Tab 1	**SB 230** by **Dean**; (Identical to H 0011) Missing Persons with Special Needs

Tab 4	**SPB 7018** by **CF**; Child Welfare					
184684	A	S	FAV	CF, Detert	btw L.102 - 103:	10/22 03:11 PM
917038	A	S	FAV	CF, Detert	btw L.258 - 259:	10/22 03:11 PM
206734	A	S	FAV	CF, Detert	Delete L.276 - 373:	10/22 03:11 PM
385888	A	S	FAV	CF, Detert	Delete L.398 - 400:	10/22 03:11 PM
255158	A	S	FAV	CF, Detert	Delete L.445 - 451:	10/22 03:11 PM
304418	A	S	FAV	CF, Detert	Delete L.471:	10/22 03:11 PM
612830	A	S	FAV	CF, Detert	Delete L.532 - 562:	10/22 03:11 PM
691122	A	S	FAV	CF, Detert	Delete L.677 - 716:	10/22 03:11 PM
287242	A	S	FAV	CF, Detert	btw L.855 - 856:	10/22 03:11 PM
903328	A	S	FAV	CF, Detert	Delete L.874:	10/22 03:11 PM
615066	A	S	FAV	CF, Detert	Delete L.927 - 936:	10/22 03:11 PM
792830	A	S	FAV	CF, Detert	Delete L.1010 - 1043:	10/22 03:11 PM
868866	A	S	FAV	CF, Detert	Delete L.1096:	10/22 03:11 PM
208674	A	S	FAV	CF, Detert	Delete L.1129 - 1146:	10/22 03:11 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Sobel, Chair
Senator Altman, Vice Chair

MEETING DATE: Thursday, October 22, 2015
TIME: 12:30—2:30 p.m.
PLACE: 301 Senate Office Building

MEMBERS: Senator Sobel, Chair; Senator Altman, Vice Chair; Senators Dean, Detert, Garcia, Hutson, and Ring

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 230** Dean (Identical H 11)	Missing Persons with Special Needs; Creating a pilot project in specified counties to provide personal devices to aid search-and-rescue efforts for persons with special needs; providing for administration of the project; requiring reports; providing for expiration; providing an appropriation, etc. CJ 10/05/2015 Favorable CF 10/22/2015 Favorable AP	Favorable Yeas 6 Nays 0
2	Report on Child Welfare - Megan Smernoff, Legislative Policy Analyst, OPPAGA		Not Considered
3	Quality Standards for Group Care - Ken Bender, Executive Director, Boys Town North Florida		Not Considered
	Consideration of proposed bill:		
4	**SPB 7018**	Child Welfare; Revising information that the Department of Children and Families is required to inform the court of at shelter hearings; revising the required information a court must include in its written orders of disposition; requiring a case plan to document that a preplacement plan has been provided and reasonable efforts to prevent out-of-home placement have been made, etc.	Submitted as Committee Bill Yeas 5 Nays 0
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 230
INTRODUCER:	Senator Dean
SUBJECT:	Missing Persons with Special Needs
DATE:	October 21, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Erickson	Cannon	CJ	**Favorable**
2.	Preston	Hendon	CF	**Favorable**
3.			AP	

I. Summary:

SB 230 creates the "Project Leo" pilot project in Baker, Columbia, Hamilton, and Suwanee counties to provide personal devices to aid search-and-rescue efforts for persons with special needs in the case of elopement.

The project is developed and administered by the Center for Autism and Related Disabilities at the University of Florida ("CARD/UF"). The bill directs the CARD/UF to develop criteria for selecting project participants. The CARD/UF selects qualifying participants on a first-come, first-served basis to the extent that funding is available. The project is voluntary and free to participants. The CARD/UF distributes the personal devices to the sheriff's offices of the participating counties. The CARD/UF funds any device monitoring costs.

The CARD/UF submits preliminary and final reports to the Governor, the Speaker of the House of Representatives, and the President of the Senate. The final report must include recommendations for modifications or continued implementation of the project.

The bill appropriates $100,000 from the General Revenue Fund to the CARD/UF for FY 2016-2017 for the purpose of implementing this act.

II. Present Situation:

Elopement of Individuals with Special Needs

Elopement, also referred to as wandering, is a safety issue that affects some individuals with disabilities, their families, and the community. Wandering is when someone leaves a safe area or

a responsible caregiver. This typically includes situations where the person may be injured or harmed as a result.[1]

Elopement and Wandering of Individuals with Autism

Elopement in children with autism might include running off from adults at school or in the community, leaving the classroom without permission, or leaving the house when the family is not looking. This behavior is considered common and short-lived in toddlers, but it may persist or re-emerge in children and adults with autism. Children with autism have challenges with social and communication skills and safety awareness. This makes wandering a potentially dangerous behavior.[2]

There are various reasons someone with autism may wander; more often than not, he or she will wander to something of interest (especially bodies of water) or away from something that is bothersome or stressful (such as uncomfortable noise or bright lights).[3]

Approximately 50 percent of children with autism have a tendency to wander or elope.[4] Families report that about half of those children who have a tendency to wander succeeded and went missing long enough to cause serious concern. A substantial portion of those children who wander are at risk for bodily harm.[5] Of those children who went missing, 24 percent were in danger of drowning and 65 percent were in danger of traffic injury.[6]

Elopement and Wandering of Individuals with Alzheimer's Disease

Wandering and elopement can also be dangerous for individuals with Alzheimer's disease and other forms of dementia. The individual may not remember his or her name or address in order to assist rescuers. They can become disoriented even in familiar places. An individual with Alzheimer's disease who wanders or elopes is most often looking for someone or something familiar, escaping a source of stress of anxiety, or may be reliving the past.[7]

Statistics indicate that in the U.S., more than 34,000 individuals with Alzheimer's disease wander out of their homes or care facilities each year.[8] Six in 10 people with some type of

---

[1] "Wandering (Elopement)," Centers for Disease Control and Prevention, available at http://www.cdc.gov/ncbddd/disabilityandsafety/wandering.html (last viewed on September 23, 2015).
[2] Information provided by the AWAARE Collaboration, available at http://awaare.nationalautismassociation.org/ (last viewed on September 23, 2015).
[3] "Why is My Child Eloping and What Can I Do?", Autism Community, available at http://www.autism-community.com/why-is-my-child-eloping-and-what-can-i-do/ (last viewed on September 23, 2015).
[4] Michelle Diament, "Autism Wandering Poses 'Critical Safety Issue,' Survey Suggests," *Autism Wandering Poses "Critical* (April 21, 2011), disability scoop, available at http://www.disabilityscoop.com/2011/04/21/autism-wandering-survey/12953/ (last viewed on September 23, 2015).
[5] Connie Anderston, et al., "Occurrence and Family Impact of Elopement in Children With Autism Spectrum Disorders," *PEDIATRICS* (October 8, 2012), available at http://pediatrics.aappublications.org/content/early/2012/10/02/peds.2012-0762.full.pdf+html (last viewed on September 23, 2015).
[6] *Id.*
[7] "Alzheimer's: Understand wandering and how to address it," Mayo Clinic, available at http://www.mayoclinic.org/healthy-living/caregivers/in-depth/alzheimers/art-20046222 (last viewed on September 23, 2015).
[8] "Wandering and Elopement Resources," National Council of Certified Dementia Practitioners, available at http://www.nccdp.org/wandering.htm (last viewed on September 23, 2015).

dementia will wander or elope;[9] additionally, it is estimated that 11-24 percent of institutionalized dementia patients wander.[10]

Anti-wandering and GPS tracking devices can be worn as a bracelet, attached to an individual's shoe or belt loop or even sewn into clothing. In the event that an individual goes missing, a caregiver can utilize products and services from the monitoring company for the device to pinpoint the wearer's location. There are a number of anti-wandering and GPS tracking devices on the market that can aid in search and rescue for individuals with special needs who are prone to wander. Two examples are the Protect and Locate (PAL) tracking system through Project Lifesaver and the Amber Alert GPS.

- The PAL is a tracking device that is worn as a watch by the individual at risk of wandering and has a companion portable receiver which notifies the caregiver of a wandering event. Through the use of cell ID location and GPS technologies, it provides the location of a wearer accurate to nine feet.[11] If an individual wearing a PAL device wanders outside of a set perimeter, the caregiver's receiver will receive an alert and the caregiver will receive an email alert and the device will send a text message with the date and location of the wandering event.[12]

  Additionally, a caregiver can press the "find" button on his or her receiver to have the location of the individual and the address displayed on the portable receiver. If the individual wearing the PAL watch/transmitter is lost, he or she can push the panic button on the PAL watch to have the current address shown on the caregiver's portable receiver.[13] The PAL tracking system costs $249.99 per unit and requires a monitoring/service plan of $29.95 per month.[14]

- The Amber Alert GPS is a small disk that can be put in an individual's purse or backpack or, with the purchase of an accessory, can be attached to the individual. The Amber Alert GPS syncs with an online tracking portal and mobile application for iPhone, Blackberry, and Droid cellular phones to provide the real-time location of the wearer.[15] It allows the caregiver to designate up to 20 "safe zones" and receive an alert each time a wearer leaves one of the designated safe zones. It also has a two-way voice feature to allow the caregiver and wearer to talk to each other through the device and an SOS button that the wearer can push in the event of an emergency to notify the caregiver and up to ten additional individuals.[16] Amber Alert GPS costs $145 per unit and requires a monitoring/service plan of $15-18 per month.[17]

---

[9] "Wandering and Getting Lost," Alzheimer's Association, available at http://www.alz.org/care/alzheimers-dementia-wandering.asp (last viewed on September 23, 2015).
[10] See footnote 8.
[11] Information about PAL (Protect And Locate) Tracking System is available from Project Lifesaver at http://www.projectlifesaver.org/Pal-info/ (last viewed on September 23, 2015).
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] Information about the Amber Alert GPS Smart Locator is available from Amber Alert GPS at https://www.amberalertgps.com/products (last viewed on September 23, 2015).
[16] *Id.*
[17] *Id.*

Center for Autism and Related Disabilities

The Center for Autism and Related Disabilities (CARD/UF) works with families, caregivers, and professionals to optimize the potential of people with autism and related disabilities. The CARD/UF serves children and adults of all levels of intellectual functioning who have autism, autistic-like disabilities, pervasive developmental disorder, dual sensory impairments (hearing and vision impaired), or a vision or hearing loss with another disabling condition.[18] There are seven non-residential CARD centers across the state and the CARD/UF serves fourteen counties in North Central Florida.[19]

III. Effect of Proposed Changes:

The bill creates s. 937.041, F.S., which creates the "Project Leo" pilot in Baker, Columbia, Hamilton, and Suwanee counties to provide personal devices to aid search-and-rescue efforts for persons with special needs in the case of elopement. The project is developed and administered by the CARD/UF.

The CARD/UF selects project participants based on criteria it develops, which must include, at a minimum, the individual's risk of elopement. Participants are selected on a first-come, first-serve basis. The number of participants is determined based on available funding within the center's existing resources.

Participation in the project is voluntary and free. Participants are provided a personal device to aid search and rescue efforts. This device is attachable to clothing or otherwise wearable. The CARD/UF distributes the personal devices to the sheriff's offices of the participating counties. The CARD/UF funds any device monitoring costs.

The CARD/UF submits preliminary and final reports to the Governor, the Speaker of the House of Representatives, and the President of the Senate. Both reports must include all of the following:

- The criteria used to select the participants.
- The number of participants.
- The age of the participants.
- The nature of the participants' special needs.
- The number of participants who elope.
- The amount of time taken to rescue a participant following elopement.
- The outcome of any rescue attempts.

Additionally, the final report must include recommendations for modifications or continued implementation of the project. The project operates to the extent of available funding within the center's existing resources. Since the bill provides that s. 937.041, F.S., expires on June 30, 2018, the project effectively ends on that date.

[18] "About CARD FAQ," Center for Autism and Related Disabilities, University of Florida, available at http://card.ufl.edu/about-card/faq/ (last viewed on September 23, 2015).
[19] *Id*. The counties served by the CARD/UF are Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Levy, Marion, Putnam, Suwannee, and Union.

The bill appropriates $100,000 from the General Revenue Fund to the CARD/UF for FY 2016-2017 for the purpose of implementing this act.

The effective date of the bill is July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The number of participants is determined based on available funding within the existing resources of the CARD/UF. The CARD/UF distributes the personal devices to the sheriff's offices of the participating counties. The CARD/UF funds any device monitoring costs.

The bill provides $100,000 from the General Revenue Fund to the CARD/UF for the purpose of implementing this act.

The Board of Governors states that there is no determinable fiscal impact to the state universities from the bill and the bill has no fiscal impact on the Board of Governors office.[20]

[20] 2016 Legislative Bill Analysis (SB 230) (September 9, 2015), State University System of Florida Board of Governors (on file with the Senate Committee on Criminal Justice).

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 937.041 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Dean

5-00275A-16 2016230__

A bill to be entitled

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

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

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

937.041 Missing persons with special needs pilot project.—

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

(2) Participants for the pilot project shall be selected based on criteria developed by the Center for Autism and Related Disabilities at the University of Florida. Criteria for participation shall include, at a minimum, the person's risk of elopement. The qualifying participants shall be selected on a first-come, first-served basis by the center to the extent of available funding within the center's existing resources. The project shall be voluntary and free to participants.

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

(4) The center shall submit a preliminary report by December 1, 2016, and a final report by December 15, 2017, to the Governor, the President of the Senate, and the Speaker of the House of Representatives describing the implementation and operation of the pilot project. At a minimum, the report shall include the criteria used to select participants, the number of participants, the age of the participants, the nature of the participants' special needs, the number of participants who elope, the amount of time taken to rescue such participants following elopement, and the outcome of any rescue attempts. The final report shall also provide recommendations for modification or continued implementation of the project.

(5) The project shall operate to the extent of available funding within the center's existing resources.

(6) This section expires June 30, 2018.

Section 2. For the 2016-2017 fiscal year, the sum of $100,000 is appropriated from the General Revenue Fund to the Center for Autism and Related Disabilities at the University of Florida for the purpose of implementing this act.

Section 3. This act shall take effect July 1, 2016.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

✓ For

10-22-2015
Meeting Date

SB 0230
Bill Number (if applicable)

Topic Rescue Devices

Amendment Barcode (if applicable)

Name Michael Daniels

Job Title Executive Director

Address 3333 N Pensacola Street
Street

Tallahassee FL 32304
City *State* *Zip*

Phone 850-766-2732

Email mdaniels@faast.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FAAST

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

No show

THE FLORIDA SENATE

APPEARANCE RECORD

Against

10/22/2015
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

230
Bill Number (if applicable)

Topic Missing Persons with Special Needs

Amendment Barcode (if applicable)

Name Kassiane Sibley

Job Title Forensic discourse assistant

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Parenting Autistic Children with Love & Acceptance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Against

22 Oct 2015
Meeting Date

230
Bill Number (if applicable)

Topic Missing Persons with Special Needs

Amendment Barcode (if applicable)

Name Max Harmony

Job Title

Address 726 W 10th Ave
Street

Phone

Tallahassee FL 32303
City *State* *Zip*

Email

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

Waive In Support

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Oct. 22, 2015
Meeting Date

SB 230
Bill Number (if applicable)

Topic Missing Persons with Special Needs

Amendment Barcode (if applicable)

Name Dixie Samson

Job Title Lobbyist

Address PO Box 98
Street

Phone 321-543-7195

Cocoa FL 32923-0098
City *State* *Zip*

Email dixiesamson@bellsouth.net

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The Arc of Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

Waive In-Support

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

10/22/15
Meeting Date

SB 230
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Missing Persons

Name Ms. Zayne Smith

Job Title Associate State Director

Address 200 W. College Ave
Street

Tally FL 32301
City *State* *Zip*

Phone 850 228-9243

Email ZSmith@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AARP Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

MLD

Meeting Date

230
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Brian Pitts

Job Title Trustee

Address 1119 Newton Ave S
Street

Phone 727/897-9291

St. Petersburg FL 33705
City State Zip

Email justice2jesus@yahoo.com

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Justice-2-Jesus

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SB 230
FINAL ACTION: Favorable
MEETING DATE: Thursday, October 22, 2015
TIME: 12:30—2:30 p.m.
PLACE: 301 Senate Office Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Dean						
X		Detert						
X		Garcia						
X		Hutson						
		Ring						
X		Altman, VICE CHAIR						
X		Sobel, CHAIR						
6	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

Florida's Child Welfare System: Out-of-Home Care

A Presentation to the Senate Committee on Children, Families, and Elder Affairs

Megan Smernoff
Senior Legislative Analyst

October 22, 2015

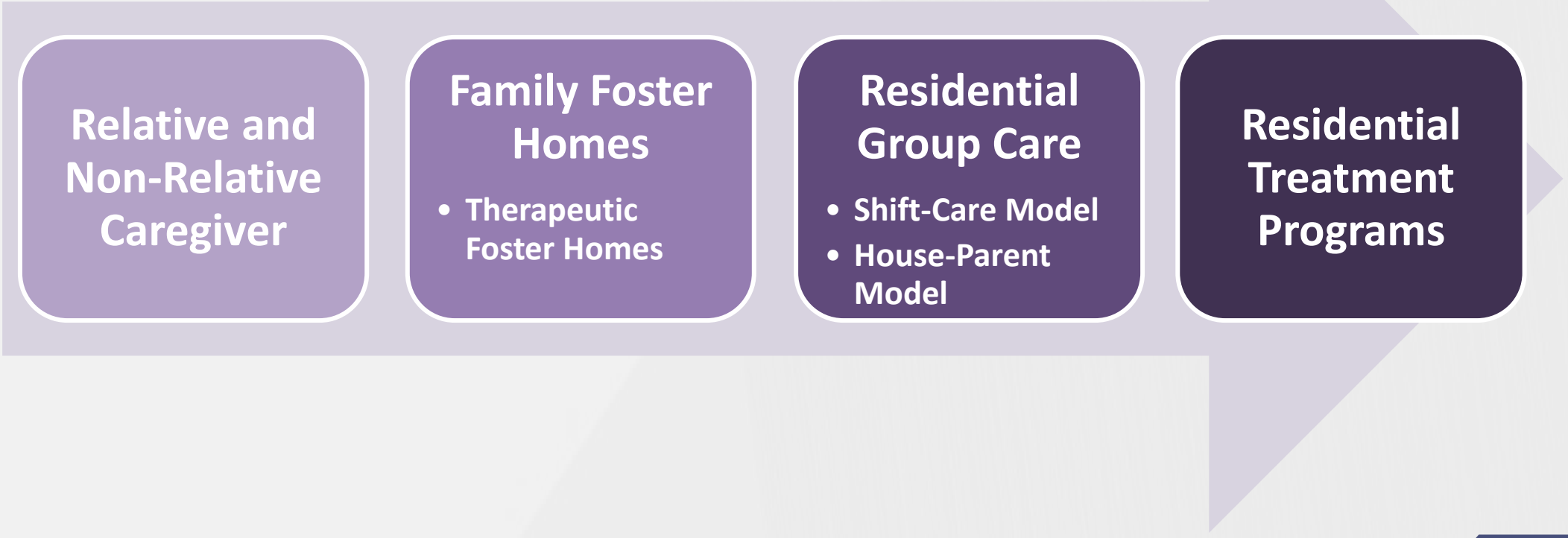
Florida's Child Welfare System

- Continuum of out-of-home care placements
- Process for determining placements
- Foster parent recruitment, training, and supports

Continuum of Out-of-Home Care

What is the Continuum of Placements for Children in Out-of-Home Care?

- Legislative intent is that children are placed in the least restrictive environment



Foster Home and Group Care Services

- Foster homes and group care must ensure safe and nurturing environments that foster healthy development
- Group care must provide or ensure access to a minimum range of activities and services

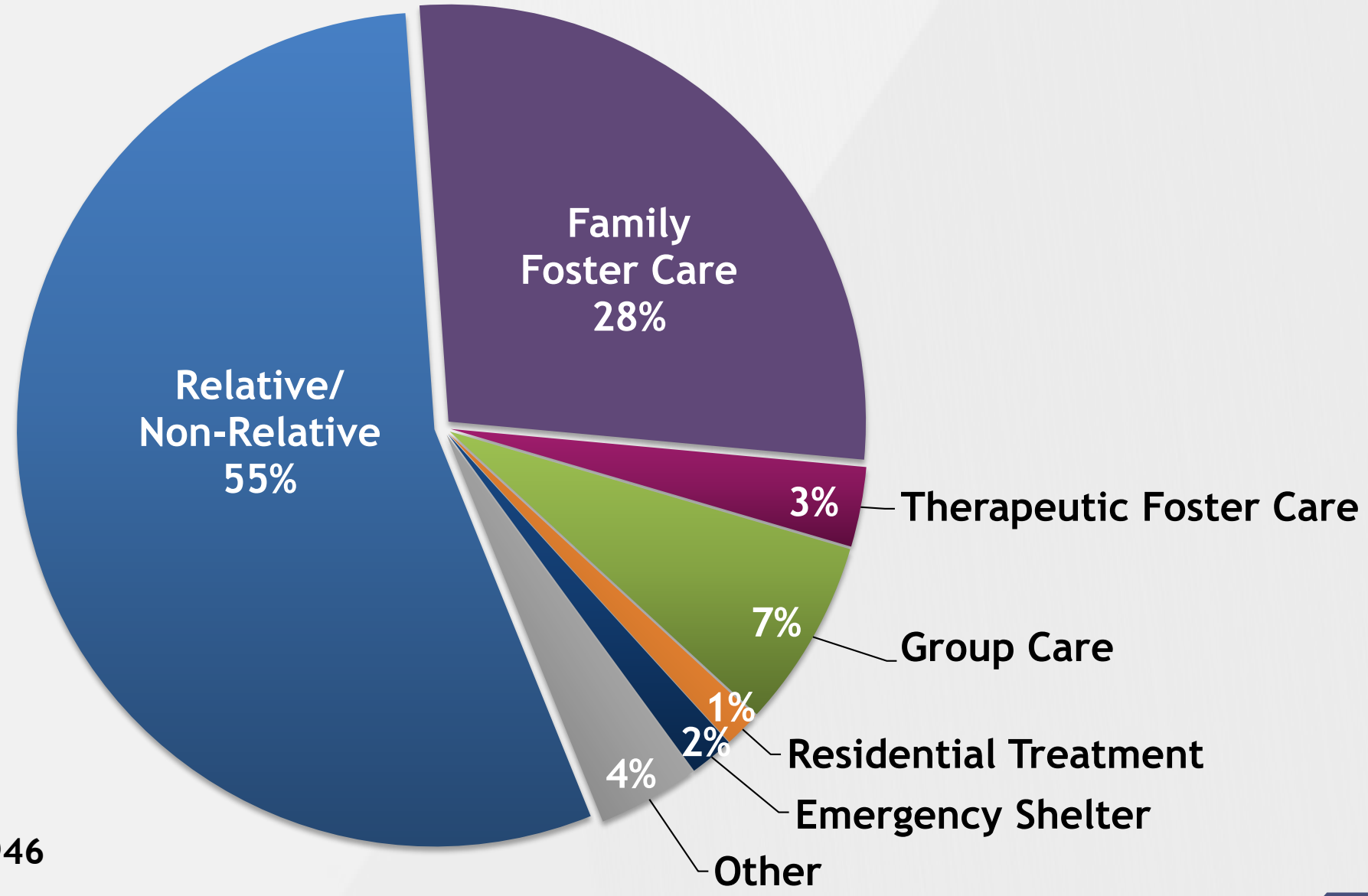
Group Care Activities and Services

- Recreation and leisure activities
- Cultural enrichment
- Transportation
- Medical and dental care
- Work activities
- Clothing and hygiene items
- Behavioral management program
- Assessments and service plans
- Educational services
- Budget training
- Life skills training

Foster Home and Group Care Costs

- Foster parents receive an average per diem of $15
- Group care average per diem rates (FY 2013-14)
  - Shift-care model $124
  - House-parent model $97
- CBCs annually negotiate rates and consider several factors
  - E.g., bed capacity, private funding, staff:client ratios, and special needs and services

