. This paragraph is not intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital before stabilization if the requirements of s. 395.1041(3)(c) have been met.

(5) UNLAWFUL ACTIVITIES RELATING TO EXAMINATION AND TREATMENT; PENALTIES.—

(a) Knowingly furnishing false information for the purpose of obtaining emergency or other involuntary admission for any person is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

(b) Causing or otherwise securing, or conspiring with or assisting another to cause or secure, without reason for believing a person to be impaired, any emergency or other involuntary procedure for the person is a misdemeanor of the

first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

(c) Causing, or conspiring with or assisting another to cause, the denial to any person of any right accorded pursuant to this chapter is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

Section 10. Section 394.4655, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 394.4655, F.S., for present text.)

394.4655 Involuntary outpatient services.—

(1)(a) The court may order a respondent into outpatient treatment for up to 6 months if, during a hearing under s. 394.467, it is established that the respondent meets involuntary placement criteria and:

1. Has been jailed or incarcerated, has been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility at least twice during the last 36 months;

2. The outpatient treatment is provided in the county in which the respondent resides or, if being placed from a state treatment facility, will reside; and

3. The respondent's treating physician certifies, within a reasonable degree of medical probability, that the respondent:

a. Can be appropriately treated on an outpatient basis; and

b. Can follow a prescribed treatment plan.

(b) For the duration of his or her treatment, the respondent must be supported by a social worker or case manager of the outpatient provider, or a willing, able, and responsible

individual appointed by the court who must inform the court, state attorney, and public defender of any failure by the respondent to comply with his or her outpatient program.

(2) The court shall retain jurisdiction over the case and parties for the entry of such further orders after a hearing as the circumstances may require. Such jurisdiction includes, but is not limited to, ordering inpatient treatment to stabilize a respondent who decompensates during his or her up to 6-month period of court-ordered treatment and meets the commitment criteria of s. 394.467.

(3) A criminal county court exercising its original jurisdiction in a misdemeanor case under s. 34.01 may order a person who meets the commitment criteria into involuntary outpatient services.

Section 11. Subsections (1) and (5) and paragraphs (a), (b), and (c) of subsection (6) of section 394.467, Florida Statutes, are amended to read:

394.467 Involuntary inpatient placement.—

(1) CRITERIA.—A person may be ordered for involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

(a) He or she has a mental illness and because of his or her mental illness:

1.a. He or she has refused voluntary inpatient placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of inpatient placement for treatment; or

b. He or she is unable to determine for himself or herself whether inpatient placement is necessary; and

2.a. He or she is incapable of surviving alone or with the help of willing, able, and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

b. There is substantial likelihood that in the near future and without services he or she will inflict serious ~~bodily~~ harm to ~~on~~ self or others, as evidenced by recent acts, omissions, or behavior causing, attempting, or threatening such harm, which includes, but is not limited to, significant property damage; and

(b) All available less restrictive treatment alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

(5) CONTINUANCE OF HEARING.—The patient and the state are independently entitled ~~is entitled, with the concurrence of the patient's counsel,~~ to at least one continuance of the hearing. The patient's continuance may be for a period of ~~for~~ up to 4 weeks and requires the concurrence of his or her counsel. The state's continuance may be for a period of up to 5 court working days and requires a showing of good cause and due diligence by the state before requesting the continuance. The state's failure to timely review any readily available document or failure to attempt to contact a known witness does not warrant a continuance.

(6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.—

(a)1. The court shall hold the hearing on involuntary

inpatient placement within 5 court working days, unless a continuance is granted.

2. Except for good cause documented in the court file, the hearing must be held in the county or the facility, as appropriate, where the patient is located, must be as convenient to the patient as is consistent with orderly procedure, and shall be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of, or is likely to be injurious to, the patient, or the patient knowingly, intelligently, and voluntarily waives his or her right to be present, and the patient's counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. Absent a showing of good cause, such as specific symptoms of the respondent's condition, the court may permit all witnesses, including, but not limited to, any medical professionals or personnel who are or have been involved with the patient's treatment, to remotely attend and testify at the hearing under oath via the most appropriate and convenient technological method of communication available to the court, including, but not limited to, teleconference. Any witness intending to remotely attend and testify at the hearing must provide the parties with all relevant documents by the close of business on the day before the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding. The facility shall make the respondent's clinical records available to the state attorney

within 24 hours of the involuntary placement petition's filing so that the state can evaluate and prepare its case before the hearing. However, these records shall remain confidential, and the state attorney may not use any record obtained under this part for criminal investigation or prosecution purposes, or for any purpose other than the patient's civil commitment under this chapter.

3. The court may appoint a magistrate to preside at the hearing on the petition and any ancillary proceedings thereto, which include, but are not limited to, writs of habeas corpus issued pursuant to s. 394.459(8). One of the professionals who executed the petition for involuntary inpatient placement certificate shall be a witness. The court shall allow testimony deemed relevant by the court under state law from individuals, including family members, regarding the person's prior history and how that history relates to the person's current condition. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall ensure that one is provided, as otherwise provided for by law. The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.

(b) If the court concludes that the patient meets the criteria for involuntary inpatient placement, it may order that the patient be transferred to a treatment facility or, if the

patient is at a treatment facility, that the patient be retained there or be treated at any other appropriate facility, or that the patient receive services, on an involuntary basis, for up to ~~90 days. However, any order for involuntary mental health services in a treatment facility may be for up to~~ 6 months. The order shall specify the nature and extent of the patient's mental illness, and, unless the patient has transferred to a voluntary status, the facility must discharge the patient at any time he or she no longer meets the criteria for involuntary inpatient treatment. The court may not order an individual with a developmental disability as defined in s. 393.063, traumatic brain injury, or dementia who lacks a co-occurring mental illness to be involuntarily placed in a state treatment facility. These individuals must be referred to the Agency for Persons with Disabilities or the Department of Elderly Affairs for further evaluation and the provision of appropriate services for their individual needs. In addition, if it reasonably appears that the individual with developmental disabilities, traumatic brain injury, or dementia would be found incapacitated under chapter 744 and the individual does not already have a legal guardian, the facility must inform the department and any known next of kin and initiate guardianship proceedings. Provided that the facility is attempting to locate appropriate placement while the guardianship hearing is pending, the facility may hold the individual until the petition to appoint a guardian is adjudicated by the court and placement is secured. ~~The facility shall discharge a patient any time the patient no longer meets the criteria for involuntary inpatient placement, unless the patient has transferred to voluntary status.~~

(c) If at any time before the conclusion of the involuntary placement hearing ~~on involuntary inpatient placement~~ it appears to the court that the person does not meet the criteria of ~~for involuntary inpatient placement under~~ this section, but instead meets the criteria for involuntary ~~outpatient services, the court may order the person evaluated for involuntary outpatient services pursuant to s. 394.4655. The petition and hearing procedures set forth in s. 394.4655 shall apply. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary~~ admission or treatment pursuant to s. 397.675, ~~then~~ the court may order the person to be admitted for involuntary assessment ~~for a period of 5 days~~ pursuant to s. 397.6957 ~~s. 397.6811~~. Thereafter, all proceedings are governed by chapter 397.

Section 12. Subsection (3) of section 394.495, Florida Statutes, is amended to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(3) Assessments must be performed by:

(a) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist as those terms are defined in s. 394.455 ~~professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~;

(b) A professional licensed under chapter 491; or

(c) A person who is under the direct supervision of a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist as those terms are defined in s. 394.455 ~~qualified professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~ or a professional licensed under

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

chapter 491.

Section 13. Subsection (5) of section 394.496, Florida Statutes, is amended to read:

394.496 Service planning.—

(5) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist as those terms are defined in s. 394.455 ~~professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~ or a professional licensed under chapter 491 must be included among those persons developing the services plan.

Section 14. Paragraph (a) of subsection (2) of section 394.499, Florida Statutes, is amended to read:

394.499 Integrated children's crisis stabilization unit/juvenile addictions receiving facility services.—

(2) Children eligible to receive integrated children's crisis stabilization unit/juvenile addictions receiving facility services include:

(a) A person under 18 years of age for whom voluntary application is made by his or her parent or legal guardian, if such person is found to show evidence of mental illness and to be suitable for treatment pursuant to s. 394.4625. A person under 18 years of age may be admitted for integrated facility services only after a hearing to verify that the consent to admission is voluntary is conducted pursuant to s. 394.4625.

Section 15. Subsection (6) of section 394.9085, Florida Statutes, is amended to read:

394.9085 Behavioral provider liability.—

(6) For purposes of this section, the terms "detoxification services," "addictions receiving facility," and "receiving

facility" have the same meanings as those provided in ss. 397.311(26)(a)4. ~~397.311(26)(a)3.~~, 397.311(26)(a)1., and 394.455 ~~394.455(40)~~, respectively.

Section 16. Subsection (3) of section 397.305, Florida Statutes, is amended to read:

397.305 Legislative findings, intent, and purpose.—

(3) It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services in the most appropriate and least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

Section 17. Present subsections (29) through (36) and (37) through (50) of section 397.311, Florida Statutes, are redesignated as subsections (30) through (37) and (39) through (52), respectively, new subsections (29) and (38) are added to that section, and subsections (19) and (23) of that section are amended, to read:

397.311 Definitions.—As used in this chapter, except part VIII, the term:

(19) "Impaired" or "substance abuse impaired" means having a substance use disorder or a condition involving the use of alcoholic beverages, illicit or prescription drugs, or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems or ~~and~~ cause socially dysfunctional behavior.

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(23) "Involuntary treatment services" means an array of behavioral health services that may be ordered by the court for persons with substance abuse impairment or co-occurring substance abuse impairment and mental health disorders.

(29) "Neglect or refuse to care for himself or herself" includes, but is not limited to, evidence that a person:

(a) Is unable to satisfy basic needs for nourishment, clothing, medical care, shelter, or safety, in a manner that creates a substantial probability of imminent death, serious physical debilitation, or disease; or

(b) Is substantially unable to make an informed treatment choice and needs care or treatment to prevent deterioration.

(38) "Real and present threat of substantial harm" includes, but is not limited to, evidence of a substantial probability that the untreated person will:

(a) Lack, refuse, or not receive services for health and safety which are actually available in the community; or

(b) Suffer severe mental, emotional, or physical harm that will result in the loss of his or her ability to function in the community or the loss of cognitive or volitional control over thoughts or actions.

Section 18. Section 397.416, Florida Statutes, is amended to read:

397.416 Substance abuse treatment services; qualified professional.—Notwithstanding any other provision of law, a person who was certified through a certification process recognized by the former Department of Health and Rehabilitative Services before January 1, 1995, may perform the duties of a qualified professional with respect to substance abuse treatment

services as defined in this chapter, and need not meet the certification requirements contained in s. 397.311(36) ~~s. 397.311(35)~~.

Section 19. Subsection (11) is added to section 397.501, Florida Statutes, to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(11) POST-DISCHARGE CONTINUUM OF CARE.—Upon discharge, the facility must inform a respondent with a serious substance use disorder of the essential elements of recovery and provide assistance with accessing a continuum of care regimen. The department may adopt rules specifying the services that may be provided to such respondents.

Section 20. Section 397.675, Florida Statutes, is amended to read:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.—A person meets the criteria for involuntary admission if there is good faith reason to believe that the person is substance abuse impaired or has a substance use disorder and a co-occurring mental health disorder and, because of such impairment or disorder:

(1) Has lost the power of self-control with respect to substance abuse, or has a history of noncompliance with

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substance abuse treatment with continued substance use; ~~and~~

(2)~~(a)~~ Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is refusing voluntary care after a sufficient and conscientious explanation and disclosure of the purpose for such services, or is incapable of appreciating his or her need for such services and of making a rational decision in that regard, although mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services; and ~~or~~

(3)(a)~~(b)~~ Without care or treatment, is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services;~~,~~ or

(b) There is substantial likelihood that in the near future and without services, the person will inflict serious harm to self or others, as evidenced by recent acts, omissions, or behavior causing, attempting, or threatening such harm, which includes, but is not limited to, significant property damage ~~has inflicted, or threatened to or attempted to inflict, or, unless admitted, is likely to inflict, physical harm on himself, herself, or another~~.

Section 21. Subsection (1) of section 397.6751, Florida Statutes, is amended to read:

397.6751 Service provider responsibilities regarding involuntary admissions.—

(1) It is the responsibility of the service provider to:

(a) Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;

(b) Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;

(c) Provide for the admission of the person to the service component that represents the most appropriate and least restrictive available setting that is responsive to the person's treatment needs;

(d) Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;

(e) Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and

(f) Take all necessary measures to ensure that each individual in treatment is provided with a safe environment, and to ensure that each individual whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

Section 22. Section 397.681, Florida Statutes, is amended to read:

397.681 Involuntary petitions; general provisions; court jurisdiction and right to counsel.—

(1) JURISDICTION.—The courts have jurisdiction of ~~involuntary assessment and stabilization petitions and~~

involuntary treatment petitions for substance abuse impaired persons, and such petitions must be filed with the clerk of the court in the county where the person is located or resides. The clerk of the court may not charge a fee for the filing of a petition under this section. The chief judge may appoint a general or special magistrate to preside over all or part of the proceedings related to the petition or any ancillary matters thereto, which include, but are not limited to, writs of habeas corpus issued pursuant to s. 397.501(9). The alleged impaired person is named as the respondent.

(2) RIGHT TO COUNSEL.—A respondent has the right to counsel at every stage of a proceeding relating to a petition for his or her ~~involuntary assessment and a petition for his or her~~ involuntary treatment for substance abuse impairment. A respondent who desires counsel and is unable to afford private counsel has the right to court-appointed counsel and to the benefits of s. 57.081. If the court believes that the respondent needs the assistance of counsel, the court shall appoint such counsel for the respondent without regard to the respondent's wishes. If the respondent is a minor not otherwise represented in the proceeding, the court shall immediately appoint a guardian ad litem to act on the minor's behalf.

(3) STATE REPRESENTATIVE.—Subject to legislative appropriation, for all court-involved involuntary proceedings under this chapter in which the petitioner has not retained private counsel, the state attorney for the circuit in which the respondent is located shall represent the state rather than the petitioner as the real party of interest in the proceeding, but the petitioner has the right to be heard. Furthermore, the state

attorney may not use any record obtained under this part for criminal investigation or prosecution purposes, or for any purpose other than the respondent's civil commitment under this chapter. Any record obtained under this subsection must remain confidential.

Section 23. Section 397.6811, Florida Statutes, is repealed.

Section 24. Section 397.6814, Florida Statutes, is repealed.

Section 25. Section 397.6815, Florida Statutes, is repealed.

Section 26. Section 397.6818, Florida Statutes, is repealed.

Section 27. Section 397.6819, Florida Statutes, is repealed.

Section 28. Section 397.6821, Florida Statutes, is repealed.

Section 29. Section 397.6822, Florida Statutes, is repealed.

Section 30. Section 397.693, Florida Statutes, is amended to read:

397.693 Involuntary treatment.—A person may be the subject of a petition for court-ordered involuntary treatment pursuant to this part~~,~~ if that person:

(1) Reasonably appears to meet ~~meets~~ the criteria for involuntary admission provided in s. 397.675; ~~and:~~

(2)~~(1)~~ Has been placed under protective custody pursuant to s. 397.677 within the previous 10 days;

(3)~~(2)~~ Has been subject to an emergency admission pursuant

to s. 397.679 within the previous 10 days; or

(4) ~~(3)~~ Has been assessed by a qualified professional within 30 ~~5~~ days~~;~~

~~(4) Has been subject to involuntary assessment and stabilization pursuant to s. 397.6818 within the previous 12 days; or~~

~~(5) Has been subject to alternative involuntary admission pursuant to s. 397.6822 within the previous 12 days~~.

Section 31. Section 397.695, Florida Statutes, is amended to read:

397.695 Involuntary treatment services; persons who may petition.—

(1) If the respondent is an adult, a petition for involuntary treatment services may be filed by the respondent's spouse or legal guardian, any relative, a service provider, or an adult who has direct personal knowledge of the respondent's substance abuse impairment and his or her prior course of assessment and treatment.

(2) If the respondent is a minor, a petition for involuntary treatment may be filed by a parent, legal guardian, or service provider.

(3) The court or the clerk of the court may waive or prohibit any service of process fees if a petitioner is determined to be indigent under s. 57.082.

Section 32. Section 397.6951, Florida Statutes, is amended to read:

397.6951 Contents of petition for involuntary treatment services.—

(1) A petition for involuntary treatment services must

contain the name of the respondent; the name of the petitioner ~~or petitioners~~; the relationship between the respondent and the petitioner; the name of the respondent's attorney, if known; ~~the findings and recommendations of the assessment performed by the qualified professional;~~ and the factual allegations presented by the petitioner establishing the need for involuntary ~~outpatient~~ services for substance abuse impairment. The factual allegations must demonstrate the reason for the petitioner's belief that the respondent:

~~(1) The reason for the petitioner's belief that the respondent is substance abuse impaired;~~

(a)~~(2) The reason for the petitioner's belief that because of such impairment the respondent~~ Has lost the power of self-control with respect to substance abuse, or has a history of noncompliance with substance abuse treatment with continued substance use; ~~and~~

(b) Needs substance abuse services, but his or her judgment is so impaired by substance abuse that he or she either is refusing voluntary care after a sufficient and conscientious explanation and disclosure of the purpose of such services, or is incapable of appreciating his or her need for such services and of making a rational decision in that regard; and

(c)1. Without services, is likely to suffer from neglect or refuse to care for himself or herself; that the neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that the harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services; or

2. There is a substantial likelihood that in the near future and without services, the respondent will inflict serious harm to self or others, as evidenced by recent acts, omissions, or behavior causing, attempting, or threatening such harm, which includes, but is not limited to, significant property damage

~~(3)(a) The reason the petitioner believes that the respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless the court orders the involuntary services; or~~

~~(b) The reason the petitioner believes that the respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care~~.

(2) The petition may be accompanied by a certificate or report of a qualified professional or a licensed physician who examined the respondent within 30 days before the petition was filed. This certificate or report must include the qualified professional or physician's findings relating to his or her assessment of the patient and his or her treatment recommendations. If the respondent was not assessed before the filing of a treatment petition or refused to submit to an evaluation, the lack of assessment or refusal must be noted in the petition.

(3) If there is an emergency, the petition must also describe the respondent's exigent circumstances and include a request for an ex parte assessment and stabilization order that must be executed pursuant to s. 397.6955(4).

Section 33. Section 397.6955, Florida Statutes, is amended

to read:

397.6955 Duties of court upon filing of petition for involuntary treatment services.—

(1) Upon the filing of a petition for involuntary treatment services for a substance abuse impaired person with the clerk of the court which does not indicate that the petitioner has retained private counsel, the clerk must notify the state attorney's office. In addition, the court shall immediately determine whether the respondent is represented by an attorney or whether the appointment of counsel for the respondent is appropriate. If, based on the contents of the petition, the court appoints counsel for the person, the clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel, created pursuant to s. 27.511, of the appointment. The office of criminal conflict and civil regional counsel shall represent the person until the petition is dismissed, the court order expires, ~~or~~ the person is discharged from involuntary treatment services, or the office is otherwise discharged by the court. An attorney that represents the person named in the petition shall have access to the person, witnesses, and records relevant to the presentation of the person's case and shall represent the interests of the person, regardless of the source of payment to the attorney.

(2) The court shall schedule a hearing to be held on the petition within 10 court working ~~5~~ days unless a continuance is granted. ~~The court may appoint a magistrate to preside at the hearing.~~

(3) A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent,

guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the respondent's spouse or guardian, if applicable; and such other persons as the court may direct. If the respondent is a minor, a copy of the petition and notice of the hearing must be personally delivered to the respondent. The clerk ~~court~~ shall also issue a summons to the person whose admission is sought, and unless a circuit court's chief judge authorizes disinterested private process servers to serve parties under this chapter, a law enforcement agency must effect service for the initial treatment hearing.

(4)(a) When the petitioner asserts that emergency circumstances exist, or when upon review of the petition the court determines that an emergency exists, the court may rely solely on the contents of the petition and, without the appointment of an attorney, enter an ex parte order for the respondent's involuntary assessment and stabilization which must be executed during the period when the hearing on the petition for treatment is pending. The court may further order a law enforcement officer or other designated agent of the court to:

1. Take the respondent into custody and deliver him or her to either the nearest appropriate licensed service provider or a licensed service provider designated by the court to be evaluated; and

2. Serve the respondent with the notice of hearing and a copy of the petition.

(b) The service provider must promptly inform the court and parties of the respondent's arrival and may not hold the respondent for longer than 72 hours of observation thereafter,

unless:

1. The service provider seeks additional time under s. 397.6957(1)(c) and the court, after a hearing, grants that motion;

2. The respondent shows signs of withdrawal, or a need to be either detoxified or treated for a medical condition, which shall extend the amount of time the respondent may be held for observation until the issue is resolved; or

3. The original or extended observation period ends on a weekend or holiday, in which case the provider may hold the respondent until the next court working day.

(c) If the ex parte order was not executed by the initial hearing date, it shall be deemed void. However, should the respondent not appear at the hearing for any reason, including lack of service, and upon reviewing the petition, testimony, and evidence presented, the court reasonably believes the respondent meets this chapter's commitment criteria and that a substance abuse emergency exists, the court may issue or reissue an ex parte assessment and stabilization order that is valid for 90 days. If the respondent's location is known at the time of the hearing, the court:

1. Shall continue the case for no more than 10 court working days; and

2. May order a law enforcement officer or other designated agent of the court to:

a. Take the respondent into custody and deliver him or her to be evaluated either by the nearest appropriate licensed service provider or by a licensed service provider designated by the court; and

b. If a hearing date is set, serve the respondent with notice of the rescheduled hearing and a copy of the involuntary treatment petition if the respondent has not already been served.

Otherwise, the petitioner and the service provider must promptly inform the court that the respondent has been assessed so that the court may schedule a hearing as soon as practicable. The service provider must serve the respondent, before his or her discharge, with the notice of hearing and a copy of the petition. However, if the respondent has not been assessed within 90 days, the court must dismiss the case.

Section 34. Section 397.6957, Florida Statutes, is amended to read:

397.6957 Hearing on petition for involuntary treatment services.—

(1)(a) The respondent must be present at a hearing on a petition for involuntary treatment services unless he or she knowingly, intelligently, and voluntarily waives his or her right to be present or, upon receiving proof of service and evaluating the circumstances of the case, the court finds that his or her presence is inconsistent with his or her best interests or is likely to be injurious to himself or herself or others.~~,~~ The court shall hear and review all relevant evidence, including testimony from individuals such as family members familiar with the respondent's prior history and how it relates to his or her current condition, and the ~~review of~~ results of the assessment completed by the qualified professional in connection with this chapter. The court may also order drug

tests. Absent a showing of good cause, such as specific symptoms of the respondent's condition, the court may permit all witnesses, such as any medical professionals or personnel who are or have been involved with the respondent's treatment, to remotely attend and testify at the hearing under oath via the most appropriate and convenient technological method of communication available to the court, including, but not limited to, teleconference. Any witness intending to remotely attend and testify at the hearing must provide the parties with all relevant documents by the close of business on the day before the hearing ~~the respondent's protective custody, emergency admission, involuntary assessment, or alternative involuntary admission. The respondent must be present unless the court finds that his or her presence is likely to be injurious to himself or herself or others, in which event the court must appoint a guardian advocate to act in behalf of the respondent throughout the proceedings~~.

(b) A respondent cannot be involuntarily ordered into treatment under this chapter without a clinical assessment being performed, unless he or she is present in court and expressly waives the assessment. In nonemergency situations, if the respondent was not, or had previously refused to be, assessed by a qualified professional and, based on the petition, testimony, and evidence presented, it reasonably appears that the respondent qualifies for involuntary treatment services, the court shall issue an involuntary assessment and stabilization order to determine the appropriate level of treatment the respondent requires. Additionally, in cases where an assessment was attached to the petition, the respondent may request, or the

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court on its own motion may order, an independent assessment by a court-appointed physician or an otherwise agreed-upon physician. If an assessment order is issued, it is valid for 90 days, and if the respondent is present or there is either proof of service or his or her location is known, the involuntary treatment hearing shall be continued for no more than 10 court working days. Otherwise, the petitioner and the service provider must promptly inform the court that the respondent has been assessed so that the court may schedule a hearing as soon as practicable. The service provider shall then serve the respondent, before his or her discharge, with the notice of hearing and a copy of the petition. The assessment must occur before the new hearing date, and if there is evidence indicating that the respondent will not voluntarily appear at the forthcoming hearing, or is a danger to self or others, the court may enter a preliminary order committing the respondent to an appropriate treatment facility for further evaluation until the date of the rescheduled hearing. However, if after 90 days the respondent remains unassessed, the court shall dismiss the case.

(c)1. The respondent's assessment by a qualified professional must occur within 72 hours after his or her arrival at a licensed service provider unless he or she shows signs of withdrawal or a need to be either detoxified or treated for a medical condition, which shall extend the amount of time the respondent may be held for observation until that issue is resolved. If the person conducting the assessment is not a licensed physician, the assessment must be reviewed by a licensed physician within the 72-hour period. If the respondent is a minor, such assessment must be initiated within the first

12 hours after the minor's admission to the facility. The service provider may also move to extend the 72 hours of observation by petitioning the court in writing for additional time. The service provider must furnish copies of such motion to all parties in accordance with applicable confidentiality requirements, and, after a hearing, the court may grant additional time or expedite the respondent's involuntary treatment hearing. The involuntary treatment hearing, however, may be expedited only by agreement of the parties on the hearing date or if there is notice and proof of service as provided in s. 397.6955 (1) and (3). If the court grants the service provider's petition, the service provider may hold the respondent until its extended assessment period expires or until the expedited hearing date. However, if the original or extended observation period ends on a weekend or holiday, the provider may hold the respondent until the next court working day.

2. Upon the completion of his or her report, the qualified professional, in accordance with applicable confidentiality requirements, shall provide copies to the court and all relevant parties and counsel. This report must contain a recommendation on the level, if any, of substance abuse and, if applicable, co-occurring mental health treatment the respondent requires. The qualified professional's failure to include a treatment recommendation, much like a recommendation of no treatment, shall result in the petition's dismissal.

(d) The court may order a law enforcement officer or other designated agent of the court to take the respondent into custody and transport him or her to or from the treating or assessing service provider and the court for his or her hearing.

(2) The petitioner has the burden of proving by clear and convincing evidence that:

(a) The respondent is substance abuse impaired, has lost the power of self-control with respect to substance abuse, or ~~and~~ has a history of lack of compliance with treatment for substance abuse with continued substance use; ~~and~~

(b) Because of such impairment, the respondent is unlikely to voluntarily participate in the recommended services after sufficient and conscientious explanation and disclosure of their purpose, or is unable to determine for himself or herself whether services are necessary and make a rational decision in that regard; and~~:~~

(c)1. Without services, the respondent is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services; or

2. There is a substantial likelihood that in the near future and without services, the respondent will inflict serious harm to self or others, as evidenced by recent acts, omissions, or behavior causing, attempting, or threatening such harm, which includes, but is not limited to, significant property damage ~~cause serious bodily harm to himself, herself, or another in the near future, as evidenced by recent behavior; or~~

~~2. The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for~~

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~~care and of making a rational decision regarding that need for care~~.

(3) ~~One of the qualified professionals who executed the involuntary services certificate must be a witness. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law, regarding the respondent's prior history and how that prior history relates to the person's current condition. The~~ Testimony in the hearing must be taken under oath, and the proceedings must be recorded. The respondent ~~patient~~ may refuse to testify at the hearing.

(4) If at any point during the hearing the court has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, is likely to neglect or injure himself, herself, or another if allowed to remain at liberty, or otherwise meets the involuntary commitment provisions of part I of chapter 394, the court may initiate involuntary examination proceedings under such provisions.

(5)~~(4)~~ At the conclusion of the hearing, the court shall either dismiss the petition or order the respondent to receive involuntary treatment services from his or her chosen licensed service provider if possible and appropriate. Any treatment order must include findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

Section 35. Section 397.697, Florida Statutes, is amended to read:

397.697 Court determination; effect of court order for involuntary treatment services.—

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(1)(a) When the court finds that the conditions for involuntary treatment services have been proved by clear and convincing evidence, it may order the respondent to receive involuntary treatment services from a publicly funded licensed service provider for a period not to exceed 90 days. The court may also order a respondent to undergo treatment through a privately funded licensed service provider if the respondent has the ability to pay for the treatment, or if any person on the respondent's behalf voluntarily demonstrates a willingness and an ability to pay for the treatment. If the court finds it necessary, it may direct the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order, or to the nearest appropriate licensed service provider, for involuntary treatment services. When the conditions justifying involuntary treatment services no longer exist, the individual must be released as provided in s. 397.6971. When the conditions justifying involuntary treatment services are expected to exist after 90 days of treatment services, a renewal of the involuntary treatment services order may be requested pursuant to s. 397.6975 before the end of the 90-day period.

(b) To qualify for involuntary outpatient treatment, an individual must be supported by a social worker or case manager of a licensed service provider or a willing, able, and responsible individual appointed by the court who shall inform the court and parties if the respondent fails to comply with his or her outpatient program. In addition, unless the respondent has been involuntarily ordered into inpatient treatment under this chapter at least twice during the last 36 months, or

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demonstrates the ability to substantially comply with the outpatient treatment while waiting for residential placement to become available, he or she must receive an assessment from a qualified professional or licensed physician expressly recommending outpatient services, such services must be available in the county in which the respondent is located, and it must appear likely that the respondent will follow a prescribed outpatient care plan.

(2) In all cases resulting in an order for involuntary treatment services, the court shall retain jurisdiction over the case and the parties for the entry of such further orders as the circumstances may require, including, but not limited to, monitoring compliance with treatment, changing the treatment modality, or initiating contempt of court proceedings for violating any valid order issued pursuant to this chapter. Hearings under this section may be set by motion of the parties or under the court's own authority, and the motion and notice of hearing for these ancillary proceedings, which include, but are not limited to, civil contempt, must be served in accordance with relevant court procedural rules. The court's requirements for notification of proposed release must be included in the original order.

(3) An involuntary treatment services order also authorizes the licensed service provider to require the individual to receive treatment services that will benefit him or her, including treatment services at any licensable service component of a licensed service provider. While subject to the court's oversight, the service provider's authority under this section is separate and distinct from the court's broad continuing

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jurisdiction under subsection (2). Such oversight includes, but is not limited to, submitting reports regarding the respondent's progress or compliance with treatment as required by the court.

(4) If the court orders involuntary treatment services, a copy of the order must be sent to the managing entity within 1 working day after it is received from the court. Documents may be submitted electronically through ~~though~~ existing data systems, if applicable.

Section 36. Section 397.6971, Florida Statutes, is amended to read:

397.6971 Early release from involuntary treatment services.—

(1) At any time before the end of the 90-day involuntary treatment services period, or before the end of any extension granted pursuant to s. 397.6975, an individual receiving involuntary treatment services may be determined eligible for discharge to the most appropriate referral or disposition for the individual when any of the following apply:

(a) The individual no longer meets the criteria for involuntary admission and has given his or her informed consent to be transferred to voluntary treatment status.

(b) If the individual was admitted on the grounds of likelihood of self-neglect or the infliction of ~~physical~~ harm upon himself or herself or others, such likelihood no longer exists.

(c) If the individual was admitted on the grounds of need for assessment and stabilization or treatment, accompanied by inability to make a determination respecting such need:

1. Such inability no longer exists; or

2. It is evident that further treatment will not bring about further significant improvements in the individual's condition.

(d) The individual ~~is~~ no longer needs treatment ~~in need of~~ services.

(e) The director of the service provider determines that the individual is beyond the safe management capabilities of the provider.

(2) Whenever a qualified professional determines that an individual admitted for involuntary treatment services qualifies for early release under subsection (1), the service provider shall immediately discharge the individual and must notify all persons specified by the court in the original treatment order.

Section 37. Section 397.6975, Florida Statutes, is amended to read:

397.6975 Extension of involuntary treatment services period.—

(1) Whenever a service provider believes that an individual who is nearing the scheduled date of his or her release from involuntary treatment services continues to meet the criteria for involuntary treatment services in s. 397.693 or s. 397.6957, a petition for renewal of the involuntary treatment services order must ~~may~~ be filed with the court ~~at least 10 days~~ before the expiration of the court-ordered services period. The petition may be filed by the service provider or by the person who filed the petition for the initial treatment order if the petition is accompanied by supporting documentation from the service provider. The court shall ~~immediately~~ schedule a hearing within 10 court working ~~to be held not more than 15~~ days after

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filing of the petition and~~. The court shall~~ provide the copy of the petition for renewal and the notice of the hearing to all parties and counsel to the proceeding. The hearing is conducted pursuant to ss. 397.6957 and 397.697 and must be before the circuit court unless referred to a magistrate ~~s. 397.6957~~.

(2) If the court finds that the petition for renewal of ~~the~~ involuntary treatment services ~~order~~ should be granted, it may order the respondent to receive involuntary treatment services for a period not to exceed an additional 90 days. When the conditions justifying involuntary treatment services no longer exist, the individual must be released as provided in s. 397.6971. When the conditions justifying involuntary treatment services continue to exist after an additional 90 days of treatment service, a new petition requesting renewal of the involuntary treatment services order may be filed pursuant to this section.

~~(3) Within 1 court working day after the filing of a petition for continued involuntary services, the court shall appoint the office of criminal conflict and civil regional counsel to represent the respondent, unless the respondent is otherwise represented by counsel. The clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel of such appointment. The office of criminal conflict and civil regional counsel shall represent the respondent until the petition is dismissed or the court order expires or the respondent is discharged from involuntary services. Any attorney representing the respondent shall have access to the respondent, witnesses, and records relevant to the presentation of the respondent's case and shall represent the~~

~~interests of the respondent, regardless of the source of payment to the attorney.~~

~~(4) Hearings on petitions for continued involuntary services shall be before the circuit court. The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this section shall be in accordance with s. 397.697.~~

~~(5) Notice of hearing shall be provided to the respondent or his or her counsel. The respondent and the respondent's counsel may agree to a period of continued involuntary services without a court hearing.~~

~~(6) The same procedure shall be repeated before the expiration of each additional period of involuntary services.~~

~~(7) If the respondent has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the respondent's competence.~~

Section 38. Section 397.6977, Florida Statutes, is amended to read:

397.6977 Disposition of individual upon completion of involuntary treatment services.—At the conclusion of the 90-day period of court-ordered involuntary treatment services, the respondent is automatically discharged unless a motion for renewal of the involuntary treatment services order has been filed with the court pursuant to s. 397.6975.

Section 39. Section 397.6978, Florida Statutes, is repealed.

Section 40. Paragraph (b) of subsection (1) of section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455 ~~s. 394.455(48)~~.

Section 41. Paragraph (e) of subsection (4) of section 464.012, Florida Statutes, is amended to read:

464.012 Licensure of advanced practice registered nurses; fees; controlled substance prescribing.—

(4) In addition to the general functions specified in subsection (3), an advanced practice registered nurse may perform the following acts within his or her specialty:

(e) A psychiatric nurse, who meets the requirements in s. 394.455(37) ~~s. 394.455(36)~~, within the framework of an established protocol with a psychiatrist, may prescribe psychotropic controlled substances for the treatment of mental disorders.

Section 42. Subsection (7) of section 744.2007, Florida Statutes, is amended to read:

744.2007 Powers and duties.—

(7) A public guardian may not commit a ward to a treatment facility, as defined in s. 394.455 ~~s. 394.455(48)~~, without an involuntary placement proceeding as provided by law.

Section 43. Paragraph (a) of subsection (2) of section 790.065, Florida Statutes, is amended to read:

790.065 Sale and delivery of firearms.—

(2) Upon receipt of a request for a criminal history record

check, the Department of Law Enforcement shall, during the licensee's call or by return call, forthwith:

(a) Review any records available to determine if the potential buyer or transferee:

1. Has been convicted of a felony and is prohibited from receipt or possession of a firearm pursuant to s. 790.23;

2. Has been convicted of a misdemeanor crime of domestic violence, and therefore is prohibited from purchasing a firearm;

3. Has had adjudication of guilt withheld or imposition of sentence suspended on any felony or misdemeanor crime of domestic violence unless 3 years have elapsed since probation or any other conditions set by the court have been fulfilled or expunction has occurred; or

4. Has been adjudicated mentally defective or has been committed to a mental institution by a court or as provided in sub-sub-subparagraph b.(II), and as a result is prohibited by state or federal law from purchasing a firearm.

a. As used in this subparagraph, "adjudicated mentally defective" means a determination by a court that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease, is a danger to himself or herself or to others or lacks the mental capacity to contract or manage his or her own affairs. The phrase includes a judicial finding of incapacity under s. 744.331(6)(a), an acquittal by reason of insanity of a person charged with a criminal offense, and a judicial finding that a criminal defendant is not competent to stand trial.

b. As used in this subparagraph, "committed to a mental institution" means:

(I) Involuntary commitment, commitment for mental defectiveness or mental illness, and commitment for substance abuse. The phrase includes involuntary inpatient placement under ~~as defined in~~ s. 394.467, involuntary outpatient placement as defined in s. 394.4655, ~~involuntary assessment and stabilization under s. 397.6818,~~ and involuntary substance abuse treatment under s. 397.6957, but does not include a person in a mental institution for observation or discharged from a mental institution based upon the initial review by the physician or a voluntary admission to a mental institution; or

(II) Notwithstanding sub-sub-subparagraph (I), voluntary admission to a mental institution for outpatient or inpatient treatment of a person who had an involuntary examination under s. 394.463, where each of the following conditions have been met:

(A) An examining physician found that the person is an imminent danger to himself or herself or others.

(B) The examining physician certified that if the person did not agree to voluntary treatment, a petition for involuntary outpatient or inpatient treatment would have been filed under s. 394.463(2)(g)4., or the examining physician certified that a petition was filed and the person subsequently agreed to voluntary treatment prior to a court hearing on the petition.

(C) Before agreeing to voluntary treatment, the person received written notice of that finding and certification, and written notice that as a result of such finding, he or she may be prohibited from purchasing a firearm, and may not be eligible to apply for or retain a concealed weapon or firearms license under s. 790.06 and the person acknowledged such notice in

writing, in substantially the following form:

"I understand that the doctor who examined me believes I am a danger to myself or to others. I understand that if I do not agree to voluntary treatment, a petition will be filed in court to require me to receive involuntary treatment. I understand that if that petition is filed, I have the right to contest it. In the event a petition has been filed, I understand that I can subsequently agree to voluntary treatment prior to a court hearing. I understand that by agreeing to voluntary treatment in either of these situations, I may be prohibited from buying firearms and from applying for or retaining a concealed weapons or firearms license until I apply for and receive relief from that restriction under Florida law."

(D) A judge or a magistrate has, pursuant to sub-sub-subparagraph c.(II), reviewed the record of the finding, certification, notice, and written acknowledgment classifying the person as an imminent danger to himself or herself or others, and ordered that such record be submitted to the department.

c. In order to check for these conditions, the department shall compile and maintain an automated database of persons who are prohibited from purchasing a firearm based on court records of adjudications of mental defectiveness or commitments to mental institutions.

(I) Except as provided in sub-sub-subparagraph (II), clerks of court shall submit these records to the department within 1 month after the rendition of the adjudication or commitment.

Reports shall be submitted in an automated format. The reports must, at a minimum, include the name, along with any known alias or former name, the sex, and the date of birth of the subject.

(II) For persons committed to a mental institution pursuant to sub-sub-subparagraph b.(II), within 24 hours after the person's agreement to voluntary admission, a record of the finding, certification, notice, and written acknowledgment must be filed by the administrator of the receiving or treatment facility, as defined in s. 394.455, with the clerk of the court for the county in which the involuntary examination under s. 394.463 occurred. No fee shall be charged for the filing under this sub-sub-subparagraph. The clerk must present the records to a judge or magistrate within 24 hours after receipt of the records. A judge or magistrate is required and has the lawful authority to review the records ex parte and, if the judge or magistrate determines that the record supports the classifying of the person as an imminent danger to himself or herself or others, to order that the record be submitted to the department. If a judge or magistrate orders the submittal of the record to the department, the record must be submitted to the department within 24 hours.

d. A person who has been adjudicated mentally defective or committed to a mental institution, as those terms are defined in this paragraph, may petition the court that made the adjudication or commitment, or the court that ordered that the record be submitted to the department pursuant to sub-sub-subparagraph c.(II), for relief from the firearm disabilities imposed by such adjudication or commitment. A copy of the petition shall be served on the state attorney for the county in

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

which the person was adjudicated or committed. The state attorney may object to and present evidence relevant to the relief sought by the petition. The hearing on the petition may be open or closed as the petitioner may choose. The petitioner may present evidence and subpoena witnesses to appear at the hearing on the petition. The petitioner may confront and cross-examine witnesses called by the state attorney. A record of the hearing shall be made by a certified court reporter or by court-approved electronic means. The court shall make written findings of fact and conclusions of law on the issues before it and issue a final order. The court shall grant the relief requested in the petition if the court finds, based on the evidence presented with respect to the petitioner's reputation, the petitioner's mental health record and, if applicable, criminal history record, the circumstances surrounding the firearm disability, and any other evidence in the record, that the petitioner will not be likely to act in a manner that is dangerous to public safety and that granting the relief would not be contrary to the public interest. If the final order denies relief, the petitioner may not petition again for relief from firearm disabilities until 1 year after the date of the final order. The petitioner may seek judicial review of a final order denying relief in the district court of appeal having jurisdiction over the court that issued the order. The review shall be conducted de novo. Relief from a firearm disability granted under this sub-subparagraph has no effect on the loss of civil rights, including firearm rights, for any reason other than the particular adjudication of mental defectiveness or commitment to a mental institution from which relief is granted.

e. Upon receipt of proper notice of relief from firearm disabilities granted under sub-subparagraph d., the department shall delete any mental health record of the person granted relief from the automated database of persons who are prohibited from purchasing a firearm based on court records of adjudications of mental defectiveness or commitments to mental institutions.

f. The department is authorized to disclose data collected pursuant to this subparagraph to agencies of the Federal Government and other states for use exclusively in determining the lawfulness of a firearm sale or transfer. The department is also authorized to disclose this data to the Department of Agriculture and Consumer Services for purposes of determining eligibility for issuance of a concealed weapons or concealed firearms license and for determining whether a basis exists for revoking or suspending a previously issued license pursuant to s. 790.06(10). When a potential buyer or transferee appeals a nonapproval based on these records, the clerks of court and mental institutions shall, upon request by the department, provide information to help determine whether the potential buyer or transferee is the same person as the subject of the record. Photographs and any other data that could confirm or negate identity must be made available to the department for such purposes, notwithstanding any other provision of state law to the contrary. Any such information that is made confidential or exempt from disclosure by law shall retain such confidential or exempt status when transferred to the department.

