Children, Families & Seniors Subcommittee

Wednesday, March 11, 2015
10:00 AM – 12:00 PM
12 HOB

Steve Crisafulli
Speaker

Gayle B. Harrell
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Children, Families & Seniors Subcommittee

Start Date and Time:	Wednesday, March 11, 2015 10:00 am
End Date and Time:	Wednesday, March 11, 2015 12:00 pm
Location:	12 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 177 Persons with Developmental Disabilities by Hill
HB 291 Involuntary Examinations of Minors by Harrell

Presentations on quality out of home care for children in the child welfare system

NOTICE FINALIZED on 03/09/2015 15:27 by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 177 Persons with Developmental Disabilities
SPONSOR(S): Hill
TIED BILLS: **IDEN./SIM. BILLS:** SB 380

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee		Tuszynski	Brazzell
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Medicaid Home and Community-Based Services (HCBS) waiver operated by the Agency for Persons with Disabilities provides supports and services that allow individuals with developmental disabilities to live in the community rather than in an institution. Currently, due to demand exceeding available funding, individuals with developmental disabilities who wish to receive HCBS waiver services are placed on a wait list for services in priority of need, unless they are in a crisis. As of March 5, 2015, 20,911 individuals were on the waiting list for developmental disability waiver services.

The bill amends s. 393.065, F.S., to require the Agency for Persons with Disabilities to allow applicants to receive home and community-based services without waiting if the individual meets eligibility requirements for services, the applicant's parent or legal guardian is a military service member on active duty, and either:

- At the time of the service member's transfer to this state, the applicant was receiving home and community-based care services in another state; or
- The applicant's parent or legal guardian is a member of the Florida National Guard or a member of the United States Reserve Forces and is based in this state.

The number of individuals who would qualify for services under these provisions is unknown.

The bill appears to have a significant negative fiscal impact on state government. See fiscal comments.

The bill provides for an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

The Agency for Persons with Disabilities (APD) is responsible for providing services to persons with developmental disabilities. A developmental disability is defined as a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, 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.[1]

APD manages the Medicaid Home and Community-Based Services (HCBS) Waiver, which provides services and supports to eligible persons with developmental disabilities. The waiver offers 28 supports and services to assist individuals to live in their community. Some of the most common services provided include residential habilitation, behavioral services, companion, consumable medical supplies, day training, supported employment and support coordination. Services provided through the HCBS waiver enable children and adults to live in the community in their own home, a family home, or in a licensed residential setting, thereby avoiding institutionalization.

Individuals three years of age and older are eligible for services under the HCBS waiver program if they have a Florida domicile and a qualifying developmental disability. Children between the ages of three and five who are at high risk of having a developmental disability are also eligible for services.

Florida's waiver program for individuals with developmental disabilities is known as "iBudget Florida". As of March 5, 2015, 30,991[2] individuals were enrolled on the waiver. The majority of waiver enrollees live in a family home with a parent, relative or guardian.

The Legislature appropriated $941,032,259 for Fiscal Year 2014-2015[3] to provide services through the HCBS waiver program, including federal match of $560,478,813.[4] However, this funding is insufficient to serve all persons desiring waiver services. To enable the agency to remain within legislative appropriations, waiver enrollment is limited. Accordingly, APD maintains a wait list for waiver services. Prioritization for the waiting list is provided in statute,[5] and also in the FY 14-15 Implementing Bill.[6]

Clients who are determined to be eligible for the waiver program are either given a slot in the program or placed on a wait list. As part of the wait list prioritization process, clients are assigned to a category as prescribed by section 393.065(5), F.S., and further refined in Section 9 of Chapter 2014-53, Laws of Florida. There are seven categories listed below in decreasing order of priority.

- Category 1 – Clients deemed to be in crisis.
- Category 2 – Children from the child welfare system at the time of:
  - Finalization of an adoption with placement in a family home;
  - Reunification with family members with placement in a family home; or
  - Permanent placement with a relative in a family home.
- Category 3 – Includes, but not limited to, clients:

[1] S. 393.063(9), F.S.
[2] E-mail from Robert Brown, Legislative Affairs Director, Agency for Persons with Disabilities. On file with Children, Families and Seniors Subcommittee. (March 5, 2015)
[3] Chapter 2014-51, Laws of Fla. (line 268)
[4] Id.
[5] S. 393.065, F.S
[6] Section 9, Chapter 2014-53, Laws of Florida

- Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;
- Who are at substantial risk of incarceration or court commitment without supports;
- Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or
- Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available.

- Category 4 – Includes, but not limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available;
- Category 5 – Includes, but not limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain or maintain competitive employment, or to pursue an accredited program of postsecondary education to which they have been accepted.
- Category 6 – Clients 21 years of age or older who do not meet the criteria for categories 1-5.
- Category 7 – Clients younger than 21 years of age who do not meet the criteria for categories 1-4.

As of March 5, 2015, there were 20,911[7] people on the waiting list for HCBS waiver program services. A majority of people on the wait list have been on the list for 5+ years.

APD HCBS Length of Wait [8]		
Length of Wait	#	%
1 year or less	1,771	8.5
1+ to 2 years	1,249	6.0
2+ to 3 years	1,493	7.2
3+ to 4 years	1,449	7.0
4+ to 5 years	1,695	8.2
5+ to 6 years	1,771	8.5
6+ to 7 years	1,695	8.2
7+ to 8 years	1,826	8.8
8+ to 9 years	1,915	9.2
9+ to 10 years	1,487	7.2
10+ years	4,413	21.3

For several years, while the agency experienced significant deficits, APD was limited to newly enrolling on the waiver only individuals determined to be in crisis. Only since FY 2013-14, when the agency has remained within budget, has the Legislature provided funding to APD to serve individuals from the waiting list who were not in crisis but had a high priority for service needs. Since July 1, 2013, APD has offered enrollment to 2,870 such individuals, and estimates that all individuals with critical needs have been offered enrollment as of July 1, 2014.

Military Family Relocations

Florida is home to 20 major military bases and three of the nation's seven unified combatant commands.[9,10]

---

[7] Supra. at FN 2.
[8] Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridian with Developmental Disabilities and Their Costs*: Second Quarter Fiscal Year 2014-15, February 2015
[9] Florida Defense Alliance, http://www.enterpriseflorida.com/wp-content/uploads/Military_Install_Map.pdf (last visited March 4, 2015).

Active-duty military service members with children or dependents with developmental disabilities who receive military orders to move may need to reestablish care for their family member with a disability in their new location. Since waivers are operated by states, service members generally must start the enrollment process over again in the new state of residence even if their child or dependent was receiving waiver services in another state.[11] Depending on the nature of the individual's need, the wait for waiver services in Florida can be significant, lasting years.

The Legislature passed HB 5003 in 2014 to allow an individual who meets eligibility requirements to receive home and community based services in this state if the individual's parent or legal guardian is an active-duty military service member and, at the time of the service member's transfer to Florida, the individual was receiving home and community-based services in another state. Since the provision was part of the appropriations implementing bill, this statutory change is in place for one year and expires July 1, 2015. As of March 5, 2015, APD has processed six requests for enrollment from military families under this temporary statutory provision. Out of the six requests for enrollment, four military families have enrolled and two families are in the process of enrollment.[12]

According to the Military One Source 2013 Demographic Report, Florida has the seventh largest population of active duty service men and women at 60,234 and the third largest population of reserve forces at 36,745, which includes the approximately 12,000 members of the Florida National Guard [13,14]

Effect of Proposed Changes

The bill amends s. 393.065, F.S., to require the Agency for Persons with Disabilities to allow an applicant who meets eligibility requirements to receive home and community-based services in this state if the applicant's parent or legal guardian is a military service member on active duty, and either:

- At the time of the service member's transfer to this state, the applicant was receiving home and community-based care services in another state; or
- The applicant's parent or legal guardian is a member of the Florida National Guard or a member of the United Sates Reserve Forces and is based in this state.

The bill creates a stand-alone provision within the statute, excepting these individuals from the wait list prioritization process.

This bill provides an effective date of July 1, 2015.

B. SECTION DIRECTORY:

Section 1: Amends s. 393.065, F.S., relating to application and eligibility determination.
Section 2: Provides an effective date of July 1, 2015.

[10] Florida Defense Alliance, http://www.enterpriseflorida.com/floridadefense/ (last visited March 5, 2015).
[11] USA4Military Families, *Issue 6: Allow service members to retain their earned priority for receiving Medicaid home and community care waivers*, http://www.usa4militaryfamilies.dod.mil/MOS/f?p=USA4:ISSUE:0::::P2_ISSUE,P2_STATE:6,FL# (last visited March 5, 2015).
[12] E-mail from Robert Brown, Legislative Affairs Director, Agency for Persons with Disabilities. On file with Children, Families and Seniors Subcommittee. (March 5, 2015)
[13] Military One Source, *2013 Demographic Report*, http://www.militaryonesource.mil/12038/MOS/Reports/2013-Demographics-Report.pdf (last visited March 4, 2015).
[14] Department of Military Affairs, http://dma.myflorida.com/about-us/ (last visited March 4, 2015).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   There is an unknown but potentially significant negative impact on state government. See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The number of military dependents given priority under this bill who would request waiver services and the funding required to serve them under this bill is unknown.

APD estimates that the service members addressed by this bill would have 534 dependents with developmental disabilities (using a 2 percent prevalence rate from the National Institutes of Health for persons with developmental disabilities requiring long term care), and that the average cost allocation per individual would be $13,688. However, APD acknowledges that the estimate of dependents is likely high because APD's eligibility criteria are narrower than the criteria for determining the prevalence rate. Additionally, it is unknown if all persons eligible will request enrollment, or if all those eligible would request enrollment in the first year available, or wait to enroll in subsequent years.

If all 534 of those dependents request enrollment on the waiver, APD estimates that the total fiscal impact would be $7,309,625. The fiscal impacts based on alternative scenarios are as follows:

Number of Eligible Dependents Requesting Enrollment	Percentage of Eligible Dependents Requesting Enrollment	Total Fiscal Impact
534	100 percent	$7,309,625
401	75 percent	$5,482,219
267	50 percent	$3,654,813
134	25 percent	$1,827,407

The increase in cost for subsequent years would be also be affected by the number of military families that moved into and out of the state based on transfer orders and those who join the reserves or National Guard annually.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to persons with developmental disabilities; amending s. 393.065, F.S.; allowing an individual whose parent or guardian is a member of the United States Armed Forces, Florida National Guard, or United States Reserve Forces to receive Medicaid home and community-based waiver services under certain conditions; providing an effective date.

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

Section 1. Subsection (7) of section 393.065, Florida Statutes, is renumbered as subsection (8), and a new subsection (7) is added to that section to read:

393.065 Application and eligibility determination.—

(7) The agency shall allow an applicant who meets the eligibility requirements of subsection (1) to receive home and community-based services in this state if:

(a) The applicant's parent or legal guardian is an active-duty military servicemember and, at the time of the servicemember's transfer to this state, the applicant was receiving home and community-based services in another state; or

(b) The applicant's parent or legal guardian is a member of the Florida National Guard or is a member of the United States Reserve Forces and based in this state.

Section 2. This act shall take effect July 1, 2015.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Children, Families & Seniors Subcommittee

Representative Hill offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (5) of section 393.065, Florida Statutes, is amended to read:

393.065 Application and eligibility determination.—

(5) Except as otherwise directed by law, beginning July 1, 2010, the agency shall assign and provide priority to clients waiting for waiver services in the following order:

(a) Category 1, which includes clients deemed to be in crisis as described in rule.

(b) Category 2, which includes children on the wait list who are from the child welfare system with an open case in the

Department of Children and Families' statewide automated child welfare information system.

(c) Category 3, which includes clients whose parent or legal guardian is:

1. An active-duty servicemember and, at the time of the servicemember's transfer to this state, the applicant was receiving home and community-based services in another state; or

2. A member of the the Florida National Guard and resides in this state.

(de) Category 43, which includes, but is not required to be limited to, clients:

1. Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;

2. At substantial risk of incarceration or court commitment without supports;

3. Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or

4. Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available.

(ed) Category 54, which includes, but is not required to be limited to, clients whose caregivers are 70 years of age or

older and for whom a caregiver is required but no alternate caregiver is available.

(fe) Category 65, which includes, but is not required to be limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain or maintain competitive employment, or to pursue an accredited program of postsecondary education to which they have been accepted.

(gf) Category 76, which includes clients 21 years of age or older who do not meet the criteria for category 1, category 2, category 3, category 4, or category 5.

(hg) Category 87, which includes clients younger than 21 years of age who do not meet the criteria for category 1, category 2, category 3, or category 4.

Within categories 3, 4, 5, 6, ~~and~~ 7, and 8 the agency shall maintain a wait list of clients placed in the order of the date that the client is determined eligible for waiver services.

Section 2. Subsection (9) of section 393.063, Florida Statutes, is amended to read:

393.063 Definitions.—For the purposes of this chapter, the term:

(9) "Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, Down syndrome, spina bifida, 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.

Section 3. This act shall take effect July 1, 2015

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

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to persons with developmental disabilities; amending s. 393.065, F.S.; adding certain individuals whose parent or guardian is a member of the United States Armed Forces or the Florida National Guard and who resides in the state to the wait list priority categories; amending s. 393.063, F.S.; revising the definition of the term "developmental disability" to include Down Syndrome; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 291 Involuntary Examinations of Minors
SPONSOR(S): Harrell
TIED BILLS: **IDEN./SIM. BILLS:** SB 954

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) K-12 Subcommittee	11 Y, 0 N	Flynn	Fudge
2) Children, Families & Seniors Subcommittee		McElroy	Brazzell
3) Education Committee			

SUMMARY ANALYSIS

The bill requires each county school health services plan to provide for immediate notification to a student's parent or guardian if the student is removed from school, school transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination. Each district school board and charter school governing board must develop a policy and procedures for such notification.

The bill amends the definition of "emergency health needs" for purposes of school health services programs to expressly include onsite evaluation for illness or injury and release to a law enforcement officer.

The bill requires a public school's principal, or his or her designee, to notify a student's parent or guardian if the student is removed from the school, school transportation, or a school-sponsored activity for an involuntary examination. The bill also provides notification requirements for receiving facilities that hold minor patients for involuntary examination.

The bill allows the school principal, or his or her designee, and the receiving facility each to delay notification by up to 24 hours if there is suspected abuse, abandonment, or neglect and delay has been deemed to be in the student's or minor patient's best interest. Delay in notification may occur only after a report of suspected abuse, abandonment, or neglect is submitted to the Department of Children and Families' central abuse hotline.