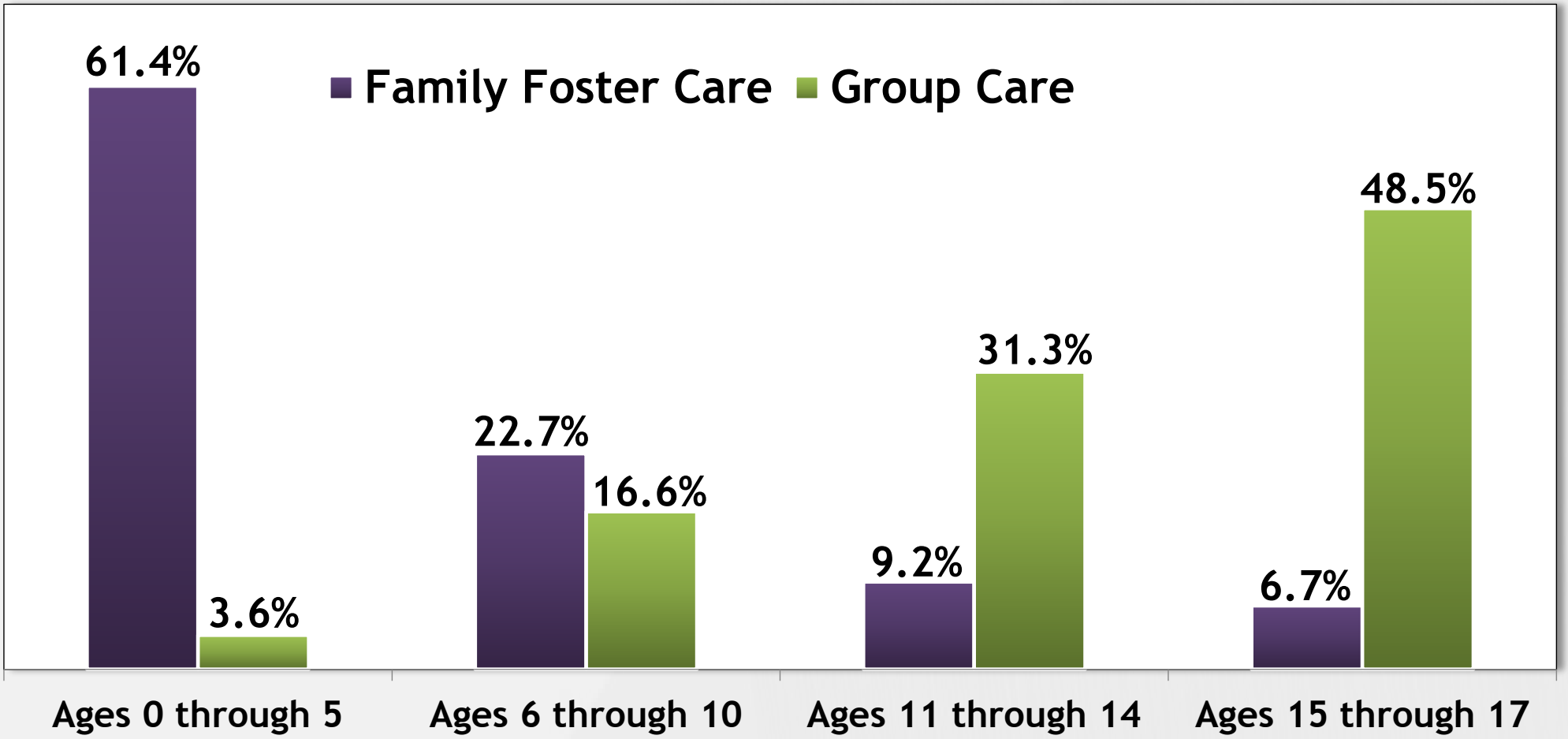
On June 1, 2015, There Were 21,946 Children in Out-of-Home Care



N = 21,946

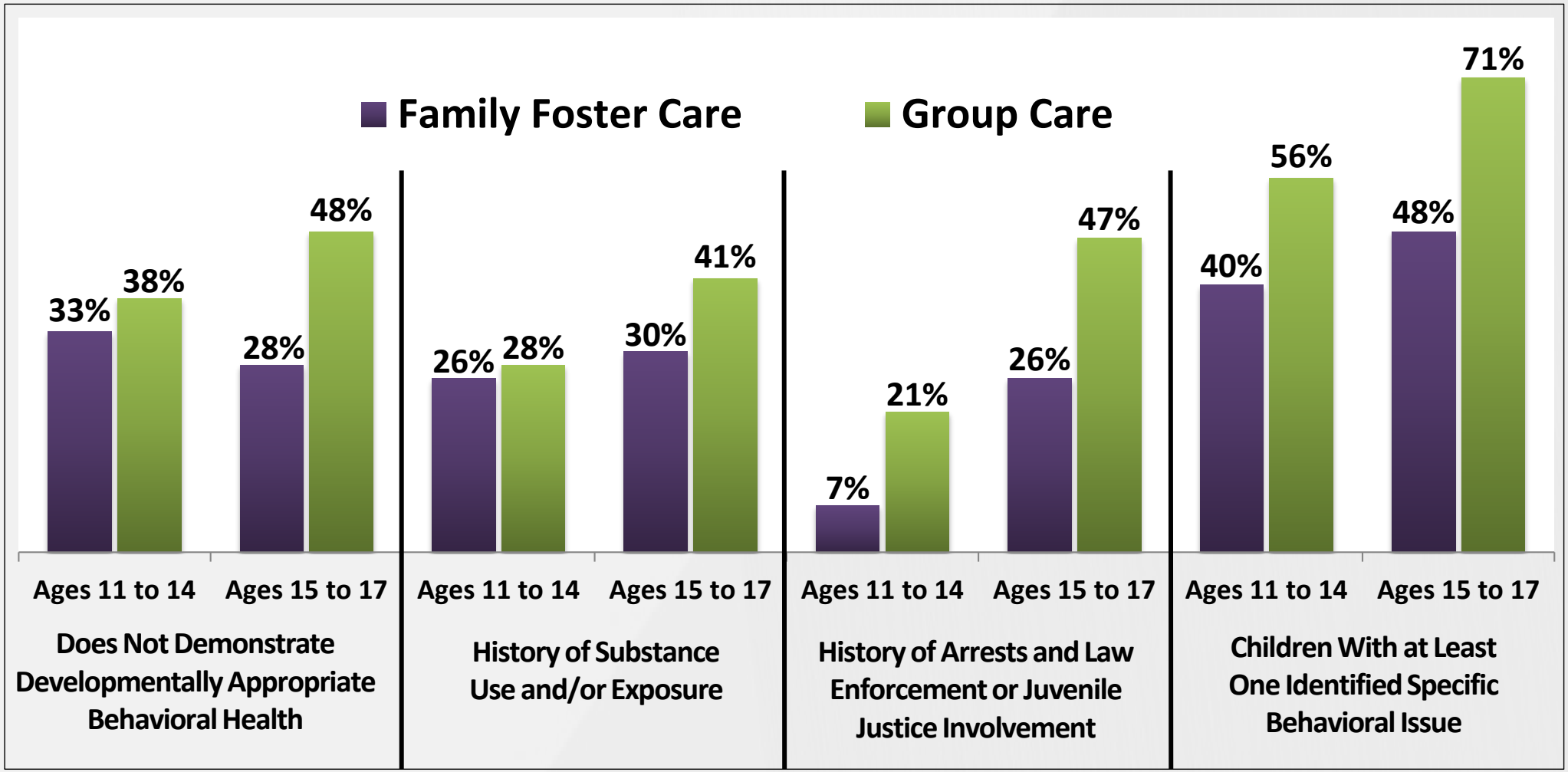
Children in Group Care Were Older

79.8% of children in group care were ages 11 through 17



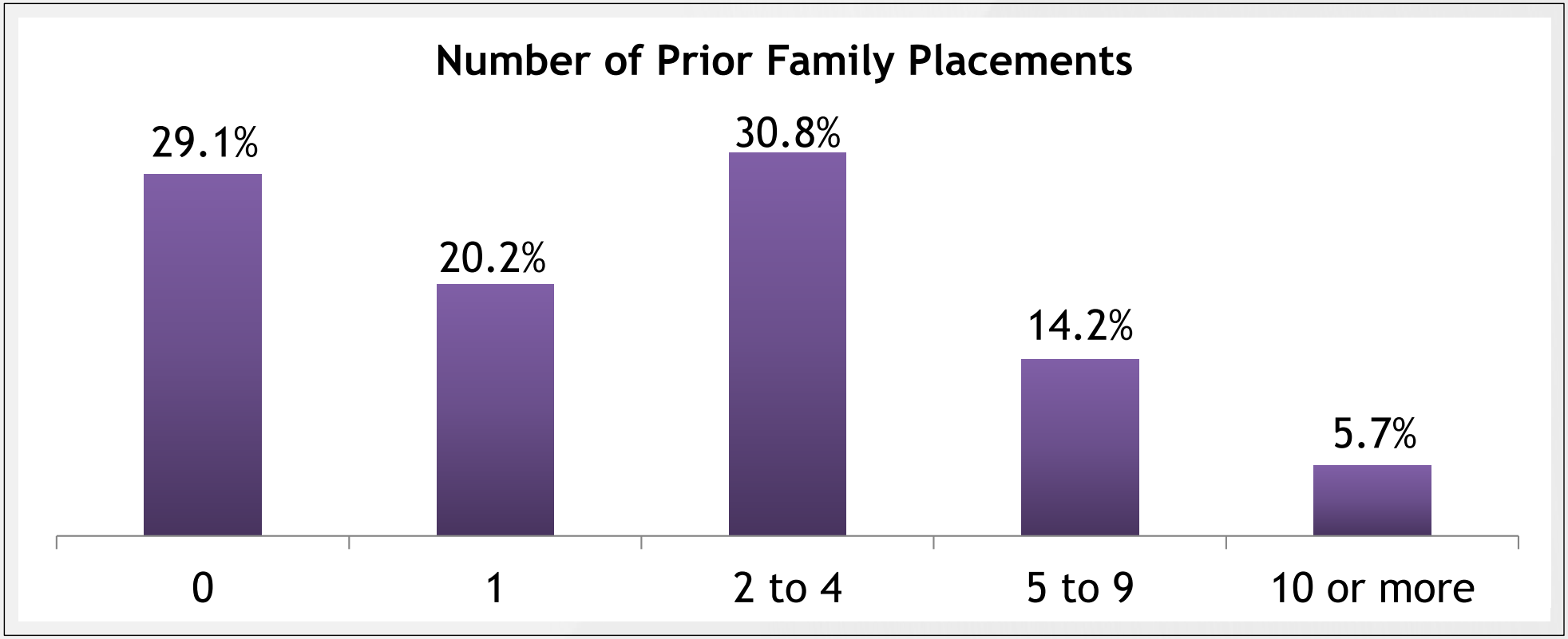
Behavioral Issues

A larger percentage of children in group care had behavioral issues



Prior Placements

Almost half of children in group care had fewer than two prior family placements



Placement Process

Placement in Out-of-Home Care

- All children in out-of-home care receive a Comprehensive Behavioral Health Assessment (CBHA)
  - Assess child's emotional, social, behavioral, and developmental functioning
  - Should be administered within 30 days
  - Should be used to determine child's needs
  - Medicaid pays for CBHA once a year

Placement in Out-of-Home Care

- CBCs use placement specialists to identify a placement
  - Driven by the goal to place children in least restrictive settings
  - Gather all available child and family information
  - Use forms to guide the process
- Bed availability may drive placement

Placement in Out-of-Home Care

- CBCs routinely assess placement options for children in group care
  - Monthly or more frequent reviews to find family-based placement
- Case managers may not be part of placement decisions
- Special considerations to *not* move
  - End of the school year or identified relative or non-relative placement

Foster Parent Recruitment, Training, and Supports

Foster Parent Recruitment

- CBCs' foster parent recruitment efforts vary
  - Community outreach (e.g., events at faith-based settings and local schools) and traditional marketing materials
  - Foster parents are recruiters
  - Some target recruitment efforts for teens

Family Foster Home Capacity

January 1, 2015 Statewide Foster Home Capacity			
Number of Foster Home Beds	Number of Foster Home Placements	Number of Open Foster Home Beds	Percentage of Foster Home Beds in Use
8,781	5,367	3,414	61%

- Not all licensed foster parents accept placements
  - Respite and family issues
  - Foster parent preference to foster younger children
  - FSFN data on parent preference incomplete

Foster Parent Training and Supports

- Foster parent training curriculums vary statewide
  - Training quality has improved
  - CBCs using foster parents to help train
- Licensing process is too long
- In-home supports and resources are not adequate
- Case manager turnover is an issue
  - In Fiscal Year 2012-13, case manager turnover rate was 30.4%

Questions?

Contact Information

Megan Smernoff, J.D.
Senior Legislative Analyst
(850) 717-0532
smernoff.megan@oppaga.fl.gov

Jennifer Johnson, M.P.H.
Health and Human Services Staff Director
(850) 717-0538
johnson.jennifer@oppaga.fl.gov

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

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

December 22, 2014

Scope

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

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

Background

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

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

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

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

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

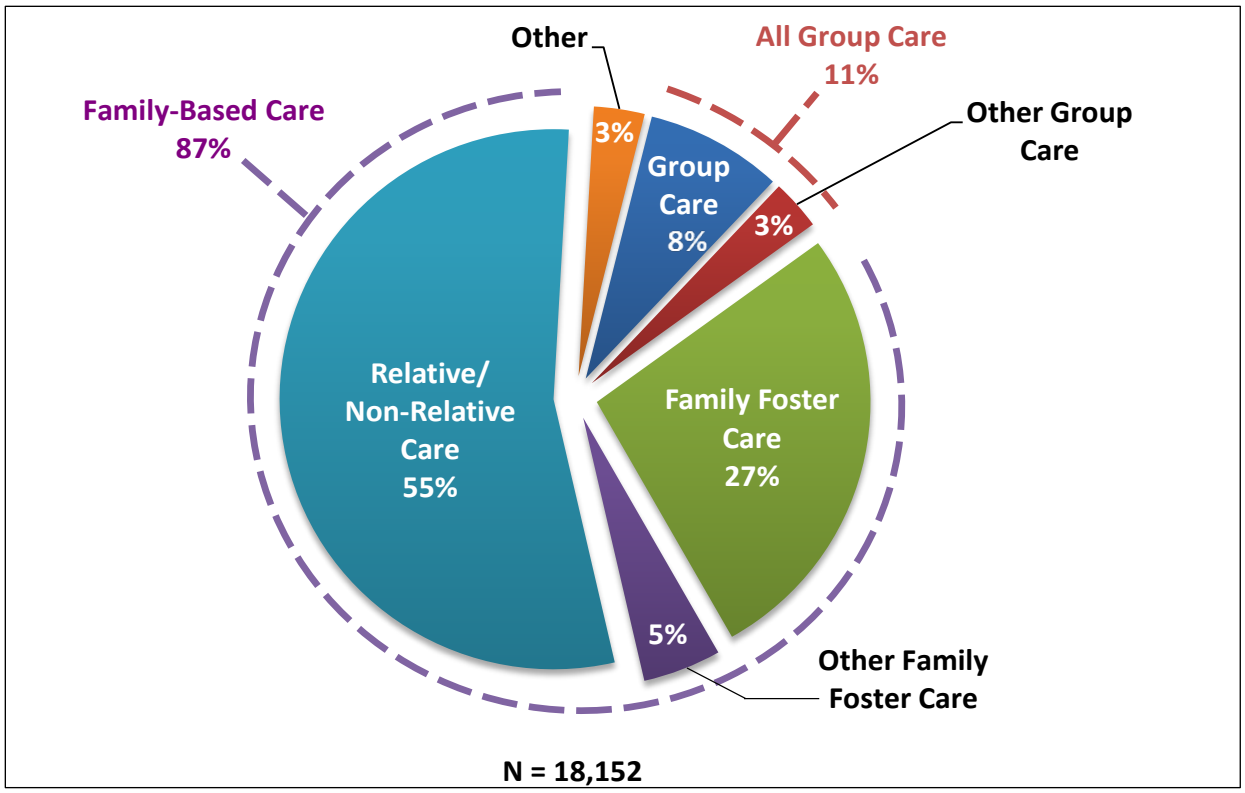
[2] Community-based care lead agencies may place children in other types of residential group care settings based on the child's needs, such as residential treatment programs, therapeutic group care, or developmental disabilities group homes.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

How is placement in residential group care determined?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

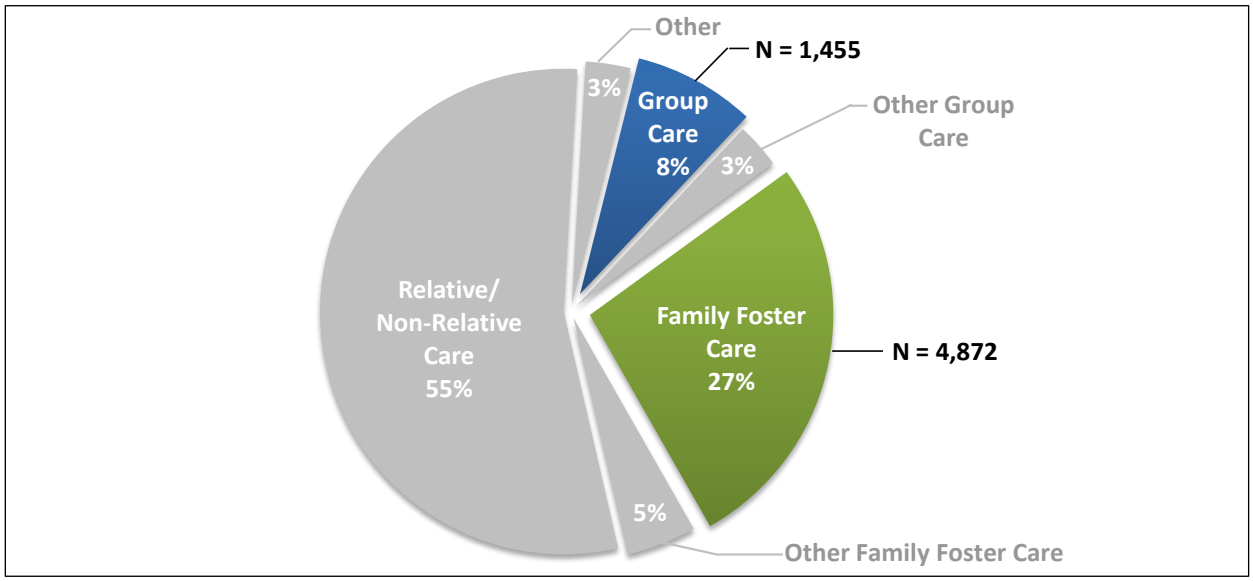
[21] Fourteen of 16 lead agency directors responded to the information request.

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

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

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

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



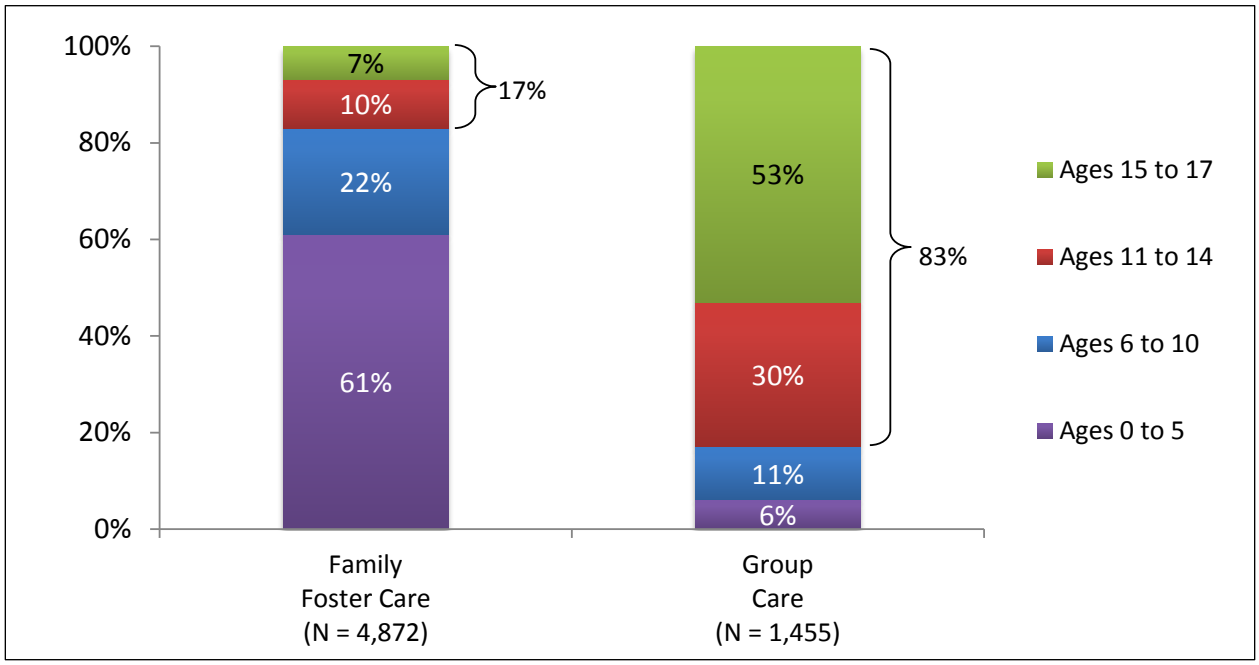
Source: OPPAGA analysis of Department of Children and Families data.

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

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

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

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



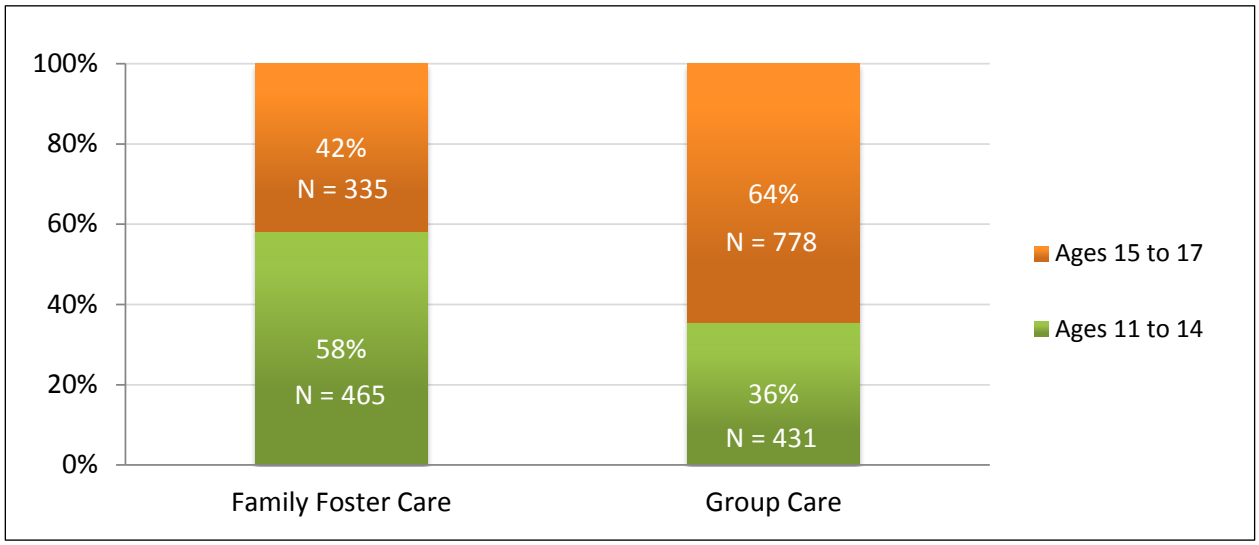
Source: OPPAGA analysis of Department of Children and Families data.

