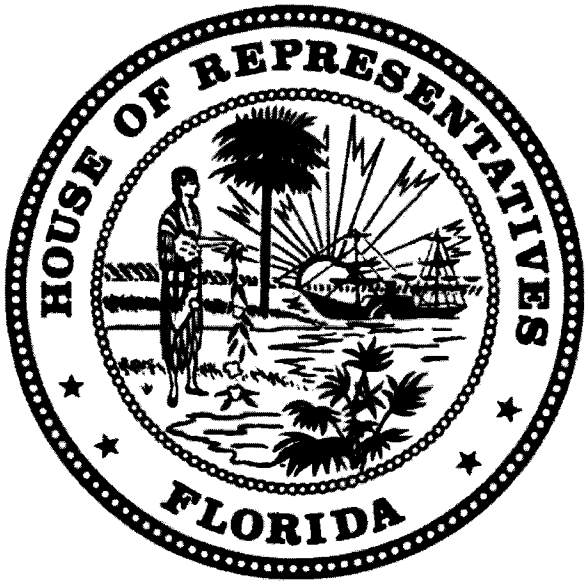

Children, Families & Seniors Subcommittee

Tuesday, March 24, 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:	Tuesday, March 24, 2015 10:00 am
End Date and Time:	Tuesday, March 24, 2015 12:00 pm
Location:	12 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

CS/HB 69 Missing Persons with Special Needs by Criminal Justice Subcommittee, Porter
HB 1193 Services for Veterans and Their Families by Ingoglia

Consideration of the following proposed committee bill(s):

PCB CFSS 15-01 -- Mental Health and Substance Abuse
PCB CFSS 15-02 -- Child Welfare

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Monday, March 23, 2015.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Monday, March 23, 2015.

NOTICE FINALIZED on 03/20/2015 15:57 by Villar.Melissa

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 69 Missing Persons with Special Needs
SPONSOR(S): Criminal Justice Subcommittee; Porter and others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 330

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Criminal Justice Subcommittee	12 Y, 0 N, As CS	Cox	Cunningham
2) Children, Families & Seniors Subcommittee		Langston	Brazzell
3) Appropriations Committee			
4) Judiciary Committee			

SUMMARY ANALYSIS

Chapter 937, F.S., establishes a variety of requirements relating to how state and local law enforcement agencies respond to and investigate reports of missing endangered persons. Currently, s. 937.0201, F.S., defines "missing endangered person" as:

- A missing child;
- A missing adult younger than 26 years of age;
- A missing adult 26 years of age or older who is suspected by a law enforcement agency of being endangered or the victim of criminal activity; or
- A missing adult who meets the criteria for activation of the Silver Alert Plan of the Florida Department of Law Enforcement (FDLE).

The bill expands the definition of the term "missing endangered person" to include "a missing person with special needs who is at risk of becoming lost or is prone to wander due to autism spectrum disorder, a developmental disability, or any other disease or condition." The bill also:

- Authorizes any person to submit a missing endangered person report concerning a missing person with special needs to the Missing Endangered Persons Information Clearinghouse (MEPIC) (so long as they have reported the person with special needs missing to a local law enforcement agency and the agency has entered the report into Florida Crime Information Center/National Crime Information Center); and
- Grants civil immunity to specified entities responding to a law enforcement agency's request to broadcast information relating to a missing person with special needs.

The bill will have an indeterminate negative fiscal impact on FDLE. There does not appear to be a fiscal impact to local governments.

The bill is effective on July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Missing Endangered Persons

Chapter 937, F.S., establishes a variety of requirements relating to how state and local law enforcement agencies respond to and investigate reports of missing endangered persons. For example, the chapter:

- Requires law enforcement agencies to submit information about "missing endangered persons" to the Missing Endangered Persons Information Clearinghouse (MEPIC), housed within the Florida Department of Law Enforcement (FDLE);[1]
- Authorizes non-law enforcement entities to submit a missing endangered person report to MEPIC in certain instances;[2]
- Requires MEPIC to establish a system of intrastate communication of information relating to missing endangered persons;[3]
- Requires MEPIC to collect, process, maintain, and disseminate information on missing endangered persons;[4] and
- Requires law enforcement agencies that locate a person previously reported as a "missing endangered person" to purge information about the case from Florida Crime Information Center/National Crime Information Center (FCIC/NCIC) and notify MEPIC.[5]

A "missing endangered person" is:

- A missing child;[6]
- A missing adult[7] younger than 26 years of age;
- A missing adult 26 years of age or older who is suspected by a law enforcement agency of being endangered or the victim of criminal activity; or
- A missing adult who meets the criteria for activation of the Silver Alert Plan[8] of the Florida Department of Law Enforcement (FDLE).[9]

Civil Immunity

Law enforcement agencies that receive a report of a missing child, missing adult, or missing endangered person must submit information about the report to other local law enforcement agencies

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[1] S. 937.022, F.S.
[2] Id.
[3] Id.
[4] Id.
[5] Id.
[6] S. 937.0201(3), F.S., "missing child" as a person younger than 18 years of age whose temporary or permanent residence is in, or is believed to be in, this state, whose location has not been determined, and who has been reported as missing to a law enforcement agency.
[7] S. 937.0201(2), F.S., "missing adult" as a person 18 years of age or older whose temporary or permanent residence is in, or is believed to be in, this state, whose location has not been determined, and who has been reported as missing to a law enforcement agency.
[8] FLORIDA DEPARTMENT OF LAW ENFORCEMENT, *Silver Alert* Action, http://www.fdle.state.fl.us/Content/Silver-Alert-Plan/Menu/Activation-Steps.aspx (last visited on March 21, 2015) (The Florida Silver Alert is used to locate missing persons suffering from an irreversible deterioration of intellectual faculties. Local and State Silver Alerts engage the public in the search for the missing person and provide a standardized and coordinated community response.).
[9] S. 937.0201, F.S.

and to FDLE.[10] In an effort to locate the missing person, the law enforcement agency that originally received the report may request, but cannot require, other specified entities (e.g., FDLE, local law enforcement entities, radio and television networks, etc.) to broadcast information about the missing person to the public.[11] Section 937.021(5), F.S., grants the entities responding to such requests immunity from civil liability if the broadcasted information relates to a missing adult, missing child, or a missing adult who meets the criteria for activation of the Silver Alert Plan.[12] Currently, the statute does not specifically provide such immunity to entities responding to a request to broadcast information relating to a missing person with special needs, though a missing person with special needs may be encompassed within the other definitions of a "missing person."

Missing Endangered Persons Information Clearinghouse

The MEPIC is housed within FDLE and serves as a central repository for all information regarding missing endangered persons.[13] MEPIC collects, processes, maintains, and disseminates information on missing endangered persons using an intrastate communication system.[14] Section 937.022, F.S., creates parameters on who can submit a missing endangered person report to MEPIC. Any person having knowledge may submit a report to MEPIC regarding a child or adult younger than 26 years old whose whereabouts is unknown, so long as the person has reported the child/adult missing to a local law enforcement agency and the agency has entered the report into FCIC/NCIC.[15] However, only the law enforcement agency having jurisdiction over the case may submit a missing endangered person report for an adult 26 years old or older or for the activation of a silver alert.[16]

Effect of Proposed Changes

Missing Persons

The bill expands the definition of the term "missing endangered person" found in s. 937.0201, F.S., to include "a missing person with special needs who is at risk of becoming lost or is prone to wander due to autism spectrum disorder, a developmental disability, or any other disease or condition." As a result:

- Law enforcement agencies will be required to submit information about missing persons with special needs to MEPIC;
- Non-law enforcement entities will be authorized to submit information about missing persons with special needs to MEPIC in certain instances; and
- MEPIC will be required to collect, process, maintain, and disseminate information about missing persons with special needs.

Civil Immunity

The bill amends s. 937.021(5), F.S., to provide immunity from civil liability to specified entities responding to a request to broadcast information relating to a missing person with special needs (as defined above). The bill mirrors the existing immunity provisions for the broadcast of missing person's information.

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[10] Ss. 937.021, 937.022, F.S.
[11] S. 937.021(5)(e), F.S.
[12] S. 937.021(5), F.S., these entities are afforded a legal presumption that they acted in good faith in broadcasting the missing person information.
[13] FLORIDA DEPARTMENT OF LAW ENFORCEMENT, *Florida Missing Endangered Persons Information Clearinghouse*, http://www.fdle.state.fl.us/MCICSearch/Index.asp (last visited March 21, 2015).
[14] S. 937.022(3), F.S.
[15] S. 937.022(3)(b)2., F.S ., this report may be made subsequent to submitting a report to the appropriate law enforcement agency, and subsequent to entry by the law enforcement agency of the child or person into FCIC and NCIC databases.
[16] S. 937.022(3)(b), F.S.

Missing Endangered Persons Information Clearinghouse

The bill amends s. 937.022, F.S., to authorize any person to submit a missing endangered person report concerning a missing person with special needs to MEPIC. Before doing so, the person must have reported the person with special needs missing to a local law enforcement agency and the agency must have entered the report into FCIC/NCIC.

B. SECTION DIRECTORY:

Section 1: Amends s. 937.0201, F.S., relating to definitions.
Section 2: Amends s. 937.021, F.S., relating to missing child and missing adult reports.
Section 3: Amends s. 937.022, F.S., relating to Missing Endangered Persons Information Clearinghouse.
Section 4: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill will have an indeterminate negative fiscal impact on FDLE as a result of the expansion of the term "missing endangered person." This will require FDLE to modify its MEPIC database to collect, process, maintain, and disseminate information about missing persons with special needs.[17]

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:

[17] Florida Department of Law Enforcement, 2015 Agency Bill Analysis for HB69, February 5, 2015 (on file with the Children, Families, and Seniors Subcommittee).

This bill appears to be exempt from the requirements of Article VII, Section 18 of the Florida Constitution because it is a criminal law.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

FDLE notes that while there are no provisions that specifically define "missing person with special needs" or identify a particular protocol regarding such individuals under any section of Chapter 937, MEPIC currently includes within its processes of reporting missing endangered persons any missing individual with any special needs (i.e. any persons with autism spectrum disorder, developmental disability, Alzheimer's disease or other form of dementia, or any other such disease or condition), or any person missing and suspected by a law enforcement agency of being endangered due to any circumstance or status of being.[18] FDLE also notes that they currently issue Missing Child Alerts for all missing children with autism.[19]

According to FDLE, existing definitions in s. 937.0201(4)(a), (b), (c), and (d), F.S., capture all missing persons, children and adults, that may be endangered. Additionally, FCIC defines missing categories of "Disabled" or "Endangered" to specifically identify missing disabled individuals. FDLE is concerned that specifying individual types of disabilities and circumstances to those that limit an individual's capacity for self-care, ability to make sound choices, seeking help when needed, or protect themselves from harm in statute may result in unintended consequences of restricting certain missing person investigative services from others who do not meet the proposed, specified criteria, but who are nonetheless missing and endangered.[20]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 3, 2015, the Criminal Justice Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment:

- Deletes the requirement that FDLE and DCF provide electronic monitoring devices to specified individuals with special needs, as well as the requirement for APD to produce of a list of persons eligible for the electronic monitoring devices; and
- Removes the requirement that FDLE incorporate training on retrieving missing persons with special needs in its law enforcement officer training.

This bill analysis is drafted to the committee substitute as passed by the Criminal Justice Subcommittee.

[18] Id.
[19] Id.
[20] Id.

A bill to be entitled

An act relating to missing persons with special needs; amending s. 937.0201, F.S.; revising the definition of the term "missing endangered person" to include certain persons with special needs; amending s. 937.021, F.S.; providing immunity from civil liability for certain persons who comply with a request to release information concerning missing persons with special needs to appropriate agencies; providing a presumption that a person recording, reporting, transmitting, displaying, or releasing such information acted in good faith; amending s. 937.022, F.S.; specifying who may submit a report concerning a missing person with special needs; providing an effective date.

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

Section 1. Paragraphs (c) and (d) of subsection (4) of section 937.0201, Florida Statutes, are amended, and paragraph (e) is added to that subsection, to read:

937.0201 Definitions.—As used in this chapter, the term:

(4) "Missing endangered person" means:

(c) A missing adult 26 years of age or older who is suspected by a law enforcement agency of being endangered or the victim of criminal activity; ~~or~~

(d) A missing adult who meets the criteria for activation of the Silver Alert Plan of the Department of Law Enforcement; or

(e) A missing person with special needs who is at risk of becoming lost or is prone to wander due to autism spectrum disorder, a developmental disability, or any other disease or condition.

Section 2. Paragraphs (d) and (e) of subsection (5) of section 937.021, Florida Statutes, are amended, and a new paragraph (d) is added to that subsection, to read:

937.021 Missing child and missing adult reports.—

(5)

(d) Upon receiving a request to record, report, transmit, display, or release information about a missing person with special needs, as described in s. 937.0201(4)(e), from the law enforcement agency having jurisdiction over the missing person, the Department of Law Enforcement, any state or local law enforcement agency, and the personnel of these agencies; any radio or television network, broadcaster, or other media representative; any dealer of communications services as defined in s. 202.11; or any agency, employee, individual, or entity is immune from civil liability for damages for complying in good faith with the request and is presumed to have acted in good faith in recording, reporting, transmitting, displaying, or releasing information pertaining to the missing person with special needs.

(e) ~~(d)~~ The presumption of good faith is not overcome if a technical or clerical error is made by any agency, employee, individual, or entity acting at the request of the local law enforcement agency having jurisdiction~~,~~ or if the information regarding an Amber Alert, Missing Child Alert, Silver Alert, missing child ~~information~~, missing adult ~~information~~, or missing person with special needs ~~Silver Alert information~~ is incomplete or incorrect because the information received from the local law enforcement agency was incomplete or incorrect.

(f) ~~(e)~~ Neither this subsection nor any other provision of law creates a duty of the agency, employee, individual, or entity to record, report, transmit, display, or release the information regarding an Amber Alert, Missing Child Alert, Silver Alert, missing child ~~information~~, missing adult ~~information~~, or missing person with special needs ~~Silver Alert information~~ received from the local law enforcement agency having jurisdiction. The decision to record, report, transmit, display, or release information is discretionary with the agency, employee, individual, or entity receiving the information.

Section 3. Paragraph (b) of subsection (3) of section 937.022, Florida Statutes, is amended to read:

937.022 Missing Endangered Persons Information Clearinghouse.—

(3) The clearinghouse shall:

(b) Provide a centralized file for the exchange of

information on missing endangered persons.

1. Every state, county, or municipal law enforcement agency shall submit to the clearinghouse information concerning missing endangered persons.

2. Any person having knowledge may submit a missing endangered person report to the clearinghouse concerning a child, an ~~or~~ adult younger than 26 years of age, or a person with special needs, as described in s. 937.0201(4)(e), whose whereabouts are ~~is~~ unknown, regardless of the circumstances, subsequent to reporting such child, ~~or~~ adult, or person with special needs missing to the appropriate law enforcement agency within the county in which the child, ~~or~~ adult, or person with special needs went ~~became~~ missing, and subsequent to entry by the law enforcement agency of the child or person into the Florida Crime Information Center and the National Crime Information Center databases. The missing endangered person report shall be included in the clearinghouse database.

3. Only the law enforcement agency having jurisdiction over the case may submit a missing endangered person report to the clearinghouse involving a missing adult age 26 years or older who is suspected by a law enforcement agency of being endangered or the victim of criminal activity.

4. Only the law enforcement agency having jurisdiction over the case may make a request to the clearinghouse for the activation of a state Silver Alert involving a missing adult if circumstances regarding the disappearance have met the criteria

for activation of the Silver Alert Plan.

Section 4. 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 Porter offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 937.041, Florida Statutes is created to read:

937.041 Missing person with special needs pilot program.-

(1) There is created a pilot project in Baker, Columbia, Hamilton, and Suwannee Counties to be known as Project Leo for the purpose of providing personal devices to aid search-and-rescue efforts for persons with special needs in the case of elopement.

(2) Participants for the pilot project shall be selected based on criteria developed by the Center for Autism and Related Disabilities at the University of Florida. Criteria for

participation shall include, at a minimum, the individual's risk of elopement. The qualifying participants shall be selected on a first-come, first-served basis by the center to the extent of available funding. The project shall be voluntary and free to participants.

(3) Under the pilot project, personal devices to aid search-and-rescue efforts that are attachable to clothing or otherwise worn shall be provided by the center to the sheriff's offices of the participating counties. The devices shall be distributed to project participants by the county sheriff's offices in conjunction with the center. The project shall fund any costs associated with monitoring of the devices.

(4) The center shall submit a preliminary report by December 1, 2015, and a final report by December 15, 2016, to the Governor, the President of the Senate, and the Speaker of the House of Representatives describing the implementation and operation of the pilot project. At a minimum, the report shall include the criteria used to select participants, the number of participants, the age of the participants, the nature of the participants' special needs, the number of participants who elope, the amount of time taken to rescue following elopement, and the outcome of any rescue attempts. The final report shall also provide recommendations for modification or continued implementation of the program.

(6) The project shall operate to the extent of available funding.

(7) This section expires June 30, 2017.

Section 2. 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:
An act relating to missing person with special needs; creating s. 937.041, F.S.; creating a pilot project in specified counties to provide personal assistive technology devices to persons with special needs to aid search-and-rescue efforts; providing for administration of the project; requiring reports; providing for expiration; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1193 Services for Veterans and Their Families
SPONSOR(S): Ingoglia
TIED BILLS: **IDEN./SIM. BILLS:** SB 1144

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

SUMMARY ANALYSIS

Veterans throughout the U.S. face mental health and substance abuse issues. The 2014 Legislature appropriated $150,000 to the Florida Department of Veterans Affairs (Florida VA) to create a pilot project expanding existing 211 (information and referral network) services to veterans in the Tampa Bay area. Through the pilot project, veterans receive information on available services, referrals to VA-funded and other community-based services, and care coordination to verify that referrals lead to successful service connections.

HB 1193 creates the Florida Veteran's Care Coordination Program (the Program) within the Department of Children and Families to provide a dedicated behavioral healthcare referral services through Florida's 211 Network. The bill requires DCF to designate "care coordination teams" to implement the Program statewide. The bill also requires the Program to provide peer support, suicide assessment, and treatment and resource coordination. In addition to the requirement for services, the bill requires the Program team to track and follow up with callers and advertise the Program.

The bill provides an appropriation of $2,000,000 in recurring general revenue funds. The bill does not appear to have a fiscal impact on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

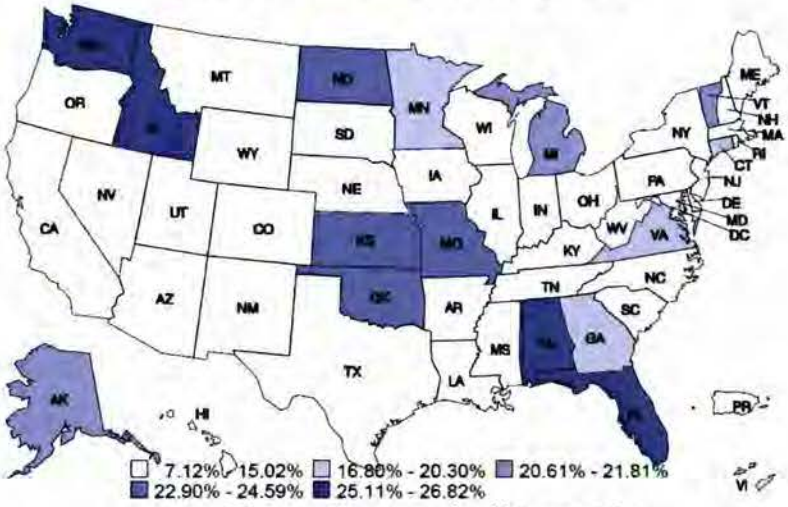
A. EFFECT OF PROPOSED CHANGES:

Current Situation

Depression and Suicide Among Veterans

Veterans throughout the U.S. face mental health and substance abuse issues. According to a 2008 study, between 5 and 15 percent of veterans who served in Iraq and Afghanistan returned with Post-Traumatic Stress Disorder (PTSD), and an additional 2 to 14 percent returned with major depression.[1] PTSD attributed to combat has affected between 2 and 17 percent of all U.S. military veterans since the Vietnam War.[2] In 2012, the Veteran's Administration (VA) released a report detailing veteran deaths from suicide from 1999 to 2009.[3] Over that ten-year span, veterans comprised approximately 22.2% of all suicides. In the the year 2010, on average, 22 veterans committed suicide per day.[4] In response to these trends, the federal government, through the VA, has established programs to connect veterans to mental health services.

Percent of Veteran Suicides by State[5]



*Among states reporting Veteran status

Federal Mental Health Care Services for Veterans

An individual who served in the active military, naval, or air service, and who was not dishonorably discharged, may qualify for VA health care benefits.[6] VA health benefits include necessary inpatient hospital care and outpatient services to promote, preserve, or restore a veteran's health. VA medical facilities provide a wide range of services, including mental health services.[7] The VA provides

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[1] INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY, at 433 (Terri Tanielian and Lisa H. Jaycox, Eds,) (2008), *available at* http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf, (last visited March 20, 2015).

[2] Lisa K. Richardson, B. Christopher Frueh, and Ronald Acierno, *Prevalence Estimate of Comabt-Related PTSD: A Critical* Review, 44 AUSTRALIAN AND NEW ZEALAND JOURNAL OF PSYCHIATRY, at 4-19 (January 2010), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2891773/ (last visited March 20, 2015).

[3] Janet Kemp and Robert Bossarte, *Suicide Data Report, 2012*, DEPARTMENT OF VETERANS AFFAIRS MENTAL HEALTH SERVICES SUICIDE PREVENTION PROGRAM, at 15, *availavble at* http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf (last visited March 20, 2015).