Section 44. This act shall take effect July 1, 2021.

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SB 828
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Tuesday, February 16, 2021
TIME: 9:00—11:30 a.m.
PLACE: 37 Senate Building

FINAL VOTE			2/16/2021 1 Book					
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Brodeur						
X		Garcia						
X		Harrell						
X		Rouson						
X		Torres						
X		Wright						
X		Albritton, VICE CHAIR						
X		Book, CHAIR						
8	0	**TOTALS**	RCS	-				
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

OFFICE OF SUBSTANCE ABUSE AND MENTAL HEALTH

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SUICIDE PREVENTION COORDINATING COUNCIL
2020 ANNUAL REPORT

Department of Children and Families
Office of Substance Abuse and Mental Health

January 1, 2021

Chad Poppell
Secretary

Ron DeSantis
Governor

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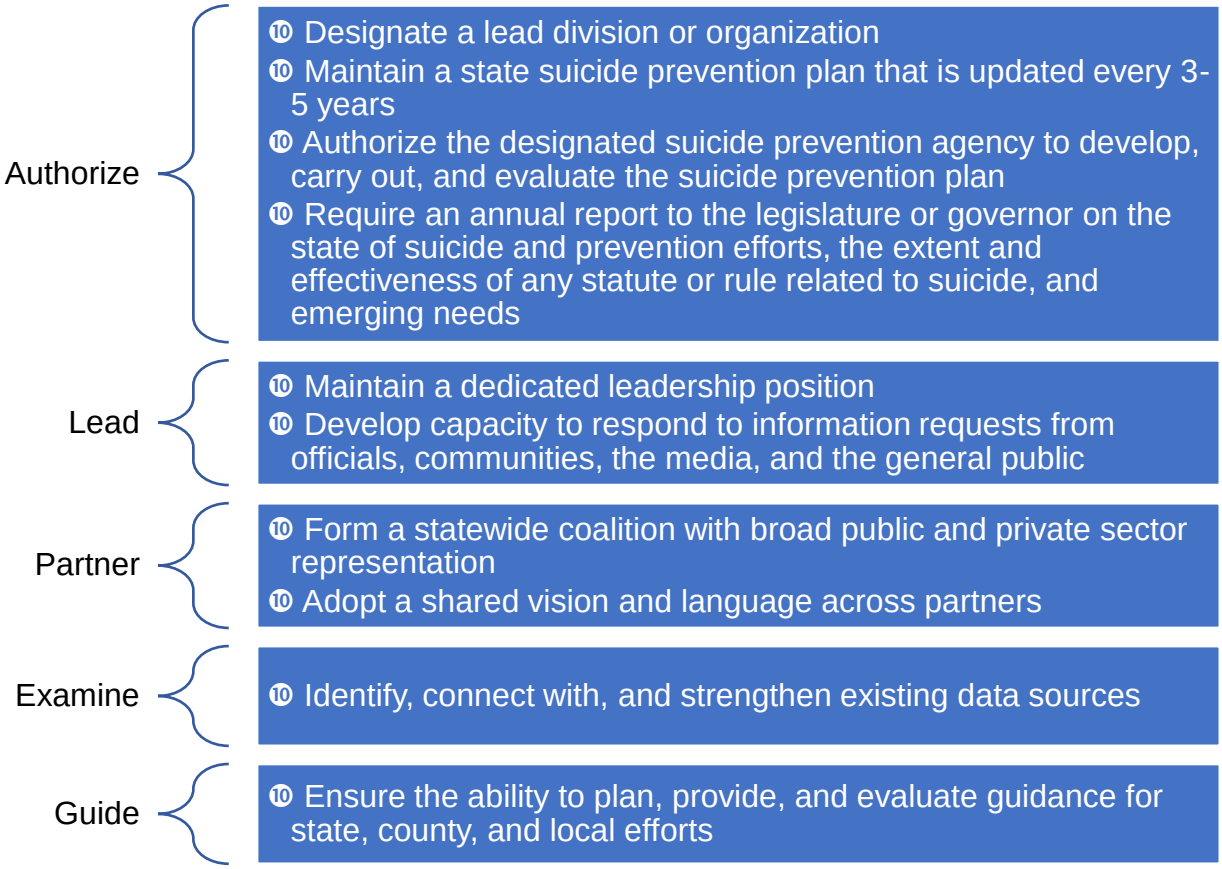
Introduction

Purpose

This report is a collaboration between the Suicide Prevention Coordinating Council, the Statewide Office for Suicide Prevention (SOSP), and the Office of Substance Abuse and Mental Health (SAMH) within the Department of Children and Families (department). The completion of this report fulfills Section 14.20195(c), F.S., which requires the Suicide Prevention Coordinating Council to "prepare an annual report and present it to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2008, and each year thereafter."

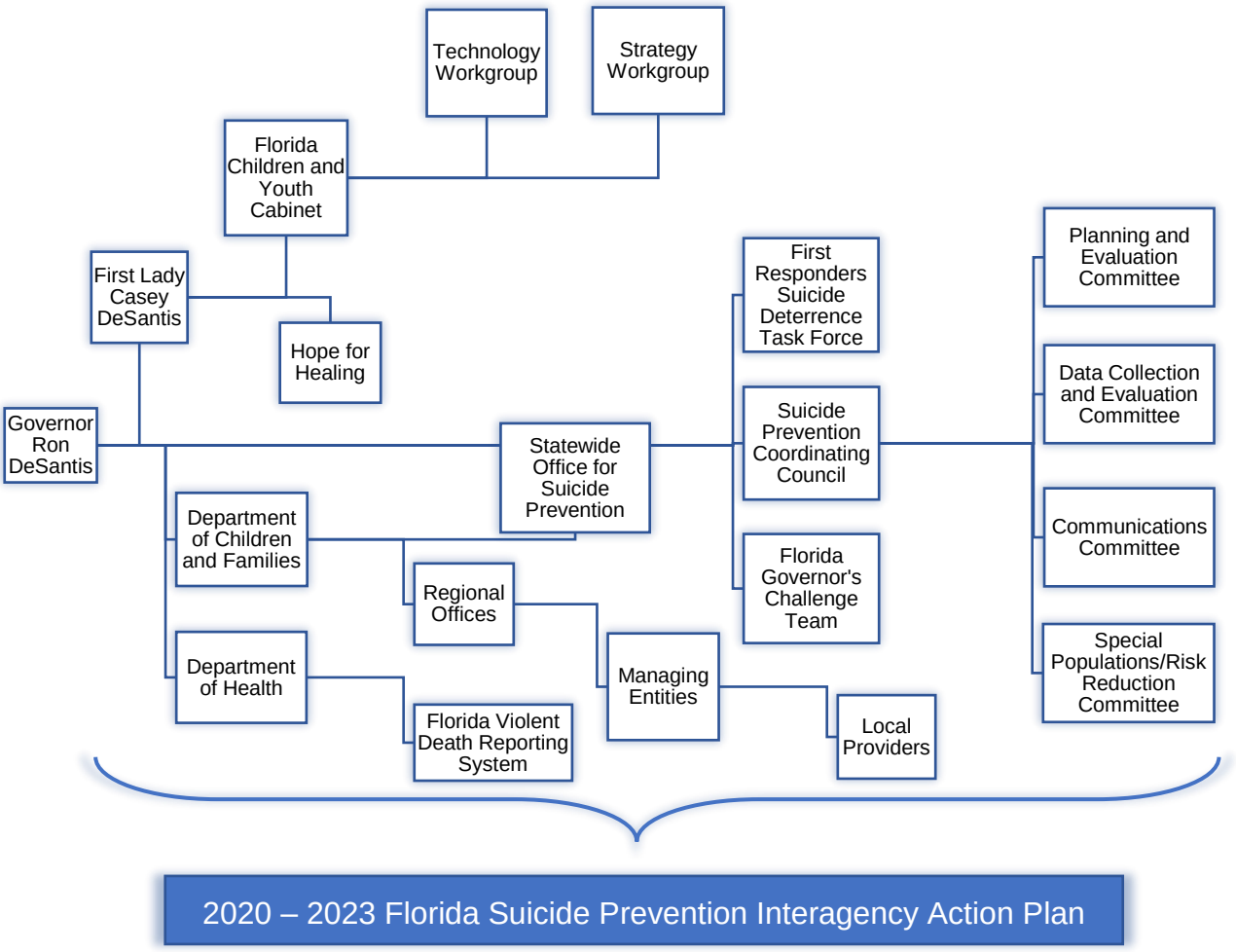
Florida Suicide Prevention Infrastructure

The Suicide Prevention Infrastructure in Florida streamlines suicide prevention efforts and aims to improve the capacity to save lives. A review of the state's infrastructure using the Suicide Prevention Resource Center's Summary Recommendations for State Suicide Prevention Infrastructure[1] shows that the current infrastructure meets the following recommendations:



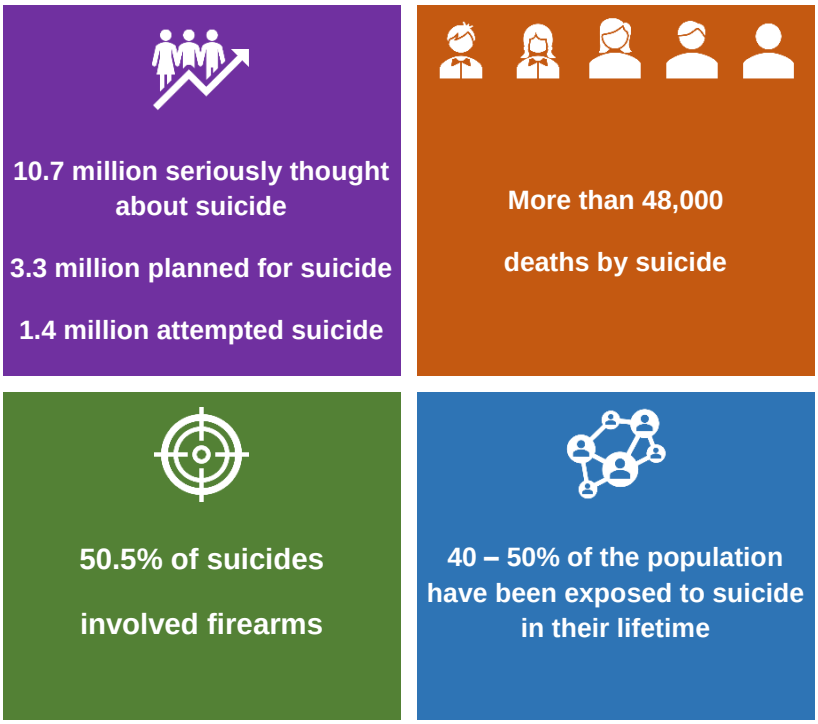
The Florida Suicide Prevention infrastructure evolved in 2020 with the increasing focus on suicide prevention by First Lady Casey DeSantis and the Florida Children and Youth Cabinet; establishment of the First Responders Suicide Deterrence Task Force by the Legislature; creation of the Florida Suicide Prevention Interagency Action Plan; involvement of the SAMH Regional Offices, Managing Entities providers and stakeholders; and formation of five committees within the Suicide Prevention Coordinating Council. Diagram 1 shows the 2020 infrastructure for suicide prevention in Florida.

Diagram 1. Florida's Suicide Prevention Infrastructure

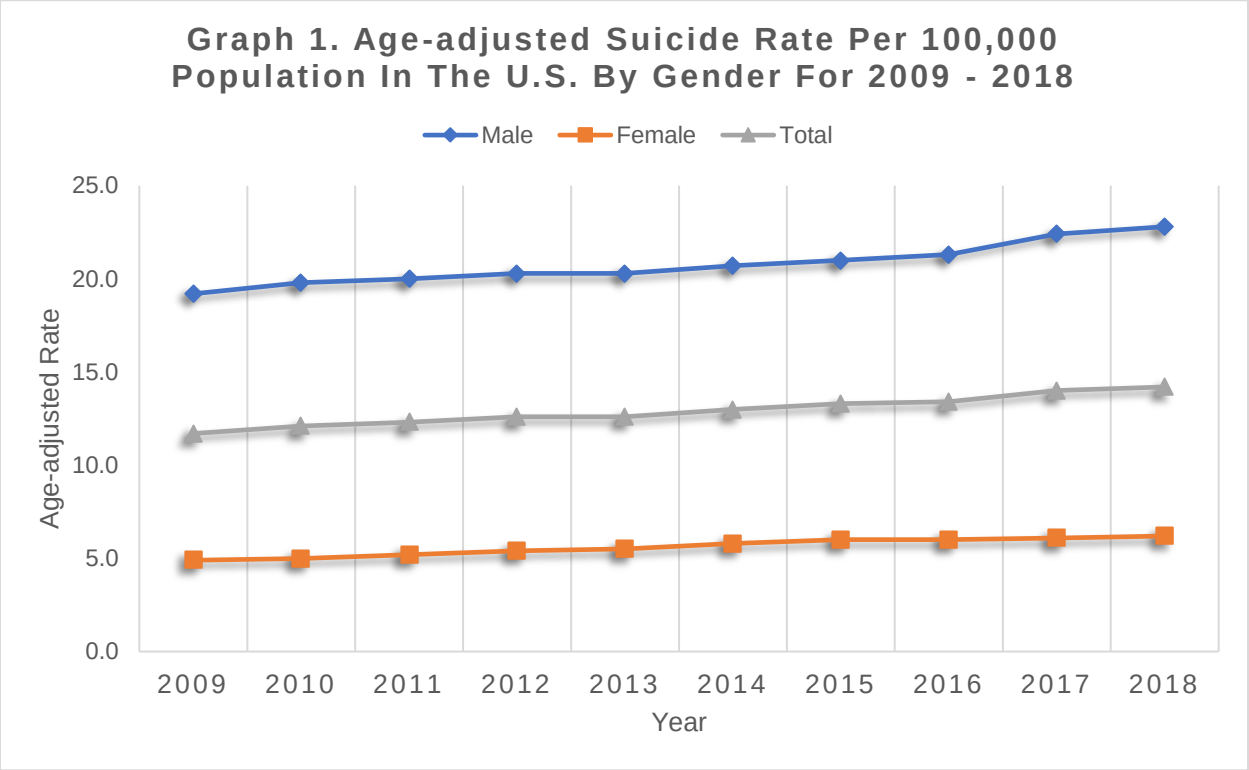


National Suicide Data

2018 National Suicide Data At-A-Glance



In 2018, suicide was the 10th leading cause of death in the United States with more than 48,000 deaths by suicide[2]. Suicide was the second leading cause of death for individuals 10 to 34 years of age, the fourth leading cause of death for 35 to 54, and the eighth leading cause of death for 55 to 64[2]. Overall, firearms were the most common method used in suicide deaths, accounting for about half of all deaths, followed by suffocation/hanging (28.6%) and poisoning (12.9%)[2].



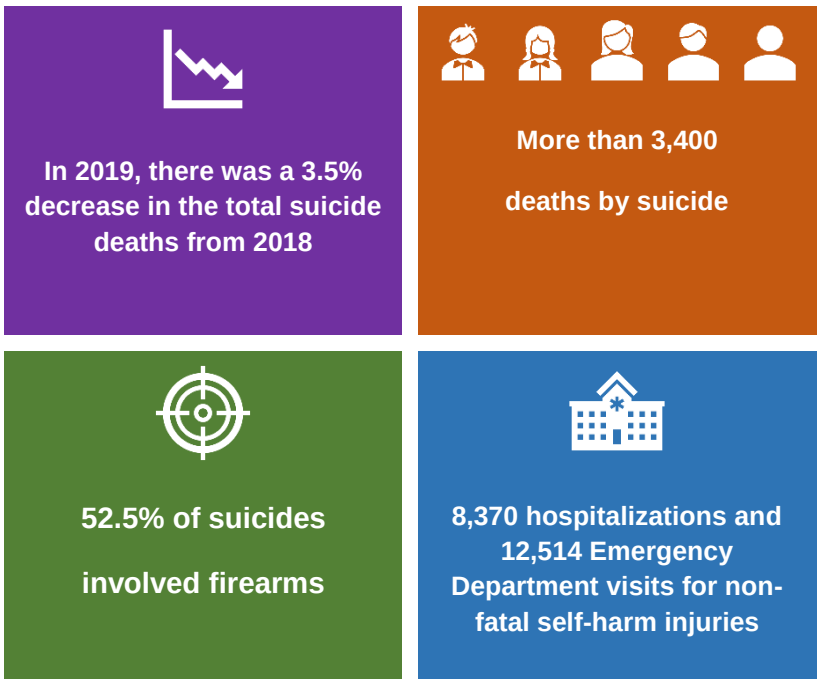
Data Sources: National Vital Statistics System – Mortality Data (2018) via CDC WONDER

From 2009 to 2018 the rate per 100,000 population in the United States for suicide increased from 12.0 to 14.8. The rate for males increased from 19.3 in 2009 to 23.4 in 2018 while the rate for females increased from 5.0 to 6.4[2].

Florida Suicide Data

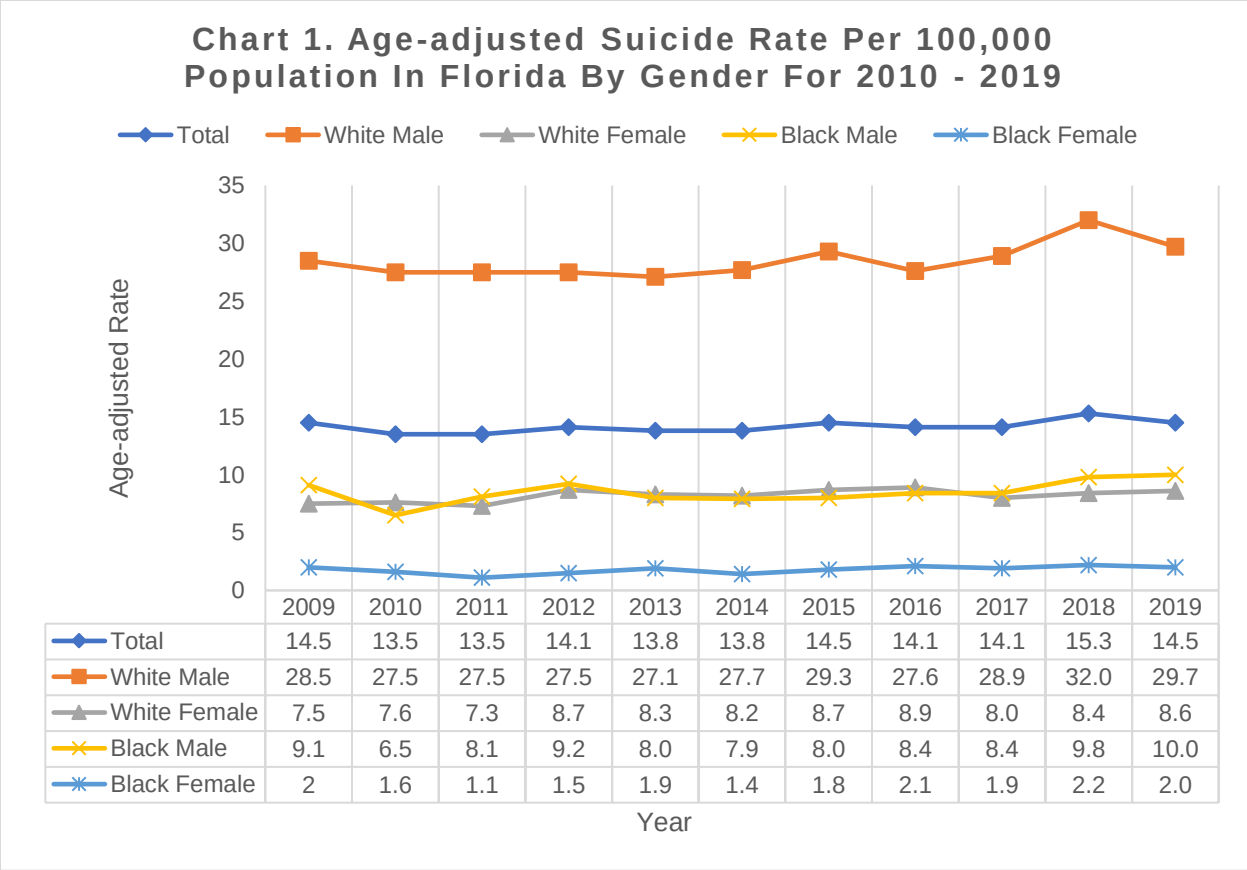
2018 National Suicide Data At-A-Glance

Florida Suicide data is available for 2019, as reported in the Florida Vital Statistics Annual Report (2020)[3] and summarized below



In 2019, 3,427 Floridians died by suicide, representing a 3.5 percent decrease from the number of deaths in 2018. Over half of suicide deaths in 2019 involved a firearm. More information on specific method can be found in Graph 4. 2019 External Causes of Death by Suicide. For non-fatal intentional self-harm injuries, a total of 8,370 hospitalizations occurred in 2019. Furthermore, there were 12,514 Emergency Department visits related to self-harm injuries. Of note, intentional self-harm includes incidents with and without intent to die, therefore, not all self-harm injuries represent suicide attempts[4]. Nevertheless, non-suicidal self-injury may incur additional risk for future suicide attempts and potentially death.

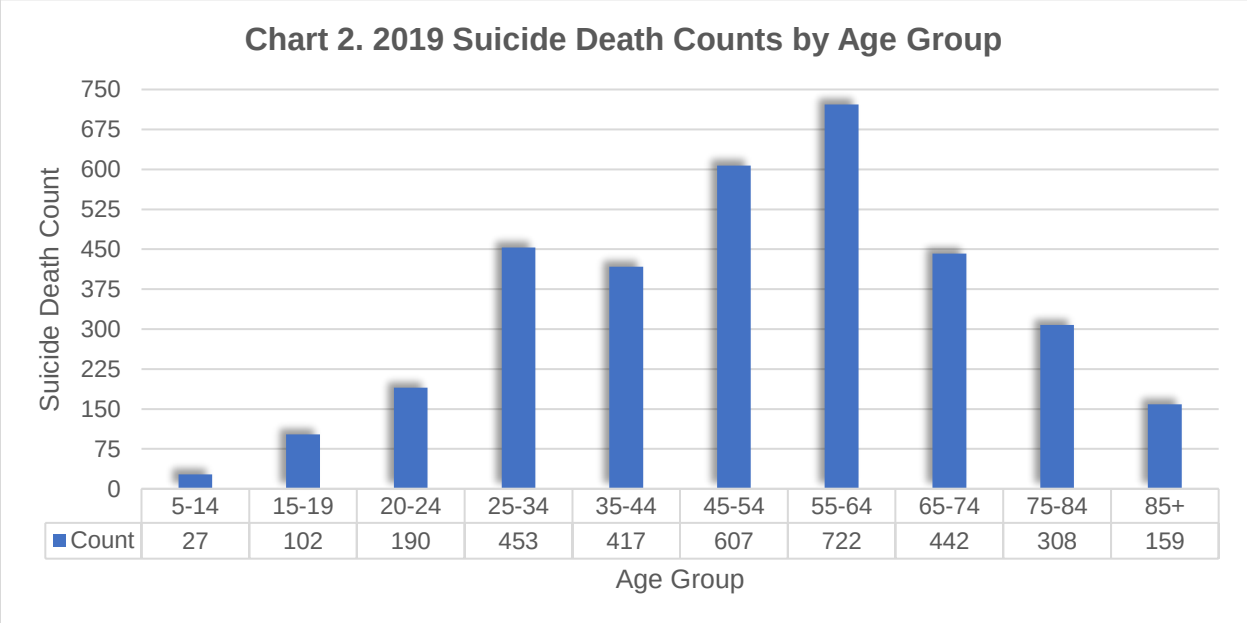
Chart 1. depicts a slight overall increase in the age-adjusted suicide death rate across genders and age groups across the previous decade. White males continue to die by suicide at the highest rate (29.7 per 100,000), followed by Black males (10.0 per 100,000), White females (8.6 per 100,000), and Black females (2.0 per 100,000)[3].



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total	14.5	13.5	13.5	14.1	13.8	13.8	14.5	14.1	14.1	15.3	14.5
White Male	28.5	27.5	27.5	27.5	27.1	27.7	29.3	27.6	28.9	32.0	29.7
White Female	7.5	7.6	7.3	8.7	8.3	8.2	8.7	8.9	8.0	8.4	8.6
Black Male	9.1	6.5	8.1	9.2	8.0	7.9	8.0	8.4	8.4	9.8	10.0
Black Female	2	1.6	1.1	1.5	1.9	1.4	1.8	2.1	1.9	2.2	2.0

Data Sources: Chart D-13: Resident Suicide Deaths and Rates per 100,000 Population, by Race and Gender, Florida, Census Years 1970-2000 and 2009-2019: Florida Vital Statistics Annual Report (2020)

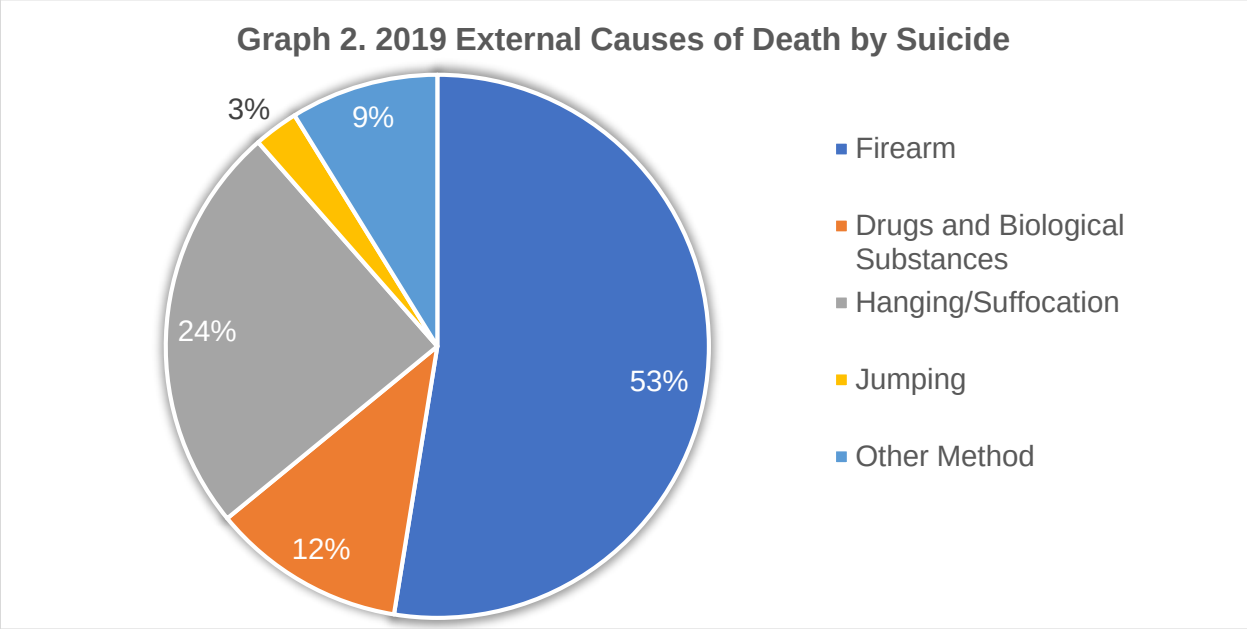
Chart 2. depicts 722 individuals 55 – 64 years old died by suicide in 2019. The age group with the second most deaths was 45 – 54, followed by those aged 25 – 34[3].



	5-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Count	27	102	190	453	417	607	722	442	308	159

Data Sources: Table D-11: Resident Deaths for Selected Causes, by Age Groups, by County, Florida, 2019: Florida Vital Statistics Annual Report (2020)

Graph 2. Provides information on the estimated percentages for each method used to die by suicide in 2019. Firearms represented the largest percentage, with about 53% of deaths caused by firearms, followed by hanging/suffocation, drugs and biological substances, other method, and jumping from a high place[3,4]. Importantly, firearms continue to be the most common used method in suicide deaths.



Data Sources: Table D-10: Resident Deaths for 358 Cause Groups, By Age Group, Florida, 2019: Florida Vital Statistics Annual Report (2020)

Florida Health Charts

All suicide-related death information is collected and housed within the DOH Florida Health CHARTS. Data is provided via a publicly available dashboard, which provides indicators and county level data for a multitude of health-related outcomes. As of July 2020, Florida Health CHARTS includes a suicide/mental health profile which provides an overview of suicide and suicide-related data[4]. The website includes a tutorial and directions/checklists: http://www.flhealthcharts.com/charts/default.aspx. The DOH Florida Health CHARTS includes the ability to access provisional 2020 data. The Statewide Office for Suicide Prevention monitors the 2020 provisional data on a monthly basis to track suicide prevention outcomes throughout the year. Given the 2020 data is provisional, death rates and counts are subject to change, and monitoring of this data is used to provide a general monitoring system of the current status of suicide within the state.

National Suicide Lifeline State Data: Florida

The National Suicide Prevention Lifeline provides free 24/7 confidential support for individuals in distress throughout the nation. The lifeline operates through a network of local crisis centers, in Florida this is 2-1-1. The Lifeline received a total of 128,659 calls initiated from Florida phone numbers in 2019[5]. A 2020 state report for Florida is not yet available, however, preliminary data indicate between January and November 2020 the lifeline received 111,153 calls initiated from Florida phone numbers. This includes individuals accessing the Veterans Crisis Line or the Spanish Subnetwork.

Florida Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) is a statewide, school-based survey of Florida's public high school students. The YRBS is a part of the Florida Youth Survey, which includes additional surveys of youth behavior across the state of Florida. Self-harm behaviors are captured within the YRBS for Florida High School students. Below is a general overview of the findings of the 2019 YRBS. For more information, on the YRBS and the Florida Youth Survey, please visit the Florida Department of Health website description found here: http://www.floridahealth.gov/statistics-and-data/survey-data/florida-youth-survey/youth-risk-behavior-survey/index.html.

2020 State Initiatives

Senate Bill 7012 (SB 7012)

During the 2020 legislative session, s. 14.20195, F.S. was expanded by Senate Bill 7012[6]. The bill broadened the duties of the SOSP within the department by requiring the office to coordinate education and training curricula on suicide prevention efforts for Veterans and services members. Furthermore, the bill solidified the inclusion of Veterans and service members in the network of community-based programs intended to improve suicide prevention initiatives. The SOSP is required to act as a clearinghouse for information and resources on suicide prevention by sharing evidence-based practices and collecting and analyzing data on trends in suicide. The Florida Department of Transportation is required to work with the SOSP in developing a plan for implementation of evidence-based suicide deterrents on all new infrastructure projects.

The duties of the Suicide Prevention Coordinating Council were also broadened by requiring the Council to make recommendations on the implementation of evidence-based mental health programs and suicide risk identification training in the annual report (please see page 25 for Council recommendations). The Council was expanded to include five additional members and remove one defunct member. The current Council includes a total of 31 voting members and one non-voting member. The focus of the Council and Department is turned towards enhancing public awareness of locations and availability of behavioral health providers.

Additionally, the expansion included the creation of the First Responders Suicide Deterrence Task Force (Task Force). See below for more information on the Task Force.

The Florida Children and Youth Cabinet

In 2019, First Lady Casey DeSantis, Chair of the Florida Children and Youth Cabinet, established two workgroups to focus on youth suicide prevention in Florida.

The Technology Workgroup is charged with identifying, connecting data, research, guidance and initiatives across state agencies and communities related to suicide and suicide ideology. Additionally, to increase actionable intelligence that can redirect social policy and services to help prevent suicide and save the lives of children and youth. Workgroup members are as follows:

- Richard Corcoran, Commissioner of Education
- Director Shan Goff, Office of Early Learning
- Former Secretary Mary Mayhew, Agency for Health Care Administration
- Surgeon General Scott Rivkees, Department of Health

The Strategy Workgroup is charged with researching the best and most-promising prevention efforts, particularly regarding mentorship. Workgroup members are as follows:

- Director, Alan Abramowitz, Guardian ad Litem, Chair
- Director, Barbara Palmer, Agency for Persons with Disability
- Secretary Chad Poppell, Department of Children and Families
- Secretary Simone Marstiller, Department of Juvenile Justice
- Superintendent, Sandra Himmel, Citrus County Schools

Hope for Healing

Hope for Healing Florida is an initiative to provide crisis services and resources for youth and families within Florida experiencing substance use and other mental health difficulties. Crisis resources provided on the Hope for Healing Florida website include suicide prevention, treatment locator service, help with depression and anxiety, resources for youth afraid to return home, and guides for youth being bullied. To learn more about Hope for Healing Florida, visit their website at https://hopeforhealingfl.com/.

Transition from 2016-2020 Florida Suicide Prevention Plan to 2020-2023 Florida Suicide Prevention Interagency Action Plan

For the past four years, suicide prevention efforts within Florida were guided by the 2016-2020 Florida Suicide Prevention Plan. With 2020 ending and the state embarking in an effort to increase collaboration with other state agencies and stakeholders; the completion of this four-year plan prompted the need for a new strategic plan for suicide prevention in Florida. The 2020-2023 Florida Suicide Prevention Interagency Action Plan (Action Plan) was created by the Florida Suicide Prevention Interagency Action Plan Committee (Committee), co-chaired by the SOSP and the DOH.

The 2020-2023 Action Plan replaces the 2016-2020 Florida Suicide Prevention Plan as the guiding document for suicide prevention efforts within Florida. The Committee followed the guidelines of the Suicide Prevention Resource Center's Strategic Planning Approach for Suicide Prevention[7]. The Action Plan identifies four focus areas, four goals, and eleven strategies and provides examples of action steps for Floridians to advance each goal and strategy. More detailed information on both plans can be found starting on page 21.

The Department of Children and Families Suicide Prevention Website

The department's Suicide Prevention website serves as a central place for suicide prevention information and resources. Included within the website are tabs specific for various suicide prevention-related topics, such as up-to-date data on suicide trends, crisis support information, and information on the Suicide Prevention Coordinating

Council. The website is organized with specialized tabs for various stakeholders and high-risk populations, such as teens and young adults, parents and adults, loss survivors, suicide attempt survivors, professionals, and military service members and veterans. Specific resources related to COVID-19 and suicide prevention are provided. Within the training section, organizations and individuals can find information on training options for suicide prevention, intervention, and postvention. The suicide prevention website is updated regularly and includes a calendar of suicide prevention events happening across the state and nation. The suicide prevention website can be accessed via this hyperlink: https://www.myflfamilies.com/service-programs/samh/prevention/suicide-prevention/index.shtml.

Suicide Prevention Coordinating Council

The Suicide Prevention Coordinating Council is comprised of 31 members and one non-voting member. In 2020, the Suicide Prevention Coordinating Council formed the following four committees to focus on different tasks relating to suicide prevention.

The Planning and Evaluation Committee develops and evaluates the statewide plan and contribute to the annual report. This committee may also make findings and recommendations; conducts research of other state suicide prevention initiatives; and review and make recommendations regarding available suicide prevention grant opportunities.

The committee met biweekly during 2020. The original objective was to assist in the development of the 2020 – 2023 Action Plan. Following the development of the plan, the committee objectives transitioned to focus on the evaluation of the Action Plan. More specifically, the objectives of the committee include (1) Develop a complete and detailed logic model to summarize goals; (2) Focus on available resources and priority needs in Florida; (3) Use current research to augment process and outcome measures; and (4) Collect and apply evaluation data to improve the implementation and the effectiveness of the 2020 – 2023 Action Plan.

The Data Collection and Analysis Committee gathers and analyzes Florida data as it relates to national data to include in the annual report. This committee collects and analyzes specific population data and identifies trends and patterns that can be used to inform strategies. The committee did not formally meet in 2020, however, have begun to identify potential data sources for suicide throughout the state of Florida. Furthermore, the Statewide Office for Suicide Prevention collaborated with the DOH to access provisional death data for 2020 to monitor potential impacts of Coronavirus Disease-2019 on suicide death trends within Florida.

The Communications Committee assists with coordinating and promoting Suicide Prevention Day/Week/Month events and Suicide Prevention Day at the Capitol. This

committee writes proclamations and publishes articles and stories. The committee is responsible for creating marketing campaigns, social media campaigns, flyers, brochures, and public service announcements; creating and distributing surveys; and coordinating speaking engagements.

The committee assisted with a social media campaign for Suicide Prevention Month. This included an organic social media post for World Suicide Prevention day on September 10, 2020. In addition to organic social media posts, the committee partnered with the DOH on a suicide prevention ad campaign. The ad campaign included a joint effort with the Trevor Project to bring awareness to the mental health needs and suicide prevention of teens in the LGBTQ community. In total, the ad campaign reached almost 130,000 individuals, with 2,671 post engagements and 2,337 link clicks. The five organic social media posts reached a total of over 163,000 individuals.

The Special Populations/Risk Reduction Committee discusses concerns related to special populations identified as at higher risk for suicide. The committee will focus on developing educational materials related to at-risk groups such as youth, Veterans, first responders, and individuals with a mental health or substance use disorder. The committee will also focus on identifying and implementing risk reduction strategies. With the recent creation of the First Responders Suicide Deterrence Task Force, the first responder population will be transitioned away from the Special Populations/Risk Reduction Committee focus.

In 2020, the committee met on a monthly basis. Notably, the committee created a survey to be disseminated to sheriff offices across the state assessing the needs and current status of suicide prevention efforts.

First Responders Suicide Deterrence Task Force

The First Responders Suicide Deterrence Task Force was established by the legislature within Senate Bill 7012. The purpose of the task force is to “make recommendations on how to reduce the incidence of suicide and attempted suicide among employed or retired first responders in the state”. The task force is comprised of seven members, including a member from the Statewide Office for Suicide Prevention, and nominated representatives from the Florida Professional Firefighters Association, the Florida Police Benevolent Association, the Florida State Lodge of the Fraternal Order of Police, the Florida Sheriffs Association, the Florida Police Chiefs Association, and the Florida Fire Chiefs Association. The task force is directed to identify or make recommendations on developing training programs and materials that would better enable first responders to cope with personal life stressors and stress related to their profession and to foster an organizational culture that meets specific requirements. Findings and recommendations for training programs and materials to deter suicide among active and retired first

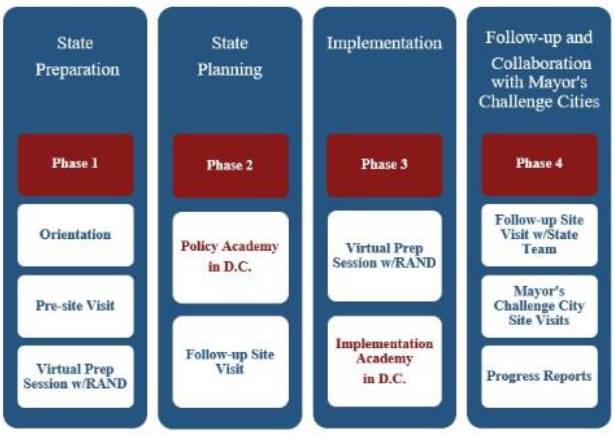
responders will be reported to the Governor, the President of the Senate, and the Speaker of the House of Representatives by each July 1, beginning in 2021 and through 2023. The Task Force is repealed on July 1, 2023.

Florida Governor's Challenge Team

On March 5, 2019, President Trump signed Executive Order (13861) on a "National Roadmap to Empower Veterans and End Suicide" that served as a call to action for the nation. The Veterans Administration and the Substance Abuse and Mental Health Services Administration (SAMHSA) partnered to launch the city-level "Mayor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families" and shortly thereafter the state-level "Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families".

Governor Ron DeSantis accepted the Governor's Challenge in December of 2019. Florida was in the second cohort of states in the country to accept this challenge and is one of 27 states that have accepted the Governor's Challenge. The purpose of the Governor's Challenge is to help local leaders in community and state governments work together to prevent suicide among Veterans. More specifically the Governor's Challenge convenes a state interagency military and civilian team of leaders to develop an implementation plan to prevent suicide among service members, Veterans, and their families that will advance the VA's *National Strategy for Preventing Veteran Suicide*[8] and incorporate evidence-based strategies from the CDC's *Preventing Suicide: A Technical package of Policy, Programs, and practices*[9]. This state-level initiative works in conjunction with the President's national PREVENTS Office and Task Force.

