## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 1269 Child Protection
**SPONSOR(S):** Health Quality Subcommittee; Harrell
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1454

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Quality Subcommittee | 11 Y, 0 N, As CS | Tuszynski | McElroy |
| 2) Health & Human Services Committee | 17 Y, 0 N | Tuszynski | Calamas |

## SUMMARY ANALYSIS

A child protection team (CPT) is a medically directed, multidisciplinary team that supplements the child protective investigation efforts of the Department of Children and Families (DCF) and local sheriffs' offices in cases of child abuse and neglect. CPTs provide expertise in evaluating alleged child abuse and neglect, assess risk and protective factors, and provide recommendations for interventions. The Statewide Medical Director for Child Protection supervises and evaluates all child protection team medical directors for each of the 15 CPTs statewide.

"Forensic interviewing" is a method to elicit accurate information from children regarding abuse and neglect during an investigation. Although national training programs in child forensic interviewing are generally based on the same body of research and practice, practice is not standardized due to the blending of different models at the local level, jurisdictional expectations, state statutes, and case law.

Sections 458.3175 and 459.0066, F.S., require an expert witness who is licensed in another jurisdiction to obtain an "expert witness certificate" from the Department of Health (DOH) before providing expert testimony in medical negligence and criminal child abuse and neglect cases.

CS/HB 1269 amends s. 39.303, F.S., to require the Surgeon General and Deputy Secretary for Children's Medical Services to consult with the Statewide Medical Director for Child Protection on decisions regarding screening, employment, and termination of CPT medical directors at headquarters and within the 15 districts statewide. The bill expands the required board certifications for CPT medical directors to include pediatrics or family medicine and changes the timeframe in which a CPT medical director with board-certification must obtain certification from 4 years to 2 years. The bill also changes "districts" to "circuits" and "district medical directors" to "child protection team medical directors" throughout the section.

The bill requires DOH to develop, maintain, and coordinate one or more sexual abuse treatment programs, details requirements for the programs, and retitles s. 39.303, F.S., to include sexual abuse treatment programs.

The bill requires DOH to convene a task force to develop a standardized protocol for forensic interviewing for children suspected of having been abused and provide staff to support the task force, as needed. The task force must include various representatives from the disciplines of law enforcement, child welfare, and mental health treatment. The bill does not require implementation of the standardized protocol but does require DOH to provide the protocol to the legislature by January 1, 2018.

The bill expands the cases in which an expert witness certificate may be used, to include cases involving abandonment, dependency, and sexual abuse.

The bill has an insignificant positive fiscal impact on DOH, and does not have a fiscal impact on local government.

The bill provides an effective date of July 1, 2017.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

