

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Storms, Chair
Senator Rich, Vice Chair

MEETING DATE: Tuesday, October 18, 2011

TIME: 10:45 a.m.—12:45 p.m.

PLACE: James E. "Jim" King, Jr., Committee Room, 401 Senate Office Building

MEMBERS: Senator Storms, Chair; Senator Rich, Vice Chair; Senators Detert, Dockery, and Latvala

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Presentation by Subcommittee on Health and Human Services Appropriations: - Interim Project 2012-109, Crisis Stabilization Units - Interim Project 2012-108, Forensic Mental Health System		Presented
2	Psychotropic Drugs - Florida Department of Children and Families		Presented
3	Other Related Meeting Documents		



The Florida Senate

Interim Report 2012-109

September 2011

Budget Subcommittee on Health and Human Services Appropriations

CRISIS STABILIZATION UNITS

Issue Description

For this interim project, the Budget Subcommittee on Health and Human Services Appropriations reviewed the following issues regarding emergency mental health stabilization services:

Revenue streams supporting these services;
Service delivery and accountability mechanisms; and
Alternative funding models that could be developed.

For Fiscal Year 2011-2012, the Florida Legislature appropriated \$111.9 million (\$105.6 million or 94 percent from general revenue) to support emergency mental health stabilization services provided through Crisis Stabilization Units (“CSUs”) for adults and children statewide. Involuntary commitment services or Baker Act services, to individuals account for 69 percent (\$76.8 million) of funds supporting emergency stabilization services, with the remaining funds (\$35.1 million) supporting voluntary services to individuals. The majority of the Baker Act funding (80%) provides services to adults. By statute, crisis stabilization services require a 25 percent match from local governments or other sources.¹

For Fiscal Year 2010-2011, the Department of Children and Families (“the Department”) there were 65 licensed CSUs with 1,131 beds statewide. Forty-five CSUs with 929 beds served adults. Twenty CSUs with 202 beds served children. CSUs provided services to 41,060 individuals (36,429 adults and 4,631 children), which was a six percent decrease from the previous year.² The Department funded the majority of these beds (61%) in Fiscal Year 2010-2011. Additional funding sources for CSUs include Medicaid, Medicare, and private insurance.

Background

Individuals experiencing severe emotional or behavioral problems often require emergency treatment to stabilize their situations before referral for outpatient services or inpatient services can occur. Emergency mental health stabilization services may be provided to voluntary or involuntary patients. Involuntary patients must be taken to one of the state’s designated receiving facilities. Receiving facilities are defined by the Florida Mental Health Act (ss. 394.451-394.4789, F.S.) and are referred to as Baker Act Receiving Facilities.^{3,4} The purpose of receiving facilities is to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. Law enforcement officers usually transport individuals requiring involuntary Baker Act examinations to the nearest receiving facility. The facility must accept individuals brought by a law enforcement officer for involuntary examination, regardless of bed availability.⁵

The Department designates facilities as a Baker Act Receiving Facility prior to licensure by the Agency for Health Care Administration (AHCA). While receiving facilities may be either public or private facilities, only

¹ s.394.67(13), F.S.

² Information provided by the Department of Children and Families

³ s. 394.455(25)(26), F.S.

⁴ According to the Department of Children and Families, the Florida Legislature enacted the Florida Mental Health Act in 1971 to revise the state’s mental health commitment laws. The Act substantially strengthened the due process and civil rights of persons in mental health facilities and those alleged to be in need of emergency evaluation and treatment. A major intent of the Act was to increase community care of persons with mental illnesses. Since the Baker Act became effective in 1972, the Legislature enacted a number of amendments to enhance the protection for civil and due process rights of persons in mental health facilities. Some of the most substantial reforms occurred in 1996, including: extending greater protections for persons seeking voluntary admission and specifying the circumstances under which receiving and treatment facilities designations may be suspended or withdrawn. The most recent revision to the Act became effective in January 2005 with the addition of the Involuntary Outpatient Placement provision of the Act.

⁵ s. 394.462, F.S.

facilities with a contract with the Department to provide mental health services to all persons, regardless of their ability to pay, and receiving state funds for this purpose are considered public receiving facilities. Section 394.4685, Florida Statutes, permits the transfer of individuals between public facilities, between public and private facilities, and private and public receiving facilities. For example, public receiving facilities may transfer an individual, at the request of a patient with the ability to pay for private treatment, to a private receiving facility. Funds appropriated for Baker Act services may only 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. Designation as a private receiving facility by the Department does not entitle the facility to receive any funding appropriated for Baker Act services.

Crisis Stabilization Units (CSUs) are public receiving facilities, receive state funding and provide a less intensive and less costly alternative to inpatient psychiatric hospitalizations for individuals presenting as acutely mentally ill. CSUs screen, assess, and admit for short-term services persons brought to the unit under the Baker Act as well as those who present themselves for services.⁶ CSUs provide services 24 hours a day, 7 days a week through a team of mental health professionals. The purpose of CSUs is to examine, stabilize, and redirect people to the most appropriate and least restrictive treatment settings, consistent with their mental health needs. Individuals often enter the public mental health system through CSUs. 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.⁷

The most recent report of Baker Act data from AHCA indicates that there were 136,120 involuntary examinations initiated in 2009. Eighty-five percent of individuals experiencing involuntary exams were adults; the average age of these persons was 37. More men had involuntary exams initiated (55%) than did women (44%). Law enforcement officials initiated almost half (49%) of the involuntary examinations, with 49 percent initiated by mental health professionals. Judges initiated the remaining two percent through ex-parte orders.⁸

Findings and/or Conclusions

Available Receiving Facility Beds Statewide

As of August 2011, the Department of Children and Families reported there were 6,224 Baker Act Receiving Facility beds statewide: 2,600 in private hospitals, 1,131 in CSUs, and 1,024 in public hospitals. State funding through the Department supports 690 (61%) of the 1,131 CSU beds in the state.

Revenue Sources and Costs for Crisis Stabilization Services

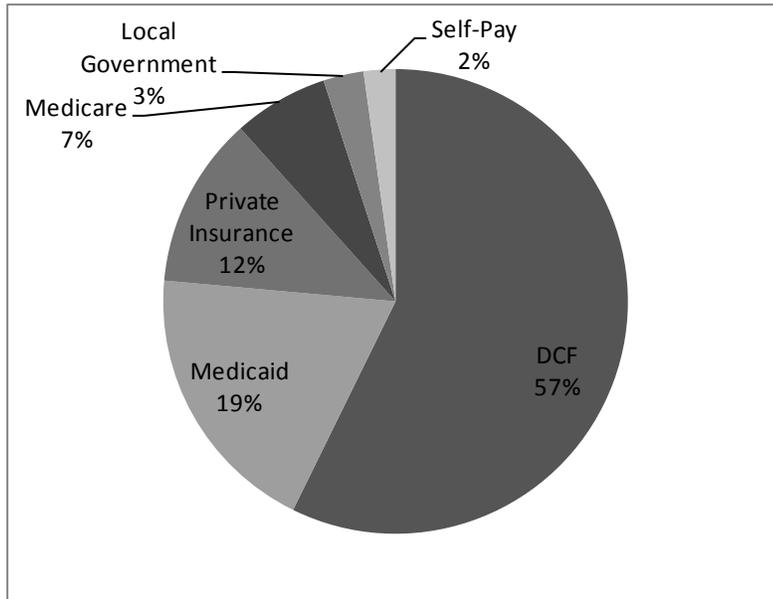
Revenue sources for CSUs include the Department, Medicaid, Medicare, local governments, and private insurance. In Fiscal Year 2009-2010, the last fiscal year for which comprehensive information on CSUs is available, 57.4 percent of revenues supporting CSUs came from DCF (see Exhibit 1).⁹

⁶s. 394.875, F.S.

⁷ ss. 394.65-394.9085, F.S.

⁸ *Report of Baker Act Data: Summary of Data from 2009*, Prepared of the Agency for Health Care Administration, Louis de la Parte Florida Mental Health Institute, University of South Florida, December 2010.

⁹ *Bed Use in Public Receiving Facilities and Treatment Facilities Fiscal Year 2009-2010 Annual Report*, Department of Children and Families, July 2011.

Exhibit 1**Crisis Stabilization Units Receive Revenues From Various Sources**

Source: *Bed Use in Public Receiving Facilities and Treatment Facilities Annual Report, Fiscal Year 2009-2010*, Department of Children and Families, July 25, 2011

The Department funded 44.6 percent of the 92,840 admissions to CSUs and 66 percent of the bed days used in Fiscal Year 2009-2010. The statewide average per diem cost regardless of payer was \$406 for all payer classes. The per diem cost for children was \$418 and the per diem cost for adults was \$394. The Department paid the lowest per diem with a statewide average of \$309. The Department also had the lowest cost per person of \$1,542. For payers other than the Department, the average per diem was \$503 and the average cost per person was \$2,432.¹⁰

Utilization Rates for Crisis Stabilization Services

Regardless of payer source, the average statewide utilization rate for CSU beds was 86.8 percent. The utilization rate for adults (91.0%) was significantly higher than for children (65.6%). For adults, there was little variation in the utilization rate between Department beds (90.2%) and other beds (92.8%). However, for children, the variation between utilization of Department beds and other beds was significant: 38.2 percent of Department beds were used compared to over 100 percent of other beds. Utilization rates for Department beds for adults and children vary greatly across regions of the state from 100 percent in the southeast to 72 percent in the northeast. The utilization rate for Department adult CSU beds range from 76 percent to 101 percent and for children from four percent to over 100 percent.¹¹

Payment Methodology for CSUs

The Department is the only payer class that purchases a specific number of licensed beds in CSUs. Non-Department payers do not purchase a predetermined number of contract days, but pay for bed days only when used. The Department contracts with CSUs for the availability of beds whether these beds are actually used or not, to ensure that beds are available to place individuals requiring involuntary examination.¹²

Limitations on Data Available on Receiving Facilities

Statutory limitations on data submitted to the Department by receiving facilities makes comparisons between public and private receiving facilities difficult. The Department currently does not receive complete or accurate information from and on receiving facilities, since only public receiving facilities are required to submit data to

¹⁰ Ibid.

¹¹ Ibid.

¹² Interview with DEPARTMENT central office mental health administrators, June 17, 2011.

the Department and only if the data is not submitted to Agency for Health Care Administration (“AHCA”). In addition, the data submitted by facilities to AHCA does not have the content or format needed by the Department to meet the current requirements of s. 394.461(4)(a)-(d) Florida Statutes. Finally, AHCA does not make data submitted by receiving facilities to the agency available to the Department.

Accountability Mechanisms for Crisis Stabilization Services

Some private receiving facilities have raised concerns to the legislature that public receiving facilities are placing individuals with public or private insurance coverage in beds designated for indigent clients and funded by the Department. The Department requested and received examples of these occurrences and is researching these cases so it can take appropriate action. However, the Department believes there are ample mechanisms in place to ensure that CSU providers are not placing third-party funded patients in state-funded beds.¹³ The mechanisms in place through statute and rule to ensure that public funding is used for the intended services and priority client groups include:

- Chapter 394, Florida Statutes, and Chapter 65E-14, F.A.C. provide comprehensive financial rules governing community mental health and substance abuse services.
- Providers must attest that all applicable federal laws, state statutes, and associated administrative rules will be followed by signing a contract with the Department.
- Providers are required to determine and document clients’ income eligibility and insurance status to ensure that the state is the payer of last resort.
- Providers furnish supporting and source documentation of service units billed to the Department to a contract manager for review prior to approving invoices for payment.
- Department contract managers monitor providers at least annually and compare a sample of client records against billings submitted by the provider.
- Department contract monitors conduct annual administrative, fiscal, and programmatic monitoring of providers, unless the provider is accredited by a nationally recognized accrediting organization.
- Department staff conduct re-designation reviews of receiving facilities every three years.
- Department contract managers and internal auditors receive and review provider’s annual Financial and Compliance Audit conducted by a Certified Public Accountant.

In addition, CSUs are licensed and reviewed by the Agency for Health Care Administration.¹⁴

Changes in the Administration and Oversight of Community Mental Health and Substance Abuse Services

Pursuant to s. 394.9082, Florida Statutes, the Department is in the process of contracting with behavioral health managing entities to administer and oversee the state’s community mental health and substance abuse services. Managing entities will assume the responsibility for purchasing, managing, and monitoring behavioral health services in the state that are now the responsibility of the Department. Section 394.9082(4)(c), Florida Statutes, requires that the Department’s contracts with managing entities provide payment methods that promote flexibility, efficiency, and accountability. In addition to improved accountability for local systems of behavioral health care services, another stated goal for managing entities is to preserve the “safety net” of publically funded behavioral health services and providers, using flexible strategies for financing behavior health services to enhance treatment and provide cost-effective care. The statute requires governance of managing entities by a community board of directors that includes consumers, community stakeholders and organization, and providers of mental health and substance abuse providers. The board of directors must also include a representative from a private receiving facility as an ex-officio member. Because/Since managing entities must follow current statutes and rules,

¹³ Interview with Stephenie Colston, Director of Substance Abuse and Mental Health Program Office, Department of Children and Families (June 17, 2011).

¹⁴ Facilities may choose to be accredited and may ask the Agency to accept their accreditation, in lieu of receiving routine on-site licensure surveys, by submitting the required documentation from an approved accreditation organization. All facilities must submit to an on-site licensure survey at initial licensure. The following accreditation organizations are recognized by AHCA for mental health facilities: The Joint Commission; Council on Accreditation (COA); and Commission on Accreditation of Rehabilitation Facilities (CARF). In addition to accreditation, AHCA reviews compliance with applicable Department of State registration and filing requirements, professional liability coverage, sanitation inspection reports, fire safety inspection reports, AIDS/HIV training, background screening, and compliance with local zoning requirements.

managing entities must pay CSU providers for bed availability rather than utilization and do not have the flexibility to explore other payment methods for CSUs.

Three managing entities already are operating (Lakeview Center, Central Florida Behavioral Health Network, and South Florida Behavioral Health Network), and the remaining three managing entities are scheduled to be operating by July 1, 2012. When the transition is complete, the Department will have 6 contracts rather than nearly 400 contracts with 137 community mental health and substance abuse providers.