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

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

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

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



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

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

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

Exhibit 8
Children in Group Care Had More Identified Behavioral Issues

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

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

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

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

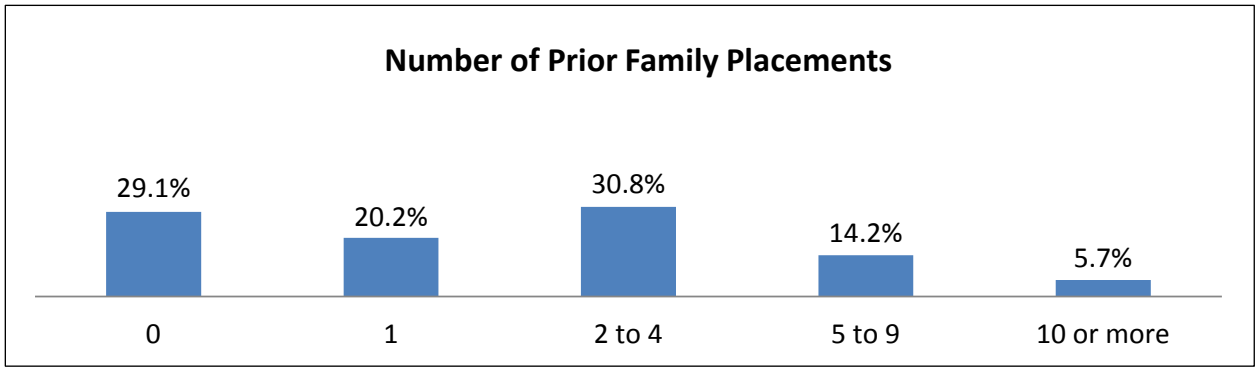
Exhibit 9
Children in Group Care Had More Identified Behavioral Issues

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

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

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

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



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

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

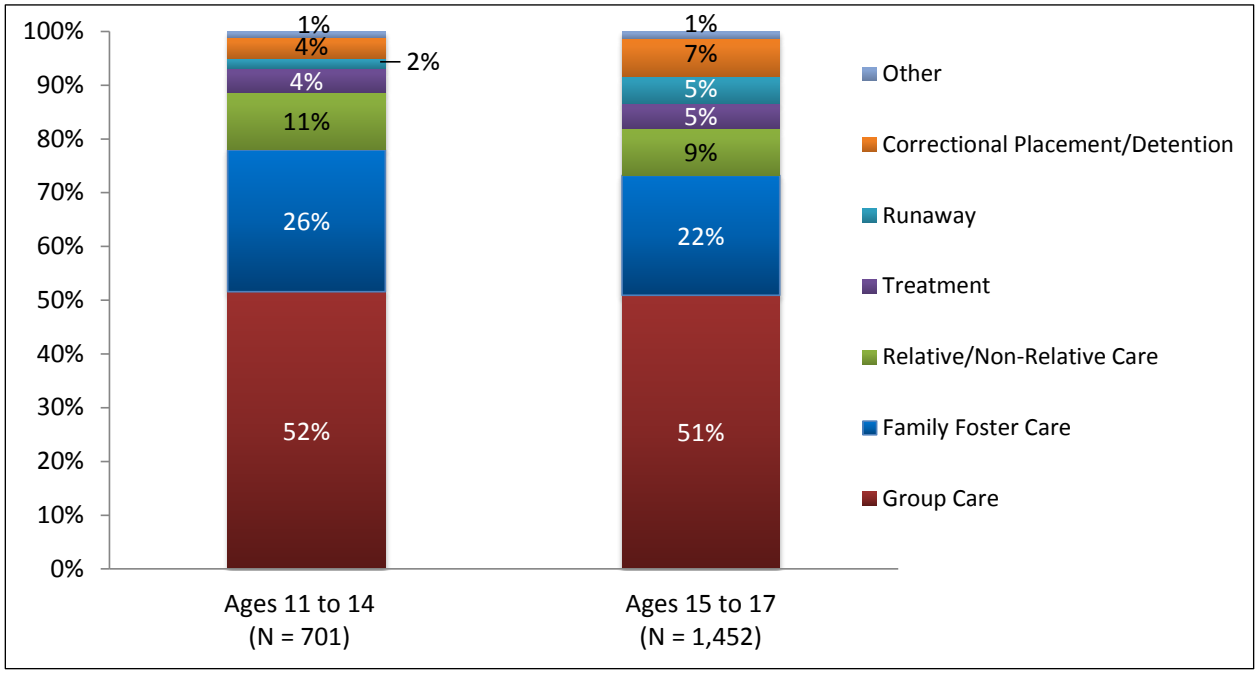
[27] To determine the number of placements a child had, we counted each time a child was placed in the care of a different family or provider. If a child was in the care of a provider and temporarily left that provider's care due to a temporary situation such as short-term hospitalization, visitation,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

Outcomes

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

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

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



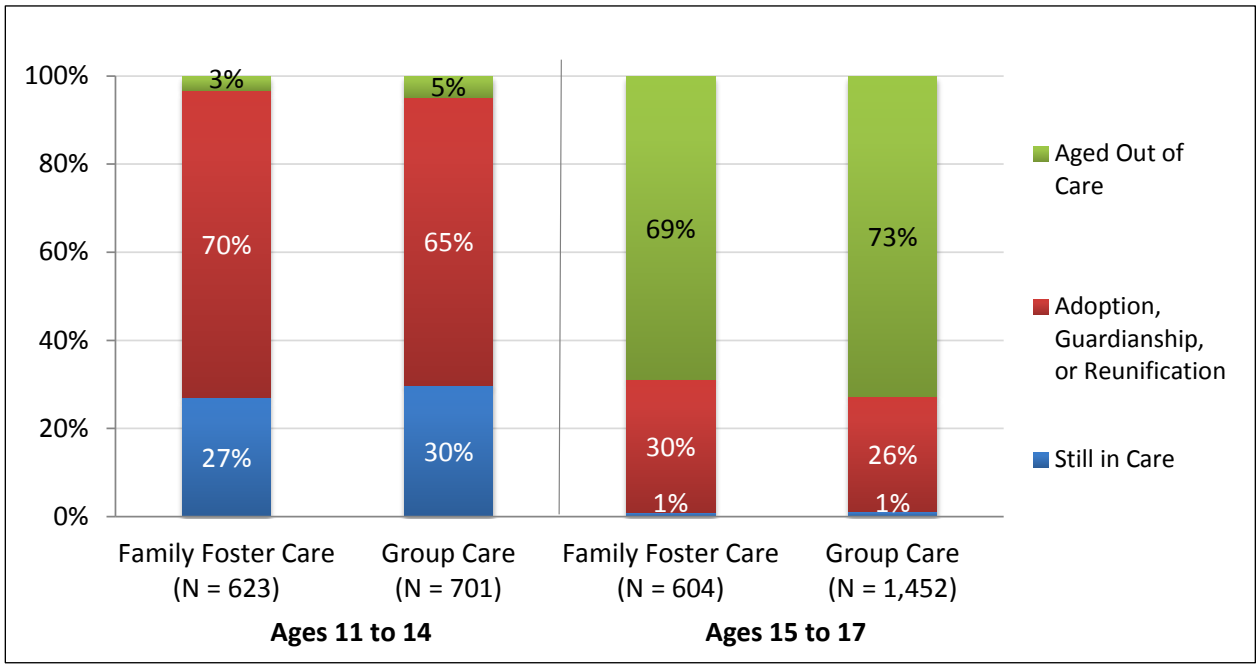
Source: OPPAGA analysis of Department of Children and Families data.

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

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

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

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



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

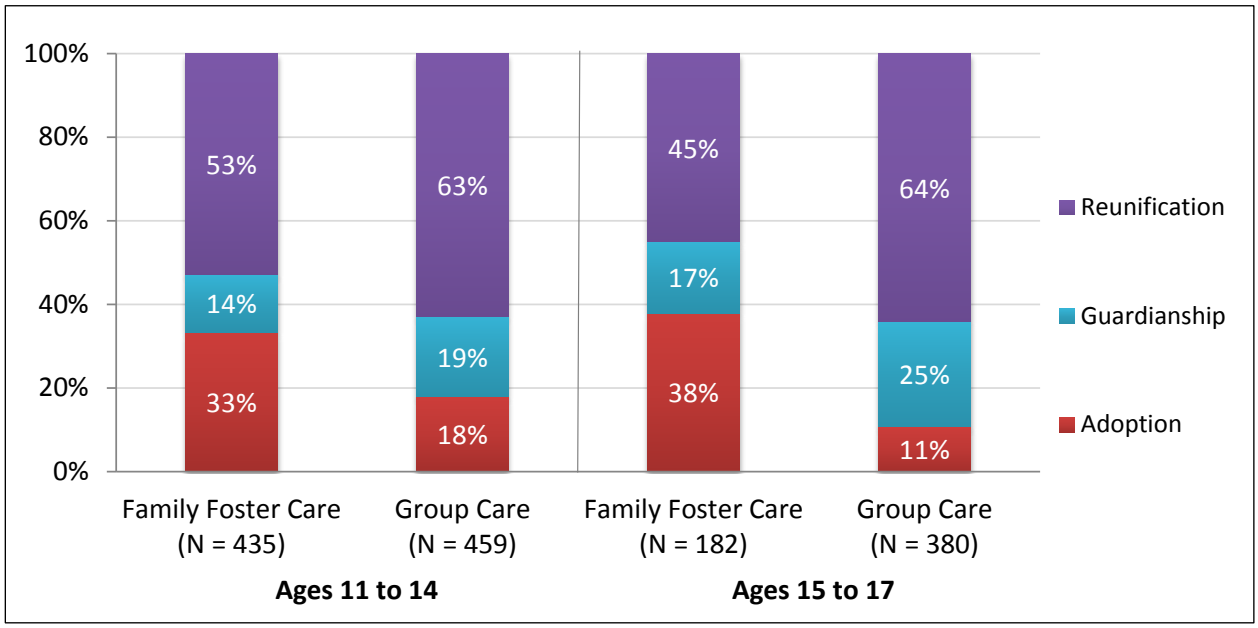
[29] When available, we used provider licensing information to distinguish between residential group care and other group care. However, due to conversion in the department's data systems used for provider licensing, data on providers' full licensing history were not available. Therefore, for this analysis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

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

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

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

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



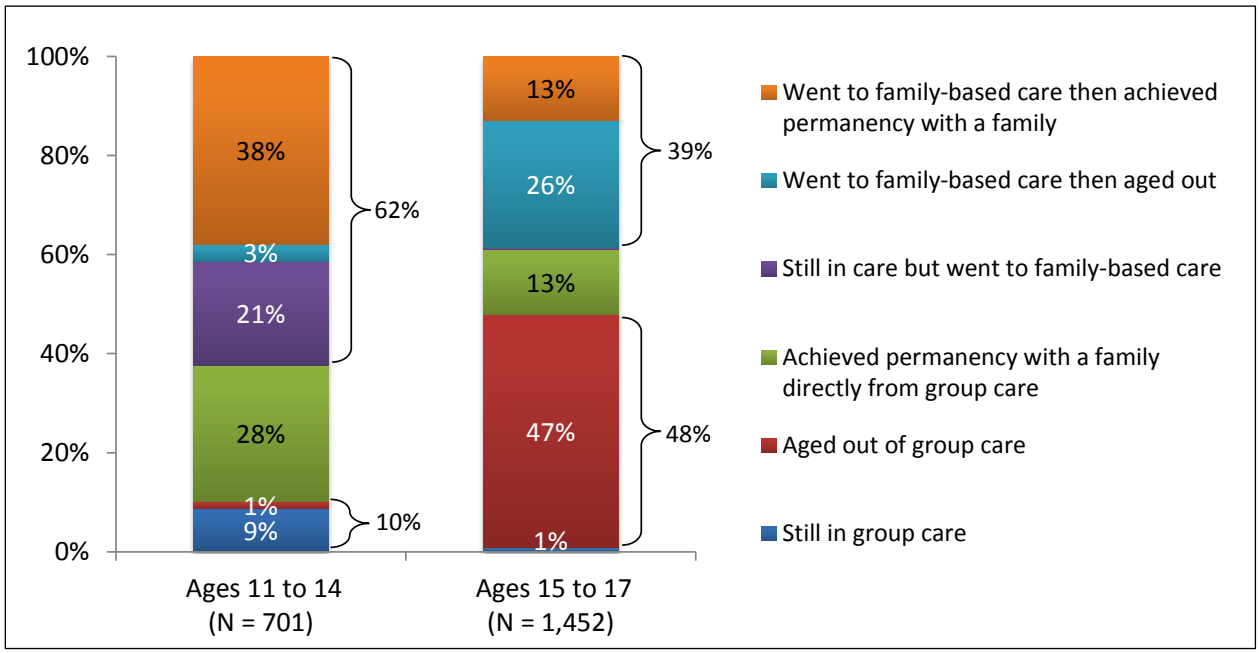
Source: OPPAGA analysis of Department of Children and Families data.

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

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

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

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



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

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

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

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

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

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

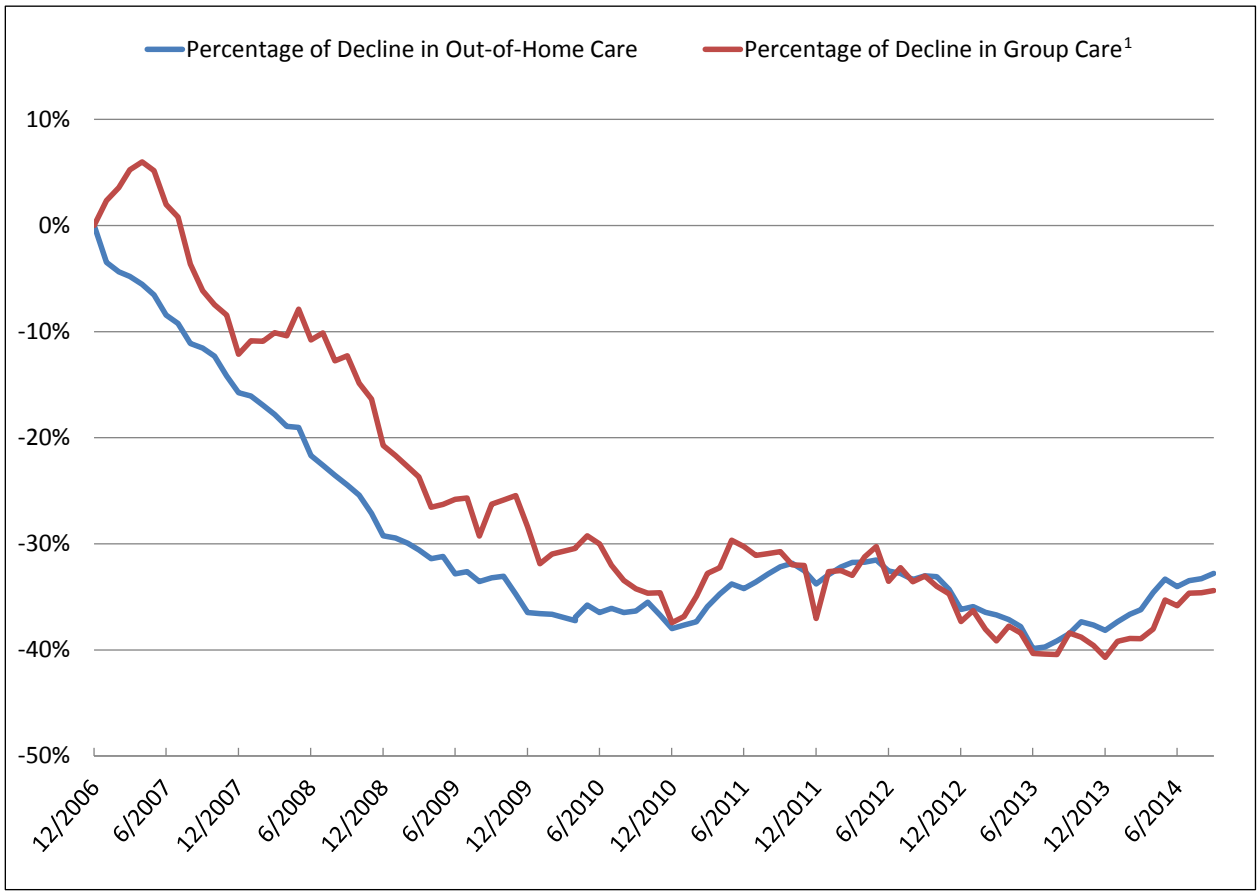
Source: OPPAGA analysis of Department of Children and Families National Youth in Transition Database data.

Appendix A

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

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

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



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

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

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

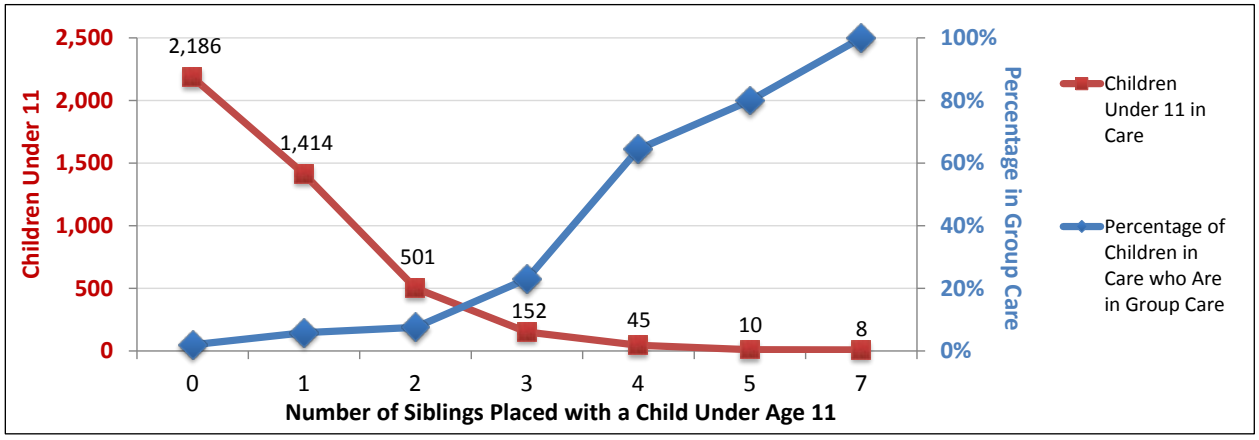
Appendix B

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

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

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

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



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

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

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

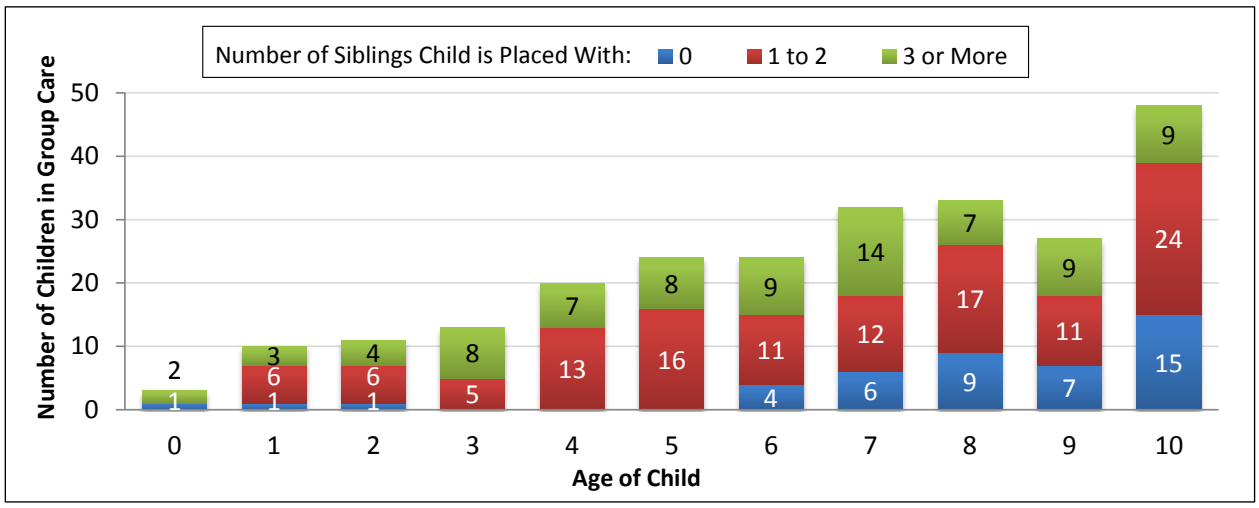
Exhibit B-2
Most Young Children in Group Care Are Placed in Care with at Least One Sibling

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

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

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

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



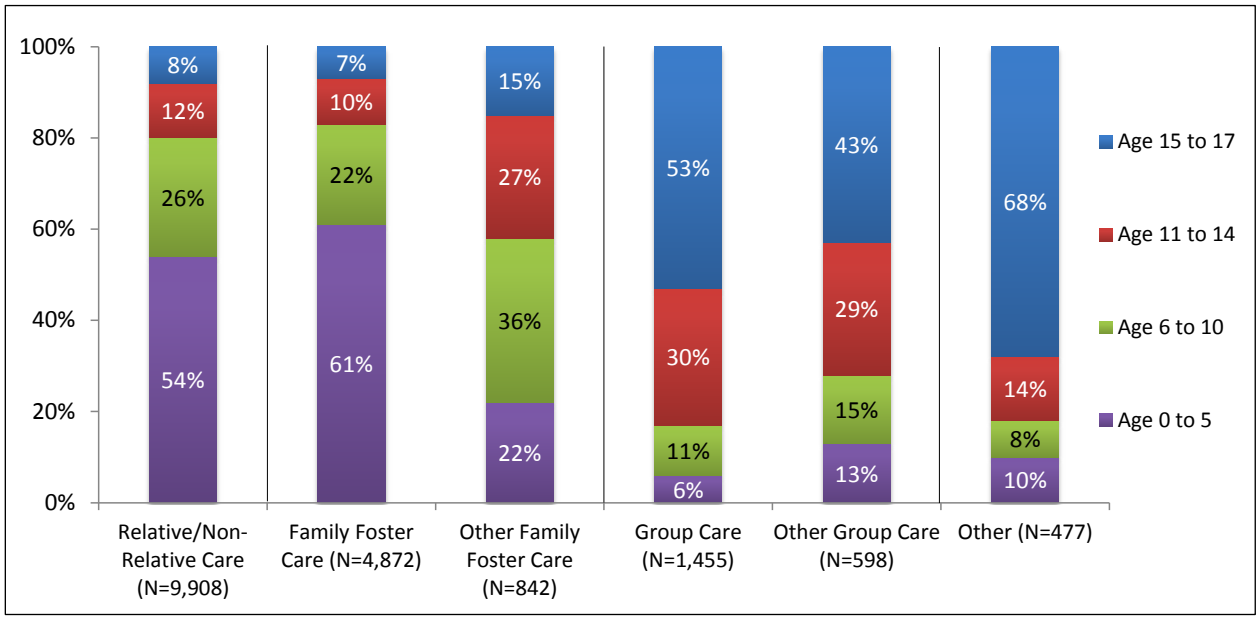
Source: OPPAGA analysis of Department of Children and Families data.