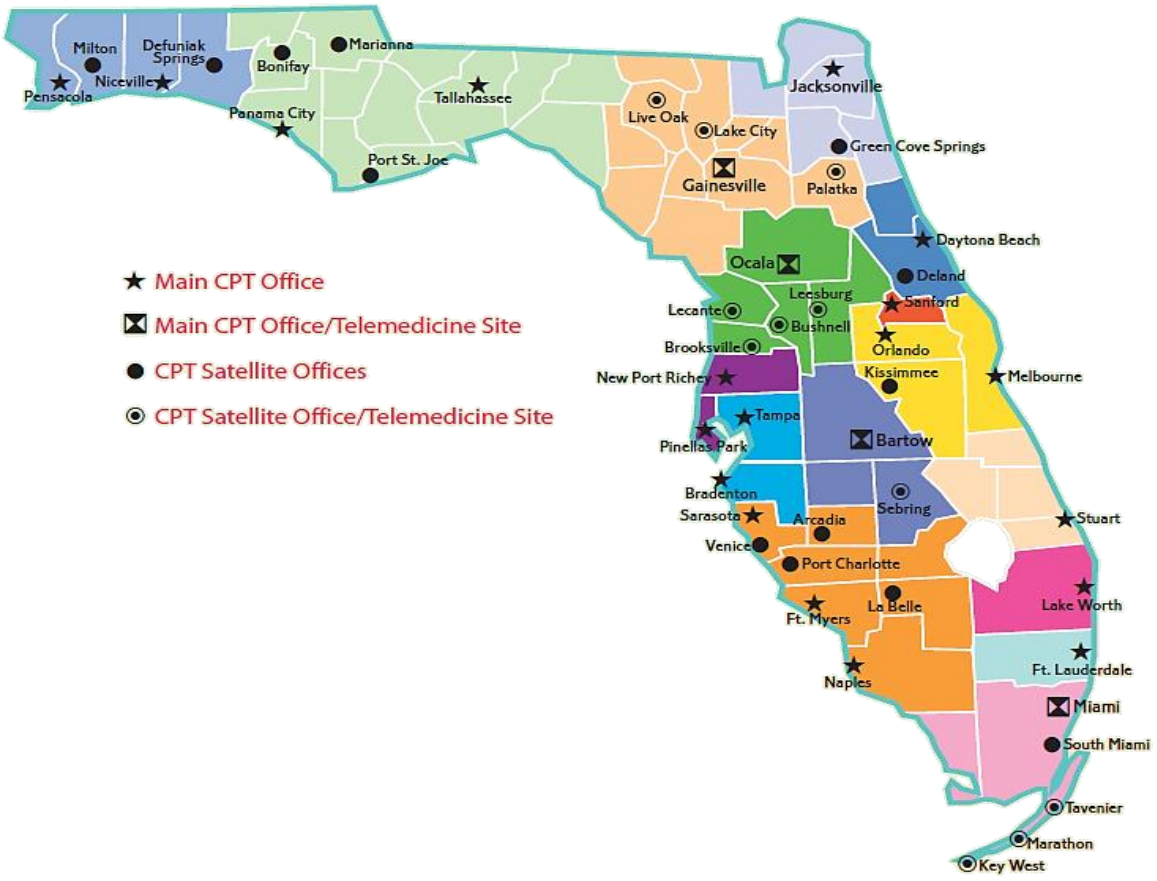
A. EFFECT OF PROPOSED CHANGES:

**Background**

Child Protection Teams

A child protection team (CPT) is a medically directed, multidisciplinary team that supplements the child protective investigation efforts of the Department of Children and Families (DCF) and local sheriffs' offices in cases of child abuse and neglect.[1] CPTs are independent community-based programs that provide expertise in evaluating alleged child abuse and neglect, assess risk and protective factors, and provide recommendations for interventions to protect children and enhance a caregiver's capacity to provide a safer environment when possible.[2] The Department of Health (DOH) Children's Medical Services (CMS) program contracts for CPT services with local community-based programs.[3]

CPTs across the state are divided into 15 districts and provide services to all 67counties by utilizing satellite offices and telemedicine sites.[4] Each of the 15 districts served by CPTs are supervised by one or multiple child protection team medical directors, depending on the size and subdivision of the particular district.[5]




[1] Florida Department of Health, Children's Medical Services. *Child Protection Teams* http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/child_protection_teams.html (last visited March 10, 2015).
[2] Id.
[3] Section 39.303, F.S.
[4] Children's Medical Services, *Child Protection Teams: CPT Statewide Directory*, available at http://www.floridahealth.gov/alternatesites/cms-kids/home/contact/cpt.pdf (last accessed March 12, 2015).
[5] Id.

The State Surgeon General and the DOH Deputy Secretary for Children's Medical Services, in consultation with the DCF Secretary, screen, employ, and terminate the Statewide Medical Director for Child Protection as well as the district-level child protection team medical directors.[6] The Statewide Medical Director for Child Protection must be a board-certified pediatrician licensed under ch. 458 or ch. 459, F.S., with a subspecialty certification in child abuse from the American Board of Pediatrics.[7] A district child protection team medical director must be board-certified pediatrician licensed under ch. 458 or ch. 459, F.S., and within 4 years after the date of his or her employment obtain a subspecialty certification in child abuse from the American Board of Pediatrics or meet the minimum credentialing requirements established by a third-party credentialing entity recognizing specialized competence in child abuse pediatrics.[8]