Options and/or Recommendations

Reduce the Number of Baker Act Funded CSU Beds for Children

Since utilization rates for children's crisis stabilization beds are low in various regions of the state, the Department should reduce the number of beds in the region where use of those beds is low. If children's beds were reduced from 202 to 100, some or all of the funds (\$7 million) currently supporting these beds could be reallocated to adult Baker Act services in those regions with high CSU utilization rates for the remainder of the fiscal year. These funds could be made available for rate agreement contracts between the Department or managing entities and private receiving facilities willing to accept the average bed rate for CSUs beds in that region and able to document the 25 percent match requirement.

Conduct a Detailed Analysis of Utilization Rates for Adults by Provider

Since utilization for adult crisis stabilization beds vary across regions, the Department should conduct a detailed analysis of bed utilization by provider. For providers with bed utilization rates below 95% for adults, the Department should reduce these providers' contracts accordingly, or work with managing entities to do so. The Department could reallocate these funds to the Department regions with the highest bed utilization rates for adults, and make those funds available for rate agreement contracts with private receiving facilities willing to accept the average bed rate for CSUs in that region and able to document the 25 percent match requirement.

Develop Alternative Payment Methods for CSUs.

The Legislature could consider directing the Department to develop alternative payment methods for CSUs. For example, the Department could consider different payment methods based upon utilization rates while ensuring Baker Act bed availability for:

- Providers with a consistently high bed utilization rates, pay for the availability of beds;
- Providers with lower than average utilization rates, pay on a two-tiered system, i.e., one rate to have state-funded beds available, and a higher rate when these bed are occupied; and
- Providers with consistently low utilization rates, pay only for bed occupancy.

Amend s. 394.9082(7)(a), Florida Statutes, Regarding the Governance of Managing Entities.

Since managing entities are responsible for contracting with and overseeing mental health and substance abuse providers in their regions, representatives of these providers should not have a role in the governance of managing entities. The Legislature should consider amending s. 394.9082(7), Florida Statutes, to require representatives of community mental health providers to be ex-officio members of the managing entity board of directors, rather than be voting members, to avoid the possibility or appearance of conflicts of interest. The potential for conflicts of interest has been addressed with governance bodies created to manage and oversee outsourced state functions. For example, when Community-Based Care Lead Agencies were created, the statute did not address the composition of the board of directors. As a result, these boards sometimes did not reflect the community and had out-of-state and contracted provider agencies as board members.¹⁵ Also, potential conflicts of interest currently are being investigated with some of the state's Regional Workforce Boards.¹⁶

¹⁵ s. 409.1671(1)(e) 9, F.S.

¹⁶ "U.S. Labor Department probes Florida workforce contracts" Orlando Sentinel, July 15, 2011.

Amend s. 394.461(4)(a), Florida Statutes, Regarding Data Submission by Public Receiving Facilities.

Section 394.461(4)(a), Florida Statutes, requires public receiving facilities to report information to the Agency for Health Care Administration such as the number of beds, contract days, admissions, length of stay and revenues by payer class. To ensure that the Department receives this information on CSU beds from the public receiving facilities with which it contracts, s. 394.461(4)(a), Florida Statutes, should be amended to ensure all public receiving facilities submit the data to both the Agency for Health Care Administration and the Department of Children and Families. In addition, the Department should include this information in its report to the Governor and the legislature required by s. 394.461(4)(d), Florida Statutes. The amended language should read:

“A facility designated as a public receiving or treatment facility under this section shall report the following data to the department unless such data are currently being submitted into the Department of Children and Family Services’ Substance Abuse and Mental Health Information System (SAMHIS). Public receiving facilities and treatment facilities that do not submit data into SAMHIS, shall report these data quarterly, even if such data are currently being submitted to the Agency for Health Care Administration.”



The Florida Senate

Interim Report 2012-108

September 2011

Budget Subcommittee on Health and Human Services Appropriations

THE FORENSIC MENTAL HEALTH SYSTEM

Issue Description

Florida's forensic mental health system is a network of state facilities and community services for adults over the age of 18 and juveniles adjudicated as adults who have a mental illness and who are involved with the criminal justice system. These forensic services include evaluations for competency to proceed with a criminal trial, treatment following a finding of not guilty by reason of insanity, and services to individuals on conditional release in the community.¹

It is in the state's interest to seek the most effective and efficient means to treat individuals requiring competency restoration services. Competency restoration is needed for individuals who are incompetent to stand trial or for individuals who are found not guilty by reason of insanity under ch. 916, Florida Statutes. In 2007, the Florida Supreme Court Task Force on the forensic treatment system recommended the development of safe and cost efficient community-based treatment alternatives to state mental health treatment facilities.² More recently, the Department of Children and Families (the "Department") issued a report from the *Mental Health Facilities Review Work Group* in 2010, which recommended:

- Expanding community-based competency restoration services through more effective and less expensive forensic hospital diversion programs, and
- Transferring appropriate hospital residents currently in forensic step-down beds to less expensive community settings.³

The Work Group report coincided with the release of a Senate interim report (2011-106) on the forensic hospital diversion pilot program operating in Miami-Dade County.⁴ The report recommended expanding the pilot program to two additional areas of the state. During the 2011 Legislative Session, the Senate Committee on Children, Families, and Elder Affairs introduced SB 2064, to provide community treatment rather than hospital treatment for individuals with forensic involvement. The bill would have expanded the Miami-Dade pilot and made other changes in the state's forensic system. While this bill passed the Senate, it died in House Messages.

The 2011 Legislature reduced funding for state-operated forensic treatment facilities by \$14.5 million in general revenue, or seven percent. This reduction resulted in the elimination of 82 surplus forensic beds.

For this interim project, the Budget Subcommittee on Health and Human Services Appropriation reviewed four issues related to the state's forensic mental health system:

- The feasibility and potential cost savings by diverting additional forensic clients from hospital placements to community-based competency restoration programs;
- The feasibility and potential cost savings of transferring clients currently in forensic step-down beds to community placements; and
- The extent to which competency restoration clients cycle between state forensic treatment facilities and county jails and detention centers.

¹ Chapter 916, F.S.

² *Mental Health: Transforming Florida's Mental Health System*, Supreme Court of the State of Florida, Steering Committee on Families and Children in the Court, November 2007.

³ *Report of the State Mental Health Treatment Facilities Work Group*, Department of Children and Families, October 2010.

⁴ Miami-Dade Forensic Alternative Center (MD-FAC).

Background

Forensic services for persons who are charged with a felony, are mentally ill, and have been found to be incompetent to proceed with their trial due to their mental illness, or who have been acquitted of a felony by reason of insanity are governed by ss. 916.111-916.17, Florida Statutes. These individuals are committed to the Department for treatment and remain under the jurisdiction of the committing court (s. 916.16, F.S.). The statute provides for forensic treatment in three settings:

1. Separate and secure forensic facilities;
2. Civil facilities; and
3. Community residential programs or other community settings.

The Department has two state-operated and two privately-operated, maximum-security forensic treatment facilities: Florida State Hospital (state operated), North Florida Evaluation and Treatment Center (state operated), South Florida Evaluation the Treatment Center (privately operated), and Treasure Coast Treatment Center (privately operated). The Department may transfer individuals who no longer require a secure setting into non-secure forensic step-down beds in one of three civil mental health treatment facilities (Florida State Hospital, Northeast Florida State Hospital, and South Florida State Hospital).⁵ The appropriation for state forensic facilities in Fiscal Year 2011-12 is \$139 million from the General Revenue Fund.

The Department's Mental Health Treatment Facilities Unit, located in its central office, assigns committed individuals to forensic treatment facilities. While the Department has the discretion to move individuals from forensic to civil facilities without the approval of the committing court, individuals may not be released into the community without a court order.⁶

Community mental health providers, funded by the Department, provide mental health treatment services to forensic clients who do not require or meet the criteria for placement in the state's forensic facilities. These providers offer the first level of treatment and assessment aimed at stabilizing the client and reducing the need for admission into a state facility. Services may include treatment and competency restoration services in jail or community settings for individuals who are able to proceed with disposition of their criminal charges without requiring facility admission. Community mental health services are provided to individuals while in county jail awaiting state facility admission and to individuals released from state mental health treatment facilities. These services include the monitoring of individuals on conditional release and individuals receiving residential or outpatient services.⁷

Findings and/or Conclusions

State Forensic Facility Bed Capacity and Cost

There are 1,098 beds in the state's secure forensic facilities and 420 non-secure forensic step-down beds in the state's civil mental health treatment facilities. As of August 24, 2011, there were 1,012 individuals in secure beds and 417 in non-secure step-down beds. The statewide utilization rate for secure beds on that date was 92 percent, and ranged from 67 percent for the North Florida Evaluation and the Treatment Center to 98 percent for Treasure Coast Forensic Treatment Center.⁸

The average cost for a secure forensic bed is \$333 per day. The lowest cost is for the South Florida Evaluation and Treatment Center (\$298) and the highest cost is for the Florida State Hospital (\$358).^{9,10}

⁵ s. 916.105(3), F.S.

⁶ s. 916.16(1), F.S.

⁷ Interview with Sally Cunningham, Chief, Department of Children and Families, Mental Health Facilities, June 17, 2011.

⁸ Data provided by the Department of Children and Families Mental Health Program Office August 2011.

⁹ When the cost of payment on the construction bond for South Florida Evaluation and Treatment Center is included, the cost per bed is \$338.

¹⁰ Department of Children and Families, Mental Health Program Office, August 21, 2011.

Recidivism for Competency Restoration Clients

For Fiscal Year 2010-2011, the Department reported that 7.8 percent of individuals restored to competency in state mental health treatment facilities and returned to jail to await trial were thereafter returned to a treatment facility prior to trial. Individuals return to state facilities because they have deteriorated emotionally and psychologically while incarcerated. Reasons for this include delays in the trial date, differences in the drug formulary between the state treatment facility and the jail, the mental fragility of the individual, and disagreements between the court-ordered competency evaluation and the forensic hospital's evaluation.¹¹

Community-Based Forensic Residential Program Models

To address a shortage of secure forensic beds in state facilities for adults committed to the Department by the court system, the Legislature appropriated \$53.1 million in Fiscal Year 2007-2008. Of these funds, \$41.6 million was to provide 343 additional beds in the state facilities and \$11.5 million was to increase secure and non-secure bed capacity by 70 beds in four community forensic programs. These community forensic programs are still in operation and are located in Tallahassee, Jacksonville, Miami, and Pembroke Pines. The beds are available to individuals statewide and managed by the Department's regional offices.¹²

Community forensic programs provide residential care and mental health services to individuals found incompetent to proceed and to individuals found not guilty by reason of insanity. All individuals served in these programs have a conditional release order issued by the court in lieu of a commitment to a state facility. These programs vary in design from an open campus with minimal supervision to programs that are physically and staff secure. The per diem costs of the programs range from \$85 for an assisted living facility with mental health overlay services, to \$291 for secure beds with an array of mental health and other services. The Department reports that these programs are successful in keeping individuals from entering or re-entering state facilities, as well as reintegrating individuals into the community in less restrictive placements when combined with intensive outpatient services.¹³

The Miami-Dade Forensic Alternative Center (MD-FAC) offers another model for community forensic programs. Started in August 2009, the Miami-Dade program is a collaborative effort between the Department and Eleventh Judicial Circuit. The MD-FAC program is a 10-bed facility serving non-violent second and third degree felons found by the court to be incompetent to proceed. Unlike the other programs, MD-FAC is the only community-based forensic commitment program. In addition to competency restoration services, the program offers a continuum of care during the commitment period and after re-entry into the community. Program staff continue to monitor individuals to ensure that treatment and support services are maintained. An advantage of this model of competency restoration is that, unlike state facilities, the program is able to keep individuals whose competency has been restored in the program rather than in jail while awaiting trial. As a result, individuals are less likely to decompensate, or lose their ability to maintain normal psychological functioning, and be declared incompetent to proceed again. Outcomes for the Miami-Dade program indicate that competency is restored more quickly (103 days) than state facilities (146 days). The Miami-Dade program also cost less per bed day (\$229) than state facilities (\$333).¹⁴

Community-Based Forensic Programs

As of June 2011, the Department reported that there were 2,210 individuals receiving treatment and support services in the community through mental health providers. Of these individuals, 69% were in forensic treatment because they were found incompetent to proceed, as opposed to being found not guilty by reason of insanity. Most of the individuals served in community based programs were charged with second or third degree felonies. These individuals are on conditional release status and are either in pre-conviction diversion programs for competency restoration services or post-commitment programs after release from a state facility. While most of

¹¹ Interview with Sally Cunningham, Chief, Department of Children and Families Mental Health Treatment Facilities, June 17, 2011.

¹² *Ibid.*

¹³ *Ibid.*

¹⁴ *Miami-Dade Forensic Alternative Center Pilot Program Status Report*, August 2011.

these individuals are served in residential programs, others live in the community and receive intensive outpatient services.¹⁵

Considerations for Establishing Community Forensic Programs

Staff interviewed officials with the Department, community mental health providers, local law enforcement, and circuit court judges to identify criteria needed for establishing and maintaining successful community forensic programs.^{16,17} The criteria identified include:

- A level of acceptance by the community with treating felons in the community;
- The support of the local judicial system for community services rather than services in state facilities;
- A focus on public safety concerns that ensures that only second and third degree felons who have no history of violent or aggressive behavior, pose no escape risk, and are amenable for treatment, are targeted for community services;
- An array of community services be provided that include residential programs with different levels of security, supported and independent living arrangements for individuals not requiring residential care, intensive outpatient services, and specialized residential and outpatient services for individuals with co-occurring disorders;
- Provider staff knowledgeable about public benefits who can assist individuals establish or re-establish these benefits as they move into community settings; and
- Provider staff to serve as liaisons with the court with knowledge about the judicial system and its requirements.