[4] Id.

[5] Id.

[6] U.S. DEPARTMENT OF VETERANS AFFAIRS, *Federal Benefits for Veterans, Dependents and Survivors*, http://www.va.gov/opa/publications/benefits_book/benefits_chap01.asp (last visited March 21, 2015).

[7] U.S. DEPARTMENT OF VETERANS AFFAIRS, *Health Benefits*, http://www.va.gov/HEALTHBENEFITS/access/medical_benefits_package.asp (last visited March 20, 2015).

specialty inpatient and outpatient mental health services at its medical centers and community-based outpatient clinics; additionally, readjustment counseling services may be available at veteran centers across the nation.[8] For veterans with serious mental illness, VA offers care tailored to help with their specific diagnosis and to promote recovery. Serious mental illnesses include a variety of diagnoses (for example, schizophrenia, depression or bipolar disorder, PTSD, and substance use disorders) that result in significant problems functioning in the community.[9]

There is a presumptive eligibility for VA health care services for psychosis and other mental illnesses to be covered as service-connected illness when a veteran experiences them within a specified period.[10] This allows certain veterans who are not otherwise eligible for VA health care to receive treatment for mental illness and other directly-related conditions at no cost.[11] The goal is to support recovery and enable veterans who experience mental health problems to live meaningful lives in their communities and to achieve their full potential.[12]

The VA operates six medical centers in Florida located at Bay Pines, Miami, Tampa, West Palm Beach, Gainesville and Lake City.[13] The VA also operates outpatient clinics for health care and Vet Centers for counseling throughout Florida.

Federal Veterans Crisis Line

The Veterans Crisis Line is a resource for veterans across the U.S. developed by the VA to connect veterans and current service members in crisis and their families and friends with information from qualified responders through a confidential, toll-free hotline, online chat, and text messaging service.[14]

The Veterans Crisis Line was launched in 2007 as the National Veterans Suicide Prevention Hotline; over the course of the program, it has answered more than 1.6 million calls and made more than 45,000 lifesaving rescues.[15] In 2009, the National Veterans Suicide Prevention Hotline added an anonymous online chat service and has engaged in more than 207,700 chats.[16]

In 2011, the "National Veterans Suicide Prevention Hotline" was re-branded as the "Veterans Crisis Line" and launched the "It's Your Call" media campaign promoting the newly-named crisis line and marketing it to both veterans and their family and friends.[17] Also in 2011, the Veterans Crisis Line introduced a text-messaging service to provide another way for Veterans to connect with confidential, round-the-clock support, and since then has responded to more than 32,300 texts.[18]

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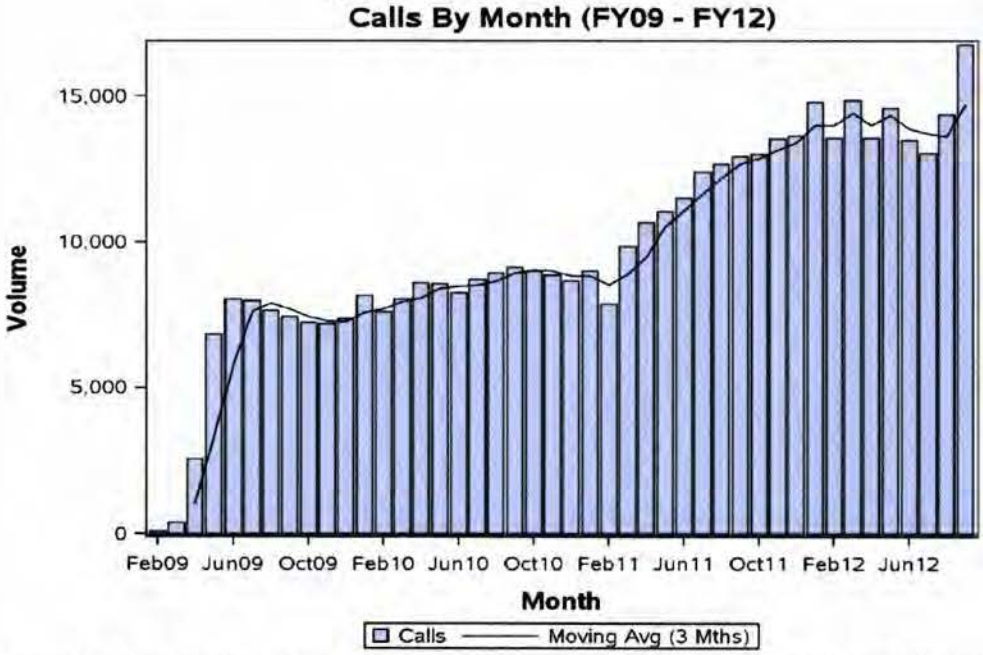
[8] *Supra*, Note 7.
[9] *Guide to VA Mental Health* Services, U.S. DEPARTMENT OF VETERANS AFFAIRS, at 10, *available at* http://www.mentalhealth.va.gov/docs/MHG_English.pdf (last visited March 20, 2015).
[10] *Supra*, Note 7.
[11] Id.
[12] Id.
[13] FLORIDA DEPARTMENT OF VETERANS' AFFAIRS, *Benefits and Services: Health Care*, http://floridavets.org/benefits-services/health-care-2/ (last visited March 20, 2015).
[14] VETERANS CRISIS LINE, *FAQs*, http://www.veteranscrisisline.net/About/FAQs.aspx (last visited March 20, 2015).
[15] VETERANS CRISIS LINE, *About the Veterans Crisis Line*, http://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx (last visited March 20, 2015).
[16] Id.
[17] *Supra*, Note 3 at 35.
[18] Supra, Note 15.

Veterans Crisis Line Call Volume[19]



Following the "It's Your Call" media campaign, there was a spike in calls to the Veterans Crisis Line. Over the span of the program the number of repeat callers has steadily increased, either reflecting a change in the type of help individuals are seeking or the expanding role the Veterans Crisis Line is playing in the provision of mental health care for veterans.[20]

Florida Department of Veterans' Affairs

Florida has the nation's third largest veteran population with more than 1.6 million veterans, comprising 12% of the state's population 18 and over.[21]

In 1988, Florida citizens endorsed a constitutional amendment to create the Florida VA as a separate agency charged with providing advocacy and representation for Florida's veterans and to intercede on their behalf with the U.S. Department of Veterans Affairs.[22] The Florida VA helps veterans gain access to federal benefits, including federally funded medical care, to improve their quality of life.

Florida 211 Network

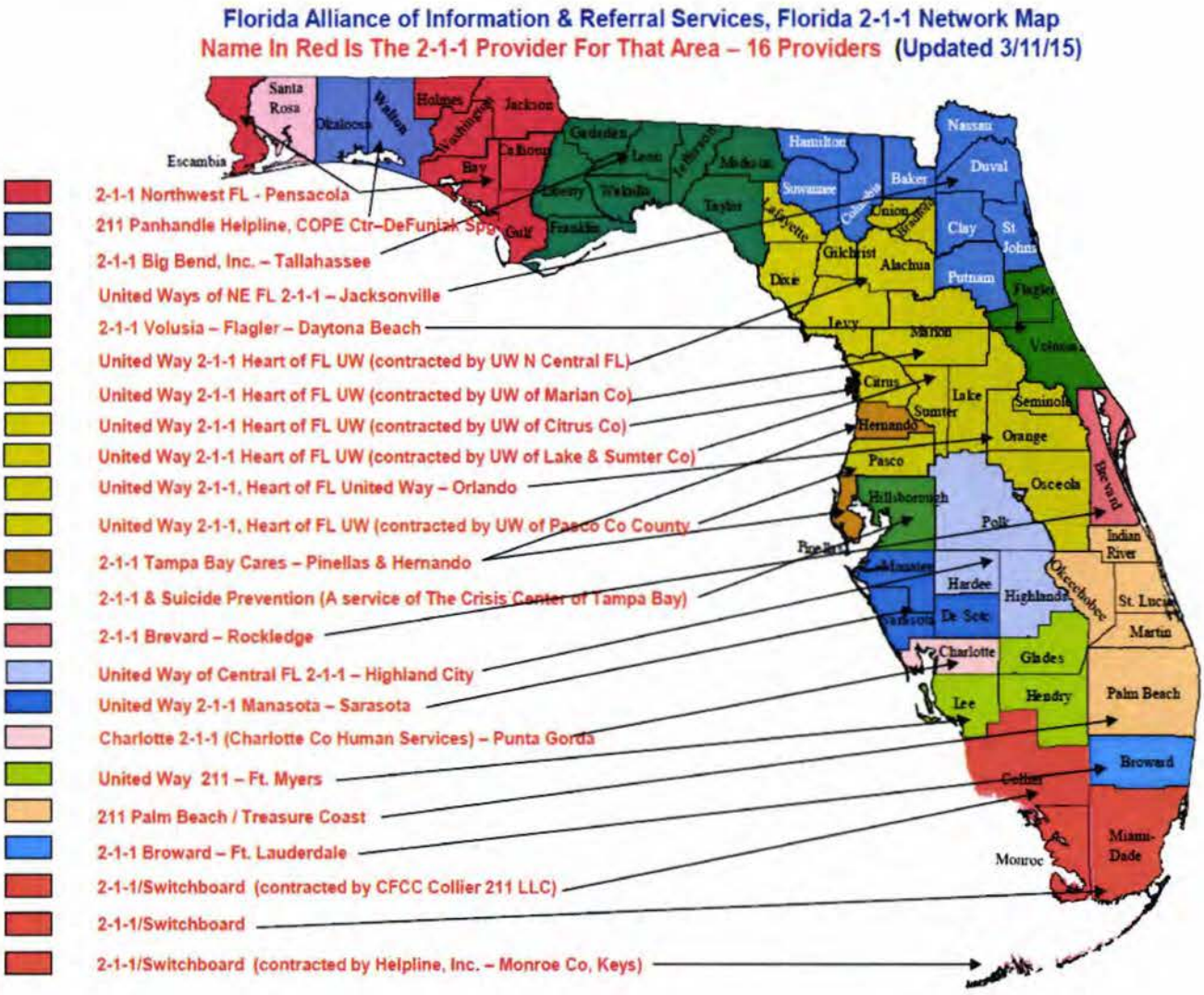
Section 408.918, F.S., establishes the Florida 211 Network, authorizing the planning, development, and implementation of a statewide network to serve as the single point of coordination for information and referral for health and human services.

A 211 network is a telephone-based service offered by nonprofit and public agencies throughout Florida and the United States that provide free, confidential information and referral services 24 hours a day, 7 days a week. The network helps callers identify and connect with health and human service programs that can meet a variety of needs, including food, housing, employment, health care, crisis counseling and more.[23] In Florida, services are available statewide through any cell phone provider as well as through landlines in all 67 counties by dialing 2-1-1.[24] In order to participate in the Florida 211 Network, a 211 provider must be fully accredited by the National Alliance of Information and Referral

[19] *Supra*, Note 3 at 36.
[20] Id.
[21] FLORIDA DEPARTMENT OF VETERANS' AFFAIRS, *Our Veterans: Fast Facts*, http://floridavets.org/our-veterans/profilefast-facts/ (last visited March 20, 2015).
[22] FLORIDA DEPARTMENT OF VETERANS' AFFAIRS, *About Us*, http://floridavets.org/about-us/ (last visited March 20, 2015).
[23] FLORIDA 2-1-1- ASSOCIATION, http://www.211florida.org/ (last visited March 20, 2015).
[24] Id.

Services or have received approval to operate, pending accreditation, from its affiliate, the Florida Alliance of Information and Referral Services.[25] There are a total of sixteen Florida 211 Network certified providers.[26]

Florida 211 Network Providers[27]



Department of Children and Families

Substance Abuse and Mental Health Program

The Florida Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery

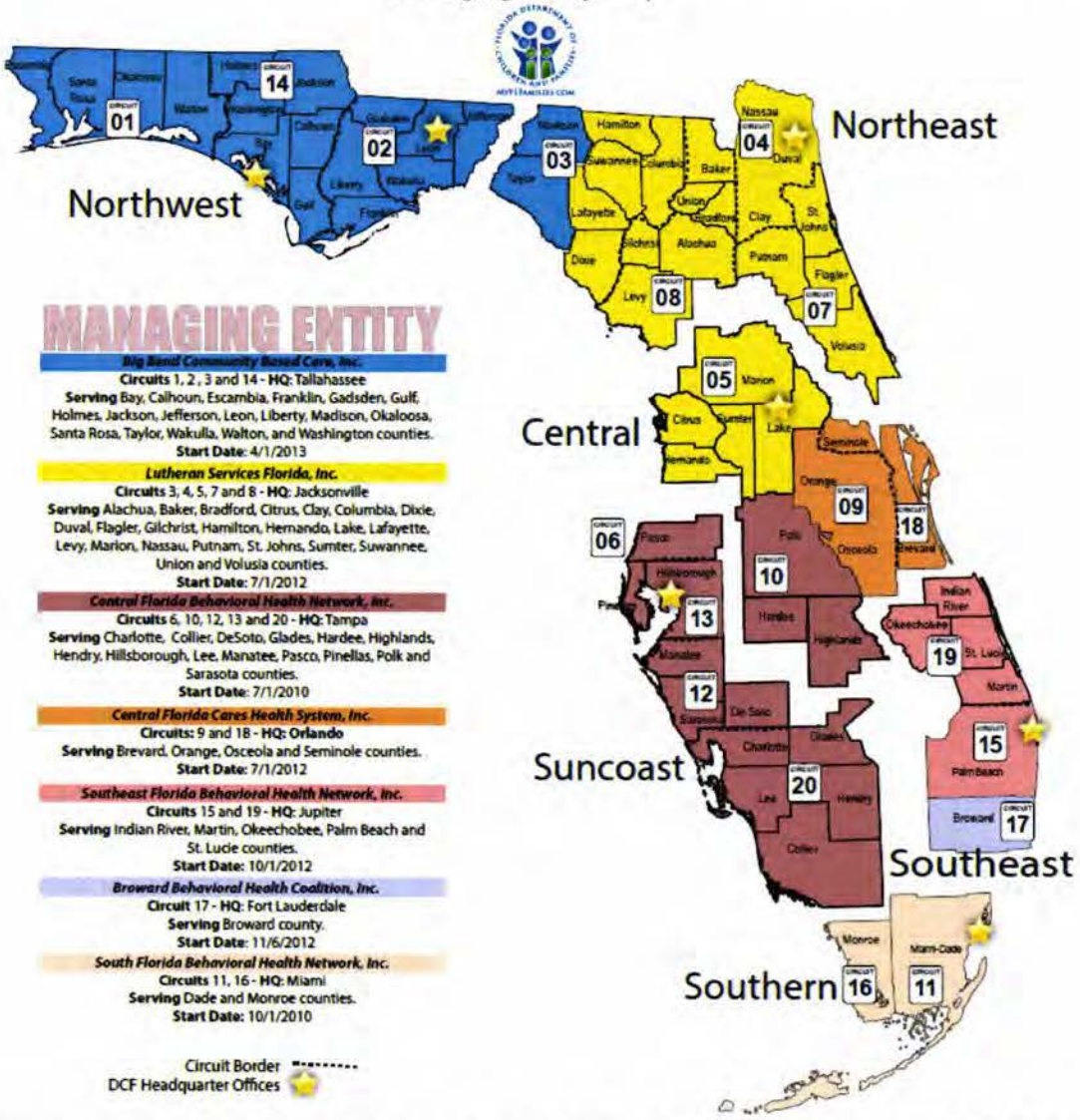
[25] S. 408.918(2), F.S.
[26] Email from Shelia Smith, President/CEO Broward 211, RE: Florida 2-1-1 Coverage Map (March 20, 2015) (email on file with Children, Families, and Seniors Subcommittee staff).
[27] Id.

support services. Services are provided in accordance with state and federally-established priority populations.[28]

Behavioral Health Managing Entities

In 2001, the Legislature authorized DCF to implement behavioral health managing entities as the management structure for the delivery of local mental health and substance abuse services.[29] This was based upon the Legislature's decision that a management structure which places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level would promote improved access to care; promote service continuity; and provide for more efficient and effective delivery of substance abuse and mental health services.[30]

Managing Entity Map[31]



The implementation of the managing entity system initially began on a pilot basis but, in 2008, the Legislature authorized DCF to implement managing entities statewide.[32] Full implementation of the

[28] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance and children at risk for initiating drug use.
[29] Ch. 2001-191, Laws.
[30] Section 394.9082, F.S.
[31] FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES, *Managing Entities*, *available at* http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities (last visited March 21, 2015).

statewide managing entity system occurred in April 2013, with all geographic regions now served by a managing entity.[33] DCF currently contracts with seven managing entities that in turn contract with local service providers for the delivery of mental health and substance abuse providers.[34]

Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.

The Crisis Center of Tampa Bay Pilot Project

The 2014 Florida Legislature appropriated $150,000 to create a pilot project expanding existing 211 services to veterans in Hillsborough, Pasco, Pinellas, Polk and Manatee counties.[35] In August 2014, the Crisis Center of Tampa Bay (CCTB), through the pilot project, expanded its services to veterans and launched the Florida Veterans Support Line (1-844-MYFLVET) in November 2014.[36] The expanded service is peer-based and veteran-specific. By calling the Florida Veterans Support Line, veterans in the Tampa Bay region are able to speak with a fellow veteran and offered:

- Comprehensive information and referral to VA-funded services and other community- based services;
- Assistance and support provided by a peer who has experienced the transition from military back to civilian life; and
- Care coordination services, including system navigation, advocacy, and ongoing support.[37]

Veterans receiving care coordination get ongoing suicide assessment, continuous safety planning, and support for an extended period of time. The CCTB pilot project aims to ensure veterans are not only receiving information on available services but are also enrolled, accepted, and attending VA-funded and other community based services.[38]

From the inception of the program in November 2014 through March 2015, the CCTB pilot project has handled 477 total calls; of those, 217 calls were referred to care coordination services.[39] The breakdown of the 477 calls during that period is as follows:

Call Origin:	Contact Made By:	Veteran Status:	Use of VA Services:
• Florida Veterans Support Line: 127 (26.6%) • Transfer from other 211 Line: 332 (69.9%) • Other: 18 (3.8%)	• Self: 397 (83.2%) • Friend/Relative: 60 (12.6%) • Organization: 18 (3.8%) • Other: 2 (0.4%)	• Veteran: 391 (82%) • Retired: 13 (2.7%) • Former Military: 5 (1%) • Reserve: 5 (1%) • Active Duty: 5 (1%)	• Yes: 201 (44%) • No: 125 (26.2%) • Unknown: 137 (28.7%) • Refused: 5 (1%)

[32] Chapter 2008-243, Laws of Florida.
[33] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY, July 18, 2014.
[34] Id.
[35] Specific appropriation 595 of HB 5001, 2014-2015 General Appropriations Act
[36] *Florida Veterans Support Line*, HELP. HOPE. HEALING., CRISIS CENTER OF TAMPA BAY BLOG, (November 10, 2014) http://blog.crisiscenter.com/2014/11/10/florida-veterans-support-line/ (last visited March 20, 2015).
[37] CRISIS CENTER OF TAMPA BAY, *Florida Veterans Support* Line, http://www.crisiscenter.com/content/115/Florida-Veterans-Support-Line.aspx (last visited March 20, 2015).
[38] Email from Travis Mitchell, Crisis Center of Tampa Bay, RE: 211 – HB 1193 (March 20, 2015) (email on file with Children, Families, and Seniors Subcommittee staff).
[39] Email from Brandee Baker, Peer Support Program Coordinator, Crisis Center of Tampa Bay, RE: Florida Veterans Support Line (March 20, 2015) (email on file with Children, Families, and Seniors Subcommittee staff).

Effect of Proposed Changes

HB 1193 requires DCF, in cooperation with the Agency for Healthcare Administration, to create the Florida's Veterans' Care Coordination Program ("the Program") in all DCF service districts. The Program will provide veterans and their families dedicated behavioral healthcare referral services, specifically mental health and substance abuse services, through the existing 211 infrastructure. DCF is to model the Program after the pilot project conducted in 2014 by the CCTB and the Florida VA.

The bill specifies that the goals of the Program are to prevent suicides by veterans; increase the number of veterans who make use of agency services; and increase the level of VA funding for needed services to veterans, thereby saving the State of Florida money.

The bill requires DCF to designate "care coordination teams" to implement the Program statewide. The bill does not provide a definition for a care coordination team. The care coordination teams are required to provide referral services to veterans and their families and expand the existing Florida 211 Network to include the optimal range of veterans' service organization and programs.

The bill requires the program to provide a number of services. The program must provide:

- Telephonic peer support;
- Crisis intervention;
- Communication of information and referral resources;
- Treatment coordination, including follow-up care;
- Suicide assessment;
- Promotion of safety and wellness of veterans and their families, including continuous safety planning and support;
- Resource coordination, including data analysis, to ensure acceptance, enrollment, and attendance by veterans and their families in VA programs and services and community-based programs and services; and
- Immediate needs assessments, including safety planning.

In addition to the requirement for services, the bill also requires the program team to take certain actions. The term "program team" is not defined in the bill. The program team must:

- Track the number of requests from callers who are veterans or family members of veterans;
- Follow-up with callers to determine whether they have acted on referrals or received the needed assistance, or if additional referrals or advocacy are needed;
- Develop communication strategies (media promotions, public service announcements, print and internet stories, community presentations) to inform veterans and their families about available services; and
- Document all calls and capture all data to improve outreach to veterans and their families.