Diagram 2. Governor's Challenge Process



Florida is currently between the "Phase 2: State Planning" and "Phase 3: Implementation" stages.

Important Milestones:

- January 2020: Pre-Site Visit
- February 2020: Policy Academy in DC along with 7 other participating states
- May 2020: Post-Academy Virtual Site Visit
- August 2020: National Virtual Reconvening of Florida's cohort of 8 states

Team sub-groups meet bi-weekly to discuss strategic action plan progress

The Florida Governor's Challenge Team is led by **Major General James S. "Hammer" Hartsell, USMC (Ret.), FDVA** with Secondary Support Lead **Lauren A. Stentz, FDVA.** The team is comprised of dedicated and passionate individuals from the following agencies and entities:

Florida Department of Veterans' Affairs	Florida Department of Children and Families	Florida Department of Elder Affairs	Florida Defense Support Task Force
Florida Air National Guard	The Crisis Center of Tampa Bay	Enterprise Florida	Vietnam Veterans of America
Florida Department of Health	Agency for Health Care Administration	The Fire Watch	Building Healthy Military Communities
VA Sunshine Healthcare Network	Florida Department of Law Enforcement	Hillsborough County Board of County Commissioners	Veterans Administration (Federal)

Below are the Identified priorities, goals, and Initiatives of the Florida Governor's Challenge team.

Priority 1: Identify Service Members, Veterans and their Families (SMVF) and Screen for Suicide Risk

Goals:

- Identify Florida's Veterans in order to increase opportunities for contact and referral to relevant resources
- Make Veterans aware of mental health resources during a critical point of increased suicide risk (separation from the military)
- Implement standardized screening for SMVF status and suicide risk in clinical and medical settings

- Involve non-VA, non-medical, and non-clinical community partners in asking about SMVF status, noticing suicide risk red flags, and referring individuals at-risk to care

Main Initiatives:

- Develop a database of all Veterans in Florida
- Add mental health resource-related wording to the Department of Veterans Affairs letter sent to all new Veterans declaring Florida as their state of residence
- Partner with clinical and medical providers/settings and promote: 1) Asking the question, 2) Screening for Suicide Risk, 3) Referring to relevant resources
- Partner with non-clinical, non-medical community organizations and promote: 1) Asking the question, 2) Noticing red flags for suicide risk, 3) Referring to relevant resources

Priority 2: Promote Connectedness and Improve Care Transitions

Goals:

- Improve awareness of and access to resources, services and benefits available to SMVF
- Improve coverage and usage of resources, services and benefits available to SMVF

Main Initiatives:

- Create a comprehensive, searchable database of region-specific resources relevant to Veterans (Completed: http://www.211atyourfingertips.org/)

Priority 3: Taking a Comprehensive Approach to Suicide Prevention for SMVF

Goals:

- Develop and execute a cohesive Governor's Challenge outreach, advertising, and media campaign
- Promote Veteran outreach that is consistent with personal preferences
- Ensure engaged, Veteran-focused participation from organizations
- Use public health approach to ensure impact on all levels of social ecology (individual relationships, community, and societal)

Main Initiatives:

- Develop a comprehensive advertising and media campaign to make the public aware of Governor's Challenge efforts and resources, and disseminate educational information
- Create a logo for the Florida Governor's Challenge

- Create a website with an overview of Florida's Governor's Challenge efforts
- Establish a designation for all organizations that significantly partner with the Florida Governor's Challenge Team (like "five start messaging")
- Serve as the publishing house for all Governor's Challenge information and materials so that all Governor's Challenge deliverables are vetted and uniformly branded

Priority 4: Lethal Means Safety and Safety Planning

Goals:

- Expand the gun lock distribution program in Florida
- Partner with priority #3 Team to include consistent, comprehensive means safety messaging in Governor's Challenge overall messaging campaign
- Increase Narcan distribution to additional communities and organizations not already receiving distribution today
- Increase attention paid to medication as lethal means
- Promote, disseminate, and provide education surrounding the VA's new Safety Planning App

Main Initiatives:

- Expand gun lock distribution efforts in Florida
- Highlight existing medication drop off boxes
- Expand Narcan distribution
- Develop and disseminate a means safety campaign
- Promote safety planning as part of means safety via the VA's Safety Planning App
- Increase the overdose prevention education and outreach activities in Florida to reduce the number of overdoses in the state

Grants

Firearm Injury Surveillance Through Emergency Rooms (FASTER)

The Florida DOH was one of seven states in the nation to receive the Firearm Injury Surveillance Through Emergency Rooms (FASTER) grant. The purpose of this grant is to collect timely state and local-level data on Emergency Department (ED) visits for nonfatal firearm injuries, which are currently limited. The collection of near real-time data on ED visits for nonfatal firearm injuries overall and by intent (i.e., intentional self-directed, unintentional, and assault-related) at the state and local-level could improve the ability to identify and respond to emerging public health problems. Current activities of this grant include discussions with colleagues in Tennessee who have been using the

Electronic Surveillance System the Early Notification of Community-based Epidemics (ESSENCE) data to monitor near or real-time suicide attempts or ideation. Currently, more than 80% of Florida hospitals use ESSENCE data, therefore, follow up discussions with Tennessee will provide information on established practices and processes for expanding and utilizing this valuable data source.

Florida Violent Death Reporting System

The Florida Department of Health is a participant in the National Violent Death Reporting System through the name Florida Violent Death Reporting System (FLVDRS). FLVDRS is supported by a grant from the Center for Disease Control (CDC) and requires data on 60% of the state homicides and suicides be collected. The FLVDRS collects and categorizes data on violent deaths from state and local medical examiners, coroners, law enforcement, toxicology reports, and vital statistics records into an anonymous database. The FLVDRS includes all types of violent deaths, including homicides and suicides, in all settings, and for all age groups. Reported data may include information on mental health problems, recent problems with employment, finances, or relationships, physical health problems, and information about circumstances of death.

In September 2020, new project year began and a FLVDRS stakeholder meeting was held. Currently, the FLVDRS operates in approximately 40% of counties within Florida and is working to expand to 60% by August 2021. DOH and USF continue to conduct outreach to law enforcement agencies, which in Florida, are decentralized and numerous.

Florida Implementation of the National Strategy for Suicide Prevention (FINS) Project

The FINS Project is a partnership of the Statewide Office for Suicide Prevention, the University of South Florida (USF), the University of Central Florida (UCF), and Florida Hospital. The purpose of the project is to adopt and integrate the National Strategy for Suicide Prevention across health and behavioral health settings and adult-serving systems in order to adequately identify, engage, and treat adults at risk for suicide. The program focuses on providing culturally competent evidence-based/best practices for suicide prevention, treatment, safety planning, and care coordination services. The project focuses efforts using a *Zero Suicide* model and includes a *Zero Suicide* advisory committee. So far, the FINS Project is meeting the anticipated goals, with ongoing suicide prevention trainings for community partners and hospital staff and an implemented care coordination program using evidence-based standards. Due to COVID-19 pandemic measures, all in-person trainings were cancelled for the remainder of 2020, with trainings transitioning to virtual platforms. Furthermore, safety precautions

were put in place to allow for the safe continuation of care coordinators' engagement with patients at hospital sites. Despite initial delays caused by COVID-19, FINS project continues to progress.

COVID-19 Emergency Response for Suicide Prevention

In May 2020, The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration announced the availability of COVID-19 Emergency Response for Suicide Prevention Grants. The purpose of the program is to support states and communities during the COVID-19 pandemic to help address mental health needs. Specifically, the program focuses on adults age 25 and older and requires a minimum of 25 percent of direct services be funded for those who are survivors of domestic violence. Three organizations within Florida were awarded the full $800,000 for 16 months.

Centerstone began implementation of the Suicide Prevention Program on November 1, 2020. The grant activities will provide rapid follow-up care and enhanced suicide prevention services to adults residing in Manatee and Sarasota counties, placing a special emphasis on supporting victims of domestic violence. Centerstone's Suicide Prevention Program delivers services in a combination of settings, including telehealth and virtual options. Services provided include coordination of care transitions, suicide risk screening and assessment, crisis management and safety planning, individual and family therapy, counseling on access to lethal means, linkages to community services/specialized care, and peer support and advocacy. The Program works actively with community partners and local stakeholders toward the goal of building and sustaining a comprehensive public health approach to suicide prevention. By providing community trainings, this program will expand evidence-based practices for suicide prevention to effectively increase the competence and confidence of others to identify and assess those at risk, preventing suicide and suicide attempts. Expanding best practices, responding rapidly to those in need, reducing access to lethal means, and improving continuity of care for at-risk individuals, Centerstone's Suicide Prevention Program will model quality suicide prevention care.

Guidance Care Center will provide rapid follow-up care and enhanced suicide prevention services to adults residing in Key West, Florida placing a special emphasis on supporting victims of domestic violence. The Guidance Care Center is in the 3-month startup phase for implementation, and is preparing to enroll clients via training, equipment acquisition, and hiring support staff. The program is for adults over 25 and is funded through November 2021.

Lutheran Services Florida will provide rapid follow-up care and enhanced suicide prevention services to adults residing in Duval County, placing a special emphasis on supporting victims of domestic violence. Lutheran has contracted with the county's major public mental healthcare provider, developed partnerships with a hospital system, domestic violence and homeless shelters to provide a safety net. The goals of the project are to screen up to 1,200 individuals and provide intensive care coordination services and treatment for up to 360 participants over the 16-month grant period.

Suicide Prevention Goals

2016-2020 Suicide Prevention State Plan (State Plan)

The 2016-2020 State Plan was organized into four strategic directions, seven goals, and 11 objectives to guide suicide prevention efforts and activities through the state of Florida. For an overview of the strategic directions, goals, and objectives, please see Appendix A. The State Plan started in 2016 and concluded in July 2020. To assess the outcome of the goals identified by the State Plan, a survey was disseminated to SAMH regional offices, Managing Entities, and their providers. Each agency was asked to rate their success in meeting the goals on a scale from 1 (not at all) to 5 (completely). Almost 100 surveys were returned and were averaged. Overall, all seven goals were determined to be met at least halfway, if not more, with a complete average of 3.918 (between "Halfway" and "Over Halfway". A table of the average response for each individual goal can be found in Appendix A.

2020-2023 Suicide Prevention Interagency Action Plan (Action Plan)

Florida transitioned to the 2020-2023 Action Plan in August 2020. State agencies committed to expand suicide prevention efforts through specific action items known as the Suicide Prevention Interagency Duties to Execute and Reach Goals (SPIDER G) to implement the goals and strategies from the Action Plan. Table 1 shows the four focus areas and goals, and 11 strategies of the 2020-2023 Action Plan. A more detailed table with action items for each agency, baseline information, and potential progress is included in Appendix B.

Table 1: Suicide Prevention Interagency Duties to Execute and Reach Goals (SPIDER G)

Focus Area		**Awareness** **Goal 1: Enhance awareness for suicide prevention**
Strategy	**1.1**	Improve access to suicide prevention resources through various media.

Strategy	**1.2**	Improve quality of information available about suicide prevention in local communities.
Strategy	**1.3**	Raise awareness on how to enhance safety.
Strategy	**1.4**	Increase the collection and analysis of suicide prevention data.
Focus Area		**Prevention** **Goal 2: Increase prevention education approaches**
Strategy	**2.1**	Implement suicide prevention trainings.
Strategy	**2.2**	Increase suicide prevention efforts to target high-risk and special populations.
Strategy	**2.3**	Adopt an evidence-based suicide prevention model.
Focus Area		**Intervention** **Goal 3: Increase effective intervention**
Strategy	**3.1**	Facilitate interagency collaboration to improve access to mental health care and suicide intervention services.
Strategy	**3.2**	Promote the use of evidence-based interventions that target suicide risk.
Focus Area		**Caring Follow-up and Support** **Goal 4: Increase caring follow-up and support efforts**
Strategy	**4.1**	Implement caring follow-up and support training in the workplace.
Strategy	**4.2**	Provide resources that assist with caring follow-up and support.

Coronavirus Disease – 2019 (COVID-19) and Suicide Prevention Efforts

Overview

With local, state, and federal government public policy measures implemented to decrease the spread of Coronavirus Disease-2019 (COVID-19), concern arises for negative secondary outcomes, such as increased mental health difficulties and suicide risk. Increased social isolation and loneliness caused by social distancing regulations increases the likelihood of mental health difficulties, such as depression, anxiety, and suicide risk. Furthermore, economic instability and financial difficulties both directly and indirectly may lead to increased suicide risk. The state of Florida is monitoring provisional 2020 suicide death data to assess for immediate impacts of COVID-19. At the time of this writing, there have been no indications of a significant increase or

differences in suicide deaths within the state of Florida compared to previous years. Mitigation of long-term outcomes, however, continue to be a priority of the Statewide Office for Suicide Prevention and the Suicide Prevention Coordinating Council.

COVID-19 Specific Activities

In response, the Suicide Prevention website has expanded to include resources specific for COVID-19. COVID-19 specific action items were included in the 2020-2023 Action Plan to foster long-term maintenance of suicide prevention efforts related to COVID-19. Furthermore, three agencies within Florida were awarded COVID-19 Emergency Response for Suicide Prevention Grants from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (see page 20).

IMPOWER, a Florida non-profit organization, has launched a no-cost mental health and substance use counseling, medication, and other services for families and individuals needing help as a result of the pandemic. Available services include treatment for adults and children experiencing mental health and/or substance use difficulties, counseling services, psychiatric care, evaluation, treatment, and medication, and assistance with connecting to resources for medication assistance and other services essential to meeting basic human needs. These services are provided via telehealth in order to reach the largest number of Florida residents who have been impacted by COVID-19.

Long-term planning for COVID-19 and recommendations

To help identify specific action items related to COVID-19 for the 2020-2023 Action Plan and to identify areas of focus as suicide prevention efforts continue, the Planning and Evaluation Committee of the SPCC conducted a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis. Through this analysis, several gaps and emerging themes were identified, as outlined below. This SWOT analysis can be used to guide suicide prevention efforts within the agencies of the SPCC.

Table 2. Identified Gaps and Emerging Themes from SWOT analysis exercise

Gaps	
1	Limited data on COVID-19 impact on suicide
2	Funding – recent grants help close this gap
3	Education – stigma for help seeking behaviors and screening
4	Outreach - hidden populations, such as older adults and hard of hearing
5	Policy /Timely Executive Orders

6	Access to internet-based services and necessary in-person services
Emerging Themes	
1	Partnerships and collaborations
2	Innovation
3	Normalize mental health
4	Flexibility
5	Messaging – emphasis destigmatizing mental health and safe social connection

2020 SPCC Council Recommendations

The SPCC makes five recommendations to decrease deaths by suicide in Florida and to mobilize resources toward achieving goals outlined in Florida's 2020-2023 Suicide Prevention Interagency Action Plan.

1. Expand Implementation of Evidence-Based Practices

Fund the department to implement and monitor evidence-based practices that focus on suicide prevention and intervention. The department would create a grant program to fund evidence-based suicide prevention programs in schools and communities and Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP). CBT-SP is an evidence-based therapeutic approach to prevent re-attempts of suicide. The model uses a risk-reduction, relapse prevention approach that includes an analysis of risk factors and stressors (e.g., relationship problems, school or work-related difficulties) leading up to and following the suicide attempt; safety plan development; skill building; and psychoeducation. CBT-SP utilizes family skill modules focused on family support and communication patterns as well as improving the family's problem-solving skills. Following implementation, it is important to continue to monitor the fidelity of evidence-based practices to ensure continued adherence to best practices overtime.

2. Focus Efforts on Support During and Post-COVID-19 Pandemic

Local, state, and federal government public policy measures implemented to decrease the spread of COVID-19, while necessary, may lead to inadvertent negative secondary outcomes, such as isolation and increases in mental health difficulties that may increase the risk for suicide. Review of provisional data available on immediate impacts of COVID-19 and suicide risk within Florida, does not indicate a significant increase. According to Crisis Text Line Trends, Florida is currently number 47th of U.S. states ranked by crises related to suicide, suggesting it is one of the lowest in the nation. In addition, since February 2020, the percent of texters from Florida texting about suicide

crises has slightly decreased about 2% each month, with less than 20% of texts being related to suicide in July 2020.

It is important to monitor these trends over time as social distancing regulations continue and to monitor long-term impacts of COVID-19 on the mental health of Floridians. Messaging strategies should be targeted towards increasing positive coping strategies in response to COVID-19-related stressors. In addition, resources should be expanded to focus on specific at-risk populations, including direct support of survivors of domestic abuse and their providers, elderly, and the healthcare/frontline workforce. Furthermore, it is recommended that monitoring of suicide-related outcomes pre-, peri-, and post-pandemic continue, as it is necessary to develop and identify areas of increased need.

3. Support Governor's Challenge Efforts for Prevention in Service Members, Veterans, and Their Families

Expand on current U.S. Department of Veterans Affairs, State of Florida departments/agencies, and community partnerships. Suicide death among Florida Veterans remain high, with 631, 686, and 647 Veterans lost to suicide in 2017, 2018, and 2019, respectively. Florida houses the third largest number of Veterans, with over 1,500,000 Veterans residing in Florida in 2018, representing approximately 7% of the population[10]. An example of current collaboration efforts is the Florida Governor's Challenge, an interagency military, Veteran, and civilian team working to develop and implement a strategic action plan to prevent suicide.

The Governor's Challenge has four main priorities, (1) Identify service members, Veterans, and their families and screen for suicide risk; (2) Promote connectedness and improve care transitions; (3) Take a comprehensive approach to suicide prevention for service members, Veterans, and their families; and (4) Lethal means safety and safety planning. Currently, the SOSP is a member of the Florida Governor's Challenge team. We must continue to focus suicide prevention efforts among this special population.

4. Add Florida Violent Death Reporting System to Statute

The Florida Violent Death Reporting System (FLVDRS) collects data from 13 counties: Miami-Dade, Duval, Broward, Palm Beach, Hillsborough, Pinellas, Orange, Osceola, Pasco, Nassau, Hamilton, Clay, and Columbia and will be expanding to additional counties to cover the entire state. A contract is in place with the University of South Florida for medical examiner and law enforcement report abstraction, outreach to law enforcement entities, and technical assistance with reviewing and analyzing FLVDRS data. Law enforcement's role in the FLVDRS is essential. Law enforcement data offer detailed information that can provide more insight into how and why a violent death occurred.

The FLVDRS is a valuable source of comprehensive information that will aid in the design and implementation of injury and violence prevention and intervention efforts in Florida and inform the efforts of state and local suicide prevention stakeholders. Currently, the FLVDRS is within its third out of five years of grant funding. The SPCC recommends that FLVDRS be statutorily mandated and funded beyond the life of the grant award. An example of a state that included NVDRS into its statutory language is Ohio (see Chapter 3701.01, Section 3701.93, Ohio violent death reporting system).

5. Focus Efforts on Effective Means Safety Counseling Programs for Parents and Youth

As highlighted in the National Strategy for Suicide Prevention, addressing access to lethal means is imperative for suicide prevention efforts. Decreasing access to lethal means is one of the most effective strategies for decreasing suicide risk, and is a key goal of the National Strategy for Suicide Prevention (Goal 6): “promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk” and is an included action item under “Strategy 1.3: Raise awareness on how to increase safety” of the 2020-2023 Florida Suicide Prevention Interagency Action Plan. The duration of a suicidal crisis is often short – minutes to hours – therefore, means safety programs work to increase time and distance between an individual in suicidal crisis and a lethal means.

One area of particular concern where lethal means counseling programs can be effective, is in addressing youth and adolescent suicide risk. Programs working with both parents and youth to decrease access to firearms and medications within the home can help decrease the chance of a youth suicide death. The SPCC recommends that efforts focus on disseminating information on effective lethal means counseling programs. Furthermore, the SPCC recommends collaboration and partnership with ongoing firearm lethal means safety initiatives, such as Project ChildSafe, which is a program of the National Shooting Sports Foundation for firearms safety and education awareness, with a focus on parents and youth.

Appendix A

Table 3. Strategies, goals, and objectives of the 2016 – 2020 Florida Suicide Prevention Plan

Strategic Direction	Goal	Objective(s)
Healthy and Empowered Individuals, Families, and Communities	1. Integrate and coordinate suicide prevention activities across multiple sectors and settings	1.1 Integrate suicide prevention into the values, culture, leadership, and workplace of a broad range of organizations, programs, and schools with a role to support suicide prevention activities 1.2 Establish effective, sustainable, and collaborative suicide prevention programming at the state, tribal, and local levels
	2. Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery	2.1 Reduce prejudice, stigma, and discrimination associated with suicidal behaviors and mental and substance use disorders
Clinical and Community Preventive Services	3. Implement and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors	3.1 Encourage community-based settings to implement effective evidence-based programs and provide education to promote wellness 3.2 Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk
	4. Provide training on the prevention of suicide and related behaviors to community and clinical service providers	4.1 Update and modify suicide prevention trainings to meet the provider's specific needs and roles.
Treatment and Support Services	5. Promote suicide prevention as a core component of health care services	5.1 Promote timely access to assessment, intervention, and effective care for individuals with heightened risks for suicide 5.2 Establish linkages between providers of mental health and substance abuse services and primary care and community-based programs, including peer support programs
	6. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at-risk for suicidal behaviors	6.1 Adopt, disseminate and implement guidelines for the assessment of suicide risk among persons receiving care in all settings. 6.2 Adopt, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.
Surveillance, Research, and Evaluation	7. Increase the usefulness of national and state level surveillance data to inform suicide prevention efforts	7.1 Identify available data to guide suicide prevention efforts

Table 4. Average response for the completion of each goal of the 2016 – 2020 Florida Suicide Prevention Plan.

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.
Average = 3.89
Goal 2: Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.
Average = 3.83
Goal 3: Implement and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors.
Average = 3.99
Goal 4: Provide training on the prevention of suicide and related behaviors to community and clinical service providers.
Average = 3.9
Goal 5: Promote suicide prevention as a core component of health care services.
Average = 4.07
Goal 6: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at-risk for suicidal behaviors.
Average = 4.24
Goal 7: Increase the usefulness of national and state level surveillance data to inform suicide prevention efforts.
Average = 3.51

Appendix B

Table 5. Overview of the baseline and progress of each specific action item of the 2020 – 2023 Suicide Prevention Interagency Action Plan.

Focus Area		**Awareness** **Goal 1: Enhance awareness for suicide prevention**		
Strategy	**1.1**	Improve access to suicide prevention resources through various media.	Baseline	Progress
Action Items	**1.1.1**	By June 2021, increase the number of Suicide Prevention Coordinating Council agencies that publish or post the National Suicide Prevention Lifeline number on the homepage of their websites and on social media platforms from three to ten agencies. Lead organization: Suicide Prevention Coordinating Council	Three agencies	
	1.1.2	By September 2021, create two public service announcements to be released on social media platforms and YouTube during Suicide Prevention Month. Lead agency: Department of Children and Families SAMH	0 announcements created	
	1.1.3	By December 2020, increase the number of resources on the agency's website regarding suicide factors relating to intellectual and development disabilities and risk reduction from zero to five resources. Lead agency: Agency for Persons with Disabilities State Office	0 resources	Completed ahead of deadline
	1.1.4	By December 2020, increase the number of Managing Entities that post information and contact numbers about the Mobile Response Team services on their websites from zero to one.	0 Managing Entities	Mobile Response Team information has been added to the website for LSF

		Lead agency: Department of Children and Families SAMH		
	1.1.5	By July 2022, increase the number of individuals who become aware of suicide warning signs, risk factors, the National Suicide Prevention Lifeline, and 2-1-1 resources from zero to 75 percent by developing a brochure to include with application packets. Lead agency: Agency for Persons with Disabilities State Office	0 Percent	The brochure has been created and is available on the website. Production is underway for providing the brochure to waiver support coordinators (WSC).
	1.1.6	By June 2021, develop a suicide prevention webpage that links to national and state resources, and other Suicide Prevention Coordinating Council participating agency suicide prevention related information. Lead agency: Department of Health	2 = slightly	The Suicide Prevention Coordinator (hired September 2020) will work with the SPCC Planning and Evaluation Team to develop this resource.
	1.1.7	By December 2020, update and increase the number of resources on the COVID-19 and Suicide Prevention webpage, including resources specific for at-risk populations, such as the elderly and healthcare workforce. Lead agency: Department of Children and Families SAMH	17 resources	
	1.1.8	By December 2020, include COVID-19 specific messaging on improving social connectedness while maintaining safe physical distance. Lead agency: Department of Children and Families SAMH	0 initiatives	The SOSP has presented to the public on Suicide Prevention strategies, including COVID-19 specific strategies.
Strategy	**1.2**	Improve quality of information available about suicide prevention in local communities.	Baseline	Progress
Action Items	**1.2.1**	By June 2022, use the Regional Outline for Expansion of Suicide Prevention Activities template that will show how local communities will further the goals of the Action Plan. Lead agencies: Department of Children and Families SAMH and Managing Entities	N/A	

	1.2.2	By June 2021, increase the number of case reviews from 0 to 60 to evaluate the involvement, consultative process, and effectiveness of the utilization of mental health professionals. Lead Agency: Department of Children and Families' Office of Child Welfare	0 Case reviews	
	1.2.3	By June 2021, provide a toolkit including suicide prevention education and resources to local departments of health in each of the 67 counties. Lead Agency: Department of Health	2 = slightly	The Suicide Prevention Coordinator (hired September 2020) will work with the Planning and Evaluation Team to develop the toolkit for distribution to Local Department of Health
Strategy	**1.3**	Raise awareness on how to enhance safety.	Baseline	Progress
Action Items	**1.3.1**	By April 2021, increase the number of resources on ways to enhance safety on the suicide prevention page of the website from zero to five. Lead Agency: Department of Children and Families SAMH	0 resources	
	1.3.2	By June 2022, increase the number of Floridians that take the *Counseling on Access to Lethal Means* (CALM) training by 20 percent from 926 trainees to 1,019. Lead Agency: Department of Children and Families SAMH	926 Trainees	An additional 50 clinicians were trained on CALM in 2020 through LSF and the COVID -19 Emergency Response for Suicide Prevention grant
	1.3.3	By April 2021, increase the number of resources on firearm safety, including resources specific for firearm dealers and ranges from zero to five. Lead Agency: Department of Children and Families SAMH	0 resources	The SOSP is working with the Governor's Challenge to identify effective messaging strategies
Strategy	**1.4**	Increase the collection and analysis of suicide prevention data.	Baseline	Progress

Action Items	**1.4.1**	By June 2022, increase suicide prevention data on the suicide prevention website. Lead Agency: Department of Children and Families SAMH	Basic numbers currently provided on website	
	1.4.2	By December 2020, complete phase one of accessible county level suicide and mental health data through implementation of a mental health-suicide profile on Florida Health CHARTS (Community Health Assessment Resource Tool Set). Lead Agency: Department of Health	0 = mental health-suicide profile not created	Completed. The Behavioral Health/Suicide Profile was released on Florida Health CHARTS July 2020, based on existing indicators in CHARTS, and feedback from the SPCC Planning and Evaluation Committee.
	1.4.3	By September 2021, provide preliminary suicide related findings of data collected by the Florida Violent Death Reporting System to the Suicide Prevention Coordinating Council. Lead Agency: Department of Health	FLVDRS currently covers 13 counties and 53% of violent deaths	Department of Health and USF continue to recruit law enforcement agency partners. From September 2020 to August 2021, the percentage of violent deaths covered within FLVDRS will increase to 60%
	1.4.4	By June 2021, provide findings from the Community Assessment for Public Health Emergency Response (CASPER). Lead Agency: Department of Health	The Monroe/Irma CASPER survey is completed.	For suicide risk, 10% of respondents has a high risk of suicidality. The Hurricane Michael, rural multi-county CASPER preliminary result revealed most respondents (94.3% had low to no risk of suicidality.
	1.4.5	By December 2020, initiate a data inventory for use in a suicide prevention data surveillance plan. Lead Organization: Suicide Prevention Coordinating Council Data Analysis Workgroup	0 percent	The committee has begun to identify potential data sources

	1.4.6	Collaborate with Department of Health in examining and comparing suicide related findings pre-, peri-, and post-COVID Lead Agency: Department of Children and Families SAMH and Department of Health	0 percent	On-going monitoring of provisional data on FL Health CHARTS
Focus Area		**Prevention** **Goal 2: Increase prevention education approaches**		
Strategy	**2.1**	Implement suicide prevention trainings.	Baseline	Progress
Action Items	**2.1.1**	By October 2022, increase the Area Agencies on Aging participation in programs related to suicide awareness and prevention to elders through the Older Americans Act Title III D program by 10 percent yearly increments from the established baseline. Lead Agency: Department of Elder Affairs	3 = Halfway	Implementation of the Applied Suicide Intervention Skills Training (ASIST). The program is targeted to older adults 60 or over and is designed to develop suicide first aid skills and competencies
	2.1.2	By June 2022, ensure the completion of Mock Suicide Drill Scenarios that are provided for all staff in Department of Juvenile Justice detention centers during each shift are maintained at 100 percent compliance. Lead agency: Department of Juvenile Justice	Completely	From January 2020 – October 2020, there have been no deficiencies found for Mock Suicide Drills in any detention center.
	2.1.3	By June 2021, increase the number schools who have completed youth suicide awareness and prevention training by 50 percent. Lead agency: Department of Education		Schools have access to state funds to continue YMHFA trainings schools seeking suicide prevention certification have trained entire staff with suicide prevention and Intervention practices

	2.1.4	By June 2021, increase suicide training for direct care staff to include 80 percent of all staff. Lead agency: Agency for Persons with Disabilities State Office	0 percent of staff	Development is underway of an online continuing education program for suicide prevention that will be required for all staff yearly.
	2.1.5	By December 2021, introduce Preventing Suicide: A Technical Package of Policy, Programs, and Practice to partners and key stakeholders through the State Health Improvement Plan. Lead Agency: Department of Health	0 Percent created	SHIP Priority Area Workgroups are currently developing 2021- 2025 goals, strategies and objectives.
	2.1.6	By June 2023, increase the number of staff who take a suicide prevention training or webinar from zero to 100 percent of staff throughout the six regions. Lead agency: Agency for Persons with Disabilities State Office	0 Percent	Development is underway of an online continuing education program for suicide prevention that will be required for all staff yearly.
Strategy	**2.2**	Increase suicide prevention efforts to target high-risk and special populations.	Baseline	Progress
Action Items	**2.2.1**	By June 2022, increase the number of Suicide Risk Screening Instruments that are rated as accurate within the Quarterly Technical Assistance Monitoring Tool from 89 percent to 95 percent. Lead agency: Department of Juvenile Justice	89 percent	Current data from January 2020 through October 2020 indicates 10 deficiencies found out of 63 monitoring points, reflecting 85% accurate administration of Suicide Risk Screening Instruments. The majority of deficiencies are attributed to staff turnover and errors made by new staff screeners.

	2.2.2	By June 2021, increase the number of suicide screenings in the Developmental Disability Centers from baseline to 75 percent. Lead agency: Agency for Persons with Disabilities State Office	0 Percent	Not yet begun. Will be coordinated with the onsite Psychology Director.
	2.2.3	By December 2020, increase the number of public service announcements on social media platforms to promote access to Mobile Response Team services from zero to three. Lead agency: Department of Children and Families	0 announcements	The SOSP has presented on suicide prevention efforts, including information on access to MRTs over 4 times, including a Facebook Live Event hosted by the Check-In Project
	2.2.4	By June 2021, engage with the construction and extraction industry workforce by identifying a representative from the industry to serve on the Suicide Prevention Interagency Action Plan/Planning and Evaluation committee. Lead agency: Department of Children and Families SAMH	0 representatives	
	2.2.5	Starting January 2021, 100% of new volunteers will complete suicide prevention training as part of their required pre-service training. By March 31, 2021, update program policies to address best practices in advocating for children who are at high-risk of suicide. Lead Agency: Guardian ad Litem	Information unavailable	
Strategy	**2.3**	Adopt an evidence-based suicide prevention model.	Baseline	Progress
Action Items	**2.3.1**	By September 2023, increase the status of Zero Suicide implementation among state agencies to strengthen the public health approach to suicide prevention and intervention from zero to 60 percent. Lead agencies: Department of Children and Families SAMH and the Department of Health	0 percent	LSF from 2018 to 2020 supported and promoted Zero Suicide implementation among its 60 providers by 50 percent.

Focus Area		Intervention Goal 3: Increase effective intervention		
Strategy	**3.1**	Facilitate interagency collaboration to improve access to mental health care and suicide intervention services.	Baseline	Progress
Action Items	**3.1.1**	By June 2022, increase referral of youth to a mental health clinician and initiate suicide precautions when suicide risk factors are identified from 96 percent to 100 percent in the detention facilities. Lead agency: Department of Juvenile Justice	96 Percent	Current data from January 2020 through October 2020 indicates the percentage has not changed significantly. However, interrater reliability of monitoring and technical assistance provided on the topic has increased/improved.
	3.1.2	By June 2022, increase the number of cases handled through care coordination contact with veterans and their families by 20 percent from the established baseline. Lead Organizations: Crisis Center of Tampa Bay and the Florida Veterans Support Line	Unavailable	
	3.1.3	Beginning June 2021 increase the number of behavioral health providers serving Veterans who are listed in the Florida 211 Directory Service or similar resource guide from its current listing of 680 providers by 5 percent yearly. Lead agency: Department of Veterans' Affairs	680 Providers	Supported Florida 211 resource directory expansion through provision of resources discovered during "Forward March" Initiative; Promoted 211 resource directory during outreach opportunities; supported legislative budget request to secure funding to expand 211 statewide

Strategy	**3.2**	Promote the use of evidence-based interventions that target suicide risk.	Baseline	Progress
Action Items	**3.2.1**	By June 2021, increase the number of *Applied Suicide Intervention Skills Training* (ASIST) from zero to four trainings with the intention of reaching 30 percent attendance by service members, veterans, or their families. Lead organizations: Crisis Center of Tampa Bay and the Florida Veterans Support Line	Zero Trainings	
	3.2.2	By June 2021, increase the number of statewide trainings for school-based mental health service providers (school psychologists, school social workers, school counselors, and licensed mental health professionals employed by schools) on suicide risk assessment from zero to three. Lead agency: Department of Education	0 trainings	Provided a training for school-based mental health providers conducted by Scott Poland on suicide prevention, intervention and after-care services for student returning to school. Other trainings are planned for this school year
Focus Area		**Caring Follow-up and Support** **Goal 4: Increase caring follow-up and support efforts**		
Strategy	**4.1**	Implement caring follow-up and support training in the workplace.	Baseline	Progress
Action Items	**4.1.1**	By December 2021, increase the number of state agencies that adopt *A Manager's Guide to Suicide Postvention in the Workplace* from zero to five. Lead Agency: Department of Children and Families SAMH	0 agencies	
Strategy	**4.2**	Provide resources that assist with caring follow-up and support.	Baseline	Progress

Action Items	**4.2.1**	By December 2021, increase the number of caring follow-up and support resources on the suicide prevention page of the website from zero to five. Lead Agency: Department of Children and Families SAMH	0 resources
	4.2.2	By March 31, 2021, establish a formal policy for providing support to Guardian ad Litem staff and volunteers after a critical incident such as a child fatality. Lead Agency: Guardian ad Litem	No policy

Appendix C

Table 6. 2020 SPCC Council Members and Designees

Representing	Appointed Official	Designee
Statewide Office for Suicide Prevention	Anna Gai, Chair, *non-voting member*	
1. Florida Association of School Psychologists	Dr. Gene Cash	
2. Florida Sheriffs Association	Matt Dunagan	
3. Florida Initiative of Suicide Prevention	Jackie Rosen	
4. Florida Suicide Prevention Coalition	Jane Bennett	
5. American Foundation of Suicide Prevention	Tara Sullivan Larsen	
6. Florida School Board Association	Karen Brill	
7. National Council for Suicide Prevention	Dr. Dan Reidenberg	
8. State Chapter of AARP	Larry Dixon	
9. Florida Behavioral Health Association	Sally Cunningham	
10. Florida Counseling Association	Dr. Carly Paro	
11. NAMI Florida	Cindy Foster	
12. Florida Medical Association	Dr. Ryan Hall	
13. Florida Osteopathic Medical Association	Dr. Ramsey Pevsner	
14. Florida Psychiatric Society	Dr. Daniel Castellanos	
15. Florida Psychological Association	Dr. Carolyn Stimel	

16. Veterans Florida	Joe Marino	
17. Florida Association of Managing Entities	Natalie Kelly	
18. Secretary of Elder Affairs	Richard Prudom	Gretta Jones
19. State Surgeon General (DOH)	Dr. Scott Rivkees	Shay Chapman
20. Commissioner of Education	Richard Corcoran	Martha Rodriguez
21. Secretary of Health Care Administration	Shevaun Harris	Dr. Timothy Buehner
22. Secretary of Juvenile Justice	Simone Marstiller	Dr. Tracy Shelby
23. Secretary of Corrections	Mark Inch	Dr. Dean Aufderheide
24. Commissioner of Florida Department of Law Enforcement	Rick Swearingen	Seth Montgomery
25. Executive Director of Department of Veterans Affairs	James Hartsell	Al Carter/ Roy Clark
26. Secretary of Department of Children and Families	Chad Poppell	Rodney Moore
27. Executive Director of Department of Economic Opportunity	Ken Lawson	Derrick Elias
28. Governor's Appointee	Donna Schulz	
29. – 31. Governor's Appointees	Vacant	

Florida SPCC Planning and Evaluation Committee

Rhonda Jackson (Chair), Department of Health

Anna Gai (Co-Chair), Department of Children and Families, Statewide Office for Suicide Prevention

Alan Mai, Department of Health, Community Health Promotion

Al Carter, Department of Veterans Affairs

Bryan Mingle, Lutheran Services Florida Health Systems

Bryan Russell, Department of Health, Disability and Health

Elizabeth Nettles, Lutheran Services Florida Health Systems

Heather Allman, Department of Children and Families

Dr. Heather Flynn, Florida State University, Center for Behavioral Health Integration

Jane Bennett, Florida Suicide Prevention Coalition

Jennifer Elmore, Florida Department of Elder Affairs

Dr. Keshia Reid, Department of Health, Office of Public Health Research

Dr. Kim Gryglewicz, University of Central Florida

Dr. Kristin Korinko, Agency for Persons with Disabilities

Laurie Blades, Guardian Ad Litem

Lynn Schultz, Building Healthy Military Communities

Margie Menzel, Guardian Ad Litem

Dr. Martha Mason, Agency for Persons with Disabilities

Mary Hodges, Department of Elder Affairs

Na'Keisha Phillips, Department of Children and Families

Tara Sullivan Larsen, American Foundation of Suicide Prevention

Dr. Owen Quinonez, Department of Health, Minority Health and Health Equity

Dr. Timothy Buehner, Agency for Health Care Administration

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BAKER ACT AND MARCHMAN ACT PROJECT TEAM REPORT

FOR FISCAL YEAR 2016-17

Department of Children and Families
Substance Abuse and Mental Health Program Office

November 24, 2015

Mike Carroll	Rick Scott
Secretary	Governor

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I. Executive Summary

I.A. PURPOSE

The following is a synthesis of the findings and recommendations of the Department of Children and Families (Department) Baker Act and Marchman Act Project Team (Project Team). It is important to note, that the Project does not recommend blending, or combining, the Baker Act and Marchman Act. The Project Team recommends the following:

- Legislative Intent language that focuses on mental and substance use disorders being diseases of the brain, and involving the local community in the planning process for behavioral health acute care services.
    - Shift to medical approach in the treatment of mental health and substance abuse.
    - Recognize that substance use and mental disorders are sub-specialties within the medical specialty health care arena.
    - Acknowledge that behavioral health disorders cause effects on individuals' ability to reason, exercise good judgment, recognize the need for services and sufficiently provide self-care, which require responsibility for their care to be relegated to third parties and/or vested in the authorities of behavioral health programs and practitioners.
    - Establish community based alternatives that include prevention, intervention and outreach to prevent need for higher levels of care and provide for care coordination and recovery oriented services upon discharge.
    - Provide funding of the community system resulting in cost savings and efficiencies across multiple systems.
    - Define specifications and minimum standards for access to care that will be available in each community.
    - Authorize licensed and certified behavioral health practitioners to exercise the full authority of their respective scopes of practice.
    - Provide the mechanism for communities in conjunction with others, to define their local behavioral health, emergency, acute care and treatment array of services.
    - Ensure that local systems of acute care services have standardized services and processes for access.
    - Ensure that local systems of care are designed to maximize available local resources, including health care services and managed care plans.
- Every county have access to either a central receiving facility, an access center, a triage center, a crisis stabilization unit or an addictions receiving facility, or have a plan that addresses accessibility.
- A transportation plan and local community plan should be developed by the managing entities for every county
    - Plans will provide exception to existing statutory requirements mandating law enforcement to transport to nearest receiving facility, to provide for consumer choice and meet specifications of the local transportation plan

- Align the statutory requirements in Chapters 394 and 397, F.S. so that the same qualified professionals are authorized to initiate involuntary examinations/assessments/stabilizations under the Baker Act and the Marchman Act.
- The requirements for the collection of data and the time frames for both the Baker Act and the Marchman Act should be aligned
- Require the collection, submission and reporting of the same data for the Marchman Act and the Baker Act, by all public receiving facilities and should be submitted to DCF using the CSU database.
- Timeframes should be standardized so that involuntary examination under the Baker Act and involuntary assessment and stabilization under the Marchman Act must be completed within 72 hours. However, a physician or physician's assistant or psychiatric nurse acting under the physician may authorize up to an additional 48 hours based on a determination of need without court involvement.