Appendix C

Demographics of Children in Group Care and Family Foster Care

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

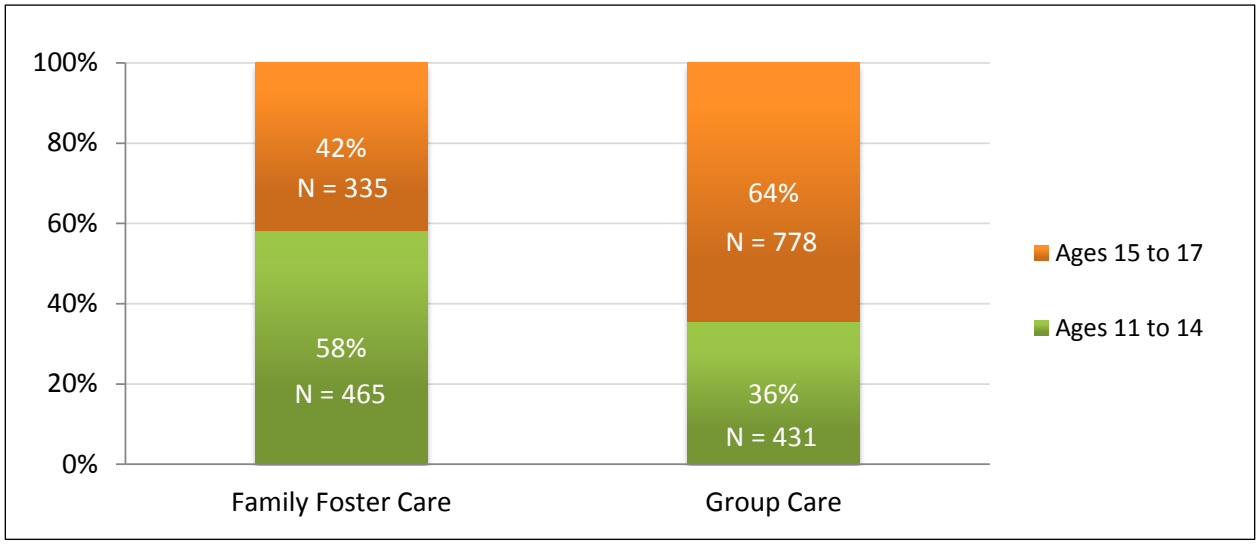
Exhibit C-1
Children in Group Care Are Older



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

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

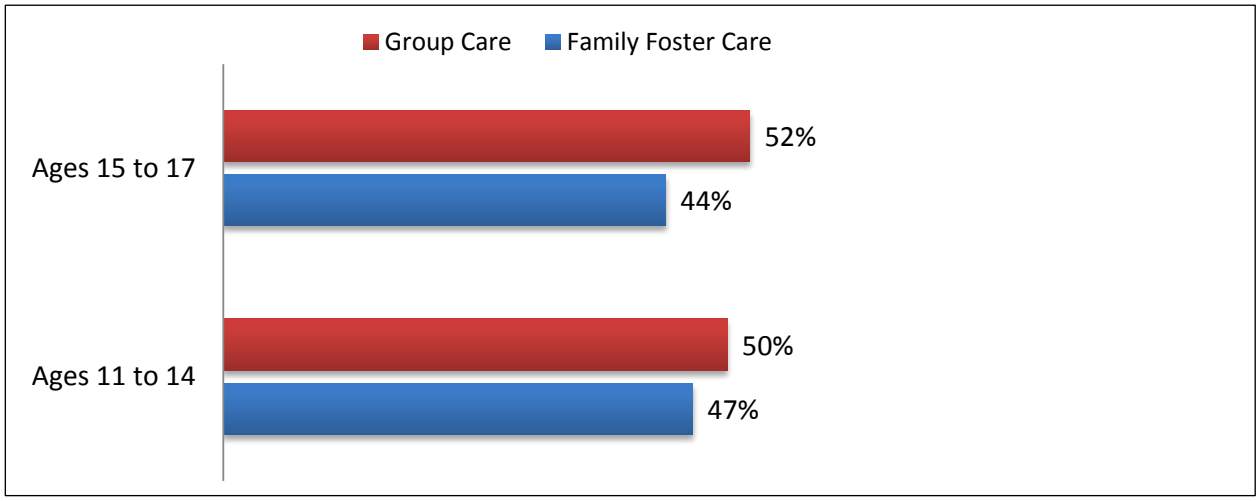
Exhibit C-2
A Larger Percentage of Children in Group Care Are Ages 15 to 17 Compared to Family Foster Care



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

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

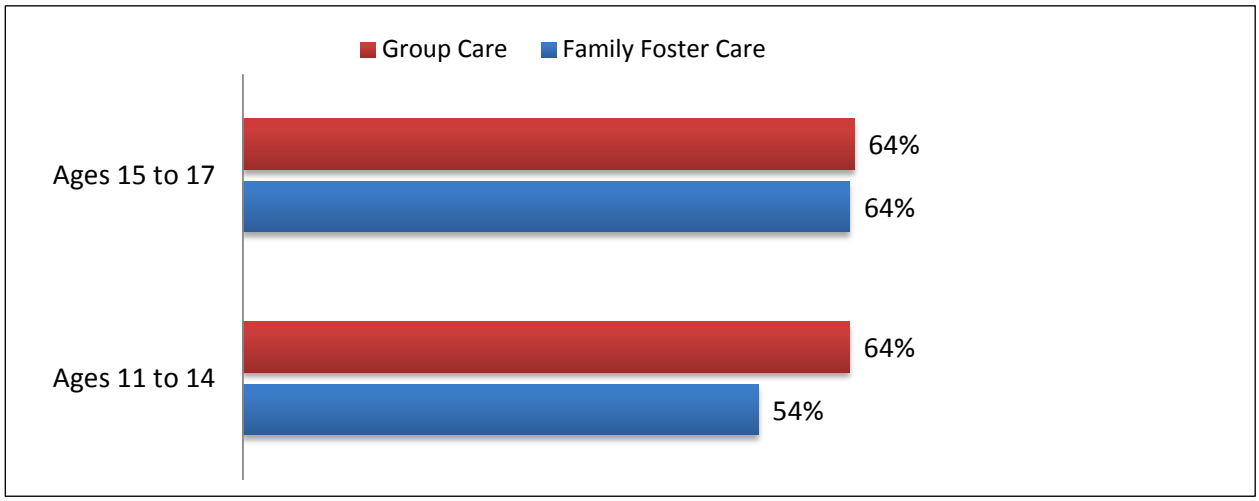
Exhibit C-3
Percentage of Male Children in Licensed Care



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

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

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



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

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

Appendix D

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

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

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

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

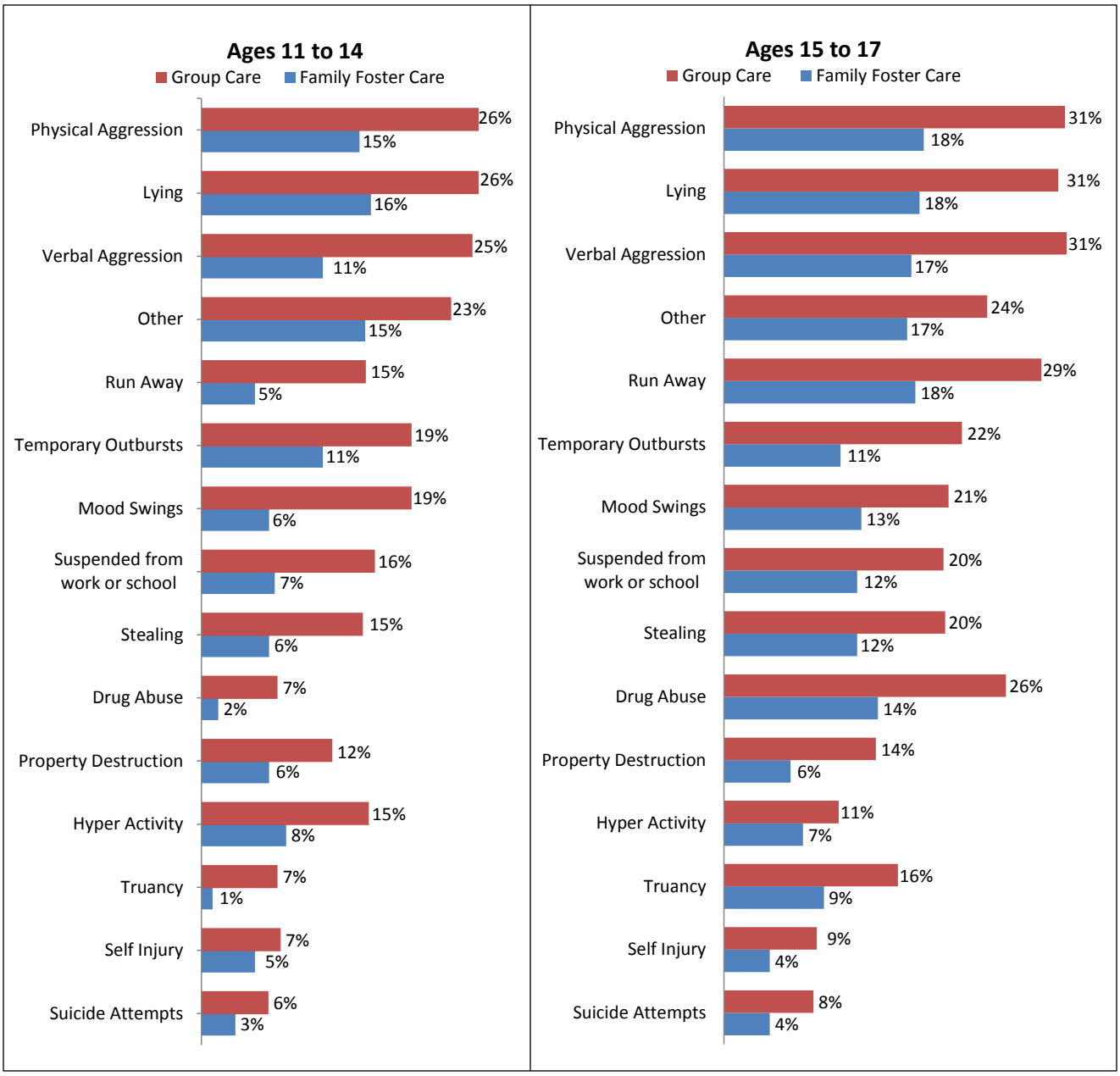
[37] An assessment was considered current if it was completed within six months before and one month after the child entered his or her current placement. Limiting the analysis to children with a current assessment or to children who entered group care for the first time did not substantially change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

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

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

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

Exhibit D
Behaviors of Children[1]



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

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

Quality Standards for Group Care

Group Care Quality Standards Presentation

September 22, 2015

Who We Are & Where We Are

- Statewide Maps:
  - All Group Homes
  - Shift Care Group Homes
  - Accredited Shift Care Group Homes
  - Family Style Group Homes
  - Accredited Family Style Group Homes

Statewide Group Homes (Shift & Family Style)

Statewide
Shift Care Group Homes

Accredited
Shift Care Group Homes

Statewide
Family Style Group Homes

Accredited
Family Style Group Homes

History

- Selection of the workgroup
  - Workgroup Makeup
    - Consists of 14 Group Care provider agencies, 4 CBCs, 5 DCF representatives, 3 Quality Management professionals, and 3 researchers
  - Workgroup Intent
    - Develop quality standards for Group Care programs that are informed by research
  - Workgroup Goal
    - The workgroup will look to assess the needs of children placed in Residential Group Care to identify and define the quality standards essential to ensuring children are receiving the quality services and supports

Research

- Research Literature Reviews
  - Boys Town National Research Institute
  - Child Welfare Institute
  - Over 25 articles critically reviewed
  - 9 articles identified with direct relevance and referenced
  - Previous research - differences

Work Product and Content

- Standards are based in research coming from 9 research articles
  1. Assessments, Admissions, and Service Planning/ Treatment Planning *(referenced in all 9 articles)*
  2. Positive, Safe Living Environment *(referenced in 4 articles)*
  3. Effectively Monitor/Report Problems *(referenced in 6 articles)*
  4. Promote Family, Culture, and Spirituality *(referenced in 9 articles)*
  5. Develop and maintain a professional, competent staff *(referenced in 5 articles)*
  6. Program Elements *(referenced in 5 articles)*
  7. Promote Education, Skills, and Positive Outcomes *(referenced in 4 articles)*
  8. Pre-Discharge/Post-Discharge Processes *(referenced in 9 articles)*
- Eight standards are made up of 59 sub-categories. all based out of research articles

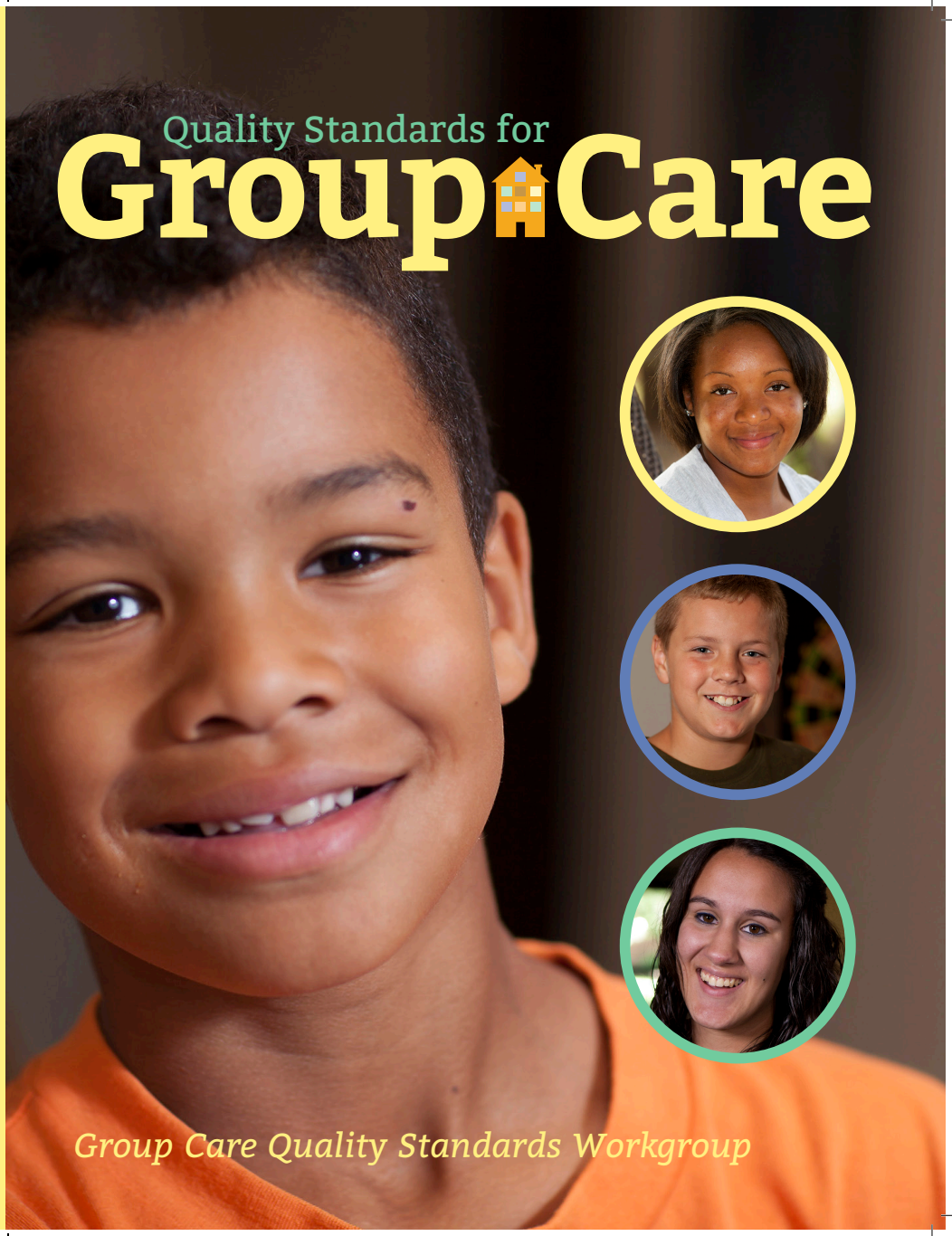
Recommendations/Results

- Recommendations
  - See Executive Summary Section *(27 bulleted sections)*
- Results
  - A Group Care Quality Standards document that is strongly based in research that is well designed to describe necessary elements needed to provide quality Group Care level services
  - National advocacy efforts

1507-255

Quality Standards for

Group Care



Group Care Quality Standards Workgroup

Quality Standards for

Group Care

Quality Standards for

Group Care

Group Care Quality Standards Workgroup Members:

Ken Bender	Chair • Executive Director • Boys Town North Florida
Brad Gregory	Co-Chair • Vice President of Programs • Florida Sheriffs Youth Ranches
Alan Lindenmuth	Quality Assurance Manager • Devereux
Brian Bostick	Executive Director • Eckerd Community Alternatives
Desmond Taylor	Executive Director • Friends of Children and Families, Inc.
Diane Schofield	Chief Executive Officer • Hands of Mercy Everywhere
Don Labrecque	Director of Quality Improvement • Florida Sheriffs Youth Ranches Commissioner, Executive Committee • Council on Accreditation (COA)
Eric Losciale	Program Manager • Children's Home Society
Evan Leach	Regional Licensing Manager, SunCoast • Florida Department of Children and Families
Gregory Zbylut	Executive Director • Boys Town Central Florida
Jillian Smath	Vice President of Operations • SOS Children's Villages - Florida
Joshonda Guerrier	Director of Child Welfare Strategic Projects, OCW • Florida Department of Children and Families
Kathleen Cowan	Executive Director • Eckerd Community Alternatives
Kimberly Pleasants	Executive Director • Children's Home Society - North Coastal Division
Kimberly Williams	Family and Community Services Director • Florida Department of Children and Families
Kirk Brown	Statewide Independent Living Coordinator, OCW • Florida Department of Children and Families
Nic Keuler	Director of Residential Services • Everyday Blessings Inc.
Patricia Babcock	Interim Director of the Florida Institute for Child Welfare • Florida State University
Ray Fischer	Chief Operating Officer • Children's Network of South Florida
Rich Stroud	Executive Director • Everyday Blessings Inc.
Rusty Kline	Director of Quality/Data Management • Devereux CBC
Schuyler Siefker	Executive Director • St. Augustine Youth Services
Shamra Boel-Studt	Assistant Professor • Florida State University
Shelley Katz	Chief Operating Officer • Children's Home Society - Corporate Office
Tom Lukasik	Vice President of Community Engagement • 4Kids of South Florida
Zandra Odum	Project Management Consultant, OCW • Florida Department of Children and Families

Table of Contents

Executive Summary 1

1. Assessments, Admission, and Service Planning/Treatment Planning 5

2. Positive, Safe Living Environment 12

3. Effectively Monitor/Report Problems 17

4. Promote Family, Culture, and Spirituality 19

5. Develop and Maintain a Professional, Competent Staff 23

6. Program Elements 26

7. Promote Education, Skills, and Positive Outcomes 31

8. Pre-Discharge/Post-Discharge Processes 35

References 39

Executive Summary

The draft standards included in this report were developed by the Group Care Quality Standards Workgroup established by the **Florida Department of Children and Families (DCF)** and the **Florida Coalition for Children (FCC)**. This workgroup was comprised of group care provider agency experts, community-based care lead agency staff members, and DCF representatives. This report is to be considered by the DCF in licensing child-caring facilities, specifically group care programs/homes. The specific standards were informed by a review of standards-related literature to ensure a high quality of group care and to determine the degree of consensus in standards that were suggested across nine of the most relevant source articles.

The draft standards recommend that:

- Evidence-based assessment tools and a multidisciplinary treatment (MDT) team are used to assess the safety risks, strengths, and needs of a youth who is being referred to group care and to determine the level of care and services required to meet his or her behavioral health needs.
- Decisions about admission are made by experienced personnel and must include the youth who is applying for care and his or her parent or legal guardian. Youth applicants and their parents or guardians are provided with information about their rights and responsibilities and are always treated with respect and dignity.
- Youth and their parents or guardians are part of the MDT team that is responsible for creating an individualized service plan/treatment plan. Plans should be strength-based and include the youth's personal treatment goals and objectives and information about any known trauma. The plan also must include goals related to the youth's family and to building natural family supports. The youth has input on who participates in the service planning/treatment planning process. Plans are reviewed by the MDT team every 90 days.
- The care environment must be safe and stable, and physical facilities must be clean and well-maintained. The basic needs (shelter, food, clothing, and personal items) of all youth are provided.
- Youth rights are well-specified and protected. Each youth has the right to file a grievance or an appeal.
- Written policies are in place that prohibit corporal punishment or restraint as a form of punishment, and the use of any practices that are demeaning, shaming, or degrading, or that would constitute verbal or emotional abuse.
- A positive peer culture approach is promoted. However, youth are protected from the problem behaviors of other youth, bullying, and punishment by their peers.
- Staff members are trained in specific protocols for de-escalating and dealing with youth problem behaviors. Critical incidents, including any use of physical restraint, are documented and reported, and these reports are reviewed regularly by agency administration. Staff members are trained to immediately report critical incidents, including questionable or abusive staff practices or youth-to-youth incidents. Supervisors must be briefed immediately.
- Appropriate external agencies must be notified about all serious allegations of unsafe, inappropriate, or abusive practices or incidents.

- Mechanisms and policies are in place that enable youth and their parents or legal guardians to communicate their needs, report problems, and file grievances. Formal procedures are in place to assess the satisfaction of youth, parents/guardians, and other key consumers.
- Policies and practices are in place to strengthen a youth's relationship and connection with his or her family and community (unless such contact is prohibited). Families are involved in treatment decisions, care, and positive activities. Youth and families should have opportunities for regular communication and visits where the youth is living, in the family's home, and in the community. Staff must be trained to be sensitive to each youth's racial, cultural, religious, and linguistic needs.
- The group care provider must maintain appropriately qualified staff members who are adequately trained in evidence-based/evidence-informed models of intervention. Staff members must demonstrate competency prior to independently caring for youth and must be supported by regularly scheduled, ongoing supervision by a qualified supervisor.
- Youth must receive care at the least-restrictive level of care and in a family-like environment.
- Youth should be allowed and encouraged to develop and maintain interests, talents, and hobbies, including participating in normal leisure/recreational activities that are appropriate to their age and developmental level.
- Policies and practices are in place that allow youth to express their personal identity and that protect the privacy and dignity of youth and their families.
- Group care providers must be licensed, accredited by a national entity, and implement an evidence-based/evidence-informed model of care. Youth have full access to required therapeutic supports that are provided by a trained, qualified, skilled workforce.
- All youth receive a medical assessment and a physical examination that determines their health status. The group care provider should provide or facilitate provision of routine medical and dental care and teach healthy living-literacy education. The group care provider should have 24/7 access to a qualified medical provider.
- Staff-to-youth ratio must be within licensing and accreditation standards. Youth follow a structured daily routine and are monitored in accordance with their individual needs.
- The group care provider should implement an effective Continuous Quality Improvement (CQI) program that provides supervision and coordinates care across services that are included in the service plan/treatment plan.
- The use of psychotropic medications by youth must be monitored by a board-certified psychiatrist and should be used at the minimum level for clinical needs.
- The educational needs of youth must be assessed and appropriate educational services must be provided or obtained. Youth are required to attend school and are encouraged to continue their post-secondary education by attending college, a technical school, or a certificate program.
- Every qualified youth should have a 504 Plan or an Individualized Educational Plan (IEP).
- Youth learn, practice, and consistently use prosocial skills and behaviors. An outcome-driven approach is used to help youth reduce symptoms and acquire skills, competencies, and knowledge needed for productive citizenship.

- Each youth's emotional, behavioral, and educational progress is monitered and reported regularly. Accountability for youth progress should be placed on program effectiveness and staff performance.
- Discharge planning should start at intake, should continue throughout services/treatment, and should involve the youth, his or her parents or legal guardians, and key stakeholders.
- Where allowable, services should be provided that strengthen the family and support family reunification. Efforts are made to educate family members about and connect them with community resources, as needed. The group care provider provides support, aftercare, and community service coordination for the youth and his or her family.
- Post-treatment outcomes for youth are monitored and include, at minimum: education outcomes; law-abiding and functional outcomes such as recidivism and success in lower levels of care; and outcomes related to the youth's connection/relationship with his or her family and community.

1 ASSESSMENTS, ADMISSION, AND SERVICE PLANNING/TREATMENT PLANNING

1.A.1 Assessment-Driven Services

1.A.1.1 Prior to admission, the referring agency must complete a functional assessment using evidence-based assessment tools that evaluates youth safety risks, strengths, and needs and includes:

- **a.** A recommendation that the program is the least-restrictive, least-intrusive intervention necessary to meet the behavioral health needs of the youth

1.A.1.2 Upon admission, a comprehensive assessment to determine the youth's strengths, needs, and service/treatment requirements is completed in a timely manner, either prior to or within the first 30 days of admission. The assessment must include a screen for alcohol and drug issues, mental health issues, medical issues, and special needs.

1.A.1.3 Assessments are conducted in a culturally and linguistically sensitive manner and take into account:

- **a.** Concerns identified from the youth's initial screening
- **b.** The youth's overall psychological function
- **c.** A description of known traumas or abuse
- **d.** A review of the youth's known medical history and any ongoing health issues
- **e.** A comprehensive history of the youth's family that includes a history of the parents/guardians and previous legal, religious, educational, and vocational details
- **f.** Identification of trauma, attachment, abuse, and neglect issues that have impacted the youth
- **g.** A comprehensive history of the youth's prior services and previous placements to date
- **h.** A current description of the family environment
- **i.** The youth's educational and vocational accomplishments
- **j.** A description of any recent previous testing or assessments
- **k.** A description of the youth's and the parent's/guardian's strengths, skills, and special interests
- **l.** A history of previous and current drug use by the youth and/or his or her family, including an assessment of the impact it had on the family
- **m.** Possible effects of group living on the youth
- **n.** The youth's ability to adjust to a group care setting
- **o.** The youth's previous out-of-home placements

p. Identification of how the youth's placement in group care will support and promote his or her welfare

1.A.1.4 Comprehensive service plans/treatment plans are developed by a multidisciplinary treatment (MDT) team, which includes all individuals and entities involved with the youth (i.e., the youth, parent/guardian, school representative, all behavioral health service providers).

1.A.1.5 The facility arranges for an appropriate level of care and, as necessary, referrals to specialized treatment programs.

1.A.1.6 Re-assessments are conducted if specific events in the treatment process include any of the following:

a. Youth makes significant improvement that is ahead of expectations

b. Youth does not make significant treatment progress

c. New symptoms are identified

d. Unusual behavioral changes are observed

e. Significant changes occur in the family situation or parental status

f. Significant environmental changes occur

g. A youth resident demonstrates a significant degree of self-destructive behavior or is hospitalized for a mental health condition

1.A.1.7 Placements with group care providers that do not have additional educational or therapeutic services on the same site should be made only after careful assessment.

1.A.1.8 Common practice frameworks include those that are trauma-informed, needs-based, and strengths-based.

a. All youth entering group care require a comprehensive assessment, and the intake process should include linking a youth's history of trauma, attachment, violence, and abuse, as well as resources and resilience, to his or her current needs and care/intervention responses.

b. The referral assessment should describe the youth's needs and strengths from the perspective of the youth, family, and referral/placement agency, as well as from all other sources of accurate information.

c. Substantive discussions of the youth and family should begin with a discussion of strengths.

d. Available information should be used or an objective, comprehensive assessment of family strengths, capabilities, and weaknesses should be conducted to determine if the family can assume responsibility for the youth's care and development.

e. In schools, group care staff should contribute to Individualized Educational Plans (IEPs) based on a careful assessment of strengths and needs that shows how the curriculum could be adapted or enriched to accommodate the youth.