B. SECTION DIRECTORY:

Section 1: Creates s. 394.9087, F.S., relating to the Florida Veterans' Care Coordination Network.
Section 2: Appropriates $2,000,000 in recurring general revenue funds.
Section 3: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

   The bill provides a $2 million appropriation to expand the existing Florida 211 Network for the purposes of providing the required services specified in the bill and administration of the program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to services for veterans and their families; creating s. 394.9087, F.S.; requiring the Department of Children and Families to establish the Florida Veterans' Care Coordination Program; providing goals of the program; requiring the designation of implementation teams; providing a list of required services; providing an appropriation; providing an effective date.

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

Section 1. Section 394.9087, Florida Statutes is created to read:

394.9087 Florida Veterans' Care Coordination Program.—

(1) The Department of Children and Families, in cooperation with the Agency for Health Care Administration and pursuant to the requirements of s. 408.913, shall establish the Florida Veterans' Care Coordination Program in all department service districts to provide veterans and their families in this state with dedicated behavioral healthcare referral services, especially mental health and substance abuse services. The department shall model the program after the proof-of-concept pilot program conducted in 2014 by the Crisis Center of Tampa Bay and the Department of Veterans' Affairs in Hillsborough, Pasco, Pinellas, Polk, and Manatee Counties.

(2) The goals of the program are to:

(a) Prevent suicides by veterans in this state.

(b) Increase the number of veterans who make use of agency services.

(c) Increase the level of Veterans Administration funding for needed services to veterans in this state, thereby saving money for the state.

(3) The department shall designate care coordination teams to implement the program statewide. The teams shall provide referral services to veterans and their families and expand the existing Florida 211 Network, authorized by s. 408.918, to include the optimal range of veterans' service organizations and programs.

(4) Services provided by the program must include:

(a) Telephonic peer support, crisis intervention, and the communication of information and referral resources.

(b) Treatment coordination, including followup care.

(c) Suicide assessment.

(d) Promotion of the safety and wellness of veterans and their families, including continuous safety planning and support.

(e) Resource coordination, including data analysis, to ensure acceptance, enrollment, and attendance by veterans and their families in Veterans Administration programs and services and community-based programs and services.

(f) Immediate needs assessments, including safety

planning.

(5) To enhance program services, program teams shall:

(a) Track the number of requests from callers who are veterans or their family members.

(b) Follow up with callers to determine whether they have acted on the referrals or received the assistance needed, or if additional referrals or advocacies are needed.

(c) Develop communication strategies, such as media promotions, public service announcements, print and Internet stories, or community presentations, to inform veterans and their families about available services.

(d) Document all calls and capture all data to improve outreach to veterans and their families.

Section 2. For the 2015-2016 fiscal year, the sum of $2 million in recurring funds is appropriated from the General Revenue Fund to the Department of Children and Families for the purpose of implementing this act.

Section 3. 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 Ingoglia offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 394.9087, Florida Statutes is created to read:

394.9087 Florida Veterans' Care Coordination Program.—

(1) Subject to appropriations, the Department of Children and Families shall establish the Florida Veterans' Care Coordination Program in consultation with the Florida Alliance of Information and Referral Services. The department shall contract with managing entities, as defined in s. 394.9082(2)(d), F.S., to enter into agreements with Florida 211 Network participants to provide veterans and their families in Florida with dedicated behavioral healthcare referral services,

especially mental health and substance abuse services. The department shall model the program after the proof-of-concept pilot program established in 2014 by the Crisis Center of Tampa Bay and the Department of Veterans' Affairs in Hillsborough, Pasco, Pinellas, Polk, and Manatee Counties.

(2) The goals of the program are to:

(a) Prevent suicides by veterans in this state.

(b) Increase the use of Veterans Administration services by veterans in this state.

(c) Increase the number of veterans who make use of other available community based services.

(3) Program services shall be available statewide. Program services shall be provided by program teams operated by Florida 211 Network participants, authorized by s. 408.918. A Florida 211 Network participant may provide services within more than one managing entity's geographic area under a single contract.

(4) The program teams shall provide referral and care coordination services to veterans and their families and expand the existing Florida 211 Network to include the optimal range of veterans' service organizations and programs. Services provided by the program must include:

(a) Telephonic peer support, crisis intervention, and the communication of information and referral resources.

(b) Treatment coordination, including coordination of follow up care.

(c) Suicide assessment.

(d) Promotion of the safety and wellness of veterans and their families, including continuous safety planning and support.

(e) Resource coordination, including data analysis, to facilitate acceptance, enrollment, and attendance by veterans and their families in Veterans Administration programs and services and community-based programs and services.

(f) Immediate needs assessments, including safety planning.

(5) To enhance program services, program teams shall:

(a) Track the number of requests from callers who are veterans or their family members.

(b) Follow up with callers to determine whether they have acted on the referrals or received the assistance needed, or if additional referrals or advocacy are needed.

(c) Develop and implement communication strategies, such as media promotions, public service announcements, print and Internet stories, or community presentations, to inform veterans and their families about available services.

(d) Document all calls and capture all necessary data to improve outreach to veterans and their families. This information shall be reported to the managing entity.

(6) The department shall provide a report on the implementation of the Veterans' Care Coordination Program to the Governor, President of the Senate, and Speaker of the House of Representatives by December 15, 2016. The contracted Florida 211

Network participants shall collect and provide the data in the format requested by the department for the department to prepare the report. The report shall include the number of calls received; demographic information of callers, including but not limited to the caller's military affiliation, veteran status, and whether or not presently receiving services through the Veterans Administration; the nature of the call, including but not limited to the concerns prompting the call and services requested; the outcome of the call, including but not limited to the service referrals made and the organizations to which the caller was referred; services received as a result of the call; follow up by the program team, including but not limited to the proportion of calls receiving follow up and the time elapsed between initial contact and follow up; impact of the program on veterans' quality of life and avoidance of negative outcomes, including arrest or suicide; and caller satisfaction with program services.

Section 2. 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:

An act relating to services for veterans and their families; creating s. 394.9087, F.S.; requiring the Department of Children and Families to establish the Florida Veterans' Care Coordination Program; providing

goals of the program; requiring the designation of implementation teams; providing a list of required services; requiring a an annual report by the department; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB CFSS 15-01 Mental Health and Substance Abuse
SPONSOR(S): Children, Families & Seniors Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee		McElroy	Brazzell

SUMMARY ANALYSIS

PCB CFSS 15-01 makes changes to the statewide system of safety-net prevention, treatment, and recovery services for substance abuse and mental health (SAMH) administered by the Department of Children and Families (DCF).

DCF currently contracts with 7 managing entities that in turn contract with local service providers to deliver SAMH services. The PCB updates statutes that provided DCF initial authority and guidance for transitioning to the managing entity system. The PCB makes changes to providing services and enhance operation of this outsourced approach by:

- Allowing managed behavioral health organizations to bid for managing entity contracts when fewer than two bids are received;
- Requiring care coordination, specifying to services that shall be provided within available resources, and prioritizing the populations served;
- Requiring DCF to develop performance standards that measure improvement in a community's behavioral health and in specified individuals' functioning or progress toward recovery;
- Specifying members for managing entities' governing boards, and requiring managed behavioral health organizations serving as managing entities to have advisory boards with that membership;
- Allowing managing entities flexibility in shaping their provider network while requiring a system for publicizing opportunities to join and evaluating providers for participation; and
- Deleting obsolete statutes regarding the transition to the managing entity system.

The PCB requires DCF to contract for a study of the safety-net system, with an interim and final report submitted on specified topics. The PCB also requires DCF and the Agency for Health Care Administration to report on options for increasing the availability of federal Medicaid SAMH services.

The PCB revises the Criminal Justice, Mental Health, and Substance Abuse Grant Program. The PCB expands the membership of the Statewide Grant Review Committee to include more non-state representatives and renames it the Policy Committee. The PCB creates a grant review and selection committee. It also streamlines the local process for applying for grants and allows DCF to require sequential intercept mapping of systems to identify where interventions may be effective.

The PCB adds family members and other interested parties as parties authorized to petition the court for the appointment of a guardian advocate to consent to treatment when the individual is not competent to do so. The PCB requires specified health care facilities to provide written information on advance directives for mental health treatment to individuals. The PCB also requires DCF to develop and publish on its website a mental health advance directive form.

The PCB requires DCF to create the Crisis Stabilization Services Utilization database for collecting utilization data from all public receiving facilities.

The PCB makes conforming changes to child welfare statutes to incorporate references to mental health treatment and mental health courts, subject to the passage of PCB JDC 15-01, which authorizes the creation of mental health courts.

The PCB repeals a variety of obsolete and duplicative statutes.

The PCB has an indeterminate negative fiscal impact for the contract for the study. The PCB also authorizes an appropriation of $175,000 for the reporting infrastructure needs of five managing entities to comply with the expanded CSU reporting requirements contained within the PCB.

The PCB provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Mental Illness and Substance Abuse

Mental health and mental illness are not synonymous. Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. Only about 17% of adults in the United States are considered to be in a state of optimal mental health.[4] This leaves the majority of the population with less than optimal mental health, for example: [5]

- One in four adults (61.5 million people) experiences mental illness in a given year;
- Approximately 6.7 percent (14.8 million people) live with major depression; and
- Approximately 18.1 percent (42 million people) live with anxiety disorders, such as panic disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder and phobias.

Many people are diagnosed with more than one mental illness. For example, people who suffer from a depressive illness (major depression, bipolar disorder, or dysthymia) often have a co-occurring mental illness such as anxiety.[6]

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[1] *Mental Health Basics*, Centers for Disease Control and Prevention. http://www.cdc.gov/mentalhealth/basics.htm (last viewed on March 17, 2015).
[2] Id.
[3] Id.
[4] Id. Mental illness can range in severity from no or mild impairment to significantly disabling impairment. Serious mental illness is a mental disorder that has resulted in a functional impairment which substantially interferes with or limits one or more major life activities. *Any Mental Illness (AMI) Among Adults*, National Institute of Mental Health. http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml (last viewed on March 17, 2015).
[5] *Mental Illness Facts and Numbers,* National Alliance on Mental Illness. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&sqi=2&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.nami.org%2Ffactsheets%2Fmentalillness_factsheet.pdf&ei=dYMlVdrWOYmqgwTBIYDQDA&usg=AFQjCNEATQZ5TXJF063JkMNgg9ZnwZb_ZA&bvm=bv.88198703,d.eXY
[6] *Mental Health Disorder Statistics,* John Hopkins Medicine. http://www.hopkinsmedicine.org/healthlibrary/conditions/mental_health_disorders/mental_health_disorder_statistics_85,P00753/ (last viewed on March 17, 2015).

Substance abuse also affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[7] In 2013, an estimated 21.6 million persons aged 12 or older were classified with having substance dependence or abuse issues.[8] Of these, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs, 4.3 million had dependence or abuse of illicit drugs but not alcohol, and 14.7 million had dependence or abuse of alcohol but not illicit drugs.[9]

Significant social and economic costs are associated with mental illness. Persons diagnosed with a serious mental illness experience significantly higher rates of unemployment compared with the general population.[10] This results in substantial loss of earnings each year[11] and can lead to homelessness. Homelessness is especially high for people with untreated serious mental illness, who comprise approximately one-third of the total homeless population.[12] Both adults and youth with mental illness frequently interact with the criminal justice system, which can lead to incarceration. For example, seventy percent of youth in juvenile justice systems have at least one mental health condition and at least twenty percent live with a severe mental illness.[13]

Substance abuse likewise has substantial economic and societal costs. In 2004, the total estimated costs of drug abuse and addiction due to use of tobacco, alcohol and illegal drugs was estimated at $524 billion a year.[14] This consists of $181 billion/year related to illegal drugs, $185 billion/year related to alcohol and $193 billion/year related to tobacco use.[15] These figures assume costs related to health care expenditures, lost earnings, law enforcement and incarceration.[16]

Mental illness and substance abuse commonly co-occur. Approximately 8.9 million adults have co-occurring disorders.[17] In fact, more than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).[18] Drug abuse can cause individuals to experience one or more symptoms of another mental illness.[19] Additionally, individuals with mental illness may abuse drugs as a form of self-medication.[20] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol

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[7] *Substance Abuse*, World Health Organization. http://www.who.int/topics/substance_abuse/en/ (last viewed on March 17, 2015).
[8] Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.samhsa.gov%2Fdata%2Fsites%2Fdefault%2Ffiles%2FNSDUHresultsPDFWHTML2013%2FWeb%2FNSDUHresults2013.pdf&ei=L74IVZydKO2SsQStroDQCg&usg=AFQjCNE8sNFxhZQfOgdkJvOgZR3fP5I0Uw (last viewed on March 17, 2015).
[9] Id.
[10] *Accounting for Unemployment Among People with Mental Illness*, Baron RC, Salzer MS, Behav. Sci. Law., 2002;20(6):585-99. http://www.ncbi.nlm.nih.gov/pubmed/12465129 (last viewed on March 17, 2015).
[11] *Supra* footnote 5.
[12] *How Many Individuals with A Serious Mental Illness are Homeless?* Treatment Advocacy Center, Backgrounder, November 2014. http://www.treatmentadvocacycenter.org/problem/consequences-of-non-treatment/2058 (last viewed on March 17, 2015).
[13] *Supra* footnote 5.
[14] Drug Abuse Costs The United States Economy Hundreds of Billions of Dollars in Increased Health Care Costs, Crime and Lost Productivity, National Institute on Drug Abuse, July 2008. http://www.drugabuse.gov/publications/addiction-science-molecules-to-managed-care/introduction/drug-abuse-costs-united-states-economy-hundreds-billions-dollars-in-increased-health (last visited on March 17, 2015).
[15] Id.
[16] Id.
[17] *About Co-Occurring*, Substance Abuse and Mental Health Services Administration. http://media.samhsa.gov/co-occurring/default.aspx (last viewed on March 17, 2015).
[18] *Co-Occurring Disorders*, Psychology Today. https://www.psychologytoday.com/conditions/co-occurring-disorders (last viewed on March 17, 2015).
[19] *Comorbidity: Addiction and Other Mental Illnesses*, U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCMQFjAA&url=http%3A%2F%2Fwww.drugabuse.gov%2Fsites%2Fdefault%2Ffiles%2Frrcomorbidity.pdf&ei=6q8NVf-iMsibNo7qg4AO&usg=AFQjCNFujSP7SHxxqB3FI7961yGQNQ56YA&bvm=bv.88528373,d.eXY (last viewed on March 21, 2015).
[20] Id.

addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.[21]

Florida's Substance Abuse and Mental Health Program

The Florida Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[22]

The Legislature appropriated $614,252,968 ($406,954,194 for mental health services and $207,298,774 for substance abuse services) to DCF for community behavioral health in FY 14-15.[23] This included $29,626,345 ($26,472,991 for mental health and $3,153,354 for substance abuse) in federal funds. In FY 2013-14, 377,519 individuals received behavioral health services through the SAMH program.

Behavioral Health Managing Entities

In 2001, the Legislature authorized DCF to implement behavioral health managing entities as the management structure for the delivery of local mental health and substance abuse services.[24] This was based upon the Legislature's decision that a management structure which places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level would:[25]

- Promote improved access to care;
- Promote service continuity; and
- Provide for more efficient and effective delivery of substance abuse and mental health services.

The implementation of the managing entity system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement managing entities statewide.[26] Full implementation of the statewide managing entity system occurred in April 2013, with all geographic regions now served by a managing entity.[27] Implementation has allowed DCF to reduce the number of direct contracts for mental health and substance abuse services from several hundred to 7.[28] DCF currently contracts with 7 managing entities that in turn contract with local service providers for the delivery of mental health and substance abuse services:[29]

- Big Bend Community Based Care- April 1, 2013 (**blue**).

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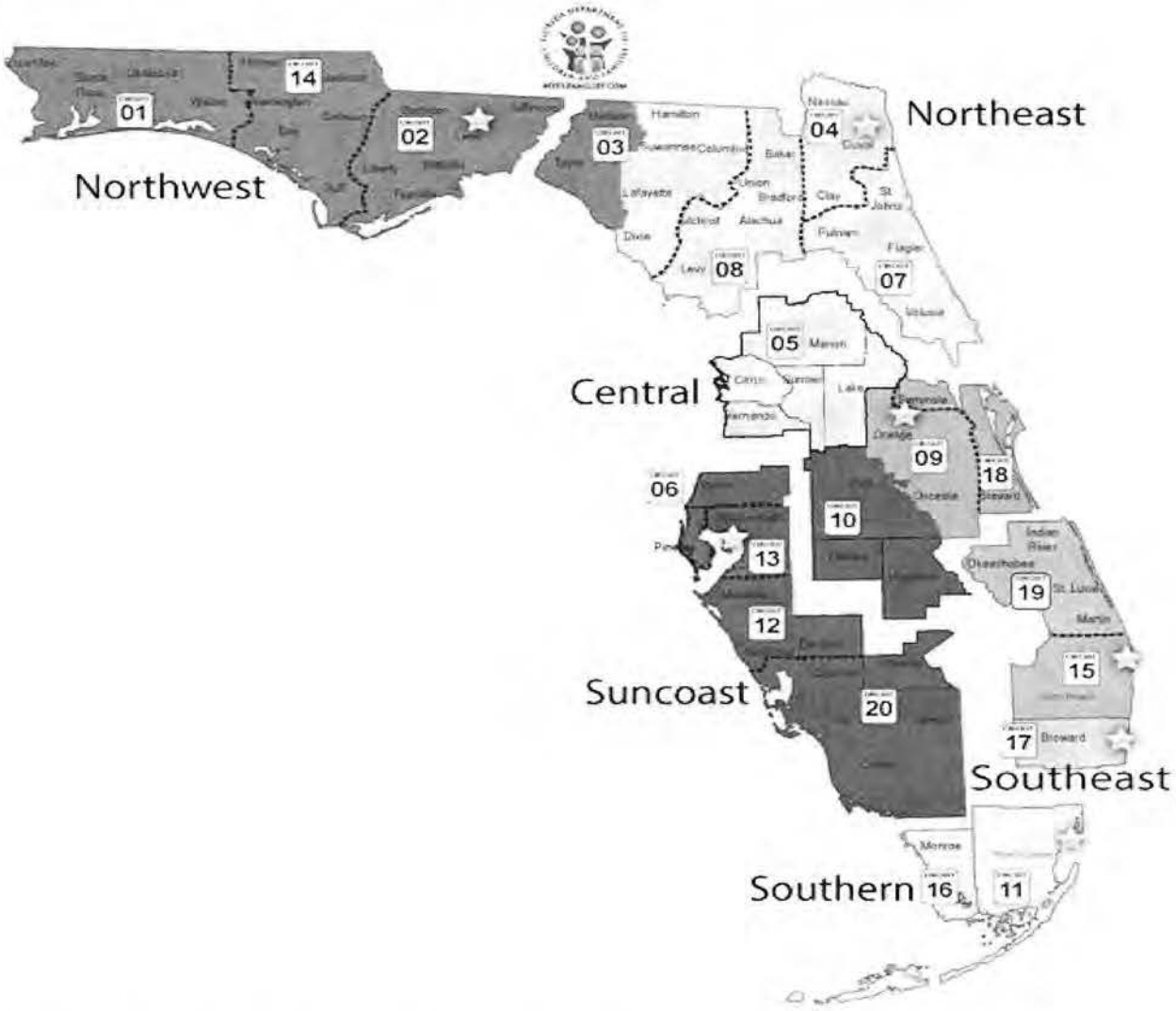
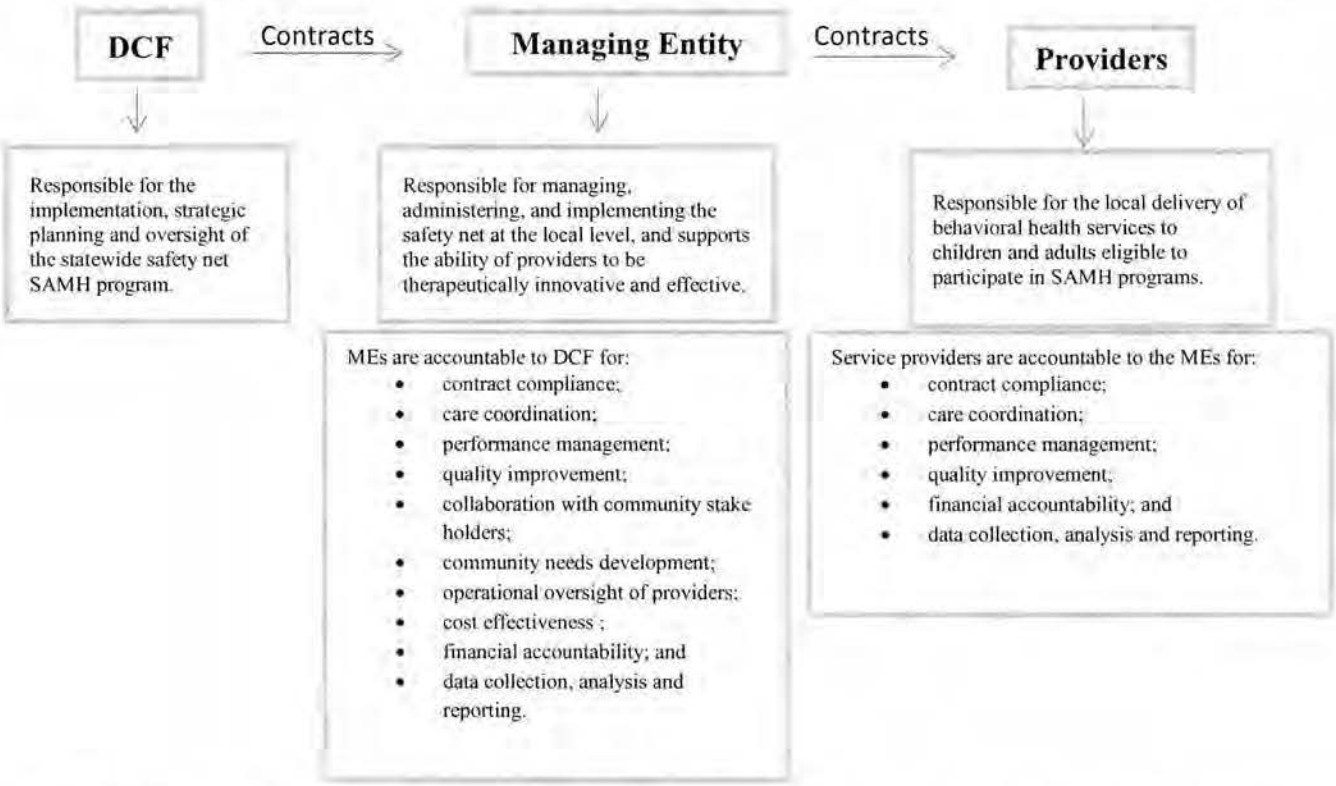
[21] *Supra* footnote 18.
[22] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance and children at risk for initiating drug use.
[23] *The Department of Children and Families Program Descriptions and Appropriation History Fiscal Year 2014-2015.*
[24] Ch. 2001-191, Laws.
[25] Section 394.9082, F.S.
[26] Chapter 2008-243, Laws.
[27] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.
[28] *Department of Children and Families Service System Management Plan, Statewide Implementation of Managing Entities or Similar Model*, July 2009.
[29] *Managing Entities*, Department of Children and Families. http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities (last visited on March 22, 2015).