The bill does not appear to have a fiscal impact on the state or local governments.

The bill has an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Involuntary Examinations under Florida's Baker Act

The Florida Mental Health Act, otherwise known as the Baker Act,[1] provides legal procedures for mental health examination and treatment,[2] including, among other things, involuntary examinations.[3] The Baker Act protects the rights of all individuals examined or treated for mental illness in Florida.[4]

Involuntary examinations under the Baker Act are psychiatric examinations conducted without the examinee's consent.[5] Involuntary examinations under the Baker Act may only be initiated by a law enforcement officer, mental health professional or physician, or circuit court order.[6] An involuntary examination may be initiated only if an individual appears to have a mental illness, presents a danger to him or herself or others, and refuses a voluntary examination or is unable to understand the need for the examination.[7] Each law enforcement agency must enter a memorandum of understanding with each receiving facility within the law enforcement agency's jurisdiction to establish a single set of protocols for the safe and secure transportation and transfer of custody of individuals for involuntary examination.[8]

Only institutions designated as a receiving facility by the Florida Department of Children and Families (DCF) may conduct an involuntary examination.[9] A physician or clinical psychologist must conduct the involuntary examination of a patient taken to a receiving facility without unnecessary delay.[10] The receiving facility may not release the patient without the documented approval of a psychiatrist, a clinical psychologist, or, if at a hospital, an attending emergency department physician experienced in diagnosing and treating mental disorders.[11] However, a patient may not be held in a receiving facility for an involuntary examination longer than 72 hours.[12]

Within the 72-hour involuntary examination period, the patient must be released or a petition for involuntary placement of the patient in outpatient or inpatient treatment must be filed in the circuit court.[13] Nearly 76 percent of involuntary examinations end without a petition for involuntary placement. The average length of stay is 4.5 days.[14]

---

[1] Chapter 1971-131, L.O.F.
[2] *See* Part I, ch. 394, F.S.; Florida Department of children and Families, *Florida's Baker Act: 2013 Fact Sheet, available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf.
[3] Section 394.463, F.S.
[4] *See* Section 394.453, F.S.; Florida Department of children and Families, *Florida's Baker Act: 2013 Fact Sheet, available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf.
[5] Section 394.463, F.S.; Florida Department of children and Families, *Florida's Baker Act: 2013 Fact Sheet, available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf
[6] Section 394.463(2), F.S.
[7] Section 394.463(1), F.S.; Florida Department of children and Families, *Florida's Baker Act: 2013 Fact Sheet, available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf.
[8] Section 394.462(k), F.S.
[9] *See* Sections 394.455(26), F.S. 394.461, and 394.463, F.S.; Florida Department of children and Families, *Florida's Baker Act: 2013 Fact Sheet, available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf
[10] Section 394.463(2)(f), F.S.
[11] *Id.*
[12] *Id.*
[13] Section 394.463(2)(i), F.S.; *see* section 394.4655(3)(a), F.S.
[14] Florida Department of children and Families, *Florida's Baker Act: 2013 Fact Sheet, available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf.

In 2011, approximately 150,000 involuntary examinations were conducted on 111,000 individuals under the Baker Act.[15] Nearly 18,000 of the examinees were children. Over the span of ten years (2002 to 2011), there was a 35 percent increase in the number of children involuntarily examined.[16]

Receiving facilities must give prompt notice of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,[17] guardian advocate,[18] attorney, and representative.[19] The notice must be made by telephone or in person within 24 hours after the patient's arrival at the facility.[20] Attempts at notification must begin as soon as reasonably possible after the patient's arrival and must be documented in the patient's clinical record.[21] However, a patient, including a minor, has the right to prohibit a receiving facility from providing this notice.[22]

School Health Services

Each county health department must jointly develop with the district school board and local school health advisory committee a school health services plan.[23] The school health services plan describes the services to be provided pursuant to the plan, the responsibility for the provision of the services, the anticipated expenditures to provide the services, and evidence of cooperative planning by local school districts and county health departments.[24]

Each health services plan must include provisions for, among other things, meeting emergency health needs in each school.[25] "Emergency health needs" is defined as "onsite management and aid for illness or injury pending the student's return to the classroom or release to a parent, guardian, designated friend, or designated health care provider."[26] Each school health services plan must be reviewed annually for the purpose of updating the plan, and the plan must be approved biennially by the school district's superintendent, school board chairperson, county health department medical director or administrator, and the Department of Health's district administrator.[27]

Health services plans are not required to provide for notification of a student's parent or guardian when the student is transported to a receiving facility for purposes of an involuntary examination under the Baker Act.[28]

K-12 Student and Parent Rights

In Florida, K-12 students and their parents are afforded certain statutory rights, including rights relating to health issues.[29] The rights enumerated by statute contain no requirement that a student's parent or guardian be notified when the student is transported to a receiving facility for purposes of an involuntary examination under the Baker Act.

---

[15] Florida Department of children and Families, *Florida's Baker Act: 2013 Fact Sheet, available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf.
[16] *Id.*
[17] Section 394.455(11), F.S.
[18] Sections 394.455(12) and 394.4589, F.S.
[19] Section 394.4599(2)(a), F.S.
[20] Section 394.4599(2)(b), F.S.
[21] *Id.*
[22] *Id.*
[23] Section 381.0056(4), F.S.
[24] Section 381.0056(2)(e), F.S.
[25] *See* Section 381.0056, F.S.
[26] Section 381.0056(2)(a), F.S.
[27] Rule 64F-6.002(3), F.A.C.
[28] *See* Sections 381.0056, F.S. and 394.4599(2)(b), F.S.
[29] *See* Section 1002.20(3), F.S.

Effect of Proposed Changes

The bill amends the definition of "emergency health needs" for purposes of school health services programs to expressly include onsite evaluation for illness or injury and release to a law enforcement officer. In addition, the bill requires each county school health services plan to provide for immediate notification to a student's parent or guardian if the student is removed from school, school transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination. Each district school board and charter school governing board must develop a policy and procedures for such notification.

The bill provides that, if a student is removed from a public school, school transportation, or a school-sponsored activity for an involuntary examination, the school principal or the principal's designee must immediately notify the student's parent.[30] If the principal or principal's designee has submitted a report to the central abuse hotline[31] for suspected abuse, abandonment, or neglect and deems delay of notification to be in the student's best interest, notification may be delayed by no more than 24 hours after the student's removal.[32]

The bill requires receiving facilities to give notice of the whereabouts of a minor patient who is being held for an involuntary examination to the patient's parent, guardian, or guardian advocate immediately after the patient's arrival at the receiving facility. The receiving facility must attempt to notify the minor patient's parent, guardian, or guardian advocate until confirmation is received either verbally, by telephonic or other form of electronic communication, or by recorded message that notification has been made. Attempts at notification must be made hourly during the first 12 hours after the patient's arrival at the facility and then once every 24 hours thereafter until confirmation is received or until the patient is released at the end of the 72-hour examination period or a petition for involuntary placement is filed with the court.[33] A minor may not prohibit a receiving facility from providing this notice.

The bill requires the receiving facility to document each attempt at notification in the patient's clinical record and provides that the facility may seek assistance from law enforcement if notification is not made within the first 24 hours after the patient's arrival. The bill allows a receiving facility to delay notification by no more than 24 hours if it has submitted a report to the central abuse hotline for suspected abuse, abandonment, or neglect and deems delay of notification to be in the patient's best interest.[34]

B. SECTION DIRECTORY:

Section 1: Amends s. 381.0056, F.S., relating to school services program.
Section 2: Amends s. 394.4599, F.S., relating to notice under the Florida Mental Health Act.
Section 3: Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
Section 4: Amends s. 1002.33, F.S., relating to charter schools.
Section 5: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[30] Section 1000.21(5), F.S.
[31] Section 39.201(1) and (2), F.S., requires a person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, other person responsible for the child's welfare, other adult, or a victim of sexual abuse by a known or suspected juvenile sexual offender to report such knowledge or suspicion to the Department of Children and Families using its central abuse hotline.
[32] The bill also applies these requirements to charter schools.
[33] *See* Section 394.463(2)(i)4., F.S.
[34] *See supra* text accompanying note 31.

1. Revenues:

   None.

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:

   None.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill vests discretion in both the school principal and the receiving facility to delay notification upon suspicion of abuse, neglect, or abandonment.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to involuntary examinations of minors; amending s. 381.0056, F.S.; revising the definition of the term "emergency health needs"; requiring school health services plans to include notification requirements when a student is removed from school, school transportation, or a school-sponsored activity for involuntary examination; amending s. 394.4599, F.S.; requiring a receiving facility to provide notice of the whereabouts of a minor patient held for involuntary examination; providing conditions for delay in notification; requiring documentation of contact attempts; amending ss. 1002.20 and 1002.33, F.S.; requiring a public school or charter school principal or a designee to provide notice of the whereabouts of a student removed from school, school transportation, or a school-sponsored activity for involuntary examination; providing conditions for delay in notification; requiring district school boards and charter school governing boards to develop notification policies and procedures; providing an effective date.

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

Section 1. Subsection (2) and paragraph (a) of subsection

(4) of section 381.0056, Florida Statutes, are amended to read:

381.0056 School health services program.—

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

(a) "Emergency health needs" means onsite evaluation, management, and aid for illness or injury pending the student's return to the classroom or release to a parent, guardian, designated friend, law enforcement officer, or designated health care provider.

(b) "Entity" or "health care entity" means a unit of local government or a political subdivision of the state; a hospital licensed under chapter 395; a health maintenance organization certified under chapter 641; a health insurer authorized under the Florida Insurance Code; a community health center; a migrant health center; a federally qualified health center; an organization that meets the requirements for nonprofit status under s. 501(c)(3) of the Internal Revenue Code; a private industry or business; or a philanthropic foundation that agrees to participate in a public-private partnership with a county health department, local school district, or school in the delivery of school health services, and agrees to the terms and conditions for the delivery of such services as required by this section and as documented in the local school health services plan.

(c) "Invasive screening" means any screening procedure in which the skin or any body orifice is penetrated.

(d) "Physical examination" means a thorough evaluation of

the health status of an individual.

(e) "School health services plan" means the document that describes the services to be provided, the responsibility for provision of the services, the anticipated expenditures to provide the services, and evidence of cooperative planning by local school districts and county health departments.

(f) "Screening" means presumptive identification of unknown or unrecognized diseases or defects by the application of tests that can be given with ease and rapidity to apparently healthy persons.

(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.~~; and~~ The plan must include, at a minimum, provisions for:

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.~~;~~

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.~~; and~~

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.

19. Immediate notification to a student's parent or guardian if the student 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, including the requirements established under ss. 1002.20(3) and 1002.33(9).

Section 2. Paragraphs (c) through (e) of subsection (2) of section 394.4599, Florida Statutes, are redesignated as paragraphs (d) through (f), respectively, paragraph (b) of that subsection is amended, and a new paragraph (c) is added to that subsection, to read:

394.4599 Notice.—

(2) INVOLUNTARY PATIENTS.—

(b) A receiving facility shall give prompt notice of the whereabouts of an adult or emancipated minor ~~a~~ patient who is being held involuntarily ~~held~~ for examination, in person or by telephonic or other form of electronic communication ~~by telephone or in person~~ within 24 hours after the patient's arrival at the facility, unless the patient requests that no notification be made. Contact attempts shall be documented in the patient's clinical record and shall begin as soon as reasonably possible after the patient's arrival. Notice that a patient is being admitted as an involuntary patient shall be given to the Florida local advocacy council no later than the next working day after the patient is admitted.

(c)1. A receiving facility shall give notice of the whereabouts of a minor patient who is being held involuntarily for examination pursuant to s. 394.463 to the patient's parent,

guardian, or guardian advocate in person or by telephonic or other form of electronic communication immediately after the patient's arrival at the facility. The facility may delay notification for no more than 24 hours if the facility has submitted a report to the central abuse hotline, pursuant to s. 39.201, based upon knowledge or suspicion of abuse, abandonment, or neglect and deems delay in notification to be in the minor's best interest.

2. The receiving facility shall attempt to notify the minor patient's parent, guardian, or guardian advocate until the receiving facility receives confirmation from the parent, guardian, or guardian advocate, either verbally, by telephonic or other form of electronic communication, or by recorded message, that notification has been made. Attempts to notify the parent, guardian, or guardian advocate must be repeated at least once every hour during the first 12 hours after the patient's arrival and once every 24 hours thereafter and must continue until such confirmation is received, until the patient is released at the end of the 72-hour examination period, or until a petition for involuntary placement is filed with the court pursuant to s. 394.463(2)(i). A receiving facility may seek assistance from law enforcement if notification is not made within the first 24 hours after the patient's arrival. The receiving facility must document notification attempts in the patient's clinical record.

Section 3. Paragraph (l) is added to subsection (3) of

section 1002.20, Florida Statutes, 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.—The public school principal or the principal's designee shall 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. The principal or the principal's designee may delay notification for no more than 24 hours 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, based upon knowledge or suspicion of abuse, abandonment, or neglect. Each district school board shall develop a policy and procedures for notification under this paragraph.

Section 4. Paragraph (q) is added to subsection (9) of section 1002.33, Florida Statutes, to read:

1002.33 Charter schools.—

(9) CHARTER SCHOOL REQUIREMENTS.—

(q) The charter school principal or the principal's

designee shall 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. The principal or the principal's designee may delay notification for no more than 24 hours 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, based upon knowledge or suspicion of abuse, abandonment, or neglect. Each charter school governing board shall develop a policy and procedures for notification under this paragraph.

Section 5. This act shall take effect July 1, 2015.

Presentations

Quality Out-of-Home Care: Placements for Our Children

House Children, Families & Seniors Subcommittee

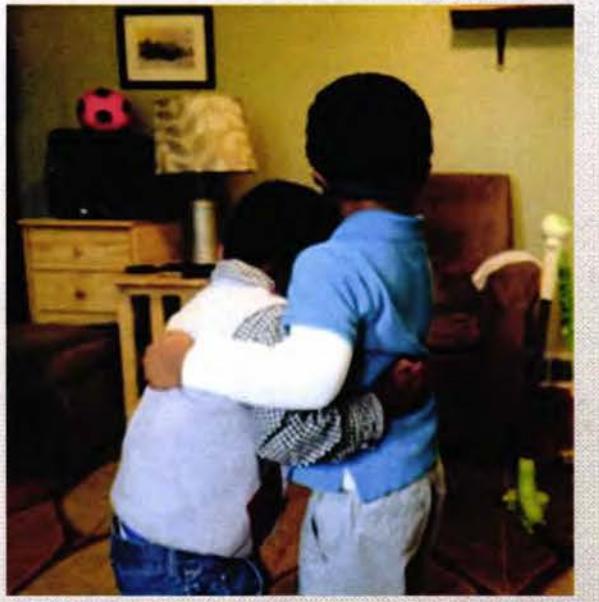
March 11, 2015

Quality Out-of-Home Care

Principles

DCF wants children in best possible placements.