Options and/or Recommendations

Close 30 Civil Beds

The Department estimates that there are approximately 40 individuals residing in non-secure, forensic step-down beds in civil facilities who have been found not guilty by reason of insanity but who no longer pose a public safety risk¹⁸. Moving these individuals into the appropriate community settings, with the approval of the court, would reduce the civil facility budget by \$3.3 million annually (based upon an average civil bed cost per day of \$303 x 365 days x 30 people). However, \$2 million of these savings would need to be redirected to communities for forensic services (based upon an average cost of the four model programs of \$184 x 365 days x 30 people). These actions would produce cost savings of \$1.3 million.

Close 30 Forensic Beds

As of August 2011, the Department reported 80 vacant forensic beds. Closing 30 of these beds in state operated facilities could reduce the forensic facility costs by as much as \$3.7 million annually (based upon the average cost per day for state facilities of \$336 x 365 days x 30 beds). These funds could be redirected to expand the community competency restoration programs. Such actions were recommended in Senate Interim Report 2011-106 and SB 2064 from the 2011 legislative session. The projected cost to expand the community competency restoration programs is \$1.7 million. This could result in savings of \$2 million to the state.

Review the Use of North Florida Evaluation and Treatment Facility

The legislature could direct the Department to review the use of the North Florida Evaluation and Treatment Facility to ensure individuals are receiving forensic services in the least costly setting. This facility, located in Gainesville, is the smallest facility in the state system with 193 beds, is 35 years old, and is more costly to operate than other more modern facilities. The Department closed 23 beds in this facility in July 1, 2011. As of August

¹⁵ Interview with Sally Cunningham, Chief, Department of Children and Families Mental Health Treatment Facilities (June 17, 2011).

¹⁶ Interviews with Stephanie Colston, Director of Substance Abuse and Mental Health, Department of Children and Families, Bob Sharpe, President, Florida Council for Community Mental Health, Inc., John Petrila, Director of the Florida Mental Health Institute's Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center, Linda McKinnon, CEO of Central Florida Behavioral Health Network, Inc., Joe Rutherford, Mental Health Care Inc., of Tampa, Michael Allen, Polk County Sheriff's Office, Valerie Westhead, Seminole County Sheriff's Office, Marilyn Ford, Volusia County Sheriff's Office, Judges Leifman, 11th circuit, Speiser, 17th circuit, Sjostram, 2nd circuit, Nilon, 8th circuit, and Marx, 15th Circuit, (June 17-August 12, 2011).

¹⁷ Interview with Judge Steven Leifman, Special Advisor to the Florida Supreme Court on Criminal Justice and Mental Health (August 1, 2011).

¹⁸ Interview with Sally Cunningham, Chief, Department of Children and Families Mental Health Facilities (June 17, 2011).

2011, the facility had a relatively low utilization rate of 67 percent. Once the Department reviews the use of this facility, it may be possible to move these individuals to other less costly facilities and programs, allowing the closure of the North Florida Evaluation and Treatment Facility.

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

10/18/2011

Date

Bill Number

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Subject Senate Interim Report on The Forensic Mental Health System

Representing DCF

Lobbyist registered with Legislature: Yes No

Pursuant to s. 11.061, Florida Statutes, state, state university, or community college employees are required to file the first copy of this form with the Committee, unless appearance has been requested by the Chair as a witness or for informational purposes. If designated employee: Time: from .m. to .m.

S-001 (04/14/10)

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

October 18, 2011

Date

NA

Bill Number

Name Drucilla Carpenter

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City State Zip

Speaking: For Against Information Appearing at request of Chair

Subject CSU + Forensic MH System

Representing Florida Senate - HHS Appropriations

Lobbyist registered with Legislature: Yes No

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S-001 (08/2005)

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

10/18/11

Date

CSU Report

Bill Number

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Appearing at request of Chair []

Subject Senate CSU Report

Representing Florida Council for Behavioral Healthcare

Lobbyist registered with Legislature: Yes [x] No []

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S-001 (04/14/10)

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

10-18-11

Date

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Subject Interim Reports

Representing FLA Public Defender Assn

Lobbyist registered with Legislature: Yes [x] No []

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S-001 (08/2005)

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

10/18/11

Date

Bill Number

Barcode

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Subject Interim Rep. on Forensic Mental Health

Representing AFSCME Florida Council 79

Lobbyist registered with Legislature: [x] Yes [] No

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Rick Scott, Governor
David E. Wilkins, Secretary

Gabriel Myers Update

Psychotropic Medication

Senate Committee on Children, Families, and Elder Affairs

Jamie Self, Executive Director
Family and Community Services

October 18, 2011

**Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families,
and Advance Personal and Family Recovery and Resiliency.**

Background

- The Gabriel Myers Workgroup presented 148 total findings and 90 recommendations to the Task Force in November 2009.
- As a result, in 2011 legislation was passed amending F.S. 409.912.

“The Agency may not pay for a psychotropic medication prescribed for a child in the Medicaid program without the express and informed consent of the child's parent or legal guardian. The physician shall document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription.”

Children Receiving Psychotropic Meds



- 14.8% of all children in Out-of-Home Care (licensed, relative/non-relative) receive psychotropic medication.
 - ❑ 28.8% of 11-17 year-olds
 - ❑ 16.9% of 6-10 year-olds
 - ❑ 1.4% of 0-5 year-olds

Number of Foster Care Youth Under DJJ Supervision on September 30, 2011

	Total Number of Youth	Number of Youth on Psychotropic Medication
Secure Detention	68	10
Residential Commitment	161	48
Total	229	58

Today



- CBC Lead Agencies are now required by contract to submit to pre-consent review.
- DCF improved internal controls and oversight of all children 0-17 in Out-of-Home Care (licensed and relative/non-relative).
- DCF implemented partnerships with the University of Florida to review Lead Agency pre-consents; the Dependency Courts to improve Judicial guidance; Agency for Health Care Administration (AHCA) for improved data sharing.

Next Steps



- Sampling cases show compliance issues with pre-consent reviews, possibly related to Florida Safe Families Network (FSFN) entry or record retention. More thorough enforcement of pre-consent review is in process.
- Planning implementation of a standardized well-being “Medical Home Model” through the Lead Agencies in local communities.
- Implement existing data sharing agreement with AHCA to maximize use of claims data.

Report of Gabriel Myers Work Group



November 19, 2009

Charlie Crist
Governor



George H. Sheldon
Secretary



EXECUTIVE SUMMARY

Florida Department of Children and Families Secretary, George H. Sheldon, appointed the Gabriel Myers Work Group in April 2009 to analyze and make recommendations regarding Gabriel Myers, a 7-year-old in foster care who apparently hanged himself on April 16, 2009 at the home of his foster parents in Margate, Florida.

The Department of Children and Families (DCF) posted all information and reports regarding the Gabriel Myers case, including what was presented to the Work Group, on the DCF Web site (<http://www.dcf.state.fl.us/admin/GMWorkgroup/index.shtml>) in order to be open and accountable to the public and to fulfill the commitment of the Department of Children and Families to transparency. The Work Group identified 147 findings in ten areas related to the case of Gabriel Myers and the use of psychotropic medication for children in out-of-home care. These findings have been used by the Work Group to identify 90 recommendations for action.

The Work Group has determined that a detailed framework of safeguards for Florida's foster children exists and is articulated in statute, administrative rule, and operating procedures. The core failures in the system, however, stem from lack of compliance with this framework and with failures in communication, advocacy, supervision, monitoring, and oversight.

As the Report notes, it is essential that all participants in Florida's child welfare system understand that each child in the care of the State should be cared for and treated as a prudent parent would. We must recognize that they are victims who have been abused, neglected, or abandoned, and whose lives require the attention and appropriate intervention of the State.

In dealing with the administration of psychotropic medications, the primary issue to be addressed by the child welfare system is not whether such medications are over-prescribed or under-prescribed in treating our children. Instead, it is whether, as part of a comprehensive treatment plan, such medications are necessary for a child in care and are properly prescribed, approved, administered, monitored, and discontinued as soon as medically appropriate. That comprehensive treatment plan should carefully address the use of other treatment alternatives before medications are considered.

The Work Group submitted this Report with these findings to the Task Force for Fostering Success, chaired by former DCF Secretary Bob Butterworth, for review and action on August 20, 2009. The recommendations that resulted from these findings are included in this final document and should guide the State of Florida, the Department of Children and Families, and its community-based partners in needed changes to the culture, policy and procedures within Florida's child welfare system.

REPORT OF GABRIEL MYERS WORK GROUP

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Report of the Gabriel Myers Work Group

Introduction

On April 29, 2009, Department of Children and Families (DCF) Secretary George H. Sheldon designated a work group to determine the facts and circumstances surrounding the death of 7-year-old Gabriel Myers on April 16, 2009. The initial police report indicated he apparently hanged himself in the shower of his foster parents' Margate home. Gabriel was brought into care on June 29, 2008, and, during the subsequent 10 months, was in foster care. He was prescribed psychotropic medications at the time of his death.

Members of the Work Group and Designated Advisors

As originally established by Secretary Sheldon, the Work Group is composed of five members:

- Dr. James D. Sewell, Assistant Commissioner (Retired), Florida Department of Law Enforcement, Chair
- Bill Janes, Assistant Secretary for Substance Abuse and Mental Health, Department of Children and Families
- Robin Rosenberg, Deputy Director, Florida's Children First
- Dr. Rajiv Tandon, Professor of Psychiatry, University of Florida College of Medicine
- Dr. Anne Wells, Chief, Medicaid Pharmacy Services, Agency for Health Care Administration

Secretary Sheldon also identified a number of advisors to assist the Work Group during the course of its efforts:

- Betty Busbee, former Chair, Florida Statewide Advocacy Council
- Theresa A. Flury, Executive Director, Statewide Guardian ad Litem Office
- Judge John Frusciante, Seventeenth Judicial Circuit
- Dr. Mike Haney, Director, Prevention and Intervention, Children's Medical Services, Department of Health

Personnel from the Department of Children and Families provided staff support for the Work Group.

Charge to the Work Group

The Work Group established by Secretary Sheldon was charged with examining three issues:

- The specific case of Gabriel Myers;
- The use of psychotropic drugs to treat children in foster care; and
- Child-on-child sexual abuse

In delivering his remarks to the Work Group at its first session, Secretary Sheldon asked the Work Group to:

- Take an independent look at this case and its implications on the way in which DCF does business throughout the State.
- Make a comprehensive examination of this case, including closely examining what went right and what went wrong.
- Draw on any necessary resources in performing this study, including members of DCF Operations and Program staffs, the Guardian ad Litem Program, ChildNet, Broward County Sheriff's Office, Margate Police Department, State Child Protection Team, Agency for Health Care Administration and necessary health care practitioners, and members of the Judiciary.
- Consider existing documentation, including the Florida Supreme Court report prepared by Judge Steven Leifman, reports submitted previously by the Florida Statewide Advocacy Council, and material previously provided to former Secretary Butterworth and Secretary Sheldon by Florida YouthShine.
- Provide a comprehensive analysis of the issues involved which would allow the Task Force for Fostering Success, chaired by General Butterworth, and the Department of Children and Families to identify and implement improvements to the system in order to reduce the chances of such a horrible event from occurring in the future.
- Complete its tasks with the sense of urgency that is expected in this agency and by Florida's children.

Meetings of the Work Group

In preparing its findings, the Work Group held seven public meetings:

- On May 14, 2009, in Ft. Lauderdale at the DCF Regional Office
- On June 8, 2009, in Tampa at the DCF Regional Office
- On June 18, 2009, in Ft. Lauderdale at the DCF Regional Office
- On July 6, 2009, in Tallahassee at the offices of the Big Bend Community Based Care Lead Agency
- On July 24, 2009, in Tampa at the DCF Regional Office
- On August 5, 2009, in Tampa at the DCF Regional Office
- On November 12, 2009, in Tampa at the DCF Regional Office

Based on sign-in rosters completed for each session, an estimated 175 individuals attended these seven meetings. The Work Group heard presentations and testimony from 32 individuals who were invited or requested the opportunity to speak.

In addition to information presented at its formal meetings, members of the Work Group reviewed myriad materials, including reports, statutes, operating procedures, and model policies, related to the issue of psychotropic medications. Copies of this material are maintained on the website created to support this Work Group (www.dcf.state.fl.us/admin.GMWorkgroup/index).

On November 12, 2009, the Work Group held its final meeting to review and discuss its recommendations to the Task Force on Fostering Success. This document includes all findings and recommendations that result from the term of this Work Group.

Findings of the Gabriel Myers Work Group

This Report documents 147 findings and 90 recommendations for system improvement resulting from the Work Group's public hearings and discussions about the issues with which it is charged. These findings fall into ten general areas:

- The Case of Gabriel Myers
- The Use of Psychotropic Medications to Treat Children in Foster Care
- Comprehensive Behavioral Health Assessments
- Information Contained in the Florida Safe Families Network
- Informed Consent and Judicial Review
- Information Sharing
- Behavioral Health Care
- Individual and Agency Accountability
- Implementation of the *Red Item Report on Psychotropic Drug Use in Foster Care*
- Ensuring Best Practices

Issue: The Case of Gabriel Myers

On April 16, 2009, 7-year-old Gabriel Myers apparently hanged himself in the residence of his foster parents. Gabriel had been adjudicated dependent on September 2, 2008, following the arrest of his mother and the filing of the abuse report that brought him into care on June 29, 2008. During the subsequent ten months, Gabriel was initially sheltered in a licensed foster home, then, after a positive home study, placed with relatives. When that placement broke down, he was returned to the licensed home in which he was initially placed. When that placement also broke down, he was sent to the licensed home in which he resided when he died. That home had previously served as a respite for Gabriel, and he was familiar with those surroundings. While in care, he received numerous mental health and behavioral assessments and underwent regular treatment from a psychiatrist and two therapists, one of whom documented that "it is clear that this child is overwhelmed with change and possibly re-experiencing trauma."

Gabriel demonstrated a number of incidents of destructive behavior and conduct problems and was treated with counseling and several psychotropic medications. In February and March 2009, Gabriel experienced a number of significant events

in life, including changes in foster homes, therapists, after-school programs, loss of privileges at home, and visitation arrangements with his mother, all of which may have contributed to his mental status at the time of his death.