1.A.1.9 The initial assessment for all types of group care services should include risks posed by the youth to self or others (including staff, peers, or community) and risks of such a placement to the youth.

1.A.1.10 The referral assessment should describe the youth's racial, ethnic, cultural, and religious background.

1.A.2 Respectful Admission Process

1.A.2.1 Admission decisions are made by experienced or licensed personnel in collaboration with the youth applicant and his or her parent or legal guardian if the applicant is a minor.

1.A.2.2 Intake, admission, service planning/treatment planning and review, discharge, and follow-up services are culturally and linguistically competent, trauma-informed, and respectful of the feelings and needs of youth and families.

1.A.2.3 Admission needs to be handled in a calm, positive, and reassuring way. A sensitively prepared admission procedure is required.

1.A.2.4 The youth and his or her parent or legal guardian participate in the admission process and are:

- **a.** Informed of available options, benefits, and consequences of planned services/treatment
- **b.** Prepared for admission, including the opportunity for a pre-admission visit, whenever possible
- **c.** Informed of how the provider organization can support the achievement of desired outcomes

1.A.2.5 Provider organizations screen and inform residents of:

- **a.** How well their request matches the organization's services
- **b.** What services will be available and when

1.A.2.6 The program defines in writing:

- **a.** Its eligibility criteria
- **b.** The scope of services and the range of client issues addressed
- **c.** Service options and levels of service
- **d.** Opportunities for active family participation and support
- **e.** Opportunities for the resident's participation in activities that promote normalcy
- **f.** A description of how the facility promotes living-unit compatibility based on age, interests, and group composition

1.A.2.7 Prompt, responsive intake practices:

- **a.** Ensure equitable treatment
- **b.** Give priority to urgent needs and emergency situations
- **c.** Support timely initiation of appropriate services

d. Provide a waiting list for and referrals to interim services, if needed

e. Provide referrals to other appropriate resources if applicants are ineligible or cannot be served in a timely manner

1.A.2.8 If the provider organization permits the use of service modalities or interventions that can be considered non-traditional, unconventional, or experimental, it:

a. Explains any benefits, risks, side effects, and alternatives to the applicant or a parent/legal guardian

b. Obtains the written informed consent of the applicant or a parent/legal guardian

c. Ensures personnel have sufficient training and/or certification, when available

d. Monitors the use and effectiveness of such interventions

1.A.2.9 The provider organization describes:

a. Personal items residents may bring with them, consistent with a safe therapeutic setting

b. Items that are discouraged or prohibited

c. The program's safety procedures and consequences that can result when prohibited items are brought to the program site

1.A.2.10 In cases where a resident's contact with his or her family is limited by court sanction, the group care provider:

a. Works to maintain contact between the resident and the parents if court sanctions allow

b. Will seek the family's participation in their youth's service planning/ treatment planning, medical treatment, and authorization of prescribed medication, if permissible

c. Will promote visitation and reunification if the court-approved case plan identifies this as a goal

1.A.2.11 The group care provider will not admit youth whose:

a. Problem behavior is beyond the program's ability to keep other youth safe

b. Needs, actions, attitudes, or values are in conflict with those of other youth (e.g., sexual perpetrators are not admitted to homes that house sexual abuse victims)

1.A.3 Develop Youth-Involved, Individualized Service Plans/ Treatment Plans

1.A.3.1 Group care services should be flexible and tailored to the individual needs of the youth and family.

1.A.3.2 Individualized service plans/treatment plans include an assessment of each youth's educational, social, emotional, behavioral, and health requirements, and identify how the placement will support and promote the welfare of each youth.

1.A.3.3 The initial service plan/treatment plan is developed within the first 30 days of a resident's placement.

1.A.3.4 Service plans/Treatment plans:

- **a.** Should be designed to help the youth develop personal service/treatment goals and objectives
- **b.** Must be written using the youth's native language
- **c.** Should be written in simple, practical language, using terms the youth can easily understand
- **d.** Are signed by the youth if he or she is old enough to sign
- **e.** Are discussed with the youth in person upon finalization
- **f.** Are copied and provided to the youth and the parents/guardians who are participating in the youth's service/treatment

1.A.3.5 Extended family members and significant others, as appropriate and with the consent of the youth, may be invited to participate in case conferences and be advised of ongoing progress.

1.A.3.6 Service plan/treatment plan reviews will be conducted every 90 days. The treatment team, the youth, and, when appropriate, his or her family, participates in a documented quarterly review of the service plan/treatment plan to assess:

- **a.** Progress toward achieving service/treatment goals and desired outcomes
- **b.** The continuing appropriateness of the goals
- **c.** The need to revise, cancel, or add new goals and/or objectives
- **d.** Unmet service and support needs
- **e.** Possibilities for maintaining and strengthening family relationships
- **f.** The need for the support of the resident's informal social network
- **g.** Agreed upon goals, strengths, desired outcomes, and timeframes for achieving them
- **h.** Services and supports to be provided, and by whom
- **i.** The signature of the youth, parent/legal guardian, and treatment team members

1.A.3.7 Service plans/treatment plans, including various goals and objectives, must take into account any previously known traumas (trauma-informed).

a. Efforts will focus on the most supportive means of resolving these traumas.

b. Plans must take into account any legal, professional, or ethical ramifications involved.

c. Trauma issues will be addressed only by qualified staff who are adequately trained or certified in dealing with childhood traumas.

d. In the event the facility does not have qualified staff, the facility will refer the resident to outside qualified resources.

1.A.3.8 Staff interventions reflect an awareness of the impact of separation and loss, and, where applicable, neglect and abuse, on the youth.

1.A.3.9 The service plan/treatment plan must include the Child and Family Strengths component.

a. Service/treatment goals will build upon the strengths of the youth and his or her family.

b. Providers are sensitive to trauma-related issues and their treatment.

c. Service plans/treatment plans will include the youth's major strengths as they were described in the initial assessment.

1.A.3.10 Unless otherwise prohibited by court sanction or other limiting treatment issues, all service plans/treatment plans will address the youth's agreed-upon permanency goal.

1.A.3.11 Service plans/treatment plans will always address the youth's needs of greatest priority, with a specific focus on issues that impact his or her immediate safety, health, legal status, and welfare.

1.A.3.12 Service plans/treatment plans for all youth over the age of 12 will incorporate goals to develop the youth's skills for independent living.

1.A.3.13 The service plan/treatment plan must include goals related to the family and to building natural family supports.

1.A.3.14 The involvement of the family in multidisciplinary treatment (MDT) team meetings provides a forum where family members can address the youth's unique needs and their voice can be heard.

a. Treatment should be family-driven, with the family included in all aspects of care.

b. The group care provider should support and actively involve the family in care and positive activities.

c. There should be a high level of family involvement and engagement.

1.A.4 Establishing and Meeting Measurable Goals

1.A.4.1 The youth, family, and treatment team should identify measurable goals and objectives (individualized for both the youth and the family) that clearly define discharge expectations.

a. A goal is a global statement that reflects a positive resolution to the identified need or problem and indicates the specific area of functioning to be addressed, including an expected outcome.

Service/Treatment Goals:

1. Should establish measurable goals and objectives
2. Are based on the most current assessment of the youth
3. Take into account the youth's age and developmental level
4. Utilize discrete behavioral elements that can be tied to specific behavioral objectives
5. Utilize a behavioral scoring system that can be easily calculated to develop a measurable context
6. Are described in a manner the youth can understand, or that can be readily explained to the youth

b. The objective is directly related to a specified goal, but is highly specific and identifies measurable steps toward achievement of the goal.

c. Goals and objectives should be consistent with each youth's needs for safety, permanency, and well-being.

1.A.4.2 Service/treatment updates include the impact services are having on the youth, including progress on and/or the degree of attainment of goals and objectives. They also should identify effective and ineffective interventions.

1.A.4.3 The behavior support and intervention plan should include procedures for monitoring the effectiveness of behavior support and interventions. The service plan/treatment plan should include timeframes for the periodic review of progress toward service goals.

1.A.4.4 Managers have mechanisms in place for assessing the quality and effectiveness of the services being provided.

2 POSITIVE, SAFE LIVING ENVIRONMENT

2.B.1 Ensure No Physical, Verbal, or Emotional Abuse

2.B.1.1 Care environments must be stable and safe in order to counter the risks associated with ongoing loss, rejection, and re-traumatization of youth that can occur in unsafe environments or through further abuse, harmful practices, and frequent changes in the living environment.

2.B.2 Respect and Maintain Youth Rights

2.B.2.1 The provider organization has a clearly articulated philosophical and practice framework in which practitioners operate that ensures a consistent approach to working with youth.

- **a.** The group care provider should develop statements of rights and responsibilities and ensure that staff members understand and adhere to them in daily practice.
- **b.** The youth's family is educated about the admission process, including the family's rights.
- **c.** The group care provider's policies and care practices reflect and/or include the rights of youth and guidelines for participation in treatment. Youth and their parents are informed of their rights by supervising social workers and group care provider staff members.
- **d.** Youth are made aware of groups and organizations that promote and protect youth rights and understand they may participate in the activities of these groups and organizations, if they choose.
- **e.** Youth rights are respected and communicated.

2.B.2.2 Staff members who are the same gender as the youth should be available to assist with certain daily living or hygiene activities that require gender-specific assistance.

2.B.2.3 The provider should ensure that youth are informed that they can file a grievance or an appeal if they believe their rights have been violated.

2.B.2.4 Written policies that prohibit the following must be in place:

- **a.** Corporal punishment
- **b.** The use of aversive stimuli and/or therapies
- **c.** Interventions that involve withholding nutrition or hydration, or that inflict physical or psychological pain
- **d.** The use of demeaning, shaming, or degrading language and bullying activities

e. Unnecessarily punitive restrictions, including restricting contact with family as a disciplinary action

f. Forced physical exercise as a way to discipline youth behaviors

g. Unwarranted use of invasive procedures or activities as a disciplinary action

h. Punitive work assignments that have no natural or logical connection to a youth's inappropriate or negative behavior

i. Punishment by peers

j. Group punishment or discipline for an individual's behavior

k. The use of physical restraint as a sanction or punishment

l. Verbal or emotional abuse

m. Exposure of youth to unsafe situations or environments

2.B.3 Basic Needs Are Met (Shelter, Food, Clothing, Personal Items)

2.B.3.1 The following basic universal needs should be met for each youth:

a. Shelter – youth has own bed and living space

b. Food – proper nutrition and three meals a day

c. Clothing (including shoes) – clothes fit the youth and are regularly laundered; clothing items are replaced as they wear out or as youth outgrow them

d. Personal items – toiletries, towels, etc.

2.B.3.2 Youth have adequate quantities of nutritious and appetizing food and their food preferences are taken into account in planning menus.

2.B.4 Clean, Hygienic, Well-Maintained Facility

2.B.4.1 Living environment is suitable, sanitary, and safe.

a. The group care home, its premises, and its equipment should be kept clean, sanitary, and in good repair at all times.

b. The group care home is kept in good structural repair and decorated to a standard that creates a pleasant ambience.

2.B.4.2 Service supervisors meet with the group care provider at least once a month to check the physical structure of the home.

2.B.4.3 A full home inspection is conducted annually by the provider organization or as part of annual state licensing.

2.B.4.4 The group care provider adheres to regulations established by local authorities (e.g., Department of Health, Fire Inspector).

2.B.4.5 For construction of a new group care home, the group care provider obtains written confirmation from a certified engineer or a qualified architect that the home complies with all statutory requirements related to fire safety and building codes.

2.B.5 Keeping Youth Safe from Other Youths' Problem Behaviors

2.B.5.1 Policies and practices address the need to protect youth from abuse by their peers.

2.B.5.2 Youth are taught to develop respect for themselves and others.

2.B.5.3 During the admission process, a comprehensive assessment identifies behaviors of each youth that may pose a physical or emotional risk to other youth living in group care. Staff members are trained to address these types of behaviors and the living environment is appropriately monitored to ensure the safety of all youth.

2.B.5.4 The group care provider demonstrates that quick and effective action is consistently taken whenever a youth threatens or compromises the physical or psychological health and safety of other youth. Safeguards and mechanisms are in place to prevent youth from harming each other, either physically or emotionally.

2.B.5.5 Staff members actively promote positive peer influences on the behavior of youth through the development of prosocial behaviors and values with all youth.

2.B.5.6 Staff members promote a positive peer culture approach, where peers provide support for one another (e.g., the group care provider has a written policy on bullying that promotes a positive and safe environment).

2.B.6 Effective Crisis Management (De-Escalation Training, Formal Policies)

2.B.6.1 The behavioral management plan includes a model of implementation that includes step-by-step instructions on how to handle each youth's problem behaviors.

2.B.6.2 Incident reports are completed for any unusual incidents.

- **a.** The group care provider should have a structured process and policy in place to respond to and review youth- and staff-related critical incidents.
- **b.** The provider's policies and procedures should address documentation and reporting requirements for serious incidents and abuse prevention.

2.B.6.3 Staff members are able to use and document other non-physical methods to de-escalate a volatile youth situation before resorting to physical restraint.

- **a.** All staff members are trained in effective de-escalation techniques and anger management techniques to eliminate the need for seclusion or restraint.
- **b.** All staff members are trained in a wide range of skills and content knowledge that will help prevent youth crises.

2.B.6.4 Staff members monitor causes of aggressive incidents and implement evidence-based/evidence-informed techniques to prevent recurrences.

2.B.6.5 All incidents of physical hold use or restriction of movement by staff are tracked and reviewed periodically by clinical and administrative staff.

2.B.6.6 Staff members respond quickly to crisis activity when it begins.

2.B.6.7 The group care provider conducts a thorough administrative review of all crisis events.

a. Reviews of the critical incidents should focus on the actions of all parties involved with the affected youth and/or staff, and use a multidisciplinary approach that includes representatives from community agencies and organizations that are involved in protecting and serving youth and their families.

b. Managers should review all incidents to see what lessons can be learned and should discuss limit-setting in regular supervision sessions. Staff should have access to a procedure in which they can raise concerns about inappropriate sanctions or controls others may be using. Once guidance is issued, the inspection units should set up procedures to monitor whether it is being followed.

2.B.6.8 When necessary, group care staff members use a method of physical restraint that is evidence-based/evidence-informed, and is based on reputable practice. There is a written policy for use of physical restraint that all staff members and youth in the group care home understand. All staff members who are responsible for the care and supervision of youth shall be trained and demonstrate their mastery of acceptable methods of physical restraint. When physical restraint is used, it is applied in a way that is consistent with the policy requirements.

2.B.7 Limited Seclusion and Restraint

2.B.7.1 The group care provider has a policy that strives for a restraint-free milieu consistent with national standards and regulations. This policy should be reviewed with staff members at least annually.

2.B.7.2 The group care provider has well-specified quality improvement processes, including periodic reviews of restraint episodes.

2.B.7.3 The group care provider uses restraint only in an emergency, when there is an imminent risk of harm to a youth or others and less-restrictive interventions are unlikely to be effective in reducing or eliminating the danger.

2.B.7.4 Physical restraint should be deployed using the minimum amount of force necessary and for the shortest period of time. The actions of staff members should be proportionate to the circumstances that resulted in a youth being physically restrained.

2.B.7.5 A group care manager records and closely monitors the use of physical restraint, and case managers and parents are informed of its use.

2.B.8 Prevention of Self-Harm

2.B.8.1 Youth should expect to be protected from harm, including self-harm. An initial assessment and ongoing risk assessments will be completed.

2.B.8.2 If a youth is deemed to be at risk of harming himself or herself, or others, there is a written protocol for assessing and determining if the youth should be transferred to an inpatient psychiatric facility.

2.B.8.3 Mechanisms are in place to prevent self-harm. If there is risk of harm to a youth, others, or property, the youth, the group care provider, and the youth's parent/guardian should develop and sign a safety plan.

3 EFFECTIVELY MONITOR/REPORT PROBLEMS

3.C.1 Staff Are Trained to Immediately Report Problems

3.C.1.1 Group care staff/direct care staff are extensively trained and supervised and receive regular clinical oversight on practices related to youth behavioral health issues, including incident reporting, diagnosis, medications, behavioral interventions, crisis intervention, incident reporting, verbal de-escalation, and passive restraint techniques.

3.C.1.2 Staff members are required to immediately report any questionable or abusive staff practices or youth-to-youth incidents. Staff members receive annual training in this area, including crisis management policies.

3.C.1.3 If a staff member uses physical restraint, a supervisor must be briefed immediately regarding the circumstances. The incident should be recorded fully and notifications provided according to the group care provider's policy.

3.C.1.4 Staff members who are involved in crisis management incidents attend debriefings to discuss the incidents and complete documentation.

3.C.2 Grievance Process

3.C.2.1 Mechanisms and policies are in place so that youth can easily communicate their needs and experiences, and report problems.

3.C.2.2 A method is in place for youth and/or parents/legal guardians to report a grievance and redress issues.

3.C.2.3 Youth in care and family/legal guardian should understand and have ready access to grievance procedures.

3.C.2.4 The program follows established grievance procedures and responds to complaints.

3.C.2.5 Records should include documentation of all consumer concerns and grievances and their resolutions, including providing evidence that steps were taken to respond to reasonable criticisms or suggestions by direct consumers.

3.C.2.6 Youth can make their complaints in confidence to any program staff member.

3.C.2.7 Staff members must listen carefully to an informal complaint and pass it on to the person who has the authority to deal with it.

3.C.3 Reporting Allegations to External Agencies and Independent Audit

3.C.3.1 All allegations of unsafe, inappropriate, or abusive practices, regardless of who makes them, must be reported as a standardized part of the program. All required outside agencies must be notified of all serious complaints and allegations.

3.C.3.2 The group care provider ensures that all youth know they have regular access to an advocate outside of the group care program and that they can share any difficulties or concerns about their care with that advocate.

3.C.3.3 Appropriate external management and monitoring arrangements are in place.

3.C.4 Surveying Stakeholders (e.g., Youth, Parent, Consumer)

3.C.4.1 Utilize a survey to assess the satisfaction of youth, parents/guardians, and other key consumers and to allow them to express concerns or complaints regarding safety issues and how services are being provided.

3.C.4.2 Utilize an independent process for validating consumer satisfaction and for addressing consumer concerns and complaints.

3.C.4.3 Provide evidence that a high percentages of all youth are satisfied with the program on dimensions that are appropriate to their status and condition.

3.C.4.4 Provide evidence that a high percentage of key consumers, such as funders, guardians, or parents, are satisfied with the program's services.

3.C.4.5 To identify and evaluate outcomes, use a follow-up process that includes:

- **a.** Measurements of overall satisfaction with the services provided by the group care provider
- **b.** An examination of post-discharge outcomes using a consumer survey that focuses on youth experiences, outlooks, and perceptions while in group care

3.C.4.6 Implement a system to report survey results. Use this system to implement a continuous quality improvement (CQI) program that collects and reports sufficient quality indicators, including satisfaction surveys from all stakeholders.

4 PROMOTE FAMILY, CULTURE, AND SPIRITUALITY

4.D.1 Maintain Youths' Emotional Link with Family and Community

4.D.1.1 The group care provider helps youth and their families strive for improved family relationships and connections, and, whenever possible, family reunification.

4.D.1.2 Youth and their families should have maximum regular contact unless it is prohibited by court sanction.

- **a.** The care environment should allow for face-to-face contact between a youth and his or her family or others unless the treatment team determines that contact with a specific individual may be detrimental to the youth's treatment goals. Such information should be documented in the youth's record. Home visits for youth and telephone communication with family members or guardians, or with a court representative/case manager if the state has custody, should be encouraged.
- **b.** A youth's family should have positive involvement in the youth's care in whatever fashion that is most feasible and appropriate.
- **c.** For youth whose return to their family is not in their best interest, the group care provider should ensure contact that promotes the preservation of family identity for the youth.
- **d.** A youth's visits with family members, significant others, and friends are encouraged.

4.D.1.3 The group care provider promotes and utilizes community-based services or resources to provide access to normalization experiences.

4.D.1.4 Priority is given to having youth stay in one community so they can continue to attend the same school and build lasting relationships with friends, teachers, and care workers. This also allows youth to join local clubs and organizations that connect them with activities and people in the community while they are in care and possibly after leaving care. Staff members should make youth aware of community involvement opportunities and how to access them.

4.D.1.5 When services cannot be provided close to a youth's home or community, the group care provider should try to maintain family ties and involve the family in service planning/treatment planning and delivery by:

- **a.** Assisting the family with travel arrangements when possible
- **b.** Coordinating or facilitating family services to be delivered in the community

c. Employing methods for telecommunication through web-based or electronic systems

4.D.2 Involve Families in Treatment Decisions, Care, and Positive Activities (Family-Centered)

4.D.2.1 An effective multidisciplinary treatment (MDT) team is one in which family members can offer their point of view early in the process. Family members are equal partners in the process, and family resources and opportunities for participation in treatment should be identified.

4.D.2.2 The group care provider reaches out to family members and involves them in every facet of assessment, service planning/treatment planning, service implementation, and review.

4.D.2.3 Parents/caregivers are kept informed about events in their youth's life. Wherever possible, they have opportunities to make a positive impact in the care of their youth and are invited to participate in events such as school meetings, functions, and medical and dental appointments.

4.D.3 Provide Training that Supports Reunification and Maintaining Family Connections

4.D.3.1 For youth who are away from their families, reunification is the preferred outcome whenever that can be done safely.

4.D.3.2 Families should be given active support, encouragement, and training, as necessary, to help make reunification and permanency successful.

4.D.3.3 Clear plans and supports need to be offered to families when reunification is the service plan/treatment plan goal.

4.D.3.4 Discharge planning should provide families with strategies that can help their youth adapt to "family life" when they return home.

4.D.3.5 Processes need to be youth-friendly while remaining family-focused, with a goal of safe and stable reunification.

4.D.3.6 Group care staff members receive training to better understand youth and family outcome measures. This training includes gaining a clear understanding of the concepts of safety, permanency, and well-being, with an emphasis on the preservation of family connections, and how to be supportive of reunification strategies, when appropriate.

4.D.4 Encourage Home Visits

4.D.4.1 Efforts are made to ensure that youth have regular and increasingly frequent visits and interactions with key family members.

a. Visits assist in supporting parent-youth attachment, promote reunification, and help in the decision-making process to establish permanency plans.

b. Strategies are in place to assist with visits for the youth's family, caregiver, and/or significant others in the youth's life.

c. All efforts made by the group care provider to facilitate family and community visits/connections should be clearly documented.

4.D.4.2 Staff members should assist the youth in mastering the skills needed to live successfully in a family setting. This includes teaching and providing advice and support before, during, and after home visits.

4.D.4.3 Family visits in the group care setting and in the family's home should be planned, conducted, and monitored as a central part of services and transition plans.

Note: *Standards 4.D.2, 4.D.3, and 4.D.4 are not applicable if legal sanctions restrict parental involvement in a youth's services/treatment (e.g., parental rights have been terminated).*

4.D.5 Promote Community Involvement

4.D.5.1 Connecting youth to the community in which he or she is receiving care should be a priority. This includes helping the youth develop and maintain peer friendships, maintaining a continuity of connection to people and resources of significance, and providing opportunities for youth to participate in community activities without demarcation. Youth should be made aware of community service options, what they offer, and how to access them.

4.D.5.2 Youth should have access (through the group care program) to community involvement activities that enhance normalcy in the youth's life while he or she resides in group care. Examples include religious activities, educational activities, family involvement, using social skills and life skills, extracurricular school activities, socialization opportunities, volunteer opportunities, student work programs, and tribal activities (where appropriate).

4.D.5.3 Proactive systems should be in place to identify potentially abusive practices regarding community involvement activities.

4.D.5.4 Discharge planning should involve coordination with community-based services to ensure a continuum of care.

4.D.5.5 The group care program should offer evidence-based/evidence-informed treatment that is specific to the youth's psychiatric, educational, developmental, and medical needs.

4.D.6 Ensure Cultural Sensitivity

4.D.6.1 The group care provider must be sensitive to a youth's racial, cultural, religious, and linguistic needs. This should automatically be part of the attention given to every youth's emotional development.