How is the best possible placement determined?



FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Quality Out-of-Home Care:
Principles

- Healthy attachments
- Normalcy
- An adult advocating for:
  - Health
  - Education
  - Activities
  - Life choices

Quality Out-of-Home Care:
Required by Law

Section 409.145(2), F.S.:

QUALITY PARENTING.—A child in foster care shall be placed only with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion and ethnicity, special physical or psychological needs, any circumstances unique to the child, and family relationships.

Quality Out-of-Home Care:
Required by Law

Quality parenting requires a caregiver to:

- Participate in development of case plan
- Be involved in all team meetings or court hearings related to the child's care
- Complete training needed related to:
  - Trauma-responsive care
  - Special needs of children
  - Working effectively with child welfare agencies, the court, the schools, and other community and governmental agencies

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Quality Out-of-Home Care:
Required by Law

Quality parenting requires a caregiver to (continued):

- Respect and support the child's family ties; assist in maintaining visitation and communication
- Advocate for the child's needs with:
  - The child welfare system
  - The court
  - Schools
  - Child care, health and mental health providers, and employers
- Participate fully in the child's medical, psychological, and dental care

Quality Out-of-Home Care:
Required by Law

Quality parenting requires a caregiver to (continued):

- Support the child's school success
- Encourage the child's participation in extracurricular activities
- Partner with other stakeholders to obtain and maintain important child well-being records
- Teach independent living skills to children between 13 and 17 years of age
- Establish and maintain naturally occurring mentoring relationships

Quality Out-of-Home Care:
Types of Placement Settings

- Family foster home
  - Traditional licensed foster homes
  - Medical and therapeutic foster homes
  - "Safe" foster homes
  - Relative, and non-relative homes
- Residential group care (house parents or shift care)
- Residential treatment facility (secured, AHCA)
- Detention facility (DJJ)

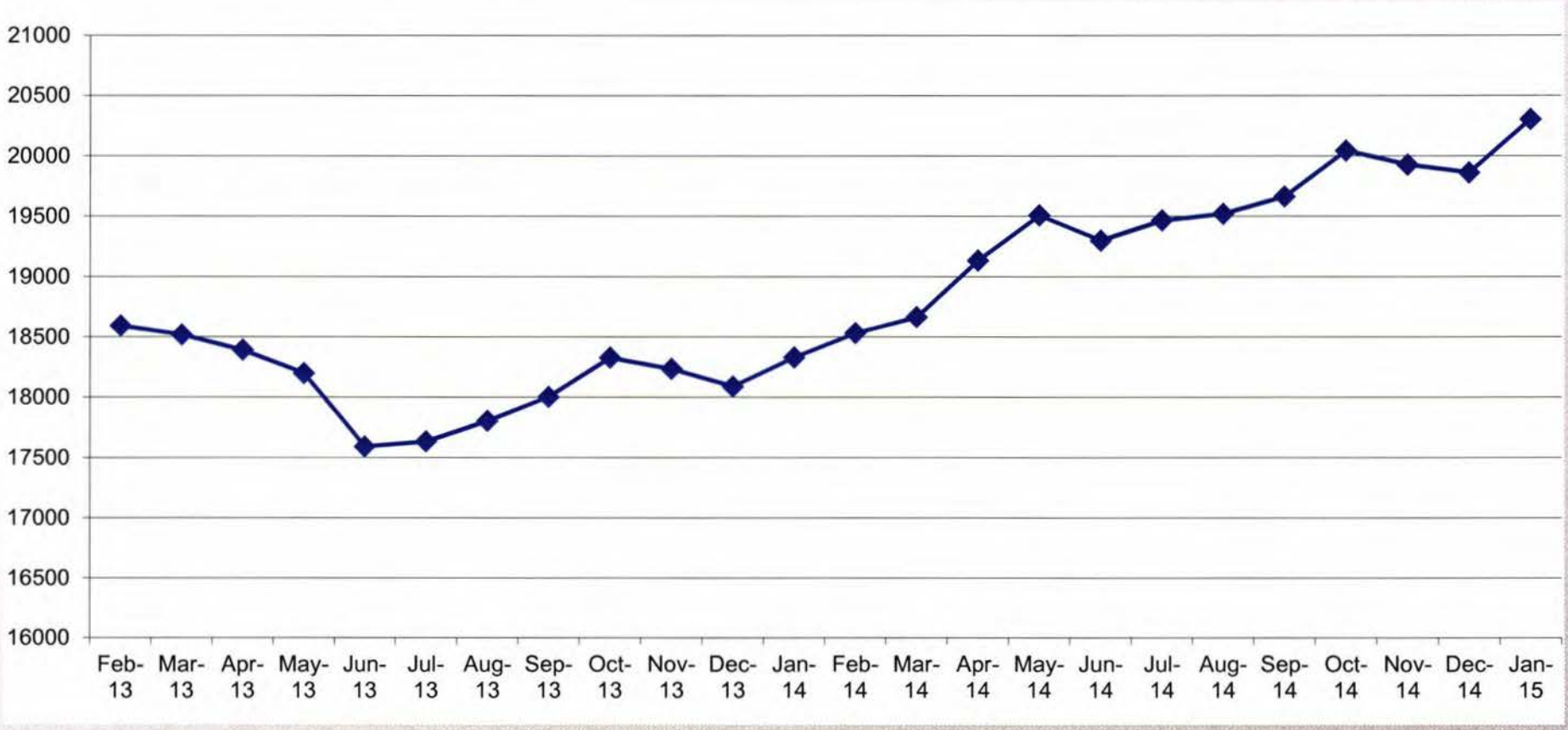
Quality Out-of-Home Care:
Types of Services Provided

- Depending on child's needs, additional services may be provided in the placement setting. Services can include:
  - Therapy/counseling
  - Behavior modification activities
  - Specialized medical treatment/equipment

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Quality Out-of-Home Care:

How Many Kids in Care?



FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Quality Out-of-Home Care:
Where are Kids Placed?

As of January 2015, there were 20,302 children in care.

Of those children:

- 8,827 were in a relative placement
- 2,034 were in a non-relative placement
- 6,734 were in a licensed family foster home
- 2,177 were in a licensed group care facility

Quality Out-of-Home Care:
Building Capacity

Short-term plans:

- Quality Family Homes – DCF Priority
  - Teen Foster Home Recruitment Initiative
- Crossover Youth/Group Care Workgroups

Long-term plans:

- Results-oriented accountability measures
  - Using placement research to plan
  - Re-purposing current providers
  - Working with the Florida Institute for Child Welfare

Quality Out-of-Home Care:

What Are the Costs?

Monthly Board Rates/Cost of Care

Relative/Non-Relative*	$248
Licensed Family Foster Home**	$439 – 527
Residential Group Care	$2,700 – 3,600
Medical Foster Care***	$1,164 – 2,037
Specialized Therapeutic Care***	$2,619 – 4,074

Janice Thomas

Assistant Secretary for Child Welfare

Janice.Thomas@myflfamilies.com

Phone: 850-717-4320

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

OPPAGA
research memorandum
THE FLORIDA LEGISLATURE'S OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

Florida's Residential Group Care Program for Children in the Child Welfare System

December 22, 2014

Scope

The Legislature directed OPPAGA to review the residential group care program for dependent children and answered three questions.

1. How is placement in residential group care determined?
2. What are the services and costs associated with residential group care?
3. How does the population of children in residential group care compare to those in family foster care?

Background

In Florida, when child welfare officials determine that children have suffered abuse or neglect and cannot safely remain with their families, they are removed from their homes and provided with safe and appropriate temporary homes. These temporary placements, referred to as out-of-home care, provide housing and services to children until they can return home to their family or achieve permanency with another family through adoption or guardianship. The Department of Children and Families (DCF) contracts with community-based care lead agencies to manage child welfare services in Florida, which includes identifying out-of-home placements for children.

Legislative intent is to place children in a family-like environment when they are removed from their homes. When possible, lead agency case managers place the children with a relative or responsible adult that the child knows and with whom they have a relationship, such as a stepparent or a close family friend. These out-of-home care placements are referred to as relative and non-relative caregivers. When a relative or non-relative caregiver placement is not possible, case managers try to place the children in family foster homes licensed by DCF.

However, some children may have extraordinary needs that require case managers to place them in an alternative licensed foster care arrangement—residential group care. The primary purpose of residential group care is to provide a setting that addresses the unique needs of children and youth who require more intensive services than a family setting can provide. Florida statutes and rules define residential group care as a living environment providing 24-hour residential care for children who are adjudicated as dependent and are expected to be in foster care for at least six months.[1, 2, 3]

DCF's Child Welfare Office licenses residential group care providers as residential child-caring agencies, and lead agencies are responsible for subcontracting with these providers. According to child welfare officials and advocacy stakeholders, there are two

[1] Section 409.1676(2)(b), *F.S.*, and Ch. 65C-14, *F.A.C.*

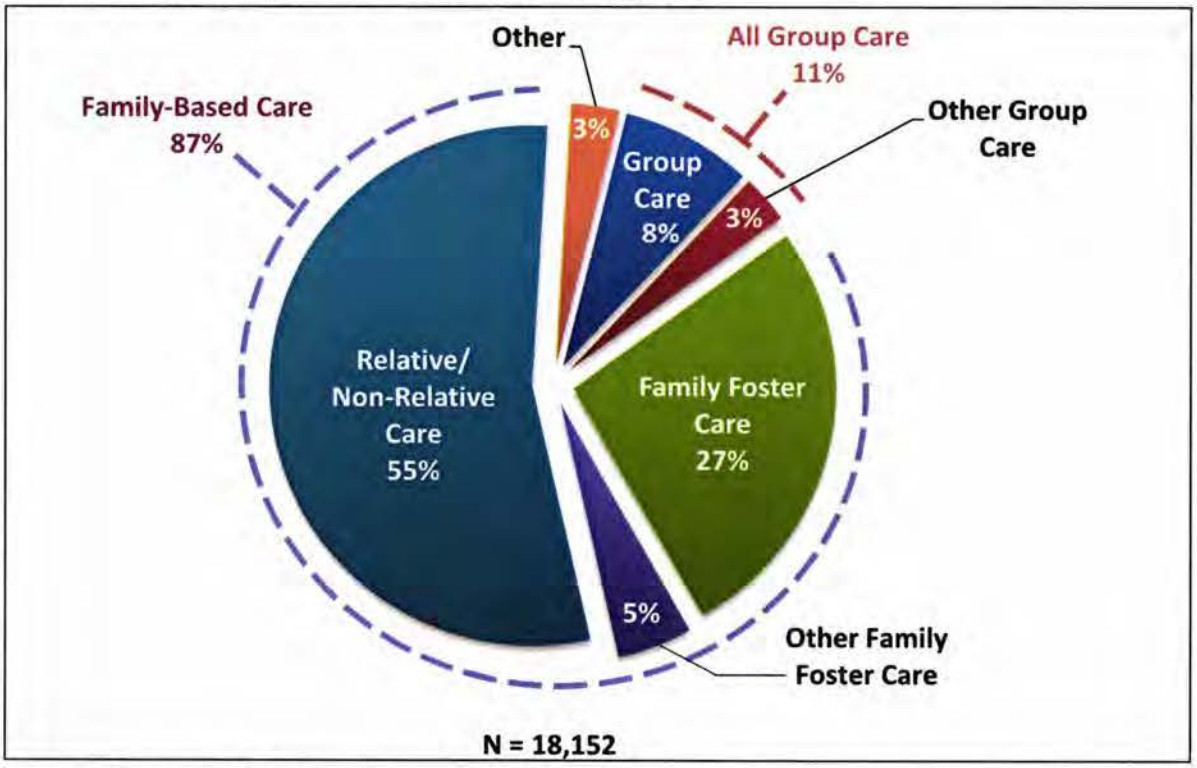
[2] Community-based care lead agencies may place children in other types of residential group care settings based on the child's needs, such as residential treatment programs, therapeutic group care, or developmental disabilities group homes.

[3] As of November 2014, the department was in the process of drafting a new group care administrative rule.

primary models of group care in Florida—shift-care group homes with staff working in shifts providing 24-hour supervision and family group homes with live-in staff, or house parents, who have an apartment within the group home.[4] In Fiscal Year 2013-14, lead agency directors identified 96 distinct providers with whom they subcontract for group care—58% as shift-care group homes and 42% as family group homes.

As shown in Exhibit 1, in Fiscal Year 2013-14, there were 18,152 dependent children in out-of-home care.[5] Eighty-seven percent of these children were in family-based care, with 55% in unlicensed care with a relative or non-relative caregiver, 27% in licensed family foster care, and 5% in other family foster care.[6] Eleven percent of children were in licensed residential group care.[7] Residential group care consists of group care (8%) and other temporary or specialty forms of group care (3%).[8, 9]

Exhibit 1
In Fiscal Year 2013-14, 11% of Children Were in Group Care[1, 2]



[1] Percentages do not total 100% due to rounding.

[2] Children were only included in this analysis if they had been in care for at least eight days.

Source: OPPAGA analysis of Department of Children and Families data.

[4] According to group care providers, the family group home model varies by whether house parents reside with their biological children or whether house parents are not permitted to reside with their biological children at the program. In addition this model varies by house-parent staffing, i.e., the pattern of time off and use of relief house parents.

[5] As of September 30, 2014, there were 19,663 children in out-of-home care.

[6] Other family foster care primarily consists of licensed therapeutic family foster care and children placed in the care of families out of state.

[7] Three percent of children were in other placements. This primarily consists of children in correctional placements (33%), who ran away (25%), were in emergency services (19%), or were on visitation (13%).

[8] Group care providers are licensed as residential child-caring agencies by the department's child welfare office.

[9] Other group care includes children in the care of providers licensed by the department as emergency shelters (40%), maternity group homes (8%), runaway shelters (6%), wilderness camps (2%), and children with providers licensed by other agencies (41%) as Statewide Inpatient Psychiatric Programs (SIPP), therapeutic group homes, or Agency for Persons with Disabilities group homes.