Findings:

1. It is clear that, throughout his placement in foster care and although he was attended by many well-meaning professionals, Gabriel Myers was “no one’s child.” No individual or agency became a champion to ensure that he was understood and that his needs were identified and met in a timely manner.
2. Specific responsibility for the treatment and care of Gabriel Myers was not clearly fixed or effectively carried out.
3. There appeared to be no sense of urgency driving the agencies and individuals responsible for Gabriel’s welfare. Because the perception of time for a child is compressed, a demonstrated sense of urgency by adults is vital.
4. The case itself was replete with missed opportunities to more effectively serve the needs of this child. Numerous warning signs that Gabriel was in crisis were evident but were not addressed adequately or in a timely manner.
5. Individuals and agencies responsible for Gabriel’s welfare did not communicate regularly or effectively. Reports on his behavior, medication, and life changes were not fully and regularly shared among those charged with ensuring his welfare. Those responsible for his care did not adequately staff recommendations for Gabriel’s case, nor did they exchange information with the treating psychiatrist.
6. Individuals and agencies responsible for Gabriel’s welfare did not communicate regularly or coordinate effectively their efforts at caring for his needs.
7. Responsible parties failed to follow established law and operating procedures governing the administration of psychotropic medication, the appropriate obtaining of either informed parental consent or judicial authorization, and the notification of all involved parties.
8. ChildNet is the Community Based Care Lead Agency providing services to foster children in Broward County, which includes the city of Margate. In the case of Gabriel Myers, the ChildNet case manager failed to adequately carry out his responsibilities.
9. There was inadequate supervision of the assigned ChildNet case manager.

10. There was inadequate oversight of the involved agencies by Department of Children and Families personnel.
11. There was inadequate, incomplete, repetitive, and at times inaccurate documentation in Gabriel's case files.
12. There was no documented effort to gather and disseminate all available information on Gabriel's background and case history.
13. Appropriate agencies failed to respond when the foster parent clearly indicated by e-mail a number of behavioral issues and that Gabriel's foster care placement was in jeopardy. No action was taken to deal with the evident stress of the foster parent or his lack of success in managing behavior with punishment.
14. No one followed up with Ohio authorities concerning Gabriel's medical and welfare history, and, specifically, his claims of sexual abuse were not investigated in a timely manner.
15. Recommendations contained in the Comprehensive Behavioral Health Assessment and in reports by other professionals charged with his care, including the Family Services Planning Team, were not effectively communicated or followed.
16. Those professionals charged with his care did not provide Gabriel Myers specific and upfront therapy to deal with identified trauma, possible post-traumatic stress disorder, and depression. The only intensive therapy was directed at the prevention of sexual behaviors.
17. The case manager and supervisor did not ensure that recommended training to prepare the foster parents to deal with Gabriel Myers' unique background and behavior was provided.
18. Parents and those professionals charged with his care apparently accepted discipline and punishment as the principle solution to Gabriel Myers' behaviors. There is little evidence of any behavioral assessment or behavioral analysis services beyond the initial Comprehensive Behavioral Health Assessment or of positive efforts to support Gabriel and encourage his success. The case demonstrated a critical shortcoming in addressing the need for a behavioral analyst to support the foster parents and more effectively address Gabriel's behaviors.
19. No signed consent form was maintained in the medical records.

20. Too many changes occurred in Gabriel's life and environment in a short period of time, with poor communication among those charged with his care, and without a coordinated assessment or response by, caregivers and those charged with his care.
21. Despite the earnest efforts of ChildNet to ensure stability, there was no true placement stability, and Gabriel Myers' final placement was with working parents who were not always available or prepared for his unique needs.
22. Gabriel Myers was left with an unauthorized caretaker on at least one occasion.
23. The Work Group was not able to obtain sufficient information from the Broward County Schools to ascertain the school's role in Gabriel's care. From the information provided to the Work Group, however, it appears that school staff were not aware or sufficiently involved in resolving problems/concerns with Gabriel Myers. We defer reporting on this specific issue until such time as we can review appropriate records.
24. As a result of the death of Gabriel Myers, the Broward County child welfare community has identified a number of measures which, if vigorously implemented, monitored, and institutionalized, should ensure more effective and comprehensive treatment of children in the future.
25. Findings and corrective actions related to Gabriel's case have and will continue to impact children across this State.

Recommendations:

- R1. The Legislature should provide appropriate funding to ensure that each child in the care of the state is assigned a Guardian ad Litem.**
- R2. The Department of Children and Families, working with its community partners, should continue to work with the Broward County School District to examine what school-related issues existed with Gabriel Myers and to strengthen future efforts at collaboration and information-sharing.**
- R3. The Department of Children and Families should require their lead agencies to develop and implement procedures that:**
 - **Fix responsibility during crisis involving a child in the care of the state**
 - **Identify and hold accountable a champion, normally the case manager, to ensure the child is treated as a prudent parent would treat their child**
 - **Involve the child and consider the child's opinion in all decision-making**

- **Ensure presenting needs are identified and met in a timely fashion**
 - **Require transparency, collaboration among those responsible for a child's care, and a demonstrated sense of urgency.**
- R4. The Department of Children and Families and its lead agencies should develop and implement a priority response system for warning signs indicating a child is in crisis.**
- R5. The Department of Children and Families should require its lead agencies to develop and implement procedures to identify and to assist foster parents who are not able to manage their child's behavior or have reached a high level of stress. Such procedures should include 24/7 availability for support and intervention during times of crisis.**
- R6. The Department of Children and Families and its lead agencies should develop and implement procedures to obtain timely out of state information essential to a new placement in Florida.**
- R7. The Broward County child welfare system should provide a semiannual report to the Task Force on Fostering Success, documenting its on-going efforts to implement, monitor, and institutionalize the measures taken to ensure more effective and comprehensive treatment of children under the care of the state.**

Issue: The Use of Psychotropic Medications to Treat Children in Foster Care

Data presented to this Work Group indicates that, nationally, some 5% of all children are treated with psychotropic medications. In Florida's foster care system, 15.2% of its children receive at least one such medication, according to a report dated August 14, 2009.

These medications are prescribed by many professionals. Some children are in treatment with psychiatrists. Others are seen by specialists in pediatric neurology or behavioral pediatrics. Many are treated in primary care settings by pediatricians and family physicians. The data are unclear on how many of these children are receiving their treatment from Advanced Registered Nurse Practitioners and Physician Assistants. Because it is often asserted that psychotropic medications in the general population of children are sometimes being used to help parents, teachers, and other caregivers to calm and manage, rather than treat children, this Work Group believes that the Department of Children and Families has a higher requirement for due diligence prior to seeking authorization for administering these medications.

While this Work Group recognizes the difficulty in assisting our children, safeguards within the State's child welfare system must ensure that children are neither needlessly medicated nor denied access to potentially beneficial

treatments, including medications. In treating our children in the care of the state, we must recognize that they are victims who have been abused, neglected, or abandoned, and whose lives require the attention and appropriate intervention of the State.

Currently, the Department of Children and Families requires a pre-consent review for all psychotropic medications prescribed to children between the ages of birth through five (5) years who are in out-of-home care when: a prescribing practitioner is initiating a psychotropic medication treatment plan; a proposed dosage change exceeds the previously anticipated range as specified in the psychotropic medication treatment plan; or a new psychotropic medication treatment plan is to be initiated. To assist child welfare personnel in meeting this requirement, the Department of Children and Families contracts with the Department of Psychiatry within the University of Florida College Of Medicine to provide medical consultation via the MedConsult Line for these mandatory pre-consent reviews.

The Department of Children and Families also contracts with the University of Florida to make available the latest information on psychotropic medications to parents, foster parents, case managers, Guardians Ad Litem and the courts. The service is designed to provide callers with information to assist in giving express and informed consent for proposed medication for children in out-of-home care or enrolled in Behavioral Health Network (BNET). There were a total of 761 calls for consultation during the FY 2008-2009. Due to the increased focus on this issue, that number is anticipated to increase to approximately 2,000 in FY 2009-2010; consequently, the DCF has amended the contract to ensure timely, statewide response.

The terms "psychotropic" and "psychotherapeutic" are frequently used to discuss the medications to which this section of the Report refers. The term "psychotropic" refers to an assortment of chemical substances that act on the brain to alter consciousness, mood, behavior, or perception; these substances include those used for recreational purposes (including alcohol, cannabis, cocaine, etc.) and a broad range of therapeutic purposes (psychotherapeutic, anesthesia, pain control, etc.). The term "psychotherapeutic" refers to medications prescribed for the management of mental and emotional disorders. It also specifically defines the group of agents that this section encompasses (antidepressants, antipsychotics, lithium and anticonvulsant mood stabilizers; stimulants and other ADHD drugs; and sedative-hypnotics). Existing Florida statutes and DCF rules, policies, and procedures, however, utilize the term "psychotropic medication," and the Report of the Work Group will continue that practice.

Findings:

26. It is essential that all participants in Florida's child welfare system understand that each child in the state's care should be cared for and treated as prudent parents would treat their own children.
27. The primary issue is not whether psychotropic medications are over-prescribed or whether they are under-prescribed; instead, it is whether such medications are necessary for a child in care and are properly prescribed as part of a comprehensive treatment plan, approved, administered, monitored, and discontinued as soon as medically appropriate.
28. A framework for safeguards exists and is defined by statute, administrative rule, and operating procedures. The core failures in the system, however, stem from lack of compliance with this framework and with failures in communication, supervision, monitoring, and oversight.
29. Pre-authorization time requirements for psychotropic medications may at times be unreasonable to allow for adequate medical decisions.
30. There exists no requirement for either the foster parent or case worker to attend physician appointments with the child; on many occasions, the child may be accompanied only by a "transporter." Often, there is no adult present who has a role in the child's treatment and who can reliably report treatment response and any adverse effects.
31. Prescribing physicians often lack complete medical history and comprehensive behavioral assessment recommendations, sometimes including basic information about the child, when writing prescriptions. The value of psychiatric assessments for children in care is often limited by this lack of medical history and documentation of current behaviors. While a limited assessment may be adequate for some urgent problems, it is not sufficient to support initiation of or on-going treatment with psychotropic medication.
32. All children should have a current physical examination which must be considered by the prescribing practitioner prior to the initiation of psychotropic medication, and physicians should ensure diligent, on-going monitoring, including appropriate tests, for children receiving such medication.
33. Physicians should commit sufficient time with each child patient to adequately evaluate and ensure proper follow-up, with necessary frequency, for their needs. Systems of care should ensure that physicians are able and required to do so.

34. Physicians should screen all children for Traumatic Brain Injury (TBI) before the initiation of psychotropic medication. Traumatic brain injuries resulting, for instance, from “shaken baby syndrome” and other head injuries, can cause the same problematic behaviors that psychotropic medications are used to treat. Yet many psychotropic medications are contraindicated for persons with TBI. Children in state care are more likely than those in the general population to have experienced a TBI.
35. The child’s height and weight should be recorded in the records of the prescribing doctor and clinically considered during each visit.
36. There appears to be no standardized requirement for the development and use of a medication discontinuation plan for a child receiving psychotropic medications.
37. There is no coordinated statewide system of updating medical education, including pharmacological issues, for physicians treating children in state care.
38. The Department of Children and Families has developed no systematic involvement of Florida’s medical community in addressing issues such as psychotropic medications for children.
39. The Agency for Health Care Administration’s Medicaid Drug Therapy Management Program for Behavioral Health has developed evidence-based guidelines, reviewed every two years, for the use of psychotropic medications for children. Beyond these, there are no regularly promulgated State guidelines for the use of psychotropic medications or the identification of best clinical practices to treat Florida’s foster children.
40. Each child should have an up-to-date, consolidated medical record, containing all health records of the child, capable of being electronically communicated and accessed by all appropriate caregivers, and preferably maintained by the primary care provider.
41. The Food and Drug Administration maintains a voluntary reporting system for adverse consequences of medication, including side effects and adverse reactions. However, adverse consequences appear to be underreported and are not fully understood by those in Florida’s child welfare system.
42. The intent of the 2005 statutory revisions requires informed consent when the medication alters brain function. Policies on the use of psychotropic medications for non-psychotherapeutic purposes and the use of traditionally non-psychotropic medications for psychotherapeutic purposes are not clear.

43. The administration of psychotropic medications must not be viewed as an action separate and apart from the child's treatment plan and without the consideration of other therapeutic interventions.
44. When medication is indicated, a combination of evidence-based therapy and medication produces better outcomes for the child. Consideration should be given to requiring children who are prescribed medication for symptoms associated with mental health or substance abuse diagnoses to receive other services and supports, including psychotherapy or behavior therapy, in addition to medication management.
45. Psychotropic medications are at times being prescribed to help parents, teachers, and other caregivers manage situations, rather than comprehensively treat, children.
46. Section 1006.0625, F.S., prohibits school district personnel from compelling a parent to place his or her child on medication. Following changes in the law in 2005, the Department of Education promulgated a memorandum to district school superintendents regarding the role of district personnel in sharing observations of academic and behavioral performance and offering interventions to address concerns. Anecdotal information indicates the need for further communication between the Department of Education and local school districts concerning this critical topic and the proper role of school personnel.
47. Children receiving medications are not adequately monitored, nor are those involved in the process adequately informed regarding the long-term implications of these medications or alternative or adjunct treatments. This is particularly troubling for children on medications with "Black Box" warnings.
48. The Department of Children and Families lacks a plan for the monitoring of psychotropic medication. A proven solution has been the response to the State's forensic bed crisis with a daily report and weekly review by senior leadership. This critical issue should be elevated to the same level of attention by DCF senior leadership.
49. The frequency and amount of psychotropic medications prescribed for children varies significantly among DCF regions.
50. There is currently no standardized, comprehensive, on-going statewide program to train case workers and caregivers on issues related to psychotropic medications, including requirements relating to informed consent, monitoring of "Black Box" medications, and on-going responsibilities of those responsible for a child's care.