Certain reports of child abuse, abandonment, and neglect to the DCF central abuse hotline must be referred to child protection teams:

- Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age.
- Bruises anywhere on a child five years of age or younger.
- Any report alleging sexual abuse of a child.
- Any sexually transmitted disease in a prepubescent child.
- Reported malnutrition or failure of a child to thrive.
- Reported medical neglect of a child.
- A sibling or other child remaining in a home where one or more children have been pronounced dead on arrival or have been injured and later died as a result of suspected abuse, abandonment or neglect.
- Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.[9]

When a CPT accepts a referral from DCF or law enforcement, it may provide one or more of the following services:

- Medical diagnosis and evaluation;
- Child forensic interviews;
- Child and family assessments;
- Multidisciplinary staffings;
- Psychological and psychiatric evaluations;
- Community awareness campaigns; and
- Expert court testimony. [10]

CPT staff also provide training services for child protection investigators, community providers of child welfare services, and emergency room staff and other medical providers in the community.[11]

*Forensic Interviewing of Child Victims of Abuse, Abandonment, and Neglect*

One of the most significant developments in child abuse and neglect intervention has centered on how to elicit accurate information from children, a process commonly referred to as "forensic interviewing."[12] Forensic interviewing began after several high-profile cases in the 1980s involving allegations of

[6] Supra, FN 3.
[7] S. 39.303(2)(a), F.S.
[8] S. 39.303(2)(b), F.S.
[9] S. 39.303(4), F.S.
[10] S. 39.303(3), F.S.
[11] S. 39.303(3)(h), F.S.
[12] Saywitz, K.J., Lyon, T.D., and Goodman, G.S., Interviewing children, *The APSAC Handbook on Child Maltreatment*, 3d ed., 2011, pg. 337–360.

daycare providers sexually abusing multiple children in their care became the subject of analysis based on the interview techniques that were used.[13] Law enforcement had relied on mental health practitioners because of their ability to establish and build rapport with children. However, these mental health practitioners used therapeutic techniques that were later deemed inappropriate for forensic purposes due to concerns of suggestibility and the encouragement of make-believe and pretend.[14]

Most child abuse investigations begin with a child forensic interview.[15] Most jurisdictions follow an established forensic interview model or protocol to guide the interviewer through various stages of a legally sound interview; these models vary in structure from highly scripted to semi-structured to flexible.[16] While there are various levels of structure, all models incorporate three general phases.

1. The **rapport-building phase** typically involves introductions with age-appropriate explanation of documentation methods, a review of the interview instructions, a discussion on the importance of telling the truth, and practice providing narrative answers and episodic memory training.
2. The **substantive phase** involves a narrative description of the events, detail-seeking strategies, clarification, and alternate hypothesis testing, when appropriate.
3. The **closure phase** that involves attention to the child's socioemotional needs, transition to nonsubstantive topics, allowing for questions, and discussion of safety or educational messages.[17]

People from multiple disciplines attend, or later review, the interview: child protective investigators; police officers and other law enforcement officials; child protection attorneys; victim advocates; and medical and mental health care practitioners. The interview provides facts and direction for those involved with the investigation and provision of services.[18]

Following two decades of research and practice, professionals have gained significant insight into how to maximize children's potential to accurately convey information about their past experiences. The multidisciplinary approach to child forensic interviews has proven to reduce fragmented and duplicative child abuse investigations, be more child-friendly, and better meet the needs of children and their families.[19] Yet, as this effort continues and practice evolves, professionals face new challenges in forensic interviewing.[20] Although national training programs in child forensic interviewing are generally based on the same body of research and practice, the field has yet to determine one standardized practice.[21] Differences in child forensic interviewing exist due to the blending of different models at the local level, jurisdictional expectations, state statute, and case law.[22] These local variations demonstrate the difficulty in creating one standard approach.