The overall number of children in residential group care has decreased in Florida since Fiscal Year 2007-08, mirroring the overall decrease in out-of-home care. DCF set a goal to reduce the number of children in out-of-home care by 50% between January 2007 and January 2012. Although it did not meet this goal, it has significantly decreased the number of children in out-of-home care. Between Fiscal Years 2007-08 and 2013-14, the average number of children in group care decreased by 33%, with the number of children in out-of-home care experiencing a similar reduction.[10] (See Appendix A for more details about this decline.) As shown in Exhibit 2, residential group care expenditures decreased by 30% during this same time period.

Exhibit 2
Since Fiscal Year 2007-08, Residential Group Care Expenditures Have Decreased 30%

State Fiscal Year	Cumulative Percentage Change in the Average Number of Children in Group Care[1]	Residential Group Care Expenditures	Cumulative Percentage Change in Residential Group Care Expenditures
2007-08		$112,240,934	
2008-09	-12%	$98,411,631	-12%
2009-10	-22%	$88,778,416	-22%
2010-11	-28%	$87,941,722	-23%
2011-12	-26%	$86,840,671	-24%
2012-13	-31%	$84,482,158	-27%
2013-14	-33%	$81,666,795	-30%

[1] This figure is calculated by averaging the number of children in care at the end of each month in the fiscal year. Both children in group care and other group care were used in this calculation.

Source: OPPAGA analysis of Department of Children and Families data.

How is placement in residential group care determined?

Florida statute and rule guide lead agencies in assessing and placing children in residential group care. Lead agencies must place all children in out-of-home care in the most appropriate available setting after conducting an assessment using child-specific factors.[11] Lead agencies must consider placement in residential group care if specific criteria are met—the child is 11 or older, has been in licensed family foster care for six months or longer and removed from family foster care more than once, and has serious behavioral problems or has been determined to be without the options of either family reunification or adoption. In addition, the assessment must consider information from several sources, including psychological evaluations, professionals with knowledge of the child, and the desires of the child concerning placement.[12] If the lead agency case mangers determine that residential group care would be an appropriate placement, the child must be placed in residential group care if a bed is available. Children who do not meet the specified criteria may be placed in residential group care if it is determined that such placement is the most appropriate for the child.[13]

DCF officials reported that they discourage lead agencies from placing children under age 12 in group care settings unless it keeps sibling groups together. In addition, department staff reported

[10] This reduction in group care use and spending was for group care and other group care combined.

[11] Child-specific factors include the child's age; sex; sibling status; physical, educational, emotional, and developmental needs; alleged maltreatment; community ties; and school placement (Rule 65C-28.004, *F.A.C.*).

[12] Section 39.523(1), *F.S.*

[13] Section 39.523(4), *F.S.*

encouraging lead agencies to focus on recruiting foster families to reduce their reliance on group care, reflecting the statutory direction that the department place children with a relative or non-relative caregiver or in a family foster home when a child is removed from their parent's custody. To reinforce efforts to reduce the use of group care for young children, DCF included a performance measure on the community-based care lead agency scorecard, a component of the department's performance measurement system, related to the use of group care for young children.[14] However, the department does not penalize lead agencies for keeping large sibling groups together in group care.[15]

Lead agencies report that they have policies and procedures emphasizing family foster care placement before considering group care placement, and when possible, they use the family group home model versus the shift-care model. The out-of-home placement process begins with lead agency placement staff trying first to locate a family foster care home before considering group care. Lead agency staff reported requiring their case management organizations to have all group care placements approved by a lead agency placement specialist, who locates an alternative placement if a group care placement is determined not to be appropriate. Lead agency staff also reported conducting regular (monthly or more frequently) reviews of children in residential group care to determine if an appropriate placement in family foster care was available.

Lead agencies reported that they limit residential group care placements to adolescents with behavioral problems and sibling groups for whom there are limited foster family home placements available. Lead agency directors prefer to place children in a family group home, and reported that most children 12 and younger are placed in these facilities. They reported using shift-care group homes with 24/7 supervision more for older children who have behavior problems or a history of physical aggression or violent behavior toward themselves, others, and/or property, or have had multiple foster care placements. Many of these adolescents have substance abuse problems or have an extensive background with delinquency. In addition, lead agencies reported using group care as a step-down placement from therapeutic group care.[16]

Lead agency directors reported using specific strategies to decrease residential group care placements. These strategies include creating an enhanced family foster care program that includes targeted recruitment of foster parents for adolescents, training foster parents to deal with difficult adolescents, paying higher foster care board rates, and providing respite care and other supports for these foster parents. Examples of supports include mental health wrap-around services for the children in their care, in-home behavioral analysis services, support groups, and mentors for foster care parents.

What are the services and costs associated with residential group care?

Licensed residential group care settings must provide an array of services and activities for children. Lead agencies must ensure that children receive the care and attention that fosters a healthy social, emotional, intellectual, and physical development regardless of whether they are with relative or non-relative caregivers or are in licensed placements (both family foster homes and group homes). Licensed residential group care programs are required to provide a minimum

---

[14] The performance measure is "children in licensed out-of-home care age 12 and under in DCF-licensed family foster homes."

[15] Section 39.001(1)(k), *F.S.*

[16] Children diagnosed as having a moderate to severe emotional disorder can receive community-based psychiatric residential treatment services in therapeutic group care. To be placed in therapeutic group care, a child must be assessed by a qualified evaluator (a licensed psychologist or psychiatrist) and have the placement authorized by a multidisciplinary team, and the team must reauthorize the placement every six months. Therapeutic group care may also be the preferred placement for children stepping down from a more restrictive residential treatment program or for those who require more intensive community-based treatment to avoid placement in a more restrictive residential treatment setting.

range of activities and services to meet children's needs for healthy development; these activities and services are specified in administrative rule. (See Exhibit 3.) For example, the group care providers must provide basic needs such as food and clothing, provide opportunities for recreation and participation in the community, arrange for necessary medical appointments, and ensure transportation to services and activities. Children with behavioral health needs receive mental health, substance abuse, and supportive services that are provided through Medicaid-funded Behavioral Health Overlay Services (BHOS). Children must be recertified every six months for BHOS eligibility by a licensed practitioner, and residential group care providers receive Medicaid reimbursement for medically necessary behavioral health services.[17]

Exhibit 3
Group Care Programs Directly Provide or Ensure Access to a Variety of Services and Activities

Service or Activity
▪ Provide a range of indoor and outdoor recreation and leisure activities
▪ Arrange for recreational and cultural enrichment in the community
▪ Provide transportation
▪ Arrange for and ensure necessary medical and dental care
▪ Ensure behavioral health counseling services
▪ Ensure participation in work activities at the program
▪ Provide clothing, personal hygiene items, and supplies
▪ Have a positive behavioral management program to correct unwanted behaviors
▪ Conduct assessments and develop service plans
▪ Arrange for educational and vocational services in the community or on-site
▪ Provide each child the opportunity to learn earning, spending, and saving money through an allowance
▪ Provide life skills training, including
o Problem solving and decision making,
o Social skills, and
o Independent living skills

Source: OPPAGA analysis of Ch. 65C-14, *F.A.C.*

Lead agency staff annually negotiate rates with group care providers. In Fiscal Year 2013-14, the 17 lead agencies contracted with 96 residential group care providers. Most lead agencies use a cost-based reimbursement methodology to pay group care providers, with payment based on a negotiated daily bed rate. In Fiscal Year 2013-14, the average per diem rate for the shift-care group home model was $124, with costs ranging from $52 to $283, while the average per diem rate for the family group home model was $97, with costs ranging from $17 to $175.[18] Residential group care is more expensive than family foster care, which pays an average daily rate of $15 intended to cover room and board expenses.[19]

Lead agency directors consider several factors when negotiating rates—the provider's budget and expenses, amount of community support (private funding), staff to client ratios, bed capacity, services provided, special per child considerations (e.g., the child needs his or her own room or requires 24-hour supervision), and the number of children to be served. Rates also vary by type of program. For example, providers serving children or adolescents requiring special

[17] Medicaid pays a daily rate of $32.75 for BHOS in group care; during Fiscal Year 2011-12, Medicaid paid an average of $3,813 per child to BHOS providers.

[18] Median per diem rates were $115 and $97 for shift-care and family group homes, respectively.

[19] By statute and rule, family foster parents are expected to provide a safe, loving, and nurturing environment and activities and support for social, emotional, intellectual, and physical development (s. 409.145(2), *F. S.*, and Ch. 65C-13, *F.A.C.*).

care and treatment, such as those serving sexually abused or sexually reactive adolescents, receive an enhanced room and board rate.

For young adults who choose to remain in the foster care system after turning 18, 25% have chosen to live in a residential group care setting. The 2013 Legislature extended foster care through 21, giving children for whom the state did not reunify with their family or achieve permanency with another family the choice to stay in foster care. The department is still revising rules to address those young adults over 18 who want to stay in residential group care settings.[20] However, lead agency directors told us that, while some adolescents wanted to stay in their current placement, most in residential group care settings did not, and alternative living arrangements were being explored for these adolescents. Lead agency directors said that residential group care providers may not be comfortable having young adults on the same campus as young teenagers or may not have the capacity to serve young adults and that no funding stream exists to help group care providers convert their programs and facilities into transitional living arrangements for the young adult population.

Lead agency directors have developed several types of placements for young adults choosing to remain in foster care. For example, group care providers are creating dorm-like settings with less structure than traditional group care programs, while providers of transitional housing and services for teenagers aging out of foster care are offering these services to young adults in extended foster care. Lead agency directors also reported working with apartment complexes to provide housing for those in extended foster care and recruiting foster families willing to take in young adults. Exhibit 4 shows the monthly costs of extended foster care placements reported by lead agencies.

Exhibit 4
Residential Group Care Is the Most Expensive Living Arrangement for Young Adults in Extended Foster Care

Living Arrangement	Average Monthly Rate	Median Monthly Rate	Monthly Rate Range
Residential Group Care	$859	$800	$297 to $1,300
Apartment	$778	$850	$410 to $1,000
Supervised Living	$567	$557	$401 to $750
Family Foster Care	$543	$533	$445 to $715

Source: OPPAGA analysis of community-based care lead agency data.

Lead agency directors reported that 282 young adults chose extended foster care from January 1, 2014, through June 30, 2014.[21] Of these young adults, 148 chose extended foster care prior to aging out of foster care and 134 previously aged out of foster care at 18 and chose to return to foster care. Lead agencies reported that 45% were in supervised living arrangements, such as transitional living programs or host homes; 25% were in residential group care; 20% were in apartments; and 11% were in a family foster home.

[20] As of November 2014, the department's rules related to extended foster care and foster care and group care licensing were still drafts. In November 2013, the department's general counsel's office issued a memorandum stating that Ch. 2013-178, *Laws of Florida*, takes precedence over the licensing rules contained in Chs. 65C-13 and 65C-14, *F.A.C.*; therefore, young adults 18 or older may not be removed from their current living arrangement. In addition, the draft rule pertaining to extended foster care must be rewritten due to concerns expressed by the Joint Administrative Procedures Committee and the Office of Fiscal Accountability and Regulatory Reform.

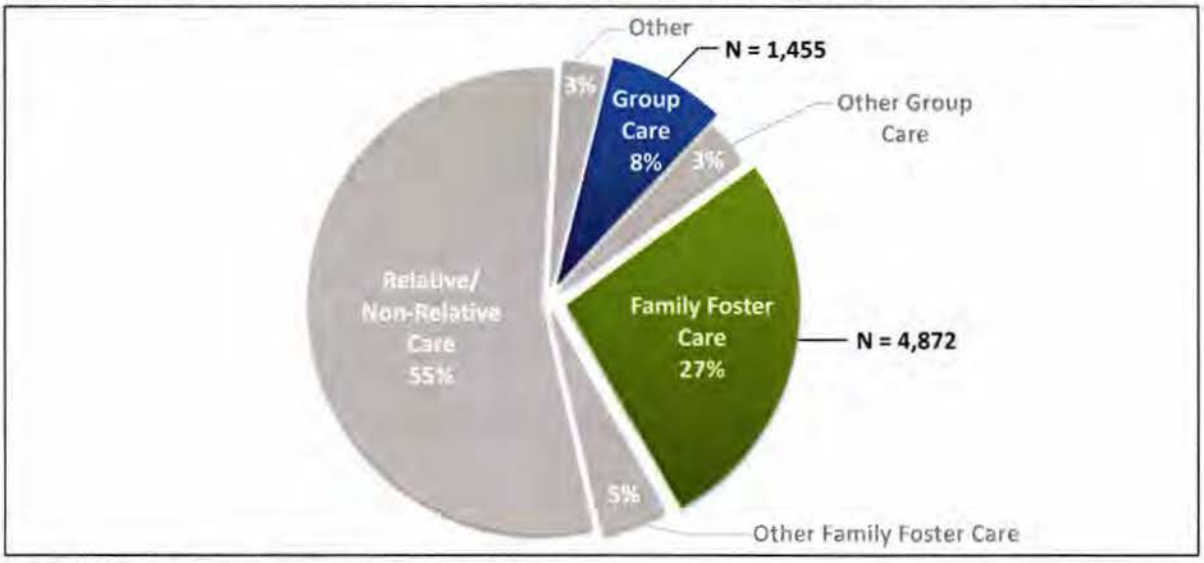
[21] Fourteen of 16 lead agency directors responded to the information request.

How does the population of children in residential group care compare to those in family foster care?

Compared to family foster care, group care programs serve primarily older children and more male and minority children with identified behavioral health issues. When younger children are placed in group care, they usually are in care with siblings. Compared to children who entered family foster care, children who entered group care ran away from care more often, spent more time in care, were placed outside of their home county more often, and were more often reunified with their parents instead of being adopted. In addition, children are in group care for a significant portion of their out-of-home placement, and although younger children (ages 11 to 14) who entered group care went on to the care of a family, many older children (ages 15 to 17) did not leave group care to enter the care of a family before turning 18. Surveys of youth also show that longer-term outcomes for children who were in group care were worse for six of nine measures.