- Lutheran Services Florida- July 1, 2012 (**yellow**).
- Central Florida Cares Health System- July 1, 2012 (**orange**).
- Central Florida Behavioral Health Network, Inc.- July 1, 2012 (**red**).
- Southeast Florida Behavioral Health- October 1, 2012 (**pink**).
- Broward Behavioral Health Network, Inc.- November 6, 2012 (**purple**).
- South Florida Behavioral Health Network, Inc.- October 1, 2012 (**beige**).



Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.

DCF, managing entities and service providers have specific responsibilities in the SAMH program.



DCF utilizes four performance measures to evaluate the performance of the managing entities:[30]

- **Systemic Monitoring** – The managing entity shall complete on-site monitoring of no less than 20% of all network service providers each fiscal year;
- **Network Service Provider Compliance** – A minimum of 95% of the managing entity's network service providers shall demonstrate annual compliance with a minimum of 85% of the applicable network service provider measures (i.e., client outcome measures) at the target levels for the network service provider established in the subcontract;
- **Block Grant Implementation** – The managing entity shall ensure 100% of the cumulative annual network service provider expenses comply with the block grant and maintenance of effort establish allocation standards; and
- **Implementation of the General Appropriations Act**: The managing entity shall meet 100% of the following requirements:
    - Implementation of specific appropriations, demonstrated by contracts with network services providers; and
    - Submission of all required plans for federal substance abuse and mental health block grants.

Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program

In 2007, the Legislature created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program (Program). The purpose of the Program is to provide funding to counties to plan, implement, or expand initiatives that increase public safety, avert increased spending on criminal and juvenile justice, and improve the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance abuse disorder, or co-occurring mental

[30] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis & Government Accountability, July 18, 2014.

health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.[31]

Currently, only a county or a consortium of counties who have established planning councils or committees may apply for a grant under the Program.[32] The county may designate an agency, including a non-county agency, as "lead agency;" however, the application must be submitted under the authority of the county.[33] Applicants may seek a one-year planning grant or a three-year implementation or expansion grant.[34] An applicant must have previously received a planning grant to be eligible for an implementation or expansion grant. A grant may not be awarded unless the applicant county, or a consortium of counties, makes available resources in an amount equal to the total amount of the grant.[35]

The Program's Statewide Grant Review Committee (Committee) is responsible for evaluating applications submitted to the Program. The Committee includes:[36]

- One representative of DCF;
- One representative of the Department of Corrections;
- One representative of the Department of Juvenile Justice;
- One representative of the Department of Elderly Affairs; and
- One representative of the Office of the State Courts Administrator.

The Committee provides written notification to DCF of the names of the applicants who have been selected to receive a grant.[37] DCF may then transfer funds, if available, to any counties or consortium of counties awarded a grant.[38] A grant may not be awarded unless the applicant county, or a consortium of counties, makes available resources in an amount equal to the total amount of the grant.[39] For fiscally constrained counties, the available resources may be at 50 percent of the total amount of the grant.[40]

Sequential Intercept Model

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems.[41] The model seeks to identify points of interception where an intervention can occur to prevent an individual from entering or penetrating deeper into the criminal justice system.[42] The interception points are:[43]

- Law enforcement and emergency services;
- Initial detention and initial hearings;
- Jail, courts, forensic evaluations, and forensic commitments;
- Reentry from jails, state prisons, and forensic hospitalization; and
- Community corrections and community support.

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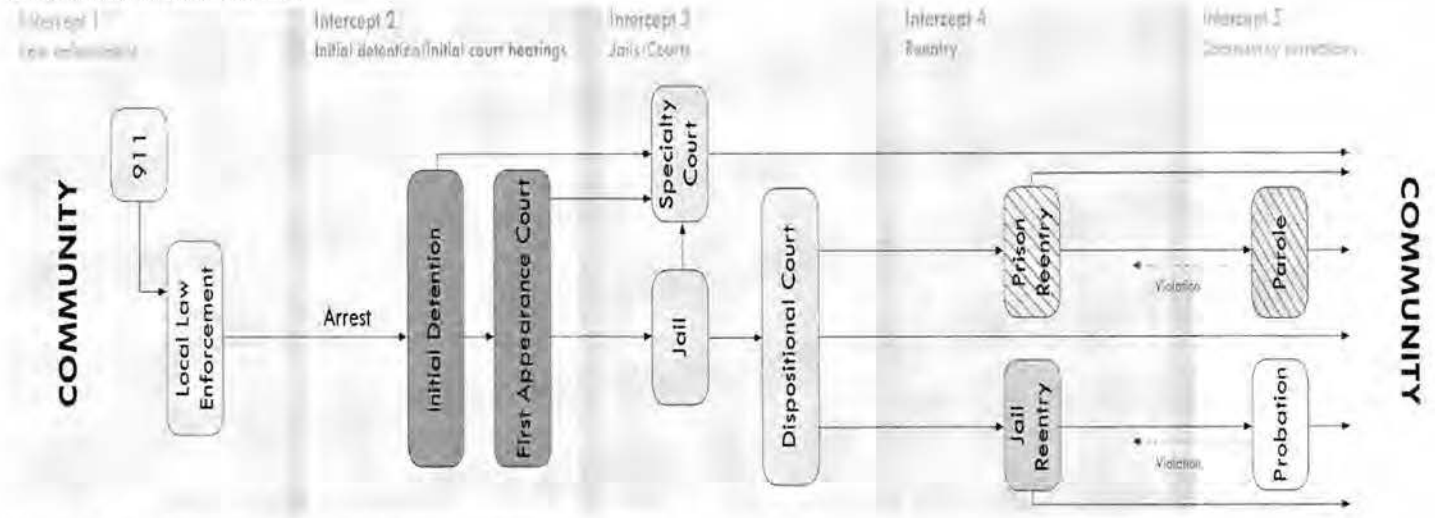
[31] Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant: Request for Applications, Department of Children and Families, May 2013.
[32] Section 394. 658(3), F.S.
[33] Id.
[34] Section 394. 656(3)(a), F.S.
[35] Section 394. 658(2)(b) and (c), F.S.
[36] Section 394. 656(2)(a-e), F.S.
[37] Section 394. 656(4), F.S.
[38] Id.
[39] Section 394. 658(2)(b) and (c), F.S.
[40] Id.
[41] *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, Munetz MR and Griffin PA, Psychiatr. Serv., 2006 April; 57(4):544-9. http://www.ncbi.nlm.nih.gov/pubmed/16603751 (last viewed on March 20, 2015).
[42] Id.
[43] Id.

Sequential Intercept Model



SAMHSA Gain Center for Behavioral Health and Justice Transformation.

A community can use the model to develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment.[44]

Florida Mental Health Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. [45] The Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[46]

Involuntary Examination and Receiving Facilities

Individuals in acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[47] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness[48]:

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination and is unable to determine for himself or herself whether examination is necessary; **and**
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **or**
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Involuntary patients must be taken to either a public or private facility which has been designated by DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term

[44] Id.
[45] Sections 394.451-394.47891, F.S.
[46] Section 394.459, F.S.
[47] Sections 394.4625 and 394.463, F.S.
[48] Section 394.463(1), F.S.

treatment.[49] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.[50] Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially-eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[51]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[52] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[53]

The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[54] Individuals often enter the public mental health system through CSUs.[55] For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by Legislature in the 1970s to ensure continuity of care for individuals.[56]

DCF's expenditures during Fiscal Year 2014-2015 through December 2014 for adult CSU, Baker Act, and Inpatient Crisis Services were approximately $39.4 million.[57] Expenditures for the same services for children in the same time period were approximately $8.5 million.[58] As of February 2015, there were 63 public receiving facilities with 2,052 beds and 67 private receiving facilities with 3,371 beds.[59] For FY 2014-15 there are 544 adult and 106 crisis stabilization beds funded by DCF.[60] There were 171,744 involuntary examinations initiated at hospitals and CSUs in calendar year 2013 (most recent report).[61]

Guardian Advocate

The Baker Act provides for the appointment of a guardian advocate for individuals who are incompetent to consent to treatment. The guardian advocate is responsible for making well-informed mental health treatment decisions for the patient. The administrator of a receiving or treatment facility may petition the court for the appointment of advocate guardian if a psychiatrist has determined that a patient is incompetent to consent to treatment.[62] The court will conduct a hearing on the petition during which a patient will have the right to testify, cross-examine witnesses, and present witnesses.[63] The court will appoint a qualified guardian advocate if it finds the patient incompetent.[64] The court may not appoint certain individuals as a guardian advocate:[65]

- An employee of the facility providing direct mental health services to the patient;

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[49] Section 394.455(26), F.S.
[50] Section 394.455(25), F.S
[51] Rule 65E-5.400(2), F.A.C.
[52] Section 394.875(1)(a), F.S.
[53] Id
[54] Id.
[55] Budget Subcommittee on Health and Human Services Appropriations, the Florida Senate, Crisis Stabilization Units, (Interim Report 2012-109) (Sept. 2011).
[56] Id. Sections 394.65-394.9085, F.S.
[57] Correspondence from the Department of Children and Families to the House of Representatives' Children, Families & Seniors Subcommittee, dated February 9, 2015.
[58] Id.
[59] Id.
[60] Id.
[61] Christy, A. (2014). Report of 2013 *Baker Act Data*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.
[62] Section 394.4598(1), F.S.
[63] Id.
[64] Id .
[65] Id.

- A DCF employee;
- An administrator of a treatment or receiving facility; or
- A member of the Florida local advocacy council.

The facility must provide a guardian advocate with sufficient information for a guardian advocate to make an informed decision.[66] This includes information related to whether the proposed treatment is essential to the care of the patient and whether the proposed treatment presents an unreasonable risk of serious, hazardous, or irreversible side effects.[67] A guardian advocate must meet and talk with the patient and the patient's physician in person (if at all possible) before giving consent to treatment.[68] The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.[69]

Guardian advocates may only provide consent for mental health treatment if the patient is incompetent. The appointment of a guardian advocate will be terminated if a patient is:

- Discharged from an order for involuntary outpatient placement or involuntary inpatient placement;
- Transferred from involuntary to voluntary status; or
- Determined by the court to be competent.

Advance Directives

Competent adults may formulate, in advance, preferences regarding a course of treatment in the event that injury or illness causes severe impairment or loss of decision-making capacity. An advance directive is a written document or oral statement designed to control certain future health care when a person becomes unable to make decisions and choices on his or her own.[70] There are five common types of advance directives:[71]

- **Living Will**- Typically is self-directed planning for the type of medical treatment a person wants in situations where he or she has been determined to be terminally ill or in a persistent vegetative state. It also addresses under what conditions an attempt to prolong life should be started or stopped.[72]
- **Durable Power of Attorney for Health Care or Designation of Health Care Surrogate**- Identifies and authorizes a person to act as a proxy to make all health care decisions for the principal in the event the principal becomes incapacitated.[73]
- **Do Not Resuscitate (DNR) Order**- Directs health care providers to **not** to use CPR if breathing or heartbeat stops.[74]
- **Advance Health Care Directive**- Self-directed planning which establishes the health care treatment decisions an individual wants in the event he or she becomes incapacitated or incompetent. These address all health care decisions, including mental health care decisions.
- **Psychiatric or Mental Health Advance Directive**- Self-directed planning which establishes the mental health care treatment decisions an individual wants in the event he or she becomes incapacitated or incompetent.

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[66] Section 394.4598(2), F.S.
[67] Id.
[68] Id.
[69] Section 394.4598(7), F.S.
[70] *Advance Directives*, American Cancer Society. http://www.cancer.org/treatment/findingandpayingfortreatment/understandingfinancialandlegalmatters/advancedirectives/advance-directives-types-of-advance-health-care-directives (last viewed on March 20, 2015). Living Wills may also contain a durable power of attorney, DNR and health care advance directives.
[71] Each of the types of advance directives may be used independently but are commonly used in conjunction with each other.
[72] Id.
[73] Id.
[74] Id.

All 50 states permit an individual to use an advance directive to express his or her wishes as to medical treatment in the event the individual becomes terminally ill or has an injury or disease making the individual unable to communicate or make medical decisions.[75] However, the requirements to create a valid advance directive vary among the states.

Under Florida law, a health care advance directive is a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care.[76] Health care advance directives include, but are not limited to, the designation of a health care surrogate, a living will, or an anatomical gift.[77] No specific form is required, and an individual can provide direction for all health care issues, including life-prolonging procedures and mental health treatment.[78] Health care facilities are required to provide each patient with written information concerning the individual's rights relating to advance directives and the facility's policies respecting the implementation of such rights.[79]

Mental Health Courts

People with mental illness comprise a significant proportion of the incarcerated criminal justice population.[80] Between 25% and 40% of all individuals with mental illness in the United States will be involved with the criminal justice system.[81] There are a variety of issues that develop with incarcerating mentally ill persons:[82]

- Jail/prison overcrowding resulting from mentally ill prisoners remaining behind bars longer than other prisoners;
- Behavioral issues disturbing to other prisoners and correctional staff;
- Physical attacks on correctional staff and other prisoners;
- Victimization of prisoners with mental illness in disproportionate numbers;
- Deterioration in the psychiatric condition of inmates with mental illness as they go without treatment;
- Relegation in grossly disproportionate numbers to solitary confinement, which worsens symptoms of mental illness;
- Jail/prison suicides in disproportionate numbers;
- Increased taxpayer costs; and
- Disproportionate rates of recidivism.

To address this issue many jurisdictions developed mental health courts.

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[75] American Bar Association, "Living Wills, Health Care Proxies, & Advance Health Care Directives," *available at* http://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/living_wills_health_care_proxies_advance_health_care_directives.html (last visited on March 20, 2015).

[76] Section 765.101(1), F.S.

[77] Id.

[78] Section 765.101(5)(a), F.S.

[79] Section 765.110(1), F.S.

[80] *Justice and Mental Health Collaboration Program: Fact Sheet*, Nathan James, Congressional Research Service, January 7, 2015. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=3&ved=0CC8QFjAC&url=http%3A%2F%2Ffas.org%2Fsgp%2Fcrs%2Fmisc%2FR43556.pdf&ei=M28LVY_HGcu5ggT3oIK4Dg&usg=AFQjCNHX1UzMTxFIRtesX1sN0fOMbET2NQ (last viewed on March 19, 2015).

[81] *Spending Money in All the Wrong Places: Jails & Prisons*, National Alliance on Mental Illness. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&ved=0CCQQFjAB&url=http%3A%2F%2Fwww.nami.org%2FContent%2FNavigationMenu%2FInform_Yourself%2FAbout_Public_Policy%2FPolicy_Research_Institute%2FPolicymakers_Toolkit%2FSpending_Money_in_all_the_Wrong_Places_Jails.pdf&ei=AUsLVbuFJYqwggSx4IL4BQ&usg=AFQjCNGyeFEsh0IjtQFmjOhUg2R5_keBEA (last viewed on March 19, 2015).

[82] *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, Treatment Advocacy Center, April 8, 2014. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&ved=0CCsQFjAB&url=http%3A%2F%2Ftacreports.org%2Fstorage%2Fdocuments%2Ftreatment-behind-bars%2Ftreatment-behind-bars.pdf&ei=k6QNVa_kDMyUNuPFgrgF&usg=AFQjCNEPJj-cXShX3wvNBRytFIKP2t0bFw (last viewed on March 21, 2015).

Mental health court is a type of problem-solving court which provides diversion from jail or prison for people with mental illness. Mental health courts vary widely among jurisdiction on several aspects, including target population, charge accepted (e.g., misdemeanor versus felony), plea arrangement, intensity of supervision, program duration, and type of treatment available.[83] Despite these differences, mental health courts typically share the following goals:[84]

- To improve public safety by reducing criminal recidivism;
- To improve the quality of life of people with mental illnesses and to increase their participation in effective treatment; and
- To reduce court- and corrections-related costs through administrative efficiencies and often by providing an alternative to incarceration.

Florida does not currently have a codified statewide mental health court program. Instead, each local jurisdiction has the authority to establish a mental health court. As a result, eligibility, program requirements, and other processes differ among the various mental health courts. For example, in order to be eligible to participate in Alachua County's Mental Health Court, a defendant must be diagnosed with a mental illness or developmental disability and be arrested for a misdemeanor or criminal traffic offense.[85] However, in order to be eligible to participate in Nassau County's Mental Health Court, the defendant must have an Axis I mental health diagnosis and have been charged with non-violent misdemeanors. Nassau County's Mental Health Court may also consider third degree felony convictions.[86] As of October 2014, there were 26 mental health courts operating in 16 counties.[87]

Child Welfare

DCF is responsible for the administration of Florida's child welfare program. The goals of the child welfare program are:[88]

- The prevention of separation of children from their families;
- The protection of children alleged to be dependent or dependent children including provision of emergency and long-term alternate living arrangements;
- The reunification of families who have had children placed in foster homes or institutions;
- The permanent placement of children who cannot be reunited with their families or when reunification would not be in the best interest of the child;
- The transition to self-sufficiency for older children who continue to be in foster care as adolescents;
- The preparation of young adults that exit foster care at age 18 to make the transition to self-sufficiency as adults; and
- The prevention and remediation of the consequences of substance abuse on families.[89]

To advance the goal of combating substance abuse in families, ss. 39.507, F.S., and 39.512, F.S., authorize dependency courts to order an individual undergo a substance abuse disorder assessment. The statutes additionally authorize a dependency court to order an individual to participate in and

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[83] *Supra*, footnote 80.
[84] FLORIDA COURTS, *Mental Health Courts*, http://www.flcourts.org/resources-and-services/court-improvement/problem-solving-courts/mental-health-courts.stml (last viewed Mar. 16, 2015).
[85] OFFICE OF THE STATE ATTORNEY EIGHTH JUDICIAL CIRCUIT, *Alachua County Mental Health Court*, http://sao8.org/Mental%20Health.htm (last viewed Mar. 16, 2015). Those charged with domestic violence, driving under the influence, and sexual offenses are excluded from the program. However, Alachua County does provide certain exemptions for defendants charged with certain crimes.
[86] NASSAU COUNTY MENTAL HEALTH COURT, Eligibility And Referral, http://www.ncmhc.org/default.cfm?page=eligibility (last viewed Mar. 16, 2015).
[87] FLORIDA COURTS, *Mental Health Courts*, http://www.flcourts.org/resources-and-services/court-improvement/problem-solving-courts/mental-health-courts.stml (last viewed Mar. 16, 2015).
[88] *Child Welfare*, Department of Children and Families. http://www.myflfamilies.com/service-programs/child-welfare (last visited on March 21, 2015).
[89] Section 39.001(6), F.S.

comply with a treatment-based drug court program.[90] Treatment-based drug court is an alternative to incarceration for defendants who enter the judicial system because of addiction and consists of an intensive, judicially monitored treatment program. [91]

Effect of the Proposed Changes

Substance Abuse and Mental Health Program

Section 394.492 establishes the definitions to be used for the child and adolescent mental health system of care funded by DCF. Section 394.492 (1),(4) and (6) respectively define "adolescent", "child or adolescent at risk of emotional disturbance" and "child or adolescent who has a serious emotional disturbance or mental illness" as involving an individual under 18 years of age. The PCB amends these subsections to extend the qualifying age from under 18 years of age to under 21 years of age. This aligns the definitions for the state program with Medicaid definitions and the age at which most individuals no longer qualify for extended foster care.

The PCB creates section 397.402, F.S., which requires DCF to modify licensure rules and procedures to create an option for a single, consolidated license for a provider that offers multiple types of mental health and substance abuse services regulated under chapters 394 and 397. Eligible providers must operate these services through a single corporate entity and a unified management structure. Any provider serving children and adults must meet standards and requirements necessary to preserve the safety of children and promote therapeutic efficacy. The PCB requires DCF to have the consolidated license created by January 1, 2016.