*Sexual Abuse Treatment Programs*

In 1998, the Legislature transferred CPT and sexual abuse treatment programs (SATP) from DCF to DOH and provided rulemaking authority for DOH to implement the SATPs.[23] These SATPs were meant to supplement the CPT in cases of sexual abuse by providing specialized treatment for victims of

[13] U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Bulletin, *Child Forensic Interviewing: Best Practices*, September 2015, pg. 3, available at: https://www.ojjdp.gov/pubs/248749.pdf (last accessed March 17, 2017).
[14] Id.
[15] Id.
[16] Id.
[17] Id, at pg. 7.
[18] Id.
[19] Bonarch, K., Mabry, J.B., and Potts-Henry, C., 2010, *Exploring nonoffending caregiver satisfaction with a children's advocacy center*s, Journal of Child Sexual Abuse 19(6):687–708.
[20] Supra, FN 13 at pg. 1.
[21] Supra, FN 13 at pg. 2.
[22] Supra, FN 13 at pg. 3.
[23] Ch. 1998-137, Laws of Fla.

sexual abuse. The statute also required the creation of a model plan for community intervention for sexual abuse victims.[24]

In 2011, the Legislature repealed the statute requiring the creation of a model plan for community intervention for sexual abuse as obsolete and concurrently deleted rulemaking authority for SATPs.[25] This removal of the requirement to create a model sexual abuse program did not remove the requirement for CMS to establish protocols for oversight and operations of SATPs in s. 39.303(1), F.S. CMS still operates SATPs throughout the state to supplement CPTs, but has no rulemaking authority to establish guidelines to ensure clinical quality or standardize processes statewide.

Expert Testimony in Child Abuse Cases and Expert Witness Certificates

Sections 458.3175 and 459.0066, F.S., require an expert witness who is licensed in another jurisdiction to obtain an "expert witness certificate" from DOH before providing expert testimony in medical negligence and criminal child abuse and neglect cases. The certificate has an application fee of $50, is valid for 2 years, and only authorizes the physician to do the following:

- Provide a verified written medical expert opinion;
- Provide expert testimony about the prevailing professional standard of care in connection with medical negligence litigation pending in this state against a physician licensed in Florida; and
- Provide expert testimony in criminal child abuse and neglect cases.[26]

Section 827.03(3), F.S., allows expert testimony in child abuse and neglect cases by physicians licensed under chapter 458, F.S., or 459, F.S., or by physicians who have obtained an expert witness certification. To provide expert testimony of mental injury in child abuse and neglect cases, physicians must be licensed under chapter 458, F.S., or 459, F.S., and have completed an accredited residency in psychiatry, or obtained an expert witness certification.

While s. 827.03, F.S., allows experts to testify in criminal child abuse and neglect cases if they have an expert witness certificate, ss. 458.3175(2) and 459.0066(2), F.S., only authorize a very narrow enumerated use of this certificate and does not currently allow physicians or osteopathic physicians to give expert testimony in dependency cases, which are non-criminal proceedings for children who have been abused, abandoned or neglected. The purpose of the dependency court is to protect children from further incidences of abuse while providing services to rehabilitate the family and increase the child protective capacity of parents.

**Effect of the Proposed Changes**

Child Protection Teams

CS/HB 1269 amends s. 39.303, F.S., to require the Surgeon General and Deputy Secretary for Children's Medical Services to consult with the Statewide Medical Director for Child Protection on decisions regarding screening, employment, and termination of child protection team medical directors within the 15 districts statewide.

The Statewide Medical Director for Child Protection is an employee of DOH and has the responsibility to supervise and evaluate all child protection team medical directors in the districts, including corrective actions and recommendations for termination, if appropriate.[27] This bill would expand the responsibilities of the Statewide Medical Director for Child Protection to also make recommendations on the screening and employment of child protection team medical directors.

[24] Id.
[25] Ch. 2011-213, Laws of Fla.
[26] S. 758.3175(2), F.S.
[27] Department of Health, Agency Analysis of 2017 House Bill 1269, p. 2 (March 20, 2017).