To compare to the population of children in group care to those in family foster care, we analyzed data from DCF's Florida Safe Families Network (FSFN). For children entering group care, we looked at whether the demographics, characteristics, and child welfare experiences leading up to their entry into group care were different from those of children entering family foster care. To analyze outcomes, we examined whether, after entering group care, children had different experiences that may affect their well-being or permanency. As shown in Exhibit 5, this analysis compares the 8% of children in group care to the 27% of children in family foster care.[22]

Exhibit 5
Comparison Analyses Are Between Children in Group Care and Children in Family Foster Care



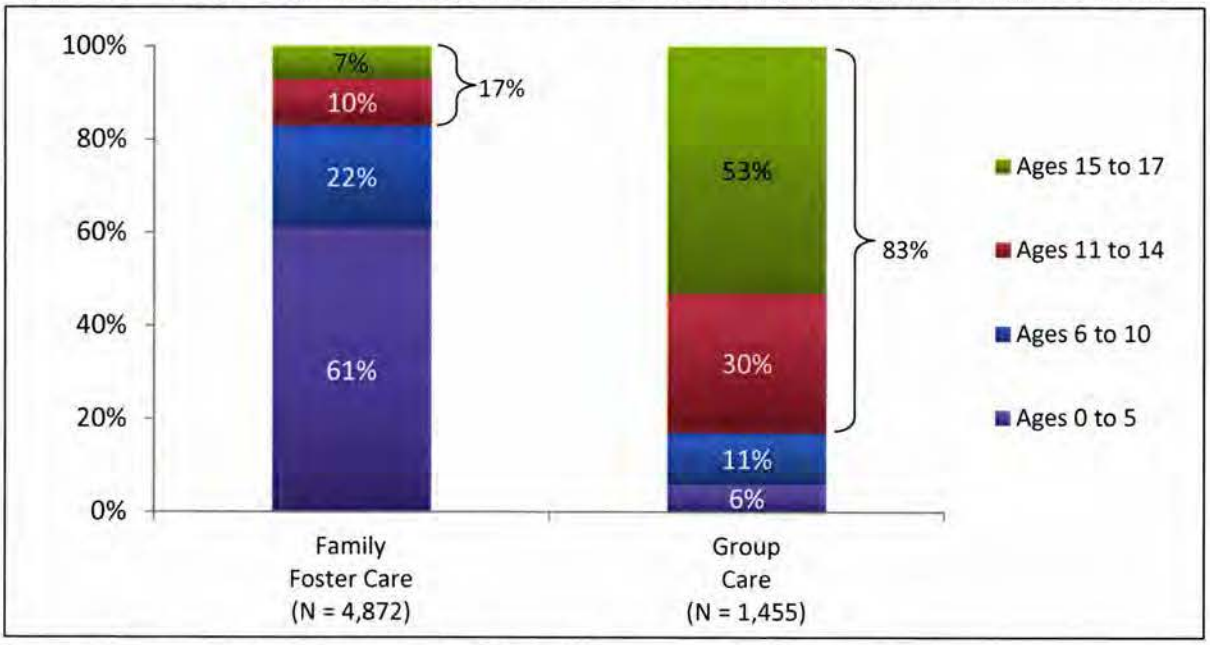
Source: OPPAGA analysis of Department of Children and Families data.

[22] For the purposes of this analysis, as specified in statute and rule, children are considered to be in group care if they are in the care of a program licensed by the DCF as a Child Caring Agency which provides staffed 24-hour residential care of children. This does not include children we categorized as in other group care, such as children in residential care licensed by other agencies (therapeutic group care, Statewide In-Patient Psychiatric facilities, or Agency for Persons with Disabilities' group homes) or children in an emergency shelter, runaway shelter, maternity home, or wilderness camp. For the purposes of this analysis, children are considered to be in family foster care if they are in the care of a foster family licensed as a traditional foster home by Florida's DCF. This does not include children in therapeutic family foster care or in foster homes licensed by other states.

Demographics, Behavioral Characteristics, and Child Welfare Experience Prior to Group Care

Group care programs primarily serve older, male, and minority children. As shown in Exhibit 6, children in group care are significantly older than children in family foster care; 83% of children in group care were 11 or older compared to 17% in family foster care. Legislative intent is to not place children under 11 in residential group care. Lead agencies told us that they typically use group care placements for younger children that are part of a large sibling group, because it can be challenging to identify family foster care placements in which the foster parents are willing to take a large number of siblings into their homes. Of the children under 11 in group care in Fiscal Year 2013-14, 82% were in group care with at least one sibling. However, only one-third of these young children in group care were placed with three or more siblings.[23] Appendix B provides additional details about the placement of young children in group care.

Exhibit 6
Eighty-Three Percent of Children in Group Care Are 11 and Older Compared to 17% in Family Foster Care



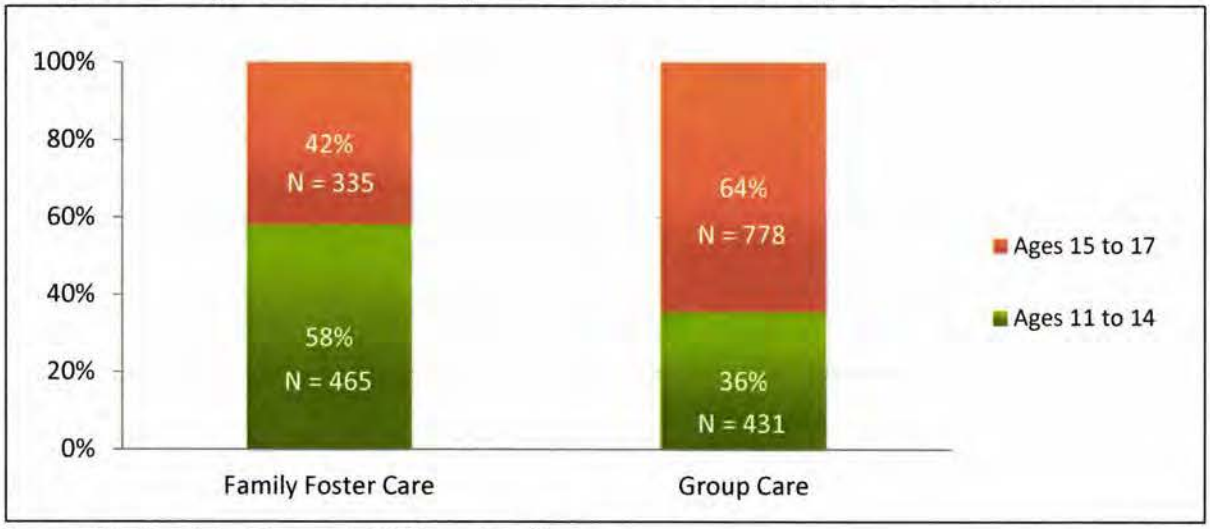
Source: OPPAGA analysis of Department of Children and Families data.

When comparing only children 11 and older, the largest demographic difference between children in group care and family foster care is that a larger percentage of children in group care are ages 15 to 17. Among children 11 and older, 64% of children in group care are ages 15 to 17; in contrast, 42% in family foster care are ages 15 to 17.[24] (See Exhibit 7.)

[23] There may be some imprecision in how FSFN data identifies group care, sibling groups, and whether children are placed together.

[24] Due to the differences between these age ranges, we analyzed the differences between children in residential group care and family foster care by these age categories.

Exhibit 7
A Larger Percentage of Children in Group Care Are Ages 15 to 17 Compared to Family Foster Care



Source: OPPAGA analysis of Department of Children and Families data.

A larger share of children in group care are male, especially among children ages 15 to 17, where 52% of children in group care are male, compared to 44% in family foster care. Consistent with national trends, children in licensed out-of-home care are disproportionately minorities, especially in group care, where 64% of children are minorities. Appendix C provides additional detail on demographics for children in group care compared to family foster care.

A larger percentage of children in residential group care have behavioral issues. Lead agency case worker assessments of the strengths and needs of families involved in the child welfare system indicate that children in group care, especially children 15 and older, are more likely to demonstrate developmentally inappropriate behavioral health. In addition, a larger percentage of children in group care have a history of arrests and involvement with law enforcement or the Department of Juvenile Justice, as well as have a history of substance abuse.[25] (See Exhibit 8.)

Exhibit 8
Children in Group Care Had More Identified Behavioral Issues

Age	Type of Care	Does Not Demonstrate Developmentally Appropriate Behavioral Health	History of Substance Use and/or Exposure	History of Arrests and Law Enforcement or Juvenile Justice Involvement
Ages 11 to 14	Family Foster Care (N = 384)	33%	26%	7%
	Group Care (N = 356)	38%	28%	21%
Ages 15 to 17	Family Foster Care (N = 262)	28%	30%	26%
	Group Care (N = 646)	48%	41%	47%

Source: OPPAGA analysis of Department of Children and Families data.

[25] Rule 65C-30.005, *F.A.C.*, requires child welfare services workers to complete a family assessment within 15 working days of the Early Services Intervention staffing and update the assessment, at a minimum, every six months thereafter. The family assessment is used to analyze the strengths and needs of the family and its members and informs the development of case plans.

Case workers also assess whether children exhibit one or more of 24 specific behavioral issues. Children in group care exhibited more of these issues than children in family foster care. As shown in Exhibit 9, for example, 71% of group care children ages 15 to 17 exhibited at least one of these behavioral issues compared to 48% in family foster care. In addition, case managers identified four or more issues for 39% of children in group care ages 15 to 17 compared to 21% in family foster care. Appendix D provides additional detail.

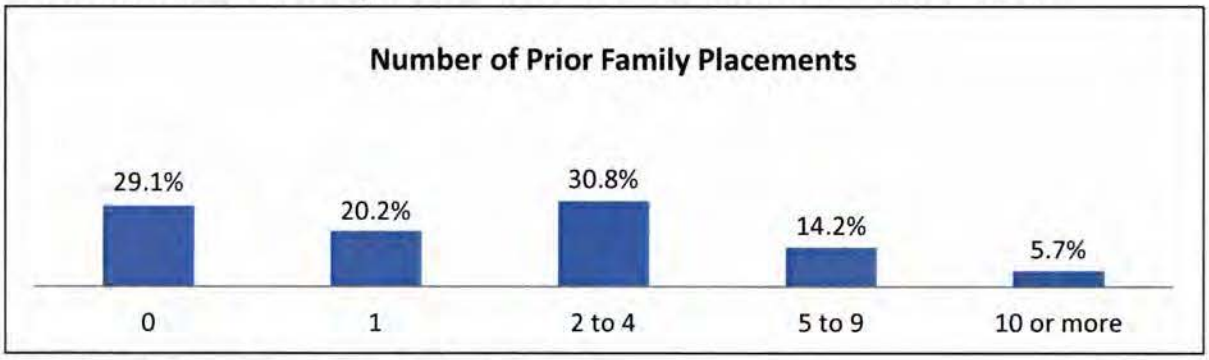
Exhibit 9
Children in Group Care Had More Identified Behavioral Issues

Age	Type of Care	Children with at Least One Identified Specific Behavioral Issue	Children with Four or More Identified Specific Behavioral Issues	Average Number of Identified Specific Behavioral Issues
Ages 11 to 14	Family Foster Care (N = 384)	40%	13%	1.2
	Group Care (N = 356)	56%	28%	2.5
Ages 15 to 17	Family Foster Care (N = 262)	48%	21%	1.9
	Group Care (N = 646)	71%	39%	3.2

Source: OPPAGA analysis of Department of Children and Families data.

Almost 50% of children in group care either had no or only one placement in a family foster home prior to group care placement. Specific criteria for determining that residential group care is the most appropriate placement include that the child has been in licensed family foster care for six months or longer and removed from family foster care more than once. Lead agency staff also reported that children assessed for residential group care include children who have had multiple failed family foster home or caregiver placements. However, 29% of children in group care had no prior placements with a family and 20% only had one prior placement with a family.[26, 27] (See Exhibit 10.)

Exhibit 10
Almost Half of Children in Group Care Have Had Fewer Than Two Prior Family Placements



Source: OPPAGA analysis of Department of Children and Families data.

[26] This analysis considers all time the child spent in out-of-home care between July 1, 2004, and the start of the placement they were in on November 15, 2013. For children in group care and family foster care on November 15, 2013, we looked at their out-of-home care histories prior to entering their current arrangement.

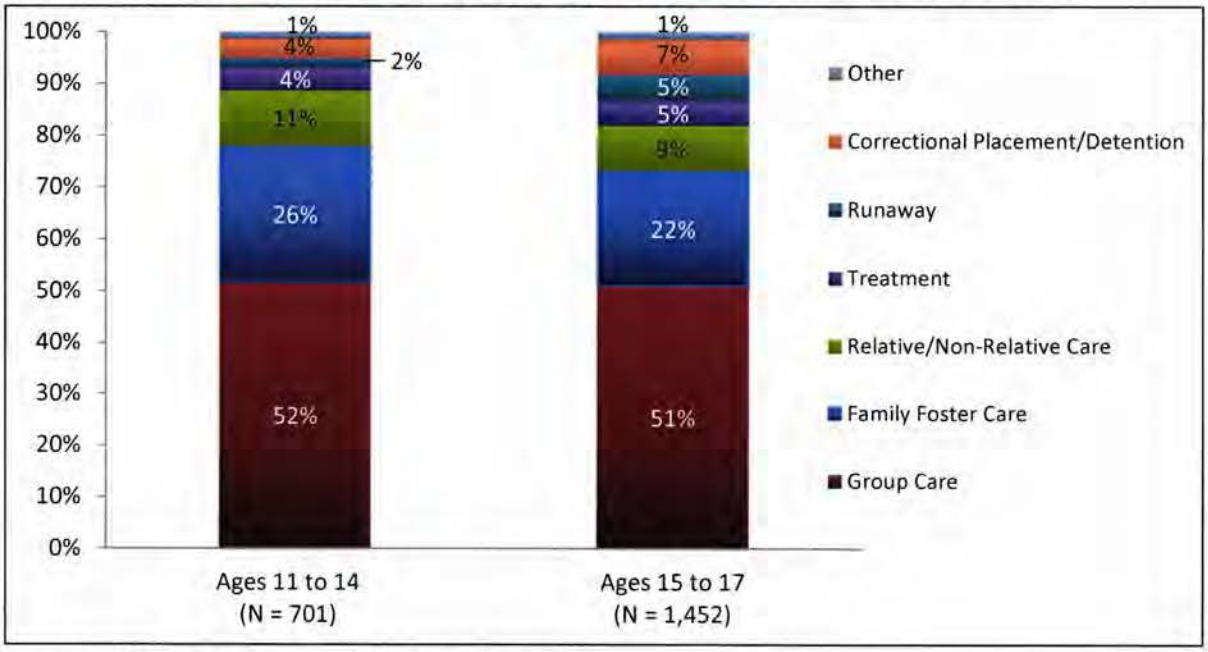
[27] To determine the number of placements a child had, we counted each time a child was placed in the care of a different family or provider. If a child was in the care of a provider and temporarily left that provider's care due to a temporary situation such as short-term hospitalization, visitation, or running away, when the child returned to the prior provider our analysis did not consider this as a new placement. All prior placements with a family were counted including unlicensed relative and non-relative placements and licensed family foster care placements.