Behavioral Health Managing Entities

The PCB amends s. 394.9082(4)(a), F.S., to allow, in limited circumstances, entities other than nonprofit organizations to serve as managing entities. DCF must first attempt to contract with nonprofit organizations for the delivery of these services. However, if fewer than two responsive bids are received to a solicitation, DCF must reissue the solicitation, and managed behavioral health organizations will be eligible to bid in addition to nonprofit organizations. The PCB defines "managed behavioral health organization" as a Medicaid managed care organization or a behavioral health specialty managed care organization operating in the state. The PCB amends the definition of "managing entity" to include "managed behavioral health organization", in addition to nonprofit organizations.

The PCB amends s. 394.9082(4)(b), F.S., to require DCF's contract with each managing entity to be a performance-based agreement requiring specific results, setting measureable performance standards and timelines, and identifying consequences for failure to achieve specified performance standards.

The PCB amends s. 394.9082(6)(d), F.S., to require managing entities to provide certain core functions, which include, among others, consumer care coordination. The PCB requires managing entities, within available resources, to contract for the provision of care coordination to facilitate the appropriate delivery of behavioral health care services for specific target populations:

- Individuals with serious mental illness who have been admitted multiple times to acute levels of care, state mental health treatment facilities, jails, or prison;
- Individuals in crisis stabilization units who are on the waitlist to a state treatment facility;
- Individuals in state treatment facilities on the waitlist to community-based care;
- Parents or caretakers with child welfare involvement;
- Individuals who account for a disproportionate amount of behavioral health expenditures; and

[90] Sections 39.507, F.S., and 39.512, F.S.
[91] *Drug Court*, First Judicial Circuit Court of Florida. http://www.firstjudicialcircuit.org/programs-and-services/drug-court (last viewed on March 21, 2015).

- Other individuals eligible for services.

The care coordination must address the holistic needs of the consumer. This includes coordination with other local systems and entities, public and private, that are involved with the consumer, such as primary health care, child welfare, behavioral health care, and criminal and juvenile justice. To the extent allowable by available resources, support services provided through care coordination may include:

- Supportive housing;
- Supported employment;
- Family support and education;
- Independent living skill development;
- Peer support;
- Wellness management and self-care; and
- Case management.

The PCB amends s. 394.9082(6)(e), F.S., to require managing entities to work with the civil court system to develop procedures for the evaluation and use of involuntary outpatient placement for individuals as a strategy for diverting future admissions to acute levels of care, jails, prisons, and forensic facilities, subject to the availability of funding for services.

The PCB amends s. 394.9082(6)(f), F.S., to allow DCF to develop additional data points which the managing entities must collect and submit, in addition to the required data points of persons served, outcomes of persons served, and the costs of services provided through the department's contract. The managing entities must report outcomes for all clients who have been served through the contract as long as they are clients of a network provider. DCF, to the extent possible, must use applicable measures based on nationally recognized standards such as the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's National Outcome Measures or those developed by the National Quality Forum, the National Committee for Quality Assurance, or similar credible sources.

The PCB additionally amends s. 394.9082(6)(f), F.S., to require DCF to work with managing entities to establish additional performance measures related to, at a minimum:

- The improvement in the overall behavioral health of a community;
- The improvement in functioning or progress in recovery of individuals served through care coordination;
- Success of strategies to divert admissions to acute levels of care.

The PCB requires the method of paying managing entities to include submission of complete and accurate data before they receive payment. It also requires consequences for performance failure.

The PCB requires managing entities that are not managed behavioral health organizations to include representatives of law enforcement, the courts, and the community-based care lead agency, as well as individuals with business expertise, on its governance board. If the managing entity is a managed behavioral health organization, it must have an advisory board that meets the requirements of s. 394.9082(7)(a), F.S.

The PCB provides managing entities flexibility to determine their network participants but requires them to have a process for publicizing opportunities for providers to join the network and evaluating to determine whether a provider may be part of its network.

The PCB also deletes a variety of obsolete requirements, primarily those relating to the transition to the managing entity structure. Some examples are provisions addressing the initial funding for managing entities, the phase-in of their responsibilities, and reporting on the transition.

Study

The PCB requires DCF to contract for a two-part study of the safety-net system with an entity with expertise in behavioral healthcare and health systems planning and administration. An interim report, due November 1, 2015, will review and provide recommendations about:

- The system's current operation and performance,
- Payment methodologies,
- Mechanisms for increased coordination between the safety-net system and other systems and funders providing mental health and substance abuse services ; and
- Performance measures.

A final report, due November 30, 2016, will also address:

- Populations that state law requires the safety-net system to serve,
- The sufficiency of the behavioral health workforce,
- Strategies to increase flexibility in providing services;
- Requirements for competency restoration;
- Involuntary commitment, including advantages and disadvantages of combining the Baker Act and Marchman Acts.

Revenue Maximization

The PCB creates s. 394.761, F.S., which requires AHCA and DCF to develop a plan to obtain federal approval for increasing the availability of federal Medicaid funding for behavioral health care. The plan must identify the amount of general revenue funding appropriated for mental health and substance abuse services which is eligible to be used as state Medicaid match. The plan must also evaluate alternative uses of increased Medicaid funding and identify the advantages and disadvantages of each alternative. AHCA and DCF are required to submit the written plan to the President of the Senate and the Speaker of the House of Representatives no later than November 1, 2015.

Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program

The PCB amends s. 394.656, F.S., and converts the Statewide Grant Review Committee to the Statewide Grant Policy Committee. The Policy Committee will consist of the existing members of the Review Committee and the following representatives:

- One representative of the Department of Veterans' Affairs;
- One representative of the Florida Sheriffs Association;
- One representative of the Florida Police Chiefs Association;
- One representative of the Florida Association of Counties;
- One representative of the Florida Alcohol and Drug Abuse Association; and
- One representative of the Florida Council for Community Mental Health.

The Policy Committee will serve as the advisory body to review policy and funding issues that help reduce the impact of persons with mental illnesses and substance use disorders on communities, criminal justice agencies, and the court system. The PCB requires DCF to create a grant review and selection committee which will be responsible for evaluating grant applications and selecting recipients. The grant review and selection committee will notify DCF of its selections.

Currently under s. 394.656, F.S., only a county or a consortium of counties may apply for a grant under the Program. The PCB amends this section to allow a not-for-profit community provider designated by the county planning council or committee, in addition to a county or consortium of counties, to apply for a grant. A not-for-profit community provider must have express, written authorization from the county to apply for a grant to ensure local matching funds are available.

The PCB amends s. 394.656, F.S., to authorize DCF to require, at its discretion, an applicant to conduct sequential intercept mapping for a project. The PCB defines sequential intercept mapping as a process for reviewing a local community's mental health, substance abuse, criminal justice, and related systems and identifying points of interceptions where interventions may be made to prevent an individual with a substance use disorder or mental illness from penetrating further into the criminal justice system.

Florida Mental Health Act

Definitions

Section 394.455(18), F.S., defines mental illness as an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. The PCB amends this section to exclude dementia and traumatic brain injuries from the definition of mental illness.

Guardian Advocate

Section 394.4598(1), F.S., of the Baker Act, permits only an administrator of a receiving or treatment facility may petition the court for the appointment of a guardian. The PCB amends this section to allow a family member of the patient or an interested party, in addition to the administrator of a receiving or treatment facility, to petition the court for the appointment of a guardian advocate.

Receiving Facilities

The PCB creates the Crisis Stabilization Services Utilization Database. The PCB directs DCF to develop, implement, and maintain standards under which a behavioral health managing entity must collect utilization data from all public receiving facilities within its geographic service area. The PCB defines "public receiving facility" as an entity that meets the licensure requirements of and is designated by DCF to operate as a public receiving facility under s. 394.875, F.S., and which is operating as a licensed crisis stabilization unit.

DCF must develop standards and protocols to be used by managing entities and public receiving facilities for the collection, storage, transmittal, and analysis of data. The standards and protocols must allow for compatibility of data and data transmittal between public receiving facilities, managing entities, and DCF. Managing entities must comply with these requirements by August 1, 2015.

A managing entity must require a public receiving facility within its provider network to submit data, in real time or at least daily, for:

- All admissions and discharges of clients receiving public receiving facility services who qualify as indigent as defined in s. 394.4787, F.S.; and
- Current active census of total licensed beds, the number of beds purchased by DCF, the number of clients qualifying as indigent occupying those beds, and the total number of unoccupied licensed beds regardless of funding.

A managing entity must require a public receiving facility within its provider network to submit data on a monthly basis which aggregates the daily data previously submitted. The managing entity must

reconcile the data in the monthly submission to the daily data to check for consistency. If the monthly aggregate data is inconsistent with the daily data, the managing entity must consult with the public receiving facility to make corrections as necessary to ensure accurate data.

A managing entity must require a public receiving facility within its provider network to submit data on an annual basis which aggregates the monthly data previously submitted. The managing entity must reconcile the data in the annual submission to the monthly data to check for consistency. If the annual aggregate data is inconsistent with the monthly data, the managing entity must consult with the public receiving facility to make corrections as necessary to ensure accurate data.

After ensuring accurate data, the managing entity must submit the data to DCF on a monthly and annual basis. The PCB requires DCF to use the reconciled data to develop a statewide database for the purpose of analyzing payments to and use of state-funded crisis stabilization services. The database must allow for analysis on both a statewide and individual public receiving facility basis.

The PCB requires DCF to adopt rules and submit a report by January 31, 2016, and annually thereafter, to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report must contain details on the PCB's implementation, including the status of the data collection process, and an analysis of the data collected.

The PCB provides DCF with rule-making authority and a nonrecurring appropriation of $175,000 to implement these provisions.

Advance Directives

Section 765.110, F.S., requires specified health care facilities to provide each patient written information concerning the patient's rights relating to advance directives. The PCB amends this section to require the health care facilities to also provide written information relating to advance directives for mental health treatment. The PCB requires DCF to develop and publish on its website a mental health advance directive form which may be used by an individual to direct future care.

Mental Health Courts

Chapter 39 sets forth the legal requirements for proceedings relating to children. Section 39.001, F.S., expressly states the goals for the state related to substance abuse treatment services in the dependency process. The PCB amends this section to include mental illness treatment services as an element of the goals. Sections 39.507, F.S., and 39.512, F.S., authorize dependency courts to order an individual to undergo a substance abuse disorder assessment. These sections also authorize dependency courts to order an individual to participate in and comply with a treatment-based drug court program. The PCB amends these sections to authorize dependency courts to order an individual to undergo a mental health disorder assessment and to participate in and comply with a treatment-based mental health court program established under s. 394.47892, F.S.

The PCB makes these amendments contingent upon the passage of PCB JDC 15-01 or similar legislation enacting s. 394.47892, F.S., authorizing the creation of treatment-based mental health court programs.

Repeals

The PCB repeals a number of obsolete and duplicative sections of statute, including:

- Section 394.4674, F.S., which requires DCF to complete a deinstitutionalization plan. This section was enacted in 1980 and is obsolete following further developments in federal law.
- Section 394.4985, F.S., which requires DCF's regions to develop and maintain an information and referral network. This duplicates other requirements.

- Section 394.745, F.S., which requires an annual report to the Legislature of compliance of substance abuse and mental health treatment providers under contract with DCF.
- Section 394.9084, F.S., authorizing the Florida self-directed care program. This is a pilot program that has been implemented.
- Section 397.331, F.S., providing definitions and legislative intent for the Drug Policy Advisory Council, which the PCB also repeals.
- Section 397.333, F.S., establishing the Statewide Drug Policy Advisory Council at the Department of Health, which is duplicative of other statewide efforts.
- Section 397.801, F.S., requiring the Departments of Education, Corrections, Law Enforcement and Children and Families to each designate substance abuse impairment coordinators, and for DCF to also designate full-time substance abuse impairment coordinators in each of its regions.
- Section 397.811, F.S., which expresses the Legislature's intent that substance abuse prevention and early intervention programs be funded.
- Section 397.821, F.S., authorizing each judicial circuit to establish juvenile substance abuse impairment prevention and early intervention councils to identify needs. The managing entity now performs these duties.
- Section 397.901, F.S., authorizing DCF to establish prototype juvenile addiction receiving facilities. This section was enacted in 1993, and these projects are completed.
- Section 397.93, F.S., specifying target populations for children's substance abuse services, which duplicates other statutory requirements. This duplicates other provisions of law.
- Section 397.94, F.S., requiring the DCF's regions to plan and provide for information and referral services regarding children's substance abuse services.
- Section 397.951, F.S., requiring DCF to ensure that treatment providers use sanctions provided elsewhere in law to keep children in substance abuse treatment.
- Section 397.97, F.S., creating the Children's Network of Care Demonstration Models and authorizing their operation for four years. These were originally established in 1999.

B. SECTION DIRECTORY:

Section 1: Amends s. 39.001, F.S., relating to purposes and intent; personnel standards and screening for proceedings relating to children.
Section 2: Amends s. 39.507, F.S., relating to adjudicatory hearings and orders of adjudication for proceedings relating to children.
Section 3: Amends s. 39.521, F.S., relating to disposition hearings and powers of disposition for proceedings relating to children.
Section 4: Amends s. 394.455, F.S., relating to definitions in the Florida Mental Health Act.
Section 5: Amends s. 394.4598, F.S., relating to guardian advocates.
Section 6: Amends s. 394.492, F.S., relating to definitions for comprehensive child and adolescent mental health services.
Section 7: Amends s. 394.656, F.S., relating to the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program
Section 8: Creates s. 394.761, F.S., relating to revenue maximization.
Section 9: Amends s. 394.9082, F.S., relating to behavioral health managing entities
Section 10: Appropriates $175,000 in nonrecurring funds from the Alcohol, Drug Abuse, and Mental Health Trust Fund.
Section 11: Requires a study of the safety-net mental health and substance abuse system.
Section 12: Creates s. 397.402, F.S., relating to single, consolidated licensure.
Section 13: Repeals s. 394.4674, F.S., relating to a plan and report.
Section 14: Repeals s. 394.4985, F.S., relating to districtwide information and referral network; implementation.
Section 15: Repeals s. 394.745, F.S., relating to an annual report; compliance of providers under contract with department.
Section 16: Repeals s. 394.9084, F.S., relating to Florida Self-Directed Care program.
Section 17: Repeals s. 397.331, F.S., relating to definitions; legislative intent regarding the Statewide Drug Policy Advisory Council.

Section 18: Repeals s. 397.333, F.S., relating to Statewide Drug Policy Advisory Council.
Section 19: Repeals s. 397.801, F.S., relating to substance abuse impairment coordination.
Section 20: Repeals s. 397.811, F.S., relating to juvenile substance abuse impairment coordination; legislative findings and intent.
Section 21: Repeals s. 397.821, F.S., relating to juvenile substance abuse impairment prevention and early intervention councils.
Section 22: Repeals s. 397.901, F.S., relating to prototype juvenile addictions receiving facilities.
Section 23: Repeals s. 397.93, F.S., relating to children's substance abuse services; target populations.
Section 24: Repeals s. 397.94, F.S., relating to children's substance abuse services; information and referral network.
Section 25: Repeals s. 397.951, F.S., relating to treatment and sanctions.
Section 26: Repeals s. 397.97, F.S., relating to children's substance abuse services; demonstration models.
Section 27: Amends s. 765.110, F.S., relating to health care facilities and providers; discipline.
Section 28: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

The PCB appropriates $175,000 in nonrecurring funds from the Alcohol, Drug Abuse, and Mental Health Trust Fund to fund the reporting infrastructure needs of five Managing Entities. The infrastructure upgrades are required to comply with the expanded CSU reporting requirements contained within the PCB.

There will indeterminate costs to DCF for the study of the safety-net mental health and substance abuse system required by section 11 of the PCB.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This PCB does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

   None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

   None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to mental health and substance abuse; amending ss. 39.001, F.S.; expressing legislative intent regarding mental illness related to the child welfare system; amending s. 39.507, F.S.; addressing consideration of mental health issues and involvement in mental health court programs in adjudicatory hearings and orders of adjudication; amending 39.521, F.S.; addressing consideration of mental health issues and involvement in mental health court programs in disposition hearings; amending s. 394.455, F.S.; revising the definition of "mental illness" to exclude dementia and traumatic brain injury; amending s. 394.4598, F.S.; allowing patients' family members or other interested parties to petition for the appointment of a guardian advocate; amending s. 394.492, F.S.; amending the definitions of "adolescent", "child or adolescent at risk of emotional disturbance", and "child or adolescent who has a serious emotional disturbance or mental illness"; amending s. 394.656, F.S.; revising the duties of the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Review Committee; providing additional members of the committee; providing duties of the committee; providing additional qualifications for committee members;

authorizing a designated not-for-profit community provider to apply for certain grants; removing provisions relating to applications for certain planning grants; creating s. 394.761, F.S.; requiring the Agency for Health Care Administration and the Department of Children and Families to develop a plan to obtain federal approval for increasing the availability of federal Medicaid funding for behavioral health care; requiring the agency and the department to submit the written plan, which must include certain information, to the Legislature by a specified date; amending s. 394.9082, F.S.; defining the term "managed behavioral health organization"; redefining the term "managing entity" to include managed behavioral health organizations; requiring the department to contract with community-based managing entities for the development of specified objectives; providing requirements for the contracting process; removing duties of the department, the secretary of the department, and managing entities; removing a provision regarding the requirement of funding the managing entity's contract through departmental funds; removing legislative intent; requiring that the department's contract with each managing entity be performance based; revising goals; deleting obsolete language regarding the transition to the managing

entity system; requiring that care coordination be provided to populations in priority order; specifying the priority order of populations; specifying the requirements for care coordination; requiring the managing entity to work with the civil court system to develop procedures regarding involuntary outpatient placement subject to the availability of funding for services; requiring the department to use applicable performance measures based on nationally recognized standards to the extent possible; including standards related at a minimum to the improvement in the overall behavioral health of a community, improvement in person-centered outcome measures for populations provided care coordination, and reduction in readmissions to acute levels of care, jails, prisons, or forensic facilities; providing requirements for the governing board or advisory board of a managing entity; revising the network management and administrative functions of the managing entities; removing departmental responsibilities; specifying that methods of payment to managing entities must include requirements for data verification and consequences for failure to achieve performance standards; requiring the Department of Children and Families to develop standards and protocols for the collection, storage, transmittal, and analysis of

utilization data from public receiving facilities; defining the term "public receiving facility"; requiring the department to require compliance by managing entities by a specified date; requiring a managing entity to require public receiving facilities in its provider network to submit certain data within specified timeframes; requiring managing entities to reconcile data to ensure accuracy; requiring managing entities to submit certain data to the department within specified timeframes; requiring the department to create a statewide database; requiring the department to adopt rules; requiring the department to submit an annual report to the Governor and the Legislature; removing a reporting requirement; authorizing, rather than requiring, the department to adopt rules; providing an appropriation; requiring a study of the safety-net mental health and substance abuse system; providing topics; repealing s. 394.4674, F.S., relating to a plan and report; repealing s. 394.4985, F.S., relating to districtwide information and referral network and implementation; repealing s. 394.745, F.S., relating to an annual report and compliance of providers under contract with department; repealing 394.9084, F.S., relating to the Florida Self-Directed Care program; repealing s. 397.331, F.S., relating to definitions; repealing s.

397.333, F.S., relating to the Statewide Drug Policy Advisory Council; creating s. 397.402, F.S.; requiring that the department modify certain licensure rules and procedures by a certain date; repealing s. 397.801, F.S., relating to substance abuse impairment coordination; repealing s. 397.811, F.S., relating to juvenile substance abuse impairment coordination; repealing s. 397.821, F.S., relating to juvenile substance abuse impairment prevention and early intervention councils; repealing s. 397.901, F.S., relating to prototype juvenile addictions receiving facilities; repealing s. 397.93, F.S., relating to children's substance abuse services and target populations; repealing s. 397.94, F.S., relating to children's substance abuse services and the information and referral network; repealing s. 397.951, F.S., relating to treatment and sanctions; repealing s. 397.97, F.S., relating to children's substance abuse services and demonstration models; amending s. 765.110, F.S.; requiring health care facilities to include information about advance directives providing for mental health treatment; requiring the Department of Children and Families to develop and publish a mental health advance directive form on its website; providing an effective date.

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

Section 1. Contingent on the passage of PCB JDC 15-01 or similar legislation enacting s. 394.47892, F.S., authorizing the creation of treatment-based mental health court programs, subsection (6) of section 39.001, Florida Statutes, is amended to read:

39.001 Purposes and intent; personnel standards and screening.—

(6) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—

(a) The Legislature recognizes that early referral and comprehensive treatment can help combat mental illnesses and substance abuse disorders in families and that treatment is cost-effective.

(b) The Legislature establishes the following goals for the state related to mental illness and substance abuse treatment services in the dependency process:

1. To ensure the safety of children.

2. To prevent and remediate the consequences of mental illnesses and substance abuse disorders on families involved in protective supervision or foster care and reduce the occurrences of mental illnesses and substance abuse disorders, including alcohol abuse or related disorders, for families who are at risk of being involved in protective supervision or foster care.

3. To expedite permanency for children and reunify healthy, intact families, when appropriate.

4. To support families in recovery.

(c) The Legislature finds that children in the care of the state's dependency system need appropriate health care services, that the impact of mental illnesses and substance abuse disorders on health indicates the need for health care services to include treatment for mental health and substance abuse disorders ~~services~~ to children and parents where appropriate, and that it is in the state's best interest that such children be provided the services they need to enable them to become and remain independent of state care. In order to provide these services, the state's dependency system must have the ability to identify and provide appropriate intervention and treatment for children with personal or family-related mental illness and substance abuse problems.