51. Department training on psychotropic medications in 2005-2006 for personnel in the state's child welfare system was not comprehensive and has not been systematically sustained for newly hired personnel within the child welfare system.
52. Participants in the child welfare system do not appear to have a comprehensive understanding of the appropriate use of psychotropic medications, the approval process, and their specific role in that process.
53. Participants in the child welfare system do not appear to have a comprehensive understanding of evidence-based practices that are known to effectively treat behavior disorders and psychiatric symptoms.
54. It does not appear that prescribing physicians are regularly engaging children in a developmentally appropriate manner in the prescription process.
55. It does not appear that prescribing physicians regularly document the child's desires and opinions in the treatment visit notes.
56. Concurrent Quality Assurance reports show that existing assessments and records are not being provided to the prescribing physician.
57. While the child's Guardian ad Litem has the responsibility for ascertaining and informing the court of the child's position, it is not clear that this is happening consistently. Furthermore, not all children in the State's care have a Guardian ad Litem.
58. Children are not routinely appointed counsel when they object to the administration of a psychotropic medication.
59. The Work Group heard a number of advocates express their view that the court should appoint an attorney for each child whose mental health needs suggest use of psychotropic medication. Further, some proffered that the best practice is for all children in dependency to be appointed an attorney (with sufficient training and experience to provide meaningful and effective assistance of counsel).
60. There is no process to ensure coordination of care between psychotropic medication prescribers and other therapeutic service providers.
61. It is not clear whether existing Medicaid funding will support more active involvement by a prescriber in therapeutic treatment of children (in contrast to payment for medication management visits).

62. The utilization of psychotropic medications to treat children continues to increase. Despite requirements for Food and Drug Administration approval of medication for use in young children, prescribing in children under the age of ten, their most formative years, is particularly concerning.
63. Third party review does not occur for all psychotropic medication of children in foster care.
64. The State requires the prescribing physician to outline an individualized psychotropic medication plan when seeking court authorization to provide such treatment to a child under state care and custody. To serve this purpose, a myriad of forms with widely discrepant content are being utilized across different judicial circuits and systems in the state. This results in confusion, inefficiency, discrepant practices, and a range of irregularities.

Recommendations:

- R8. All decision making should be guided by the principle that it is important to comprehensively address all concerns in a child's life--health, education, and social/emotional issues--as well as providing behavioral supports and parent training, so that a child's behavioral and mental health issues can be addressed in the least restrictive setting and in the context of a comprehensive treatment plan.**
- R9. The State of Florida, through Governor Crist and Secretary Sheldon, should raise the issue of the use of psychotropic medications to treat children in state care to national prominence in order to develop a comprehensive nationwide approach.**
- R10. The Legislature should examine current statutes and provide sufficient funding to allow the court to appoint an attorney for each child for whom psychotropic medication is prescribed. At a minimum, an attorney should be appointed for any child who objects to being administered psychotropic medication or requests legal representation.**
- R11. The Legislature should amend the requirement for a pre-consent consultation for all children in out-of-home care under age six. Instead, the consultation should be expanded to include all children age eleven and under who are prescribed two or more psychotropic medications.**
- R12. The Legislature should review current statutes to ensure that procedural safeguards employed for the use of psychotropic medications are applied to all medications that alter brain function,**

regardless of the purpose of the prescription, to ensure they are adequate.

- R13.** The Legislature should amend Section 39.407, F.S., to change the term "medical report" to "Medical Treatment Plan" so that interventions focus on treatment and the holistic needs of the child.
- R14.** The Legislature should authorize the Department to develop a single medical treatment plan form with standardized information that can be utilized in all judicial circuits across the state.
- R15.** The Legislature should ensure that State statutes and Department of Children and Families policies, procedures, and practices recognize that children should be fully involved and allowed to participate in court hearings and treatment decisions. As part of this, prescribers should be required to confer with and seek assent from each child and to document the child's position. The Department of Children and Families should be required to inform the Court of the child's position.
- R16.** The Legislature should review Florida statutes to ensure requirements are practical and clearly defined for:
- Prescribing psychotropic medications
 - Obtaining informed consent
 - Obtaining the child's assent
 - Requiring a parent, case worker, or other adult responsible for the child's care to attend each medical appointment with the child
 - Administering and monitoring psychotropic medications
 - Discontinuing, when appropriate, psychotropic medications. To include a formal plan for discontinuation
 - Notifying involved parties.
 - Reporting adverse incidents
- R17.** The Legislature should require all prescribing physicians to report adverse consequences of psychotropic medications; all adverse effects should become a record in the medical file of a child in the care of the state.
- R18.** The Legislature should allow Advanced Registered Nurse Practitioners and Physician Assistants to provide information to parents and legal guardians in order to obtain express and informed consent for treatment.

- R19.** The Legislature should preclude any participation by children in State care in clinical trials relating to the development of new psychotropic medications.
- R20.** The Department of Children and Families should require its lead agencies to develop and implement treatment protocols which ensure collaboration among those responsible for a child's care. These protocols should specifically address the role of the use of psychotropic medications and the need to share all relevant information with all parties involved in the child's care.
- R21.** The Department of Children and Families, working with its community partners, should provide recommendations to the Department regarding improvement of collaboration in treating children under the care of the state, including:
- Sharing of information in the Comprehensive Behavioral Health Assessment;
 - Providing specific and upfront therapy in response to assessments;
 - Collaborating throughout the foster care experience for the child;
 - Providing periodic/ongoing assessments as appropriate.
- R22.** The Department of Children and Families, working with its community partners, should ensure that those involved in a child's care are required to complete training on psychotropic medications including requirements for informed consent, monitoring of "Black Box" medication warnings, signs and symptoms to be monitored for adverse reactions, and their responsibilities in the monitoring process.
- R23.** The Department of Children and Families should, by rule, prohibit the prescription of a psychotropic medication to any child removed from his/her home during the first 30 days of out-of-home care, unless that child is already on psychotropic medications or if the case meets emergency criteria. This rule should ensure that the trauma associated with removal is addressed through immediate therapy and counseling.
- R24.** The Department of Children and Families should define in rule parameters for a mandatory second opinion for all children receiving psychotropic medications.
- R25.** The Department of Children and Families should require its lead agencies to develop and implement procedures and practices that ensure that caregivers are promptly and appropriately trained regarding the behaviors, medications (dosage, documentation and

possible reactions), proper handling of children, and numbers to call for assistance or emergencies when children in their care are prescribed psychotropic medications.

- R26.** The Department of Children and Families should develop a policy governing and encouraging the reporting of adverse reactions to medications to the Food and Drug Administration.
- R27.** The Department of Children and Families should study the variances in amounts of psychotropic medications prescribed in its six regions to identify issues and guide best practices.
- R28.** The Department of Children and Families should ensure that the process of pre-authorization reviews for psychotropic medication is flexible enough to allow for thoughtful individual medical evaluation and a timely response.
- R29.** The Department of Children and Families should require its lead agencies to ensure standardized, on-going and reality based training regarding requirements for those involved in a child's care, which include:
- Prescribing psychotropic medications using evidence-based practices
 - Understanding the use and effects of psychotropic medications in children
 - Obtaining clear and documented informed consent
 - Obtaining the child's assent
 - Monitoring psychotropic medications and their physical and behavioral effects on the child
 - Terminating, when appropriate, psychotropic medications
 - Notifying involved parties
 - Monitoring of "Black Box" warnings and other emerging information on risks and side effects
 - Addressing children's needs through comprehensive children's mental health (behavioral and psychiatric meds) and evidence-based services
 - Understanding child and adolescent development
 - Understanding the neuro-developmental effects of prenatal substance exposure

- **Understanding the neuro-developmental effects of psychotropic medication and recognizing side-effects and contra-indications**
- **Recognizing common mental health disorders in the child welfare population**
- **Recognizing and understanding the impact of traumatic brain injury**
- **Using effective treatment options for these mental health disorders**
- **Recognizing signs of Post Traumatic Stress Disorder**
- **Recognizing the difference between normal childhood behaviors, trauma-related behaviors, and true mental health disorders**

R30. The Department of Children and Families, working with its community partners, should develop and conduct additional training for supervisory staff on meeting roles and responsibilities on:

- **Recognizing and adequately dealing with warning signs in a child in a timely manner.**
- **Meeting case documentation requirements.**
- **Obtaining informed consent for administering psychotropic medications.**

R31. The Department of Children and Families and its lead agencies should clearly articulate the expectations for each caregiver, including attendance at appointments and conferences with physicians, other medical professionals, and teachers, and hold them accountable for compliance with these expectations.

R32. The Department of Children and Families, working with its community partners, should require clinical rating scales and other measures to monitor and quantify response to target symptoms and progress to treatment goals in each treatment plan.

R33. The Department of Children and Families, through its community partners, should require prescribing physicians to conduct or review a current physical examination prior to prescribing a psychotropic medication. Physicians also should be required to record and consider the child's height, weight, and body mass index during each visit.

R34. The Department of Children and Families should require that the initial medical assessment of a child in the care of the state include screening for traumatic brain injury. In addition, a screening for brain injury should be required if a prescription for psychotropic

medication is indicated. Such screening should determine any additional evaluations which should be completed.

- R35.** The Department of Children and Families should work with its Federal partners to improve the protocols for prescribing, administering, and monitoring psychotropic medications.
- R36.** The Department of Children and Families should include in its contract with the University of Florida College of Medicine pre-consent authorization when any psychotropic medication is prescribed for any children under the age of eleven.
- R37.** The Department of Children and Families, working with its community partners, should endeavor to create a system of care focusing on the continuity and quality of care and in which a child is not forced to change treating professionals upon residential moves. As part of this, the Department should require its lead agencies to conduct a special staffing attended by all those involved in the child's care whenever a child is moved between residential placements and when primary care and behavioral health specialists change. Those responsible for a child's care should develop a plan to ensure continuity of care and minimal disruption to the child's well-being.
- R38.** The Department of Children and Families and the Agency for Health Care Administration should jointly review the Florida Medical Handbook to ensure consistency with these recommendations.
- R39.** The Agency for Health Care Administration, in partnership with the University of South Florida, should continue and expand its efforts to monitor prescribing practices of doctors with large volume of psychotropic medication prescriptions.
- R40.** Any other State agency, such as the Department of Juvenile Justice, charged with dealing with children in State care should ensure that their policies, procedures, practices, oversight, and data systems relating to psychotropic medications are adequate, up-to-date, and meet legal standards.

Issue: Comprehensive Behavioral Health Assessments

The Comprehensive Behavioral Health Assessment (CBHA) is a psycho-social assessment that allows a comprehensive look at a child's behavioral health needs. Required within 30 days in all shelter cases and allowed under other circumstances, the purpose of the Comprehensive Behavioral Health Assessment is to integrate and interpret existing information and provide functional information to decision-makers in determining:

- The most appropriate out-of-home placement;

- Intervention strategies to accomplish family preservation, re-unification, or re-entry and permanency planning; and
- Comprehensive service plans and behavioral health services that, when indicated, are incorporated into the child's case plan.

CBHAs must be performed by a licensed mental health practitioner or under the supervision of such a practitioner. Each must include direct observation of the child in three settings: home, school, and community. Children who are enrolled in Medicaid who meet specific criteria may have a CBHA performed once a year, and a CBHA may be requested when a child faces significant changes in his life or environment.

Findings:

65. The goal of the Department of Children and Families is that all children entering out of home care who are Medicaid eligible are provided a Comprehensive Behavioral Health Assessment (CBHA). Testimony before this Work Group, however, indicated that not every child in foster care is eligible for or receives the Comprehensive Behavioral Health Assessment. The Department's goal should be a Comprehensive Behavioral Health Assessment on all children coming into foster care.
66. Children currently entering state care who do not always receive Comprehensive Behavioral Health Assessments include children who are not Medicaid eligible (primarily immigrant children); children who do not enter via or remain in "shelter status" long enough for a CBHA to be ordered; and children who are placed in unlicensed settings (relative or non-relative placements).
67. While often used early in a foster child's involvement with DCF, the Comprehensive Behavioral Health Assessment is not used on a regular basis to indicate progress of the child within the system unless there are clear emotional disturbances and a follow-up is requested.
68. While subsequent CBHAs may be performed in certain circumstances, this Work Group received no evidence that CBHAs are routinely ordered for all children whose behaviors are deteriorating and whose emotional needs are escalating.
69. Case plans too often show a gap between those services identified in the CBHA and those reflected in the child's case plan.
70. Case plans too often reflect a gap between services identified in the CBHA and those actually being provided to the child.

Recommendations:

- R41.** The Legislature should allocate sufficient funding to provide Comprehensive Behavioral Health Assessments (CBHA) to children who are not Medicaid eligible.
- R42.** The Department of Children and Families should require its lead agencies to ensure multi-disciplinary staffings are conducted for all children with complex needs and for those who remain in care for longer than eighteen months.
- R43.** The Department of Children and Families should require its lead agencies to develop and implement a process to determine, at least once a year, whether each child in State care for more than eighteen months would benefit from an updated psychological or behavioral health assessment; provide that assessment; and provide the services recommended therein. The services recommended in the assessment should be added to the child's case plan.
- R44.** The Department of Children and Families should require its lead agencies to ensure that all children in the child welfare system receive the Comprehensive Behavioral Health Assessment.
- R45.** The Department of Children and Families should require each lead agency to ensure that the Comprehensive Behavioral Health Assessment is always made available to the prescriber of psychotropic medications prior to the prescribing of psychotropic medications for the child.
- R46.** The Department of Children and Families, working with its lead agencies, should develop and monitor quality assurance standards to ensure the implementation of recommendations contained in the Comprehensive Behavioral Health Assessments.

Issue: Information contained in the Florida Safe Families Network (FSFN)

On April 20, 2009, Florida Safe Families Network (FSFN) records reflected that 1,949 of Florida's 20,453 children in out-of-home care were being treated with psychotropic medications. Subsequently, following increased attention on the issue and with additional training for child welfare personnel, an October 30, 2009 report indicated that 2,848 of 19,789 children in out-of-home care were actually receiving psychotropic medications.