Estimate of the cost to address the needs for expanded acute care capacity ranged from $133 million to $ 298 million. We recognize that those consensus estimates can result in the immediate discounting of the Project Team's recommendations based on the projected cost. (Appendix 2).

Instead, we would recommend the following:

- The Legislature should consider a multiple year approach to addressing the acute care service capacity within Florida's communities.
- This approach would reflect a commitment and investment in mental health and substance abuse services that would be designed to meet local behavioral health acute care needs over time.
- Appropriations should be targeted to those services that include acute care beds, but also place a premium of funding lower cost services designed to reduce demand on inpatient, crisis stabilization, and detoxification services; such as, mobile crisis response teams. In addition, improved care coordination across Medicaid, and other health plans and other funding sources to reduce demand on publically funded services and expand community treatment options.
- Building community residential and housing options for persons with a major mental or substance use disorders.
- Provide options for funding a community's treatment capacity to address the needs of the most in need and vulnerable. Only with a sustained commitment will these issues that have placed Florida's behavioral health system in "crisis," ultimately be successfully resolved.

I.B. INTRODUCTION

During the 2015 regular session of the Florida Legislature, proposed legislation aimed at making substantive changes to Part I of Chapter 394, F.S., which addresses the Baker Act. Senate Bill 7070 would have combined certain features of Chapter 397, F.S., or the Marchman Act, into one comprehensive statute that combines voluntary and involuntary treatment for persons with mental illness and substance use disorders into one comprehensive law.

Although the bill did not become law, it created considerable legislative, executive agency, and public interest in the current state of mental health and substance abuse services. Public discussion specifically

addressed public access to acute care services and the belief that current statutes do not adequately address issues of access, availability, and the organization of these essential services.

II. BACKGROUND

II.A. BAKER ACT

In 1971, the Florida Legislature enacted the Florida Mental Health Act (Part I of Chapter 394, F.S.), a comprehensive revision of the state's century-old mental health commitment laws. The law, commonly referred to as the "Baker Act," was designed to significantly strengthen and protect the due process and civil rights of individuals in mental health facilities and ensure public safety.

In 1978, through proviso, the Legislature authorized the creation of Crisis Stabilization Units (CSUs) and short-term residential treatment facilities (SRTs) to provide a less costly, less intensive, and less restrictive alternative to inpatient hospitalization for examination/crisis stabilization and also for placement/long-term treatment. The most recent major revision to the Baker Act was in 2004 when the Legislature created Involuntary Outpatient Placement as an involuntary treatment option (effective January 1, 2005).

Crisis services are defined in s. 394.67(3), F.S., as emergency interventions that are designed to prevent further deterioration of the individual's mental health. They include short-term evaluation, stabilization, and brief intervention. Once stabilized, individuals are redirected to the most appropriate and least restrictive treatment settings consistent with their needs. Most publically funded crisis services are provided in CSUs, which are located in receiving facilities for individuals on voluntary and involuntary status.

Receiving and treatment facilities are defined by the Florida Mental Health Act (ss. 394.451-47891, F.S.) and are designated by the Department to receive and hold individuals on involuntary status under emergency conditions or for psychiatric evaluation. These facilities, referred to as Baker Act Receiving Facilities, provide brief, intensive crisis services to individuals who require emergency mental health stabilization. (Appendix 3).

Section 394.461, F.S., authorizes the Department to designate community facilities as a receiving facility. Any other facility within the state, including a private or federal facility, may be so designated by the Department, provided such designation is agreed to by the governing body or authority of the facility.

II.B. MARCHMAN ACT

In 1970, the Florida Legislature enacted Chapter 397, F.S., governing the Treatment and Rehabilitation of Drug Dependents. The following year, it enacted Chapter 396, F.S., titled the Myers Act as the state's "Comprehensive Alcoholism Prevention, Control, and Treatment Act," modeled after the federal Hughes Act.

Since individuals with substance abuse issues often don't contain their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction did not address the problems faced by Florida's citizens.

In 1993, Representative Steven Wise introduced legislation to merge Chapters 396 and 397, F.S., into a single law, Chapter 397, F.S., that clearly outlined legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination, and children's substance abuse services. The chapter was named the "Hal S. Marchman Alcohol and Other Drug Services Act of 1993," and is commonly referred to as the Marchman Act.

Addiction receiving facilities are defined in Chapter 397, F.S., and are designated by the Department as secure, acute care facilities that provide, at a minimum, detoxification and stabilization services and are operated 24 hours per day, 7 days per week to serve individuals found to be substance use impaired.

Unlike the Baker Act that requires facilities to accept persons brought by law enforcement officers, the Marchman Act requires facilities to refuse acceptance of persons if it would cause the facility to go over licensed census, to accept responsibility for a person beyond the safe management of the program, or if the person is unable to pay the cost of a private program. However, if the facility is a licensed hospital and the officer believes the person has an emergency medical condition as a result of the substance abuse issues, a hospital must accept the person under the federal EMTALA law and perform a medical screening and stabilization prior to releasing the person or transferring him or her to another appropriate facility. (Appendix 4).

When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

II.C. EMERGENCY EXAMINATION AND TREATMENT OF INCAPACITATED PERSONS ACT

Section 401.445, F.S., governs the emergency examination and treatment when an emergency medical condition is life-threatening and the individual is unable to provide informed consent to examination, transport, or treatment.

II.D. ACCESS TO EMERGENCY SERVICES AND CARE

Section 395.1041, F.S., establishes state requirements equivalent to the federal EMTALA/COBRA law, which prohibits the denial of emergency services and care by hospitals and physicians, and enforcing the ability of individuals to get all necessary and appropriate emergency care within the capability and capacity of each hospital. This statute also requires hospitals to adhere to rights and involuntary examination procedures provided by the Baker Act, regardless of whether the hospital is designated as a receiving or treatment facility. However, this is not a requirement for individuals being involuntarily assessed and stabilized under the Marchman Act.

III. PROCESS

In June 2015, the Department convened the Baker Act and Marchman Act Project Team (Project Team). This report builds upon the proposed changes to the court processes for the Baker Act and Marchman

Act considered by the Florida Supreme Court's Task Force on Substance Abuse and Mental Health Issues in the Courts. The Project Team was charged with developing recommendations and specifications to integrate access to the Baker Act and Marchman Act by defining a community system of behavioral health acute care services that:

1. Provides a single point of access to acute emergency care, intervention, and treatment services;
2. Ensures that individuals are determined to meet criteria for voluntary and involuntary examination and treatment for a mental illness or a substance use disorder have access to required services;
3. Ensures that each county or circuit has access to a designated receiving facility that, at a minimum, can screen, evaluate, and refer individuals to the appropriate level of care;
4. Ensures that individuals, their families, law enforcement agencies, judges and other court professionals, behavioral health professionals, and the public are aware of the locations of designated receiving facilities, access centers, or triage centers;
5. Determine the existing capacity for Addiction Receiving Facilities (ARFs), CSUs, and detoxification facilities;
6. Develops a standard or benchmark for determining the need for additional bed capacity over and above the capacity met through Medicaid, Medicare, and private insurance based on the number of beds per capita; and
7. Estimates the cost of the proposed recommendations based on several different models, or methods of calculation.

The composition of the Project Team included representatives of state agencies, community hospitals, non-profit substance abuse and mental health provider organizations, managing entities, professional trade and provider associations, court professionals and personnel, law enforcement, local government, Medicaid managed care organizations, consumers, and experienced practitioners and administrators from acute care service programs in the substance abuse and mental health system. Stakeholders from these diverse backgrounds participated in Project Team meetings that were conducted over the course of three months. This broad range of participation resulted in the recommendations that are presented in this report.

IV. RECOMMENDATIONS

Legislative Intent	
Relevant Statute(s)	ss. 394.453, 394.66, and 397.305, F.S.
Discussion	During the Project Team meetings, team members expressed concern for the need to revise current legislative intent in Chapters 394 and 397, F.S., to reflect the changes and advances in the behavioral health field, as well as clearly establish priorities, rights, and key policy statements. Most importantly, the current legislative intent language does not recognize substance use and mental disorders as diseases of the brain or as a medical sub-specialty.
Recommendations	Amend current legislative intent language in Chapters 394 and 397, F.S., to incorporate language that clearly and affirmatively establishes the Legislature's intent to:

	1. Shift to medical approach in the treatment of mental health and substance abuse recognizing that substance use and mental disorders are diseases of the brain, and are complex medical issues whose etiology and progression involve interactive biological, genetic, psychological, cultural, and social factors. 2. Recognize that Substance Use and Mental Disorders are sub-specialties within the medical specialty health care arena of Behavioral Health. Treatment saves lives, improves the health of the affected individuals and families, and reduces negative impacts to society. 3. State the importance of data collection and utilization to inform decisions regarding funding, client needs, access to services, and information regarding the behavioral health acute care system. 4. Establish and fund community-based alternatives that include prevention, intervention and outreach, as well as recovery-oriented services in the community to prevent the need for and use of higher levels of care. In addition, provide for the coordination of comprehensive care and recovery oriented services upon discharge from all levels of care. 5. Provide proper and appropriate funding of the community behavioral health system of care which will result in cost-savings and efficiencies across multiple systems, including criminal justice/law enforcement, healthcare, etc. 6. Define the specifications and minimum standards for access to care that will be available in or accessible by each community based on funding. 7. Authorize licensed and certified behavioral health practitioners to exercise the full authority of their respective Scopes of Practice in the performance of professional functions necessary to carry out the intent of this statute. 8. Provide the mechanism for communities in conjunction with the Department, local governments, law enforcement, courts, behavioral health managing entities, and consumers and families to define a local, accessible behavioral health system, including emergency, acute care and treatment array of services are: accessible, well defined, and readily understood in each community. 9. Ensure that local systems of behavioral health acute care services have standardized services and processes for accessing services. 10. Ensure that local systems of care are designed to maximize available local resources including health care services and managed care plans. 11. Expand the use of mobile crisis teams and other alternative intervention options in the community.

Single Point of Access	
Relevant Statute(s)	s. 394.461, F.S.
Discussion	The current Baker Act and Marchman Act differ in several key points related to receiving facilities, including who may provide assessments and evaluations, the time permitted to conduct an involuntary examination, authority to release individuals, and specific administrative functions such as notifications to other involved persons and data collection and reporting. Current statutes establish five routes to crisis services for individuals with mental or substance use disorders, four of them involuntary. The Baker Act and Marchman Act differ significantly in addressing involuntary assessment. This includes defining methods of initiation, criteria, time frames, and disposition alternatives. Revising the statutes to align the process, and standardize the forms for petitions and certificates, while retaining the ability to identify whether the primary basis is a mental or substance use disorder, would significantly reduce bureaucratic barriers to accessing crisis evaluations and still protect individual rights through due process in any involuntary proceedings.
Recommendations	The Department has provided a brief description of a central receiving facility, access center, and triage center as examples of single points of access for the purposes of this report. It is recommended that the Legislature authorize the Department to develop administrative rules to establish the specific standards, functions, and services for any facilities providing a single point of access. **Central Receiving Facility** The concept of a Central Receiving Facility (CRF) is an integrated mental health crisis stabilization unit and addictions receiving facility as currently described in s. 394.4612, F.S., and Rule 65E-12.110, F.A.C. The CRF can be a single point of entry with or without an Access Center or Triage Center into the mental health and substance abuse system for assessments, and appropriate placement of adults experiencing a mental health or substance abuse crisis. It is important to note that not all counties may have the financial resources or demand for acute care services to support a CRF as the single point of access. Counties need the flexibility and an availability of options to provide services. **Access Center** An Access Center (AC) may be available, at a minimum, 12 hours per day, seven days per week for individuals experiencing a low level substance abuse, mental health, or co-occurring crisis after receiving a standardized screening. This

	location can be a separate and freestanding facility. The primary purpose is to assist the public in accessing services. **Triage Center** A Triage Center (TC) is a community-based option that is an initial point of entry into the community mental health and substance abuse system. A TC should be integrated so that the facility and its staff have the ability, at a minimum, to assess, examine, and refer individuals to the appropriate level of care.

Transportation	
Relevant Statute(s)	ss. 394.462, 394.4685, 394.9082, 397.6772, 397.6793, 397.6795, F.S.
Discussion	Under the requirements of the Baker Act, regardless of how an examination is initiated, law enforcement must transport an individual to the nearest Baker Act receiving facility to be examined unless a Transportation Exception Plan has been approved by the Secretary of the Department. The designated law enforcement agency may decline to transport the individual to a receiving facility only if: 1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of individuals to receiving facilities pursuant to this section at the sole cost of the county; and 2. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the individual or others. However, when a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination under the Baker Act and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.[1]

[1] Section 394.462(1)(e), F.S.

	The current requirements for involuntary assessment and stabilization under the Marchman Act specify that law enforcement are only required to transport an individual in protective custody. For involuntary assessments and stabilization initiated by persons or means other than protective custody, the Marchman Act allows for, but does not require, the transportation of individuals and permits individuals other than law enforcement to provide the transportation. Specifically, for a court-ordered assessment and stabilization, the Court may order law enforcement to transport a person to nearest appropriate licensed service provider. Transportation for Emergency Admission may be provided by an applicant for a person's emergency admission, spouse or guardian, law enforcement officer, or health officer. Regardless of how the involuntary assessment and stabilization is initiated, the Marchman Act does not require an individual to be transported to the nearest receiving facility. Instead, depending on how the involuntary assessment and stabilization was initiated, an individual may be transported to a hospital, licensed detoxification facility, addiction receiving facility, jail, or a less intensive component of a licensed service provider for assessment only. Currently, the Baker Act and Marchman Act do not require any formal planning regarding the transportation of individuals who meet the criteria under these statutes. However, the Baker Act allows for the development of a Transportation Exception Plan, and also specifies that each law enforcement agency shall develop a memorandum of understanding with each receiving facility within the law enforcement agency's jurisdiction which reflects a single set of protocols for the safe and secure transportation of the individual and transfer of custody of the person.[2] These protocols must also address crisis intervention measures.
Recommendations	1. Establish requirements for the transportation of individuals for involuntary assessment/stabilization, and involuntary treatment, as well as, the transfer of individuals between facilities, under the Marchman Act that mirror and align with the corresponding requirements in the Baker Act.[3] 2. Require the Managing Entities, in consultation with the board of county commissioners and local law enforcement agencies, to develop a Transportation Plan for each county or circuit within the managing entity's assigned region that defines the specifications and

[2] Section 394.462(1)(k), F.S.

[3] Sections 394.462 and 394.4685, F.S.

	minimum standards for transportation and access to behavioral health acute care services that will be present or available in each community. 3. Each Transportation Plan must address, at a minimum, the following: a. Specify the models of Community Intervention options available and the roles, processes, and responsibilities of those programs in diverting individuals from acute care placements. b. Specify how local hospitals, designated receiving facilities, and acute care inpatient and detoxification providers will coordinate activities to screen, assess, examine, stabilize, and refer individuals presented on an involuntary basis under the Baker Act or Marchman Act. c. Specify the responsibility for, and the means by which, individuals in a behavioral health crisis will be transported to and between facilities for involuntary examinations and treatment, involuntary court proceedings and resulting commitments under the Baker Act and Marchman Act. d. The method of transferring individuals after law enforcement has relinquished physical custody of the individual at a designated receiving facility. The receiving facilities must provide or arrange for their transportation to another facility or appropriate placement. The managing entities must submit transportation plans to the Department for final review and approval. Plans must be submitted every three years and updated as needed.

Qualified Professionals	
Relevant Statute(s)	Part I of Chapter 394, Part V of Chapter 397, and s. 397.311, F.S.
Discussion	**Scope of Practice** There is significant variation in the authorized scope of practice for qualified professionals established in Chapters 394 and 397, F.S. This variation has created inconsistencies between the Baker Act and Marchman Act in how involuntary examinations (i.e. professional certificates) are initiated, and who has the authority to conduct assessments, examinations, and discharge of individuals. Furthermore, the limitations placed on certain qualified professionals under the Marchman Act to initiate professional certificates, and under the Baker Act, to assess, admit, and discharge individuals, restrict the privileges, or scope of practice that these professionals are statutorily granted under the purview of their license.

Qualified Professionals	
	Physician Shortage In February 2015, a study of physician supply and demand commissioned by the Teaching Hospital Council of Florida and the Safety Net Hospital Alliance of Florida found the physician shortage will grow to 7,000 physician specialists by 2025. This shortfall spans 19 specialties, with the largest areas of need in psychiatry, general surgery, rheumatology, and thoracic surgery.[4] The current supply of specialists in Florida is insufficient to provide a level of care consistent with the national average, after taking into consideration differences in the demographics and health risk factors between Florida and the nation. Of the specialties included in the projected shortage, psychiatry is expected to have the most severe physician specialty deficit with a 55 percent shortfall statewide by 2025.[5] **Access to Care** The disconnect between the authority to access, evaluate, and discharge individuals under the Baker Act and Marchman Act, along with the current and projected statewide shortage of psychiatrists will create significant barriers to accessing and initiating care.
Recommendations	1. Align statutory requirements in Chapters 394 and 397, F.S. so that the same qualified professionals authorized to initiate involuntary examinations under the Baker Act are also authorized to initiate involuntary assessments and stabilizations under the Marchman Act. 2. Authorize the following qualified professionals, as defined in their respective chapters, to initiate involuntary examination/assessment under the Marchman Act and Baker Act: a. Physician; b. Physician Assistant; c. Psychiatrist; d. Psychologist; e. Advanced Registered Nurse Practitioner;

[4] Study: Florida Facing Critical Shortage of Physician Specialists through 2025. PRNewswire. February 17, 2015. http://www.prnewswire.com/news-releases/study-florida-facing-critical-shortage-of-physician-specialists-through-2025-300037111.html site last accessed on October 14, 2015.

[5] *Florida Physician Workforce Analysis: Forecasting Supply and Demand.* IHS Global. Commissioned by the Teaching Hospital Council of Florida and the Safety Net Hospital Alliance of Florida. February 2015. http://mediad.publicbroadcasting.net/p/healthnewsfl/files/201502/SNHAF_Physicians_Workforce_Analysis_2015-v5.pdf site last accessed on October 14, 2015.

Qualified Professionals	
	f. Advanced Registered Nurse Practitioner having a specialty in psychiatry licensed under part I of chapter 464; g. Licensed Mental Health Counselor; h. Licensed Clinical Social Worker; and i. Licensed Marriage and Family Therapist 3. Provide an exception to limit the authority of Certified Addiction Professionals to initiate only involuntary assessment and stabilization under the Marchman Act. 4. All licensed health care professionals in Chapters 394 and 397, F.S., should have experience and be cross trained in both substance abuse and mental health.

Data	
Relevant Statute(s)	ss. 394.461, 394.463, 394.4655, 394.467, 394.9082, F.S.
Discussion	**Baker Act Data** The Baker Act (Part I of Chapter 394, F.S.), as well as Part IV of Chapter 394, F.S., contain several provisions requiring the submission, collection and reporting of Baker Act-related data for private and public receiving facilities to the Department and the Agency for Health Care Administration (AHCA). This has not only created confusion and increased the administrative burden on providers, but it has also resulted in inconsistent and siloed data due to incompatible and unintegrated data systems and processes. As a result, the meaningful use and analysis of this data is severely diminished. *(Please see the below table for a summary of data submission requirements).* Additionally, during the 2015 Regular Session, CS/HB 79 was passed and signed into law, amending Part IV of Chapter 394, F.S., directing the Department to develop, implement, and maintain a Crisis Stabilization Services Utilization Database (CSU Database) whereby behavioral health managing entities collect utilization data from psychiatric public receiving facilities.[6] Public receiving facilities within a managing entity's provider network are required to submit utilization data in real time, or at least daily, to the managing entity. This includes the number of indigent patients admitted and discharged, the current active

[6] These facilities operate under Department designation as crisis stabilization units where emergency mental health care is provided. General Revenue funding for community mental health services pays for space in receiving facilities to care for the indigent. Managing entities must comply with the bill's requirements for data collection by August 1, 2015

census of licensed beds, the number of beds purchased by the Department, and the number of unoccupied licensed beds regardless of payor source.

As a result, the establishment of data reporting requirements in both Part I and Part IV of Chapter 394, F.S., has unintentionally created conflicting statutory requirements for the submission of data to the Department.

Data Submitted to the Department
Facilities designated as public receiving or treatment facilities shall report to the Department on an annual basis the following data, *unless these data are currently being submitted to the Agency for Health Care Administration (AHCA)*: 1. Number of licensed beds. 2. Number of contract days. 3. Number of admissions by payor class and diagnoses. 4. Number of bed days by payor class. 5. Average length of stay by payor class. 6. Total revenues by payor class. "Payor class" means Medicare, Medicare HMO, Medicaid, Medicaid HMO, private-pay health insurance, private-pay health maintenance organization, private preferred provider organization, the Department of Children and Families, other government programs, self-pay patients, and charity care.[7]
A managing entity shall require a public receiving facility within its provider network to submit data, in real time or at least daily, to the managing entity for: 1. All admissions and discharges of clients receiving public receiving facility services who qualify as indigent, as defined in s. 394.4787; 2. Current active census of total licensed beds 3. Number of beds purchased by the Department 4. Number of clients qualifying as indigent occupying the Department-purchased beds 5. Total number of unoccupied licensed beds regardless of funding. The managing entities must report this data to the Department, using the CSU database, on a monthly and annual basis.[8]
The Office of Clerks of Court shall submit to the Department a copy of the following: 1. Petition for involuntary outpatient placement and individualize treatment

[7]Section 394.461(4), F.S.

[8] Section 394.9082(10), F.S.

	plan[9] 2. Continued involuntary outpatient placement certificate and treatment plan[10] 3. Petition for involuntary inpatient placement[11] **Data Submitted to the Agency for Health Care Administration** The Agency for Health Care Administration shall receive and maintain copies of the following: 1. Ex-parte orders for involuntary examination[12] 2. Mental Health Professional certificates for initiating involuntary examinations[13] 3. Law enforcement reports (involuntary examination)[14] 4. Involuntary outpatient placement orders[15] 5. Involuntary inpatient placement orders[16] *Note: The Baker Act Reporting Center at the Louis de la Parte Florida Mental Health Institute receives data on behalf of AHCA, which allows it to meet its statutorily required receipt and reporting of this information. Currently, Baker Act receiving facilities must mail the involuntary examination initiation forms and a coversheet with critical information about each examination initiated to the Baker Act Reporting Center. Staff at the Reporting Center must manually process and enter the data contained in the involuntary examination initiation forms.* **Marchman Act Data** Currently, there are no statutory requirements for the collection, submission, or reporting of Marchman Act-related to the Department. However, the Office of the State Courts Administrator publishes data on the number of Marchman Act and Baker Act petitions filed and disposed. The data are based on information received from the Clerks of Court and are extracted from a static database containing the official trial court statistics.[17]
Recommendations	1. Require the collection, submission, and reporting of the same data for the Marchman Act as currently required for the Baker Act by all designated receiving facilities, as well as any other licensed providers accepting

[9] Section 394.4655(3)(c), F.S.

[10] Section 394.4655(7)(a)(4), F.S.

[11] Section 394.467(3), F.S.

[12] Section 394.463(2)(e), F.S.

[13] Section 394.463 (2)(a)(3), F.S.

[14] Section 394.463 (2)(a)(2), F.S.

[15] Section 394.4655(6)(b)(2), F.S.

[16] Section 394.463(2)(e), F.S.

[17] http://trialstats.flcourts.org/TrialCourtStats.aspx Site last accessed on October 15, 2015.

	individuals under the Marchman Act (i.e. central receiving facilities, access centers, triage centers, CSUs, ARFs, and detoxification providers). 2. Require all Marchman Act data and all Baker Act data submitted by public and private receiving to Department and AHCA, to be submitted using the existing CSU Database established in s. 394.9082(10), F.S. The existing CSU database will need to be enhanced to allow for the collection, storage, submission, and analysis of Marchman Act data. The enhanced database should be renamed the Acute Care Database to accurately reflect the data being collected. 3. Revise requirements in s. 394.461(4), F.S., to remove exception for the submission of data to the Department if data is currently being submitted to AHCA. Instead, allow for the sharing of Baker Act data with AHCA. 4. Transfer statutory language and requirements pertaining to both the CSU database in s. 394.9082(10), F.S., and public receiving and treatment facilities data in s. 394.461(4)(a)-(b), F.S., to a new section in Part IV of Chapter 394, F.S. The new section in Part IV should blend the requirements in s. 394.9082(10), F.S., and s. 394.461(4)(a)-(b), F.S., and incorporate recommendations in this section for the reporting requirements for Marchman Act and Baker Act. 5. Require all Baker Act and Marchman Act Involuntary Petitions, Court Orders, Professional Certificates, Law Enforcement Reports, and treatment plans to be electronically submitted (or uploaded) using the Acute Care Database. Provide for the secure electronic transmission, and storage of all documents and data entered into the system consistent with 42 CFR Part II, HIPAA, and Chapters 394 and 397, F.S. AHCA would have access to all Baker Act-related data and documents, while the Department would have access to all Baker Act and Marchman Act-related data and documents.[18]

Additional Considerations	
Recommendations	1. In light of the recommendations in this report, the Department's methods of purchasing capacity for CSU, ARF, and residential detoxification beds warrants additional analysis of capacity versus utilization, and consideration of alternative methods of purchasing capacity for crisis services and payment methodologies. 2. The current Baker Act and Marchman Act differ substantially in who is authorized to initiate petitions for involuntary treatment, the criteria, placement options, the role of the state attorney and public defender, and time frames for orders. Alignment in the processes and

[18] The Department would not share Marchman Act-related data with the Agency for Health Care Administration due to the confidentiality requirements of 42 CFR Part II, HIPAA, and Chapter 397, F.S.

	documentation required by these statutes can reduce bureaucratic barriers to accessing court-ordered treatment, while retaining the important protections of due process. 3. Unlike the Baker Act, the Marchman Act does not include any provisions explicitly prohibiting the charging of fees for the filing of petitions for involuntary assessment and stabilization, or involuntary treatment. The charging of fees for the filing of a petition(s) creates a barrier to accessing services. 4. Standardize time frames so that hearings for involuntary treatment petitions must be held within five court working days of filing; orders for initial or continuing involuntary treatment are for 90-day increments, with an option for courts to order more frequent reviews. 5. Consider standardizing timeframes so that involuntary examination under the Baker Act and involuntary assessment and stabilization under the Marchman Act must be completed within 72 hours. However, a physician or physician's assistant or psychiatric nurse acting under the physician may authorize up to an additional 48 hours based on a determination of need without court involvement. If admitted involuntarily, total time combined may not exceed 72 hours unless there is further court involvement or the physician identifies a need for the additional 48 hours.

V. Appendices

Appendix 1. Baker Act and Marchman Act Project Team Participants

Appendix 2. Baker Act and Marchman Act Project Team Fiscal Subcommittee's Cost Methodologies and the Public Consulting Group (PCG) Crisis Stabilization Reimbursement Transition Plan

Appendix 3. CSU-SRT Statewide Map

Appendix 4. Addiction Receiving Facilities Statewide Map

Appendix 5. Public and Private Receiving Facilities

Appendix 6. Mobile Crisis Teams

Appendix 1

Participant	Affiliation
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Rich Rasmussen	Florida Hospital Association
Pamela Carter	Central Florida Behavioral Health Network
Sheriff Robert A. "Bob" Gualtieri	Pinellas County Sheriff's Office
Natalie Kelly	Florida Association of Managing Entities

Appendix 2

Baker Act and Marchman Act Project Team Fiscal Subcommittee's Cost Methodologies

In costing the Baker Act and Marchman Act three different methodologies were employed in an effort to triangulate results and to validate the projected cost to implement a "no wrong door" approach to mental health and substance abuse services statewide.

A variety of data sources were utilized in the development of the methodologies including the Department of Children and Families report on state funded CSU Beds, Detox beds, Addiction Receiving Facility (ARF) beds, hospital discharge data, and Managing Entity (ME) contractual information.

Assumptions:

The methodologies for cost of detox and ARF bed are based on reimbursement levels paid by the managing entities for the previous fiscal year. Cost methodology for the CSU beds is based on a study conducted by the Public Consulting Group (PCG) under contract with the Department of Children and Families based on a requirement included in the 2012 General Appropriations Act and issued on January 2013. These costs assume that beds are purchased on a bed availability model. If this is changed to a per diem reimbursement method, the costs would be higher.

There are no fixed capital outlay costs included.

The ratios are applied to the statewide population and the methodologies do not result in a projected cost by DCF Circuit, Medicaid region, or other geography.

Methodology 1: Beds Per Capita

Method 1: Beds per Capita Using DCF Funded Capacity					
	Total Beds Needed*	**DCF Funded Beds**	**Additional Beds Needed**	**CSU Unit Cost**	**Cost per Year for Additional Beds**
CSU Bed Need	1951	696	1255	$ 378.50**	$173,345,040
*DCF rule 65E-12.104(8), FAC, provides a guideline for planning CSU bed capacity of 10 beds per 100,000 people. Given the state population of 19,507,369, this generates a need of 1951 beds.					
**The $378.50 cost per bed was determined in the Public Consulting Group report commissioned by the Department of Children and Families titled: Department of Children and Families Crisis Stabilization Reimbursement Plan, 2013.					
	Total Beds Needed	**DCF Funded ARF and Detox Beds**	**Additional Beds Needed**	**Detox Unit Cost**	**Cost per Year for Additional Beds**
DCF Funded Detox Beds	975	377	598	$280.00	$61,153,256
The detox bed standard of 1 bed per 20,000 people is a proxy for discussion.					

				Grand Total Additional Cost	$234,498,295

This methodology calculates the number of beds that would be necessary statewide to meet the guideline of 10 beds per 100,000 population for CSU beds (per DCF Rule 65E-12.104(8) and the guideline of 5 beds per 100,000 population for Detox beds statewide (a proxy as no guideline exists in Rule at present). The cost is derived by projecting the cost per bed x the number of additional beds needed x 365 days (assuming that the beds are at capacity annually).

Detail:

DCF rule 65E-12.104(8) provides a guideline for Crisis Stabilization Unit (CSU) bed capacity of 10 beds per 100,000 population (or 1 bed per 10,000 people). According to the Bureau of Economic and Business Research the current population in Florida is 19,507,369. Applying the ratio of 1 bed: 10,000 population results in a total need of 1,951 CSU beds statewide.

Currently there are 696 DCF funded CSU beds (contracted CSU beds) statewide. Using a formula of (Total beds– Contracted beds= Additional bed need), 1,251 additional beds are needed statewide.

At a CSU Unit Cost of $378.50 per day (the bed cost reported in the Public Consulting Group (PCG) report of 2013) the cost per year for these additional beds is $173,345,040.

Research revealed that there is no standard in rule for Detox bed capacity. A standard of 1 bed per 20,000 population (5 beds per 100,000 population) was used in this Beds Per Capita methodology, and is a proxy for discussion. Applying the ratio of 1 bed: 20,000 population results in a total need of 975 Detox beds statewide. Currently there are 377 DCF funded Detox beds (DCF licensed and contracted Detox beds), resulting in a need of 598 additional Detox Beds.

The cost per day of Detox bed is $280.00 (the average current DCF reimbursement/contracted rate). The total cost per year for these additional beds is $61,153,256.

The grand total of the annual cost of the additional DCF funded CSU beds and DCF funded Detox beds needed statewide to meet the guidelines is $234,498,295.

Methodology 2: Central Receiving Facility Model

Method 2: Central Receiving Facility Model					
	Total Beds Needed	**AHCA Licensed CSU Beds and DCF Licensed**	**Additional Beds Needed**	**CSU Unit Cost**	**Cost per Year for Additional Beds**

		Detox Beds			
CSU/Detox Bed Need	3701	1541	2160	$ 378.50	$ 298,346,941
This system relies on flexible CSU, SRT, hospital, Detox, and Addictions Receiving Facility Beds. The combined total of all these beds equals 233, which based on a population of 1.2 million in Orange County results in a current capacity of 1.98 beds per 10,000 population.					
This system relies on funding from various sources: local, state, and private sources.					

The Orange County central receiving facility (CRF) has been operational for at least 10 years and is the result of an integrated model and funding system of service that brings together Law Enforcement, Mental Health and Substance Abuse providers, Justice and other stakeholders. The CRF is the single point of entry for mental health and substance abuse services in Orange County and provides services under both the Baker Act and Marchman Act.

Detail:

This model uses a variety of inpatient services including

Baker Act/Mental Health (193 beds):

87 Adult CSU beds, 20 Children CSU beds, 56 Hospital-contracted CSU beds, 30 Short Term Residential Treatment (SRT) beds; and Marchman Act/Substance Abuse (40 beds):

40 Detox beds

For a total of 233 beds. Note that 12 Addiction Receiving Facility beds are imbedded in the 87 Adult CSU beds and can be utilized based on demand.

According to the Bureau of Economic and Business Research the current population in Orange County is 1,227,995, resulting in a standard of 1.9 beds per 10,000 population. This is almost double the standard in the Bed Per Capita methodology. Applying this ratio to the statewide population (above) results in a need of 2,160 additional CSU and Detox beds statewide to bring the entire statewide system up to the central receiving facility model standard.

At a cost of $378.50 per day per bed, the annual additional cost is $298,346,941.

Methodology 3:

Method 3: 2014 Needs Assessment		
ME	**CSU Beds Unmet +**	**Detox Beds Unmet + Unfunded**

	Unfunded		
BBCBC	$2,427,836	$240,462	
BBHC	$7,803,999	$3,827,756	
CFBHN	$29,240,230	$5,209,649	
CFCHS	$25,264,316	$12,684,487	
LSF	$12,198,507	$2,028,571	
SEFBHN	$5,671,071	$2,577,580	
SFBHN	$21,629,091	$2,530,728	
Total	$104,235,052	$29,099,233	
		Grand Total	$133,334,285

Methodology 3 includes figures for unmet and unfunded need by managing entity according to self-reported data acquired by surveying Florida Council for Community Mental Health members in 2014. The survey included data regarding current utilization of services, wait list for services and current bed capacity and reimbursement rates compared to actual cost of providing the service.

The total additional annual funding necessary to meet the utilization need for CSU beds is $104,235,052 and $29,099,233 for Detox beds for a total of $133,334,285.

Actual Provider Cost:
This cost was generated on actual provider cost using figures developed by Public Consulting Group (PCG), an independent consultant contracted by the Department in 2013. According to PCG report entitled 'Department of Children and Families Crisis Stabilization Reimbursement Plan' the Average Cost per Bed Day is $378.50 for CSU beds.

In summary, costs for funding a "no wrong door" approach range from $133 - $298M, depending on which model is used. This represents total additional costs and should be funded between a partnership of state government, local governments, Medicaid and local communities.

State of Florida
Department of Children and Families
Crisis Stabilization Reimbursement Transition Plan

January 1, 2013

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1. INTRODUCTION

This *Crisis Stabilization Reimbursement Transition Plan* is presented by the Department of Children and Families to the Florida Legislature to fulfill the requirements of the legislative proviso found in Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346. This proviso mandates the Department to develop a plan to transition from capacity-based reimbursement to utilization-based ("per diem") reimbursement for mental health crisis stabilization services.

This section of the Transition Plan provides essential background information for understanding the proposed reimbursement model and its rationale, and the process that was used to develop it. Section 2 provides definitions of technical terms used throughout the document. Section 3 reports the results of a quantitative analysis of providers' costs of providing crisis stabilization services in Florida. Section 4 reports the results of a qualitative analysis of three of the state's local crisis stabilization systems of care. Section 5 describes the Department's proposed method of utilization-based reimbursement to meet the requirements of the legislative proviso. Section 6 describes the statutory and regulatory changes that would be required to implement the proposed method. Section 7 describes the steps the Department would need to take to implement the method. Section 8 discusses the potential impact of implementing the proposed reimbursement method.

Florida's Mental Health Crisis Services System

Florida's mental health crisis services system is governed by the Baker Act (Chapter 394, Part 1, Florida Statutes), which authorizes the Department to manage programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders through emergency rehabilitative services for persons requiring intensive short-term and continued treatment for recovery. The Baker Act provides for the involuntary examination of individuals who, due to mental illness, present a threat to themselves or others, or are unable to care for themselves on a basic level. The Baker Act also allows individuals who are competent to consent to be admitted for crisis services on a voluntary basis if they appear to have a mental illness and may benefit from treatment.

Requirements of the Legislative Proviso

In proviso of the 2012 General Appropriations Act, the Florida Legislature mandated that:

> "The department shall develop a plan to modify the method of expending funds for crisis stabilization services to establish per diem reimbursement for covered services provided to qualified patients. The department's recommended method shall be budget neutral and shall allow use of available funds to reimburse a variety of providers, including public

receiving facilities, community mental health programs, licensed acute care hospitals, or other approved facilities. The plan shall be submitted to the Legislature no later than January 1, 2013 and shall identify steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.)

Thus the essential requirements of the plan are that it:

a) Establish utilization-based ("per diem") reimbursement.
b) Maintain budget-neutrality.
c) Allow reimbursement of a variety of provider types to the extent possible.

The Department has decided to incorporate two additional major elements in the plan, which were not specifically mandated by the proviso:

d) Competitive procurement of Department-funded crisis stabilization services by managing entities (MEs).
e) Utilization management of Department-funded crisis stabilization services by MEs.

Crisis Stabilization Unit (CSU) Workgroup

The Crisis Stabilization Unit (CSU) Workgroup was convened by the Department and met monthly from May through November 2012 (except during July) to advise the Department on the development of this Transition Plan. Workgroup participants included executives of hospitals and CSU providers, representatives of the law enforcement community, and Department staff. The Workgroup was charged with advising on the following matters: the process and criteria to be used in the establishment of per diem reimbursement; criteria to be used in the competitive procurement process for crisis stabilization services; possible changes to the requirements for a facility to be designated as a Baker Act receiving facility; possible changes to the roles of public and private receiving facilities; and types of facilities that should be eligible to serve as receiving facilities.

Public Consulting Group (PCG)

Public Consulting Group (PCG) was contracted by the Department to facilitate the meetings of the CSU Workgroup and conduct related research. PCG conducted a quantitative analysis of utilization, funding and provider costs throughout the state's crisis stabilization system. PCG also evaluated the crisis stabilization service systems as they currently operate in three of the Department's regions, in order to provide background information for the development of this Transition Plan. PCG also collaborated with Department staff in the development of this Transition Plan document.

Managing Entities (MEs)

The Department is in the process of implementing managing entities (MEs) statewide. MEs are private, non-profit corporations contracted by the Department to take over many of the administrative responsibilities that had previously belonged to the regional or circuit offices of the Department. MEs are already operating in most of the state and are expected to cover the entire state by March 1, 2013. The central role of MEs is to subcontract with community mental health and substance abuse providers that are funded by the Department, including public receiving facilities. Thus, the reimbursement model described in Section 5 of this Transition Plan assigns MEs (rather than the Department) responsibility for competitively procuring public receiving facility contracts.

2. DEFINITIONS

This section defines key terms that are used throughout this Transition Plan.

1) **Baker Act:** Chapter 394, Part I, Florida Statutes; regulates mental health services; provides for the involuntary examination of individuals who, due to mental illness, present a threat to themselves or others, or are unable to care for themselves on a basic level; allows individuals who are competent to consent to be admitted for crisis services on a voluntary basis if they appear to have a mental illness and may benefit from treatment.

2) **Budget neutral:** Not requiring any legislative appropriations above the level appropriated for the most recent fiscal year.

3) **Capacity-based reimbursement (or funding):** A funding mechanism wherein the Department contracts with each public receiving facility for a certain number of beds to be available for Department clients, and provides the same amount of reimbursement to the facility each year regardless of the number of beds actually used by Department clients.

4) **Client:** Any individual receiving services in any substance abuse or mental health facility, program, or service, which facility, program, or service is operated, funded, or regulated by the department. (s. 394.67(2), F.S.)

5) **Crisis stabilization services:** Brief, intensive services provided twenty-four (24) hours per day, seven (7) days per week for individuals experiencing a mental health crisis. Crisis stabilization services include services associated with involuntary examination and voluntary admission under the Baker Act.

6) **Crisis stabilization unit (CSU):** A program that provides an alternative to inpatient hospitalization and that provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state. (s. 394.67(4), F.S.)

7) **Department client:** A client whose household income is below the Federal poverty guideline; who has no payor source available other than the Department; and who is receiving services from a Department-contracted provider. Department clients are eligible for Department-funded crisis stabilization services.

8) **Express and informed consent:** Consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to

enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. (s. 394.455(9), F.S.)

9) **Facility:** Any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness. (s. 394.455(10), F.S.)

10) **Incompetent to consent to treatment:** A person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment. (s. 394.455(15), F.S.)

11) **Involuntary examination:** A mental health examination conducted by a receiving facility under the authority of the Baker Act and without the express and informed consent of the individual examined, for the purpose of determining whether the individual meets criteria for involuntary placement. An involuntary examination may be initiated by a licensed health care professional, a law enforcement officer, or by the circuit court upon petition from any party. The criteria for involuntary examination are that the individual appears to have a mental illness, presents a danger to self or others because of the mental illness, and that no less restrictive alternative is available to relieve the danger. (s. 394.463, F.S.)