(d) It is the intent of the Legislature to encourage the use of the treatment-based mental health court program model established by s. 394.47892 and drug court program model established by s. 397.334 and authorize courts to assess children and persons who have custody or are requesting custody of children where good cause is shown to identify and address mental illnesses and substance abuse disorders ~~problems~~ as the court deems appropriate at every stage of the dependency process. Participation in treatment, including a treatment-based mental health court program or a treatment-based drug court program, may be required by the court following adjudication. Participation in assessment and treatment before ~~prior to~~

adjudication is ~~shall be~~ voluntary, except as provided in s. 39.407(16).

(e) It is therefore the purpose of the Legislature to provide authority for the state to contract with mental health service providers and community substance abuse treatment providers for the development and operation of specialized support and overlay services for the dependency system, which will be fully implemented and used as resources permit.

(f) Participation in a treatment-based mental health court program or a ~~the~~ treatment-based drug court program does not divest any public or private agency of its responsibility for a child or adult, but is intended to enable these agencies to better meet their needs through shared responsibility and resources.

Section 2. Contingent on the passage of PCB JDC 15-01 or similar legislation enacting s. 394.47892, F.S., authorizing the creation of treatment-based mental health court programs, subsection (10) of section 39.507, Florida Statutes, is amended to read:

39.507 Adjudicatory hearings; orders of adjudication.—

(10) After an adjudication of dependency, or a finding of dependency where adjudication is withheld, the court may order a person who has custody or is requesting custody of the child to submit to a mental health or substance abuse disorder assessment or evaluation. The assessment or evaluation must be administered by a qualified professional, as defined in s. 397.311. The court

may also require such person to participate in and comply with treatment and services identified as necessary, including, when appropriate and available, participation in and compliance with a treatment-based mental health court program established under s. 394.47892 or a treatment-based drug court program established under s. 397.334. In addition to supervision by the department, the court, including the treatment-based mental health court program or treatment-based drug court program, may oversee the progress and compliance with treatment by a person who has custody or is requesting custody of the child. The court may impose appropriate available sanctions for noncompliance upon a person who has custody or is requesting custody of the child or make a finding of noncompliance for consideration in determining whether an alternative placement of the child is in the child's best interests. Any order entered under this subsection may be made only upon good cause shown. This subsection does not authorize placement of a child with a person seeking custody, other than the parent or legal custodian, who requires mental health or substance abuse disorder treatment.

Section 3. Contingent on the passage of PCB JDC 15-01 or similar legislation enacting s. 394.47892, F.S., authorizing the creation of treatment-based mental health court programs, paragraph (b) of subsection (1) of section 39.521, Florida Statutes, is amended to read:

39.521 Disposition hearings; powers of disposition.—

(1) A disposition hearing shall be conducted by the court,

if the court finds that the facts alleged in the petition for dependency were proven in the adjudicatory hearing, or if the parents or legal custodians have consented to the finding of dependency or admitted the allegations in the petition, have failed to appear for the arraignment hearing after proper notice, or have not been located despite a diligent search having been conducted.

(b) When any child is adjudicated by a court to be dependent, the court having jurisdiction of the child has the power by order to:

1. Require the parent and, when appropriate, the legal custodian and the child to participate in treatment and services identified as necessary. The court may require the person who has custody or who is requesting custody of the child to submit to a mental health or substance abuse disorder assessment or evaluation. The assessment or evaluation must be administered by a qualified professional, as defined in s. 397.311. The court may also require such person to participate in and comply with treatment and services identified as necessary, including, when appropriate and available, participation in and compliance with a treatment-based mental health court program established under s. 394.47892 or treatment-based drug court program established under s. 397.334. In addition to supervision by the department, the court, including the treatment-based mental health court program or treatment-based drug court program, may oversee the progress and compliance with treatment by a person who has

custody or is requesting custody of the child. The court may impose appropriate available sanctions for noncompliance upon a person who has custody or is requesting custody of the child or make a finding of noncompliance for consideration in determining whether an alternative placement of the child is in the child's best interests. Any order entered under this subparagraph may be made only upon good cause shown. This subparagraph does not authorize placement of a child with a person seeking custody of the child, other than the child's parent or legal custodian, who requires mental health or substance abuse disorder treatment.

2. Require, if the court deems necessary, the parties to participate in dependency mediation.

3. Require placement of the child either under the protective supervision of an authorized agent of the department in the home of one or both of the child's parents or in the home of a relative of the child or another adult approved by the court, or in the custody of the department. Protective supervision continues until the court terminates it or until the child reaches the age of 18, whichever date is first. Protective supervision shall be terminated by the court whenever the court determines that permanency has been achieved for the child, whether with a parent, another relative, or a legal custodian, and that protective supervision is no longer needed. The termination of supervision may be with or without retaining jurisdiction, at the court's discretion, and shall in either case be considered a permanency option for the child. The order

terminating supervision by the department shall set forth the powers of the custodian of the child and shall include the powers ordinarily granted to a guardian of the person of a minor unless otherwise specified. Upon the court's termination of supervision by the department, no further judicial reviews are required, so long as permanency has been established for the child.

Section 4. Subsection (18) of section 394.455, Florida Statutes, is amended to read:

394.455 Definitions.—As used in this part, unless the context clearly requires otherwise, the term:

(18) "Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, dementia, traumatic brain injuries, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

Section 5. Subsection (1) of section 394.4598, Florida Statutes, is amended to read:

394.4598 Guardian advocate.—

(1) The administrator, a family member of the patient, or an interested party may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist

that the patient is incompetent to consent to treatment. If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and a guardian with the authority to consent to mental health treatment appointed, it shall appoint a guardian advocate. The patient has the right to have an attorney represent him or her at the hearing. If the person is indigent, the court shall appoint the office of the public defender to represent him or her at the hearing. The patient has the right to testify, cross-examine witnesses, and present witnesses. The proceeding shall be recorded either electronically or stenographically, and testimony shall be provided under oath. One of the professionals authorized to give an opinion in support of a petition for involuntary placement, as described in s. 394.4655 or s. 394.467, must testify. A guardian advocate must meet the qualifications of a guardian contained in part IV of chapter 744, except that a professional referred to in this part, an employee of the facility providing direct services to the patient under this part, a departmental employee, a facility administrator, or member of the Florida local advocacy council shall not be appointed. A person who is appointed as a guardian advocate must agree to the appointment.

Section 6. Subsections (1), (4), and (6) of section 394.492, Florida Statutes, are amended to read:

394.492 Definitions.—As used in ss. 394.490-394.497, the term:

(1) "Adolescent" means a person who is at least 13 years of age but under 21 ~~18~~ years of age.

(4) "Child or adolescent at risk of emotional disturbance" means a person under 21 ~~18~~ years of age who has an increased likelihood of becoming emotionally disturbed because of risk factors that include, but are not limited to:

(a) Being homeless.

(b) Having a family history of mental illness.

(c) Being physically or sexually abused or neglected.

(d) Abusing alcohol or other substances.

(e) Being infected with human immunodeficiency virus (HIV).

(f) Having a chronic and serious physical illness.

(g) Having been exposed to domestic violence.

(h) Having multiple out-of-home placements.

(6) "Child or adolescent who has a serious emotional disturbance or mental illness" means a person under 21 ~~18~~ years of age who:

(a) Is diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; and

(b) Exhibits behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community, which behaviors are not considered to be a

temporary response to a stressful situation.

The term includes a child or adolescent who meets the criteria for involuntary placement under s. 394.467(1).

Section 7. Section 394.656, Florida Statutes, is amended to read:

394.656 Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program.—

(1) There is created within the Department of Children and Families the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program. The purpose of the program is to provide funding to counties with which they can plan, implement, or expand initiatives that increase public safety, avert increased spending on criminal justice, and improve the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance abuse disorder, or co-occurring mental health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.

(2) The department shall establish a Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Policy ~~Review~~ Committee. The committee shall include:

(a) One representative of the Department of Children and Families;

(b) One representative of the Department of Corrections;

(c) One representative of the Department of Juvenile

Justice;

(d) One representative of the Department of Elderly Affairs; ~~and~~

(e) One representative of the Office of the State Courts Administrator;

(f) One representative of the Department of Veterans' Affairs;

(g) One representative of the Florida Sheriffs Association;

(h) One representative of the Florida Police Chiefs Association;

(i) One representative of the Florida Association of Counties;

(j) One representative of the Florida Alcohol and Drug Abuse Association; and

(k) One representative of the Florida Council for Community Mental Health.

(3) The committee shall serve as the advisory body to review policy and funding issues that help reduce the impact of persons with mental illnesses and substance use disorders on communities, criminal justice agencies, and the court system. The committee shall advise the department in selecting priorities for grants and investing awarded grant moneys.

(4) The department shall create a grant review and selection committee that has experience in substance use and mental health disorders, community corrections, and law

enforcement. To the extent possible, the ~~members of the~~ committee shall have expertise in ~~grant writing,~~ grant reviewing~~,~~ and grant application scoring.

(5)~~(3)~~(a) A county or not-for-profit community provider designated by the county planning council or committee, as described in s. 394.657, may apply for a 1-year planning grant or a 3-year implementation or expansion grant. The purpose of the grants is to demonstrate that investment in treatment efforts related to mental illness, substance abuse disorders, or co-occurring mental health and substance abuse disorders results in a reduced demand on the resources of the judicial, corrections, juvenile detention, and health and social services systems.

(b) To be eligible to receive a 1-year planning grant or a 3-year implementation or expansion grant~~,~~:

1. A county ~~applicant~~ must have a ~~county~~ planning council or committee that is in compliance with the membership requirements set forth in this section.

2. A not-for-profit community provider must be designated by the county planning council or committee and have written authorization to submit an application. A not-for-profit community provider must have written authorization for each application it submits.

(c) The department may award a 3 year implementation or expansion grant to an applicant who has not received a 1 year planning grant.

(d) The department may require an applicant to conduct sequential intercept mapping for a project. "Sequential intercept mapping" means a process for reviewing a local community's mental health, substance abuse, criminal justice, and related systems and identifying points of interceptions where interventions may be made to prevent an individual with a substance use disorder or mental illness from penetrating further into the criminal justice system.

(6) ~~(4)~~ The grant review committee shall select the recipients and notify the department ~~of Children and Families~~ in writing of the names of the applicants who have been selected by the committee to receive a grant. Contingent upon the availability of funds and upon notification by the review committee of those applicants approved to receive planning, implementation, or expansion grants, the department ~~of Children and Families~~ may transfer funds appropriated for the grant program to a selected recipient ~~any county awarded a grant~~.

Section 8. Section 394.761, Florida Statutes, is created to read:

394.761 Revenue Maximization.--

The agency and the department shall develop a plan to obtain federal approval for increasing the availability of federal Medicaid funding for behavioral health care. The agency and the department shall submit the written plan to the President of the Senate and the Speaker of the House of Representatives no later than November 1, 2015. The plan shall

identify the amount of general revenue funding appropriated for mental health and substance abuse services which is eligible to be used as state Medicaid match. The plan must evaluate alternative uses of increased Medicaid funding, including seeking Medicaid eligibility for the severely and persistently mentally ill; increased reimbursement rates for behavioral health services; adjustments to the capitation rate for Medicaid enrollees with chronic mental illness and substance use disorders; supplemental payments to mental health and substance abuse providers through a designated state health program or other mechanisms; and innovative programs for incentivizing improved outcomes for behavioral health conditions. The plan shall identify the advantages and disadvantages of each alternative and assess the potential of each for achieving improved integration of services. The plan shall identify the types of federal approvals necessary to implement each alternative and project a timeline for implementation.

Section 9. Sections (2) and (4) through (11) of section 394.9082, Florida Statutes, are amended to read:

394.9082 Behavioral health managing entities.—

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

~~(b) "Decisionmaking model" means a comprehensive management information system needed to answer the following management questions at the federal, state, regional, circuit, and local provider levels: who receives what services from which providers with what outcomes and at what costs?~~

~~(c)~~ "Geographic area" means a county, circuit, regional, or multiregional area in this state.

(c) "Managed behavioral health organization" means a Medicaid managed care organization or a behavioral health specialty managed care organization operating in the state.

(d) "Managing entity" means a corporation that is organized in this state, is designated or filed as a nonprofit organization under s. 501(c)(3) of the Internal Revenue Code, or a managed behavioral health organization, which ~~and~~ is under contract to the department to manage the day-to-day operational delivery of behavioral health services through an organized system of care pursuant to subparagraph (4)(a)1.

(4) CONTRACT FOR SERVICES.—

(a)1. The department shall first attempt to ~~may~~ contract for the purchase and management of behavioral health services with community-based non-profit organizations with competence in managing networks of providers serving persons with mental health and substance use disorders to achieve the goals and outcomes provided in this section ~~managing entities~~. However, if fewer than two responsive bids are received to a solicitation for a managing entity contract, the department shall reissue the solicitation, and managed behavioral health organizations shall also be eligible to bid. In evaluating responses to a solicitation, the department must consider at a minimum the following factors:

a. Experience serving persons with mental health and

substance use disorders.

b. Establishment of community partnerships with behavioral health providers.

c. Demonstrated organizational capabilities for network management functions.

2. The department may require a managing entity to contract for specialized services that are not currently part of the managing entity's network if the department determines that to do so is in the best interests of consumers of services. ~~The secretary shall determine the schedule for phasing in contracts with managing entities. The managing entities shall, at a minimum, be accountable for the operational oversight of the delivery of behavioral health services funded by the department and for the collection and submission of the required data pertaining to these contracted services.~~ A managing entity shall serve a geographic area designated by the department. The geographic area must be of sufficient size in population and have enough public funds for behavioral health services to allow for flexibility and maximum efficiency.

~~(b) The operating costs of the managing entity contract shall be funded through funds from the department and any savings and efficiencies achieved through the implementation of managing entities when realized by their participating provider network agencies. The department recognizes that managing entities will have infrastructure development costs during start-up so that any efficiencies to be realized by providers~~

~~from consolidation of management functions, and the resulting savings, will not be achieved during the early years of operation. The department shall negotiate a reasonable and appropriate administrative cost rate with the managing entity. The Legislature intends that reduced local and state contract management and other administrative duties passed on to the managing entity allows funds previously allocated for these purposes to be proportionately reduced and the savings used to purchase the administrative functions of the managing entity. Policies and procedures of the department for monitoring contracts with managing entities shall include provisions for eliminating duplication of the department's and the managing entities' contract management and other administrative activities in order to achieve the goals of cost-effectiveness and regulatory relief. To the maximum extent possible, provider monitoring activities shall be assigned to the managing entity.~~

(b) ~~(c)~~ The department's contract with each managing entity must be a performance-based agreement requiring specific results, setting measureable performance standards and timelines, and identifying consequences for failure to achieve specified performance standards.

(c) Contracting and payment mechanisms for services must promote clinical and financial flexibility and responsiveness and must allow different categorical funds to be integrated at the point of service. The contracted service array must be determined by using public input, needs assessment, and

evidence-based and promising best practice models. The department and managing entities may employ care management methodologies, prepaid capitation, and case rate or other methods of payment which promote flexibility, efficiency, and accountability.

(5) GOALS.—The department and managing entities shall: ~~goal of the service delivery strategies is to provide a design for an effective coordination, integration, and management approach for delivering effective~~

(a) Effectively deliver behavioral health services to persons who are experiencing a mental health or substance abuse crisis, who have a disabling mental illness or a substance use or co-occurring disorder, and require extended services in order to recover from their illness, or who need brief treatment or longer-term supportive interventions to avoid a crisis or disability. ~~Other goals include:~~

~~(a) Improving accountability for a local system of behavioral health care services to meet performance outcomes and standards through the use of reliable and timely data.~~

(b) ~~Enhancing the continuity of care~~ Provide a coordinated, integrated system of care for all children, adolescents, and adults who enter the publicly funded behavioral health service system.

(c) ~~Preserving the "safety net" of publicly funded behavioral health services and providers, and recognizing and ensuring continued local contributions to these services, by~~

~~establishing locally designed and community-monitored systems of care.~~

(d) Provide ~~Providing~~ early diagnosis and treatment interventions to enhance recovery and prevent hospitalization.

(e) Improve ~~Improving~~ the assessment of local needs for behavioral health services.

(f) Improve ~~Improving~~ the overall quality of behavioral health services through the use of evidence-based, best practice, and promising practice models.

(g) ~~Demonstrating improved~~ Improve service integration between behavioral health programs and other programs, such as vocational rehabilitation, education, child welfare, primary health care, emergency services, juvenile justice, and criminal justice.

(h) Provide ~~Providing~~ for additional testing of creative and flexible strategies for financing behavioral health services to enhance individualized treatment and support services.

~~(i) Promoting cost-effective quality care.~~

~~(j) Working with the state to coordinate admissions and discharges from state civil and forensic hospitals and coordinating admissions and discharges from residential treatment centers.~~

~~(k) Improving the integration, accessibility, and dissemination of behavioral health data for planning and monitoring purposes.~~

~~(l) Promoting specialized behavioral health services to~~

~~residents of assisted living facilities.~~

~~(m) Working with the state and other stakeholders to reduce the admissions and the length of stay for dependent children in residential treatment centers.~~

~~(n) Providing services to adults and children with co-occurring disorders of mental illnesses and substance abuse problems.~~

~~(o) Providing services to elder adults in crisis or at-risk for placement in a more restrictive setting due to a serious mental illness or substance abuse.~~

(6) ESSENTIAL ELEMENTS. ~~It is the intent of the Legislature that~~ The department may plan for and enter into ~~contracts with managing entities to manage care in geographical areas throughout the state.~~

(a) The managing entity must demonstrate the ability of its network of providers to comply with the pertinent provisions of this chapter and chapter 397 and to ensure the provision of comprehensive behavioral health services. The network of providers must be comprehensive enough to meet client needs and include, but need not be limited to, community mental health agencies, substance abuse treatment providers, and best practice consumer services providers.

~~(b) The department shall terminate its mental health or substance abuse provider contracts for services to be provided by the managing entity at the same time it contracts with the managing entity.~~

~~(c) The managing entity shall ensure that its provider network is broadly conceived. All mental health or substance abuse treatment providers currently under contract with the department shall be offered a contract by the managing entity.~~

(d) The department shall ~~may~~ contract with managing entities to provide the following core functions:

1. Financial accountability.

2. Allocation of funds to network providers in a manner that reflects the department's strategic direction and plans.

3. Provider monitoring to ensure compliance with federal and state laws, rules, and regulations.

4. Data collection, reporting, and analysis.

5. Operational plans to implement objectives of the department's strategic plan.

6. Contract compliance.

7. Performance management.

8. Collaboration with community stakeholders, including local government.

9. System of care through network development.

10. Consumer care coordination.

a. To the extent allowed by available resources, the managing entity shall contract for the provision of care coordination to facilitate the appropriate delivery of behavioral health care services in the least restrictive setting, based on standardized level of care determinations, recommendations by a treating practitioner, and the consumer and

their family, as appropriate. In addition to treatment services, care coordination shall address the holistic needs of the consumer. It shall also involve coordination with other local systems and entities, public and private, that are involved with the consumer, such as primary health care, child welfare, behavioral health care, and criminal and juvenile justice. Care coordination shall be provided to populations in the following order of priority:

(I) Individuals with serious mental illness who have experienced multiple arrests, involuntary commitments, admittances to a state mental health treatment facility, or episodes of incarceration or have been placed on conditional release for a felony or violated condition of probation multiple times as a result of their behavioral health condition.

(II) Individuals in crisis stabilization units who are on the waitlist to a state treatment facility.

(III) Individuals in state treatment facilities on the waitlist to community-based care.

(IV) Parents or caretakers with child welfare involvement.

(V) Individuals who account for a disproportionate amount of behavioral health expenditures.

(VI) Other individuals eligible for services.

b. To the extent allowed by available resources, support services provided through care coordination may include but not be limited to the following, as determined by the individual's needs:

(I) Supportive housing, including licensed assisted living facilities, adult family care homes, mental health residential treatment facilities, and department-approved programs. Each housing arrangement must demonstrate an ability to ensure appropriate levels of residential supervision.

(II) Supported employment.

(III) Family support and education.

(IV) Independent living skill development.

(V) Peer support.

(VI) Wellness management and self-care.

(VII) Case management.

11. Continuous quality improvement.

12. Timely access to appropriate services.

13. Cost-effectiveness and system improvements.

14. Assistance in the development of the department's strategic plan.

15. Participation in community, circuit, regional, and state planning.

16. Resource management and maximization, including pursuit of third-party payments and grant applications.

17. Incentives for providers to improve quality and access.

18. Liaison with consumers.

19. Community needs assessment.

20. Securing local matching funds.

(e) The managing entity shall ensure that written

cooperative agreements are developed and implemented among the criminal and juvenile justice systems, the local community-based care network, and the local behavioral health providers in the geographic area which define strategies and alternatives for diverting people who have mental illness and substance abuse problems from the criminal justice system to the community. These agreements must also address the provision of appropriate services to persons who have behavioral health problems and leave the criminal justice system. The managing entity shall work with the civil court system to develop procedures for the evaluation and use of involuntary outpatient placement for individuals as a strategy for diverting future admissions to acute levels of care, jails, prisons, and forensic facilities, subject to the availability of funding for services.

(f) Managing entities must collect and submit data to the department regarding persons served, outcomes of persons served, and the costs of services provided through the department's contract, and other data points as required by the department. ~~The department shall evaluate managing entity services based on consumer-centered outcome measures that reflect national standards that can dependably be measured.~~ To the extent possible, the department shall use applicable measures based on nationally recognized standards such as the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's National Outcome Measures or those developed by the National Quality Forum, the National Committee

for Quality Assurance, or similar credible sources. The managing entities shall report outcomes for all clients who have been served through the contract as long as they are clients of a network provider, even if the network provider serves that client during a portion of the year through non-contract funds. Within current resources, the department shall work with managing entities to establish performance standards related to, at a minimum:

1. The extent to which individuals in the community receive services.

2. The improvement in the overall behavioral health of a community.

3. The improvement in functioning or progress in recovery ~~improvement~~ of individuals served through care coordination, as determined using person-centered measures tailored to the population ~~of quality of care for individuals served~~.