4.D.6.2 The group care provider will:

a. Collaborate with other community partners for services that maintain a youth's cultural and religious connections

b. Assist youth by providing supportive communication and cultural activities through family visitations, and through participation in tribal traditions (where appropriate), cultural educational activities, cultural community awareness opportunities, and other social support connections

c. Recognize and acknowledge that youth have an active voice regarding their religious activities, including their decisions about religious beliefs, religious traditions, and religious worship desires and preferences

4.D.6.3 Youth should have access within the group care program to activities that foster identification with the people and the values of a youth's community and cultural heritage.

4.D.6.4 For American Indian youth, the group care provider should strive to ensure the continuity of the youth's cultural connections and the involvement of the youth's tribal community in the treatment approach and services.

4.D.6.5 Each youth and family has the right to receive culturally competent and linguistically appropriate services.

4.D.7 Help Youth Develop Religious, Spiritual, and Moral Values

The group care provider will:

4.D.7.1 Develop relationships between youth and churches, synagogues, community service agencies, and any other agencies that support the growth and acceptance of positive values; support each youth's choice of worship activity/spiritual beliefs

4.D.7.2 Provide youth with opportunities to develop religious practices consistent with their needs

4.D.7.3 Provide staff modeling and teach a sense of spiritual well-being that includes a sense of personal worth, a sense of purpose in one's life, and a sense of connectedness to other people

4.D.7.4 Help youth develop a sense of morality and responsibility for their actions

4.D.7.5 Respect every youth's right to be recognized for his or her uniqueness, including gender, culture, religion, and belief

5 DEVELOP AND MAINTAIN A PROFESSIONAL, COMPETENT STAFF

5.E.1. Appropriately Qualified Staff

5.E.1.1 The group care home is managed by qualified persons who provide care according to state regulations and meet national accreditation standards.

5.E.1.2 Psychiatric group care services are informed by a child psychiatrist and a team led by mental health professionals.

5.E.1.3 Staff should be specifically trained in the area of specialized need, and employment applications and human resources documentation should specifically address the criteria used to determine specialized qualifications.

5.E.1.4 The group care home has adequate levels of experienced staff to fulfill its purpose and functions. The home must have at least one qualified staff member at the child care-leader level on each shift.

5.E.1.5 Staff members are experienced and qualified to meet the complex array of needs of youth in care.

5.E.1.6 Salary standards are periodically reviewed to meet group care standards in order to attract and retain staff with sufficient ability and qualifications.

5.E.2 Comprehensive Staff Training

5.E.2.1 Staff members are trained in evidence-based/evidence-informed models of interventions.

5.E.2.2 Staff members are trained to protect youth, respect their rights, and prevent abuse.

5.E.2.3 Staff members are trained and retrained to teach educational, physical, and prosocial skills.

5.E.2.4 Training/instruction is skill-based and evidence-based/evidence-informed.

5.E.2.5 The group care program promotes close adult-youth relationships by carefully selecting and training staff members who have the most frequent and direct contact with youth.

5.E.2.6 Staff members are appropriately trained in crisis intervention in accordance with state licensing and national accrediting standards as it pertains to the use of physical restraint.

5.E.2.7 The group care provider should provide a comprehensive program of preservice training so that all new staff members can acquire the knowledge, skills, and motivation needed to effectively provide direct services to youth and their families. Training areas include:

a. First-aid, CPR, medication management, fire safety, psychiatric diagnosis, crisis management, documentation, and behavioral management

b. Behavioral health issues, including diagnosis, medications, behavioral interventions, crisis intervention, incident reporting, verbal de-escalation, and passive restraint techniques

c. Cultural competency

d. Additional training as necessary so staff members can effectively address the needs of the population of youth being served by the group care home

5.E.2.8 Measurable competency is required before any direct care staff member can independently (i.e., without shadowing or close supervision that may occur as part of training) begin caring for youth. Staff members must be able to:

a. Demonstrate that they possess the personal and technical competency to teach prosocial skills and values

b. Demonstrate that they have the technical competence to teach a wide range of adaptive skills through both modeling and organized curricula

c. Demonstrate their competency in all topics not otherwise covered as part of preservice training

5.E.2.9 The group care provider provides supervisors and other staff members with a comprehensive in-service and ongoing training program that helps them maintain and expand the knowledge and skills necessary to provide quality services. In-service training should be built into the program schedule on a frequent, regular, and continuing basis.

5.E.2.10 Supervisory training includes hiring practices, ongoing training, supervision, and appraisal of staff.

5.E.3 Criminal Record Screen for Staff

5.E.3.1 A comprehensive record screening is required for all staff, relief staff, and student interns, and volunteers are appropriately vetted before beginning their duties. This includes:

a. Checking past employer references, including the most recent reference

b. A criminal record review, including requests for checks from federal or other police authorities, as appropriate

c. Fingerprint screening on a national and local level

d. A review of applicants' driver's license and driving record

e. Face-to-face interviewing

f. Obtaining FBI clearance

g. Conducting child abuse screening

5.E.3.2 Any criminal activity involving staff members is reported to local law enforcement.

5.E.4 Supervision and Support for Staff

5.E.4.1 All group care staff members will receive regularly scheduled supervision.

- **a.** Sufficient supervisory, administrative, and support staff should be provided and be available as needed.
- **b.** Supervision provides for individualized mentoring and coaching.
- **c.** Supervision focuses on the model of care and supports its implementation.
- **d.** Supervision ensures that skills are effectively applied.

5.E.4.2 Clinical supervision occurs weekly and includes other members of the treatment team as needed.

5.E.4.3 Group care staff/direct care staff members must receive regular and ongoing supervision by a qualified program supervisor.

5.E.4.4 Therapists must receive weekly supervision with at least a licensed clinician.

5.E.4.5 Regular and formal supervision details are recorded.

5.E.4.6 Group care provider administrators should initiate systems to monitor the provision of supervision.

6 PROGRAM ELEMENTS

6.F.1 Provide the Least-Restrictive Level of Care

6.F.1.1 The group care provider provides the safest and least-restrictive level of care possible while continuing to act in the best interests of the youth.

6.F.2 Provide Care in a Family-Like Environment

6.F.2.1 Permanence, stability, a sense of connectedness, cultural identity, and family-like support are all critical elements in developing youth into healthy adults. The group care provider should endeavor to provide these critical elements and ensure their availability to every youth in its care.

- **a.** Family-style care is appropriate to a youth's needs.
- **b.** Staff members and youth do family activities together (e.g., eating meals, doing household chores, playing board games, etc.) and these activities are regarded as positive social events.

6.F.3 Normalization Activities

6.F.3.1 Youth have opportunities to develop and maintain interests, talents, and hobbies.

- **a.** Allow normal activities and freedoms that are appropriate to a youth's needs.
- **b.** Promote access to the healthy activities and freedoms that are typically associated with normal youth development.
- **c.** Identify a youth's talents, hobbies, and special interests.
- **d.** Emphasize normalization and reintegration; for example, youth should receive educational services in the community or should attend their own school, whenever this is possible.
- **e.** Access to participation in a wide variety of clubs or other prosocial activities should stimulate a youth's natural curiosities and interests.
- **f.** The group care provider celebrates festive occasions and each youth's birthday in a special way.

6.F.3.2 Youth should have access to leisure/recreational activities. The leisure/recreation domain includes community resources in the neighborhood and community of the youth's group care placement or permanent home.

- **a.** Allow socialization activities that are appropriate to the youth's needs.
- **b.** Ensure youth have access to physical exercise and opportunities to practice and play sports.
- **c.** Provide age-appropriate play and recreational facilities for youth.

d. Develop recreational budgets that are sufficient to provide youth with structured weekend and holiday activities.

6.F.4 Promote the Personal Identity of Youth

6.F.4.1 Youth have opportunities to imprint their own identity in their rooms and on their belongings.

a. Youth have personal belongings.

b. Youth have a safe and protected space for their personal items.

c. Youth are encouraged to personalize their bedroom with photos, toys, and personal items.

d. Youth are encouraged to make appropriate choices about their personal appearance and clothing, with support and advice from their caregivers.

6.F.5 Respect for Privacy

6.F.5.1 Youth have private living areas (bedroom, bathroom) and private areas for therapy.

6.F.5.2 Every youth and family has a right to personal privacy, confidentiality, and dignity.

6.F.5.3 Space is provided within the group care home where youth can have visits from friends, family members, or social workers; the space is private and visits will not disrupt the rest of the group care home.

6.F.5.4 Case and care records are stored in a way that ensures effective care planning and maintains appropriate levels of privacy and confidentiality for youth and their families.

6.F.5.5 Youth can make and receive telephone calls.

6.F.6 **Strong Program** (Research, Clear Model of Care, Best Practices, Model Fidelity)

6.F.6.1 The group care provider will provide evidenced-based/evidence-informed programs/practices, including:

a. A clearly defined model of care

b. A sound theoretical perspective and overarching practice framework for group care service delivery, including outlining the key principles and features of trauma-informed care

c. Supports for staff members as they implement the model and its practice with consistency and fidelity

d. A clear statement of what conditions the program does and does not treat and the types of treatment provided

6.F.6.2 The group care program offers different modalities of evidence-based/evidence-informed treatment.

6.F.6.3 The program follows national and state guidelines for treatment of mental disorders.

6.F.6.4 An experienced and qualified person monitors the group care home on a regular basis to ensure compliance with standards and best practices.

6.F.7 Full Range of Needed Services

6.F.7.1 Well-planned and well-resourced group care integrates a spectrum of services that includes transition supports, specialized clinical services, and a trained, qualified, skilled workforce.

6.F.7.2 Core elements include full access to required therapeutic supports for all youth.

6.F.7.3 All youth in care have early access to the best available services, expertise, and specialists they may require. Supervisors and group care provider staff members should keep a record of attempts to access these services, including efforts to:

a. Obtain supports and seek advice from other service agencies and private practitioners on specific therapeutic issues

b. Identify specific therapeutic needs and options for each youth (e.g., speech and language pathology, occupational therapy, family therapy)

6.F.7.4 If a needed service is identified through the assessment and service planning/treatment planning process but is not available through the group care provider, the treatment team should work with referring agencies and the youth's family to advocate for and obtain the needed service.

6.F.8 Licensure and Accreditation

6.F.8.1 Supervising therapeutic staff should hold appropriate licenses and credentials as required by local law and regulations.

6.F.8.2 Licensed professionals should have experience that is specific to youth diagnoses and family issues.

6.F.8.3 The group care program is licensed and has external monitoring on validated standards.

6.F.8.4 The group care provider will obtain a national accreditation in support of best-practice standards.

6.F.8.5 The provider should adhere to licensing requirements and accreditation standards, use competency-based training, and institute periodic retraining of staff.

6.F.9 Physical Health of Youth

6.F.9.1 The group care provider should have access to a qualified medical provider who is available 24 hours a day, 7 days a week.

6.F.9.2 All youth receive a medical assessment and physical examination in accordance with state licensing standards and national accreditation standards.

6.F.9.3 Referral assessments should describe a youth's health status, including current diagnoses, illnesses, injuries, communicable diseases, and current medications.

6.F.9.4 Youth should receive healthy living literacy education.

6.F.9.5 The group care provider should provide or facilitate provision of routine medical and dental services according to recommended well-child schedules.

6.F.9.6 Youth should:

a. Have access to a general practitioner
b. Remain registered with their family general practitioner, when possible
c. Be able to request the gender of the general practitioner who sees/treats them
d. Have a medical identification card that contains insurance information (e.g., private insurer, Medicare, Medicaid)
e. Be trained in the use of health insurance

6.F.9.7 Youth and parents are consulted regarding the health and dental care of the youth.

6.F.10 Close Supervision of Youth

6.F.10.1 Youth follow a daily structured routine that is designed to help meet their behavioral, treatment, and therapeutic needs.

6.F.10.2 Staff members supervise and monitor youth activities in accordance with the needs of each youth as specified in his or her service plan/treatment plan.

6.F.11 Quality Improvement Approach

6.F.11.1 The group care provider should develop and conduct a continuous quality improvement (CQI) program that is implemented across all services. The provider will identify staff members who conduct quality improvement.

6.F.11.2 The group care provider's quality improvement efforts ensure consistent program implementation and standard attainment across locations, services, and individual staff.

6.F.12 Regular Staff Meetings to Coordinate Care

6.F.12.1 Staff meetings and other forums take place regularly to facilitate good communication, cooperation, and consistency among staff members in implementing service plans/treatment plans, providing consistency of care, and maintaining youth and staff safety.

6.F.12.2 The group care provider should incorporate regular meetings that include discussions of youth behaviors and daily/shift issues related to youth treatment.

6.F.13 Collaborative Care (Multisystem Coordination)

6.F.13.1 The group care provider has a multidisciplinary treatment (MDT) team.

6.F.13.2 Treatment is an extension of service plans/treatment plans formulated in previous clinical settings.

6.F.13.3 The group care team approach should include the following potential participants: the youth and his or her parents/guardians, siblings, and grandparents; temporary caregivers; clergy; former teachers; counselors; group care staff members; and workers from the referral/placement agency and any other involved agencies.

6.F.13.4 Working cooperatively, the group care provider should clearly define the services for which each member of the MDT team is responsible. In order to provide the most effective services to youth and families, the working relationships among organizations should be collaborative and complementary.

6.F.14 Strive for Smaller Groups, Low Youth-to-Staff Ratio

6.F.14.1 Staffing ratios should be in accordance with state licensing and national accreditation standards.

6.F.14.2 Staffing levels must adequately meet the needs of all youth. Staff levels should be primarily based on the functions and objectives of the group care home and not on the numbers of youth being served.

6.F.15 Psychotropic Medications Are Psychiatrically Monitored at the Minimum for Clinical Needs

6.F.15.1 When medications are administered to youth, medication monitoring is provided by a board-certified psychiatrist, preferably one specializing in child and adolescent psychiatry.

6.F.15.2 A youth's psychotropic medication should be managed so he or she is receiving the minimum dosage required for clinical needs.

6.F.15.3 If a youth is on psychotropic medications, he or she is being seen by a psychiatrist on a monthly basis for medication management.

6.F.15.4 All medication management meetings are documented.

7 PROMOTE EDUCATION, SKILLS, AND POSITIVE OUTCOMES

7.G.1 Academic Testing

7.G.1.1 The group care provider is responsible for ensuring assessment, consultation, and planning for the education of each youth who is receiving services; for acting as a liaison with community educational services (the schools youth attend or special community-based educational services); and for sharing with staff members the educational elements that may affect the youth's adjustment and development.

7.G.1.2 The group care provider's educational services should provide or obtain an accurate and comprehensive educational assessment of each youth, using standardized/assessment tools. This should include assessing whether a youth needs special educational services. If not previously done, academic testing, as well as vision, speech, and language testing, should also be included.

7.G.2 Education Progress

7.G.2.1 The group care provider should ensure that each youth receives the education that is most appropriate to his or her individual needs, either by providing it directly or through arrangement, contract, or agreement with other resources.

7.G.2.2 The group care provider will require each youth to attend school, or an alternative educational program, for as long as the youth is entitled to educational services. Youth should receive accredited educational services.

7.G.2.3 The group care provider should encourage each student to pursue continuing his or her formal education in college, technical school, or a certificate program. Each student who wants to continue his or her education should receive assistance to identify and explore education options.

7.G.2.4 The group care program values education and the educational needs of each youth are addressed. Each youth is encouraged to reach his or her educational potential and receives necessary assistance toward that goal.

7.G.2.5 A formal educational plan should be in place for each youth within 30 days of admission. The plan should be coordinated with the student's home school.

7.G.2.6 A youth's educational progress should be routinely and frequently assessed using standardized, criterion-referenced assessments.

7.G.2.7 Outcomes should demonstrate that youth achieve one year of progress for each year of school they successfully complete while in group care, as indicated by standardized achievement tests, or achieve progress that is commensurate with their abilities where developmental limitations exist.

7.G.2.8 The group care staff members take an interest in each youth's education and support each youth.

7.G.2.9 Youth with deficits in educational attainment receive support through extra tutoring.

7.G.2.10 The group care provider assigns a responsible person(s) who shows interest in a youth's educational progress, encourages the youth to apply himself or herself, takes notice of school reports, and attends school events.

7.G.2.11 Students are given clear information about resources to which they are entitled or could apply for in order to further their educational development (e.g., music tutoring, study aids, computers, books).

7.G.3 Support for Special Education Needs

7.G.3.1 Every qualified youth should have a 504 Plan or an Individualized Educational Plan (IEP).

7.G.3.2 Where feasible, and no later than one week after admission, the group care provider requests and receives a youth's IEP or school records from the youth's home school or most recent school.

7.G.3.3 The educational services of the group care provider should adhere to the needs articulated in the youth's IEP and provide special education services as needed.

7.G.3.4 The group care provider should ensure that an IEP is developed for each youth with special needs for whom it is required by law and regulation.

7.G.3.5 A youth's engagement in education is supported through minimizing disruptions to his or her education.

7.G.4 Vocational Opportunities

7.G.4.1 When a traditional educational program is not viable for a youth, the group care provider's educational services should provide or obtain a vocational assessment for that youth.

7.G.4.2 Youth of graduation age are counseled on additional educational and vocational opportunities.

7.G.5 Development of Prosocial Behavioral Skills

7.G.5.1 Staff members teach prosocial skills, values, and behaviors through youth supervision, crisis management, daily living support, prosocial skill development, recreational activities, behavioral intervention, youth advocacy, and participation in the assessment and service planning/ treatment planning processes.

7.G.5.2 Youth learn, practice, and consistently use prosocial skills and behaviors.

7.G.5.3 Staff members teach youth how to work cooperatively with their peers and help them develop social skills, problem-solving capacity, and emotional support.

7.G.5.4 Each youth's prosocial skills include building positive relationships with family, peers, staff members, and others.

7.G.6 Symptom Reduction

7.G.6.1 An outcomes-driven approach to symptom reduction should demonstrate that substantial percentages of all youth improve in their major referral areas.

7.G.6.2 A youth's progress should be validated by using standards such as objective assessment tools or independent, professionally credentialed external evaluators.

7.G.6.3 In identifying and evaluating outcomes, the group care provider should specifically target outcomes that reduce symptom severity during placement.

7.G.7 Skills, Competencies, and Knowledge Needed for Life after Group Care

7.G.7.1 Youth should have opportunities to learn and master developmentally appropriate skills that move them toward maturity, autonomy, and self-sufficiency. Outcomes should be determined through the following post-departure measures:

- **a.** Stable family setting or independent-living status
- **b.** Employment, education, or military status
- **c.** High school graduation/GED rates
- **d.** Low delinquency and arrest rates
- **e.** Low readmission/recidivism rates
- **f.** Successful transition to adulthood

7.G.7.2 The group care provider should teach a curriculum of independent-living skills that fits the age and developmental level of each youth.

7.G.7.3 In collaboration with the local Community-Based Care (CBC) agency, the group care provider should use a standardized life skills assessment instrument as soon as possible after a youth's 14th birthday to establish a benchmark for progress on the development of skills in the areas of:

- **a.** Educational and vocational development
- **b.** Interpersonal skills
- **c.** Financial management
- **d.** Household management
- **e.** Self-care

7.G.8 Measure and Regularly Report Youth's Emotional, Behavioral, and Education Progress

7.G.8.1 The group care program has the responsibility to collect data on service/treatment outcomes and assess whether the program is achieving positive outcomes in the interventions it provides.

7.G.8.2 The group care program should provide and document updates on the progress or lack of progress of youth in care, including the areas of target behaviors, skill acquisition by youth and family, youth's/family's response to treatment, obstacles to treatment, and special circumstances.

7.G.8.3 The group care provider should help the youth (as age-appropriate) and family members evaluate their services in light of their desired outcomes, and determine whether modifications are necessary to improve progress.

7.G.8.4 The group care provider should regularly review service/treatment goals and objectives with the youth and the family, make necessary revisions in the service plan/treatment plan, and reinforce efforts to achieve desired outcomes.

7.G.8.5 Program managers have mechanisms in place for assessing the quality and effectiveness of services provided by the program, particularly in the area of positive outcomes for youth.

7.G.8.6 Staff members should periodically test youth on independent-living skills.

7.G.9 Place Accountability for Youth Progress on Program Structure

7.G.9.1 Utilize an evaluation framework to support an understanding of how best to make a positive difference for youth as they move through group care.

7.G.9.2 Identify and measure progress in achieving outcomes for youth and families being served, as well as outcomes for the service system. Document success in meeting goals and be accountable to the youth and families being served and to the community.

7.G.9.3 Demonstrate a functional relationship between program methods and youth skill development through ongoing assessment of youth skill acquisition and skill needs.

8 PRE-DISCHARGE/POST-DISCHARGE PROCESSES

8.H.1. Transition Planning (Education, Employment, and Treatment)

8.H.1.1 The group care provider should begin discussing the transition and discharge process with the youth and family at intake, and they should know the projected transition goal and date as early as possible.

8.H.1.2 Transition planning should support a youth's education, employment, and service/treatment transition plans.

8.H.1.3 Transition from the service plan/treatment plan includes a focus on continuity of relationships, family connection, family healing work, and community connection.

8.H.1.4 Youth should be prepared for leaving the group care home in ways that are appropriate to their age, development level, understanding, and maturity. This preparation reflects their permanency plan.

8.H.1.5 Whenever possible and permissible, staff members will maintain ongoing supportive relationships and contact with youth who have left the program.

8.H.1.6 Unless restricted by court sanctions, a youth's family should also be involved in the transition planning process as much as possible, and the group care provider will work with the youth and family to develop a plan for the youth to live in the community.

8.H.1.7 The group care provider helps youth obtain or compile documents that enable them to function independently. At a minimum, these include a valid state identification or driver's license, Social Security information, health information, and financial literacy information.

8.H.2 Provide Services That Support Family Reunification

8.H.2.1 The group care provider coordinates follow-up and ongoing involvement with a youth's parents or guardians.

8.H.2.2 In preparation for program departure, overnight stays by the youth with his or her parents/guardians provides an opportunity for the youth and family members to practice skills they learned during treatment. A visitation report is completed upon the youth's return from each visit and/or therapeutic leave.

8.H.2.3 The group care provider should deliver maximum support as youth prepare for transition. For youth and families whose goal is reunification, the provider should focus on delivering or coordinating support and connections they need in order to make reunification possible and successful.

8.H.2.4 Where indicated, the group care provider should actively engage the youth's family in counseling services to improve and support family functioning, examine special needs and stresses of the youth and family, facilitate changing attitudes and behaviors that will increase the youth's opportunity for success after reunification, examine the family members' appropriate roles, and/or improve parenting skills.

8.H.3 Connect Family to Community Resources

8.H.3.1 Discharge planning should review and take advantage of all applicable community resources. The youth and family should be introduced to potential mentors, groups, and services that can support them during and after transition.

8.H.4 Aftercare

8.H.4.1 The group care provider will provide support, aftercare, and community service coordination for the youth and their family and help former youth residents connect with a wide range of personal or professional services. This includes providing referrals and making all appointment dates prior to a youth's discharge.

8.H.5 Educational Outcomes (post-discharge)

8.H.5.1 The group care program conducts a follow-up that measures the educational and vocational progress and gains of former youth. Positive outcomes include:

- **a.** A substantial percentage of school-aged former youth are continuing their education
- **b.** A substantial percentage of former youth who are older than 19 have graduated high school or obtained a GED
- **c.** Former youth who received group care services during adolescence are able to complete high school or obtain a GED

8.H.6 Functional Outcomes (post-discharge)

8.H.6.1 The group care program conducts a follow-up that measures the living arrangement status of former youth. Positive outcomes include:

- **a.** A substantial percentage of former youth successfully depart to less-restrictive placements
- **b.** A low percentage of former youth are re-admitted to higher levels of care
- **c.** A substantial percentage of former youth maintain ongoing contact with family members and friends

8.H.7 Law-Abiding Outcomes (post-discharge)

8.H.7.1 The group care program conducts a follow-up that measures recidivism rates (arrest/incarceration) of former youth. Positive outcomes include:

- **a.** A substantial percentage of former youth have not been arrested or incarcerated
- **b.** One-year post-discharge arrest rates for former youth are equal to or less than the norms for their age group

8.H.8 Adulthood Transition Outcomes (post-discharge)

8.H.8.1 The group care program conducts a follow-up that measures long-term outcomes for former youth who are young adults. Positive outcomes include:

- **a.** A substantial percentage of former youth are either employed, in school (post-secondary education), or serving in the military

References

Bender, K. (2014). **Residential care models: A model review for Florida's system.** Tallahassee, FL: Boys Town North Florida.

Child Welfare League of America. (2004). **Standards of excellence: CWLA standards of excellence for residential services.** Washington, DC: Author.

Community Care. (2012). **Performance standards: Individualized residential treatment/community rehabilitation residential host home.** State College, PA: Author.

Council on Accreditation. (2015). **Council on Accreditation standards: Administrative service delivery and standards for group living services (GLS).** New York, NY: Author.