12) **Private facility:** Any hospital or facility operated by a for-profit or not-for-profit corporation or association that provides mental health services and is not a public facility. (s. 394.455(22), F.S.)

13) **Public facility:** Any facility that has contracted with the Department to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose in accordance with contracts negotiated by the Department's Regional Office or by a Managing Entity (ME). All CSUs are public receiving facilities; hospitals may be either public or private receiving facilities. (s. 394.455(25), F.S.)

14) **Receiving facility:** 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. (s. 394.455(26), F.S.)

15) **Transportation exception plan (TEP):** A plan authorized by the Department and by a Board of County Commissioners pursuant to s. 394.462(4), F.S., allowing individuals

within a specific county to be transported to a receiving facility other than the nearest one under specified circumstances to improve service coordination and better meet clinical needs.

16) **Universal service requirement:** The requirement under s. 394.462(1) (j), F.S. that receiving facilities accept all individuals brought by law enforcement for involuntary examination.

17) **Utilization rate:** A ratio calculated for each facility providing crisis stabilization services by dividing the number of bed days actually utilized by Department clients during a year by the number of bed days contracted for by the Department.

18) **Utilization-based funding:** A funding mechanism wherein the Department reimburses providers on a per diem basis for the number of bed days actually used by Department clients.

19) **Utilization target**: In the reimbursement method proposed by this Transition Plan, the minimum number of bed days used by Department clients during a fiscal year which a crisis stabilization services provider must provide in order to receive the full value of the provider's contract with its managing entity (ME).

20) **Voluntary admission:** The admission of an individual to a facility with the individual's express and informed consent.

3. PROVIDER COSTS IN FLORIDA'S CRISIS STABILIZATION SYSTEM

A key component of any analysis of reimbursement methodologies for a system of care is a review of existing provider data. In this section, we have documented the analysis of the current crisis stabilization system in Florida on the basis of the provider costs of providing crisis stabilization services to Department clients. The following subsection will provide an overview of the methodology used to capture crisis stabilization service provider costs, the data collection process, and the analysis of the provider data. Limitations of the data are also discussed. It should be emphasized that the analyses reported here concern the providers' costs of providing services, not the cost to the Department.

In conducting the analysis, the data was reviewed in multiple ways to provide various perspectives on the system. The data was initially reviewed on a statewide basis and broken out by total cost per bed day for adult and children's units combined and then the cost per bed day by adults and by children's units discretely. The second analysis was done in a similar fashion; however the data was broken out based on Department region. The third analysis compared the cost per bed day for a crisis stabilization unit (CSU) versus a hospital receiving facility.

Data Collection Methodology

Public Consulting Group (PCG) initially set out to conduct a quantitative analysis of the crisis stabilization system in Florida with a focus on Department-funded providers (public receiving facilities) with the results of the analysis to be used to inform future rate development exercises. At the August, 2012 CSU Workgroup meeting, PCG initiated the discussion about the future data collection efforts to be completed. During this discussion, PCG staff identified the data they would seek to collect from crisis stabilization providers. PCG noted that, because Medicare and Medicaid cost reports were not available for all providers, this data collection effort would likely require the development of a survey to be completed by all crisis stabilization service providers. CSU Workgroup participants proposed using the data provided by the public receiving facilities in the Department's Agency Capacity Reports rather than developing a new survey tool and asking providers to duplicate existing efforts. One limitation of this option is that, in general, only the crisis stabilization providers designated as public receiving facilities have completed the Agency Capacity Reports; as a result, the private receiving facilities would still have needed to be asked to complete a survey in order to capture a comprehensive data set.

Following the August CSU Workgroup meeting, Department staff, in consultation with PCG, began developing utilization-based reimbursement models to be presented during the September CSU Workgroup meeting. Through these discussions, it became apparent that rates would be set in negotiations with the Managing Entities; therefore, there was no need for this Transition Plan

to specify rates or rate formulas. The Department agreed that PCG should proceed with the quantitative analysis using the Agency Capacity Report data for the public receiving facilities. The remainder of this section describes the data collection efforts and the analysis of the data obtained.

Data Collection Process

Prior to collecting data, PCG conducted initial research to better understand Agency Capacity Reports, the data included in them, limitations of this data, and the role of these reports in contract negotiations between the Department and the public receiving facilities. As part of these efforts, PCG interviewed staff of two managing entities (MEs): South Florida Behavioral Health Network and Lutheran Services of Florida. Some of the key conclusions follow.

- ***Reimbursement rates are calculated based on 100% utilization rates.*** One of the main limitations of the Agency Capacity Report data is that it assumes a utilization rate of 100 percent. While this assumption was acceptable under the capacity-based model, it presents a challenge in using the data to determine an appropriate rate for utilization-based funding. One ME staff member suggested that the maximum days be calculated using 85% as an estimate for the utilization rate. This alone, however, would not address the issue of different utilization rates for adults and children. In reviewing the analysis in the following pages it should be noted that all rates are based on this same assumption of 100% utilization as this is the representation of the actual data reported by providers.

- ***The Role of Agency Capacity Reports in contract negotiations varies by ME and Department region.*** The use of Agency Capacity Report data in contract negotiations varies across the state. Agency Capacity Reports are often not used in determining the rate the crisis stabilization providers receive. It was noted by one of the managing entities interviewed that due to the statewide maximum rates that are set in rule for both adult and child crisis stabilization services, there is little room for the negotiation of rates. Therefore, the Agency Capacity Report data is only used to determine rates for providers who are found to have rates below the statewide maximum rates, in which case those providers would receive a rate based on the costs identified in their Agency Capacity Report. In the rare event that the DCF Regional Office or Managing Entity makes the determination to appeal for a higher rate for a provider, the Agency Capacity Report data may be used to support that request.

Following PCG's research on the Agency Capacity Report data, PCG contacted the Department's regional contract managers to begin data collection. PCG, with the help of DCF Central Office, also reached out to the Department's Regional Managers and to the managing entities to assist in the collection of the Agency Capacity Report data. One of the greatest

challenges of this phase of the engagement has been the identification of the appropriate staff to provide the Agency Capacity Report data, since the Department's regions are in various stages of implementing the managing entities.

Analysis of Agency Capacity Reports

The analysis of the Department-funded crisis stabilization system presented in the following sections is based on the data reported by the public receiving facilities on their Agency Capacity Reports. The data was received through the Department's regional offices; the managing entities; and in some cases directly from the providers themselves. PCG has accepted the data as reported without any substantial audit efforts. In the preparation of the analysis, PCG would like to note the following major limitations:

- ***Data has been received for 28 public receiving facilities.*** At the time of this analysis, PCG has only received data for 28 public receiving facilities out of a total of 64 possible providers. In some cases, the data has been combined for a provider with multiple locations as was the case for the four PEMHS locations. While considering the providers that submitted one report for multiple locations does help to reduce the number of facilities for whom no data was received, there are still a significant number of facilities not included in this analysis.

- ***Some providers did not differentiate between adult and children's services.*** Another limitation of the analysis is that some providers that were identified as having both adult and children's services only provided data in the aggregate for all crisis stabilization services. Where possible, PCG attempted to separate the bed capacity data between adult and children's categories with the reported expense separated proportionally between the two. As a result, the analysis of the cost per bed day for the adult versus children's services may not provide as clear a distinction as might be expected.

The Appendix lists those public receiving facilities that have submitted Agency Capacity Report data included in the analyses. PCG also received data from Sarasota Memorial Hospital (Bayside Center for Behavioral Health) and Central Florida Behavioral Hospital (Baycare Behavioral Health). However, as private receiving facilities, their data was excluded from the analysis.

PCG has conducted three separate analyses on the cost per bed day as reported on the Agency Capacity Report by the public receiving facilities. The first analysis looks at the statewide cost per bed day, while the second analysis looks at the cost per bed day on a regional basis. The third and final analysis compares the cost per day for crisis stabilization units (CSUs) versus hospital providers. In each of the three analyses, we have examined the data in the aggregate (including both adult and children's services); for adult services only; and for children's services only.

Statewide Analysis

In the statewide analysis, the Agency Capacity Report data for all providers has been combined to identify the statewide average cost per bed day. Again, this analysis looks at adult and children's data both separately and in combination. The following table summarizes the results.

	Statewide
Total Bed Days Available	314,432
Total Expense	$ 119,013,554
Average Cost per Bed Day	**$ 378.50**
Total Bed Days Available - Adult	272,136
Total Expense - Adult	$ 102,597,490
Average Cost per Bed Day - Adult	**$ 377.01**
Total Bed Days Available - Child	42,296
Total Expense - Child	$ 16,416,063
Average Cost per Bed Day - Child	**$ 388.12**

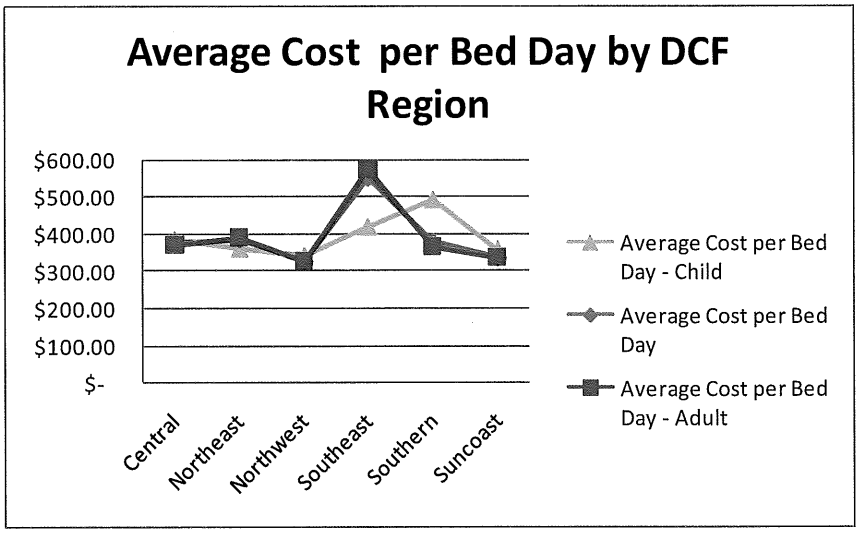
The analysis of the cost per bed day on the statewide basis illustrates two key points: first, the statewide average cost per bed day for crisis stabilization services ($378.50) is greater than the state's maximum rate of $291.24; second, the average cost per bed day for children's crisis stabilization services ($388.12) is higher than the cost per bed day for adult crisis stabilization services ($377.01).

Regional Analysis

The regional analysis, like the statewide analysis, includes the available bed days, the total expense and the cost per bed day. It should be noted that there are limitations to this analysis given the limited number of Agency Capacity Reports received. For example, Agency Capacity Report data was only received for three of the fifteen public receiving facilities in the Central region. Likewise, the data for the Southeast region includes only two of the eleven public receiving facilities.

	REGION					
	Central	Northeast	Northwest	Southeast	Southern	Suncoast
Total Bed Days Available	29,930	61,050	22,070	29,565	58,412	113,406
Total Expense	$ 11,210,965	$ 23,587,556	$ 7,263,521	$ 16,279,237	$ 22,229,902	$ 38,442,374
Average Cost per Bed Day	**$ 374.57**	**$ 386.37**	**$ 329.11**	**$ 550.63**	**$ 380.57**	**$ 338.98**
Total Bed Days Available - Adult	21,900	50,830	21,749	24,820	52,572	100,266
Total Expense - Adult	$ 8,112,871	$ 19,902,856	$ 7,153,600	$ 14,281,777	$ 19,354,605	$ 33,791,782
Average Cost per Bed Day - Adult	**$ 370.45**	**$ 391.56**	**$ 328.92**	**$ 575.41**	**$ 368.15**	**$ 337.02**
Total Bed Days Available - Child	8,030	10,220	321	4,745	5,840	13,140
Total Expense - Child	$ 3,098,094	$ 3,684,700	$ 109,921	$ 1,997,460	$ 2,875,296	$ 4,650,592
Average Cost per Bed Day - Child	**$ 385.81**	**$ 360.54**	**$ 342.43**	**$ 420.96**	**$ 492.35**	**$ 353.93**

The cost per bed day is quite variable across the different regions in the state. Further, given that a large number of beds included in the analysis were adult beds, the average cost per bed day for adults closely mirrors that of the aggregate average cost per bed day. The following chart depicts the variability in cost per bed day across the five regions of the state for which Agency Capacity Report data was received.



Crisis Stabilization Unit (CSU) vs. Hospital Analysis

The final component of the analysis was to look at the cost per bed day for the CSU providers against the cost per bed day for the hospital providers. Like the previous two analyses, this analysis compares the cost per bed day in the aggregate and then the cost per bed day for adults and children separately. One limitation of this analysis is that, of the thirteen public receiving facilities that are hospitals, only five submitted Agency Capacity Report data to be included in the analysis. A second limitation is that, of the five hospitals for which data was included in the

analysis, only one reported costs associated with children's beds. The following table presents the results of this analysis based on the data received from those five hospitals.

	CSU	Hospital
Total Bed Days Available	267,618	46,815
Total Expense	$ 94,351,606	$ 24,661,948
Average Cost per Bed Day	**$ 352.56**	**$ 526.80**
Total Bed Days Available - Adult	230,067	42,070
Total Expense - Adult	$ 79,933,003	$ 22,664,488
Average Cost per Bed Day - Adult	**$ 347.43**	**$ 538.73**
Total Bed Days Available - Child	37,551	4,745
Total Expense - Child	$ 14,418,603	$ 1,997,460
Average Cost per Bed Day - Child	**$ 383.97**	**$ 420.96**

The costs per bed day for crisis stabilization services in the hospital setting were significantly higher than the costs per bed day for crisis stabilization services in the stand-alone CSUs. This is consistent with the general understanding that CSUs provide a less costly alternative to hospitalization. While the table above shows that the average cost per bed day for adults is greater than that for children's, this may not be an accurate representation as the children's data includes only one hospital.

Conclusions

As the preceding analyses illustrate, the cost per day for crisis stabilization services in Florida are on average over $375 per day. While there are some providers whose cost per day is less than this figure, the preceding analyses clearly show that the existing maximum (model) rate of $291.24 per day, as defined in Florida Statute, does not cover the costs incurred by crisis stabilization providers in serving DCF clients. Given the language in the legislative proviso and the requirement to remain budget neutral within a utilization-based reimbursement approach it is safe to assume that providers will continue to realize reimbursement at rates below their costs in providing these services.

4. EVALUATION OF CRISIS STABILIZATION SYSTEMS OF CARE

To inform the development of the proposed reimbursement model, Public Consulting Group (PCG) conducted a qualitative evaluation of three of the state's existing local mental health crisis systems of care: Broward County, Circuit One, and Orange County. The findings of this evaluation are reported in this section.

The Broward County System of Care

Broward County, which includes Ft. Lauderdale, has three public receiving facilities, as well as five hospitals serving as private receiving facilities. The county uses a central receiving facility model that allows the burden of Department clients to be shared equitably, primarily across the three public receiving facilities and, when necessary, across the five private receiving facilities. Since a payment model that would be based on a central receiving facility structure is proposed in Section 5 of this plan, PCG interviewed staff from the Department's Southeast Regional Office familiar with Broward's system of care.

In the mid-1990s, the Department decided that Broward County had an excess of crisis stabilization beds; the Department reorganized the system with input from stakeholders, downsizing from 90 beds to 60 beds. All of the receiving facilities had been clustered in part of the county; new facilities were contracted in different areas of the county.

Currently, there are three CSUs in Broward County: one in the central area, one in the eastern area, and one in the southwestern area. Individuals are transported to the nearest receiving facility, whether public or private, and are transferred, if necessary, after being evaluated at that facility. Only one CSU admits children; all three admit adults.

By opening three sites, Broward increased the number of funded beds; yet there are still circumstances in which there is a significant amount of overflow. When overflow occurs and there are no publicly-funded beds available, there is a rotation between the private facilities that accept individuals for whom they know they will not be reimbursed for providing services. Private hospitals have been accepting individuals in this situation for the past few years. One of the Broward CSUs is located in a private hospital that has a larger capacity than can be funded; however, the hospital will provide additional beds without reimbursement when needed.

The three public facilities take turns acting as a central receiving facility by managing the system for transporting indigent patients to private facilities in overflow situations. Each month, a different public facility maintains the log that records which private facility is up on the rotation to accept an indigent patient. The individual is then sent to whichever facility is next on the

rotation, as long as they have an available bed, which is typically easy to determine as the availability of beds at each facility is recorded daily.

Law enforcement is not responsible for transporting individuals after they have been brought to a facility and evaluated; the facility is responsible for transporting them to another facility, if necessary.

Workgroup participants expressed concerns about the conflict of interest that could arise from a central receiving facility providing clinical services and determining transfer destinations. In Broward this problem is mitigated by the three public receiving facilities rotating the responsibility for determining transfer destination.

The Department regional staff interviewed noted that the system of care depends on positive relationships among the Department's Regional Office, the public facilities, and the private facilities, and on the commitment of the administration at the private facilities. Whenever there is a change in administration at the private facilities, there is cause for concern that the relationship may change.

The central receiving facility model used in Broward County has worked well in that community, and seems to function best in more densely populated areas. There are other aspects of Broward that make it unique: the county and other local stakeholders provide funding at a higher level than in most areas of the state; and outpatient services have been reduced in order to shift funding to crisis stabilization services. Thus, replicating the central receiving facility model that is used in Broward may not be feasible in other regions in the state due to the different levels of funding, community support, and population density.

Regional office staff also encouraged the workgroup to ensure that the Baker Act Task Force is maintained through the current changes to the CSU structure; they emphasized the importance of this group, consisting of essential stakeholders that have been meeting regularly since 1975, and its contributions to the success of the central receiving facility.

The Circuit One System of Care

The Department's Circuit One, identical in boundaries to the First Judicial Circuit, is located in the western portion of the Florida Panhandle and is comprised of four counties: Escambia, Okaloosa, Santa Rosa, and Walton. Circuit One is part of the Department's Northwest Region. The Circuit One system of care already functions under what may be called a "quasi-utilization-based" model. Thus it serves as an informative model for the transition to utilization-based funding. PCG interviewed staff of Lakeview Center, the managing entity responsible for Circuit One, about their system of care and the benefits and challenges associated with it.

Circuit One's quasi-utilization-based model was the result of a change in the payment methodology implemented by the ME a few years ago. The Northwest Region's public receiving facilities operate with a capitated model, but they also are required to show that their funding is reflective of the number of beds used. The facility maintains a data warehouse where information concerning utilization is collected from monthly reports; funding is based on this utilization data. The two CSUs in Circuit One, Lakeview Center and Bridgeway Center, submit annual utilization reports to the data warehouse and are subject to an annual contract negotiation to set target rates.

Currently, when a Department client is brought to a CSU that is at capacity, the client is transferred to another facility that has available beds. If there are no Department-funded beds left in any of the public facilities in Circuit One, clients are transported to a local hospital private receiving facility.

PCG asked ME staff about the advisability of implementing a tiered rate structure, wherein facilities would receive a higher rate for the first one to three days and a lower rate thereafter. Theoretically, such a rate structure could yield shorter stays by incentivizing more efficient treatment and discharge planning. The ME does not use tiered rates; staff explained this would not be necessary as there is no incentive to hold individuals overlong as it is: it would damage relations with law enforcement and other community stakeholders since there would be a lack of bed availability.

The Department's proposed reimbursement model (described in Section 5 of this Transition Plan) includes competitive procurement of public receiving facilities by MEs. Lakeview Center staff expressed some concerns about the introduction of competitive procurement for crisis stabilization services. CSUs are presently the lowest cost provider of these services (as discussed in Section 3); and Lakeview Center uses the maximum ("model") rate for it subcontracted providers. Lakeview Center staff report that if they had to use competitive procurement to award their contracts, the rates would likely increase. Providers would then increase their rates, which could detriment the whole system.

Lakeview Center's use of a quasi-utilization-based model in Circuit One has not resulted in any change of funding levels. There has been an increase in administrative workload as providers must now demonstrate they are providing a certain number of bed days of services in order to receive their contracted funding. However, facilities have had no difficulty meeting their utilization target. Nevertheless, utilization-based funding as it exists in the Northwest Region may not work for smaller CSUs elsewhere in the state that cannot rely on having their beds filled consistently.

The Orange County System of Care

In Orange County, which includes Orlando, a central receiving facility, the Central Receiving Center (CRC), has served individuals in need of substance abuse services as well as those in need of Baker Act crisis stabilization services since 2002. Law enforcement transports individuals to the CRC where, after an initial assessment, the individual is either released or transported to the most appropriate facility based on clinical needs, payor source, and bed availability.

Public and private receiving facilities (including CSUs and hospitals) work in cooperation with the CRC and accept transfers from it. Department clients are assigned to facilities on a rotating basis to ensure fair and efficient sharing of the burden of care. Members of the CRC staff manage the rotation list, which does not pose a conflict of interest as the CRC does not house any crisis stabilization beds. For the first few years of operation, in order to ensure fairness, an administrative service organization (ASO) was hired to manage the assignment of clients to facilities. Eventually, the facilities took over this task themselves, with responsibility for managing the process rotating among the facilities each month. Orange County has a Transportation Exception Plan (TEP), as authorized under s. 394.462(4), F.S., allowing law enforcement to bypass the nearest receiving facility and transport all individuals in crisis directly to the CRC.

Prior to the adoption of the central receiving facility model, Baker Act transportation had become a significant burden on law enforcement; officers were spending hours at a time in hospital emergency departments, monitoring individuals who were awaiting examination. Now, officers need only spend a few minutes at the CRC to drop off an individual for examination. As a result, the central receiving facility model has strong support from local law enforcement agencies.

Orange County's system of care has proven to work well and is arguably replicable in some other areas of the state. The facility has served to decrease the incarceration rate of individuals with mental illnesses and substance abuse issues in the region, by giving this population access to rapid assessments and appropriate referrals.

5. PROPOSED METHOD OF UTILIZATION-BASED REIMBURSEMENT

The legislative proviso mandating this plan states, in its entirety, that:

> "The department shall develop a plan to modify the method of expending funds for crisis stabilization services to establish per diem reimbursement for covered services provided to qualified patients. The department's recommended method shall be budget neutral and shall allow use of available funds to reimburse a variety of providers, including public receiving facilities, community mental health programs, licensed acute care hospitals, or other approved facilities. The plan shall be submitted to the Legislature no later than January 1, 2013 and shall identify steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.)

This section describes the proposed reimbursement model. The Basic Model would apply statewide while the Access Centers Option could be implemented in particular geographic areas at the discretion of the MEs. With or without the Access Centers Option, the Basic Model:

- Meets the requirements of the legislative proviso to implement utilization-based funding while remaining budget neutral.
- Introduces competitive procurement and utilization management.
- Maintains the universal service requirement.

The Basic Model

The features of the Basic Model would apply statewide. The managing entities (MEs) would be largely responsible for the implementation and operation of the approach. The ME would divide their geographic area into procurement areas and competitively procure one or more public receiving facilities for each procurement area. The procurement areas would be based on community need, location of existing facilities, and utilization history. Maps delineating procurement areas would be subject to final approval by the Department. Bids would be accepted from any crisis stabilization unit (CSU) or hospital licensed to provide psychiatric care, located within the procurement area, and able to demonstrate the ability to meet the Baker Act requirements for designation as a receiving facility. Analysis by Department staff and Public Consulting Group has determined that no other types of facilities would have the capability to provide Baker Act services; comments from the CSU Workgroup confirm this. Bidders would be eligible regardless of for-profit or non-profit status, and could include new entrants to the Baker

Act market. Integrated crisis stabilization unit/addictions receiving facilities (CSU-ARFs), which focus on co-occurring substance abuse and mental health disorders, would be eligible to bid.

MEs would establish criteria for competitive procurement, including quality of care indicators, costs, and strength of community partnerships. The MEs would have the option of formally eliciting public input on these procurement criteria, including feedback from key stakeholders such as local providers, law enforcement agencies, county and municipal governments, and consumer and family advocacy organizations. At the managing entity's discretion, this process could include public meetings. The contracts resulting from the procurement process would be awarded for a four year term, the same as the term of the Department's contracts with the MEs. As at present, facilities that were not awarded contracts, or did not bid for them, could still be designated by the Department as private receiving facilities.

The reimbursement for crisis stabilization services would be on a utilization (per diem) basis with the MEs negotiating rates with each public receiving facility in the procurement process. In order to maintain budget neutrality, the MEs would also negotiate monthly reimbursement caps with these providers, taking into consideration providers' costs and the number of licensed beds. Monies paid to providers by MEs could not exceed the monthly cap, which would be set to ensure the ME does not exceed its total budget for crisis stabilization services. The MEs would be required to report to the Department in a monthly or quarterly reconciliation process to ensure all Department funding is being expended in an appropriate manner. Public receiving facilities would continue to be required to accept individuals for examination, regardless of ability to pay, even after reaching their monthly reimbursement cap. The same requirement would apply to private receiving facilities.

Finally, the MEs would negotiate monthly utilization targets, in terms of the number of bed days utilized by Department clients. In setting utilization targets, MEs would have the option of using data reflecting utilization history for the region, circuit, county, or procurement area, as long as this was done consistently across the ME's subcontracted providers. MEs could use the Department's available historical utilization data, or data the MEs themselves have collected, or may collect in the future.

Reimbursement rates, reimbursement caps, and utilization targets would be set in such a way that a provider would earn the full value of the reimbursement cap as long as their utilization did not fall significantly (2 - 10%) below the historical norm for adult services. Children's services would have a larger cushion (15%). This would help providers adapt to the new system by giving them a cushion so that they would not lose revenue if there is a small decline in utilization. However, if utilization fell further, the provider would see a decline in revenue.

The following steps summarize the process for determining the utilization targets and reimbursement caps for adult units:

1. Negotiate a reimbursement cap dollar amount based on the number of licensed beds, available budget, and market conditions;
2. Select a utilization target for adult services that is between 90% and 98% of the number of bed–days expected to be utilized, based on historical data (85% for children's services);
3. Divide the reimbursement cap by the target number of bed days to calculate the bed-day rate; and
4. Reallocate reimbursement caps among providers annually, based on utilization patterns.

For adult units, providers may earn less than the value of their reimbursement cap, because actual utilization may fall below the utilization target. However, setting the target slightly below 100% would help providers adapt to the new system by giving them a cushion so that they would not lose revenue if there is a small decline in utilization. For children's units, rates and utilization targets would be set in a similar manner, except that the utilization target would be set at 85% of the historical norm, allowing children's crisis stabilization services providers to have a relatively stable revenue stream even though utilization may be highly variable. This would allow the MEs to accommodate the relatively low utilization levels for children's units that arise from the small number of beds in children's units and the high variability of utilization. This flexibility is necessary to ensure that children's beds are available when they are needed, even if they are at times unused.

In addition to the crisis stabilization services, MEs would have flexibility to include contract provisions for reimbursement for alternative services that reduce the need for crisis stabilization, including mobile crisis services and drop-in centers. The reimbursement for these services would, however, count toward the reimbursement cap for that provider. MEs would also have the option of building into subcontracts incentives for providers to divert individuals into less costly and less restrictive alternative crisis services, when appropriate.

Finally, under the Basic Model, MEs would provide utilization management for contracted providers. The utilization management function would include:

- Automatic preauthorization by the ME for reimbursement of three bed days for individuals admitted for involuntary examination, based on the facility's determination that the individual does not meet criteria for release in the "initial mandatory involuntary examination" required by Rule 65E-5.2801(1);

- Automatic preauthorization by the ME for additional days for individuals awaiting hearing for involuntary placement after the filing of the petition by the facility;
- Automatic preauthorization for individuals on a waiting list for admission to a state mental health treatment facility; and
- Concurrent review by the ME for reimbursement of voluntary admissions.

The Access Centers Option

The Access Centers Option uses competitive procurement to select the central receiving facility (access center), which would itself be a contracted receiving facility, as well as other contracted receiving facilities. As in the Basic Model, MEs would negotiate rates, reimbursement caps, and utilization targets with individual providers. Facilities not awarded contracts could still be designated as private receiving facilities. All public receiving facilities would be obligated by contract to accept transfers of individuals, as assigned by the access center, within the capability and licensed capacity of the destination facility.

The features of the Access Centers Option would be added on to the Basic Model in certain counties, or portions of counties, at the discretion of MEs. The Access Centers Option leverages the concept of central receiving facilities, which already exist and work well in some areas of the state.

The main features and functions of the access center under this option are listed below.

- The access center would receive and examine all individuals transported by law enforcement. The access center would complete the "initial mandatory involuntary examination" required by Rule 65E-5.2801(1), unless immediate transfer was needed for medical reasons. This would allow access centers to release individuals (when clinically appropriate) without transferring them to another facility. The initial exam includes the following elements:
    - A review of the individual's documented recent behavior that led to the exam being initiated;
    - A brief psychiatric history;
    - A face-to-face examination by a physician or clinical psychologist;

  - The ME could require by contract that the initial exam be done by a psychiatrist; and
  - The ME could require by contract that the initial exam be completed within a certain time frame, such 6 hours, in order to improve the efficiency of the system of care.

- The access center would provide brief crisis intervention and refer to outpatient services to avoid admissions when clinically appropriate.
- The access center would receive a standard rate negotiated with the ME for each individual examined.
- The access center would determine whether the individual met criteria for involuntary examination and release the individual promptly if the criteria were not met.
- The access center would transfer clients to another receiving facility if criteria were met, or if extended observation were necessary.
- The access center would approve reimbursement of bed days as in the Basic Model, except that no bed days would be needed if the individual were released directly from the access center.
- The access center would provide overflow capacity when all other local receiving facilities (public and private) were at licensed capacity.

The Access Center Option, like the Basic Model, would incorporate utilization management. Under this option, the ME would assign one of its own staff members to each access center to function as a utilization management specialist ensuring that clinical functions would be separated from utilization management functions. The ME utilization management specialist would determine transfer destination systematically, based on the clinical needs of the individual, payor source available, and bed availability. Basic protocols for determining transfer destination would be included in Transportation Exception Plans (TEPs), making them subject to public comment and approval by the Department. More detailed criteria for transfers – especially medical criteria - would be subject to ME discretion, but codified in written procedures.

6. REQUIRED STATUTORY AND REGULATORY REVISIONS

The Department, in consultation with Public Consulting Group (PCG), conducted an analysis to identify any changes to statute or rule that would be required in order to implement the reimbursement model proposed in Section 5 of this report. The only needed change identified is an amendment to Rule 65E-14.021 (Unit Cost Method of Payment), Florida Administrative Code, to eliminate the maximum ("model") rate ($291.24) for crisis stabilization services. This would give managing entities the flexibility they need to negotiate rates with each subcontracted public receiving facility based on market conditions and available budget. Under the proposed model, there would be no maximum, minimum, or "model" rate.

7. STEPS FOR IMPLEMENTATION OF THE PROPOSED REIMBURSEMENT METHOD

The legislative proviso mandating this Transition Plan required that the Plan identify "steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.) This section describes those steps.

Steps for Implementation

1) *The Department will complete the statewide implementation of managing entities (MEs).*

   This Department initiative has been in progress for several years and is expected to be completed by March 1, 2013. Since MEs play a central role in the proposed reimbursement method, it will not be possible to fully implement the method until the MEs are fully operational.

2) *The Department will amend Rule 65E-14.021 (Unit Cost Method of Payment), Florida Administrative Code, to eliminate the maximum "model" rate for crisis stabilization services.*

   The Department is presently reviewing Rule Chapter 65E-14, F.A.C., which governs reimbursement of Department-funded substance abuse and mental health services. The Department anticipates proposing extensive amendments to this rule chapter, including amendments to accommodate the expanding role of MEs. Elimination of the maximum "model" rate for crisis stabilization services will be included among the proposed amendments. The target date for adoption of these amendments is July 1, 2013.

3) *The Department will negotiate amendments to its contracts with MEs to require that the MEs implement the proposed reimbursement method, including competitive procurement of public receiving facilities.*

   Existing contracts between the Department and the MEs require MEs to competitively procure subcontracted services to the extent possible; however, these existing contracts provide minimal guidance on the procurement process. Contract amendments will provide more detailed guidance regarding public receiving facilities. The timeline for these contract amendments to take effect depends upon the stage of implementation of the ME. However, if the Department implements the proposed reimbursement method, these contract amendments are expected to take effect for all MEs by January 1, 2014.

4) *The MEs will competitively procure public receiving facility contracts and implement the proposed reimbursement method.*

   The timeline for implementation of the new reimbursement model depends on the implementation of the MEs and the effective dates of contract amendments with MEs. However, if the Department implements the proposed reimbursement method, it is expected to be in full effect statewide by July 1, 2014.

5) *The Department will review and approve competitive procurement criteria and procurement area maps proposed by MEs, and require revisions as needed.*

6) *The Department will provide ongoing technical assistance to the MEs and their subcontracted providers to implement the new reimbursement method.*

8. POTENTIAL IMPACT OF THE PROPOSED REIMBURSEMENT METHOD

The Department, in consultation with Public Consulting Group and the CSU Workgroup, has sought to develop the proposed reimbursement method to meet the requirements of the legislative proviso (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346) in a manner that is consistent with the Department's mission and beneficial to the Department's clients. However, some Workgroup participants representing providers of crisis stabilization services have expressed concerns about potential adverse impacts of the proposed reimbursement method. This section describes the potential benefits and potential adverse impacts of the proposed reimbursement method, and highlights provisions intended to mitigate the workgroup's concerns. This section also discusses other issues raised by the workgroup related to the Baker Act system of care.

Potential Benefits of the Proposed Reimbursement Model

The proposed reimbursement method will make the Baker Act system of care more flexible and responsive by requiring that reimbursement caps be reallocated annually on the basis of changes in utilization. This will mean that resources will be reallocated regularly from low utilization providers to high utilization providers. Under the current system, such reallocation occurs only sporadically. Moreover, the utilization management features of the proposed reimbursement method have the potential to increase efficiency in the system of care, reducing unnecessary admissions and reducing lengths of stay, especially for individuals with complex discharge planning requirements. This could reduce costs substantially.

The proposed reimbursement model may also make it possible to serve more clients within existing resources by increasing utilization rates. Historically, the statewide utilization rate for Department-funded beds is 90.2% for adults and 38.2% for children. If these utilization rates were to rise to 95% for adults and 85% for children (based on the utilization targets in the proposed reimbursement model), with statewide Department-funded bed capacity remaining the same, the number of bed days utilized by Department clients would increase by 9,500 for adults and 13,470 for children. Based on historical average lengths of stay, this would translate into services provided for an additional 1,803 adults and 4,388 children per year.[1] Recent history suggests a significant increase in crisis stabilization services may be needed in the coming years.

[1] Staff analysis based on *Bed Use in Public Receiving Facilities and Treatment Facilities Fiscal Year 2009-2010.* http://www.dcf.state.fl.us/programs/samh/publications/csu0910.pdf

The total number of Baker Act involuntary examinations grew steadily from 122,000 in 2007 to 143,000 in 2010, an increase of 17% in just three years.[2]

However, it is important to note that actual utilization levels are subject to the influence of many factors, and cannot be predicted with any confidence. Utilization of crisis stabilization services may not need to increase to the extent noted above; in particular such a large increase in utilization is not likely for children's beds. To the extent these additional services are not needed, cost savings could result or resources could be diverted to other areas. Managing entities will have the option of diverting resources to less costly, less restrictive, alternative crisis services that could reduce the need for involuntary examinations, such as mobile crisis services and drop-in centers.

Potential Adverse Impacts of Proposed Reimbursement Model

The major advantage of the existing, capacity-based reimbursement method is that it ensures the stability of the system of care; concerns expressed by the CSU Workgroup have centered on the possible loss of this stability. The lack of competitive procurement for crisis stabilization services has meant a relatively stable pool of public receiving facilities. Most providers have been operating in the crisis stabilization market for many years. There are only occasionally new entrants to - or exits from - the market. This stable tenure has allowed providers to develop strong relationships with key community stakeholders: law enforcement agencies, county governments, non-receiving facility hospitals, and the Department. Turnover of public receiving facility administrators is relatively low, making it easier to maintain these relationships. These relationships are critical to the functioning of the Baker Act system.

Some workgroup participants have expressed concerns that competitive procurement could push longstanding providers - particularly CSUs - out of the market, disrupting local systems of care that the Department has built over many years. The proposed reimbursement model tries to address this concern by allowing managing entities (MEs) to include strength of community partnerships as a possible criterion for competitive procurement, and by giving MEs the option of incorporating formal public input into the development of procurement criteria and procurement area maps. Moreover, the Department must give final approval of these criteria and maps.

Workgroup participants have also emphasized that capacity-based funding has provided a reliable revenue stream for public receiving facilities, enabling them to remain in the market

[2] *Annual Report of Baker Act Data: Summary of 2010 Data.*
http://bakeract.fmhi.usf.edu/document/BA_Annual_Report_2010.pdf

though the maximum bed-day rate for crisis stabilization services ($291.64) has not increased for many years. As shown by the analysis reported in Section 3 of this Plan, the Department's bed-day rates are considerably lower than providers' actual costs of providing services. This is only possible because services for Department clients are effectively subsidized by other payor sources (such as Medicaid) which pay higher rates. Department funding has been a critical component of the crisis services funding system, despite the Department's low rates, simply because Department funding is stable from month to month, and usually from year to year. Some Workgroup participants have expressed concerns that the transition to utilization-based funding will force some CSU providers out of the market by depriving them of a stable revenue stream. The proposed reimbursement model attempts to address this issue by requiring MEs to set utilization targets for adult units 2-10% below historical utilization norms. This allows a cushion so that providers will not lose revenue if they experience a modest decline in utilization rates.

The concern about losing a reliable revenue stream is especially relevant to children's CSUs, which have smaller numbers of beds than adult CSUs (often only 2-4 beds) and, therefore, are more affected by fluctuations in utilization. Children's CSU have historically had low utilization rates; and the Department has generally accepted these low utilization rates to ensure that beds are available for children when they are needed. The proposed reimbursement model attempts to address this issue by requiring MEs to set utilization targets for children's units 15% below historical utilization norms.

Staffing Requirements for Crisis Stabilization Units (CSUs)

Staffing requirements for CSUs are governed by Rule 65E-12.105 (Minimum Staffing Standards), F.A.C. A certain number of registered nurses (one or two) and mental health treatment staff (one to three) are required to be available on-site at a CSU. The number depends on the number of licensed beds and the time of day.

Some Workgroup participants representing CSU providers suggested that Rule 65E-12.105 should be amended so that the number of staff required is proportional to the number of individuals actually receiving services at the time, rather than proportional to the number of licensed beds. Such a change may allow providers to use resources more efficiently without compromising clinical care standards. The Department intends to study this issue.

Transportation Exception Plans (TEPs)

Normally, an individual transported by law enforcement for involuntary examination under the Baker Act must be transported to the nearest receiving facility. Transportation Exception Plans (TEPs), authorized by s. 394.462(4), F.S., allow individuals within a specific county to be transported to a receiving facility other than the nearest under specified circumstances, in order to improve service coordination and better meet clinical needs. TEPs must be approved by the Department and by the Board of County Commissioners. TEPs currently exist in twelve of Florida's 67 counties. In some counties, such as Broward (as discussed in Section 4 of this

Transition Plan), a TEP is the foundation of a central receiving facility system of care model. In other counties, a TEP targets specific populations, such as minors or elderly people, allowing them to bypass the nearest receiving facility and be transported directly to the facility that can serve them best.

Some Workgroup participants suggested that many counties not currently served by a TEP would benefit from one. As the experiences of Broward and Orange Counties (described in Section 4) have shown, a TEP can greatly increase the efficiency of resource utilization within a system of care. The proposed reimbursement model includes an Access Centers Option which incorporates a central receiving facility; this would require a TEP to implement. Even counties where the ME chooses not to implement the Access Centers Option may benefit from a TEP. The Department intends to instruct its Regional Offices and MEs to study the issue of implementing TEPs where appropriate.

Funding Levels for Crisis Stabilization Services

There was a strong consensus among CSU Workgroup participants that current funding levels for mental health services in Florida are insufficient to meet the needs of individuals in need of these services. Most receiving facilities for adults operate at near 100% utilization. Legislative appropriations for mental health services, including crisis stabilization services, have not increased in many years; nor has the maximum ("model") rate ($291.64) for crisis stabilization services. As discussed in Section 3, providers' actual costs per bed day ($378.50) are much higher than the model rate. Crisis stabilization services for Department clients are effectively subsidized by other payor sources, especially Medicaid. This situation may not be sustainable as provider costs increase due to inflation and other factors impacting the cost of health care services. Moreover, insufficient funding for non-crisis services contributes to the need for crisis services. Individuals are less likely to experience mental health crises when they have access to outpatient mental health services and community supports such as supportive housing and drop-in centers. Therefore, CSU Workgroup participants urged that increased funding for mental health services, including crisis stabilization services, be considered.