3. The success of strategies to divert admissions to acute levels of care and jail, prison, and forensic facility admissions. At a minimum, performance standards shall consider the number and proportion of clients who, during a specified period, experience multiple admissions to acute levels of care, jails, prisons, or forensic facilities.

4. Consumer and family satisfaction.

5. The satisfaction of key community constituents such as law enforcement agencies, juvenile justice agencies, the courts, the schools, local government entities, hospitals, and others as

appropriate for the geographical area of the managing entity.

(g) The Agency for Health Care Administration may establish a certified match program, which must be voluntary. Under a certified match program, reimbursement is limited to the federal Medicaid share to Medicaid-enrolled strategy participants. The agency may take no action to implement a certified match program unless the consultation provisions of chapter 216 have been met. The agency may seek federal waivers that are necessary to implement the behavioral health service delivery strategies.

(7) MANAGING ENTITY REQUIREMENTS.—The department may adopt rules and standards and a process for the qualification and operation of managing entities which are based, in part, on the following criteria:

(a) ~~A managing entity's~~ The governance structure of a managing entity that is not a managed behavioral health organization shall be representative and shall, at a minimum, include consumers and family members, appropriate community stakeholders such as representatives of law enforcement, the courts, and the community-based care lead agency, ~~and organizations,~~ individuals with business expertise, and providers of substance abuse and mental health services as defined in this chapter and chapter 397. If there are one or more private-receiving facilities in the geographic coverage area of a managing entity, the managing entity shall have one representative for the private-receiving facilities as an ex

officio member of its board of directors. If the managing entity is a managed behavioral health organization, it shall have an advisory board that meets the requirements of this section.

~~(b) A managing entity that was originally formed primarily by substance abuse or mental health providers must present and demonstrate a detailed, consensus approach to expanding its provider network and governance to include both substance abuse and mental health providers.~~

(c) A managing entity must submit a network management plan and budget in a form and manner determined by the department. The plan must detail the means for implementing the duties to be contracted to the managing entity and the efficiencies to be anticipated by the department as a result of executing the contract. The department may require modifications to the plan and must approve the plan before contracting with a managing entity. Provider participation in the network is subject to credentials and performance standards set by the managing entity. The department may not require the managing entity to conduct provider network procurements in order to select providers. However, the managing entity shall have a process for publicizing opportunities to participate in its network, evaluating new participants for inclusion in its network, and evaluating current providers to determine whether they should remain network participants. ~~The department may contract with a managing entity that demonstrates readiness to~~

~~assume core functions, and may continue to add functions and responsibilities to the managing entity's contract over time as additional competencies are developed as identified in paragraph (g). Notwithstanding other provisions of this section, the department may continue and expand managing entity contracts if the department determines that the managing entity meets the requirements specified in this section.~~

~~(d) Notwithstanding paragraphs (b) and (c), a managing entity that is currently a fully integrated system providing mental health and substance abuse services, Medicaid, and child welfare services is permitted to continue operating under its current governance structure as long as the managing entity can demonstrate to the department that consumers, other stakeholders, and network providers are included in the planning process.~~

(e) Managing entities shall operate in a transparent manner, providing public access to information, notice of meetings, and opportunities for broad public participation in decisionmaking. The managing entity's network management plan must detail policies and procedures that ensure transparency.

(f) Before contracting with a managing entity, the department must perform an onsite readiness review of a managing entity to determine its operational capacity to satisfactorily perform the duties to be contracted.

(g) The department shall engage community stakeholders, including providers and managing entities under contract with

the department, in the development of objective standards to measure the competencies of managing entities ~~and their readiness to assume the responsibilities described in this section,~~ and the outcomes to hold them accountable.

~~(8) DEPARTMENT RESPONSIBILITIES.—With the introduction of managing entities to monitor department-contracted providers' day-to-day operations, the department and its regional and circuit offices will have increased ability to focus on broad systemic substance abuse and mental health issues. After the department enters into a managing entity contract in a geographic area, the regional and circuit offices of the department in that area shall direct their efforts primarily to monitoring the managing entity contract, including negotiation of system quality improvement goals each contract year, and review of the managing entity's plans to execute department strategic plans; carrying out statutorily mandated licensure functions; conducting community and regional substance abuse and mental health planning; communicating to the department the local needs assessed by the managing entity; preparing department strategic plans; coordinating with other state and local agencies; assisting the department in assessing local trends and issues and advising departmental headquarters on local priorities; and providing leadership in disaster planning and preparation.~~

(9) FUNDING FOR MANAGING ENTITIES.—

(a) A contract established between the department and a

managing entity under this section shall be funded by general revenue, other applicable state funds, or applicable federal funding sources. A managing entity may carry forward documented unexpended state funds from one fiscal year to the next; however, the cumulative amount carried forward may not exceed 8 percent of the total contract. Any unexpended state funds in excess of that percentage must be returned to the department. The funds carried forward may not be used in a way that would create increased recurring future obligations or for any program or service that is not currently authorized under the existing contract with the department. Expenditures of funds carried forward must be separately reported to the department. Any unexpended funds that remain at the end of the contract period shall be returned to the department. Funds carried forward may be retained through contract renewals and new procurements as long as the same managing entity is retained by the department.

(b) The method of payment for a fixed-price contract with a managing entity must provide for:

1. A 2-month advance payment at the beginning of each fiscal year and equal monthly payments thereafter.

2. Payment upon verification that the managing entity has submitted complete and accurate data as required by the contract, pursuant to s. 394.74(3)(e).

3. Consequences for failure to achieve specified performance standards.

(10) CRISIS STABILIZATION SERVICES UTILIZATION DATABASE.—

The department shall develop, implement, and maintain standards under which a managing entity shall collect utilization data from all public receiving facilities situated within its geographic service area. As used in this subsection, the term "public receiving facility" means an entity that meets the licensure requirements of and is designated by the department to operate as a public receiving facility under s. 394.875 and that is operating as a licensed crisis stabilization unit.

(a) The department shall develop standards and protocols for managing entities and public receiving facilities to be used for data collection, storage, transmittal, and analysis. The standards and protocols must allow for compatibility of data and data transmittal between public receiving facilities, managing entities, and the department for the implementation and requirements of this subsection. The department shall require managing entities contracted under this section to comply with this subsection by August 1, 2015.

(b) A managing entity shall require a public receiving facility within its provider network to submit data, in real time or at least daily, to the managing entity for:

1. All admissions and discharges of clients receiving public receiving facility services who qualify as indigent, as defined in s. 394.4787; and

2. Current active census of total licensed beds, the number of beds purchased by the department, the number of clients qualifying as indigent occupying those beds, and the

total number of unoccupied licensed beds regardless of funding.

(c) A managing entity shall require a public receiving facility within its provider network to submit data, on a monthly basis, to the managing entity which aggregates the daily data submitted under paragraph (b). The managing entity shall reconcile the data in the monthly submission to the data received by the managing entity under paragraph (b) to check for consistency. If the monthly aggregate data submitted by a public receiving facility under this paragraph is inconsistent with the daily data submitted under paragraph (b), the managing entity shall consult with the public receiving facility to make corrections as necessary to ensure accurate data.

(d) A managing entity shall require a public receiving facility within its provider network to submit data, on an annual basis, to the managing entity which aggregates the data submitted and reconciled under paragraph (c). The managing entity shall reconcile the data in the annual submission to the data received and reconciled by the managing entity under paragraph (c) to check for consistency. If the annual aggregate data submitted by a public receiving facility under this paragraph is inconsistent with the data received and reconciled under paragraph (c), the managing entity shall consult with the public receiving facility to make corrections as necessary to ensure accurate data.

(e) After ensuring accurate data under paragraphs (c) and (d), the managing entity shall submit the data to the department

on a monthly and an annual basis. The department shall create a statewide database for the data described under paragraph (b) and submitted under this paragraph for the purpose of analyzing the payments for and the use of crisis stabilization services funded by the Baker Act on a statewide basis and on an individual public receiving facility basis.

(f) The department shall adopt rules to administer this subsection.

(g) The department shall submit a report by January 31, 2016, and annually thereafter, to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides details on the implementation of this subsection, including the status of the data collection process and a detailed analysis of the data collected under this subsection ~~REPORTING.—Reports of the department's activities, progress, and needs in achieving the goal of contracting with managing entities in each circuit and region statewide must be submitted to the appropriate substantive and appropriations committees in the Senate and the House of Representatives on January 1 and July 1 of each year until the full transition to managing entities has been accomplished statewide.~~

(11) RULES.—The department may ~~shall~~ adopt rules to administer this section ~~and, as necessary, to further specify requirements of managing entities~~.

Section 10. For the 2015-2016 fiscal year, the sum of $175,000 in nonrecurring funds is appropriated from the Alcohol,

Drug Abuse, and Mental Health Trust Fund to the Department of Children and Families to implement the provisions of 394.9082(10).

Section 11. The department shall contract for a study of the safety-net mental health and substance abuse system administered by the department with an entity with expertise in behavioral healthcare and health systems planning and administration. The department shall submit an interim report by November 1, 2015, addressing subsections (1), (3), (4), and (8), and a final report by November 30, 2016, addressing all subsections. At a minimum, the study shall include:

(1) Baseline evaluation of the system's current operation and performance.

(2) Review of the populations required by state law to be served through the safety-net system and recommendations for prioritizing, revising, or removing them as required populations for services.

(3) Payment methodologies that would incentivize earlier intervention, appropriate matching of individuals' needs with services, increased coordination of care, and obtaining increased value for public funds while maintaining the safety-net aspect of the system.

(4) Mechanisms for increased coordination and integration between behavioral health and support services provided in different settings, such as criminal justice and child welfare, or paid for by other funders, such as Medicaid, through means

including but not limited to increased sharing of data regarding individuals' treatment histories and judicial involvement, consistent with federal limitations on such sharing.

(5) Evaluation of the ability of the behavioral health workforce to meet current demand, including consideration of recruitment, retention, turnover, and shortages.

(6) Strategies to increase flexibility in meeting the behavioral health needs of a community and eliminate programmatic, regulatory, and bureaucratic barriers that impede efforts to efficiently deliver behavioral health services.

(7) Options for revising requirements for competency restoration to reduce state funds expended on this function and increase the involvement of individuals with services that will result in long-term stabilization and recovery while maintaining public safety.

(8) Performance measures that would better measure the contributions of the safety-net system in improving the behavioral health of a community, such as addressing recidivism, readmittance to acute levels of care, and improvements in individuals' level of functioning.

(9) Best practices in involuntary commitment in other states and recommended changes to the Baker and Marchman Acts, including a discussion of the advantages and disadvantages of consolidating them. To facilitate this, the Supreme Court's Task Force on Substance Abuse and Mental Health Issues in the Courts is requested to provide a report including its

recommendations to the Governor, President of the Senate, and Speaker of the House of Representatives no later than November 30, 2016.

Section 12. Section 397.402, Florida Statutes, is created to read:

397.402 Single, consolidated licensure.--No later than January 1, 2016, the department shall modify licensure rules and procedures to create an option for a single, consolidated license for a provider that offers multiple types of mental health and substance abuse services regulated under chapters 394 and 397. Providers eligible for a consolidated license must operate these services through a single corporate entity and a unified management structure. Any provider serving both adults and children must meet departmental standards for separate facilities and other requirements necessary to the safety of children and promote therapeutic efficacy.

Section 13. Section 394.4674, Florida Statutes, is repealed.

Section 14. Section 394.4985, Florida Statutes, is repealed.

Section 15. Section 394.745, Florida Statutes, is repealed.

Section 16. Section 394.9084, Florida Statutes, is repealed.

Section 17. Section 397.331, Florida Statutes, is repealed.

Section 18. Section 397.333, Florida Statutes, is repealed.

Section 19. Section 397.801, Florida Statutes, is repealed.

Section 20. Section 397.811, Florida Statutes, is repealed.

Section 21. Section 397.821, Florida Statutes, is repealed.

Section 22. Section 397.901, Florida Statutes, is repealed.

Section 23. Section 397.93, Florida Statutes, is repealed.

Section 24. Section 397.94, Florida Statutes, is repealed.

Section 25. Section 397.951, Florida Statutes, is repealed.

Section 26. Section 397.97, Florida Statutes, is repealed.

Section 27. Subsections (1) and (4) of section 765.110, Florida Statutes, is amended to read:

(1) A health care facility, pursuant to Pub. L. No. 101-508, ss. 4206 and 4751, shall provide to each patient written information concerning the individual's rights concerning advance directives, including advance directives providing for mental health treatment, and the health care facility's policies respecting the implementation of such rights, and shall document in the patient's medical records whether or not the individual has executed an advance directive.

(4) The Department of Elderly Affairs for hospices and, in consultation with the Department of Elderly Affairs, the Department of Health for health care providers; the Agency for Health Care Administration for hospitals, nursing homes, home health agencies, and health maintenance organizations; and the Department of Children and Families for facilities subject to part I of chapter 394 shall adopt rules to implement the provisions of the section. The Department of Children and Families shall develop a mental health advance directive form

which may be used by an individual to direct future care. The Department of Children and Families shall publish the suggested form on its website.

Section 28. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2015.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. PCB CFSS 15-01 (2015)

Amendment No. 1

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 Adkins offered the following:

Amendment

Between lines 407 and 408, insert:

(l) One administrator of a state-licensed limited mental health assisted living facility.

Amendment No. 2

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 Adkins offered the following:

Amendment (with title amendment)

Remove lines 420-438 and insert:

(5)(3)(a) A county, or not-for-profit community provider or managing entity designated by the county planning council or committee, as described in s. 394.657, may apply for a 1-year planning grant or a 3-year implementation or expansion grant. The purpose of the grants is to demonstrate that investment in treatment efforts related to mental illness, substance abuse disorders, or co-occurring mental health and substance abuse disorders results in a reduced demand on the resources of the judicial, corrections, juvenile detention, and health and social services systems.

(b) To be eligible to receive a 1-year planning grant or a 3-year implementation or expansion grant,:

1. A county applicant must have a county planning council or committee that is in compliance with the membership requirements set forth in this section.

2. A not-for-profit community provider or managing entity must be designated by the county planning council or committee and have written authorization to submit an application. A not-for-profit community provider or managing entity must have written authorization for each

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

Remove line 28 and insert:
provider or managing entity to apply for certain grants; removing

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. PCB CFSS 15-01 (2015)

Amendment No. 3

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 Harrell offered the following:

Amendment

Remove lines 498-499 and insert:

Medicaid managed care organization currently under contract with the Medicaid managed medical assistance program in this state pursuant to part IV of ch. 409 or a behavioral health specialty managed care organization.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB CFSS 15-02 Child Welfare
SPONSOR(S): Children, Families & Seniors Subcommittee; Harrell
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee		Tuszynski	Brazzell

SUMMARY ANALYSIS

Last year, the Legislature passed SB 1666, a major reform of the child welfare system. Among its many provisions, SB 1666:

- Created the Critical Incident Rapid Response Team (CIRRT) to conduct a root-cause analysis of certain child deaths and critical incidents,
- Expanded the number and types of cases reviewed through the Child Abuse Death Review (CADR) process,
- Required multi-agency staffings for cases alleging medical neglect, and
- Created the Florida Institute for Child Welfare (FICW), requiring it to submit an interim report by February 1, 2015.

The PCB addresses issues related to the implementation of SB 1666.

To address the increased volume of cases reviewed through the CADR process and to better align it with the newly created CIRRT process, the PCB clarifies the roles of the two types of committees within the CADR process and imposes specific reporting requirements. The PCB also permits the Secretary of DCF to deploy CIRRTs in response to other child deaths in addition to those with verified abuse and neglect in the last 12 months. The PCB also requires more frequent reviews and reports by the CIRRT advisory committee.

The PCB also requires a multi-agency staffing to be convened for cases of alleged medical neglect, clarifying that the staffing shall be convened only if medical neglect is substantiated by the child protection team.

The PCB implements a recommendation from the FICW's interim report specifying that services provided to children in the child welfare system shall be trauma-informed.

The PCB does not have a fiscal impact on state or local government.

The PCB provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

SB 1666

SB 1666 was passed in 2014 in response to concerns about the number of deaths of children known to the child welfare system. SB 1666 made a number of changes to state law to improve the investigation of and subsequent response to allegations of abuse or neglect. Among those changes were the creation of the Critical Incident Rapid Response Team (CIRTT), expansion of the number and types of cases reviewed through the Child Abuse Death Review (CADR) process, and the creation of the Florida Institute for Child Welfare (FICW).

Child Abuse Death Review

The state Child Abuse Death Review (CADR) is a statewide multidisciplinary, multiagency child abuse death assessment and prevention system.[1] The CADR was initiated in 1999 in response to the death of Kayla McKean and legislative concern that, of the 80 children who died from substantiated child abuse or neglect in Florida during 1998, almost one third (32%) had prior contact with the child protection system.[2]

The purposes of CADR reviews are to:

- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse;[3]
- Develop a communitywide approach to address such cases and contributing factors, whenever possible;[4]
- Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse;[5] and
- Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.[6]

Florida's CADR is a two tiered review system comprised of the State Child Abuse Death Review Committee and local review committees operating across the state. These committees work cooperatively to review the facts and circumstances surrounding child deaths that are reported through the central abuse hotline.

The State Child Abuse Death Review Committee is housed within the Department of Health (DOH) and consists of representatives from the Department of Health (DOH), the Department of Children and Families (DCF), the Department of Legal Affairs, the Department of Law Enforcement, the Department of Education, the Florida Prosecuting Attorneys Association, Inc., and the Florida Medical Examiners

[1] S. 383.402(1), F.S.
[2] Florida Child Abuse *Death Review Team, First Annual Report*, September 2000, available at http://www.flcadr.com/reports/_documents/2000-annual-report.pdf (last viewed March 20, 2015).
[3] S. 383.402(1)(a), F.S.
[4] S. 383.402(1)(b), F.S.
[5] S. 383.402(1)(c), F.S.
[6] S. 383.402(1)(d), F.S.

Commission, whose representative must be a forensic pathologist.[7] In addition, the State Surgeon General must appoint the following members to the CADR:

- The Statewide Medical Director for Child Protection;
- A public health nurse;
- A mental health professional who treats children or adolescents;
- An employee of the DCF who supervises family services counselors and who has at least 5 years of experience in child protective investigations;
- A medical director of a child protection team;
- A member of a child advocacy organization;
- A social worker who has experience in working with victims and perpetrators of child abuse;
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program;
- A law enforcement officer who has at least 5 years of experience in children's issues;
- A representative of the Florida Coalition Against Domestic Violence; and
- A representative from a private provider of programs on preventing child abuse and neglect.[8]

Local review committees have the primary responsibility of reviewing all child abuse and neglect deaths reported to the child abuse hotline and assisting the state committee in data collection and reporting.[9] The local review committees are comprised of members determined by the state committee and a local state attorney.[10] Statute requires no other staffing requirements or structure for the local review committee.

Prior to the passage of SB 1666, the CADR only reviewed child deaths verified to be the result of abuse or neglect. SB 1666 requires CADR to review all deaths reported to the central abuse hotline. This resulted in an increase in the number of deaths that must be reviewed through this process. For example, in calendar year 2014, 82 deaths were verified to be the result of abuse or neglect out of 440 total deaths reported to the hotline.[11]

Critical Incident Rapid Response Team

The Critical Incident Rapid Response Team (CIRRT) process involves an immediate root-cause analysis of critical incidents to rapidly determine the need to change policies and practices related to child protection and welfare.[12] DCF is required to conduct CIRRT reviews of child deaths if the child or another child in the home was the subject of a verified report of abuse or neglect within the previous 12 months.[13] DCF is authorized to deploy CIRRT's for other serious incidents reported to the central abuse hotline.

Statute requires that the CIRRT include at least five professionals with expertise in child protection, child welfare, and organizational management. A majority of the team must reside in judicial circuits outside the location of the incident.[14]

An advisory committee of experts in child protection and welfare is tasked with meeting annually to conduct an independent review of the CIRRT reviews and submit an annual report which includes findings and recommendations.[15]

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[7] S. 383.402(2)(a), F.S.
[8] S. 383.402(2)(b), F.S.
[9] S. 383.402(7), F.S.
[10] S. 383.402(6), F.S.
[11] Florida Department of Children and Families, *Child Fatality Statewide Data*, available at http://www.dcf.state.fl.us/childfatality/state.shtml (last viewed March 21, 2015).
[12] S. 39.2015(1), F.S.
[13] S. 39.2015(2), F.S.
[14] S. 39.2015(3), F.S.
[15] S. 39.2015(11), F.S.

CIRRTs have been deployed 11 times since 2014. The types of deaths reviewed by CIRRT were caused by inflicted trauma, unsafe sleep, natural causes, and a dog mauling. CIRRT reports have identified issues with process and policies. These issues have prompted immediate changes such as updating the Maltreatment Index[16] to allow for the presence of obvious mental health symptoms to be categorized as problematic[17] and amending related protocol to facilitate immediate response priority for obvious mental health symptoms.[18]

Medical Neglect

While there is no definition of the term "medical neglect" in chapter 39, F.S., the definition of "neglect" encompasses cases of medical neglect. Neglect is defined as when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired. [19]

Section 39.3068, F.S. requires that reports of alleged medical neglect be handled in a prescribed manner. It specifies that:

- Reports of medical neglect must be investigated by staff with specialized training in medical neglect and medically complex children.
- The investigation identifies any immediate medical needs of the child and uses a family-centered approach to assess the capacity of the family to meet those needs.
- Any investigation of cases involving medically complex children include determination of Medicaid coverage for needed services and coordination with AHCA to secure such covered services.
- A case staffing be convened and attended by staff from DCF's child protective investigations unit, Children's Legal Services, the child protection team, Children's Medical Services, the Agency for Health Care Administration, the community-based care lead agency, and any providers of services to the child.