Daly, D.L., & Peter, V.J. (1996). **National performance standards for residential care: A policy initiative from Father Flanagan's Boys' Home.** Boys Town, NE: Father Flanagan's Boys' Home.

Department of Communities. (2010). **A contemporary model of residential care for children and young people in care.** Brisbane, AU: Author.

Department of Health and Children. (2001). **National standards for children's residential centres.** Dublin, IRL: The Stationary Office.

Houston, M., Trivedi, H., Axelson, A., Barron-Seabrook, S., Berland, D., Glasser, M., Goldman, S., Jackson, A., Ponfick, L., Sarvet, B., Schreter, R., Shain, B., & Sarvet, B. (2010). **Principles of care for treatment of children and adolescents with mental illnesses in residential treatment centers.** Washington, DC: American Academy of Child and Adolescent Psychiatry.

Skinner, A. (1992). **Another kind of home: A review of residential child care.** Glasgow, SCT: The Scottish Office.

Thompson, R.W., Huefner, J.C., Daly, D.L., & Davis, J.L. (2014). **Why quality residential care is good for America's at-risk kids: A Boys Town initiative.** Boys Town: NE: Boys Town Press.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SPB 7018
INTRODUCER:	Children, Families, and Elder Affairs Committee
SUBJECT:	Child Welfare
DATE:	October 27, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon		**CF Submitted as Committee Bill**

I. Summary:

Many states are moving in the direction of reducing the use of residential group homes for children in foster care. This shift of mission reflects a growing consensus within the child-welfare field that group home settings for foster children, while sometimes necessary, should be used appropriately. To lower the number of group care placements, states have two main options: providing more preventive support for unsafe families and recruiting more people, including relatives and fictive kin, to serve as foster parents.

Placement instability is harmful to children in foster care. Research shows an association between frequent placement disruptions and adverse child outcomes, including poor academic performance and social or emotional adjustment difficulties such as aggression, withdrawal, and poor social interaction with peers and teachers. Despite this evidence, there has been limited intervention by child welfare systems to reduce placement instability as a mechanism for improving outcomes for children. A thorough assessment process to determine the appropriate placement is the most effective way to reduce multiple placements.

SPB 7018 addresses these issues by requiring community-based care lead agencies to have available a full array of services, including intervention services, to help keep children from coming into foster care and requiring more accountability for the outcomes of service delivery. The bill also creates a uniform assessment process to determine the appropriate placement for each child entering the child welfare system.

The bill requires the department, in collaboration with other entities, to develop a continuum of care for children that establishes levels of care in both family foster care and residential group care and to revise rules and licensing standards to reflect those levels of care.

The bill repeals a number of sections of statute related to residential group homes that would become obsolete upon passage of the bill.

The bill is anticipated to have an insignificant fiscal impact on state government.

The bill provides an effective date of July 1, 2016.

II. Present Situation:

Placement Options for Children in Out-of-Home Care

Federal law has long supported the belief that all children should grow up in families. The Adoption Assistance and Child Welfare Act of 1980 codified the concept that children should be cared for in their own homes whenever it is possible to do so safely and in new permanent homes when it is not. To preserve the well-being of children who enter the system, out-of-home placements must be in the least restrictive setting possible that is most like a family.[1] Florida has likewise codified the concept of least restrictive setting.[2]

The Adoption and Safe Families Act of 1997 (ASFA), signed into law in November 1997, was the most significant piece of legislation dealing with child welfare since the enactment of the Adoption Assistance and Child Welfare Act. The legislation was in response to growing concerns that child welfare systems across the country were not providing for the safety, permanency, and well-being of children in an adequate and timely fashion. The new law aimed to reaffirm the focus on child safety in case decision making and to ensure that children did not languish and grow up in foster care, but instead were connected with permanent families.[3] Florida was one of the first states to enact the provisions of ASFA.[4]

Placement with Relatives or Kinship Care

A large body of research acknowledges the evidence that children in kinship care are less likely to change placements and benefit from increased placement stability, compared with children in general foster care. Placement stability is a common goal of child welfare systems and has consistently been shown to result in better outcomes for all children living in out-of-home care. Children in kinship care are also more likely to remain in their same neighborhood, be placed with siblings, and have consistent contact with their birth parents than children in foster care, all of which might contribute to less disruptive transitions into out-of-home care.[5]

In addition to adoption and reunification, ASFA included placement with relatives, legal guardians, or another planned permanent-living arrangements as appropriate permanency options for children who cannot be reunified with their parents. While ASFA encouraged states to see fit and willing relatives as permanent family options, it did so without offering ongoing financial assistance to help relatives who were foster parents caring for children as their guardians outside

---

[1] Adoption Assistance and Child Welfare Act of 1980, Pub. L. 96–272, 42 USC s. 675.
[2] See ss. 39.407, 39.6012 and 409.165, F.S.
[3] The Urban Institute. Golden, O. and Ehrle Macomber, J. (2009) *Intentions and Results: A Look Back at the Adoption and Safe Families Act, available at:* http://www.urban.org/research/publication/intentions-and-results-look-back-adoption-and-safe-families-act (last visited October 18, 2015).
[4] Chapter 98-403, Laws of Florida.
[5] Rubin, D., Downes, K., et al. *Impact of Kinship Care on Behavioral Well-being for Children in Out-of-Home Care* Archives of Pediatric and Adolescent Med. 2008;162(6):550-556.

of foster care.[6] ASFA provided incentives to encourage movement of children to adoptive families, but no similar fiscal incentives to help children leave care to live permanently with legal guardians or relatives who were not adopting them.[7] Other provisions of ASFA created challenges for a child to be placed with a fit and willing relative. Specifically, ASFA regulations require that relative foster homes be licensed in the same way as foster homes for children in non-relative placements, with only limited case-specific exceptions.[8]

More recent federal legislation, the 2008 Fostering Connections to Success and Increasing Adoptions Act (Fostering Connections), makes this requirement a bit less restrictive by allowing states to waive non-safety related licensing standards for relative homes on a case-by-case basis. Fostering Connections also supports states in providing financial subsidies to kinship legal guardianship placement as long as certain conditions have been met. Florida has not implemented the provisions of Fostering Connections related to relative guardianship.[9]

Florida did, however, recognize the importance of relative placements by creating the Relative Caregiver Program in 1998 to provide financial assistance to eligible relatives caring for children who would otherwise be in the foster care system.[10] Nonetheless, this recognition provided benefits in an amount less than those provided to foster parents or adoptive parents. While the statewide average monthly rate for children judicially placed with relatives or nonrelatives who are not licensed as foster homes may not exceed 82 percent of the statewide average foster care rate,[11] currently, the monthly amount of the payment is far less than that:[12]

- Age zero through five years – $242
- Age six through 12 years – $249
- Age 13 to 18 years – $298

In addition, children living with relatives are often not eligible for other benefits provided to children living in licensed foster care.[13] According to the department, in August 2015, Florida had 22,087 children in out-of-home care, with 9,800 of those living in relative placements.

Family Foster Homes

Family foster homes offer the next least restrictive environment following kinship care for children in need of out-of-home placements. Florida does not have enough family foster homes and does not have an adequate array of homes necessary to meet the variety of needs of children

[6] The Urban Institute. Allen, M.L. and Davis-Pratt, B. (2009) *The Impact of ASFA on Family Connections for Children*. *available at:* http://www.urban.org/research/publication/intentions-and-results-look-back-adoption-and-safe-families-act (last visited October 18, 2015).
[7] Although some relatives seek to adopt, grandparents sometimes are especially hesitant because of the need first to terminate their own children's parental rights and the hope that these adult sons or daughters will one day be able to resume parenting.
[8] The Urban Institute. Allen, M.L. and Davis-Pratt, B. (2009) *The Impact of ASFA on Family Connections for Children*. *available at:* http://www.urban.org/research/publication/intentions-and-results-look-back-adoption-and-safe-families-act (last visited October 18, 2015).
[9] P.L. 110-351.
[10] Section 39.5085, F.S. In 2014 the program was expanded to include nonrelative caregivers. Chapter 2014-224, Laws of Florida.
[11] *Id*.
[12] 65C-28.008, F.A.C.
[13] See s. 409.1451, F.S.

in out-of-home placements. It is a problem that has existed for at least 15 years. In 2001, it was reported that "Florida's foster care system was overwhelmed with many problems during the past several years as evidenced by law suits, grand jury investigations, and special investigations such as the District 7 Child Safety Strike Force."[14]

The Justification Review of the Child Protection Program in the Department of Children and Family Services, February, 2001, by the Office of Program Policy Analysis and Government Accountability (OPPAGA),[15] reported the following problems with Florida's foster care system:

- The number of admissions to foster care increased by 13 percent between FY 1998-99 and FY 1999-00.
- The department increased its foster home capacity by only 5 percent between FY 1997-98 and 1998-99 even after receiving 70 new FTEs from the 1999 Legislature solely for the purpose of recruiting new foster families.
- The number of children needing care outpaced the number of foster homes leaving many foster home overcrowded.

Lawsuits also alleged numerous problems associated with the foster care system, including failure on the part of the state to develop an array of foster care settings to ensure a safe and secure placement for each foster child, particularly in respect to foster homes for large sibling groups and teenagers.[16]

Florida responded to the lack of foster homes by enacting legislation in 2001 and 2002 to increase the utilization of residential group home placements until additional foster homes could be recruited.[17] In addition to requiring that any dependent child 11 years of age or older who has been in licensed family foster care for 6 months or longer, who is then moved more than once and who is a child with extraordinary needs must be assessed for placement in licensed residential group care, funds were also authorized to be used for one-time startup funding for residential group care purposes that include, but are not limited to, remodeling or renovation of existing facilities, construction costs, leasing costs, purchase of equipment and furniture, site development, and other necessary and reasonable costs associated with the startup of facilities or programs.[18]

At the same time, the department expressed concerns that the provisions of the proposed legislation were contrary to the literature, contrary to guidance from the federal government, and contrary to the fact that movement over the past decade was away from group home care.[19]

---

[14] Committee on Children and Families. *Senate Staff Analysis and Economic Impact Statement*. CS/CS/SB 1214, March 29, 2001.

[15] Office of Program Policy Analysis and Government Accountability. *Justification Review of the Child Protection Program in the Department of Children and Family Services*. Report Number 01-14, February, 2001. *available at*: http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0114rpt.pdf. (last visited October 17, 2015).

[16] See, for example, *Foster Children v Bush*, 329 F.3d 1255 (11th Cir.2003) and *Ward, et al. v Feaver, et al* 2000 WL34025227 U.S. District Court S.D. Florida.

[17] See ss. 39.523, 409.1676, 409.1677 and 409.1679, F.S.

[18] Section 39.523, F.S.

[19] Testimony from committee meetings: Senate Children and Families Committee, SB 623, January 30, 2002; Senate Children and Families Committee, SB 1214, March 14, 2001; House Child and Family Security Committee, HB 1145, March 15, 2001; House Child and Family Security Committee, HB 755, February 7, 2002.

Residential Group Care

Residential group care as a placement option for children in the child welfare system who are in out-of-home care has many forms and functions, including serving as a child placement option and as a treatment component of the children's mental health system of care. The multiple roles of group care make an analysis of its effectiveness difficult and complex.[20]

Some working in child welfare contend that all residential group care is potentially harmful and that its use should be eliminated. Others support the position that such placements are beneficial for some children in certain situations. Other stakeholders favor the wholesale use of group care as an alternative to the shortage of family placements or reliance on family placements that may expose children to further risk. Both positive and negative claims about the effectiveness of residential group care and its alternatives are often made without sufficient evidence.[21]

There appears to be a growing consensus within the child-welfare community that residential group home settings for children in out-of-home care are sometimes necessary but should be used sparingly and only for the length of time necessary to place the child in a less restrictive environment. While some states have been more successful than others, many states have tried to decrease reliance on group home care.[22]

KVC Health Systems, a private company hired to provide child-welfare services in eastern Kansas and a number of other states, has been very successful in reducing the number of children in residential group care, reporting that only three percent of the 3,100 children it oversees are in group settings, primarily for short-term psychiatric treatment, while virtually all the others are placed with foster families. That's a dramatic change from 1997, when 30 percent of KVC's children were in group care placements.[23]

Several child welfare organizations are advocating for an overhaul of the federal funding system for child welfare, with a goal of shifting funding from residential group home settings to alternatives such as family-based care. One proposal by the Annie E. Casey Foundation and one of its partners, the Jim Casey Youth Opportunities Initiative, suggests that federal reimbursement should be eliminated for shelters and group care for children under 13 years of age while federal reimbursement should be allowed for older children's group care only for short periods when necessary for psychiatric treatment or other specialized care.[24] U.S. Sen. Orrin Hatch, chair of the U.S. Senate Finance Committee, recently held two hearings related to reducing reliance on

---

[20] Barth, R. (2002). *Institutions vs. foster homes: The empirical basis for the second century of debate*. Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families, *available at*: http://resourcecentre.savethechildren.se/sites/default/files/documents/2344.pdf. (last visited October 17, 2015).

[21] Child Welfare League of America. (2008*). Residential Transitions Project Phase One Final Report, available at*: http://rbsreform.org/materials/Residential%20Transitions%20Project%20-%204%2030%2008%20_2_.pdf . (last visited October 17, 2015).

[22] *Id*. Also see California Health and Human Services Agency. California's Child Welfare Continuum of Care Reform, January 2015, *Children's Rights, What Works in Child Welfare Reform: Reducing Reliance on Congregate Care in Tennessee*, July 2011, and The Annie E. Casey Foundation, *Rightsizing Congregate Care, A Powerful First Step in Transforming Child Welfare System*, 2010.

[23] Crary, D. *Foster care: U.S. Moves to phase out group care for foster kids,* Christian Science Monitor. May 17, 2014, *available at*: http://www.csmonitor.com/The-Culture/Family/2014/0517/Foster-care-US-moves-to-phase-out-group-care-for-foster-kids. (last visited October 17, 2015).

[24] *Id*.

residential group care placements. The written statement submitted for the May 19, 2015 hearing by Dr. Jeremy Kohomban, President and CEO of The Children's Village in New York,[25] stated:

> In fact, the time has come for private providers to make a change in how we do business, and more providers than you might think are rising to this challenge. Just as public agencies must change, so must private agencies. Our business models must move away from mostly residential care and toward community-and family-based care that is targeted, effective and short-term—including, of course, short-term effective residential care as needed for emergency interventions. You may hear complaints from private providers in your district. They may say this kind of change is hard. Or that the needs of children and families cannot be met using these new models of care. But the evidence is not on their side…
>
> For many years, Children's Village was a reform school on a leafy green residential campus. It looks lovely—like a safe place for kids. And it is a safe place for youth to live temporarily to stabilize and be treated. But leafy green trees do not make a whole child. Belonging and family does… Generally speaking, children do not benefit from being miles away from their families. Even when their families are poor or struggling with problems such as addiction. If you help the parents, you help the children and build a working family. It is time that private provider's look beyond our campuses and our in-patient medical models and find effective ways to meet the needs of children while they live with their families or foster families.
>
> If providers complain, it is because the task before us is immensely challenging… But change is required, for the sake of our children. Because we know that in community after community, taxpayers are paying a lot of money to house children away from their families, when significantly better results are possible through well designed, appropriately funded, performance-focused community-and family-based care.

Nationally, according to the Adoption and Foster Care Analysis and Reporting System (AFCARS) data, in 2012, nearly half (47 percent) of all children in care lived in the foster family homes of non-relatives. Just over one-quarter (28 percent) lived in family foster homes with relatives, often referred to as "kinship care." Six percent of foster children lived in group homes, eight percent lived in institutions, four percent lived in pre-adoptive families, and the rest lived in other types of facilities.[26] These are not substantially different from the proportions at the beginning of the decade, though there has been a slight decrease in the number of foster children in group homes and institutions, and a corresponding increase of those in home care.[27] In Florida, 11 percent of children in foster care are in residential group care and 83 percent of the children in group care are 11 years of age and older, compared to 17 percent in family care settings.[28]

---

[25]

[26] U.S. Department of Health and Human Services Administration for Children and Families, Children's Bureau. The AFCARS Report (2013) *available at*: http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport19.pdf. (last visited October 17, 2015).

[27] Child Trends Data Bank, Foster Care Indicators on Children and Youth (2014) *available at*: http://www.childtrends.org/wp-conte00000nt/uploads/2014/07/12_Foster_Care.pdf. (last visited October 16, 2015).

[28] Office of Program Policy and Government Accountability. Research Memorandum. *Florida's Residential Group Care Program for Children in the Child Welfare System*. December 2014.

Residential group homes are one of the most expensive placement options for children in the child welfare system. The costs of group home care far exceed those for foster care or treatment foster care. The difference in monthly cost can be between six and 10 times higher than foster care and between two and three times higher than treatment foster care. Since there is virtually no evidence that these additional expenditures result in better outcomes for children, there is no cost benefit justification for group care, when other placements are available.[29]

In Florida, unlike rates for foster parents and relative caregivers which are set in statute and in rule, community-based care lead agencies annually negotiate rates for residential group home placements with providers. In Fiscal Year 2013-2014, the average per diem rate for the shift-care group home model was $124, with costs ranging from $52 to $283. The average per diem rate for a family group home model was $97, with costs ranging from $17 to $175. Family foster home care pays an average daily rate of $15.[30] The cost of group home care in Florida for Fiscal Year 2013-2014 was $81.7 million.[31]

III. Effect of Proposed Changes:

Section 1 amends s. 39.01, F.S., relating to definitions, to create a definition of the term "conditions for return" which applies when consideration is being given to the department returning a child.

Section 2 amends s. 39.013, F.S., relating to jurisdiction and right to counsel, to continue court jurisdiction until the age of 22 for young adults with a disability who choose to remain in extended foster care. This is consistent with the provisions of s. 39.6251, F.S.

Section 3 amends s. 39.402, F.S., relating to placement in a shelter, to require the court order for placement of a child in shelter contain a written finding that the placement proposed by the department is in the least restrictive and most family-like setting that meets the needs of the child, unless that type of placement is unavailable.

Section 4 amends s. 39.521, F.S., relating to disposition hearings, to require the court order for disposition contain a written finding that the placement of the child is in the least restrictive and most family-like setting that meets the needs of the child, as determined by the required assessments.

Section 5 amends s. 39.522, F.S., relating to postdisposition change of custody, to change the standard for the court to return a child to the home from "substantially complied with the terms of the case plan" to "circumstances that caused the out-of-home placement have been remedied" with in-home safety plan in place.

---

[29] Barth, R. (2002). *Institutions vs. foster homes: The empirical basis for the second century of debate.* Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families, available at: http://resourcecentre.savethechildren.se/sites/default/files/documents/2344.pdf. (last visited October 17, 2015).

[30] Office of Program Policy and Government Accountability. Research Memorandum. *Florida's Residential Group Care Program for Children in the Child Welfare System* (December 2014).

[31] *Id*.

Section 6 amends s. 39.6011, F.S., relating to the development of case plans, to rearrange and restructure the section. The section now states the purpose of a case plan and requires documentation that a preplacement assessment of the service needs of the child and family, and preplacement preventive services, if appropriate, have been provided and that reasonable efforts to prevent out-of-home placement have been made. Procedures for involving the child in the case planning process are revised and put in a separate subsection.

Section 7 amends s. 39.6012, F.S., relating to case plan requirements for services and tasks for parents and safety, permanency and well-being for children, to rearrange and restructure the section. The bill requires documentation in the case plan that the required placement assessments have been completed; that the child has been placed in the least restrictive, most family-like setting or if not, the reason for the alternative placement; and that if the child has been placed in a residential group care setting, regular reviews and updates to the case plan must be completed.

The bill also requires that provisions in the case plan relating to visitation and contact of the child with his or her parents and/or siblings also apply to extended family members and fictive kind. The term "fictive kin" is defined as individuals that are unrelated to the child by either birth or marriage, but have an emotionally significant relationship with the child that would take on the characteristics of a family relationship.

Section 8 amends s. 39.6035, relating to the transition plan, to clarify that the transition plan must be approved by the court before the child's 18th birthday.

Section 9 amends s. 39.621, F.S., relating to permanency determinations by the court, to add provisions relating to maintaining and strengthening the placement. These provisions are current law in s. 39.6011, F.S., and they are being relocated to s. 39.621, F.S.

Section 10 amends s. 39.701, F.S., relating to judicial review, to add a requirement to the social study report for judicial review include documentation that the placement of the child is in the least restrictive, most family-like setting that meets the needs of the child as determined through assessment. The section also requires the court to order the department and the community-based care lead agency to file a written notification before a child changes placements if possible. If such notification before changing placements is not possible, the notification shall be filed immediately following a change. This flexibility would accommodate those cases when a child must be moved on short notice or after work hours.

Section 11 creates s. 409.142, F.S., relating to intervention services for unsafe children, to provide legislative findings that intervention services and supports are designed to strengthen and support families in order to keep them safely together and to prevent children from entering foster care. The bill also states legislative intent for the department to identify evidence-based intervention programs that remedy child abuse and neglect, reduce the likelihood of foster care placement by supporting parents and relative or nonrelative caregivers, increase family reunification with parents or other relatives, and promote placement stability for children living with relatives or nonrelative caregivers. The section defines the term "intervention services and supports", provides the types of intervention services that must be available for eligible individuals, provides eligibility for intervention services, requires a monitoring plan to be submitted by each community-based care lead agency to the department by October 1, 2016 and

requires an annual report on specified data from the lead agencies to the department as part of the Results Oriented Accountability Program under s. 409.997, F.S.

Section 12 creates s. 409.143, F.S., relating to assessment and determination of appropriate placements for children in care, to state legislative findings and intent relating to the assessment of children in order to determine the most appropriate placement for each child in out-of-home care. The bill defines the terms "child functioning level," "comprehensive behavioral health assessment" and "level of care." The bill requires an initial placement assessment whenever a child has been determined to need an out-of-home placement and requires the department to document these initial assessments in the Florida Safe Families Network (FSFN) and update the case plan.

The bill requires procedures in s. 39.407, F.S., to be followed whenever a child is being placed in a residential treatment facility, and prohibits placement decisions from being made by an individual or entity that has a conflict of interest with an agency being considered for placement.

The bill also requires a follow-up comprehensive behavioral health assessment to be completed for each child placed in out-of-home care; requires certain information to be included in the assessment; requires that the assessment be completed within 30 calendar days after the child enters out-of-home care; and requires the department to use the results of the comprehensive assessment to determine the child's functioning level and the level of care needed by the child.

The bill requires the establishment of permanency teams by the department or the community-based care lead agencies to regularly convene a multi-disciplinary staffing to review the appropriateness of the child's placement and provides what is to be included in the review. An annual report to the Governor, the President of the Senate and the Speaker of the House of Representatives is required by October 1 of each year that includes specified data.

Section 13 creates s. 409.144, F.S., relating to continuum of care, to provided legislative findings and intent related to the safety, permanency, and well-being of children in out-of-home care. The section defines the terms "continuum of care," "family foster care," "level of care," "out-of-home care," "and "residential group care."

The bill requires the department, in collaboration with the Florida Child Welfare Institute, the Quality Parenting Initiative, and the Florida Coalition for Children to develop a continuum of care for the placement of children in out-of-home care that includes both family foster care and residential group care by December 31, 2017. To implement the continuum the department must:

- Establish levels of care that are clearly defined with the qualifying criteria for placement at each level identified;
- Revise licensure standards and rules to reflect the services and supports provided by a placement at each level of care and include the quality standards that must be met by licensed providers;
- Develop policies and procedures to ensure that placements are appropriate for each child as determined by the required assessments and staffings and last only long enough to resolve the issue that required the placement;

- Develop a plan to recruit, train and retain specialized foster homes for pregnant and parenting teens that are designed to provide an out-of-home placement option that will enable them to live in the same foster family home while caring for the child and working towards independent care of the child;
- Work with the Department of Juvenile Justice to develop specialized placements for children who are involved with both the dependency and the juvenile justice systems.

The bill requires an annual report by the department to the Governor, the President of the Senate and the Speaker of the House of Representatives and provides for the contents of the report.

Section 14 amends s. 409.1451, F.S., relating to the Road-to-Independence Program, to create a process for making federal education and training vouchers available to a child or young adult in out-of-home care if he or she meets certain eligibility requirements and provides that the department may adopt rules to implement the program.

Section 15 amends s. 409.988, F.S., relating to duties of community-based care lead agencies, to require lead agencies to ensure the availability of a full array of services necessary to meet the needs of all individuals within their local system of care. The section also requires the department to report annually to the Governor, the President of the Senate and the Speaker of the House of Representatives on the adequacy of the available service array by lead agency.