In addition to the appointment of the Gabriel Myers Work Group, Secretary Sheldon ordered a special quality assurance (QA) review of every child in out-of-home-care on psychotropic medications. As of October 30, 2009, the Department's quality assurance division has reviewed 2,952 cases and issued 5,551 corrective action requests to provider agencies. These action requests address deficiencies with legal informed consent, court orders, treatment plans,

and data entry errors in the FSFN data system. Corrective actions are being tracked at the local level and progress is reported via on-going conference calls. The Department has completed the review of children ages 0-17.

The Gabriel Myers Work Group received on-going briefings on the progress of these quality assurance reviews, which clearly identify deficiencies in data contained in FSFN and specify corrective action needed. Each of these reports has been included on the Gabriel Myers Web site reflecting the activities of this Work Group.

Findings:

71. FSFN data are frequently incomplete and inaccurate. The information contained in FSFN is only as good as the information entered from the field; errors in input, regardless of the reasons for such errors, will continue to yield faulty information.
72. DCF and Community Based Care Lead Agencies staff indicated that, as currently structured, FSFN is a data capture system that provides little support for effective case management.
73. The pilot project being conducted by OurKids, the Community Based Care Lead Agency for Miami-Dade/Monroe Counties, is an outstanding application of MindShare as a platform for better analytical and case management applications of FSFN data.
74. Case managers are required to enter medical information into FSFN, yet often do not understand the information and cannot verify its accuracy.
75. FSFN has too many “free text” and “other” sections which complicate timely and effective use of the data system as an adequate monitoring device.
76. The list of psychotropic medications in FSFN, while extensive, does not include all drugs used for such purposes. Testimony indicated that the purpose of the list is unclear to child welfare system participants and prescribing physicians.
77. It must be recognized that FSFN is only a data system; by itself, it does not replace adequate supervision and monitoring.

Recommendations:

- R47. The Department of Children and Families should require its lead agencies to continue its efforts to ensure the quality, completeness, timeliness, usefulness, and accuracy of case documentation and information contained within the Florida Safe Families Network.**

R48. The Department of Children and Families should continue to utilize technology and identify technology solutions, including enhancements to the Florida Safe Families Network, to resolve problems identified in this report including:

- **Elimination of duplication of data entry**
- **Cataloguing of treatments and medications**
- **Monitoring of status of psychotropic medications in the prescription / consent / administration process.**
- **Allowing all parties access to verify information**
- **Establishing a “stop” or flag system when an action does not occur**
- **Facilitating and documenting information exchange**
- **Facilitating supervisory monitoring/review and management oversight**
- **Strengthening and aligning data systems**

R49. The Department of Children and Families should continue refinements to the Florida Safe Families Network to increase its “user friendliness” and to reduce the number of free text and “other” entries.

R50. The Department of Children and Families should develop a web-based program for referral, treatment and tracking of children prescribed psychotropic medications to replace duplicative forms linked to FSFN and make the program accessible to all pertinent persons.

R51. The Department of Children and Families, working with its community partners, must continue to improve the usefulness of the Florida Safe Families Network for case management in the field.

R52. The Department of Children and Families should clarify the intent of listing psychotropic medications in Florida Safe Families Network.

Issue: Informed Consent and Judicial Review

Section 39.407, Florida Statutes, describes in detail the process for obtaining express and informed consent for the administration of psychotropic medications to children in the custody of the department. Subsection (3)(a) of that statute requires that any physician prescribing such medications to a child in the custody of the department must attempt to obtain “express and informed consent” as defined in s. 394.455(9), F.S. and described in s. 394.459(3)(a), F.S. For children whose parents’ rights have not been terminated, the prescribing physician must

attempt to obtain written express and informed consent from the child's parent or legal guardian.

Before giving express and informed consent, the following information must be provided and explained in plain language to the child's parent or legal guardian and to the child, if age appropriate:

- the reason for admission or treatment;
- the proposed treatment;
- the purpose of the treatment to be provided;
- the common risks, benefits, and side effects thereof;
- the specific dosage range for the medication, when applicable;
- alternative treatment modalities;
- the approximate length of care;
- the potential effects of stopping treatment;
- how treatment will be monitored; and
- that any consent given for treatment may be revoked orally or in writing before or during the treatment period by the parent.

To assist the physician with securing the express and informed consent of the parent or legal guardian, the Department of Children and Families or its local partners must take steps necessary to facilitate the inclusion of the parent or legal guardian in the child's consultation with the physician.

If the parent is unavailable or unwilling to give express and informed consent, if the parent is unknown, or if the parent's parental rights have been terminated, a court order authorizing the administration of psychotropic medication must be requested. Except in defined emergency situations, that judicial review and court authorization must be obtained prior to the administration of the medication.

The motion requesting authorization for the administration of the medication must be filed by attorneys representing the State and be accompanied by a written report signed by the prescribing physician. The required elements of the medical report are outlined in the statute and closely track the requirements for express and informed consent, above. The prescribing physician is not required to testify in any hearing on the motion unless the court orders attendance or a party subpoenas the physician. Any objection to the motion must be filed within 2 working days of receipt of the motion by a party. If an objection is received, the court must schedule a hearing on the motion "as soon as possible."

Findings:

78. The on-going analysis of data contained within the Florida Safe Families Network (FSFN) clearly showed that a significant portion of cases involving the administration of psychotropic medications to foster children did not meet the legal requirements relating to express and informed consent.

79. The on-going analysis of data contained within the Florida Safe Families Network (FSFN) clearly showed that a significant portion of cases involving the administration of psychotropic medications to foster children did not meet the legal requirements relating to judicial review.
80. Psychotropic medication is routinely administered to children in Florida without express and informed consent of their parents, or in their absence, without judicial authorization.
81. The prescribing physician's report/affidavit varies among circuits; there is no common, statewide form. Information on these forms is often repetitive and/or unnecessary for the action requested.
82. The treatment plan does not clearly specify the expected length of treatment with recommended medication and a discontinuation plan for that medication.
83. Informed consent for use of psychotropic medications is a systemic problem. It appears that, too often, parents and/or the court are unaware of critical issues involving medications, procedures are not followed, and documentation requirements are ignored.
84. There is often insufficient exchange of information for parents or judges to make an informed decision involving psychotropic medications.
85. There is no evidence that children are routinely provided notice of the proposed treatment with information on how to object in a timely fashion.
86. The pre-consent process is unclear, particularly if a child is already taking a medication.
87. The pre-consent age requirement is not understood (under 5 or under 6?)
88. The prescribing physician too often yields to pressure and fails to meet the legal and ethical duty to obtain express and informed consent before psychotropic medication is administered.
89. Informed consent cannot be obtained without a direct conversation between the prescriber or a trained designee, and the person with authority to provide the consent, whether the parent, legal guardian, or the judge. An exchange of paper can never substitute for the oral interchange and visual cues required for the prescriber (or designee) to ascertain that the "consenter" understands the decision being made.

90. Informed intermediaries can be used as a tool to ensure effective communication and facilitate the obtaining of informed consent. Such an approach is not currently utilized in Florida's child welfare system.
91. A true informed consent document should be signed by the parent in the presence of the prescribing physician who has explained all components of informed consent, including treatment alternatives.
92. Child welfare workers are expected to facilitate contact between the child's parents and the physician. The child welfare worker cannot act for the physician and obtain express and informed consent for treatment.
93. There are numerous barriers to arranging a personal meeting between the "prescriber" and "consenter" - whether that be the parent or the court (e.g., it may be difficult for parents working full-time at low wage jobs to leave work for a physician's appointment, and frequently physicians do not have time to appear before the judge).
94. Courts lack what was referred to as the "intimacy of daily association" with the affected foster children. Consequently, in determining the appropriateness of psychotropic medication, they must rely on information provided by a variety of other individuals, including the case manager, foster parent, Guardian ad Litem, behavior analyst, therapist, and physician.
95. As a general principle, courts will be able to render better decisions for children if judges sitting on the dependency bench have experience either as jurists or practitioners. Judges should not be placed in dependency unless they want to be there. Courts with strict rotation schedules should be encouraged to retain experienced dependency judges to work on behalf of children.
96. Judges can more effectively meet the needs of children in the care of the state if:
 - They receive more education on treatment alternatives available to address behavior disorders and psychiatric symptoms.
 - They receive more education on the types of psychotropic medications and the illness they are designed to treat.
 - They are advised on best practices for obtaining informed consent and use of psychotropic medication in children.
 - They are provided with a judge's desk reference that would enable them to quickly access important information about each drug.
 - They are provided with a bench card to give them an at-a-glance guide on what they need to know or what evidence they need to take in order to render a decision.

- There is a uniform statewide affidavit, developed with the input of physicians and other participants within the process, which will provide the information the court needs to make a decision.
 - There is an easier way to obtain a true second opinion (not just a consultation on the MedConsult Line).
97. Children should be fully involved in and allowed to participate in court hearings involving their welfare and treatment in a developmentally appropriate fashion.
 98. Court orders approving the use of psychotropic medications do not always contain other specific medical follow-up steps, such as blood and other appropriate tests, necessary to ensure the child's well-being.
 99. Medical ethics and best practices require that the "informed consent" process include an effort by the physician to obtain assent from children who lack the capacity to provide informed consent. Assent is a process by which a provider of medical services helps the patient achieve a developmentally appropriate awareness of the nature of his or her condition; informs the patient of what can be expected with tests and treatment; makes a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding; and solicits an expression of the patient's willingness to accept the proposed care.
 100. The American Academy of Child and Adolescent Psychiatry (AACAP) has promulgated a list of specific questions that decision makers should have answered before the child begins taking psychiatric medication. This list of questions is more tailored to the unique needs of children than the current "informed consent" guidelines in statute and may be appropriate for further review.

Recommendations:

- R53. The Department of Children and Families should require that informed consent be given only after a direct conversation between the prescriber or trained designee and the parent, legal guardian, or judge authorized to give consent.**
- R54. The Department of Children and Families should require that the child's position on taking a prescribed psychotropic medication be recorded in their treatment plan.**
- R55. The Department of Children and Families, working with its community partners, the medical community, and the State Court system, should develop and adopt a uniform, less complex and lengthy informed consent form for use statewide.**

- R56. The Department of Children and Families, working closely with the Office of State Court Administration (OSCA) and local court administrators, should develop and provide on-going education for judges and court staff on treatment alternatives, psychotropic medications, informed consent, and appropriate processes involving the court with the child welfare system.**
- R57. The Department of Children and Families should work with local chief judges and encourage the assignment of experienced judges with an interest in family and children's issues to work on behalf of children.**
- R58. The Department of Children and Families, working with its community partners, should improve the court referral process that allows for other specific medical follow-up steps, such as blood and other appropriate tests, necessary to ensure the child's well-being.**

Issue: Information Sharing

Florida's foster care system requires the involvement of a number of agencies, both governmental and private, and myriad individuals to successfully manage the care of these children. When they have unique behavioral or medical needs, the involvement of other professionals becomes even more necessary. In such cases, it is vitally important that all participants in a child's welfare regularly exchange critical information and continually communicate with other involved caregivers. Especially in complex cases, the use of multidisciplinary teams fosters the focus of a variety of professional expertise and viewpoints on the solution of that child's specific issues. This process demands a continuous, consistent, coordinated system of care such as that recommended for individuals with both mental health and substance use disorders.

Findings:

101. The sharing of information, whether through interpersonal contact or data exchange, must ensure integrated care for Florida's foster children and eliminate fragmentation of efforts.
102. Data available through a number of systems (e.g., FSFN, AHCA Medicare, and MedConsult Line) are not regularly reviewed to indicate anomalies in the number of children receiving psychotropic medications or to ensure accuracy of data.
103. The results of the Comprehensive Behavioral Health Assessment are not always transmitted to and shared among others involved in the child's treatment, including the treating psychiatrist.

104. The results of the Comprehensive Behavioral Health Assessment do not replace a functional behavior assessment.
105. There is a need for a Web-based information system which, with proper security safeguards, allows access by those responsible for a child's care.
106. Florida lacks data on children aging out of the care of the state and their continued use of psychotropic medication. Anecdotal evidence suggests that many youth discontinuing medications after reaching adulthood may not suffer adverse effects.
107. Child abuse death reviews have consistently identified the need for multidisciplinary staffings on complex cases. Currently, multidisciplinary staffings are not routinely conducted.
108. Prescribing physicians do not always have access to all of the information about the child's medical, therapeutic and behavioral history that is available in the child welfare system.
109. Sharing of information is primarily affected by two Federal laws, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which governs the use and disclosure of private health information, and the Family Education Rights and Privacy Act of 1974 (FERPA, also known as the Buckley Amendment), which protects the privacy of student educational records. It appears that misunderstandings concerning the intent and requirements of these laws foster artificial barriers to the sharing of information among foster children in care, especially with and between schools and between treating personnel.
110. The current system requires numerous pieces of paper, necessitating duplication of information entries and creating a burden for all involved, and may result in inaccurate or incomplete information going to the persons who need it.
111. Technology and technological solutions to many of the problems identified in this report can be better employed to:
 - eliminate the duplication of entries; catalogue the treatments and medications of children;
 - track the status of a prescribed medication in the prescription/consent/administration process and monitor any changes in prescriptions;
 - allow all parties (and counsel) to view and confirm the accuracy of information; generate a "stop" or flag when system requirements, such as informed consent, do not occur; and
 - facilitate and document information exchanges between therapists and prescribers.

112. Prescribing physicians lack financial incentive to participate in multi-disciplinary treatment teams.
113. All persons with daily contact with a child (caregiver, school, day care) should have access to pertinent information concerning symptoms, medication side effects, expected changes in behavior, when to contact prescriber or an emergency room, and necessary on-going monitoring.
114. Standardized information sheets on most commonly used medications are available through the Food and Drug Administration and pharmacies and could be used more effectively in sharing information within the child welfare system.
115. Complete and accurate medical records are indispensable to safe and effective usage of psychotropic medications.
116. Continuity of medical care, to the extent possible, will promote the well-being of children.
117. No existing quality assurance review determines whether the child's health records are complete and up to date.
118. Information systems and information-sharing practices should be capable of triggering a specific response from designated agencies when a pattern of warning signs of crisis for a child in State care emerges.
119. Elimination of needless and duplicative paperwork should result in efficiencies that lead to better care.