Outcomes

To examine the outcomes of children after entering group care, we selected a group of children who entered group care or family foster care in federal Fiscal Year 2010-11 and looked at their experiences through May 2014. We found that, compared to children who entered family foster care, children who entered group care ran away from care more often, spent more time in care, were placed outside of their home county more often, and were more often reunified with their parents instead of being adopted. In addition, children are in group care for a significant portion of their out-of-home placement, and although younger children (11 to 14) who entered group care went on to the care of a family, many older children (15 to 17) did not leave group care to enter the care of a family before turning 18. Surveys of youth also show that longer-term outcomes for children who were in group care were worse for six of nine measures.

Children are in group care for a significant portion of their out-of-home placement, and a larger percentage of children in group care were placed outside of their home county. Child welfare advocates recommend that states use group care as a time-limited placement to stabilize children with more severe behavioral issues and treatment needs so that they can spend most of their time in the care of a family (family foster home or relative or non-relative caregiver). However, as shown in Exhibit 11, most children who entered group care did not leave group care to spend most of their time in the care of a family.[28] On average, they spend over half of their time in group care and about one-third of their time in the care of a family; nearly a quarter of these children spent over 90% of their time in group care. In addition, children who entered group care were placed out of the county in which they resided nearly twice as often as children entering family foster care (45% and 25%, respectively). This may be partly due to the limited availability of group care facilities in certain counties or attempts to place children with group care providers whose programs better address the children's specific needs.

Exhibit 11
On Average, Children in Residential Group Care Spend Over Half of Their Time in This Setting



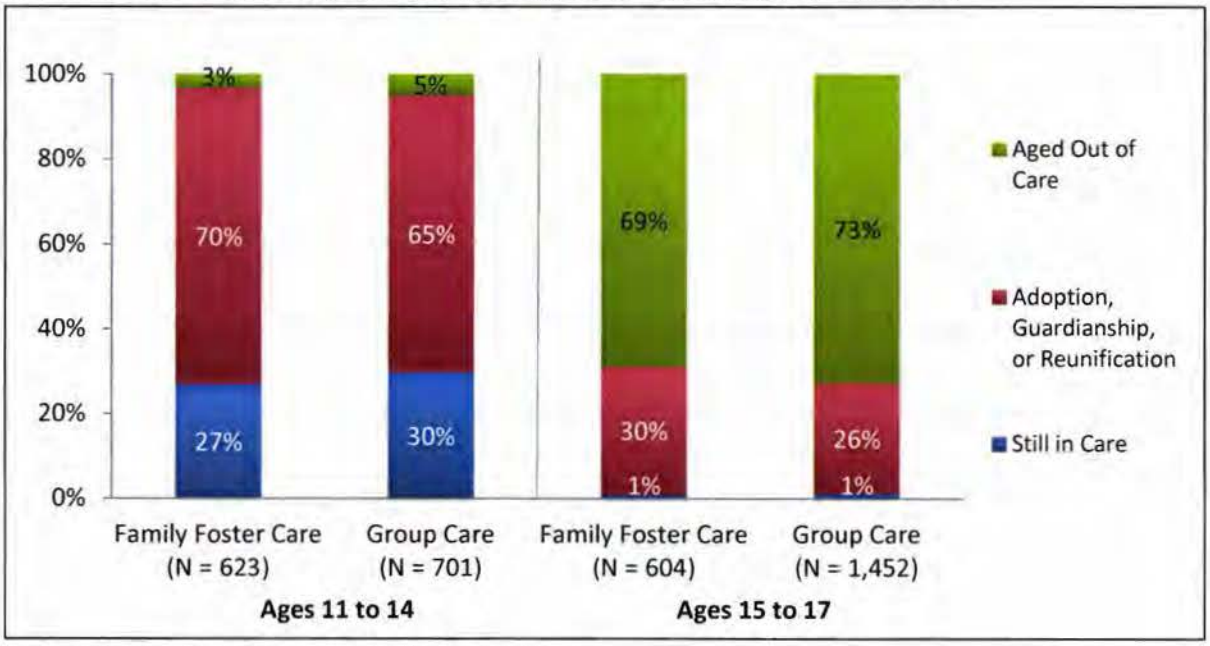
Source: OPPAGA analysis of Department of Children and Families data.

[28] This analysis is based on children who entered group care in Fiscal Year 2010-11.

Children run away from group care more than family foster care. For example, over 37% of children who entered group care at age 16 ran away from the group home compared to 21% of children who entered a family foster home at age 16. Given the behavioral issues of children who enter group care, this larger percentage could be expected. However, children who entered group care did not have a history of running away before entering group care. Over their entire time in out-of-home care, 47% of children in our analysis ran away from at least one of their group care placements even though only 15% of these children had been reported as running away before they entered group care.[29]

Although a similar percentage of children in both types of care achieve permanency in a family home, children in group care take longer to achieve permanency. Children typically leave the child welfare system either by being reunified with their parent or caregiver, entering permanent guardianship, being adopted, or aging out of care. Prior to implementation of extended foster care in Fiscal Year 2013-14, if a child was not discharged from the child welfare system to a permanent family home, when she/he turns 18, the child ages out of care. Exhibit 12 shows that, of children who entered group care between ages 11 and 14, about 65% were discharged to a permanent family home, compared to 70% of children who entered family foster care.[30] Most of the children who entered care between 15 and 17 aged out of care, with only 26% of children who entered group care and 30% of children who entered family foster care being discharged to a permanent family home before turning 18.

Exhibit 12
A Similar Share of Children in Group and Family Foster Care Achieved Permanency



Source: OPPAGA analysis of Department of Children and Families data.

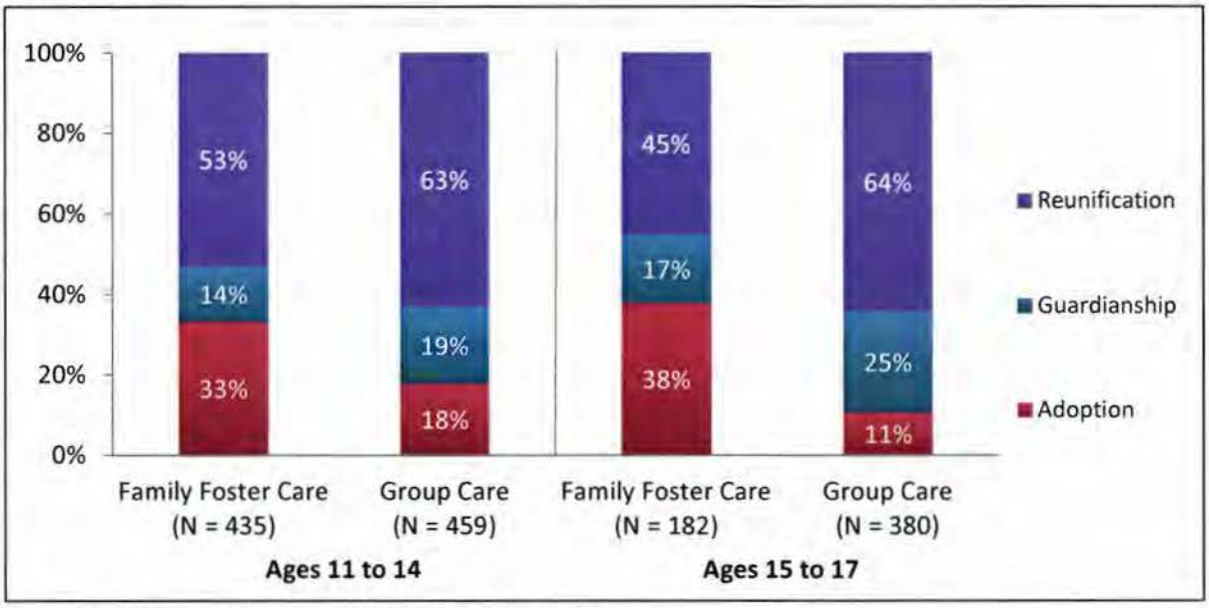
[29] When available, we used provider licensing information to distinguish between residential group care and other group care. However, due to conversion in the department's data systems used for provider licensing, data on providers' full licensing history were not available. Therefore, for this analysis we identified a person's first residential group care placement as the first residential placement lasting at least 15 days. This criterion was used to help minimize the likelihood that we counted an emergency shelter placement as residential group care. However, this may have counted some other group care placements as residential group care.

[30] This analysis looked at children who entered group care or family foster care in Federal Fiscal Year 2010-11 and followed them until May 2014.

However, it tends to take slightly longer for children who enter group care to be discharged to a permanent family home. Within one year of entering care, children who were in group care who had not turned 18 had a 34% likelihood of having been discharged to a permanent family home compared to 38% for children who were in family foster care. In addition, at three years after entering care, children in group care had a 68% likelihood of having been discharged to a permanent family home compared to 73% for children who were in family foster care.[31]

Children who achieved permanency from group care were more often reunified and less often adopted than children who achieved permanency from family foster care. As shown in Exhibit 13, of children ages 15 to 17 who were discharged to a permanent family home from family foster care, 45% were reunified with their parents or caregivers and 38% were adopted. In contrast, 64% of children who achieved permanency from group care were reunified while 11% were adopted. The lower adoption rate for children who were in group care may be partly due to the fact that most children are adopted by their foster parents or a relative or non-relative caregiver. Since children who were in group care tend to spend less of their time in family-based care, their exposure to potential adoptive parents may be reduced.

Exhibit 13
Children in Group Care Are More Often Reunified and Less Often Adopted Than Children in Family Foster Care



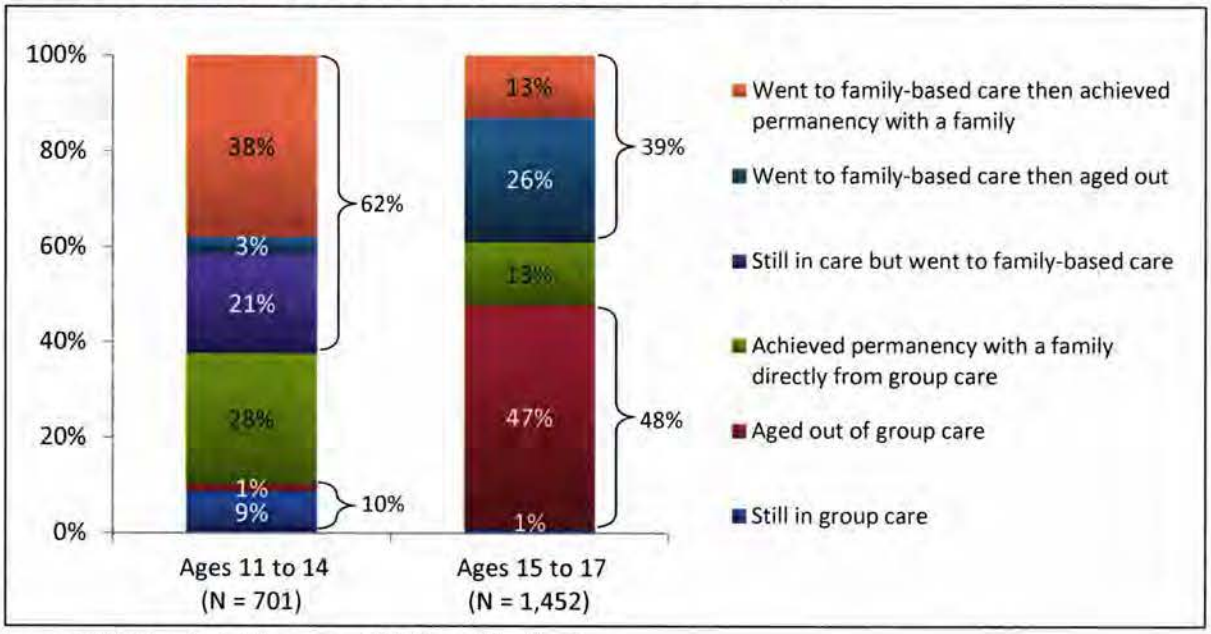
Source: OPPAGA analysis of Department of Children and Families data.

Although most younger children who entered group care went on to the care of a family, a large percentage of older children (ages 15 to 17) turned 18 without moving on to the care of a family . As shown in Exhibit 14, of the children who entered group care between ages 11 and 14,

[31] To examine time to permanency, we selected a cohort of all children who entered out-of-home care between ages 11 and 16 in federal Fiscal Year 2010-11 and went into family foster care or group care before the end of the year. We tracked their care through May 12, 2014. Since children age out of care if they have not achieved permanency by the time they turn 18, we have different lengths of time to track permanency for children who entered care at different ages. Therefore, we used the Kaplan-Meier product-limit estimator, which accounts for these differences, to estimate the probability of having achieved permanency for children who have not yet aged out of care.

only 10% had not moved on to the care of a family.[32] Slightly more than 60% went on to family foster care or a relative or nonrelative caregiver, and another 28% were discharged directly from group care into a permanent family home. In contrast, 48% of children who entered group care between ages 15 and 17 turned 18 without moving on to the care of a family. Only 39% went on to family foster care or a caregiver, and only 13% were discharged directly from group care into a permanent family home.

Exhibit 14
Most Younger Children Left Group Care to Enter the Care of a Family



Source: OPPAGA analysis of Department of Children and Families data.

Surveys of Florida youth suggest that longer-term outcomes are slightly worse for children who were in group care. The National Youth in Transition Database (NYTD) Survey is primarily the results of a survey of youth who age out of foster care, asking them about their outcomes since they left care. Although there is some evidence that NYTD survey responses are not fully representative of all children who had been in care, it is one of the most useful sources of information about long-term outcomes for children who had been in care.[33] As shown in Exhibit 15, outcomes for Florida youth who aged out of care were worse for children who were in group care on six of nine selected measures. For example, 25% of 18- to 19-year-old respondents who had been in group care had not completed the 11th grade compared to 18% who had been in family foster care.

[32] This analysis is based on the status of children as of May 2014.