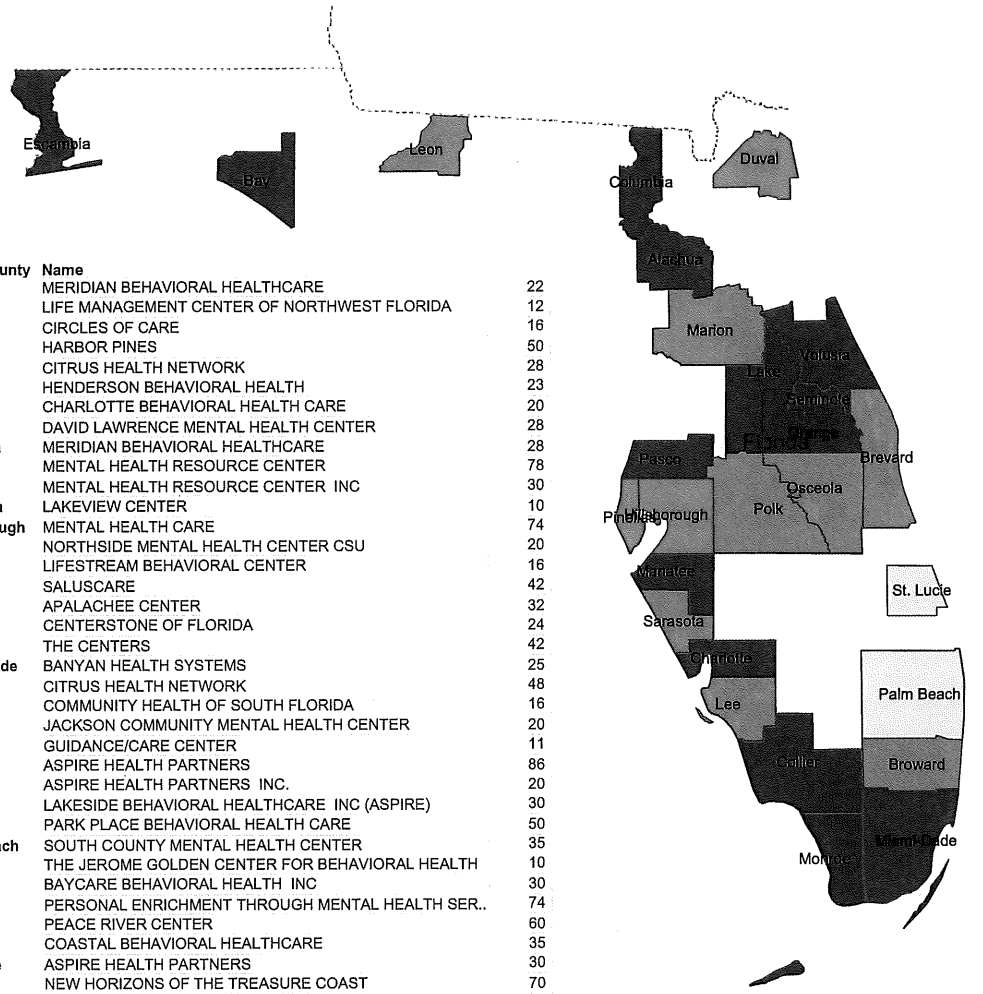
APPENDIX:
RECEIVING FACILITIES REPORTING DATA FOR PROVIDER COST ANALYSES

Apalachee Center, Inc.
Bridgeway Center
Centers, The
Charlotte Behavioral Health Care, Inc.
Citrus Health
Coastal Behavioral Health Care
Community Health of South Florida, Inc.
David Lawrence Center
Depoo Hospital
Flagler Hospital
Fort Lauderdale Hospital
Guidance Care Center, Inc.
Henderson Behavioral Health
Jackson Memorial Hospital
Jackson North Community Mental Health Center
Lakeview Center
Lee Mental Health Center, Inc.
Life Management Center of Northwest Florida
Lifestream Behavioral Center
Manatee Glens Corporation
Mental Health Care, Inc.
Mental Health Resource Center / Mental Health Center of Jacksonville
Meridian Behavioral Health Care
Miami Behavioral Health Center
New Horizons Community Mental Health Center
Northeast Florida State Hospital, Bldg. 57
Northside Mental Health Center, Inc.
Peace River Center for Personal Development
Personal Enrichment through Mental Health Services, Inc
SMA Behavioral Health Services

PUBLIC CONSULTING
GROUP

Appendix 3

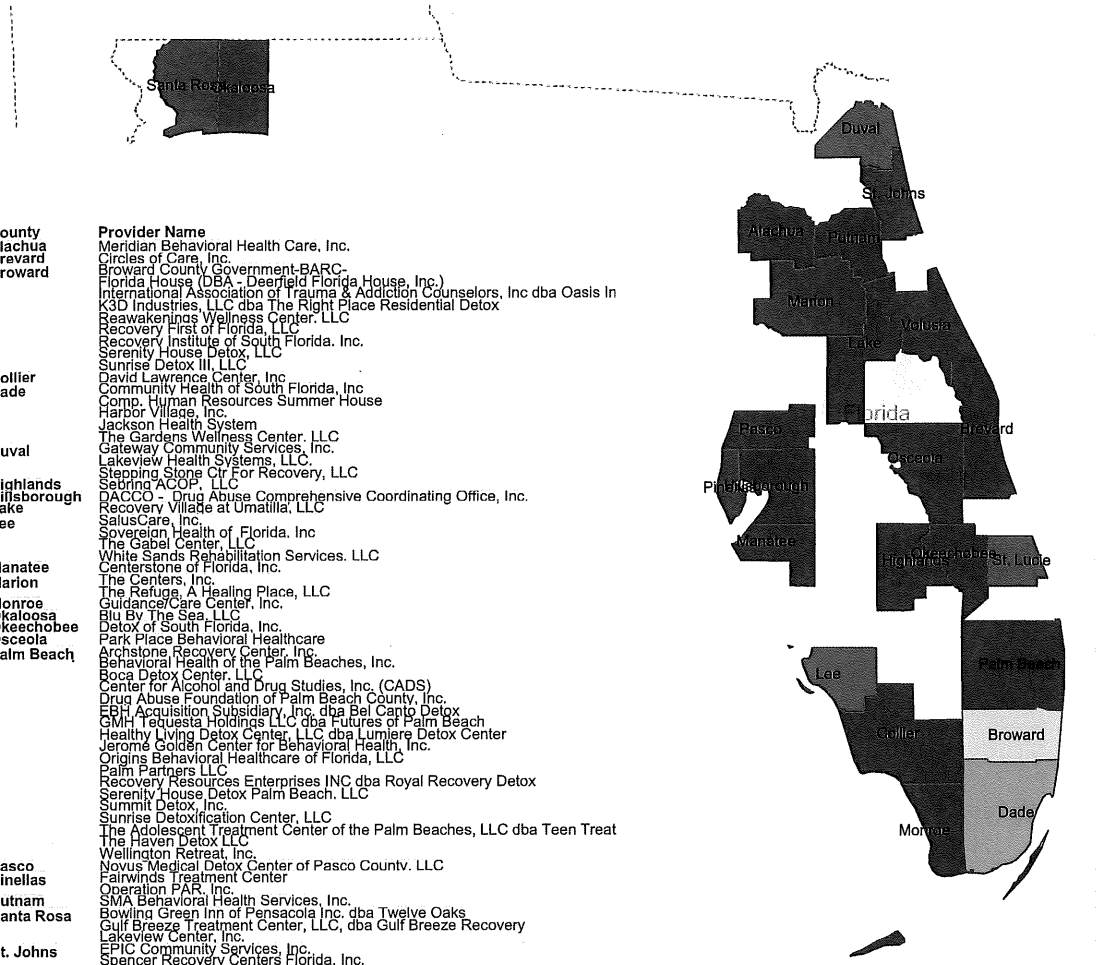
CSUs and SRTs



Street County	Name	
Alachua	MERIDIAN BEHAVIORAL HEALTHCARE	22
Bay	LIFE MANAGEMENT CENTER OF NORTHWEST FLORIDA	12
Brevard	CIRCLES OF CARE	16
	HARBOR PINES	50
Broward	CITRUS HEALTH NETWORK	28
	HENDERSON BEHAVIORAL HEALTH	23
Charlotte	CHARLOTTE BEHAVIORAL HEALTH CARE	20
Collier	DAVID LAWRENCE MENTAL HEALTH CENTER	28
Columbia	MERIDIAN BEHAVIORAL HEALTHCARE	28
Duval	MENTAL HEALTH RESOURCE CENTER	78
	MENTAL HEALTH RESOURCE CENTER INC	30
Escambia	LAKEVIEW CENTER	10
Hillsborough	MENTAL HEALTH CARE	74
	NORTHSIDE MENTAL HEALTH CENTER CSU	20
Lake	LIFESTREAM BEHAVIORAL CENTER	16
Lee	SALUSCARE	42
Leon	APALACHEE CENTER	32
Manatee	CENTERSTONE OF FLORIDA	24
Marion	THE CENTERS	42
Miami-Dade	BANYAN HEALTH SYSTEMS	25
	CITRUS HEALTH NETWORK	48
	COMMUNITY HEALTH OF SOUTH FLORIDA	16
	JACKSON COMMUNITY MENTAL HEALTH CENTER	20
Monroe	GUIDANCE/CARE CENTER	11
Orange	ASPIRE HEALTH PARTNERS	86
	ASPIRE HEALTH PARTNERS INC.	20
	LAKESIDE BEHAVIORAL HEALTHCARE INC (ASPIRE)	30
Osceola	PARK PLACE BEHAVIORAL HEALTH CARE	50
Palm Beach	SOUTH COUNTY MENTAL HEALTH CENTER	35
	THE JEROME GOLDEN CENTER FOR BEHAVIORAL HEALTH	10
Pasco	BAYCARE BEHAVIORAL HEALTH INC	30
Pinellas	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SER..	74
Polk	PEACE RIVER CENTER	60
Sarasota	COASTAL BEHAVIORAL HEALTHCARE	35
Seminole	ASPIRE HEALTH PARTNERS	30
St. Lucie	NEW HORIZONS OF THE TREASURE COAST	70
Volusia	SMA BEHAVIORAL HEALTH SERVICES	30

Appendix 4

Addiction Receiving Facilities



County	Provider Name
Alachua	Meridian Behavioral Health Care, Inc.
Brevard	Circles of Care, Inc.
Broward	Broward County Government-BARC-
	Florida House (DBA - Deerfield Florida House, Inc.)
	International Association of Trauma & Addiction Counselors, Inc dba Oasis In
	K3D Industries, LLC dba The Right Place Residential Detox
	Reawakenings Wellness Center, LLC
	Recovery First of Florida, LLC
	Recovery Institute of South Florida, Inc.
	Serenity House Detox, LLC
	Sunrise Detox III, LLC
Collier	David Lawrence Center, Inc
Dade	Community Health of South Florida, Inc
	Comp. Human Resources Summer House
	Harbor Village, Inc.
	Jackson Health System
	The Gardens Wellness Center, LLC
Duval	Gateway Community Services, Inc.
	Lakeview Health Systems, LLC.
	Stepping Stone Ctr For Recovery, LLC
Highlands	Sebring ACOP, LLC
Hillsborough	DACCO - Drug Abuse Comprehensive Coordinating Office, Inc.
Lake	Recovery Village at Umatilla, LLC
Lee	SalusCare, Inc.
	Sovereign Health of Florida, Inc
	The Gabel Center, LLC
	White Sands Rehabilitation Services, LLC
Manatee	Centerstone of Florida, Inc.
Marion	The Centers, Inc.
	The Refuge, A Healing Place, LLC
Monroe	GuidanceCare Center, Inc.
Okaloosa	Blu By The Sea, LLC
Okeechobee	Detox of South Florida, Inc.
Osceola	Park Place Behavioral Healthcare
Palm Beach	Archstone Recovery Center, Inc.
	Behavioral Health of the Palm Beaches, Inc.
	Boca Detox Center, LLC
	Center for Alcohol and Drug Studies, Inc. (CADS)
	Drug Abuse Foundation of Palm Beach County, Inc.
	EBH Acquisition Subsidiary, Inc. dba Bel Canto Detox
	GMH Tequesta Holdings LLC dba Futures of Palm Beach
	Healthy Living Detox Center, LLC dba Lumiere Detox Center
	Jerome Golden Center for Behavioral Health, Inc.
	Origins Behavioral Healthcare of Florida, LLC
	Palm Partners LLC
	Recovery Resources Enterprises INC dba Royal Recovery Detox
	Serenity House Detox Palm Beach, LLC
	Summit Detox, Inc.
	Sunrise Detoxification Center, LLC
	The Adolescent Treatment Center of the Palm Beaches, LLC dba Teen Treat
	The Haven Detox LLC
	Wellington Retreat, Inc.
Pasco	Novus Medical Detox Center of Pasco County, LLC
Pinellas	Fairwinds Treatment Center
	Operation PAR, Inc.
Putnam	SMA Behavioral Health Services, Inc.
Santa Rosa	Bowling Green Inn of Pensacola Inc. dba Twelve Oaks
	Gulf Breeze Treatment Center, LLC, dba Gulf Breeze Recovery
	Lakeview Center, Inc.
St. Johns	EPIC Community Services, Inc.
	Spencer Recovery Centers Florida, Inc.
St. Lucie	Florida Center For Recovery, Inc.
	New Horizons of the Treasure Coast, Inc.
	Starting Point Detox, LLC dba Unity Detox Center
	Unity Recovery Center, Inc.
Volusia	SMA Behavioral Health Services, Inc.

Appendix 5

Facility Type	Name	Street County	License Status	Total Licensed Beds	Adult	Child	Adult & Child
Crisis Stabilization Unit	APALACHEE CENTER	Leon	LICENSED	28	24	4	28
Crisis Stabilization Unit (ARF)	ASPIRE HEALTH PARTNERS	Orange	LICENSED	30	30		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS	Seminole	LICENSED	30	30		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS	Orange	LICENSED	27	27		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS INC.	Orange	LICENSED	20		20	
Crisis Stabilization Unit	BANYAN HEALTH SYSTEMS	Miami-Dade	LICENSED	25	25		
Crisis Stabilization Unit (ARF)	BAYCARE BEHAVIORAL HEALTH INC	Pasco	LICENSED	30	30		
Crisis Stabilization Unit	CENTERSTONE OF FLORIDA	Manatee	LICENSED	24			24
Crisis Stabilization Unit	CHARLOTTE BEHAVIORAL HEALTH CARE	Charlotte	LICENSED	20			20
Crisis Stabilization Unit	CIRCLES OF CARE	Brevard	LICENSED	16		16	
Crisis Stabilization Unit (JARF)	CITRUS HEALTH NETWORK	Miami-Dade	LICENSED	24		24	
Crisis Stabilization Unit	CITRUS HEALTH NETWORK	Miami-Dade	LICENSED	24	24		
Crisis Stabilization Unit	COASTAL BEHAVIORAL HEALTHCARE	Sarasota	LICENSED	20	20		
Crisis Stabilization Unit	COASTAL BEHAVIORAL HEALTHCARE	Sarasota	LICENSED	15	15		
Crisis Stabilization Unit	COMMUNITY HEALTH OF SOUTH FLORIDA	Miami-Dade	LICENSED	16	16		
Crisis Stabilization Unit	DAVID LAWRENCE MENTAL HEALTH CENTER	Collier	LICENSED	28			28
Crisis Stabilization Unit	GUIDANCE/CARE CENTER	Monroe	LICENSED	11	11		
Crisis Stabilization Unit	HARBOR PINES	Brevard	LICENSED	50	50		
Crisis Stabilization Unit	HENDERSON BEHAVIORAL HEALTH	Broward	LICENSED	23	23		
Crisis Stabilization Unit	JACKSON COMMUNITY MENTAL HEALTH CENTER	Miami-Dade	LICENSED	20	20		
Crisis Stabilization Unit	LAKESIDE BEHAVIORAL HEALTHCARE INC (ASPIRE)	Orange	LICENSED	30	30		
Crisis Stabilization Unit	LAKEVIEW CENTER	Escambia	LICENSED	10	10		
Crisis Stabilization Unit	LIFE MANAGEMENT CENTER OF NORTHWEST FLORIDA	Bay	LICENSED	12			12
Crisis Stabilization Unit	LIFESTREAM BEHAVIORAL CENTER	Lake	LICENSED	16			16
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	14		14	
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	30	30		
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	30	30		
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	24	24	0	24
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	24			24
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	30			30
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER INC	Duval	LICENSED	30	30		
Crisis Stabilization Unit	MERIDIAN BEHAVIORAL HEALTHCARE	Alachua	LICENSED	22			22
Crisis Stabilization Unit	MERIDIAN BEHAVIORAL HEALTHCARE	Columbia	LICENSED	28			28
Crisis Stabilization Unit	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	30	30		
Crisis Stabilization Unit (ARF)	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	20		20	
Crisis Stabilization Unit	NORTHSIDE MENTAL HEALTH CENTER CSU	Hillsborough	LICENSED	20	20		
Crisis Stabilization Unit	PARK PLACE BEHAVIORAL HEALTH CARE	Osceola	LICENSED	30	30		
Crisis Stabilization Unit	PARK PLACE BEHAVIORAL HEALTH CARE	Osceola	LICENSED	20		20	
Crisis Stabilization Unit	PEACE RIVER CENTER	Polk	LICENSED	30			30
Crisis Stabilization Unit (ARF)	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	15		15	
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	15	15		
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	30	30		
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	14	14		
Crisis Stabilization Unit	SALUSCARE	Lee	LICENSED	30	30		
Crisis Stabilization Unit (ARF)	SALUSCARE	Lee	LICENSED	12		12	
Crisis Stabilization Unit	SMA BEHAVIORAL HEALTH SERVICES	Volusia	LICENSED	30	30		
Crisis Stabilization Unit	SOUTH COUNTY MENTAL HEALTH CENTER	Palm Beach	LICENSED	20	20		
Crisis Stabilization Unit	SOUTH COUNTY MENTAL HEALTH CENTER	Palm Beach	LICENSED	15	15		
Crisis Stabilization Unit	THE CENTERS	Marion	LICENSED	30	30		
Crisis Stabilization Unit	THE CENTERS	Marion	LICENSED	12		12	
Crisis Stabilization Unit	THE JEROME GOLDEN CENTER FOR BEHAVIORAL HEALTH	Palm Beach	LICENSED	10			10
SRT	APALACHEE CENTER	Leon	LICENSED	4	4		
SRT	ASPIRE HEALTH PARTNERS	Orange	LICENSED	29	29		
SRT	CITRUS HEALTH NETWORK	Broward	LICENSED	28	28		
SRT	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	20	20		
SRT	PEACE RIVER CENTER	Polk	LICENSED	30	30		

Appendix 6

Mobile Crisis Teams Statewide

Northwest Region

- Youth Mobile Crisis Team- Duval- Child Guidance Center 904-448-4700 x308

Northeast Region

- None

SunCoast Region

- Mental Health Center – 819-239-8064 – Hillsborough County
- Peace River Center – 269-519-0575 – Polk County
- Manatee Glens – 941-782-4299 – Manatee County

Southeast Region

- New Horizons: Catchment area is the Treasure Coast & Okeechobee (St. Lucie, Martin, Indian River, & Okeechobee). Not West Palm Beach. Andrea Gates- 772-672-8476. Also, the direct number for our Mobile Crisis Response Team is 772-672-8470.
- South County Mental Health Center: Karyn Green (561) 637-1001 - Palm Beach Area (Adults and Children)
- The Jerome Golden Center : Donna Harris (561) 383-5841 - West Palm Beach Area (Children and Adults)
- Henderson Youth Emergency Services (YES): Ben Galloso (954) 713-5100 Ext 2402 - Broward County Area- (Children)
- Henderson Mobile Crisis Response Team: Elizabeth Rosonow (954)463-0911 - Broward County Area (Adults).

Southern Region

- Banyan Mobile Crisis Team, (305)774-3616 &(305)774-3617, serving Miami-Dade County

Central Region

- Mobile Crisis Team for Circuit 18 (Brevard)only 321-632-2737

2021 AGENCY LEGISLATIVE BILL ANALYSIS
Department of Children and Families

BILL INFORMATION	
BILL NUMBER:	SB 828
BILL TITLE:	**Mental Health and Substance Abuse**
BILL SPONSOR:	Senator Book
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1) Children, Families, and Elder Affairs
2) Judiciary
3) Appropriations
4)
5)

CURRENT COMMITTEE
Children, Families, and Elder Affairs

SIMILAR BILLS	
BILL NUMBER:	HB 405
SPONSOR:	Representative Maney

PREVIOUS LEGISLATION	
BILL NUMBER:	SB 870
SPONSOR:	Senator Book
YEAR:	2020
LAST ACTION:	SB 870 Died in Judiciary, companion bill(s) passed, see CS/SB 7012 (Ch.2020-39)

IDENTICAL BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

Is this bill part of an agency package?
No.

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	2/1/2021 For further information, please contact John Paul Fiore at (850) 488-9410.
LEAD AGENCY ANALYST:	Heather Allman, DCF, SAMH
ADDITIONAL ANALYST(S):	Devon Tran, DCF, SAMH Elaine Fygetakis, DCF, SMHTF
LEGAL ANALYST:	Ivory Avant, DCF, OGC
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POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 828 will create significant changes to the processes for mental health and substance abuse examinations and treatment in Florida. The bill makes the following substantive changes:

- Defines the terms “neglect or refuse to care for himself or herself” and “real and present threat of substantial harm”.
- Mandates that facilities inform persons with a serious mental illness and a serious substance use disorder be informed of “the essential elements of recovery” and assisted to access a post-discharge continuum of care regimen.
- Adds specific requirements for verifying the assent of a minor’s voluntariness for admission to a facility.
- If the minor’s assent to voluntary admission is not verified in the specified manner, requires the facility administrator of a receiving facility to refer the case involving a minor’s admission to the clerk of the court for the appointment of a public defender within 24 hours.
- Allows individuals to be admitted as a civil patient in a state treatment facility without a transfer evaluation.
- Restricts courts from ordering an individual with a developmental disability as defined in s. 393.063, F.S who lacks a co-occurring mental illness to a state mental health treatment facility for involuntary inpatient placement; requiring that such individuals must be referred to the Agency for Persons with Disabilities (APD) or the Department of Elder Affairs (DOEA) for further evaluation and the provision of appropriate services.
- Repeals several sections of Part V of the Marchman Act, relating to involuntary assessment and stabilization, and adds language to sections of involuntary treatment to place processes in the repealed sections.
- Allows the court to order six months of involuntary outpatient treatment if the individual meets the criteria for involuntary placement.
- Changes the term “involuntary treatment” to “involuntary services.”

The bill has an effective date of July 1, 2021.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

The Department of Children and Families’ (Department) Office of Substance Abuse and Mental Health (SAMH) is recognized as the single state authority for substance abuse and mental health services. SAMH is statutorily responsible for the planning and administration of all publicly funded substance abuse and mental health services, and for licensing substance abuse providers.

Part I of Chapter 394, F.S., otherwise referred to as The Baker Act, defines and establishes procedures for involuntary examination and treatment of individuals with mental illness who are believed to be a danger to themselves or others. Prior to a voluntary admission to a designated receiving facility for evaluation and crisis stabilization, s. 394.4625(1)(a), F.S., requires a minor to undergo a hearing to verify the voluntariness of the consent. A hearing is not required for persons 18 years of age or older making application by express and informed consent for admission. The "hearing" referred to in this section for minors has been determined to be judicial, rather than administrative.

Chapter 397, F.S., the Hal S. Marchman Alcohol and Other Drug Services Act, provides the legislative authority to support a system of care that includes prevention, intervention, clinical treatment, and recovery support services for substance use. Parts I and V of the Marchman Act define and establish procedures for involuntary substance abuse admissions. The Marchman Act encourages individuals to seek services on a voluntary basis and to be actively involved in planning their own services with the assistance of qualified professionals. However, services often come as a result of outside intervention on behalf of the individual in need. An individual must meet specific criteria in order to be considered eligible for substance abuse services on an involuntary basis. The Marchman Act establishes three non-court and two court-involved admission procedures under which substance abuse assessment, stabilization, and services can be obtained on an involuntary basis.

2. EFFECT OF THE BILL:

Section 1
This section amends s. 394.455, F.S., relating to the definition section of the Baker Act. This section adds a new definition for "neglect or refuse to care for himself or herself" to mean that a person is unable to satisfy basic needs that may result in death or serious harm, or the person is substantially unable to make an informed treatment choice and needs care or treatment to prevent deterioration. This section adds a definition for a "real and present threat of substantial harm" to include evidence that an untreated person will lack, refuse, or not receive services for health or safety, or will suffer severe harm leading to an inability to function cognitively or in their community generally.

The definition of "real and present threat of substantial harm" includes the phrase "lack, refuse, or not receive services which are actually available in the community". Refusal of treatment may not constitute a threat of harm to oneself or others. For example, an individual who declines therapy for depression may never suffer from harm, or intend to harm themselves or anyone else. In addition, these criteria do not include active threats or attempts to harm oneself or others. Those actual verbalized threats or actions are not included in this definition.

The new definitions provide additional clarification regarding the meaning of these terms to better enable petitioners to understand when the criteria are met or not. The Department will need to revise associated forms through rulemaking and provide training to law enforcement, practitioners, and public stakeholders.

Section 2
This section of the bill amends s. 394.459, F.S., relating to the rights of patients. It adds a subsection mandating that facilities inform persons with a serious mental illness of "the essential elements of recovery" and support access to a post-discharge continuum of care regimen. These individuals with serious mental illness may be provided "the essential elements of recovery". The Department may adopt rules specifying the services that may be provided to individuals with serious mental illness.

The phrase "essential elements of recovery" is not defined.

Section 3
This section of the bill amends s. 394.4598, F.S., relating to guardian advocates, removing the reference to s. 394.4655, F.S, regarding involuntary outpatient services.

This section has no impact on the Department.

Section 4
This section of the bill amends s. 394.4599, F.S. relating to involuntary admission, removing the reference to s. 394.4655(1), F.S., which defines criminal county court.

This section has no impact on the Department.

Section 5
This section of the bill amends s. 394.461, F.S., to state that the court may not consider the substantive information in the transfer evaluation unless the evaluator "testifies at the hearing." This could result in the court not having sufficient information to make a determination about suitable placement for the individual. It is unknown whether the changes to this section would affect admissions to state mental health treatment facilities, if the substantive information written in the transfer evaluation is not considered when the evaluator is not present at the hearing.

Section 6
Section 394.4615, F.S., relating to clinical records, confidentiality, is amended. It deletes one of the two purposes for releasing the clinical record to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals. The remaining purpose is to determine if the person meets involuntary outpatient placement criteria. This section also deletes the service provider as a party to whom the clinical record may be released.

Section 7
This section of the bill amends s. 394.462, F.S., relating to transportation of individuals to and from receiving facilities, to delete one referenced section from Chapter 397, F.S. regarding court-involved admissions. It adds another section from Chapter 397, F.S., relating to involuntary hearings for substance abuse treatment.

If enacted, this amendment will have minimal impact on the Department.

Section 8

This section of the bill amends s. 394.4625, F.S. regarding examination and treatment of individuals who present for voluntary admission. This section establishes that minors may be admitted to a facility based on the express and informed consent of the minor's parent or legal guardian in conjunction with the minor's assent. The assent of the minor must include specific agreement by the minor to remain at the facility for examination and treatment and must be verified through a clinical assessment that is documented in the minor's record and conducted within 12 hours after arrival at the facility by a licensed professional. The minor must be provided with an explanation as to what to expect and when they may be released in language that is appropriate to the minor's age, experience, maturity, and condition.

The minor must be advised or their right to request legal counsel and the facility administrator must file notice of the minor's voluntary placement with the court within one court working day. The court shall appoint a public defender who may review the voluntariness of the minor's admission to the facility and may interview and represent the minor, having access to all relevant witnesses and records. This section requires that unless the minor's assent is verified in this manner, a petition for involuntary placement must be filed with the court or they must be released to their parent or legal guardian within 24 hours after arriving at the facility.

The proposed "within 24 hours" may cause uncertainty regarding the of filing of the petition for involuntary services. A petition for involuntary services must be based on two professional opinions, who have personally examined the individual within the past 72 hours. The limitation to "within 24 hours" may not be sufficient time for facilities to fulfil the examination requirements needed to make decisions regarding the minor's legal status.

In addition, this section amends s. 394.4625(4), F.S. to add that a minor who applies to be transferred from involuntary status to voluntary status must be verified through the procedures outlined in s. 394.4652(1)(a)2., before the transfer occurs.

Section 9

This section amends s. 394.463(1), F.S. providing that a person may be subject to an involuntary examination if the person is likely to suffer from neglect or refuse to care for themselves; which is a threat of serious harm to their wellbeing; and it is not apparent that such harm may be avoided through the help of willing, *able, and responsible* family members or friends. This section also provides that if there is a substantial likelihood that, *in the near future and* without care or treatment, the person will *inflict serious* harm to self or others. This section adds that the evidence of likelihood for harm can be acts, omissions, or behaviors that can include significant damage to property.

Section 394.463(2), F.S., is amended in the bill to add that the facility must notify the Department of any individual who has been examined or committed three times or more within a 12-month period. As written, the bill would require facilities to develop specific system notification within their infrastructure that is able to alert the Department that those individuals have reached the threshold. The Department currently collects data about all involuntary examinations through a contract with the Baker Act Reporting Center (BARC) at the University of South Florida in accordance with s. 394.463, F.S.; the status of involuntary examination (admitted or released), was added to The Baker Act cover sheet form in May 2020. The BARC may be able to provide data to the Department about individuals with three or more involuntary examinations within a 12-month period, however, the bill does not specify what the Department and facilities would be required to do with that information. Many individuals have Medicaid or commercial insurance benefits, and those individuals' related behavioral health needs are managed by those entities. If the language proposed by the bill implies that the Department would provide care coordination or some other type of intervention to individuals with three or more examinations in a 12-month period, additional funding may be required.

This section creates s. 394.463(5), F.S., regarding penalties for unlawful activities relating to examination and treatment. The unlawful activities detailed in this section are: (a) knowingly furnishing false information for the purpose of obtaining emergency or other involuntary admission for any person; (b) causing or conspiring with another to cause, any involuntary mental health procedure for the person without a reason for believing a person is impaired; or, (c) causing, or conspiring to cause, any person to be denied their rights under the mental health statutes unlawful acts would be a misdemeanor of the first degree, punishable as provided by a fine up to $5,000.

Section 10

This section substantially rewords s. 394.4655, F.S. regarding involuntary outpatient services. Section 394.4655(1)(a), F.S., allows the court to order six months of involuntary outpatient treatment if the individual meets the criteria for involuntary placement and has been jailed or incarcerated, involuntarily admitted into a facility, or received forensic or correctional mental health treatment, at least twice during the past 36 months. The outpatient treatment must be provided where the individual will reside. Also, the individual's treating physician must certify that the individual can be more appropriately treated on an outpatient basis and can follow a treatment plan.

Section 394.4655(1)(b), F.S., states that, for the duration of his or her treatment, the respondent must be supervised by a social worker, case manager of an outpatient provider, or a willing, able, and responsible individual appointed by the court. This supervisor must inform the court, state attorney, and public defender of any failure by the respondent to comply with his or her outpatient program. Also, this section adds that criminal county courts may order a person into involuntary outpatient services.

As revised in the bill, the language removes the criteria limiting involuntary outpatient services to adults.

Section 11

This section of the bill amends s. 394.467, F.S., relating to involuntary inpatient placement. This section adds the term "able" to the persons inability to survive without the assistance of willing and responsible family or friends. Also, it mirrors amended language to 394.463, F.S., relating to involuntary examination criteria. This section provides that with respect to a hearing on involuntary inpatient placement, both the patient and the state are independently entitled to at least one continuance of the hearing. The patient's continuance may be for a period of up to four weeks and requires concurrence of the patient's counsel. The state's continuance may be for a period of up to five court working days and requires a showing of good cause and due diligence by the state before it can be requested. The state's failure to timely review readily available documents, or failure to attempt to contact a known witness does not merit a continuance. This section allows for all witnesses to a hearing to appear telephonically or by other remote means. This section also allows the state attorney to access the patient, any witnesses, and any records needed to prepare its case.

This section also amends s. 394.467(1)(a)2.b., F.S., by deleting the word "bodily" from the phrase "serious bodily harm" when referencing the likelihood of harm to justify involuntary placement. The section is additionally amended to stipulate that individuals will be considered for involuntary placement when they are likely to commit "serious harm" to themselves or others, which includes "but is not limited to, significant property damage." The inclusion of "significant property damage" may increase civil commitments to state mental health treatment facilities. This section adds new language that allows for "acts" or "omissions" to be utilized as evidence for involuntary placement.

This section increases the period of time during which a patient being treated on an involuntary basis may be retained at a treatment facility or otherwise continue to receive inpatient services for up to six months. This section also states a court may not order an individual with a developmental disability as defined in s. 393.063, F.S., traumatic brain injury, or dementia, who lacks a co-occurring mental illness; requiring that such individuals must be referred to the Agency for Persons with Disabilities (APD) or the Department of Elder Affairs (DOEA) for further evaluation and the provision of appropriate services. If it reasonably appears that the individual would be found incapacitated, and the individual does not already have a legal guardian, the facility must inform the Department and any known next of kin and initiate guardianship proceedings. The facility may hold the individual until the petition to appoint a guardian is heard by the court and placement is secured.

Section 12

This section of the bill amends s. 394.495, F.S., relating to the child and adolescent mental health system of care. It identifies professionals who can perform an assessment and who can directly supervise others who conduct an assessment as "a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist", as well, as professionals licensed under s. 394.455, F.S.

This section has no impact on the Department.

Section 13

This section amends s. 394.496, F.S., relating to service planning under comprehensive child and adolescent mental health services. Like Section 12, this section identifies professionals who can develop a service plan as "a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist", as well, as professionals licensed under s. 394.455, F.S.

This section has no impact on the Department.

Section 14

This section amends s. 394.499, F.S., relating to integrated children's crisis stabilization unit/juvenile addictions receiving facility services. It adds the terms "parent or legal" in front of guardian to state: (a) A person under 18 years of age for whom voluntary application is made by his or her *parent or legal* guardian. Also, the bill adds a statutory reference to the voluntary admissions section in statute (s. 394.4625, F.S.).

This section of the bill will have no impact on the Department.

Section 15

This section amends s. 394.9085, F.S., relating to behavioral provider liability. The amended language re-numbers the subsection for the definition for "Receiving facility".

This section of the bill will have no impact on the Department.

Section 16

This section amends s. 397.305, F.S., relating to the Legislative findings, intent, and purpose of the Substance Abuse Services Chapter. This section adds the term "most appropriate" to state: It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services in the *most appropriate and* least restrictive environment.

This section of the bill will have no impact on the Department.

Section 17

This section re-designates certain subsections relating to s. 397.311, F.S., relating to definitions for the substance abuse services chapter. Also, it adds the new definitions proposed in Section 1 of this bill.

This section of the bill will have no impact on the Department.

Section 18

This section amends s. 397.416, F.S., relating to qualified professionals for substance abuse treatment services to re-designate a statutory reference.

This section of the bill will have no impact on the Department.

Section 19

This section of the bill amends s. 397.501, F.S., relating to rights of individuals receiving substance abuse services. This section adds a subsection requiring facilities to inform persons with a serious substance use disorder about the "essential elements of recovery" and provide assistance to access a continuum of care regimen. Under this section, the Department may adopt rules specifying the services that may be provided.

Section 20

This section amends s. 397.675, F.S., relating to the criteria for involuntary admissions for substance abuse services. This section adds the term "substance use disorder" to the qualifications of a person who meets the criteria for involuntary admission. This section of the bill mirrors the statutory section of the Marchman Act to the proposed changes to the involuntary treatment criteria under the Baker Act, as detailed in Section 11 of this bill.

Section 21

This section amends s. 397.6751, F.S., relating to substance abuse service provider responsibilities regarding involuntary admissions. This section adds the term "most appropriate". It requires that all individuals who are

involuntarily admitted receive the *most appropriate* and least restrictive environment conducive to the patient's treatment needs.

Best practice and Department rules for providers already dictate that behavioral health treatment is appropriate, necessary, individualized, and least restrictive. This section of the bill will have no impact on the Department.

Section 22

This section of the bill amends s. 397.681, F.S., relating to involuntary petitions, general provisions, court jurisdiction, and right to counsel regarding Marchman Act services. This section adds a new subsection requiring, for court-involved proceedings, that the state attorney represent the state rather than the petitioner in all proceedings for involuntary admissions. The state attorney may access a wide variety of documents, media, and reports to evaluate and prepare its case. The records will remain confidential. The petitioner cannot access any of these records not entered into the court file. The state attorney cannot use the records for any purpose other than civil commitment, including criminal investigation or prosecution.

Providers and facility administrators are impacted by these changes to accommodate the state attorneys' efforts in obtaining access to records, and to the respondent. This section of the bill will not impact the Department.

Section 23

This section repeals s. 397.6811, F.S., relating to involuntary assessment and stabilization. It appears that the bill is streamlining the involuntary treatment process by adding new language in other sections of the bill to regulate the involuntary treatment process.

This section of the bill will have no impact on the Department.

Section 24

This section repeals s. 397.6814, F.S., relating to involuntary assessment and stabilization; contents of petition. It appears that the bill is streamlining the involuntary treatment process by adding new language in other sections of the bill to regulate the involuntary treatment process.

This section repeals all the involuntary assessment and stabilization sections of the law. However, without that level of services, it is challenging to determine when the assessment is required and how it is utilized for the admission process.

Section 25

This section repeals s. 397.6815, F.S., relating to involuntary assessment and stabilization; procedure. It appears that the bill is streamlining the involuntary treatment process by adding new language in other sections of the bill to regulate the involuntary treatment process.

This section repeals the involuntary assessment and stabilization procedure sections of the law. Without this section of law, it may be challenging to determine when the assessment is required and how it is utilized for the admission process.

Section 26

This section repeals s. 397.6818, F.S., relating to court determination. It appears that the bill is streamlining the involuntary treatment process by adding new language in other sections of the bill to regulate the involuntary treatment process.

In repealing the court determination section of the statutes regulating involuntary admissions procedures for substance abuse services, is will be challenging to determine when and how this process will be utilized.

Section 27

This section repeals s. 397.6819, F.S., relating to involuntary assessment and stabilization; responsibility of licensed service provider. It appears that the bill is streamlining the involuntary treatment process by adding new language in other sections of the bill to regulate the involuntary treatment process.

This section of the bill will have no impact on the Department.

Section 28

This section repeals s. 397.6821, F.S., relating to extension of time for completion of involuntary assessment and stabilization. It appears that the bill is streamlining the involuntary treatment process by adding new language in other sections of the bill to regulate the involuntary treatment process.

Other proposed amendments in this bill change these extension of time requirements. The Department will likely be required to amend rules and conduct needed training.

Section 29

This section repeals s. 397.6822, F.S., relating to disposition of individual after involuntary assessment. It appears that the bill is streamlining the involuntary treatment process by adding new language in other sections of the bill to regulate the involuntary treatment process.

This section of the bill will have no impact on the Department.

Section 30

This section of the bill amends s. 397.693, F.S., relating to involuntary treatment, to add that a person subject to involuntary treatment merely needs to "reasonably appear to meet" the admission criteria instead of meeting the admission criteria. This section changes the time frame for assessment by a qualified professional from 30 days to 5 days and deletes the admission criteria that a person was subject to involuntary assessment and stabilization or alternative involuntary admission with the previous 12 days.

Section 31

This section amends s. 397.695, F.S., relating to involuntary services. In this section, the term services is changed to "treatment". A subsection is added to state that fees for service of process may be waived or prohibited.

This section of the bill will have no impact on the Department.

Section 32

This section of the bill amends s. 397.6951, F.S., relating to the contents of the petition for involuntary services. This section replaces "services" with "treatment". This section removes the requirement that petitions for involuntary treatment contain findings and recommendations of the qualified professional's assessment.

This section requires a petition for involuntary treatment to show the petitioner's belief that the individual:

a) Lost the power of self-control or has a history of noncompliance with treatment;
b) Needs the services, but the substance abuse has impaired their judgment; and,
c) Without the services, the individual will likely suffer from neglect or refuse to care for themselves which poses a real and substantial threat of harm and is unavoidable without the help of others or provision of services; or, there is substantial likelihood of serious harm to self or others, including significant property damage.

This section provides that a petition may be accompanied by a certificate or report of a qualified professional or licensed physician who conducted the examination within the past 30 days. The certificate must contain the professional's findings and if the respondent refuses to submit to an examination must document the refusal.

This section provides that in the event of an emergency, the petition must also include a description of the exigent circumstances and a request for an ex-parte assessment and stabilization order.

This section of the bill will have no impact on the Department.

Section 33

This section amends s. 397.6955, F.S., relating to duties of the court upon filing of petition for involuntary treatment. This section amends the duties of the court upon the filing of a petition for involuntary treatment, requiring the clerk of court to notify the state attorney of the filed petition, in addition to notifying the respondent's counsel if appointed. The court must schedule a hearing on the petition within 10 court working days unless a continuance is granted.

If an emergency is asserted, then the court may rely solely on the contents of a petition to enter an ex parte order for an involuntary assessment and stabilization of the respondent. The court may order a law enforcement officer or other designated agent to take the respondent into custody and deliver them to the nearest treatment facility; and, serve that person with the notice of the hearing and a copy of the petition, if a hearing date was set. Also, under this section, the service provider has 72 hours of observation unless certain conditions specified in the bill are present.

This section of the bill will have no impact on the Department.