Recommendations:

- R59. The Legislature should ensure sufficient funding that foster children aging out of the system, who are on psychotropic medications or involved in therapeutic treatment, be provided with a method, including financial support, to continue such treatment for a specified period of time after discharge if not covered by insurance plans through employment or other means.**
- R60. The Department of Children and Families should work with the Department of Education and local school districts, in compliance with existing interagency agreements, to develop procedures to facilitate the release of a child's school information from school officials to those charged with his/her care.**
- R61. The Department of Children and Families, working with the Department of Education and Department of Health, should ensure**

that training on the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the Family Educational Rights and Privacy Act of 1974 (FERPA) is conducted for staff in child welfare, behavioral medicine, and schools to facilitate sharing of treatment and other child welfare information.

- R62. The Department of Children and Families, working with its community partners, should develop and implement a Web-based information system which, with proper security safeguards, allows access by those responsible for a child's care and facilitates the rapid exchange of information.
- R63. The Department of Children and Families, working with the Agency for Health Care Administration and the Department of Health, should encourage all medical providers to use electronic medical records and provide the technical support for the use of such records.
- R64. The Department of Children and Families, in partnership with the Department of Education and each county school system, should develop and implement procedures to share information regarding treatment, problems, and response for a child in State care in crisis.
- R65. The Department of Children and Families, working with its community partners, should implement a training and quality assurance monitoring plan that addresses sharing of information among those responsible for a child's care and stakeholders.
- R66. The Department of Children and Families should review data in multiple information systems (Florida Safe Families Network, Agency for Health Care Administration, Medicare, and MedConsultLine) on a regular basis to detect anomalies in the number of children receiving psychotropic medications and to ensure accuracy of data across data systems.

Issue: Behavioral Health Care

Coverage of children within the State's foster care system is provided by a number of mental health plans and a number of funding sources, chiefly Medicaid. The Child Welfare Pre-Paid Mental Health Plan (CWPPMHP) covers children in licensed out of home care in most, but not all of the state. Community Mental Health covers children in licensed out of home care in AHCA Areas 1 and 6 (except Hillsborough). A managed care plan covers children in Broward. Children who are not in licensed out of home care (at home under supervision, in relative or non-relative care) are not eligible for the CWPPMHP. Children who move between licensed and unlicensed placements will almost always change therapists. Even within the CWPPMHP, children who move between contracted

residential providers often change therapists as the providers employ the therapists.

Findings:

120. The child welfare system does not maximize outcomes for children when it fails to provide them with consistent therapy provided by persons with whom they have a positive therapeutic relationship.
121. The fragmentation of the existing mental health delivery ensures discontinuity of care when a child's residence changes.
122. Coverage is fragmented among mental health plans.
123. Current mental health coverage does not adequately provide behavioral support to caregivers, a situation frequently due to the lack of available competent and appropriately credentialed providers.
124. Medicaid will not pay for non-cognitive behavioral therapy, including applied behavior analysis, for children with cognitive impairments who are not on a waiver from the Agency for Persons with Disabilities.
125. Children are enrolled and unenrolled in health care plans without the knowledge and participation of caregivers which can cause discontinuity of care. Although the Agency for Health Care Administration permits parents/guardians to select a health plan for their children, the caregivers of children in the child welfare system are not in direct communication with AHCA. Information about plan selection and assignment is frequently not communicated to caregivers by the responsible Community Based Care agency. As a consequence, caregivers do not find out about re-assignment until a service provider declines treatment.
126. Evidence based practices show improved outcomes for caregivers who receive parent training and direct support when caring for children with problem behaviors, yet those services are not routinely offered and are difficult to obtain when requested.
127. Funding for behavioral supports has decreased.
128. Caregivers are able to select health care providers for the children; a change of caregiver may result in change in health care provider.
129. It is important to leave selection of provider to the caregiver; they will most often choose providers that are convenient and they trust, thus enhancing the likelihood that they will obtain care.

130. If children have a "medical home," described by Children's Medical Services (CMS) of the Department of Health as "continual and comprehensive care that is managed and coordinated by a primary health care provider," then their complete record can easily be transferred to a new referral, and caregivers can be required to select providers who meet requirements of providing "medical home" (perhaps using the CMS Network Credentialing Criteria).
131. Current laws, rules, procedures, and practices do not clearly articulate the standard of psychiatric or behavioral health care expected for children in state care.
132. As children move between residential placements their primary care and behavioral health providers often change, impacting the continuity and quality of care.
133. The designation of a health care advocate for each foster child could ensure on-going review, communication, and responsiveness to the medical needs of each child.

Recommendations:

- R67. The Legislature should ensure adequate funding to support mental health needs of children in State care and encourage more active involvement by a prescriber in the therapeutic treatment of children whether or not they are Medicaid eligible.**
- R68. The Department of Children and Families should determine the costs to provide equivalent health and behavioral health care to children who are not Medicaid eligible.**
- R69. The Department of Children and Families, in conjunction with the Department of Health Children's Medical Services, should establish a medical home for all children in the care of the State.**
- R70. The Department of Children and Families, working with its community partners, should ensure that health care advocate positions, staffed by trained medical personnel are attached to case management organizations to assist in facilitating health care for children. Such positions, acting as "informed intermediaries" can also serve as a liaison between the prescribing physician and decision maker to facilitate informed consent in those cases where those parties cannot meet directly.**
- R71. The Department of Children and Families should increase the involvement of its Substance Abuse and Mental Health Program Office in the child welfare system with emphasis on:**

- **Reducing fragmentation of coverage in mental health plans**
- **Integrating Departmental services**
- **Increasing use of evidence-based practices**
- **Improving the involvement of and support for the treatment team, foster parents, and other stakeholders in behavioral health care**

R72. Rather than automatically enroll children in State care into Medicaid HMOs for physical health care, the Department of Children and Families should instead elect "fee for service" or "Medipass" as the default option. The Department, through its lead agencies, should then facilitate a discussion between the Agency for Health Care Administration and the caregivers to determine whether an HMO would be in the child's best interest and require affirmative election of HMO by caregiver/case manager.

R73. The Agency for Health Care Administration should revise its definition of medical necessity as it applies to children to ensure that it is in agreement with the federal definition.

Issue: Individual and Agency Accountability

The care of Florida's foster children demands the accountability of those concerned with ensuring their welfare and protecting their interests. To that end, each participating individual and agency in the child welfare system must clearly understand, commit to, and fulfill their defined role. In particular, agencies throughout the State must accept and exercise their responsibility for the accountability of those in their charge, and the Department of Children and Families must effectively exercise its responsibility for the oversight of those who work within this partner-driven system.

Findings:

134. The responsibilities for the treatment of a foster child are well established in statute and administrative code. However, in application and particularly within local systems of care, the child welfare system lacks a clear delineation of and education on the roles and responsibilities of all those involved in the treatment of a foster child, including the case worker, foster parent, physician, judge, Guardian ad Litem, attorney, and contracted providers.

135. Within the Department of Children and Families, issues related to the mental health of children fall within the responsibilities of both the Office of Family Safety and the Office of Children's Mental Health, with no clear definition of the responsibilities or coordination required of each.

136. The Department of Children and Families lacks a central medical leadership position, such as a Chief Medical Officer, charged with

ensuring coordination of all medical and psychiatric efforts of and decisions by the agency.

137. Regardless of any other areas of personal skills or expertise, it is critical that the case manager be viewed as the subject matter expert on a single item: each child assigned to his/her care.
138. There is a need for enhanced oversight of children in the care of the state by the judiciary assigned to dependency cases.
139. Assigned responsibility, and the subsequent accountability, for ensuring on-going compliance with agreements among agencies (e.g., the Interagency Agreement to Coordinate Services for Children Served by the Florida Child Welfare System) and for action plans resulting from cases such as Rilya Wilson or the Red Item Report, are lacking.
140. Performance measures for the Department of Children and Families and their community-based partners should reflect the core issues related to the use of psychotropic medication to treat Florida's foster children, including compliance with statutory safeguards.
141. Contractual accountability and performance requirements for community-based care agencies and the providers with whom they contract appear to be loosely monitored and enforced by the Department of Children and Families.
142. Administrative requirements placed on those involved in the system with meeting the needs of the child are duplicative, excessive, and often not followed.
143. The contract between DCF and the University of Florida College of Medicine currently does not include mandatory pre-consent authorization review if the psychotropic medication prescribed for children under the age of six is used solely for non-psychotherapeutic purposes.

Recommendations:

- R74. The Department of Children and Families should seek funding for a Chief Medical Officer within the Office of the Assistant Secretary for Substance Abuse and Mental Health, with subsidiary positions in each Region to provide consultation to Community Based Care staff when needed for questions, concerns, or assistance of a medical nature.**
- R75. The Department of Children and Families should clearly articulate the relationship, responsibilities, and coordination required between the Office of Family Safety and Office of Children's Mental Health on issues related to children's mental health.**

- R76. The Department of Children and Families, working with its community partners, must clearly define and fix expectations and responsibilities for treatment and care among those charged with the care of the child, including the case worker, foster parent, physician, judge, Guardian ad Litem, attorney, and contracted providers.**
- R77. The Department of Children and Families, working with its community partners, must clearly define and ensure appropriate training on the roles, responsibilities, and expectations of all persons involved in the child's life and case.**
- R78. The Department of Children and Families, working with its community partners, must clearly develop and utilize management indicators to monitor agency performance in child welfare system**
- R79. The Department of Children and Families, working with its community partners, must clearly define warning signs of crisis indicating when a child is in trouble and identify who is responsible to respond.**
- R80. The Department of Children and Families, working with its community partners, must review rules, policies, and practices to eliminate duplicative requirements for case documentation.**
- R81. The Department of Children and Families must clearly define, continually monitor, and actively enforce contractual accountability and performance requirements for lead agencies and the providers with whom they contract.**
- R82. In order to longitudinally assess the impact of psychotropic medications, the Department of Children and Families should contract for independent research studies to examine the outcomes for former foster youth who were administered psychotropic medication while in state care and to compare those outcomes with children who did not receive psychotropic medications.**
- R83. The Department of Children and Families should regularly compare data on the number of children receiving psychotropic medications on FSFN, AHCA, Medicare, and Med Consult Line information systems for inconsistencies.**
- R84. The Department of Children and Families and its lead agencies should implement quality assurance procedures to monitor effectively actions required by case managers and supervisors. The procedures should be briefed to the Secretary of Children and Families.**

R85. The Department of Children and Families and its lead agencies should maintain an on-going review of all items noted in quality assurance reports to ensure continued compliance with identified deficiencies and recommendations.

R86. The Department of Children and Families, in conjunction with appropriate State and community partners, should develop and promulgate an action plan for the implementation of the recommendations contained in this Report by January 31, 2010. Monitoring of this action plan should occur through both Departmental management and quarterly reports to the Task Force on Fostering Success.

Issue: Implementation of the *Red Item Report on Psychotropic Drug Use in Foster Care*

In its 2003 Report to Governor Jeb Bush, the Statewide Advocacy Council recommended that the State:

- Develop and implement a quality assurance program for monitoring the use of these drugs in children. Such a system would ensure that appropriate attempts at behavior management were implemented and that the prescribing of drugs is a last resort.
- Develop a Plan of Care to include counseling for anger, self-esteem, positive reinforcement, dealing with fear and attitude, and character building traits. Not all foster children will need this counseling but it should be available for those that do.
- Ensure that appropriate standardized written informed consent is obtained prior to starting any child on psychotropic medication. This consent should include information about any risks and expected benefits, including possible side effects and alternative treatments.
- Ensure that everyone who administers psychotropic medications to children in a foster care setting is trained to recognize the side effects of medications.
- Ensure that pediatric psychiatrists perform medical examinations prior to implementation of these drugs. These doctors understand and recognize potential side effects of these drugs when used in children.
- Ensure that foster care records for each child contain organized information and that medical records are easily found.
- Ensure when more than one physician is ordering medications that Medical Passports are current and made available to each physician.

The Statewide Advocacy Council concluded that “It is imperative that the foster care children in the State of Florida receive the necessary medical treatment they need, however, unnecessary dispensing of psychotropic medication remains a threat to them. Until there is more information regarding the safety and efficiency of these drugs, Florida’s foster care children should be monitored closely. The

information in this report should be immediately incorporated into an agenda in order to preserve and protect the health, safety, welfare and rights of children in foster care.”

Findings:

144. These recommendations offer a common sense approach to ensuring that children in the care of the state will have adequate assessment for any treatment needs and have access to a wide array of treatments. Everyone involved in the care of these children has a responsibility for their safety. If any treatment is necessary, including medication, it must be closely monitored for safety and effectiveness.
145. While the Department of Children and Families began implementation of some of these recommendations, their practice has not been institutionalized into the policies, procedures, or performance of the agency or its community-based partners.

Recommendation:

R87. The Department of Children and Families should immediately implement and institutionalize the recommendations from the *Red Item Report on Psychotropic Drug Use in Foster Care*.

Issue: Ensuring Best Practices

In a presentation before the Gabriel Myers Work Group, Dr. Christopher Bellonci offered a number of principles necessary to ensure best practices in screening, assessment, and treatment of mental health issues in child welfare:

Principle 1: In establishing informed consent, information must be given to the child, youth, family (bio-parent, foster parent, or caregiver), and the caseworker/state-assigned decision maker about the treatment options (both medication and non-medication options), the risks/side effects and benefits of the medication, the targeted symptoms, and the course of treatment.

Principle 2: The child welfare agency must document (for example, in the medical passport) the medications the child or youth is taking, the child’s or youth’s response to the medications, risks/side effects and benefits of the medications, and the time-frames for the elicited response. This documentation will follow the child or youth throughout his or her stay in care.

Principle 3: The prescriber should have ongoing communication with the child and caregiver to monitor treatment response and side-effects on a continuing basis, and discuss with the child adherence to medications and any medication changes in the context of an engaged collaborative therapeutic relationship.