[33] NYTD survey responses do not provide an accurate reflection of the longer-term outcomes of all children who had been in Florida's child welfare system for several reasons. First, the NYTD survey only reflects the experiences of youth who aged out of care by May 30, 2013, who are about 2/3 to 3/4 of the 15- to 17-year-olds we analyzed. Second, about half of the youth who were eligible to take the survey responded and they are a biased subset of those eligible to respond. In particular, youth who exhibited certain behavioral issues in their family assessments had about a 4% to 12% lower response rate. Lastly, comparisons between survey responses and FSFN data provide some limited evidence that the answers of some respondents may be inaccurate. Forty-four percent (417 of 947) of youth in group care who aged out of care by May 2013 and 53% (210 of 393) of youth in family foster care who aged out of care responded to a NYTD survey.

Exhibit 15
National Youth in Transition Database Survey Outcomes for Former Foster Care Children in Florida

Outcomes	Family Foster Care NYTD Respondents (N = 210)	Group Care NYTD Respondents (N = 417)
Have not completed 11th grade	18%	25%
Have not earned a high school diploma or GED	43%	43%
Unemployed and not in school	10%	16%
Does not have an open bank account	24%	34%
In jail or homeless	2%	7%
Does not reside in own residence	52%	56%
Receives public support (Welfare, housing, or food assistance)	56%	57%
Does not have access to transportation	25%	25%
Does not have a supportive adult in his or her life	20%	17%

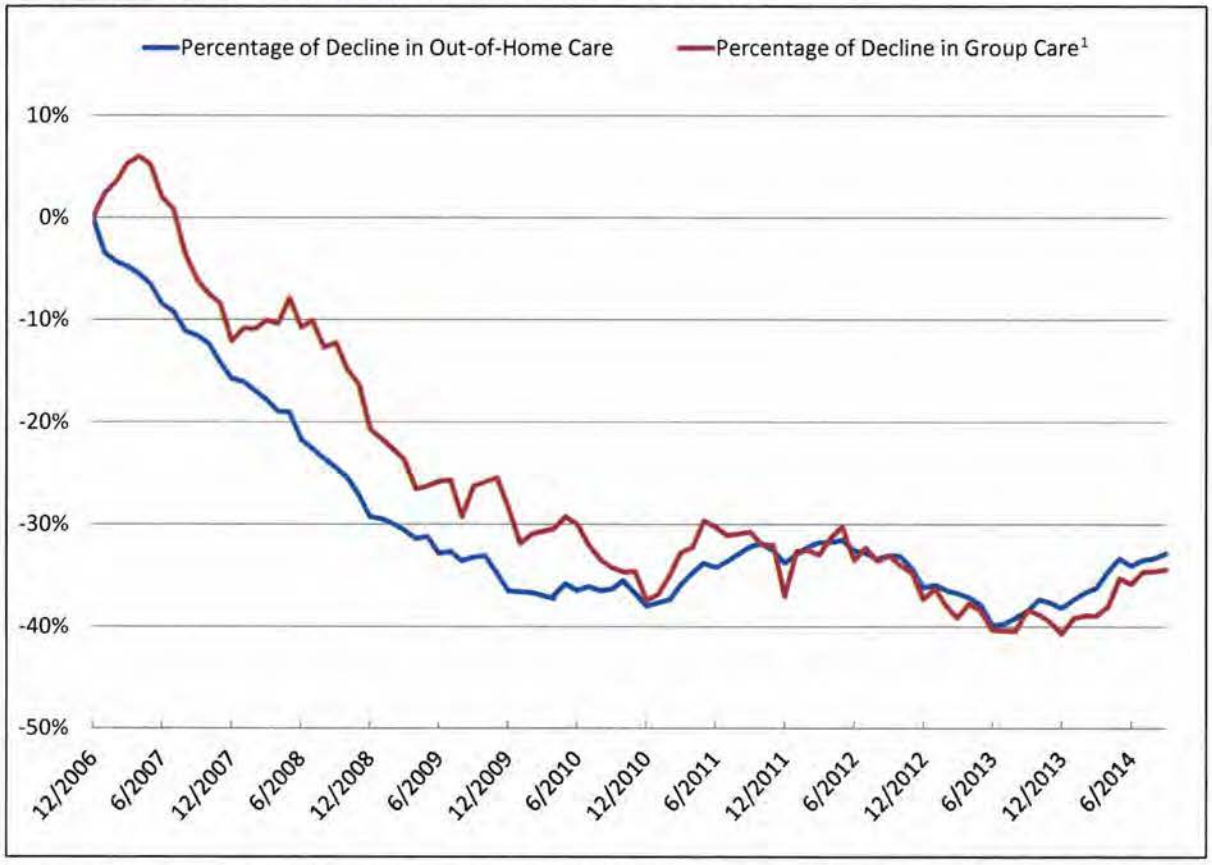
Source: OPPAGA analysis of Department of Children and Families National Youth in Transition Database data.

Appendix A

The Number of Children in Out-of-Home Care and Group Care Has Decreased

Since January 2007, the number of total children in out-of-home care and the number in group care decreased. The department set a goal to reduce the number of children in out-of-home care by 50% between January 2007 and January 2012. By January 2012, the number of children in out-of-home care had decreased by over 30%, with group care experiencing a similar reduction. On December 31, 2006, there were 29,255 children in out-of-home care, of which 11% (3,348) were in group care. As of September 30, 2014, there were 19,663 children in out-of-home care, of which 11% (2,196) were in group care. This represents a 33% reduction in out-of-home care and a 34% reduction in group care.[34]

Exhibit A-1
The Use of Group Care Decreased at a Similar Rate as Total Out-of-Home Care



[1] The trend for group care includes all children in group care at the end of each month, including children in the care of providers licensed by the department as emergency shelters, runaway shelters, wilderness camps, and maternity group homes and children with providers licensed by other agencies as Statewide Inpatient Psychiatric Programs, therapeutic group homes, or Agency for Persons with Disabilities' group homes.

Source: OPPAGA analysis of Department of Children and Families data.

[34] The percentage decline for children in group care is 1% different between Exhibit 2 and Exhibit A-1 is because the data for Exhibit 2 is calculated using a different starting point and is based on the average annual number of children in care, while Exhibit A-1 is based on the number of children in care at a given point in time.

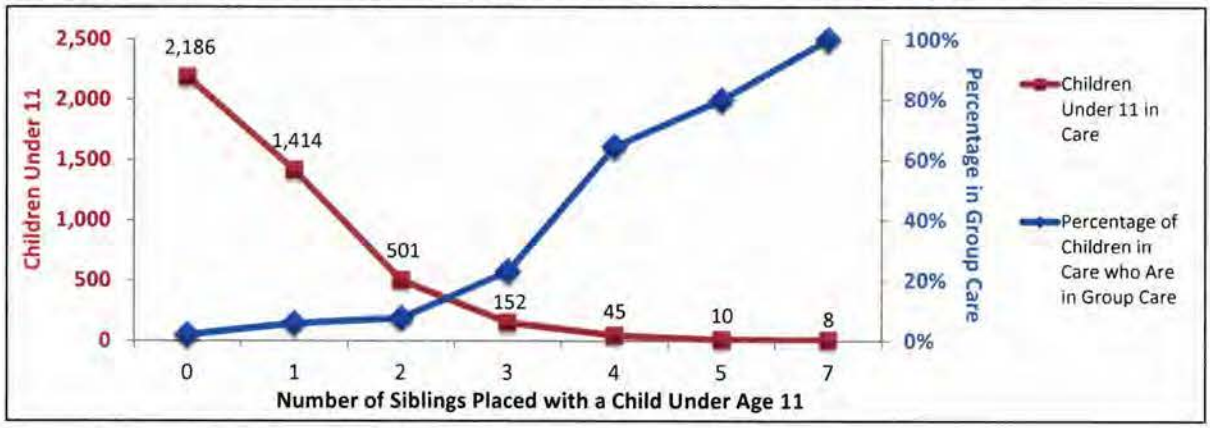
Appendix B

Most Young Children in Group Care Are Not in Care with Many Siblings

While younger children in group care are with siblings, there are few young children in group care with many of their siblings. Lead agency staff reported that children under age 11 typically are not placed in group care unless family foster care placements that will keep siblings together are unavailable. In particular, they reported that it may be challenging to identify foster parents who are willing to take a large number of siblings into their homes. Exhibits B-1 through B-3 show that most young children who are in group care are placed there with at least one sibling, and when children are in care with a large number of siblings (three or more), they are placed in group care. However, there are many young children in group care who do not appear to be in care with a large number of siblings.[35]

In Exhibit B-1, the red line, which is the number of children under age 11 in licensed care (family foster care or group care), shows there are few young children who are placed in licensed care together with a large number of their siblings. The blue line, which is the percentage of the young children who are in group care, shows that when larger sibling groups are kept together, they are typically kept together in group care.

Exhibit B-1
Young Children Placed with Many Siblings in Licensed Care Are Usually in Group Care



Source: OPPAGA analysis of Department of Children and Families data.

[35] A small number of these young children may be in other types of residential placements, such as maternity homes or emergency shelters. In addition, some of these children may be temporarily separated from siblings because one or more siblings ran away, entered a correctional placement or emergency care, or were on visitation.

As shown in Exhibit B-2, 82% of young children in group care were in care with at least one of their siblings. In contrast, 47% of young children in family foster care were placed with at least one sibling. However, only one-third of the young children in group care were with three or more of their siblings.

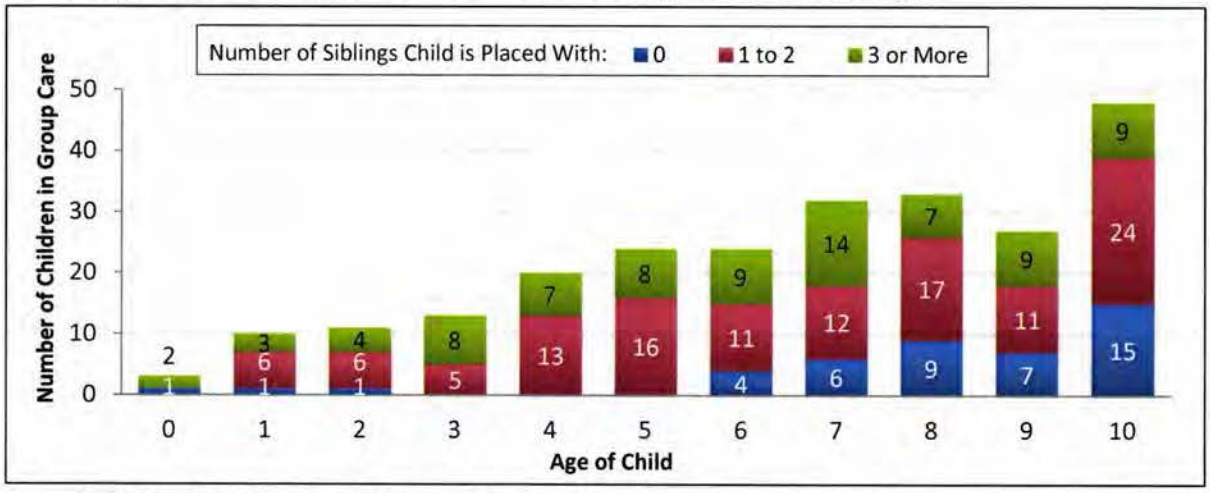
Exhibit B-2
Most Young Children in Group Care Are Placed in Care with at Least One Sibling

Placement with Siblings for Children Under Age 11	Family Foster Care (N = 4,071)	Group Care (N = 245)
Percentage of children placed with at least one sibling	47%	82%
Percentage of children placed with three or more siblings	3%	33%

Source: OPPAGA analysis of Department of Children and Families data.

Exhibit B-3 shows that among children ages 0 to 10, the older children (6 to 10) are more often placed in group care with few siblings. For example, 60% (49 of 81) of children under the age of six in group care were placed with fewer than three siblings. For children ages 6 to 10 in group care, 71% (116 of 164) are placed together with fewer than three siblings, and 25% (41 of 164) are placed with no siblings.

Exhibit B-3
Few Young Children in Group Care Are Placed with a Large Number of Siblings



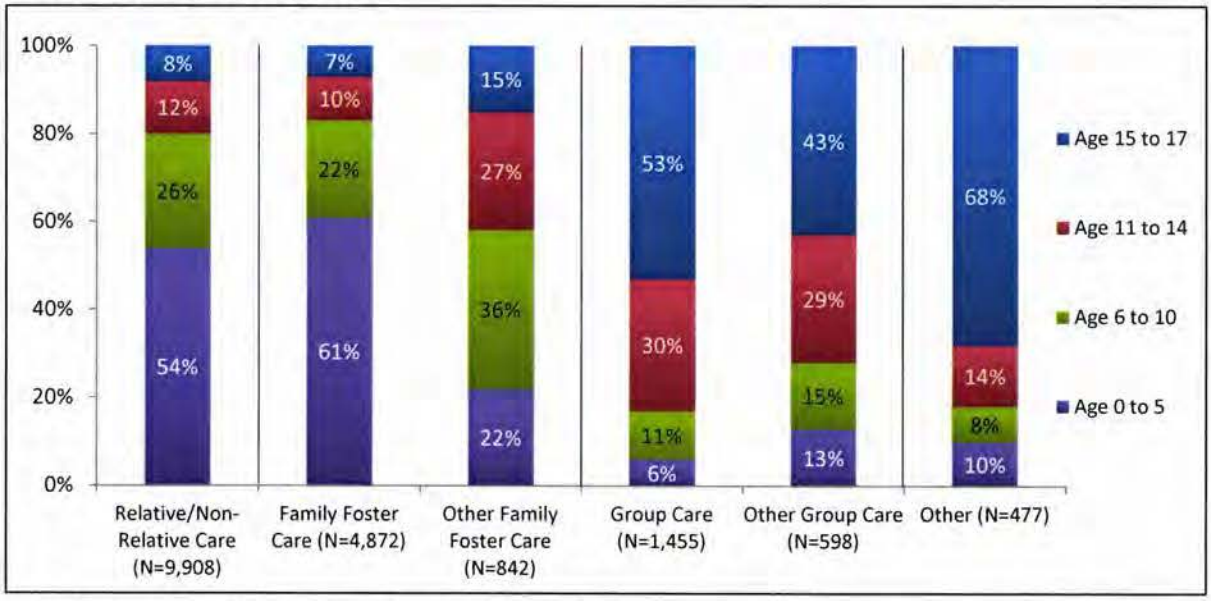
Source: OPPAGA analysis of Department of Children and Families data.