The bill also expands the required board certifications for child protection team medical directors to include pediatrics or family medicine. The bill will also shorten the time period in which newly hired child protection team medical directors have to obtain a subspecialty certification in child abuse from the American Board of Pediatrics or meet the minimum credentialing requirements established by a third-party credentialing entity recognizing specialized competence in child abuse pediatrics from 4 years to 2 years. These changes will allow DOH to consider more than just board-certified pediatricians when hiring for these positions while also maintaining protections for children by requiring specialized training in child abuse for those physicians in a shorter timeframe.

The bill also changes "districts" to "circuits" and "district medical directors" to "child protection team medical directors" throughout the section. This aligns language with Florida's 15 judicial circuits and provides for consistent titles within the section.

*Forensic Interviewing of Child Victims of Abuse, Abandonment, and Neglect*

The bill requires CMS to convene a task force to develop a standardized protocol for forensic interviewing for children suspected of having been abused. DOH is required to provide staff to support the task force, as needed. The task force must include the Statewide Medical Director for Child protection, the executive director of the Guardian ad Litem program, and representatives from the Florida Prosecuting Attorneys Association, the Florida Psychological Association, the Florida Public Defender Association, Children's Medical Services, a community-based care lead agency, the Florida Sheriffs Association, the Florida Chapter of the American Academy of Pediatrics, the Florida Network of Children's Advocacy Centers, and others designated by Children's Medical Services.

The bill requires the task force to provide the standardized protocol for forensic interviewing to the President of the Senate and the Speaker of the House by January 1, 2018. The bill does not require implementation of the protocol.

*Sexual Abuse Treatment Programs*

The bill retitles s. 39.303, F.S., from "Child protection teams" to "Child protection teams and sexual abuse treatment programs." The bill requires CMS to develop, maintain, and coordinate one or more sexual abuse treatment programs for children under the age of 18 who are alleged to be victims of sexual abuse, his or her siblings, non-offending caregivers, and family members impacted by the alleged sexual abuse. The programs are required to provide specialized treatment to assist in the recovery from sexual abuse, prevent developmental impairment, restore pre-abuse levels of developmental functioning, and promote healthy relationships. The bill also provides rulemaking authority for CMS to implement these programs. This change codifies current practice by authorizing CMS to provide the sexual abuse treatment programs they have already developed, as well as adopt rules that establish guidelines to ensure clinical quality and standardized processes statewide.

<u>Expert Testimony in Child Abuse Cases and Expert Witness Certificates</u>

The bill expands the cases in which an expert witness certificate may be used. Sections 458.3175, 459.0066, and 827.03, F.S., are amended to include cases involving dependency, and sexual abuse of a child. This change allows physicians from other jurisdictions who hold an expert witness certification to provide expert testimony in criminal child abuse and neglect cases to also provide expert testimony in dependency court and cases involving sexual abuse of a child.

The bill provides for an effective date of July 1, 2017.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 39.303, F.S., relating to child protection teams; services; eligible cases.
**Section 2:** Amends s. 458.3175, F.S., relating to expert witness certificate.
**Section 3:** Amends s. 459.0066, F.S., relating to expert witness certificate.

**Section 4:** Amends s. 827.03, F.S., relating to expert testimony.
**Section 5:** Provides for an effective date of July 1, 2017.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill has an insignificant positive fiscal impact on DOH. The number of increased witness certification applications and the amount of additional fees collected is unknown. This number is not expected to be significant.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect local or county government.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority for DOH to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 21, 2017, the Health Quality Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Changed “districts” to “circuits” throughout the section to align with judicial circuits;
- Changed “district medical directors” to “child protection team medical directors”;
- Expanded required board certifications allowed for child protection team medical directors to include pediatrics or family medicine;
- Changed the timeframe in which a child protection team medical director with board-certification must obtain certification from 4 years to 2 years;
- Required consultation with the Statewide Medical Director for Child Protection to screen, employ and terminate CPT medical directors;
- Reinserted a provision, inadvertently deleted by the bill, requiring quality assurance collaboration between CMS and DCF on referrals; and
- Required CMS to develop, maintain, and coordinate one or more sexual abuse treatment programs and details requirements for the program and retitles s. 39.303, F.S., to include sexual abuse treatment programs.

The analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.