Principle 4: Recognized clinical rating scales or other measures should be used to quantify the response of the child’s target symptoms to treatment and the progress

made toward treatment goals. In the initial phase of treatment (during the initial three months on a particular medication or regiment), visits should take place on at least a monthly basis, or more frequently if the child's condition is unstable or worsening.

Principle 5: Caseworkers will know or have training on:

- child and adolescent development
- neuro-developmental effects of prenatal substance exposure
- common mental health disorders in the child welfare population
- effective treatment options for these mental health disorders

Principle 6: Youth and families should be provided ongoing information on the diagnosed mental health disorder, effective treatment options, and managing life with the condition, including:

- what to expect in the future
- how severe the condition is
- can the youth not take medication in the future
- what can be done instead of medication
- how to access help in the future

Principle 7: The agency should ensure transition planning in advance of youth leaving care that includes identification of providers and source of payment for treatment.

Principle 8: The child welfare agency should encourage, support, and monitor the mental health needs and access to psychotherapeutic medications and other mental health services for birth families.

Principle 9: The agency should periodically conduct reviews of patterns of psychotherapeutic medication use within its caseload, on an aggregate- and provider-specific basis, and take necessary action in response to findings of such reviews.

Findings:

146. Principles such as those listed above should be accepted and clearly articulated as necessary and appropriate for the treatment of children within Florida's child welfare system.
147. The training reflected in Principle 5 should be extended to all participants in the child welfare system.

Recommendations:

- R88. As previously noted in this Report, all decision making should be guided by the principle that it is important to comprehensively address all the concerns in a child's life--health, education, and social/emotional issues--as well as to provide behavioral supports and**

parent training, so that a child's behavioral and mental health issues can be addressed in the least restrictive setting and in the context of a comprehensive treatment plan.

- R89. In any legislation arising from this Report, the Legislature should utilize these guiding principles as the statement of legislative intent and expected standards of care for children in the care of the state.**
- R90. The Department of Children and Families should ensure that all rules and policies articulate clearly the standards of psychiatric or behavioral health care expected for children in the care of the state and that practices at all levels of the child welfare system meet these standards.**

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

10-18-11

Date

Bill Number

Name Jamie Self

Phone 850 488 8762

Address 1317 Winewood Blvd

E-mail jamie-self@dcf.state.fl.us

Street

32394

Job Title Director

City

State

Zip

Speaking: For Against Information

Appearing at request of Chair

Subject Psychotropic Meds

Representing D.C.F.

Lobbyist registered with Legislature: Yes No

Pursuant to s. 11.061, Florida Statutes, state, state university, or community college employees are required to file the first copy of this form with the Committee, unless appearance has been requested by the Chair as a witness or for informational purposes.

If designated employee: Time: from .m. to .m.

S-001 (08/2005)

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

Oct. 18, 2011

Date

Bill Number

Barcode

Name Dr. Anderson

Phone 850-410-1097

Address

E-mail Phyllis.Anderson@dij.state.fl.us

Street

Job Title DHA - 3 - Sites

City

State

Zip

Falkenberg, Les Petes, bmf

Speaking: For Against Information

Appearing at request of Chair

Subject

Representing DSS Foster Youth on Psychotropic Drugs

Lobbyist registered with Legislature: Yes No

Pursuant to s. 11.061, Florida Statutes, state, state university, or community college employees are required to file the first copy of this form with the Committee, unless appearance has been requested by the Chair as a witness or for informational purposes.

If designated employee: Time: from .m. to .m.

S-001 (04/14/10)

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

Oct. 18, 2011 Date

Bill Number

Barcode

Name Ana Maria Sanchez
Address 2737 Centerview Dr. Tallahassee FL 32399

Phone 850-241-1097
E-mail anamon@sanchez@dij.state.fl.us
Job Title LAD

Speaking: [] For [] Against [X] Information
Subject ISS Foster youth on psychotropic Drugs
Representing ISS

Appearing at request of Chair [X]

Lobbyist registered with Legislature: [X] Yes [] No

Pursuant to s. 11.061, Florida Statutes, state, state university, or community college employees are required to file the first copy of this form with the Committee, unless appearance has been requested by the Chair as a witness or for informational purposes.
If designated employee: Time: from .m. to .m.

S-001 (04/14/10)

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

10/18/11 Date

Bill Number

Barcode

Name Gayla Sumter
Address 2737 Centerview Dr. Tallahassee FL 32399

Phone 850-
E-mail gayla.sumter@dij.state.fl.us
Job Title Director of Mental Health and Substance Abuse Services

Speaking: [] For [] Against [X] Information
Subject
Representing

Appearing at request of Chair [X]

Lobbyist registered with Legislature: [] Yes [X] No

Pursuant to s. 11.061, Florida Statutes, state, state university, or community college employees are required to file the first copy of this form with the Committee, unless appearance has been requested by the Chair as a witness or for informational purposes.
If designated employee: Time: from .m. to .m.

S-001 (04/14/10)

CourtSmart Tag Report

Room: SB 401
Caption: Senate Children, Families, and Elder Affairs Committee

Case:

Type:
Judge:

Started: 10/18/2011 10:51:44 AM
Ends: 10/18/2011 12:39:36 PM **Length:** 01:47:53

10:51:46 AM Roll Call
10:52:00 AM Senator Storms opening remarks
10:54:05 AM Claude Hendon, Staff Director, Subcommittee on Health and Human Services Appropriations Interim Project 2012-109, Crisis Stabilization Units
10:55:02 AM Senator Storms comments
10:55:37 AM Claude Hendon, Staff Director, Subcommittee on Health and Human Services Appropriations Interim Project 2012-109, Crisis Stabilization Units continued
11:00:53 AM Senator Storms remarks
11:00:59 AM Senator Dockery questions
11:01:10 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:01:12 AM Senator Dockery question
11:01:30 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:01:49 AM Senator Storms question
11:01:58 AM Senator Detert remarks
11:02:18 AM Senator Dockery question
11:02:37 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:02:46 AM Senator Dockery question
11:02:51 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:03:01 AM Senator Storms question
11:03:18 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:03:45 AM Senator Storms question
11:03:52 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:03:58 AM Senator Storms remarks
11:04:25 AM Senator Detert question
11:04:34 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:04:52 AM Senator Rich question
11:05:00 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:05:08 AM Senator Rich question
11:05:13 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:05:22 AM Senator Rich question
11:05:27 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:05:36 AM Senator-Elect Audrey Gibson question
11:06:05 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:06:37 AM Senator-Elect Audrey Gibson question
11:06:47 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:07:20 AM Senator Storms questions
11:09:14 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:09:23 AM Senator Storms remarks
11:09:59 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:10:04 AM Senator Storms questions
11:11:07 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:12:03 AM Senator Storms remarks and question
11:12:38 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:12:58 AM Senator Storms question
11:13:37 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:13:47 AM Senator Storms comments
11:14:47 AM Claude Hendon, Staff Director HHS Subcommittee, comments
11:15:28 AM Senator Storms remarks
11:16:01 AM Claude Hendon, Staff Director HHS Subcommittee, response
11:16:22 AM Senator Storms comments and question
11:16:54 AM Senator Rich comments
11:17:08 AM Senator Storms comments

11:17:27 AM Claude Hendon, Staff Director, Subcommittee on Health and Human Services Appropriations Interim Project 2012-108, Forensic Mental Health System

11:22:23 AM Senator Rich question

11:22:52 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:22:55 AM Senator Rich remarks

11:23:02 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:23:16 AM Senator Storms remarks

11:23:25 AM Senator Rich comments

11:23:47 AM David Sofferin, Assistant Secretary for Substance Abuse and Mental Health, Department of Children and Families

11:25:30 AM Senator Storms comments and question

11:26:49 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:27:37 AM Senator Storms remarks and question

11:28:58 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:29:24 AM Senator Storms question

11:29:48 AM Drucilla Carpenter, Senior Legislative Analyst OPPAGA, response

11:29:54 AM Senator Storms question

11:29:59 AM Drucilla Carpenter, OPPAGA, response

11:30:08 AM Senator Storms question

11:30:12 AM Drucilla Carpenter, OPPAGA, response

11:30:14 AM Senator Storms question

11:30:29 AM Drucilla Carpenter, OPPAGA, response

11:30:41 AM Senator Storms comments

11:31:31 AM Drucilla Carpenter, OPPAGA, response

11:31:45 AM Senator Storms remarks and question

11:32:30 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:33:02 AM Senator Storms remarks and question

11:33:31 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:34:20 AM Senator-Elect Audrey Gibson question

11:34:52 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:35:24 AM Senator-Elect Audrey Gibson question

11:36:00 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:36:25 AM Senator-Elect Audrey Gibson comment

11:36:29 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:36:56 AM Senator-Elect Audrey Gibson remarks

11:37:05 AM Senator Storms comments

11:38:30 AM Claude Hendon, Staff Director HHS Subcommittee, response

11:38:39 AM Senator Storms comments

11:40:21 AM Karen Koch, Florida Council for Behavioral Healthcare, remarks

11:41:46 AM Senator Storms question

11:42:04 AM Karen Koch, Florida Council for Behavioral Healthcare, response

11:47:52 AM Senator Storms question

11:47:57 AM Karen Koch, Florida Council for Behavioral Healthcare, response

11:48:37 AM Senator Storms comment

11:48:45 AM Dan Hendrickson, Assistant Public Defender, Florida Public Defender's Association, remarks

11:55:34 AM Doug Martin, Legislative Director AFSCME Florida Council 79, remarks

12:00:10 PM Senator Storms question

12:00:15 PM Doug Martin, Legislative Director AFSCME Florida Council 79, response

12:00:19 PM Senator Storms question

12:00:21 PM Doug Martin, Legislative Director AFSCME Florida Council 79, response

12:00:25 PM Senator Storms question

12:00:31 PM Doug Martin, Legislative Director AFSCME Florida Council 79, response

12:00:43 PM Senator Storms question

12:00:55 PM Doug Martin, Legislative Director AFSCME Florida Council 79, response

12:01:12 PM Senator Latvala question

12:01:37 PM Doug Martin, Legislative Director AFSCME Florida Council 79, response

12:01:40 PM Senator Latvala question

12:01:44 PM Doug Martin, Legislative Director AFSCME Florida Council 79, response

12:01:52 PM Senator Latvala question

12:02:02 PM Claude Hendon, Staff Director HHS Subcommittee, response

12:02:34 PM Senator Latvala remark

12:02:42 PM Senator Rich remarks

12:03:34 PM Senator Storms remarks
12:07:11 PM Jamie Self, Executive Director of DCF Family and Community Services, Psychotropic Medications
12:08:24 PM Senator Storms question
12:08:30 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:08:36 PM Senator Storms remarks
12:09:13 PM Senator Latvala question
12:09:28 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:09:43 PM Senator Latvala question
12:09:47 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:10:19 PM Senator Storms question
12:10:22 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:10:28 PM Senator Storms remarks
12:10:41 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:11:15 PM Senator Storms question
12:11:26 PM Senator-Elect Audrey Gibson remarks
12:11:36 PM Senator Storms remarks
12:12:42 PM Jamie Self, Executive Director of DCF Family and Community Services, continued remarks
12:17:18 PM Senator Dockery question
12:17:31 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:18:15 PM Senator Dockery question
12:18:21 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:18:32 PM Senator Dockery question
12:18:41 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:19:25 PM Senator Dockery question
12:19:34 PM Senator Storms remarks
12:20:41 PM Senator Dockery question
12:20:51 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:21:02 PM Senator Dockery remarks
12:21:09 PM Jamie Self, Executive Director of DCF Family and Community Services, response
12:21:31 PM Phyllis Anderson, M.D. Designated Health Authority Department of Juvenile Justice, remarks
12:22:27 PM Senator Storms remarks
12:22:34 PM Phyllis Anderson, M.D. Designated Health Authority Department of Juvenile Justice, response
12:22:38 PM Senator Storms questions
12:22:53 PM Phyllis Anderson, M.D. Designated Health Authority Department of Juvenile Justice, response
12:23:12 PM Senator Storms remarks and question
12:23:26 PM Phyllis Anderson, M.D. Designated Health Authority Department of Juvenile Justice, response
12:24:04 PM Senator Storms questions
12:24:14 PM Phyllis Anderson, M.D. Designated Health Authority Department of Juvenile Justice, response
12:24:26 PM Senator Storms remarks
12:24:38 PM Phyllis Anderson, M.D. Designated Health Authority Department of Juvenile Justice, response
12:25:42 PM Senator Storms remarks and question
12:26:35 PM Ana Maria Sanchez, Legislative Affairs Director Department of Juvenile Justice, response
12:27:18 PM Senator Storms questions
12:27:28 PM Ana Maria Sanchez, Legislative Affairs Director Department of Juvenile Justice, response
12:27:57 PM Senator Storms remarks
12:28:07 PM Phyllis Anderson, M.D. Designated Health Authority Department of Juvenile Justice, continued remarks
12:29:10 PM Gayla Sumner, Director of Mental Health and Substance Abuse Services Department of Juvenile Justice, remarks
12:30:20 PM Senator Storms remarks
12:30:45 PM Senator-Elect Audrey Gibson question
12:30:58 PM Gayla Sumner, Director of Mental Health and Substance Abuse Services Department of Juvenile Justice, response
12:31:09 PM Senator-Elect Audrey Gibson question
12:31:30 PM Gayla Sumner, Director of Mental Health and Substance Abuse Services Department of Juvenile Justice, response
12:33:27 PM Senator Storms question
12:34:36 PM Gayla Sumner, Director of Mental Health and Substance Abuse Services Department of Juvenile Justice, response
12:34:45 PM Senator Storms question
12:34:54 PM Gayla Sumner, Director of Mental Health and Substance Abuse Services Department of Juvenile Justice, response
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12:37:27 PM Gayla Sumner, Director of Mental Health and Substance Abuse Services Department of Juvenile Justice, response
12:39:14 PM Senator Latvala remarks
12:39:23 PM Senator Storms remarks
12:39:31 PM Adjourn