Appendix C

Demographics of Children in Group Care and Family Foster Care

Children in group care are significantly older than children in family-based care. As shown in Exhibit C-1, the distribution of children by age varies across types of out-of-home care. More children in group care were 11 or older compared children in family foster care. Other family foster care primarily consists of licensed therapeutic family foster care and children placed in the care of families out of state. Other group care includes children in the care of providers licensed by the department as emergency shelters, runaway shelters, wilderness camps, and maternity group homes, and children with providers licensed by other agencies as Statewide Inpatient Psychiatric Programs, therapeutic group homes, or group homes for persons with developmental disabilities. Other placements consist of children in correctional placements and children who ran away, were in emergency services, or were on visitation.

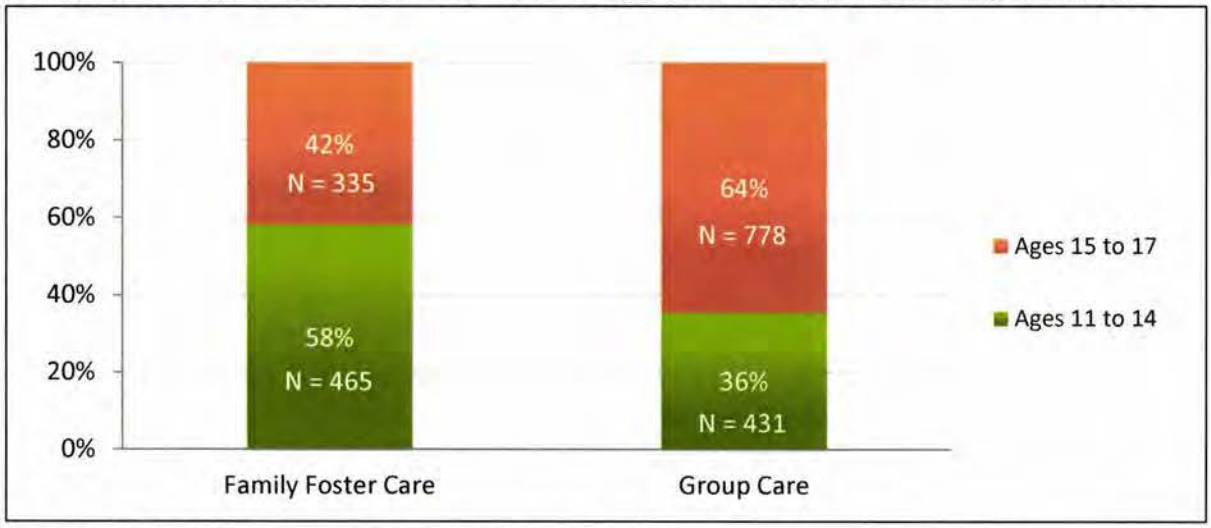
Exhibit C-1
Children in Group Care Are Older



Source: OPPAGA analysis of Department of Children and Families data.

Group care programs serve primarily older, male, and minority children. Our analysis focused on children 11 and older in group care and family foster care. As shown in Exhibits C-2 through C-4, the largest demographic difference between children in group care and family foster care is that children in group care are older. Exhibit C-2 shows that among children 11 or older, 64% of children in group care are 15 to 17, compared to 42% in family foster care.

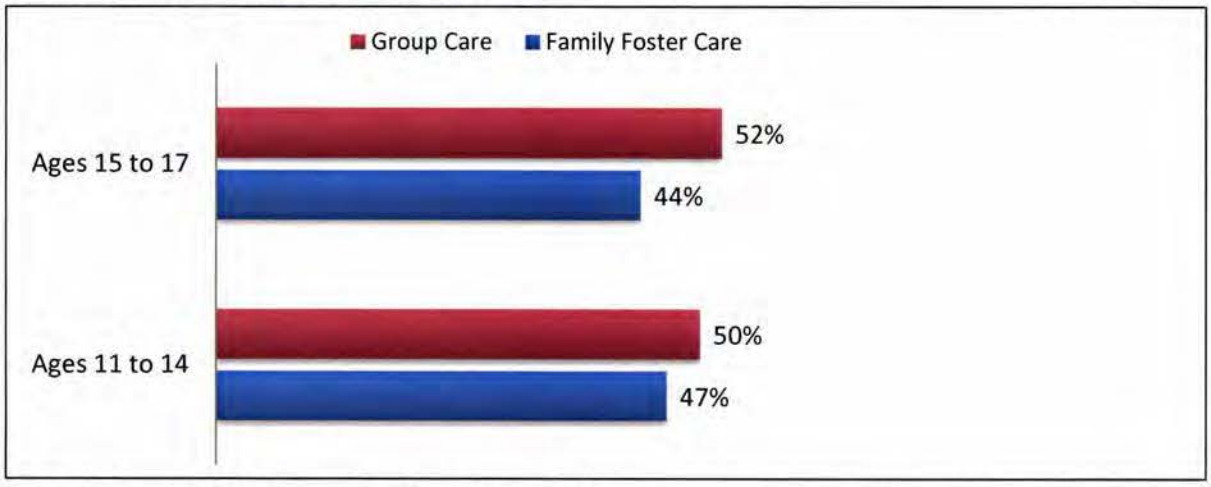
Exhibit C-2
A Larger Percentage of Children in Group Care Are Ages 15 to 17 Compared to Family Foster Care



Source: OPPAGA analysis of Department of Children and Families data.

Exhibit C-3 shows that, compared to family foster care, a larger share of children in group care are male. Fifty-two percent of children ages 15 to 17 in group care are male, compared to 44% in family foster care.

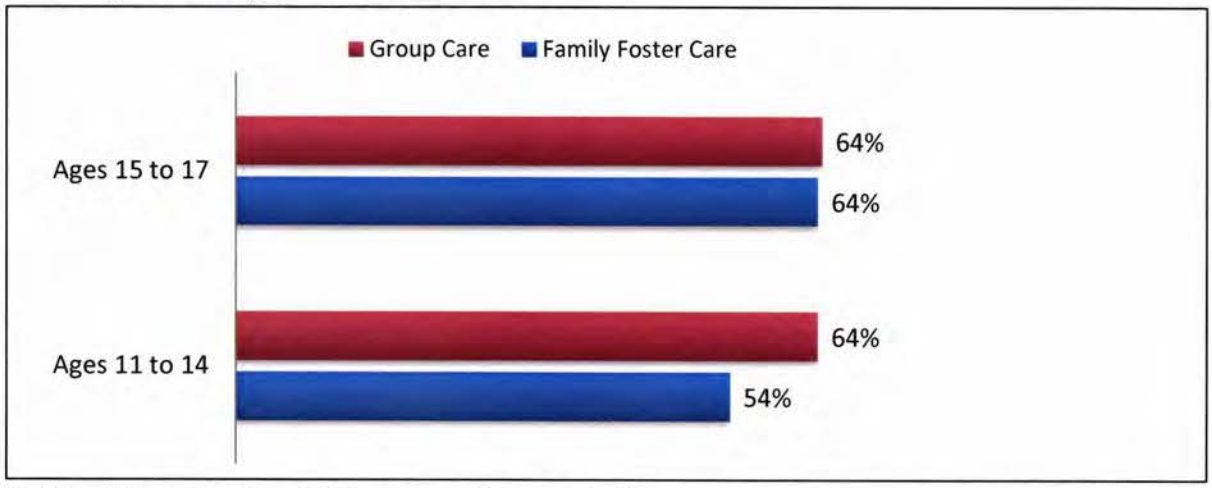
Exhibit C-3
Percentage of Male Children in Licensed Care



Source: OPPAGA analysis of Department of Children and Families data.

As is the case nationally, a larger percentage of children in out-of-home care are minorities, especially group care. Exhibit C-4 shows that 64% of children ages 11 to 14 in group care are minorities, compared to 54% in family foster care. Among children ages 15 to 17, 64% of children in both group care and family foster care are minorities.

Exhibit C-4
Percentage of Minority Children in Licensed Care[1]



[1] For this exhibit, white non-Hispanic children were considered non-minorities.

Source: OPPAGA analysis of Department of Children and Families data.

Appendix D

Assessed Behavioral Issues of Children in Group Care and Family Foster Care

Data shows children in group care exhibited more behavioral issues than children in family foster care. Child welfare services workers are required to complete a family assessment when a family begins receiving services as a result of a child protective investigation.[36] To determine whether group care is primarily used to provide care for adolescents with behavioral problems, we obtained family assessment data for children who were in licensed family foster care or group care on November 15, 2013. To minimize the likelihood that children's assessed behaviors were influenced by the type of care they were in, for each child we attempted to identify the assessment closest to, but before, they entered this placement.[37] Although the percentage of children with a complete assessment varied substantially throughout the state, overall about 91% of children had a family assessment, and about 67% had an assessment near when they entered family or group care.[38, 39] Family assessments are similarly complete for children in group care and family foster care.

The assessment includes a determination of whether the child exhibits one or more of 24 specific behavioral issues.[40] Exhibits D-1 and D-2 show that children in group care exhibited nearly all of the behavioral issues at a higher rate than children in family foster care. For example, 71% of children ages 15 to 17 exhibited at least one of these behavioral issues compared to 48% of children in family foster care. In addition, 39% of children in group care ages 15 to 17 had four or more issues identified compared to 21% of children in family foster care.

---

[36] Rule 65C-30.005, *F.A.C.*, requires child welfare services workers to complete a family assessment within 15 working days of the Early Services Intervention staffing and update the assessment, at a minimum, every 6 months thereafter. The family assessment is used to analyze the strengths and needs of the family and its members and informs the development of case plans.

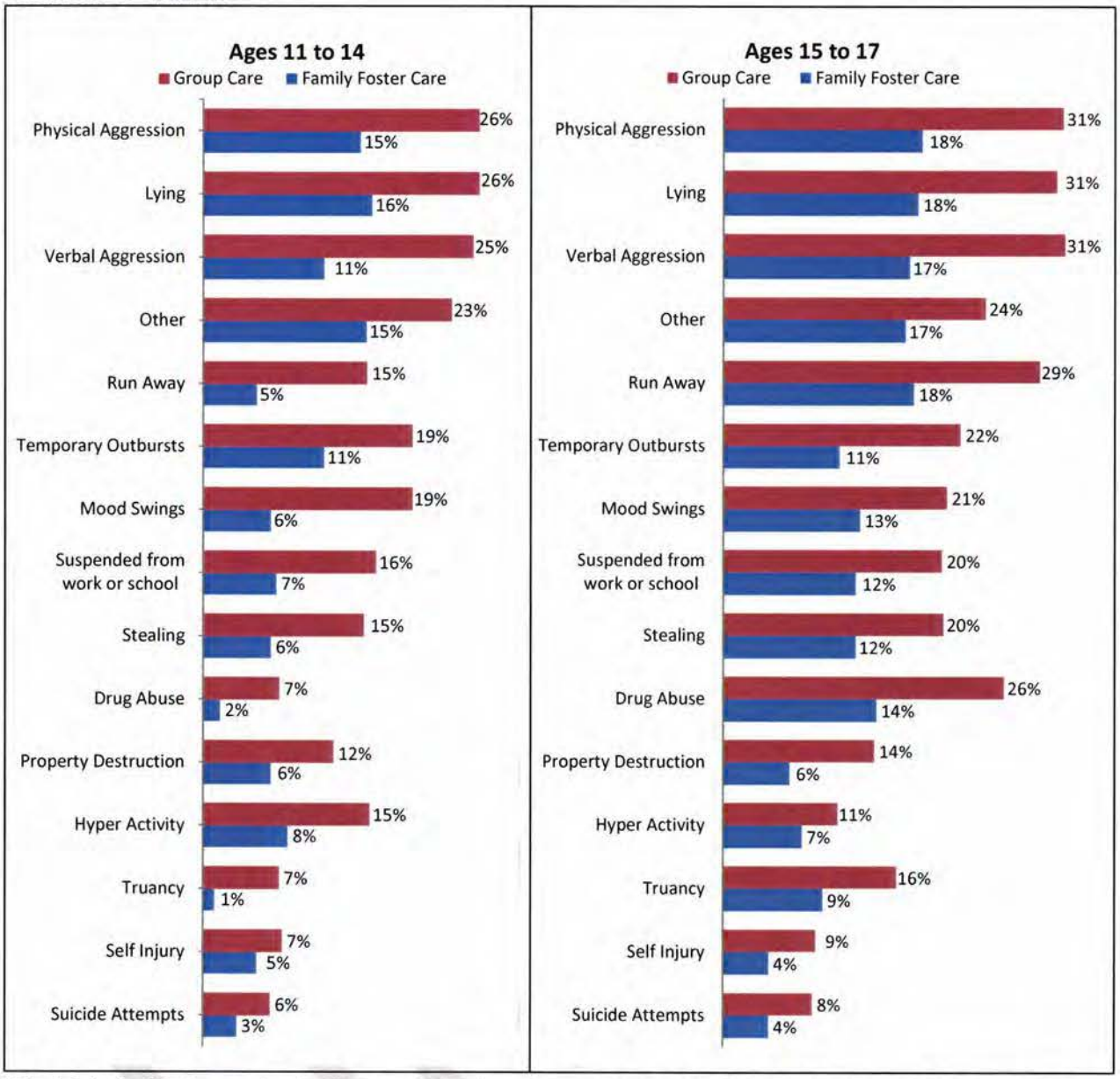
[37] An assessment was considered current if it was completed within six months before and one month after the child entered his or her current placement. Limiting the analysis to children with a current assessment or to children who entered group care for the first time did not substantially change the results. As such, we present the results for all children who had an assessment recorded in FSFN.

[38] This does not include Our Kids, Florida's largest community-based care lead agency, which did not complete the standard family assessment in FSFN. At the time of our review, Our Kids was using an alternative assessment instrument, known as structured decision making. Our Kids will transition to using Florida's revised statewide standard assessment instrument. At the time of our review, Our Kids had about 10% of the state's population of children in family foster care and group care over the age of 11.

[39] Child Net of Palm Beach had, by far, the lowest percentage, with only 49% of children having a complete assessment and only 23% of children having a current assessment.

[40] The exhibits only show 15 behavioral issues, because the 10 least common behavioral issues were collapsed into the category Other. These issues are sleep disturbances, bed wetting, withdrawn or lethargic behavior, fire setting, harming animals, frequent crying, frequent physical complaints, eating disorders, bizarre hallucinations, and other issues.

Exhibit D
Behaviors of Children[1]



[1] Other includes the following categories: sleep disturbances, bed wetting, withdrawn or lethargic behavior, fire setting, harming animals, frequent crying, frequent physical complaints, eating disorders, bizarre hallucinations, and other issues.

Source: OPPAGA analysis of Department of Children and Families data.