Section 34

This section amends s. 397.6957, F.S., relating to hearings on petitions for involuntary treatment. This section mandates that a respondent be present during a hearing on an involuntary treatment petition unless the respondent has knowingly and willingly waived their right to appear. Testimony from family members familiar with the respondent's history and how it relates to their current condition is permissible. This section allows for all witnesses to a hearing to appear telephonically or by other remote means.

This section provides that if the respondent has not previously been assessed by a qualified professional, the court must allow 10 days for the respondent to undergo such evaluation, unless the court suspects that the respondent will not appear at a rescheduled hearing or refuses to submit to an evaluation, the court may enter a preliminary order committing the respondent to an appropriate treatment facility until the rescheduled hearing date. The respondent's evaluation must occur within 72 hours of arrival at the treatment facility, unless the individual shows signs of withdrawal, the need for detoxification, or treatment of their medical condition. If the facility cannot have the evaluation completed in this time period, they must petition the court for an extension of time not to extend beyond a period of 72 hours before the rescheduled hearing. Copies of the evaluation report must be provided to all parties and their counsel, and the respondent may be held, and treatment initiated until the rescheduled hearing. The court may order law enforcement to transport the respondent as needed to and from a treatment facility to the court for the rescheduled hearing.

This section allows the court to initiate involuntary proceedings at any point during the hearing if it reasonably believes that the respondent is likely to injure themselves if allowed to remain free. Any treatment order entered by the court at the conclusion of the hearing must contain findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives. This section also allows such orders to designate specific service providers. In this section of the bill, if after 90 days the respondent remains unassessed, then the court shall dismiss the case.

If the respondent is a minor the assessment must be initiated within the first 12 hours after admission to the facility. The service provider may file a petition the court to extend the 72 hours period. The court may grant the request and the petitioner may hold the respondent until its extended assessment period expires until the hearing date. The qualified professional shall make a report and provide it to all required parties with a recommendation for the appropriate level of care for substance abuse and co-occurring mental health treatment, if needed. The petition shall be dismissed if no recommendation for treatment is included in the report. The court may order law enforcement to take the respondent into custody and transport them to the court hearing.

This section requires the petitioner to prove, through clear and convincing evidence that the respondent is substance abuse impaired, has lost the power of self-control with respect to substance abuse, and has a history of lack of compliance with treatment. This section requires the petitioner to also prove that it is likely that the respondent poses a threat of substantial harm to their own well-being and it is apparent that such harm may not be avoided through the help of willing, able, and responsible family member or friends or the provision of services, or that there is a substantial likelihood that, unless admitted, the respondent will cause harm to themselves or others, which may include property damage.

Section 35

This section of the bill amends s. 397.697, F.S., relating to court determination and effect of the court order for involuntary treatment. This section states that, in order to qualify for involuntary outpatient treatment, an individual must be accompanied by a willing, able, and responsible advocate who will inform the court if the individual fails to comply with their outpatient program. This section also requires that if outpatient treatment is offered in lieu of inpatient treatment, it may be offered for up to six months if it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment at least twice during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician

certifies that the respondent can be more appropriately treated on an outpatient basis, can follow a treatment plan, and is not likely to become more dangerous or deteriorate if such a plan is followed.

This section of the bill creates s. 397.697(1)(b), F.S., to describe qualifications for involuntary outpatient treatment. This section states that, in order to qualify for involuntary outpatient services, an individual must be supported by a social worker, case manager of an outpatient provider, or a willing, able, and responsible individual appointed by the court. This supervisor must inform the court, state attorney, and public defender of any failure by the respondent to comply with his or her outpatient program. The section states that unless the respondent has been involuntarily ordered into inpatient treatment at least twice during the last 36 months or demonstrated the ability to substantially comply with outpatient treatment while waiting for residential treatment to become available, they must receive an assessment from a qualified professional recommending outpatient services which must be available in the county which the respondent is located and it must appear likely that the respondent will follow an outpatient care plan.

This section requires the court to retain jurisdiction in all cases resulting in involuntary inpatient treatment so that it may monitor compliance with treatment, change treatment modalities, or initiate contempt of court proceedings as needed.

As currently written, this section does not distinguish involuntary outpatient treatment from voluntary outpatient treatment.

Section 36

This section amends s. 397.6971, F.S., relating to early release from involuntary services. The bill clarifies that individuals may be determined eligible under certain criteria including if the individual was admitted for the likelihood of self-neglect or the infliction of harm upon themselves or others and this likelihood no longer exists. Under this section, the term “services” is replaced with “treatment” throughout this section.

This section of the bill will have no impact on the Department

Section 37

This section of the bill amends s. 397.6975, F.S., relating to the extension of involuntary services. Under this section, the term “services” is replaced with “treatment” throughout. This section also adds that a petition for extending treatment may be filed by the service provider or by the person who filed the petition for the initial treatment order if the petition includes supporting documentation. The court’s requirement for scheduling a hearing is reduced from 15 days to 10 court working days. This section of the bill also deletes the requirement for the court to appoint the office of criminal conflict and civil regional counsel to represent the individual. Also deleted are requirements for: the hearings to occur before the circuit court; providing a notice of the hearing to the respondent and their counsel and allowing the respondent and their counsel to agree to continued involuntary services without a hearing; mandating the same court procedure for each involuntary services extension; and, mandating that the court consider testimony and evidence regarding competence if the respondent was previously found incompetent.

Section 38

This section amends s. 397.6977, relating to the disposition of individual upon completion of involuntary service. Under this section, the term “services” is replaced with “treatment” throughout.

This section of the bill will have no impact on the Department.

Section 39

This section repeals s. 397.6978, F.S., relating to relating to guardian advocates; patients’ incompetent consent; and, substance abuse disorder.

This section of the bill will have no impact on the Department.

Section 40

This section amends s. 409.972, F.S., relating to Medicaid enrollment, to change a statute cross reference.

This section of the bill will have no impact on the Department.

Section 41
This section amends s. 464.012, F.S., relating to licensure of advanced practice registered nurses, fees, and controlled substance prescribing, to change a statute cross reference.

This section of the bill will have no impact on the Department.

Section 42
This section amends s. 744.2007, F.S., relating to powers and duties of the public guardians to change a statute cross reference.

This section of the bill will have no impact on the Department.

Section 43
This section amends s. 790.065, F.S., relating sale and delivery of firearms to eliminate cross references.

This section of the bill will have no impact on the Department.

Section 44

This section provides an effective date of July 1, 2021.

3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?

If yes, explain:	Yes. The Legislation allows the Department to adopt rules specifying the mental health and substance use treatment services that may be provided post-discharge involuntary assessment and treatment. Rulemaking will also be needed to create and amend Baker Act forms.
What is the expected impact to the agency's core mission?	None.
Rule(s) impacted (provide references to F.A.C., etc.):	Chapters 65E-5 and 65D-30, F.A.C.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

List any known proponents and opponents:	Unknown.
Provide a summary of the proponents' and opponents' positions:	Unknown.

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?

If yes, provide a description:	No.
Date Due:	N/A
Bill Section Number(s):	N/A

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL?

Board:	No.

Board Purpose:	N/A
Who Appoints:	N/A
Appointee Term:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Office of Administrative Services finds that there are no expenditures generated by this bill.
Does the legislation increase local taxes or fees?	The Department's Office of Administrative Services finds that this bill does not increase local taxes or fees.
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	The Department's Office of Administrative Services finds that this section is not applicable.

2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Office of Administrative Services finds there may be expenditures generated by this bill. Section 1 – There is a minimal fiscal impact for costs associated with rulemaking and training. The Department will amend current contracts to incorporate new training for law enforcement, practitioners, and public stakeholders. Section 9 – There is an indeterminate cost associated with Department being notified by facilities of any individual who has been examined or committed three times or more within a 12-month period. It is unclear if the Department's current data collection through a contract with the Baker Act Reporting Center (BARC) at the University of South Florida in accordance with s. 394.463, F.S., will meet the requirements of this section. It is also unclear what the Department is required to do with this information. Please see Technology Impact section for additional fiscal impact resulting from indeterminate technology needs.

Does the legislation contain a State Government appropriation?	The Department's Office of Administrative Services finds that there is no State Government appropriation provided by this bill.
If yes, was this appropriated last year?	The Department's Office of Administrative Services finds this section is not applicable.

3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Office of Administrative Services finds there may be expenditures generated by this bill. Section 5 – There is an indeterminate cost associated with providers' evaluators who complete transfer evaluations having to testify at hearings. Section 6 – There is an indeterminate cost associated with providers' having to obtain clinical records to prepare a treatment plan or determine if the person has the capacity to treat the individual.
Other:	The Department's Office of Administrative Services finds that this section is not applicable.

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?

Does the bill increase taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not increase taxes, fees, or fines.
Does the bill decrease taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not decrease taxes, fees, or fines.
What is the impact of the increase or decrease?	The Department's Office of Administrative Services finds that this section is not applicable.
Bill Section Number:	The Department's Office of Administrative Services finds that this section is not applicable.

TECHNOLOGY IMPACT

Does the legislation impact the agency's technology systems (i.e., IT support, licensing software, data storage, etc.)?	As noted in the analysis for Section 9, it is not clear if the Baker Act Receiving Centers (BARCs) would handle the work described. If the program office determines that system changes are needed to support the work, there could be a technology impact, but the extent of the impact and any related cost estimates would be based on requirements defined by the program at that time.
If yes, describe the anticipated impact to the agency including any fiscal impact.	Based on information currently available, impact (if any) is not known at this time.

FEDERAL IMPACT

Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)?	The Department's Office of Substance Abuse and Mental Health does not find that there will a federal impact due to the provisions of this bill.
If yes, describe the anticipated impact including any fiscal impact.	The Department's Office of Substance Abuse and Mental Health finds that this section is not applicable.

ADDITIONAL COMMENTS

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	The Department's Office of General Counsel has no comments or concerns with this bill.

OFFICE OF THE STATE COURTS ADMINISTRATOR
2021 JUDICIAL IMPACT STATEMENT

BILL NUMBER: SB 828 DATE: February 12, 2021

SPONSOR(S): Senator Book

STATUTE(S)AFFECTED: ss. 394.455, 394.459, 394.4598, 394.4599, 394.461, 394.4615, 394.462, 394.4625, 394.463, 394.4655, 394.467, 394.495, 394.496, 394.499, 394.9085, 397.305, 397.311, 397.416, 397.501, 397.675, 397.6751, 397.681, 397.6811, 397.6814, 397.6815, 397.6818, 397.6819, 397.6821, 397.6822, 397.693, 397.695, 397.6951, 397.6955, 397.6957, 397.697, 397.6971, 397.6975, 397.6977, 397.6978, 409.972, 464.012, 744.2007, and 790.065, F.S.

COMPANION BILL(S): HB 405

AGENCY CONTACT: Sean M. Burnfin

TELEPHONE: (850) 922-0358

ASSIGNED OSCA STAFF: CK

I. SUMMARY: The bill makes substantial revisions to the Baker Act and the Marchman Act.

II. EFFECT OF PROPOSED CHANGES: The effects of the bill on Baker Act and Marchman Act proceedings are addressed as part of the discussion of potential impacts on judicial and court workload in Section III, below.

III. ANTICIPATED JUDICIAL OR COURT WORKLOAD IMPACT: The bill makes multiple changes to the Baker Act and the Marchman Act that could affect judicial or court workload. At a minimum, judges hearing these cases will need training to learn the new provisions in this bill.

Some provisions of the bill are anticipated to result in additional judicial activity, such as having additional Baker Act involuntary petitions, rescheduling certain Baker Act placement hearings to ensure an evaluator is present, or holding status hearings while a child is held for civil contempt under the Marchman Act changes. Additionally, the bill clarifies and expands eligibility criteria for both acts, which could result in some additional cases, although a significant impact on judicial workload is not anticipated from this change.

Other provisions of the bill will promote efficiency in and enhancement of Baker Act and Marchman Act proceedings, such as authorizing courts to order involuntary outpatient services as part of an involuntary inpatient proceeding under the Baker Act and allowing

the assessment and stabilization proceedings to be addressed in the same petition with court-ordered treatment under the Marchman Act. Further, making the state attorney the real party in interest in a Marchman Act case where the petitioner has not retained private counsel will improve efficiency when petitions are filed by family members without private counsel.

The precise overall impact of the bill on judicial and court workload is not known. Following is detailed information on how the bill affects Baker Act and Marchman Act proceedings and, in turn, may affect judicial workload and court operations.

Baker Act Provisions

The amendments to s. 394.461, F.S., prohibit the court in a hearing for placement in a state treatment facility from considering substantive information in the transfer evaluation unless the evaluator testifies at the hearing. This may cause some hearings to be reset because the evaluator is not present. The number of hearings that would be reset cannot be determined.

The amendments to s. 394.4625, F.S., revise the requirements for the voluntary admission of minors and the transfer of a minor to voluntary status. A minor may only be admitted to a facility on the basis of the express and informed consent of the minor's parent or legal guardian in conjunction with the minor's assent. The minor's assent is an affirmative agreement by the minor to remain at the facility for examination and treatment. The minor's assent must be verified through a clinical assessment that is documented in the minor's clinical record and conducted within 12 hours after arrival at the facility by a licensed professional authorized to initiate an involuntary examination under s. 394.463, F.S. The facility must advise the minor of his or her right to request and have access to legal counsel. The facility administrator must file with the court a notice of a minor's voluntary placement within 1 court working day after the minor's admission to the facility. The court shall appoint a public defender who may review the voluntariness of the minor's admission to the facility and further verify his or her assent. The public defender may interview and represent the minor and must have access to all relevant witnesses and records. If the public defender does not review the voluntariness of the admission, the clinical assessment of the minor's assent serves as verification of assent. Unless the minor's assent is verified in accordance with the above, a petition for involuntary placement must be filed with the court or the minor must be released to his or her parent or legal guardian within 24 hours after arriving at the facility. A minor's assent to a transfer to voluntary status must be verified using the same procedures as discussed above for a voluntary admission. Some additional workload will result to appoint public defenders. The number of appointments resulting from the amendment cannot be determined.

The amendments to ss. 394.463 and 394.455, F.S., clarify and expand the involuntary examination criteria for the Baker Act. The definition is expanded to include property damage in the "cause harm" section of the criteria. The "neglect" section is expanded by the new definitions for "neglect or refuse to care for himself or herself" and "real and

present threat of substantial harm" to add mental and emotional harm and prevent deterioration. The expanded criteria could result in an increase in involuntary examination petitions filed and granted. The number of additional petitions, if any, cannot be determined. Section 394.463, F.S., is also amended to create criminal penalties for knowingly providing false information to obtain emergency or involuntary treatment for any person. It cannot be determined how many additional prosecutions would result from the new criminal penalties.

The amendments to s. 394.4655, F.S., eliminate the existing procedures for involuntary outpatient services under the Baker Act. Instead, involuntary outpatient services can be ordered by the court for up to six months in lieu of inpatient treatment as part of involuntary inpatient proceedings under s. 394.467, F.S., if the person meets involuntary placement criteria and has been jailed or incarcerated, has been involuntarily committed to a treatment facility, or has received mental health services in a forensic or correctional facility at least twice during the last 36 months. This change should not increase judicial workload. All cases for involuntary services (inpatient and outpatient) would proceed through the involuntary inpatient process. However, the change could increase the use of involuntary outpatient services if available. Involuntary outpatient services are underutilized because of lack of resources, and the current procedural process is more onerous than the involuntary inpatient process. Currently, involuntary outpatient services can only be ordered for 90 days. Involuntary outpatient services after the 90-day period can be extended by petition and hearing. Increasing the period that involuntary outpatient services can be ordered to 6 months may reduce the number of extensions needed. The reduction in hearings and petitions to extend involuntary outpatient services cannot be determined.

The amendments to s. 394.467, F.S., should not increase judicial workload other than effort and training by judges handling Baker Act cases to learn the new procedures. Instead, the proposed changes may enhance the court process. The facility will be required to make the clinical record available to the state attorney within 24 hours of the filing of the involuntary placement petition so that the state can evaluate and prepare its case. Because of the short time frames for these hearings, there are instances where the state is unable to contact or subpoena the necessary witnesses in time for the hearing. As a result, the state's evidence is inadmissible hearsay, and the petition is dismissed. Allowing the state attorney at least one continuance of up to 5 court working days for cause and allowing the state attorney access to the clinical record before the hearing should aid the state in its case preparation and enhance the court process. Another problem for these hearings is witness availability. Authorizing witnesses to remotely attend and testify at the hearing and requiring that witnesses must provide documents by the close of business on the day before the hearing should help facilitate the court process. The precise impact of these changes cannot be determined.

Marchman Act Provisions

The amendments to ss. 397.675 and 397.311, F.S., clarify and expand the involuntary admissions criteria for the Marchman Act. The definition is expanded to include property

damage in the “cause harm” section of the criteria. The “neglect” section is expanded to add mental and emotional harm and prevent deterioration. The expanded criteria could result in an increase in petitions filed and granted. However, any increase that would result cannot be determined.

The amendment to s. 397.681, F.S., provides that subject to a legislative appropriation, the state attorney represents the state rather than the petitioner as the real party of interest in involuntary proceedings under the Marchman Act in which the petitioner has not retained private counsel. However, the petitioner has a right to be heard. These changes should not affect the overall number of cases. However, many Marchman Act petitions are filed pro se by family members. Making the state attorney the real party in interest in a Marchman Act case where the petitioner has not retained private counsel will improve efficiency when petitions are filed by family members without private counsel. The workload impact from these changes cannot be determined.

The Marchman Act currently has separate procedures for court-ordered involuntary assessments and stabilizations and for court-ordered involuntary services. Each requires filing a petition and a hearing unless an ex parte emergency order is issued. The bill repeals all provisions for court-ordered involuntary assessments and stabilization (ss. 397.6811 to 397.6822, F.S.) and combines the two procedures into a consolidated involuntary treatment process. Only one petition would be filed instead of two.

Currently, when a petition for assessment and stabilization is filed, the court can either issue an ex parte order or have a hearing within 10 days. If a petition for involuntary services is subsequently filed, the court must hold a hearing on that petition within 5 days. Thus, under the current law for the court to order an involuntary assessment and then order involuntary services, there would be two hearings held within 10 days and 5 days of the filing of the petitions. Under the proposed consolidated involuntary treatment process, a single petition is filed. The petition may request an ex parte order or an expedited hearing if it is an emergency. The court can issue an ex parte order or schedule a hearing within 10 court working days. If there is a hearing and the respondent has not been assessed, the court can order an involuntary assessment if it appears the that the respondent qualifies for involuntary services. If an assessment is ordered, the hearing on involuntary treatment is continued for up to 10 court working days. Thus, under the consolidated involuntary treatment process, there would still be two hearings, one within 10 court working days of filing the petition and one scheduled within 10 court working days of an order for involuntary assessment.

Combining everything into an involuntary treatment process would reduce the number of petitions filed because only one petition is filed instead of two. Workload may be reduced because each petition involves service of process and appointment of counsel if the respondent is not represented. The impact would depend on how many fewer petitions would result, and cannot be determined. Judicial workload may not be significantly affected because there may still be a similar number of hearings required where assessments must be ordered and another hearing set. Currently, the hearings are scheduled as the petitions are separately filed. Under the amendments, courts would be

required to reschedule hearings within 10 court working days. Although the total number of hearings held would be about the same, the changes in scheduling requirements could put pressure on court scheduling in some circuits. The impact cannot be determined.

Currently, if a person is assessed and stabilized through a non-court-ordered admission, a petition for involuntary services would be filed and the court would schedule a hearing within 5 days. Under the bill, a petition for involuntary treatment would be filed and the court would have to hold a hearing within 10 court working days. The only difference where the assessment and stabilization is not court-ordered is that the court would have additional time to schedule the hearing.

The amendments to ss. 397.693 and 397.6951, F.S., increase the time in which a person must be assessed by a qualified professional from 5 days to 30 days for purposes of a petition for involuntary treatment. The change could increase the number of persons eligible for involuntary treatment petitions. It cannot be determined how many, if any, additional petitions would result.

The amendments to s. 397.6957, F.S., authorize the court to permit all witnesses to remotely attend and testify at the hearing. Any witness attending remotely must provide the parties all relevant documents by the close of business on the day before the hearing. Allowing witnesses to testify remotely could help facilitate the hearing process. Currently, a significant problem is getting medical practitioners to testify at these hearings because of the time and commuting burdens.

Currently, a person may be admitted for assessment and stabilization for 5 days. If the provider is unable to complete the assessment, the provider can request additional time not to exceed 10 days. The amendments would require that the person be assessed within 72 hours or 12 hours if a minor. This would be consistent with the time frames prescribed by the Baker Act. If the provider is unable to complete the assessment, the provider can request additional time. It cannot be determined what the impact would be on the number of requests for additional time that would result from the change.

The amendment to s. 397.695, F.S., permits the courts or the clerk to waive service of process fees if the petitioner is indigent. Waiving the service of process fees could increase the number of petitions filed. The increase, if any, cannot be determined.

The amendments to s. 397.697, F.S., provide the requirements for involuntary outpatient treatment and clarify that the court retains jurisdiction to enter further orders including civil contempt. It cannot be determined how many, if any, additional contempt hearings would result.

The amendments to s. 397.6975, F.S., reduce the time frame for scheduling a hearing for extension of involuntary treatment from within 15 days to 10 court working days and allow petitions to be filed by the original petitioner as well as the service provider. The shortened time frame could cause scheduling pressure in some circuits.

IV. IMPACT TO COURT RULES/JURY INSTRUCTIONS: None anticipated.

V. ESTIMATED FISCAL IMPACTS ON THE JUDICIARY:

A. Revenues: None anticipated.

B. Expenditures: The fiscal impact of this legislation cannot be accurately determined due to the unavailability of data needed to quantifiably establish the effects on judicial time and workload, as discussed in Section III, above.

Trial court judicial workload is measured using a case weighting system that calculates the amount of time that it takes for a judge to dispose of a case. Passage of this bill may impact the case weighting system. The number of case filings using the case weighting system is used to determine the needs for additional judicial resources each year. Any judicial workload changes in the future as a result of this bill will be reflected in the Supreme Court's annual opinion regarding certification of the need for additional judges.

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

2-16-21
Meeting Date

THE FLORIDA SENATE

APPEARANCE RECORD

SB 828
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Mental Health and Substance Abuse

Name Steve Leifman

Job Title Judge

Address 1351 N.W. 12th Street
Street

Phone (305) 548-5394

Miami — Florida — 33125
City — *State* — *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Steering Committee on Problem-Solving Courts

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

2/16/2021
Meeting Date

828
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Mental Health and Substance Abuse

Name Karen Woodall

Job Title Executive Director

Address 579 E. Call St.
Street

Phone 850-321-9386

Tallahassee — *City* | Fl — *State* | 32301 — *Zip*

Email fcfep@yahoo.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Center for Fiscal & Economic Policy

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

Meeting Date

SB 828
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Mental Health & Substance Abuse

Name DAVID NICA, Jr

Job Title Exec Vice President

Address
Street

Phone

City State Zip

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hospital Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE

APPEARANCE RECORD

2/16/21
Meeting Date

828
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Baker Act

Name Sara Mollo

Job Title Public Defender 6th Judicial Circuit

Address 14250 49th Street N
Street

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Clearwater — Florida — 33762
City — *State* — *Zip*

Email saramollo@wearethehope.org

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Public Defender Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/21
Meeting Date

SB 928
Bill Number (if applicable)

Topic Mental Health and Substance Abuse

Amendment Barcode (if applicable)

Name Natalie Kelly

Job Title CEO

Address 122 S. Calhoun St
Street

Tallahassee FL 32301
City *State* *Zip*

Phone (850) 510-5747

Email Natalie@floridamanagingentities.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Association of Managing Entities

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/24/21
Meeting Date

828
Bill Number (if applicable)

Topic Mental Health & Substance Abuse

Amendment Barcode (if applicable)

Name Angie Gallo

Job Title Advocate

Address _____ Phone 407-718-9925
Street

_____ Email _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Alliance for Public Schools

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 828
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senators Book and Gainer
SUBJECT:	Mental Health and Substance Abuse
DATE:	February 17, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Cox	CF	**Fav/CS**
2.			JU	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 828 modifies the Baker Act and makes significant changes to the Marchman Act, the statutory processes for mental health and substance abuse examinations and treatment, respectively. The bill makes all of the following substantive changes:

- Defines the terms "neglect or refuse to care for himself or herself" and "real and present threat of substantial harm" under both the Baker Act and Marchman Act.
- Requires facilities to inform persons with a serious mental illness or a serious substance use disorder of "the essential elements of recovery" and provide assistance in accessing a post-discharge continuum of care regimen.
- Provides specific requirements for verifying the assent of a minor's voluntariness for admission to a facility.
- If the minor's assent to voluntary admission is not verified in the specified manner, requires the facility administrator of a receiving facility to refer the case involving a minor's admission to the clerk of the court for the appointment of a public defender within 24 hours.
- Allows individuals to be admitted as a civil patient in a state treatment facility without a transfer evaluation.
- Makes the state attorney the "real party of interest" in Marchman Act cases before the courts.
- Prohibits courts from ordering an individual with a developmental disability, as defined in s. 393.063, F.S, who lacks a co-occurring mental illness to a state mental health treatment facility for involuntary inpatient placement and requiring that such individuals instead be referred to specified agencies for further evaluation and the provision of appropriate services.

- Repeals several sections of the Marchman Act, specifically those relating to involuntary assessment and stabilization, and relocates and amends such language into the provisions for involuntary treatment.
- Allows the court to order six months of involuntary outpatient treatment in lieu of inpatient treatment by a court as part of involuntary inpatient proceedings under s. 394.467, F.S., if the person had been twice ordered into inpatient treatment during the last 36 months and meets the criteria for involuntary placement.
- Changes the term "involuntary treatment" to "involuntary treatment services" in every instance where the term appears in ch. 397, F.S.
- Prohibits a court, in a hearing for placement in a treatment facility, from considering substantive information in the transfer evaluation unless the evaluator testifies at the hearing.
- Requires the facility administrator to file a petition for involuntary admission and a petition for voluntary admission within 72 hours of a voluntary admission of a minor or request to transfer a minor to voluntary status.
- Requires the clerk, upon filing, to appoint a public defender who will coordinate with the facility administrator to schedule a voluntariness hearing, which is a clinical, non-court proceeding.
- Requires the voluntariness hearing to occur within seven court working days of an involuntary petition being filed unless a continuance is granted.
- Requires the involuntary petition to be withdrawn if the minor's consent is found to be voluntary.
- If consent is found to be involuntary, requires that the minor must be discharged.
- Repeals all provisions for court-ordered involuntary assessments and stabilization (ss. 397.6811 to 397.6822, F.S.), and combines these procedures into a consolidated involuntary treatment process.
- Provides that a petition for involuntary treatment be filed.
- Requires the court to hold a hearing within ten court working days.
- Amends s. 394.467(7), F.S., removing a 90-day cap in this section (implemented in 2016) as it is irrelevant on this provision given that long-term treatment has always been for up to six months.
- Ensures consistency to other changes made by the act which remove the 90-day cap on the amount of time an individual can be held at a receiving facility.

The Department of Children and Families (the DCF) states that the bill is anticipated to have an indeterminate, negative fiscal impact on the agency, as well as on private sector substance use disorder treatment providers. See Section V. Fiscal Impact Statement.

The bill has an effective date of July 1, 2021.

II. Present Situation:

Mental Health and Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to

contribute to his or her community. The primary indicators used to evaluate an individual's mental health are:

- Emotional well-being, which is described as perceived life satisfaction, happiness, cheerfulness, peacefulness;
- Psychological well-being, which includes self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- Social well-being, which is described as social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, and sense of community.[1]

Mental illness encompasses all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning. Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.[2]

Mental illness affects millions of people in the United States each year. Approximately one in five adults live with a mental illness and an estimated 49.5% of adolescents aged 13-18 have a mental disorder.[3] Suicide is the tenth overall leading cause of death in the nation and the second leading cause of death among individuals between the ages of 10 and 24.[4] In 2019, 3,427 lives were lost to suicide in Florida.[5]

The Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[6] The Baker Act deals with Florida's mental health commitment laws, and includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations.[7] The Baker Act also protects the rights of all individuals examined or treated for mental illness in Florida.[8]

Involuntary Examination

Individuals suffering from an acute mental health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be

[1] *See* the World Health Organization, *Mental Health: Strengthening Our Response*, available at https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response; the Association for Mental Health and Wellness, *What is Mental Health?*, available at http://mhaweek.org/what-is-mental-health/ (all sites last visited February 10, 2021).
[2] *Id*.
[3] National Institute on Mental Health (NIMH), *Mental Illness*, available at https://www.nimh.nih.gov/health/statistics/mental-illness.shtml; The NIMH, *Mental Illness – Prevalence of Any Mental Disorder Among Adolescents*, available at https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_155771 (all sites last visited February 10, 2021).
[4] National Institute on Mental Health, *Suicide*, available at https://www.nimh.nih.gov/health/statistics/suicide.shtml (last visited February 10, 2021).
[5] The Department of Children and Families (The DCF), *Suicide Prevention Coordinating Council 2020 Annual Report*, p. 7. (January 1, 2021)(on file with the Senate Committee on Children, Families, and Elder Affairs).
[6] Chapter 71-131, L.O.F..; The Baker Act is contained in ch. 394, F.S.
[7] Sections 394.451-394.47891, F.S.
[8] Section 394.459, F.S.

provided on a voluntary or involuntary basis.[9] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; and
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.[10]

The involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[11]
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;[12] or
- A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion.[13]

Involuntary patients must be taken to either a public or private facility which has been designated by the DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold, or refer, as appropriate, involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment or transportation to the appropriate service provider.[14] The patient must be examined by the receiving facility within 72 hours of the initiation of the involuntary examination and specified actions must be taken within that time frame to address the individual needs of the patient.[15]

Involuntary Outpatient Placement

A person may be ordered to involuntary outpatient services upon a finding of the court that by clear and convincing evidence that all of the following factors are met:

- The person is 18 years of age or older;
- The person has a mental illness;

[9] Sections 394.4625 and 394.463, F.S.
[10] Section 394.463(1), F.S.
[11] Section 394.463(2)(a)1., F.S. Additionally, the order of the court must be made a part of the patient's clinical record.
[12] Section 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.
[13] Section 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record
[14] Section 394.455(40), F.S.
[15] Section 394.463(2)(g), F.S.

- The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
- The person has a history of lack of compliance with treatment for mental illness;
- The person has, within the immediately preceding 36 months:
  - Been involuntarily admitted to a receiving or treatment facility, or has received mental health services in a forensic or correctional facility, at least twice; or
  - Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others;
- The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;
- The person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being;[16]
- It is likely that the person will benefit from involuntary outpatient placement; and
- All available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.[17]

A petition for involuntary outpatient placement may be filed by the administrator of either a receiving facility or a treatment facility. [18] The petition must allege and sustain each of the criterion for involuntary outpatient placement and be accompanied by a certificate recommending involuntary outpatient placement by a qualified professional and a proposed treatment plan.[19]

The petition for involuntary outpatient placement must be filed in the county where the patient is located. However, if the patient is being placed from a state treatment facility, the petition must be filed in the county where the patient will reside.[20] When the petition has been filed, the clerk of the court must provide copies of the petition and the proposed treatment plan to the DCF, the managing entity, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel.[21]

Once a petition for involuntary outpatient placement has been filed with the court, the court must hold a hearing within five business days, unless a continuance is granted.[22] The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioner, as the real party in interest in the proceeding.[23] The court must appoint the public defender to represent the person who is the subject of the petition, unless that person is otherwise represented by counsel.[24]

[16] This factor is evaluated based on the person's treatment history and current behavior.
[17] Section 394.4655(2), F.S.
[18] Section 394.4655(4)(a), F.S.
[19] Section 394.4655(4)(b), F.S.
[20] Section 394.4655(4)(c), F.S.
[21] *Id*.
[22] Section 394.4655(7)(a)1., F.S.
[23] *Id*.
[24] Section 394.4655(5), F.S. This must be done within one court working day of filing of the petition.

At the hearing on involuntary outpatient placement, the court shall consider testimony and evidence regarding the patient's competence to consent to treatment; if the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate[25] If the court concludes that the patient meets the criteria for involuntary outpatient placement it must issue an order for involuntary outpatient services.[26] The order must specify the duration of involuntary outpatient services, up to 90 days, and the nature and extent of the patient's mental illness.[27] The order of the court and the treatment plan shall be made part of the patient's clinical record.[28]

If, at any time before the conclusion of the initial hearing on involuntary outpatient placement, it appears to the court that the person meets the criteria for involuntary inpatient placement does not meet the criteria for involuntary outpatient services then the court may order the person admitted for involuntary inpatient examination.[29]

Involuntary Inpatient Placement

A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

- He or she is mentally ill and because of his or her mental illness:
  - He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement or is unable to determine for himself or herself whether placement is necessary; and
  - He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services; and
  - Without treatment, is likely to suffer from neglect or refuse to care for himself or herself; and
  - Such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
  - There is a substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
- All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.[30]

The administrator of the receiving or treatment facility that is retaining a patient for involuntary inpatient treatment must file a petition for involuntary inpatient placement in the court in the county where the patient is located.[31] Upon filing, the clerk of the court must provide copies to

[25] Section 394.4655(7)(d), F.S.
[26] Section 394.4655(7)(b)1., F.S.
[27] *Id*.
[28] *Id*.
[29] Section 394.4655(7)(c), F.S. Additionally, if the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to the Marchman Act, the court may order the person to be admitted for involuntary assessment pursuant to the statutory requirements of the Marchman Act.
[30] Section 394.467(1), F.S.
[31] Section 394.467(2) and (3), F.S.

the DCF, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located.[32]

The court proceedings for involuntary inpatient placement closely mirror those for involuntary outpatient services.[33] However, unlike an order for involuntary outpatient services. However, the laws governing involuntary inpatient placement are silent regarding the court's order becoming part of the patient's clinical record.

Substance Abuse

Substance abuse is the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Substance use disorder (SUD) is determined based on specified criteria included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).[34] According to the DSM-5, a diagnosis of SUD is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[35] SUD occurs when an individual chronically uses alcohol or drugs, resulting in significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[36] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[37] Imaging studies of brains belonging to persons with SUD reveal physical changes in areas of the brain critical to judgment, decision making, learning and memory, and behavior control.[38]

In 2018, approximately 20.3 million people aged 12 or older had a SUD related to corresponding use of alcohol or illicit drugs within the previous year, including 14.8 million people diagnosed with alcohol use disorder and 8.1 million people diagnosed with drug use disorder.[39] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, opioids, hallucinogens, and stimulants.[40]

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[32] Section 394.467(3), F.S.
[33] *See* s. 394.467(6) and (7), F.S.
[34] The World Health Organization, *Mental Health and Substance Abuse*, available at https://www.who.int/westernpacific/about/how-we-work/programmes/mental-health-and-substance-abuse; the National Institute on Drug Abuse (NIDA), *The Science of Drug Use and Addiction: The Basics*, available at https://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics (last visited February 12, 2021).
[35] The National Association of Addiction Treatment Providers, *Substance Use Disorder*, available at https://www.naatp.org/resources/clinical/substance-use-disorder (last visited February 8, 2021).
[36] The SAMSHA, *Substance Use Disorders,* http://www.samhsa.gov/disorders/substance-use (last visited February 8, 2021).
[37] The NIDA, *Drugs, Brains, and Behavior: The Science of Addiction*, available at https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited February 8, 2021).
[38] *Id*.
[39] The Substance Abuse and Mental Health Services Administration (The SAMHSA), *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*, p. 2, available at https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf (last visited February 8, 2021).
[40] The Rural Health Information Hub, *Defining Substance Abuse and Substance Use Disorders*, available at https://www.ruralhealthinfo.org/toolkits/substance-abuse/1/definition (last visited February 8, 2021).

The Marchman Act

In the early 1970s, the federal government enacted laws creating formula grants for states to develop continuums of care for individuals and families affected by substance abuse.[41] The laws resulted in separate funding streams and requirements for alcoholism and drug abuse. In response to the laws, the Florida Legislature enacted chs. 396 and 397, F.S., relating to alcohol and drug abuse, respectively.[42] Each of these laws governed different aspects of addiction, and thus had different rules promulgated by the state to fully implement the respective pieces of legislation.[43] However, because persons with substance abuse issues often do not restrict their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not adequately address Florida's substance abuse problem.[44] In 1993, legislation was adopted to combine ch. 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act).[45]

The Marchman Act encourages individuals to seek services on a voluntary basis within the existing financial and space capacities of a service provider.[46] However, denial of addiction is a prevalent symptom of SUD, creating a barrier to timely intervention and effective treatment.[47] As a result, treatment typically must stem from a third party providing the intervention needed for SUD treatment.[48]

Involuntary Admissions

The Marchman Act establishes a variety of methods under which substance abuse assessment, stabilization and treatment can be obtained on an involuntary basis. There are five involuntary admission procedures that can be broken down into two categories depending upon whether the court is involved.[49] Three of the procedures do not involve the court, while two require direct petitions to the circuit court. The same criteria for involuntary admission apply regardless of the admission process used.[50]

An individual meets the criteria for an involuntary admission under the Marchman Act when there is good faith reason to believe the individual is substance abuse impaired and, because of such impairment, has lost the power of self-control with respect to substance use, and either:

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[41] The DCF, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5. (on file with the Senate Children, Families, and Elder Affairs Committee).
[42] *Id*.
[43] *Id*.
[44] *Id*.
[45] Chapter 93-39, s. 2, L.O.F., which codified current ch. 397, F.S.
[46] *See* s. 397.601(1) and (2), F.S. An individual who wishes to enter treatment may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service provider.
[47] Darran Duchene and Patrick Lane, *Fundamentals of the Marchman Act*, Risk RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Programs, available at http://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited February 10, 2021) (hereinafter cited as "Fundamentals of the Marchman Act").
[48] *Id*.
[49] *Id*.
[50] *Id*.

- Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision in that regard;[51] or
- Without care or treatment:
  - The person is likely to suffer from neglect or refuse to care for himself or herself;
  - Such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and
  - It is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
  - There is substantial likelihood that the person:
    - Has inflicted, or threatened to or attempted to inflict physical harm on himself, herself, or another; or
    - Is likely to inflict, physical harm on himself, herself, or another unless he or she is admitted.[52]

Non-Court Involved Involuntary Admissions

The three types of non-court procedures for involuntary admission for substance abuse treatment under the Marchman Act include protective custody, emergency admission, and the alternative involuntary assessment for minors.

Law enforcement officers use the protective custody procedure when an individual is substance-impaired or intoxicated in public and such impairment is brought to the attention of the officer.[53] The purpose of this procedure is to allow the person to be taken to a safe environment for observation and assessment to determine the need for treatment. A law enforcement officer may take the individual to their residence, to a hospital, a detoxification center, or an addiction receiving facility, whichever the officer determines is most appropriate.[54]

If the individual in these circumstances does not consent to protective custody, the officer may do so against the person's will, without using unreasonable force. Additionally, the officer has the option of taking an individual to a jail or detention facility for his or her own protection. Such detention cannot be considered an arrest for any purpose and no record can be made to indicate that the person has been detained or charged with any crime.[55] However, if the individual is a minor, the law enforcement officer must notify the nearest relative of a minor in protective custody without consent.[56]

The second process, emergency admission, authorizes an individual who appears to meet the criteria for involuntary admission to be admitted to a hospital, an addiction receiving facility, or a detoxification facility for emergency assessment and stabilization, or to a less intensive

[51] Section 394.675(2)(a), F.S. However, mere refusal to receive services does not constitute evidence of lack of judgment with respect to the person's need for such services.
[52] Section 397.675(2)(b), F.S.
[53] Section 397.677, F.S. The individual can be a minor or adult under this process.
[54] Section 397.6771, F.S. A person may be held in protective custody for no more than 72 hours, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody, Section 397.6773, F.S.
[55] Section 397.6772(1), F.S.
[56] Section 397.6772(2), F.S.

component of a licensed service provider for assessment only.[57] Individuals admitted for involuntary assessment and stabilization under this provision must have a certificate from a specified health professional[58] demonstrating the need for this type of placement and recommending the least restrictive type of service that is appropriate to the needs of the individual.[59]

Lastly, the alternative involuntary assessment for minors provides a way for a parent, legal guardian, or legal custodian to have a minor admitted to an addiction receiving facility to assess the minor's need for treatment by a qualified professional.[60]

Court Involved Involuntary Admissions

The two court involved Marchman Act procedures are involuntary assessment and stabilization, which provides for short-term court-ordered substance abuse services,[61] and involuntary services, which provides for long-term court-ordered substance abuse services.[62] Both are initiated through the filing of a petition.[63]

Involuntary Assessment and Stabilization

An individual's spouse, legal guardian, any relative, a private practitioner, the director of a licensed service provider or the director's designee, or any adult who has direct personal knowledge of the individual's substance abuse impairment may file a petition for involuntary assessment and stabilization on behalf of the individual.[64] If the individual is a minor, only a parent, legal guardian, legal custodian, or licensed service provider may file such a petition.[65]

The petition for involuntary assessment and stabilization must contain:

- The name of the applicant or applicants (the individual(s) filing the petition with the court);
- The name of the respondent (the individual whom the applicant is seeking to have involuntarily assessed and stabilized);
- The relationship between the respondent and the applicant;
- The name of the respondent's attorney, if known; and
- Facts to support the need for involuntary assessment and stabilization, including the reason for the applicant's belief that:
    - The respondent is substance abuse impaired;

[57] Section 397.679, F.S.
[58] Section 397.6793(1), F.S., provides a list of professionals that include a physician, a clinical psychologist, a physician assistant working under the scope of practice of the supervising physician, a psychiatric nurse, an advanced practice registered nurse, a mental health counselor, a marriage and family therapist, a master's-level-certified addictions professional for substance abuse services, or a clinical social worker
[59] Section 397.6793, F.S. The certificate can be from a physician, advanced practice registered nurse, a psychiatric nurse, a clinical psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, or a physician assistant working under the scope of a practice of the supervising physician, or a master's-level-certified addictions professional for substance abuse services.
[60] Section 397.6798, F.S.
[61] *See* ss. 397.6811 through 397.6822, F.S.
[62] *See* ss. 397.693 through 397.6978, F.S.
[63] Section 397.681, F.S. The court may not charge a filing fee for these petitions.
[64] Section 397.6811(1), F.S.
[65] Section 397.6811(2), F.S.