Currently, the statutory language requires that a multiagency staffing occur on any case that alleges medical neglect, whether or not the allegation was substantiated as medical neglect by the child protection team.

Community Based Care Organizations

DCF contracts for foster care and related services with lead agencies, also known as community-based care organizations (CBCs). The transition to outsourced provision of child welfare services was intended to increase local community ownership of service delivery and design.[20]

Under this localized system, CBCs are responsible for providing foster care and related services. These services include, but are not limited to, family preservation, emergency shelter, and adoption.[21] CBCs contract with a number of subcontractors for case management and direct care services to

[16] A tool used by the central abuse hotline to guide consistent and accurate decision making, including descriptions of the evidence needed to reach findings for each specific alleged maltreatment. Maltreatment is the abuse or neglect inflicted upon the child; examples include abandonment, burns, fractures, failure to protect, etc.
[17] Critical Incident Rapid Response Team Report, *Phoebe Jonchuck*, available at http://www.dcf.state.fl.us/childfatality/cirrt/2015-005865.pdf (last viewed March 21, 2015).
[18] Id.
[19] S. 39.01(44), F.S.
[20] *Community-Based Care*, The Department of Children and Families, accessible at http://www.myflfamilies.com/service-programs/community-based-care (last viewed March 19, 2015).
[21] Id.

children and their families.[22] There are 18 CBCs statewide, which together serve the state's 20 judicial circuits.[23] The law requires DCF to contract with CBCs through a competitive procurement process.[24]

Even under this outsourced system, DCF remains responsible for a number of child welfare functions. These functions include operating the abuse hotline, performing child protective investigations (which determine whether children need to be removed from their homes because of abuse or neglect), and providing child welfare legal services.[25] DCF is also ultimately responsible for program oversight and the overall performance of the child welfare system.[26]

Each month CBCs are graded by DCF according to their performance on a scorecard. The scorecard evaluates the CBCs on 12 key measures to determine how well the CBCs are meeting the most critical needs of these at-risk children and families. Scorecards are posted online monthly.[27]

Currently, under this privatized care model, many services are provided through contracts with subcontracted service providers. Statute requires the services provided by these contracted entities to be supported by research or be considered best child welfare practices. The statute allows for innovative services such as family-centered, cognitive-behavioral, and trauma-informed.

Florida Institute for Child Welfare

The Florida Institute for Child Welfare (FICW) was created by SB 1666 as a consortium of the state's public and private university schools of social work to advance the well-being of children and families by improving the performance of child protection and child welfare services through research, policy, analysis, evaluation, and leadership development. The FICW is required to submit an annual report that presents significant research findings and results of other programs, and make specific recommendations for improving child protection and child welfare services.

The FICW submitted an interim report on February 1, 2015, in accordance with statute.[28] The report addressed topics including recommendations for the need for a child welfare strategic plan, results oriented accountability, data analytics, safety, permanency, well-being, workforce, and the CIRRT. Most of the interim report's recommendations can be implemented without further statutory authorization. However, statutory changes are needed to implement recommendations that the frequency of the CIRRT advisory committee's reviews increase from annually to quarterly and that trauma-informed services be emphasized in statute.

Trauma-Informed Practice

The FICW interim report recommended that trauma-informed practices be emphasized in statute. Children in the child welfare system have often suffered tremendous trauma due to abuse or neglect. This trauma can have a lifelong effect on their physical and mental health, education, relationships, and social function. To provide trauma-informed care to children, youth, and families involved with the child welfare system, professionals must understand the impact of trauma on child development and learn how to effectively minimize its effects without causing additional trauma.[29] Untreated child trauma is a root cause of many of the most pressing problems that communities face, including poverty, crime, low

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[22] Id.
[23] *Community Based Care Lead Agency Map*, The Department of Children and Families, accessible at http://www.myflfamilies.com/service-programs/community-based-care/cbc-map (last accessed March 19, 2015).
[24] The Department of Children and Families, *Competitive Procurement*, accessible at: http://www.myflfamilies.com/service-programs/community-based-care/competitive-procurement (last accessed March 19, 2015).
[25] Supra. at FN 8.
[26] Id.
[27] The Department of Children and Families, *CBC Scorecard*, accessible at http://www.myflfamilies.com/about-us/planning-performance-measures/cbc-scorecard (last accessed March 19, 2015).
[28] S. 1004.615(7), F.S.
[29] U.S. Department of Health & Human Services, *Trauma-Informed Practice,* available at https://www.childwelfare.gov/topics/responding/trauma/ (last viewed March 22, 2015).

academic achievement, addiction, mental health problems, and poor health outcomes.[30] There are evidence-based treatments and services developed that are highly effective for child traumatic stress; improving access to effective evidence-based treatments for children who experience traumatic stress can reduce suffering and decrease the costs of health care.[31]

Effect of Proposed Changes

Child Abuse Death Review

The PCB revises the CADR process in several ways. The bill amends s. 383.3068, F.S., to clarify the intent of the Legislature, specifying the data-based, epidemiological focus of the child abuse death assessment and prevention system as well as clarifying the cooperative roles of the two committees.

State Committee

The bill clarifies that the state committee shall provide direction and leadership of the review system, analyze the data and recommendations of the local committees, identify issues and trends within that data and make recommendations for statewide action. The bill also adds a substance abuse treatment professional to the state committee, and limits the number of appointments a member may serve to no more than three consecutive terms.

Local Committee

The bill clarifies that the local committee shall conduct individual case reviews, generate information for the state committee, and recommend and implement improvements at the local level. The bill specifies that local committee membership shall include representatives from:

- The local state attorney's office;
- The local DCF child protective investigations unit;
- The DOH child protection team;
- The local CBC;
- Law enforcement;
- The school district;
- A mental health treatment provider;
- A domestic violence organization;
- A substance abuse treatment provider; and
- Any other members determined by guidelines developed by the state committee.

The bill also requires, to the extent possible, that the individuals involved with a child whose death is being reviewed should be present at the review. It also specifies that reports by local committees contain certain information, such as any systemic issues identified and recommendations for improvement.

Data and Report

The bill requires the use of the Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths. It also specifies that the data in the annual state committee report must be presented on an individual calendar year basis and in the context of a multi-year trend. The report must include:

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[30] The National Child Traumatic Stress Network, *Policy Issues*, available at http://www.nctsn.org/resources/policy-issues (last viewed March 22, 2015).
[31] The National Child Traumatic Stress Network, Understanding Child Trauma, available at http://www.nctsn.org/sites/default/files/assets/pdfs/policy_and_the_nctsn_final.pdf (last viewed March 22, 2015).

- Descriptive statistics;
- A detailed analysis of the incidence and causes of death;
- Specific issues identified in current policy, procedure, regulation or statute and recommendations to address them from both the state and local committees; and
- Other recommendations to prevent deaths from child abuse based on the reported data.

Critical Incident Rapid Response Team

The bill amends s. 39.2015, F.S., to allow a CIRRT to be deployed, at the secretary's discretion, for other child deaths besides those with a verified report of abuse or neglect in the last 12 months, to include those where there was an open investigation. The bill also requires the CIRRT advisory committee to meet quarterly and submit quarterly reports. This will allow more rapid identification of and response to trends surfaced through the CIRRT process.

Medical Neglect

The bill amends s. 39.3068, F.S., and requires a multi-agency staffing to be convened for cases of alleged medical neglect, clarifying that the staffing shall be convened only if medical neglect is substantiated by the child protection team.

Community-Based Care Organizations

The bill amends s. 409.988, F.S., and requires that the community-based care lead agency must serve children using trauma-informed services.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 39.2015, F.S., related to critical incident rapid response team.
Section 2: Amends s. 39.3068, F.S., related to reports of medical neglect.
Section 3: Amends s. 383.402, F.S., related to child abuse death review.
Section 4: Amends s. 409.988, F.S., related to lead agency duties.
Section 5: Provides for an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

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:

Requiring trauma-informed services may necessitate CBC's amending contracts with subcontractors providing direct services to children to include this requirement, if their contracts do not currently do so. The PCB does not provide a definition of "trauma-informed".

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to child welfare; amending s. 39.2015, F.S.; allowing critical incident rapid response teams to review deaths other than those with ; requiring quarterly reports from the advisory committee; amending s. 39.3068, F.S.; requiring case staffings when medical neglect is substantiated; amending s. 383.402, F.S.; requiring an epidemiological child abuse death assessment and prevention system; providing intent for the operation and interaction between the state and local death review committees; limiting state committee members to three consecutive terms; providing for per diem and reimbursement of expenses; specifying duties of the state committee; providing for the convening of county or multicounty local review committees and support by the county health department directors; specifying membership of local review committees and other meeting attendees; specifying duties; requiring an annual statistical report; specifying requirements for the report; changing references to "districts" and "district administrators"; amending s. 409.988; requiring community-based care lead agencies to provide trauma-informed services; providing an effective date.

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

Section 1. Subsections (2) and (11) of section 39.2015, Florida Statutes, are amended to read:

39.2015 Critical incident rapid response team.—

(2) An immediate onsite investigation conducted by a critical incident rapid response team is required for all child deaths reported to the department if the child or another child in his or her family was the subject of a verified report of suspected abuse or neglect during the previous 12 months. The secretary may direct an immediate investigation for other cases involving death or serious injury to a child, including but not limited to those occurring during an open investigation.

(11) The secretary shall appoint an advisory committee made up of experts in child protection and child welfare, including the Statewide Medical Director for Child Protection under the Department of Health, a representative from the institute established pursuant to s. 1004.615, an expert in organizational management, and an attorney with experience in child welfare, to conduct an independent review of investigative reports from the critical incident rapid response teams and to make recommendations to improve policies and practices related to child protection and child welfare services. The advisory committee shall meet and ~~By October 1 of each year, the advisory committee shall~~ submit quarterly reports ~~a report~~ to the secretary which include ~~includes~~ findings and recommendations. The secretary shall submit the reports ~~report~~ to the Governor,

the President of the Senate, and the Speaker of the House of Representatives.

Section 2. Subsection (3) of section 39.3068, Florida Statutes, is amended to read:

39.3068 Reports of medical neglect.—

(3) The child shall be evaluated by the child protection team as soon as practicable. If ~~After receipt of the report from~~ the child protection team reports that medical neglect was substantiated, the department shall convene a case staffing which shall be attended, at a minimum, by the child protective investigator; department legal staff; and representatives from the child protection team that evaluated the child, Children's Medical Services, the Agency for Health Care Administration, the community-based care lead agency, and any providers of services to the child. However, the Agency for Health Care Administration is not required to attend the staffing if the child is not Medicaid eligible. The staffing shall consider, at a minimum, available services, given the family's eligibility for services; services that are effective in addressing conditions leading to medical neglect allegations; and services that would enable the child to safely remain at home. Any services that are available and effective shall be provided.

Section 3. Section 383.402, Florida Statutes, is amended to read:

383.402 Child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committees.—

(1) INTENT. It is the intent of the Legislature to establish a statewide multidisciplinary, multiagency, epidemiological child abuse death assessment and prevention system that consists of state and local review committees. The ~~state and local review~~ committees shall review the facts and circumstances of all deaths of children from birth to ~~through~~ age 18 which occur in this state and are reported to the central abuse hotline of the Department of Children and Families. The state committee and the local review committees shall work cooperatively. The state committee shall primarily provide direction and leadership of the review system and analyze data and recommendations from local committees to identify issues, trends, and recommended action on a statewide basis. The local committees shall primarily conduct individual case reviews of deaths, generate information, and make recommendations and implementing improvements at the local level. The ~~purpose of the~~ review shall ~~be to~~ use a data-based, epidemiological approach to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.

(b) Whenever possible, develop a communitywide approach to address such causes ~~cases~~ and contributing factors.

(c) Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse.

(d) Make ~~and implement~~ recommendations for changes in law, rules, and policies at the state and local levels, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.

(e) Implement such recommendations to the extent possible.

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.

(a) Membership.

1. The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the State Surgeon General, who shall serve as the state committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

a. ~~1.~~ The Department of Legal Affairs.

b. ~~2.~~ The Department of Children and Families.

c. ~~3.~~ The Department of Law Enforcement.

d. ~~4.~~ The Department of Education.

e. ~~5.~~ The Florida Prosecuting Attorneys Association, Inc.

f. ~~6.~~ The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

2. ~~(b)~~ In addition, the State Surgeon General shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies listed in paragraph (a), and ensuring that the committee

represents the regional, gender, and ethnic diversity of the state to the greatest extent possible:

a. ~~1.~~ The Department of Health Statewide Child Protection Team Medical Director ~~for Child Protection~~.

b. ~~2.~~ A public health nurse.

c. ~~3.~~ A mental health professional who treats children or adolescents.

d. ~~4.~~ An employee of the Department of Children and Families who supervises family services counselors and who has at least 5 years of experience in child protective investigations.

e. ~~5.~~ The medical director of a child protection team.

f. ~~6.~~ A member of a child advocacy organization.

g. ~~7.~~ A social worker who has experience in working with victims and perpetrators of child abuse.

h. ~~8.~~ A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program.

i. ~~9.~~ A law enforcement officer who has at least 5 years of experience in children's issues.

j. ~~10.~~ A representative of the Florida Coalition Against Domestic Violence.

k. ~~11.~~ A representative from a private provider of programs on preventing child abuse and neglect.

l. A substance abuse treatment professional.

2. The members of the state committee shall be appointed to staggered terms of office which may not exceed 2 years, as

determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.

3. Members of the state committee shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) ~~(3)~~ Duties. The State Child Abuse Death Review Committee shall:

1. ~~(a)~~ Develop a system for collecting data from local committees on deaths that are reported to the central abuse hotline ~~the result of child abuse~~. The system must include a protocol for the uniform collection of data statewide, which shall at a minimum use the Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths ~~uses existing data collection systems to the greatest extent possible~~.

2. ~~(b)~~ Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.

~~(c) Prepare an annual statistical report on the incidence and causes of death resulting from reported child abuse in the~~

~~state during the prior calendar year. The state committee shall submit a copy of the report by October 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report must include recommendations for state and local action, including specific policy, procedural, regulatory, or statutory changes, and any other recommended preventive action.~~

3. ~~(d)~~ Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse. Training shall be provided by the Florida Coalition Against Domestic Violence, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise.

4. ~~(e)~~ Develop statewide uniform guidelines, standards, and protocols, including a protocol for standardized data collection~~,~~ and reporting, for local child abuse death review committees, and provide training and technical assistance to local committees.

5. ~~(f)~~ Develop statewide uniform guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.

6. ~~(g)~~ Study the adequacy of laws, rules, training, and

services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.

7.~~(h)~~ Provide consultation on individual cases to local committees upon request.

8.~~(i)~~ Educate the public regarding the provisions of chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.

9.~~(j)~~ Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.

10.~~(k)~~ Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.

~~(4) The members of the state committee shall be appointed to staggered terms of office which may not exceed 2 years, as determined by the State Surgeon General. Members are eligible for 2 reappointments. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.~~

~~(5) Members of the state committee shall serve without compensation but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.~~

(3) LOCAL DEATH REVIEW COMMITTEES.

~~(6)~~ At the direction of the State Surgeon General, a county or multicounty death review committee shall be convened ~~the director of each county health department, or the directors of two or more county health departments by agreement, may convene and support a county or multicounty child abuse death review committee~~ in accordance with the protocols established by the State Child Abuse Death Review Committee and supported by the local county health department directors.

(a) Membership. Each local committee must include local representatives from:

1. The ~~a local~~ state attorney's office~~, or his or her designee.~~,

2. The Medical Examiner's Office.

3. The local Department of Children and Families child protective investigations unit.

4. The Department of Health child protection team.

5. The community-based care lead agency.

6. Law enforcement.

7. The school district.

8. A mental health treatment provider.

9. A domestic violence organization.

10. A substance abuse treatment provider.

11. ~~and~~ Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.

To the extent possible, individuals from these organizations or entities who were involved with a child whose death was verified as caused by abuse or neglect, or with the family of such child, shall attend any meetings where the child's case is being reviewed. The members of a local committee shall be appointed to 2-year terms and may be reappointed. ~~The local committee shall elect a chairperson from among its members.~~ Members shall serve without compensation but may receive ~~are entitled to~~ reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) ~~(7)~~ Duties. Each local child abuse death review committee shall:

1. ~~(a)~~ Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee. The local committee shall complete the individual case report in the Child Death Review Case Reporting System to the fullest extent possible.

2. ~~(b)~~ Submit written reports as required by ~~at the direction of~~ the state committee. The reports must include:

a. Nonidentifying information on individual cases.

b. A listing of any system issues identified through the review process and recommendations for system improvements and needed resources, training, and information dissemination where gaps or deficiencies may exist.

~~and~~

c. Any ~~the~~ steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

3.~~(c)~~ Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.

4.~~(d)~~ Abide by the standards and protocols developed by the state committee.

5.~~(e)~~ On a case-by-case basis, request that the state committee review the data of a particular case.

(4) ANNUAL STATISTICAL REPORT. The state committee shall prepare and submit an annual statistical report by October 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report must be comprehensive and include data, trends, analysis, findings, and recommendations for state and local action regarding deaths from child abuse. Data must be presented on an individual calendar year basis and in the context of a multi-year trend. At a minimum, the report must include:

(a) Descriptive statistics, including demographic information regarding victims and caregivers and about the causes and nature of deaths.

b. A detailed statistical analysis of the incidence and causes of deaths.

c. Specific issues identified within current policy,

procedure, regulation, or statute and recommendations to address them from both the state and local committees.

e. Other recommendations to prevent deaths from child abuse based on an analysis of the data presented in the report.

(5) ~~(8)~~ ACCESS TO AND USE OF RECORDS. Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:

(a) Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under chapter 393, chapter 394, or chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and $1 per fiche for microfiche records.

(b) Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Families, the Department of Health, the Department of Education, or the Department of Juvenile Justice.

(c) ~~(9)~~ The State Child Abuse Death Review Committee or a

local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.

(d) ~~(10)~~ The state committee and any local committee may share any relevant information that pertains to the review of the death of a child.

(e) ~~(11)~~ A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.

(f) ~~(12)~~ The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure

to obey the subpoena is punishable as provided by law.

(g) ~~(13)~~ This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.

(h) ~~(14)~~ A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this subsection does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This subsection does not apply to any person who admits to committing a crime.

(6) ~~(15)~~ DEPARTMENT OF HEALTH RESPONSIBILITIES.

(a) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.

(b) ~~(16)~~ To the extent that funds are available, the Department of Health may hire staff or consultants to assist a

review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.

(c) ~~(17)~~ For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the State Surgeon General may substitute an existing entity whose function and organization include the function and organization of the committees established by this section.

(7) ~~(18)~~ DEPARTMENT OF CHILDREN AND FAMILIES' RESPONSIBILITIES.

(a) Each regional managing director ~~district administrator~~ of the Department of Children and Families must appoint a child abuse death review coordinator for the region ~~district~~. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:

1. ~~(a)~~ Coordinating with the local child abuse death review committee.

2. ~~(b)~~ Ensuring the appropriate implementation of the child abuse death review process and all regional ~~district~~ activities related to the review of child abuse deaths.

3. ~~(c)~~ Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.

4. ~~(d)~~ Maintaining a system of logging child abuse deaths

covered by this procedure and tracking cases during the child abuse death review process.

5.~~(e)~~ Conducting or arranging for a Florida Safe Families Network ~~Abuse Hotline Information System (FAHIS)~~ record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.

6.~~(f)~~ Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.

7.~~(g)~~ Notifying the regional managing director ~~district administrator~~, the Secretary of the Department of Children and Families, the Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all ~~child abuse~~ deaths meeting criteria for review as specified in this section within 1 working day after case closure ~~verifying the child's death was due to abuse, neglect, or abandonment~~.

8.~~(h)~~ Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the regional managing director ~~district administrator~~ and the Secretary of the Department of Children and Families.

9.~~(i)~~ Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.

Section 4. Subsection (3) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(3) SERVICES.—A lead agency must serve dependent children through services that are trauma-informed and supported by research or are best child welfare practices. The agency may also provide innovative services, including, but not limited to, family-centered, cognitive-behavioral, trauma-informed interventions designed to mitigate out-of-home placements.

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

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. PCB CFSS 15-02 (2015)

Amendment No. 1

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 Harrell offered the following:

Amendment

Remove line 256 and insert:

9. A certified domestic violence center.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. PCB CFSS 15-02 (2015)

Amendment No. 2

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 Harrell offered the following:

Amendment (with title amendment)

Between lines 442 and 443, insert:

Section 4. Paragraph (a) of subsection (1) of section 409.986, Florida Statutes, is amended to read:

409.986 Legislative findings and intent; child protection and child welfare outcomes; definitions.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) It is the intent of the Legislature that the Department of Children and Families provide child protection and child welfare services to children through contracting with community-based care lead agencies. Agencies shall prioritize the use of services that are evidence-based and trauma-informed. Counties that provide children and family services with at least

40 licensed residential group care beds by July 1, 2003, and that provide at least $2 million annually in county general revenue funds to supplement foster and family care services shall continue to contract directly with the state. It is the further intent of the Legislature that communities have responsibility for and participate in ensuring safety, permanence, and well-being for all children in the state.

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

Remove line 22 and insert:

administrators"; amending s. 409.986; requiring community-based care lead agencies to prioritize evidence-based and trauma-informed services; amending s. 409.988; requiring