- Because of such impairment, the respondent has lost the power of self-control with respect to substance abuse; and
- The respondent:
  - Has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
  - Will refuse, or has refused voluntary care and based on his or her judgement being so impaired from the substance abuse, he or she is incapable of appreciating his or her need for care and of making a rational decision regarding the need for care. [66]

Once the petition is filed with the court, the court issues a summons to a respondent and must schedule a hearing to take place within ten days. Alternatively, the court can issue an ex parte order immediately.[67] Under the ex parte order, the court may order a law enforcement officer or other designated agent of the court to take the respondent into custody and deliver him or her to the nearest appropriate licensed service provider.[68]

A court must conduct the hearing in accordance with s. 397.6811(1), F.S., and hear all relevant testimony. If the court determines that a respondent meets the criteria for involuntary assessment and stabilization, it must immediately enter an order that authorizes the involuntary assessment and stabilization of the respondent or, in the alternative, enter an order dismissing the petition if a respondent does not meet the criteria.[69]

If the court determines a respondent meets the criteria for involuntary assessment and stabilization, it may order him or her to be admitted for a period of five days[70] to a hospital, licensed detoxification facility, or addictions receiving facility for involuntary assessment and stabilization.[71] During that time, an assessment is completed on the individual.[72] Under certain circumstances, this order may be extended to complete the assessment.[73]

Based on the involuntary assessment at a hospital, detoxification facility, addictions receiving facility, or less restrictive component, the qualified professional must either:
- Release the individual and, if appropriate, refer the individual to another treatment facility or service provider, or to community services;
- Allow the individual to remain voluntarily at the licensed provider; or
- Hold the individual if a petition for involuntary treatment has been initiated.[74]

[66] Section 397.6814, F.S. Further, if the person has refused to submit to an assessment, that fact must be included in the petition.
[67] Section 397.6815, F.S.
[68] Section 397.6815(2), F.S.
[69] Section 397.6818(1), F.S. This section also provides for the written findings that must be included in the order.
[70] Section 397.6819, F.S.
[71] Section 397.6811, F.S. The individual may also be ordered to a less restrictive component of a licensed service provider for assessment only upon entry of a court order or upon receipt by the licensed service provider of a petition.
[72] Section 397.6819, F.S. The licensed service provider must assess the individual without unnecessary delay using a qualified professional. If an assessment is performed by a qualified professional who is not a physician, the assessment must be reviewed by a physician before the end of the assessment period.
[73] *See* s. 397.6819, F.S., for exceptions.
[74] Section 397.6822, F.S. The timely filing of a petition for involuntary services authorizes the service provider to retain physical custody of the individual pending further order of the court.

Involuntary Services

A person may be court-ordered for involuntary treatment if he or she meets the eligibility criteria for involuntary admission and has been involved in one of the following Marchman Act processes within certain timeframes:

- Protective custody or emergency admission within the previous ten days.
- Assessment by a qualified professional within five days.
- Involuntary assessment and stabilization or alternative involuntary admission pursuant to s. 397.6822, F.S.,[75] within the previous 12 days.[76]

An individual's spouse, legal guardian, any relative, or service provider, or any adult who has direct personal knowledge of the individual's substance abuse impairment or prior course of assessment and treatment may file a petition for involuntary services on behalf of the individual.[77] If the individual is a minor, only a parent, legal guardian, or service provider may file such a petition.[78]

Similar to a petition for involuntary assessment and stabilization, a petition for involuntary services must contain the same identifying information for all parties and attorneys and facts to support the same eligibility criteria as described above.[79] Upon filing of a petition, the court must schedule a hearing to be held within five days, and must provide a copy of the petition and notice of hearing to all parties and anyone else the court determines. The court also issues a summons to the person whose admission is sought.[80]

In a hearing for involuntary services, the petitioner must prove by clear and convincing evidence that:

- The individual is substance abuse impaired and has a history of lack of compliance with treatment for substance abuse;
- Because of such impairment the person is unlikely to voluntarily participate in the recommended services or is unable to determine for himself or herself whether services are necessary; and
- The respondent meets either of the following:
  - Without services the individual:
    - Is likely to suffer from neglect or refuse to care for himself or herself and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and
    - That there is a substantial likelihood that without services the individual will cause serious bodily harm to himself, herself, or another in the near future, as evidenced by recent behavior; or

[75] Section 397.6822, F.S., refers to disposition of an individual after involuntary assessment, including release or referral to another treatment facility or service provider, or to community services; voluntary retention of the individual; or retention of an individual pending a petition for involuntary services.
[76] Section 397.693, F.S.
[77] Section 397.695(1), F.S.
[78] Section 397.695(2), F.S.
[79] Section 397.6951, F.S.
[80] Section 397.6955(1) through (3), F.S.

- The individual's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.[81]

At the hearing, the court must hear and review all relevant evidence, including the results of the involuntary assessment by a qualified professional, and either dismiss the petition or order the individual to receive involuntary choices from his or her chosen licensed service provider, if possible and appropriate. The respondent must be present unless the court finds that his or her presence is likely to be injurious to himself or herself or others. If such finding is made, a guardian advocate must be appointed to act on behalf of the respondent.[82]

If the court finds that the conditions for involuntary services have been proven, it may order the respondent to receive involuntary services with a publicly funded licensed service provider for up to 90 days.[83] Alternatively, if the individual or a person on the individual's behalf is able and willing to pay for services, the court may also order the individual to receive services at a privately funded licensed service provider.[84] If an individual continues to need involuntary services, the licensed service provider can petition the court for continuances for up to 90 days.[85] Unless an extension is requested, the individual is released after 90 days.[86]

Confidentiality of Records

Baker Act

Section 394.4615, F.S., in part, provides that clinical records related to procedures under the Baker Act are confidential and exempt[87] and may not be disclosed without written consent of the individual, with certain exceptions. Such exceptions include specified disclosure by the individual, a guardian, or a guardian advocate.[88] Court records under the Baker Act are also confidential and exempt from disclosure.[89] The clerk of the court is authorized to disclose court records to certain entities, including parties to the proceedings and certain governmental entities.[90]

Marchman Act

All service provider records related to procedures under the Marchman Act are confidential and exempt and may not be disclosed without written consent of the individual, with certain exceptions.[91] Additionally, petitions for involuntary assessment and stabilization, court orders,

[81] Section 397.6957(2), F.S.
[82] Sections 397.6957(1), F.S.
[83] Section 397.697(1), F.S
[84] *Id*.
[85] The licensed service provider must file its petition at least 10 days before the 90-day period expires. A hearing must be held within 15 days. Section 397.6975, F.S.
[86] Section 397.6977, F.S.
[87] Custodians of records designated as "confidential and exempt" may not disclose the record except under circumstances specifically defined by the Legislature. *See WFTV, Inc. v. The School Board of Seminole*, 874 So. 2d 48 (Fla. 5th DCA 2004).
[88] Section 394.4615(1)-(2), F.S.
[89] Section 394.464(1), F.S.
[90] Section 394.464(1)-(2), F.S.
[91] Section 397.501(7), F.S.

and related records that are filed with the court under the Marchman Act are confidential and exempt from disclosure.[92] However, the clerk of the court may disclose such records to certain entities, including parties to the proceedings and certain governmental entities.[93]

Transportation to a Facility

Baker Act

The Baker Act requires each county to designate a single law enforcement agency to transfer the person in need of services. If the person is in custody based on noncriminal or minor criminal behavior, the law enforcement officer will transport the person to the nearest receiving facility. If, however, the person is arrested for a felony the person must first be processed in the same manner as any other criminal suspect. The law enforcement officer must then transport the person to the nearest facility, unless the facility is unable to provide adequate security.[94]

The Baker Act prohibits the detention in jail of a mentally ill person if he or she has not been charged with a crime.[95]

Marchman Act

The Marchman Act authorizes an applicant seeking to have a person admitted to a facility, the person's spouse or guardian, a law enforcement officer, or a health officer to transport the individual for an emergency assessment and stabilization.[96] Further, law enforcement officers are authorized to temporarily detain substance-impaired persons in a jail setting. An adult not charged with a crime may be detained for his or her own protection in a municipal or county jail or other appropriate detention facility. Detention in jail is not considered to be an arrest, is temporary, and requires the detention facility to provide if necessary the transfer of the detainee to an appropriate licensed service provider with an available bed.[97]

Individual Bill of Rights

Both the Marchman Act and the Baker Act provide an individual bill of rights.[98] Rights in common include the right to:

- Dignity;
- Quality of treatment;
- Not be refused treatment at a state-funded facility due to an inability to pay;
- Communicate with others;
- Care and custody of personal effects; and
- Petition the court on a writ of habeus corpus.

[92] Section 397.6760(1), F.S.
[93] Section 397.6960(1)-(2), F.S.
[94] Section 394.462(1)(f)-(g), F.S.
[95] Section 394.459(1), F.S.
[96] Section 397.6795, F.S.
[97] Section 397.6772(1), F.S.
[98] Section 397.501, F.S., provides "Rights of Individuals" for individuals served through the Marchman Act; section 394.459, F.S., provides "Rights of Individuals" for individuals served through the Baker Act.

The individual bill of rights also imposes liability for damages on persons who violate individual rights.[99] The Marchman Act ensures the right to habeus corpus, which means that a petition for release may be filed with the court by an individual involuntarily retained or his or her parent or representative.[100] In addition to the petitioners authorized in the Marchman Act, the Baker Act permits the DCF to file a writ for habeus corpus on behalf of the individual.[101]

The Florida Bar's Special Committee on Mental Health

In 2017, the Florida Bar developed a special committee on mental health and substance use issues (The Committee).[102] One of the primary directives of the committee was reviewing the state's behavioral health laws and recommending changes as it saw fit.[103] The Committee recommended a number of changes, including, in part:

- Making the State Attorney the "real party in interest" in Marchman Act cases, having the Clerk of Court notify the State Attorney when cares are filed, and having access to all relevant persons and records in each case;[104]
- Increasing and standardizing the length of time for courts to hold both Baker and Marchman Act hearings following the filing of a petition from five to days to ten days;[105]
- Allowing witnesses to appear telephonically at both Baker and Marchman Act hearings absent good cause being shown to require their physical presence, and standardizing scenarios which allow the respondent to be excused from attending the hearing;[106]
- Standardizing the amount of time Baker Act patients can be held at both local and state-owned treatment facilities to a six-month maximum in both instances;[107]
- Requiring individuals who are initially subject to a Baker Act with traumatic brain injury or dementia to be referred to the Agency for Persons with Disabilities (the APD) or the Department of Elder Affairs (the DOEA);[108]
- Granting the State Attorney the right to a seven-day working continuance in Baker Act cases if good cause is shown, and express access to all relevant records;[109]
- Expressly defining "neglect or refusal to care for one's self" and "real and present threat of substantial harm";[110]
- Standardizing the admission criteria, petition contents, and court's treatment finding for Baker Act and Marchman Act cases;[111]

[99] Sections 397.501(10)(a) and 394.459(10), F.S.
[100] Section 397.501(9), F.S.
[101] Section 394.459(8)(a), F.S.
[102] The Florida Bar, *The Florida Bar's Special Committee on Mental Health 2018 Interim Report*, April 25, 2018, p. 1, available at https://www-media.floridabar.org/uploads/2018/05/2018-Interim-Report-Special-Committee-on-Mental-Health.pdf. (last visited February 8, 2021)(hereinafter cited as "The Florida Bar").
[103] *Id*.
[104] *Id.* at p. 4.
[105] *Id.* at p. 5.
[106] *Id*. at p. 5-7
[107] The Florida Bar, p. 7.
[108] *Id*. at p. 7-8.
[109] *Id*. at p. 8.
[110] *Id*.
[111] *Id*. at p. 10.

- Granting the public defender and regional counsel access the right to access their respective clients that are hospitalized or in a treatment facility;[112]
- Replacing the word 'services' with the word 'treatment' in both the Baker and Marchman Acts, as this is the term commonly used by litigants;[113] and
- Waiving the $80 service of process fee for litigants in Marchman Act proceedings.[114]

The Committee originally crafted this series of legislative proposals for the 2019 Legislative Session.[115] Several of the proposed recommendations were contained in SB 818 (2019)[116] and SB 870 (2020).[117]

III. Effect of Proposed Changes:

Baker Act – Definitions, Criteria, Rights of Individuals

The bill amends s. 394.455, F.S., defining "neglect or refuse to care for himself or herself" to include, but not be limited to, evidence that a person:

- Is unable to satisfy basic needs for nourishment, clothing, medical care, shelter, or safety in a manner that creates a substantial probability of imminent death, serious physical debilitation, or disease; or
- Is substantially unable to make an informed treatment choice and needs care or treatment to prevent deterioration.

The bill defines "real and present threat of substantial harm" to include, but not be limited to, evidence of a substantial probability that the untreated person will:

- Lack, refuse, or not receive services for health and safety which are actually available in the community; or
- Suffer severe mental, emotional, or physical harm that will result in the loss of his or her ability to function in the community or the loss of cognitive or volitional control over thoughts or actions.

The bill amends s. 394.459, F.S., requiring that a patient with a serious mental illness who has been released after being Baker Acted must be provided with information regarding the essential elements of recovery and provided with assistance in accessing a continuum of care regimen. The DCF is provided with rulemaking authority to determine what services may be available in such regimens. Current law requires the state to provide involuntary treatment at a state hospital, but does not require Baker Act patients to be provided with information about the essential elements of recovery or assistance in accessing a continuum of care regimen.

The bill amends s. 394.461, F.S., authorizing civil patients to be admitted to designated receiving facilities under the Baker Act without undergoing a transfer evaluation. The bill also provides that, before the close of the state's case in a Baker Act hearing for involuntary placement, the

[112] The Florida Bar, p. 12.
[113] *Id*.
[114] *Id*.
[115] *Id* at p. 1.
[116] *See* SB 818 (2019 Reg. Session).
[117] *See* SB 870 (2020 Reg. Session).

state may establish that a transfer evaluation was performed and that the document was properly executed by providing the court with a copy of the transfer evaluation. The bill also prohibits the court from considering the substantive information in the transfer evaluation unless the evaluator testifies at the hearing.

The bill amends s. 394.4615, F.S., eliminating provisions referring to s. 394.4655, F.S., relating to involuntary outpatient services, rendered inapplicable by the bill.

The bill amends s. 394.462, F.S., updating cross references to changes made by the act.

Baker Act – Voluntary Admissions and Procedures Related to Minors

The bill amends s. 394.4625, F.S., requiring a person to show evidence of mental illness in order to be admitted to a facility on a voluntary basis. Adults must consent in writing, and minors may only be admitted on a voluntary basis if both the minor and their parent or guardian give express and informed consent. The minor's assent is considered an affirmative agreement to remain at the facility for examination. A minor's assent must be verified through a clinical assessment performed within 12 hours of arrival at the facility. The examining professional must provide the minor with the following information:

- An explanation as to why they are at the facility;
- What to expect while at the facility; and
- When they can expect to be released, using language that is appropriate to the minor's:
  - Age;
  - Experience;
  - Maturity; and
  - Condition.

The professional must document that the minor can understand this information. The facility administrator must file notice with the court of the minor's voluntary placement within one day of admission.

A public defender must be appointed by the court to review the voluntariness of the minor's admission and verify assent. The public defender can interview and represent the minor and must be given access to all relevant witnesses and records. If the public defender does not review the minor's assent, the bill provides that the clinical record may serve as verification of assent. If assent is not verified, a petition for involuntary placement must be filed or the minor must be released to their parent or guardian within 24 hours of arrival at the facility.

Baker Act – Involuntary Admissions, Involuntary Outpatient Services, Criminal Penalties

Involuntary Examination

The bill amends s. 394.463, F.S., providing that a person is subject to an involuntary examination if there is a substantial likelihood that without care or treatment the person will cause serious harm to themselves or others in the near future, as evidenced by his or her recent behavior, actions, or omissions, which includes, but is not limited to, property damage. This provision of the bill provides more specificity than current criteria, which only references certain harmful actions as evidenced by recent behavior.

The bill authorizes, rather than requires as in current law, law enforcement to transport those who appear to meet Baker Act criteria to receiving facilities. It also requires receiving facilities to inform the DCF of any person who has been Baker Acted three or more times within a 12-month period. The bill also makes it a first degree misdemeanor[118] to:

- Knowingly furnish false information for the purpose of obtaining emergency or other involuntary admission for any person;
- Cause, or conspire with another to cause, any involuntary mental health procedure for the person without a reason for believing a person is impaired; or,
- Cause, or conspire with another to cause, any person to be denied their rights under the mental health statutes.

Involuntary Outpatient Services

The bill amends s. 394.4655, F.S., providing that in lieu of inpatient treatment, a court may order a respondent in a Baker Act case into outpatient treatment for up to six months if it is established that the respondent meets involuntary placement criteria and:

- Has been jailed or incarcerated, involuntarily ordered into inpatient treatment, or has received services at a forensic or correctional facility at least twice during the past 36 months;
- The outpatient provider is in the same county as where the respondent resides or will reside; and
- The respondent's treating physician certifies that:
  - The respondent can be more appropriately treated on an outpatient basis; and
  - Can follow a treatment plan.[119]

The bill requires that for the duration of their treatment, the respondent must have a willing, able, and responsible social worker or case manager, or individual appointed by the court who will inform the court of any failure to comply with the treatment plan. The court is required to retain jurisdiction over the parties for entry of further orders after a hearing and the court may order inpatient treatment to stabilize a respondent who decompensates during their period of court-ordered treatment if they continue to meet the other statutorily required criteria for commitment. Further, the bill authorizes a criminal county court to order a person who meets the commitment criteria into involuntary outpatient services.

The bill eliminates all other existing procedures of s. 394.4655, F.S., pertaining to criteria and procedures for involuntary examination.

Involuntary Inpatient Placement

The bill amends s. 394.467, F.S., adding to the criteria related to infliction of serious harm that recent acts or omissions may also be considered as behaviors that may be considered when considering if a person meets the criteria and that such behavior may include, but is not limited to, significant property damage.

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[118] A first degree misdemeanor is punishable by up to one year in jail and fine. This bill specifically authorizes that the fine is punishable up to $5,000. Sections 775.082 and 775.083(1)(g), F.S.

[119] The bill is silent regarding payment of involuntary outpatient treatment services. However, without private insurance or Medicaid, it must be presumed that the DCF would be required to pay for such treatment.

The bill provides that with respect to a hearing on involuntary inpatient placement, both the patient and the state are independently entitled to at least one continuance of the hearing. The patient's continuance may be for a period of up to 4 weeks and requires concurrence of the patient's counsel. The state's continuance may be for a period of up to 5 court working days and requires a showing of good cause and due diligence by the state before it can be requested. The state's failure to timely review any readily available document or failure to attempt to contact a known witness does not merit a continuance.

The bill allows for all witnesses to a hearing to appear telephonically or by other remote means, absent a showing of good cause. The bill requires any witness appearing telephonically to provide all parties with all relevant documents by the close of business the day prior to the hearing. The bill requires the court to allow testimony deemed relevant by the court under state law from individuals, including family members, regarding the person's prior history and how that history relates to the person's current condition.

The bill allows the court to appoint a magistrate to preside at the hearing on the petition or any ancillary matters, including but not limited to, writs of habeas corpus issued under the Baker Act, rather than just over the proceedings as is authorized in current law.

Additionally, the bill mandates that the court allow testimony which it deems relevant from individuals, including family members, regarding the person's history and how that history related to the current condition of the individual.

The bill also requires the facility to make available to the state attorney to access the patient, any witnesses, and any clinical records needed to prepare its case within 24 hours of the involuntary placement petition being filed. Such records must remain confidential and may not be used for criminal investigation or prosecution purposes, or any purpose other than those related to the patient's civil commitment.

If the court finds that a patient meets the criteria for involuntary inpatient placement and the court seeks to order the patient to be transferred to a treatment facility or retained in the patient's current or another treatment facility, the bill requires the facility holding the patient to discharge the patient at any time he or she no longer meets the involuntary inpatient treatment criteria unless the patient has transferred to voluntary status.

The bill prohibits the court from ordering an individual with a developmental disability as defined under s. 393.063, F.S., who lacks a co-occurring mental illness, into a state treatment facility. Such individuals must be referred to the APD or the DOEA for further evaluation and the provision of appropriate services for their individual needs. This expands current law which prohibits such orders and requires similar referrals for persons with traumatic brain injury or dementia.

In addition, if it reasonably appears that the individual would be found incapacitated under ch. 744, F.S.,[120] and the individual does not already have a legal guardian, the bill requires the receiving facility to inform the DCF and any known next of kin and initiate guardianship proceedings. The receiving facility may hold the individual until the petition to appoint a guardian is heard by the court and placement is secured.

The bill also amends s. 394.467(6)(c) and 394.467(7), F.S., changing the maximum amount of time an individual may be held under the Baker Act at a receiving facility or a state-operated treatment facility[121] from 90 days to six months. The change to s. 394.467(7), F.S., is technical in nature, as involuntary admission at a treatment facility is currently capped at six months.

Marchman Act – Defintions and Criteria

The bill amends s. 397.305, F.S., revising legislative intent related to the Marchman Act to include that patients be placed in the most appropriate and least restrictive environment conducive to long-term recovery while protecting individual rights.

The bill amends s. 397.311, F.S., relating to definitions under the Marchman Act, to make the same changes to definitions in statute to the Marchman Act as the bill makes to the Baker Act described above. Additionally, the bill defines "impaired" or "substance abuse impaired" to mean having a substance use disorder or a condition involving the use of alcoholic beverages, illicit or prescription drugs, or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems or cause socially dysfunctional behavior.

The bill amends s. 397.501, F.S., requiring that a patient with a serious substance abuse addiction be provided with information on the elements of a coordinated system of care upon release from an addiction receiving facility. The DCF is provided with rulemaking authority to determine what services may be provided to patients.

The bill amends s. 397.675, F.S., adding and clarifying criteria for involuntary admission under the Marchman Act. The criteria is amended in the following manner:

- Expanding the application of the criteria to a person who has a history of noncompliance with treatment, in addition to person who have lost the power of self-control with respect to substance use;
- Requiring that the person is refusing voluntary care after a sufficient and conscientious explanation and disclosure of the purpose for treatment, rather than be so impaired in judgment that he or she is incapable of appreciating the need for services;
- Clarifying the provision related to the lack of family or friends to care for the person to indicate that the willing family or friend must also be able and responsible;
- Providing that the substantial harm to the person must be in the near future if services are not provided and that the person will inflict serious harm to self or others, as evidenced by recent

[120] Chapter 744, F.S., governs procedures related to the appointment and judicial management of guardians and guardianships.

[121] "Treatment facility" is defined in s. 394.455(48), F.S., to mean "a state-owned, state-operated, or state-supported hospital, center, or clinic designated by the department for extended treatment and hospitalization, beyond that provided for by a receiving facility, of persons who have a mental illness, including facilities of the United States Government, and any private facility designated by the department."

acts, omissions, or behavior causing, attempting, or threatening such harm, which includes, but is not limited to, significant property damage.

The bill amends s. 397.6751, F.S., relating to service provider responsibilities regarding involuntary admissions, requiring that all patients admitted under the Marchman Act be placed in the most appropriate and least restrictive environment conducive to the patient's treatment needs.

Marchman Act – Court-Related Provisions

The bill amends s. 397.681, F.S., revising language to specify that courts have jurisdiction of involuntary treatment petitions, rather than involuntary assessment and stabilization petitions. The bill also specifies that petitions may be filed with the clerk of court in the county where the subject of the petition resides, in addition to where he or she is located as in current law. The bill allows the chief judge in Marchman Act cases to appoint a general or special magistrate to preside over all, or part, of the proceedings related to the petition or any ancillary matters, including but not limited to, writs of habeas corpus issued under the Marchman Act, rather than just over the proceedings as is authorized in current law.

The bill provides that subject to appropriation, the state attorney must represent Florida, rather than the petitioner, as the real party of interest in all Marchman Act proceedings where the respondent has not obtained private counsel. The bill prohibits the state attorney from using records obtained pursuant to Marchman Act cases for any purpose other than those relating to the respondent's civil commitment under the Act and requires the records to remain confidential.

The bill amends s. 397.693, F.S., relating to involuntary treatment, amending the criteria for when a person may be the subject of court-ordered involuntary treatment petition under the Marchman Act to if the person:

- *Reasonably appears to meet*, rather than meets, the criteria enumerated in s. 397.675, F.S.;
- Has been placed under protective custody pursuant to s. 397.677, F.S., within the previous 10 days;
- Has been subject to an emergency admission under section 397.679, F.S., within the previous 10 days; or
- Has been assessed by a qualified professional within the past 30 days, rather than the previous five days.

The bill amends s. 397.695, F.S., relating to involuntary treatment, changing instances of 'treatment' to 'treatment services' throughout the section and allowing the court to waive or prohibit service of process fees for respondents deemed indigent under s. 57.082, F.S.[122]

The bill amends 397.6951, F.S., relating to the required contents for a petition for involuntary treatment, changing instances of 'treatment' to 'treatment services' throughout the section and removing the requirement that a petition for involuntary treatment contain findings and recommendations of an assessment by a qualified professional.

[122] Section 57.082, F.S., provides processes and criteria for the determination of civil indigent status.

The bill modifies the criteria for a petition for involuntary treatment under the Marchman Act in the substantively similar manner as the bill modifies the criteria for involuntary admission under the Baker Act as discussed above. The bill also provides that a petition may be accompanied by a certificate or report of a qualified professional or licensed physician who has examined the respondent within the 30 days preceding the filing of the petition. The certificate must contain the professional's findings and if the respondent refuses to submit to an examination must document the refusal. The bill provides that in the event of an emergency requiring an expedited hearing, the petition must contain documented reasons for expediting the hearing.

The bill amends s. 397.6955, F.S., requiring the clerk of court to notify the state attorney upon the filing of a petition for involuntary treatment services under the Marchman Act if the petition does not indicate that the petitioner has retained private counsel; or, in the alternative, notify the respondent's counsel if any has been retained. The bill also amends the time period in which the court is required to schedule a hearing on the petition to within ten court working days, rather than five, unless a continuance is granted.

In the case of an emergency, or when upon review of the petition the court determines that an emergency exists, the court may rely exclusively upon the contents of the petition and, without an attorney being appointed, enter an ex parte order for the respondent's involuntary assessment and stabilization which must be executed during the period when the hearing on the petition for treatment is pending. The court may further order a law enforcement officer or other designated agent of the court to:

- Take the respondent into custody and deliver him or her to either the nearest appropriate licensed service provider or a licensed service provider designated by the court to be evaluated; and
- Serve the respondent with the notice of hearing and a copy of the petition.

In such instances, the bill requires a service provider to promptly inform the court and parties of the respondent's arrival and refrain from holding the respondent for longer than 72 hours of observation thereafter, unless:

- The service provider seeks additional time under s. 397.6957(1)(c), F.S., and the court, after a hearing, grants that motion;
- The respondent shows signs of withdrawal, or a need to be either detoxified or treated for a medical condition, which will serve to extend the amount of time the respondent may be held for observation until the issue is resolved; or
- The original or extended observation period ends on a weekend or holiday, in which case the provider may hold the respondent until the next court working day.

Under the bill, if the ex parte order was not executed by the initial hearing date, it is deemed void. If the respondent does not appear at the hearing for any reason, including lack of service, and upon reviewing the petition, testimony, and evidence presented, the court reasonably believes the respondent meets the Marchman Act commitment criteria and that a substance abuse emergency exists, the bill allows the court to issue or reissue an ex parte assessment and stabilization order that is valid for 90 days. If the respondent's location is known at the time of the hearing, the court:

- Must continue the case for no more than ten court working days; and

- May order a law enforcement officer or other designated agent of the court to:
  - Take the respondent into custody and deliver him or her to be evaluated either by the nearest appropriate licensed service provider or by a licensed service provider designated by the court; and
  - If a hearing date is set, serve the respondent with notice of the rescheduled hearing and a copy of the involuntary treatment petition if the respondent has not already been served.

The bill requires the petitioner and the service provider to promptly inform the court that the respondent has been assessed so that the court can schedule a hearing as soon as is reasonable. The bill requires the service provider to serve the respondent, before his or her discharge, with the notice of hearing and a copy of the petition. If the respondent has not been assessed within 90 days, the bill requires the court to dismiss the case.

The bill amends s. 397.6957, F.S., requiring a respondent to be present during a hearing on an involuntary treatment services petition unless the respondent has knowingly, intelligently, and voluntarily waived their right to appear, or upon proof of service, the court finds that the respondent's presence is inconsistent with their best interests or will likely be harmful to them.

The bill authorizes the court to consider testimony from family members familiar with the respondent's history and how it relates to their current condition. The bill also permits the court to utilize drug testing for respondents in Marchman Act cases. The bill allows witnesses, such as medical professionals or personnel involved in treatment of the respondent, to testify remotely via the most appropriate and convenient technological method of communication available to the court, including but not limited to teleconference, and allows any witnesses intending to remotely to attend and testify at the hearing as long as they provide the parties with all relevant documents by close of business on the day before the hearing. Current law requires the respondent to be present at such hearings unless the court finds appearance to be harmful, in which case the court must appoint a guardian advocate to appear on the respondent's behalf.

The bill prohibits a respondent from being involuntarily ordered into treatment if a clinical assessment is not performed, unless the respondent is present in court and expressly waives the assessment. Outside of emergency situations, if the respondent is not, or previously refused to be, assessed by a qualified professional and, based on the petition, testimony, and evidence presented, it appears that the respondent qualifies for involuntary treatment services, the bill requires the court to issue an involuntary assessment and stabilization order to determine the correct level of treatment for the respondent. In Marchman Act cases where an assessment was attached to the petition, the bill allows the respondent to request, or the court on its own motion to order, an independent assessment by a court-appointed physician or another physician agreed to by the court and the parties.

An assessment order issued in accordance with the bill is valid for 90 days, and if the respondent is present or there is either proof of service or the respondent's whereabouts are known, the bill provides that the involuntary treatment hearing may be continued for no more than 10 court working days. Otherwise, the petitioner and the service provider are required to promptly inform the court that the respondent has been assessed in order for the court to schedule a hearing as soon as practicable. The bill mandates that the service provider serve the respondent, before his or her discharge, with the notice of hearing and a copy of the petition. The bill requires the

assessment to occur before the new hearing date. However, if there is evidence indicating that the respondent will not voluntarily appear at the hearing, or is a danger to self or others, the bill permits the court to enter a preliminary order committing the respondent to an appropriate treatment facility for further evaluation until the new hearing date. As stated above, the bill requires the court to dismiss the case if the respondent still has not been assessed after 90 days.

Assessments conducted by a qualified professional under the bill must occur within 72 hours after the respondent arrives at a licensed service provider unless the respondent displays signs of withdrawal or a need to be either detoxified or treated for a medical condition. In such cases, the amount of time the respondent may be held for observation is extended until that issue is resolved. If the assessment is conducted by someone other than a licensed physician, the bill requires review by a licensed physician within the 72-hour period.

If the respondent is a minor, the bill requires the assessment to begin within the first 12 hours after the respondent is admitted and the service provider may request to extend the 72 hours of observation by petitioning the court in writing for additional time; however the service provider is required to provide copies of the motion to all parties in accordance with applicable confidentiality requirements. The bill permits the court to grant additional time or expedite the respondent's involuntary treatment hearing is determined to be appropriate after a hearing. The involuntary treatment hearing can only be expedited by agreement of the parties on the hearing date or if there is notice and proof of service. If the court grants the service provider's petition, the service provider is permitted to hold the respondent until its extended assessment period expires or until the expedited hearing date. In cases where the original or extended observation period ends on a weekend or holiday, the provider is only permitted to hold the respondent until the next court working day.

The bill requires the qualified professional, in accordance with applicable confidentiality requirements, to provide copies of their completed report to the court and all relevant parties and counsel. The report is required to contain a recommendation on the level, if any, of substance abuse and any co-occurring mental health treatment the respondent may need. The qualified professional's failure to include a treatment recommendation results in the petition's dismissal.

The bill grants the court the authority to order a law enforcement officer or other designated agent of the court to take the respondent into custody and transport them to or from the treating or assessing service provider and the court for their hearing.

The bill provides that the court may initiate involuntary examination proceedings at any point during the hearing if it has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, is likely to neglect or injure himself, herself, or another if not committed,, or otherwise meets the involuntary commitment provisions covered under the Baker Act. The bill requires any treatment order to include findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

The bill amends s, 397.697, F.S., relating to court determinations and the effect of a court order for involuntary services, providing that in order to qualify for involuntary outpatient treatment an individual must be accompanied by a willing, able, and responsible advocate, or a social worker or case manager of a licensed service provider, who will inform the court if the individual fails to

comply with their outpatient program. The bill also requires that if outpatient treatment is offered in lieu of inpatient treatment, it must be available in the county where the respondent resides and it may be offered for up to six months if it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment at least twice during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician certifies that the respondent can be more appropriately treated on an outpatient basis and can follow a treatment plan.

The bill requires the court to retain jurisdiction in all cases resulting in involuntary inpatient treatment so that it may monitor compliance with treatment, change treatment modalities, or initiate contempt of court proceedings as needed. The bill also permits hearings to be set with the court to address the ancillary matters for which the bill extends jurisdiction, provided the proceedings are served in accordance with court procedural rules. The bill clarifies that while subject to the court's oversight, a service provider's authority is separate and distinct from the court's continuing jurisdiction.

The bill amends s. 397.6975, F.S., related to extension of involuntary services periods, providing that a service provider may petition the court for an extension of an involuntary treatment period at any point before the expiration of the current treatment period if the individual in treatment appears to need additional care, removing the current requirement that the petition be filed at least 10 days before the expiration of the current court-ordered treatment period. The bill requires the court to immediately schedule a hearing to be held not more than 10 court working days after the filing of the petition to extend. The bill allows the court to order additional treatment if the original time period will expire before the hearing is concluded and it appears likely to the court that additional treatment will be required.

The bill deletes remaining provisions in s. 397.6975, F.S., found in current subsection (3)-(7). Section 397.6975, F.S., which currently provide for the following:

- Section 397.6975(3) provides that within 1 court working day after the filing of a petition for continued involuntary services, the court is required to appoint the office of criminal conflict and civil regional counsel to represent the respondent, unless the respondent is otherwise represented by counsel.
- Section 397.6975(4), F.S., requires hearings on petitions for continued involuntary services to be held before circuit court, and allowing the court to appoint a magistrate to preside over the hearing. This subsection requires the court to adhere to procedures for obtaining an order pursuant to section 397.697.
- Section 397.6975(5), F.S., provides that notice of a hearing must be provided to the respondent or his or her counsel, and that the respondent and the respondent's counsel may agree to a period of continued involuntary services without a court hearing.
- Section 397.6975(6), F.S., provides that the same procedure is to be repeated before the expiration of each additional period of involuntary services.
- Section 397.6975(7), F.S., requires the court to consider testimony and evidence regarding the respondent's competence in instances where the respondent has previously been found incompetent to consent to treatment.

The bill repeals the following provisions relating to court-ordered, involuntary assessments and stabilization under the Marchman Act:

- Section 397.6811, F.S., relating to involuntary assessment and stabilization;
- Section 397.6814, F.S., relating to the contents of a petition filed in a hearing on involuntary assessment and stabilization;
- Section 397.6815, F.S., relating to court procedures for hearings on involuntary assessments and stabilization;
- Section 397.6818, F.S., relating to court determinations in a hearing on involuntary assessments and stabilization;
- Section 397.6819, F.S., relating to the responsibility of licensed service providers pertaining to involuntary assessments and stabilization;
- Section 397.6821, F.S., relating to extensions of time for completion of involuntary assessments and stabilization; and
- Section 397.6822, F.S., relating to dispositions of individuals after involuntary assessments.

The bill combines these processes into a consolidated involuntary treatment process under sections 397.6951-397.6975, F.S. Currently, if a person is assessed and stabilized through a non-court-ordered admission, a petition for involuntary services would be filed and the court would schedule a hearing within five days. Under the bill, a petition for involuntary treatment would be filed and the court would have to hold a hearing within ten court working days.

Baker Act – Cross-References and Technical Changes

The bill amends ss. 394.495 and 394.496, F.S., explicitly updating professionals involved in the Baker Act from a list of cross referenced statutes to a list of professional titles, including:

- Clinical psychologist;
- Clinical social worker, physician;
- Psychiatric nurse;
- Psychiatrist; or
- Person working under the direct supervision of one of these health care professionals.

The bill amends s. 394.499, F.S., relating to integrated children's CSU or juvenile addiction receiving facility services, revising "guardian" to "parent or legal" guardian, to state: a person under 18 years of age for whom voluntary application is made by his or her parent or legal guardian. Also, the bill adds a statutory reference to the voluntary admissions section presently in statute (s. 394.4625, F.S.). These are technical changes made to conform with the modifications to section 394.4625, F.S., in section 8 in the bill.

The bill amends s. 394.9085, F.S., relating to behavioral provider liability, adding cross references to ss. 397.311(26)(a)4. and 394.455, F.S., and eliminating cross references to ss. 397.311(26)(a)3. and 394.455(40), F.S.

The bill amends ss. 394.4598 and 394.4599, F.S., relating to guardian advocates and involuntary admission, respectively, to conform cross-references to changes made by the act.

Marchman Act - Cross-References and Technical Changes

The bill makes the following technical changes related to current Marchman Act provisions:

- Amends s. 397.416, F.S., conforming a cross-reference to changes made in the act.
- Amends s. 397.6971, related to early release from involuntary services, to change all instances of the word 'services' to 'treatment services.'
- Amends s. 397.6977, F.S., relating to disposition of individual completion of involuntary treatment services, to change all instances of the word 'services' to 'treatment services.'
- Repeals s. 397.6978, F.S., relating to guardian advocates; patients incompetent to consent; and substance abuse disorder.
- Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment in Medicaid programs, to change a cross reference.
- Amends s. 464.012, F.S., relating to the scope of practice for advanced registered nurse practitioners to correct a cross reference.
- Amends s. 744.2007, F.S., relating to powers and duties of guardians, to correct a cross-reference.
- Amends s. 790.065, relating to the sale and delivery of firearms, to eliminate cross references.

The bill provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The DCF anticipates that the bill may impact private service providers required to complete transfer evaluations, as they will be required to testify at related court hearings.[123] The DCF also anticipates an indeterminate impact to private providers who will need to obtain clinical records to prepare a treatment plan or determine if a provider has the capacity to treat a particular individual.[124]

C. Government Sector Impact:

The DCF anticipates that there will be an indeterminate fiscal impact on the agency associated with rulemaking and training.[125] The DCF also predicts and indeterminate impact resulting from the bill's requirement that the agency notify facilities of any individual who has been examined or committed three or more times in a 12-month period.[126]

The Office of the State Courts Administrator (OSCA) states that trial court judicial workloads may be impacted by the bill, however any specific impact is indeterminate at this time and will be reflected in the Supreme Court's annual opinion regarding certification of the need for additional judges.[127]

VI. Related Issues:

None.

VII. Statutes Affected:

This bill substantially amends sections 394.455, 394.459, 394.4598, 394.4599, 394.461, 394.4615, 394.462, 394.4625, 394.463, 394.4655, 394.467, 394.495, 394.496, 394.499, 394.9085, 397.305, 397.311, 397.416, 397.501, 397.675, 397.6751, 397.681, 397.693, 397.695, 397.6951, 397.6955, 397.6957, 397.697, 397.6971, 397.6975, 397.6977, 409.972, 464.012, 744.2007, and 790.065 of the Florida Statutes.

This bill repeals sections 397.6811, 397.6814, 397.6815, 397.6818, 397.6819, 397.6821 and 397.6822, and 397.6978 of the Florida Statutes.

[123] The DCF, Agency Analysis of SB 828 (2021), p. 13. (February 1, 2021)(on file with the Senate Committee on Children, Families, and Elder Affairs).
[124] *Id*.
[125] *Id*. at p. 12.
[126] *Id*.
[127] The OSCA, *Senate Bill 828 Judicial Impact Statement*, p. 6 (February 12, 2021)(on file with the Senate Committee on Children, Families, and Elder Affairs).

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on February 16, 2021:

The CS:

- Amends s. 394.467(7), F.S., removing a 90-day cap in this section (implemented in 2016) as it is irrelevant on this provision given that long-term treatment has always been for up to six months; and
- Ensures consistency to other changes made by the act which remove the 90-day cap on the amount of time an individual can be held at a receiving facility.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.