Section 16 amends s. 39.202, F.S., relating to confidentiality of records and reports in cases of child abuse or neglect, to revise the designation of an agency.

Section 17 amends s. 39.302, F.S., relating to protective investigations of institutional child abuse, abandonment or neglect, to correct a cross reference.

Section 18 amends s. 39.524, F.S., relating to safe-harbor placement, to correct a cross reference.

Section 19 amends s. 39.6013, F.S., relating to case plan amendments, to correct a cross reference.

Section 20 amends s. 394.495, F.S., relating to child a adolescent mental health system of care, to correct a cross reference.

Section 21 amends s. 409.1678, F.S., relating to specialized residential options for children who are victims of sexual exploitation, to correct a cross reference.

Section 22 amends s. 960.065, relating to eligibility for awards, to correct a cross reference.

Section 23 amends s. 1002.3305, F.S., relating to the College-Preparatory Boarding Academy Pilot Program for at-risk students, to correct a cross reference.

Section 24 repeals s. 39.523, F.S., relating to placement in residential group care.

Section 25 repeals s. 409.141, F.S., relating to equitable reimbursement methodology for residential group home care.

Section 26 repeals s. 409.1676, F.S., relating to comprehensive residential group care services to children who have extraordinary needs.

Section 27 repeals s. 409.1677, F.S., relating to model comprehensive residential services programs.

Section 28 repeals, s. 409.1679, F.S., relating to additional requirements and reimbursement methodology for residential group care.

Section 29 provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Most community based care lead agencies make the determination of the placement of a child in foster care. In some areas of the state however, private, non-profit agencies under contract with the community based care lead agency determine placements of foster children. The bill prohibits an agency under contract with the community based care lead agency from providing placement services and operating group homes. The bill does this to ensure there is no conflict of interest for the placement agency in recommending placements in group homes operated by that same agency. Some providers may have to choose between providing placement services and operating group homes.

C. Government Sector Impact:

The extent to which the bill reduces the number of children in group home care and increases the number of children in foster homes, the bill would have a positive fiscal impact on the state. The average cost of group care with shift care workers is $124 per day per child, the average cost of group care with house parents is $97 per day per child,

and the average cost of foster home is $15 per day per child.[32] The amount of such an impact is indeterminate.

The bill revises current practices in assessment and placement of children in foster care. To the extent that these new procedures are more costly than current practices, the bill would have a negative fiscal impact on the state. The amount of such an impact is indeterminate.

The bill revises current court procedures in the case planning and placement of children in foster care. To the extent that these new procedures are more costly than current practices, the bill would have a negative fiscal impact on the state. The amount of such an impact is indeterminate.

Finally, the bill authorizes education and training vouchers for certain children in foster care under certain circumstances. The fiscal impact of this change is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 39.01, 39.013, 39.202, 39.302, 39.402, 39.521, 39.522, 39.524, 39.6011, 39.6012, 39.6013, 39.6035, 39.621, 39.701, 394.495, 409.1451, 409.1678, 409.988, 960.065, and 1002.3305,

This bill creates the following sections of the Florida Statutes: 409.142, 409.143, and 409.144

This bill repeals the following sections of the Florida Statutes: 39.523, 409.141, 409.1676, 409.1677, and 409.1679.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[32] Office of Program Policy and Government Accountability. Research Memorandum. *Florida's Residential Group Care Program for Children in the Child Welfare System*. December 2014.

184684

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 102 and 103
insert:

Section 1. Section 39.01, Florida Statutes, is amended to read:

39.01 Definitions.—When used in this chapter, unless the context otherwise requires:

(20) "Conditions for return" means the circumstances that caused the out-of-home placement have been remedied to the

184684

extent that the return of the child to the home with an in-home safety plan will not be detrimental to the child's safety, well-being, and physical, mental and emotional health.

Section 2. Subsection (2) of section 39.013, Florida Statutes, is amended to read:

39.013 Procedures and jurisdiction; right to counsel.—

(2) The circuit court has exclusive original jurisdiction of all proceedings under this chapter, of a child voluntarily placed with a licensed child-caring agency, a licensed child-placing agency, or the department, and of the adoption of children whose parental rights have been terminated under this chapter. Jurisdiction attaches when the initial shelter petition, dependency petition, or termination of parental rights petition, or a petition for an injunction to prevent child abuse issued pursuant to s. 39.504, is filed or when a child is taken into the custody of the department. The circuit court may assume jurisdiction over any such proceeding regardless of whether the child was in the physical custody of both parents, was in the sole legal or physical custody of only one parent, caregiver, or some other person, or was not in the physical or legal custody of any person when the event or condition occurred that brought the child to the attention of the court. When the court obtains jurisdiction of any child who has been found to be dependent, the court shall retain jurisdiction, unless relinquished by its order, until the child reaches 21 years of age, with the following exceptions:

(a) If a young adult chooses to leave foster care upon reaching 18 years of age.

(b) If a young adult does not meet the eligibility

requirements to remain in foster care under s. 39.6251 or chooses to leave care under that section.

(c) If a young adult petitions the court at any time before his or her 19th birthday requesting the court's continued jurisdiction, the juvenile court may retain jurisdiction under this chapter for a period not to exceed 1 year following the young adult's 18th birthday for the purpose of determining whether appropriate services that were required to be provided to the young adult before reaching 18 years of age have been provided.

(d) If a petition for special immigrant juvenile status and an application for adjustment of status have been filed on behalf of a foster child and the petition and application have not been granted by the time the child reaches 18 years of age, the court may retain jurisdiction over the dependency case solely for the purpose of allowing the continued consideration of the petition and application by federal authorities. Review hearings for the child shall be set solely for the purpose of determining the status of the petition and application. The court's jurisdiction terminates upon the final decision of the federal authorities. Retention of jurisdiction in this instance does not affect the services available to a young adult under s. 409.1451. The court may not retain jurisdiction of the case after the immigrant child's 22nd birthday.

(e) If a young adult with a disability remains in foster care, jurisdiction shall continue until the young adult chooses to leave foster care or upon the young adult reaching 22 years of age, whichever occurs first.

184684

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete line 2
and insert:
An act relating to child welfare; amending s. 39.01,F.S.; defining term; amending s. 39.013, F.S.; extending court jurisdiction to age 22 for young adults with disabilities in foster care; amending s. 39.402,

917038

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 258 and 259
insert:

Section 3. Subsection (2) of section 39.522, Florida Statutes is amended to read:

39.522 Postdisposition change of custody.—The court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing.

917038

(2) In cases where the issue before the court is whether a child should be reunited with a parent, the court shall determine whether the circumstances that caused the out-of-home placement have been remedied ~~parent has substantially complied with the terms of the case plan~~ to the extent that the return of the child to the home with an in-home safety plan will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health ~~of the child is not endangered by the return of the child to the home~~.

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

And the title is amended as follows:

Delete line 9

and insert:

in its written orders of disposition; amending s. 39.522, F.S.; providing conditions under which a child may be returned home with an in-home safety plan; amending s.

206734

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 276 - 373
and insert:
(b) Be developed in a face-to-face conference with the parent of the child, any court-appointed guardian ad litem, the child's attorney and, if appropriate, the temporary custodian of the child. The parent may receive assistance from any person or social service agency in preparing the case plan. The social service agency, the department, and the court, when applicable,

206734

shall inform the parent of the right to receive such assistance, including the right to assistance of counsel.

(c) Be written simply and clearly in English and, if English is not the principal language of the child's parent, in the parent's principal language, to the extent practicable.

(d) Describe a process for making available to all physical custodians and family services counselors the information required by s. 39.6012(2) and for ensuring that this information follows the child until permanency has been achieved.

(e) Specify the period of time for which the case plan is applicable, which must be as short a period as possible for the parent to comply with the terms of the plan. The case plan's compliance period expires no later than 12 months after the date the child was initially removed from the home, the date the child was adjudicated dependent, or the date the case plan was accepted by the court, whichever occurs first.

(f) Be signed by all of the parties. Signing the case plan constitutes an acknowledgment by each of the parties that they have been involved in the development of the case plan and that they are in agreement as to the terms and conditions contained in the case plan. The refusal of a parent to sign the case plan does not preclude the court's acceptance of the case plan if it is otherwise acceptable to the court. The parent's signing of the case plan does not constitute an admission to any allegation of abuse, abandonment, or neglect and does not constitute consent to a finding of dependency or termination of parental rights. The department shall explain the provisions of the case plan to all persons involved in its implementation, before the signing of the plan.

206734

(3) PARTICIPATION BY THE CHILD.— It is important that the child be involved in all aspects of the case planning process, including development of the plan, as well as the opportunity to review, sign and receive a copy of the case plan. The child, when the child has attained 14 years of age or the child is otherwise at the appropriate age and capacity, shall:

(a) Be included in the face-to-face conference to develop the plan under this section and have the opportunity to express a placement preference, and have the option to choose two members of the case planning team who are not a foster parent or caseworker for the child.

(b) Sign the case plan, unless there is reason to waive the child's signature.

(c) Receive an explanation of the provisions of the case plan from the department.

(d) Be provided a copy of the case plan:

1. After the case plan has been agreed upon and signed; and

2. Within 3 business days before the disposition hearing after jurisdiction attaches and the plan has been filed with the court.

(e) The child shall not be included in any aspect of the case planning process when information will be revealed or discussed that the child should be informed of in a more therapeutic, less traumatic setting.

(4) NOTICE TO PARENTS.—The case plan must document that each parent has been advised of the following by written notice:

(a) That he or she may not be coerced or threatened with the loss of custody or parental rights for failing to admit the abuse, neglect, or abandonment of the child in the case plan.

Participation in the development of a case plan is not an admission to any allegation of abuse, abandonment, or neglect, and does not constitute consent to a finding of dependency or termination of parental rights.

(b) That the department must document a parent's unwillingness or inability to participate in developing a case plan and must provide such documentation in writing to the parent when it becomes available for the court record. In such event, the department will prepare a case plan that, to the extent possible, conforms with the requirements of this section. The parent must also be advised that his or her unwillingness or inability to participate in developing a case plan does not preclude the filing of a petition for dependency or for termination of parental rights. If the parent is available, the department shall provide a copy of the case plan to the parent and advise him or her that, at any time before the filing of a petition for termination of parental rights, he or she may enter into a case plan and that he or she may request judicial review of any provision of the case plan with which he or she disagrees at any court hearing set for the child.

(c) That his or her failure to substantially comply with the case plan may result in the termination of parental rights, and that a material breach of the case plan may result in the filing of a petition for termination of parental rights before the scheduled completion date.

(5) DISTRIBUTION AND FILING WITH THE COURT.—The department shall adhere to the following procedural requirements in developing and distributing a case plan:

(a) After the case plan has been agreed upon and signed by

206734

the parties, a copy of the case plan must immediately be given to the parties and to other persons as directed by the court.

(b) In each case in which a child has been placed in out-of-home care, a case plan must be prepared within 60 days after the department removes the child from the home and must be submitted to the court for review and approval before the disposition hearing.

(c) After jurisdiction attaches, all case plans must be filed with the court, and a copy provided to all of the parties whose whereabouts are known not less than 3 business days before the disposition hearing. The department shall file with the court, and provide copies of such to all of the parties, all case plans prepared before jurisdiction of the court attached.

(d) A case plan must be prepared, but need not be submitted to the court, for a child who will be in care for 30 days or less unless that child is placed in out-of-home care for a second time within a 12-month period.


385888

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 398 - 400
and insert:
child, foster parents, or legal custodians. If the parent's substantial compliance with the case plan requires the department to provide services to the parent or the child and the parent agrees to begin compliance with the case plan before it is accepted by the court, the department shall make appropriate referrals for services which will allow the parents

385888

to immediately begin the agreed-upon tasks and services.

255158

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 445 - 451
and insert:
safe and proper care that is appropriate to his or her needs. Participation by the child must meet the requirements under 39.6011.

304418

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete line 471
and insert:
placed more than 50 miles from the child's home, the reasons

612830

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 532 - 562
and insert:
(d) *Health care*.—To the extent that they are available and accessible, the names and addresses of the child's health and behavioral health providers, a record of the child's immunizations, the child's known medical history, including any known health issues, the child's medications, and any other relevant health and behavioral health information must be

612830

attached to the case plan and updated throughout the judicial review process.

(e) *Contact with family extended family and fictive kin.*—When out-of-home placement is made, the case plan must include provisions for the development and maintenance of sibling relationships and visitation, if the child has siblings and is separated from them, a description of the parent's visitation rights and obligations and a description of any visitation rights with extended family members as defined in s. 751.011. As used in this paragraph, the term "fictive kin" means, individuals that are unrelated to the child by either birth or marriage, but have an emotionally significant relationship with the child that would take on the characteristics of a family relationship. As soon as possible after a court order is entered the following must be provided to the child's out-of-home caregiver:

1. Information regarding any court-ordered visitation between the child and the parents, and the terms and conditions necessary to facilitate such visits and protect the safety of the child.

2. Information regarding the schedule and frequency of the visits between the child and his or her siblings, as well as any court-ordered terms and conditions necessary to facilitate the visits and protect the safety of the child.

3. Information regarding the schedule and frequency of the visits between the child and any extended family member or fictive kid, as well as any court-ordered terms and conditions necessary to facilitate the visits and protect the safety of the child.

612830

(f) *Independent living.—*

1. When appropriate, the case plan for a child who is 13 years of age or older, must include a written description of the life skills services to be provided by the caregiver that will assist the child, consistent with his or her best interests, in preparing for the transition from foster care to independent living. The case plan must be developed with the child and individuals identified as important to the child, and must include the steps the agency is taking to ensure that the child has a connection to a caring adult.

691122

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 677 - 716
and insert:
(d) *Orders.*—
1. Based upon the criteria ~~set forth~~ in paragraph (c) and the recommended order of the citizen review panel, if any, the court shall determine whether ~~or not~~ the social service agency shall initiate proceedings to have a child declared a dependent child, return the child to the parent, continue the child in

691122

out-of-home care for a specified period of time, or initiate termination of parental rights proceedings for subsequent placement in an adoptive home. Amendments to the case plan must be prepared as prescribed in s. 39.6013. If the court finds that ~~the prevention or reunification efforts of the department will allow~~ the child can safely ~~to~~ remain in the ~~safely at~~ home with an in-home safety plan, ~~or be safely returned to the home~~ the court shall allow the child to remain in ~~or return to~~ the home ~~after making a specific finding of fact that the reasons for the creation of the case plan have been remedied to the extent that the child's safety, well-being, and physical, mental, and emotional health will not be endangered~~.

2. The court shall return the child to the custody of the parents with an in-home safety plan at any time it determines that they have met conditions for return ~~substantially complied with the case plan~~, and if the court is satisfied that return of the child to the home ~~reunification~~ will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health.

3. If, in the opinion of the court, the social service agency has not complied with its obligations as specified in the written case plan, the court may find the social service agency in contempt, shall order the social service agency to submit its plans for compliance with the agreement, and shall require the social service agency to show why the child could not safely be returned to the home of the parents.

4. If possible, the court shall order the department to file a written notification before a child changes placements or living arrangements. If such notification is not possible before

691122

the change, the department must file a notification immediately following a change. A written notification filed with the court must include assurances from the department that the provisions of s. 409.145 and administrative rule relating to placement changes have been met.

287242

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Between lines 855 and 856
insert:
(a) "Child functioning level" means specific categories of child behaviors and needs.

903328

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete line 874
and insert:
preplacement assessment tool that must include an analysis, based on information available to the department at the time of the assessment, of

615066

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 927 - 936
and insert:
(f) Upon receipt of a child's completed comprehensive assessment, the child's case manager will review the assessment, and document whether a less restrictive, more family-like setting for the child is recommended and available. The department must document determinations resulting from the comprehensive assessment in the Florida Safe Families Network

615066

and update the case plan to include identified needs of the child, specified services and supports to be provided by the out-of-home care placement setting to meet the needs of the child, and diligent efforts to transition the child to a less restrictive, family-like setting.

792830

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 1010 - 1043
and insert:
(e) "Residential group care" means a 24-hour, live-in environment that provides supervision, care, and services to meet the physical, emotional, social, and life skills needs of children served by the dependency system. Services may either be provided by residential group care staff who are qualified to perform the needed service, or a community-based service

792830

provider with clinical expertise, credentials, and training to provide services to the children being served.

(3) DEVELOPMENT OF CONTINUUM.—The department, in collaboration with the Florida Institute for Child Welfare, the Quality Parenting Initiative and the Florida Coalition for Children, shall develop a continuum of care for the placement of children in care, including but not limited to, both family foster care and residential group care. To implement the continuum of care, the department must by December 31, 2017:

1. Establish levels of care in the continuum that are clearly and concisely defined with the qualifying criteria for placement for each level identified.

2. Revise licensure standards and rules to reflect both the supports and services provided by a placement at each level of care as well as the complexity of the needs of the children served. This must include attention to the need for a particular category of provider in a community before licensure can be considered; quality standards of operation that must be met by all licensed providers; numbers and qualifications of staff that are adequate to effectively serve children with the issues the facility seeks to serve; and a well-defined process tied to specific criteria that lead to licensure suspension or revocation.

3. Develop policies and procedures necessary to ensure that placement in any level of care is appropriate for each specific child, is determined by the required assessments and staffings, and lasts only as long as necessary to resolve the issue that required the placement.

4. Develop a plan to recruit, train and retain specialized


792830

family foster homes for pregnant and parenting children and young adults. These family foster homes must be designed to provide an out-of-home placement option for young parents and their children to enable them to live in the same family foster home while caring for the child and working towards independent care of the child.

5. Develop, in collaboration with the Department of Juvenile Justice, a plan to develop specialized out-of home placements for children who are involved with both the dependency and the juvenile justice systems.

868866

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete line 1096
and insert:
pursuant to s. 1003.435, Florida Statutes.

208674

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
10/22/2015	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 1129 - 1146
and insert:
(b) Lead agencies shall ensure the availability of a full array of services to address the complex needs of all children, including teens, and caregivers served within their local system of care. Lead agencies shall ensure that sufficient flexibility exists within the service array to adequately match services to the unique characteristics of families served, including ages of


208674

children, cultural considerations, and parental choice.

(c) The department shall annually complete an evaluation of the service array adequacies, engagement of trauma-informed and evidenced-based programming, and the impact of available services to the outcomes of children served by lead agencies and subcontracted providers of lead agencies. The evaluation report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each year.

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

FOR CONSIDERATION By the Committee on Children, Families, and Elder Affairs

586-00791-16 20167018pb

A bill to be entitled

An act relating to child welfare; amending s. 39.402, F.S.; revising information that the Department of Children and Families is required to inform the court of at shelter hearings; revising the written findings required to be included in an order for placement of a child in shelter care; amending s. 39.521, F.S.; revising the required information a court must include in its written orders of disposition; amending s. 39.6011, F.S.; providing the purpose of a case plan; requiring a case plan to document that a preplacement plan has been provided and reasonable efforts to prevent out-of-home placement have been made; amending s. 39.6012, F.S.; requiring the case plan to be based upon a certain assessment; requiring the child to be involved in developing the case plan under certain circumstances; requiring the case plan to include a schedule of monthly, face-to-face meetings between the parents and case managers; specifying that a child who is 12 years of age or older shall be given the opportunity to review, sign, and receive a copy of the case plan; requiring the case plan to document additional information regarding the placement, permanency, and education of the child; requiring additional information relating to a parent's visitation rights and obligations to be provided to the out-of-home caregiver; requiring the department and the community-based provider to assist the child in developing a transition plan after the child

586-00791-16 20167018pb

reaches a certain age; specifying certain information to be addressed in the transition plan; amending s. 39.6035, F.S.; requiring court approval of a transition plan before the child's 18th birthday; amending s. 39.621, F.S.; creating an exception to the order of preference for permanency goals under ch. 39, F.S., for maintaining and strengthening the placement; authorizing the new permanency goal to be used in specified circumstances; amending s. 39.701, F.S.; revising the information which must be included in a specified written report under certain circumstances; requiring a court to order the Department of Children and Families and the community-based care lead agency to file a written notification; creating s. 409.142, F.S.; providing legislative findings and intent; defining the term "intervention services and supports"; providing specified intervention services and supports; providing eligibility for services and supports; providing requirements for the provision of services and supports; requiring each community-based care lead agency to submit a plan to the department by a certain date; requiring each community-based care lead agency to annually collect and submit a report to include specified information for each child to whom intervention services and supports are provided; requiring the department to adopt rules; creating s. 409.143, F.S.; providing legislative findings and intent; defining terms; requiring an initial placement assessment for certain children under specified

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

circumstances; requiring every child placed in out-of-home care to be referred within a certain time for a comprehensive behavioral health assessment; requiring the department or the community-based care lead agency to establish special permanency teams to overcome difficulties with adjustment of children to home placement; requiring the department to submit a report annually to the Governor and the Legislature on the placement of children in licensed out-of-home care; creating s. 409.144, F.S.; providing legislative findings and intent; defining terms; requiring the department to develop a continuum of care for the placement of children in care settings; requiring the department to submit a report annually to the Governor and the Legislature on the continuum of care; requiring the department to adopt rules; amending s. 409.1451, F.S.; requiring that the child was living in licensed care on or after his or her 18th birthday as a condition for receipt of aftercare services; requiring the department to provide education training vouchers; providing eligibility requirements; prohibiting vouchers from exceeding a certain amount; providing rulemaking authority; amending s. 409.988, F.S.; requiring lead agencies to ensure the availability of a full array of family support services; requiring the department to submit a report annually to the Governor and Legislature on the availability of family support services; amending ss. 39.202 and 1002.3305, F.S.; conforming cross-

references; revising the designation of an agency with access to records; repealing s. 39.523, F.S., relating to the placement of children in residential group care; repealing s. 409.141, F.S., relating to equitable reimbursement methodology; repealing s. 409.1676, F.S., relating to comprehensive residential group care services to children who have extraordinary needs; repealing s. 409.1677, F.S., relating to model comprehensive residential services programs; repealing s. 409.1679, F.S., relating to additional requirements and reimbursement methodology; providing an effective date.

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

Section 1. Paragraphs (f) and (h) of subsection (8) of section 39.402, Florida Statutes, are amended to read:

39.402 Placement in a shelter.—

(8)

(f) At the shelter hearing, the department shall inform the court of:

1. Any identified current or previous case plans negotiated under this chapter in any judicial circuit ~~district~~ with the parents or caregivers ~~under this chapter~~ and problems associated with compliance;

2. Any adjudication of the parents or caregivers of delinquency;

3. Any past or current injunction for protection from domestic violence; and

4. All of the child's places of residence during the prior 12 months.

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

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

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

3. That the placement proposed by the department is in the least restrictive and most family-like setting that meets the needs of the child, unless it is otherwise documented that the identified type of placement needed is not available.

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

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

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

or eliminate the need for removal if:

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

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

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

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

7.~~6.~~ That the department has made reasonable efforts to keep siblings together if they are removed and placed in out-of-home care unless such placement is not in the best interest of each child. It is preferred that siblings be kept together in a foster home, if available. Other reasonable efforts shall include short-term placement in a group home with the ability to accommodate sibling groups if such a placement is available. The department shall report to the court its efforts to place siblings together unless the court finds that such placement is not in the best interest of a child or his or her sibling.

8.~~7.~~ That the court notified the parents, relatives that are providing out-of-home care for the child, or legal custodians of the time, date, and location of the next

dependency hearing and of the importance of the active participation of the parents, relatives that are providing out-of-home care for the child, or legal custodians in all proceedings and hearings.

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

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

Section 2. Paragraph (d) of subsection (1) of section 39.521, Florida Statutes, is amended to read:

39.521 Disposition hearings; powers of disposition.—

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

(d) The court shall, in its written order of disposition, include all of the following:

1. The placement or custody of the child, including whether the placement is in the least restrictive and most family-like

setting that meets the needs of the child, as determined by assessments completed pursuant to s. 409.143.

2. Special conditions of placement and visitation.

3. Evaluation, counseling, treatment activities, and other actions to be taken by the parties, if ordered.

4. The persons or entities responsible for supervising or monitoring services to the child and parent.

5. Continuation or discharge of the guardian ad litem, as appropriate.

6. The date, time, and location of the next scheduled review hearing, which must occur within the earlier of:

a. Ninety days after the disposition hearing;

b. Ninety days after the court accepts the case plan;

c. Six months after the date of the last review hearing; or

d. Six months after the date of the child's removal from his or her home, if no review hearing has been held since the child's removal from the home.

7. If the child is in an out-of-home placement, child support to be paid by the parents, or the guardian of the child's estate if possessed of assets which under law may be disbursed for the care, support, and maintenance of the child. The court may exercise jurisdiction over all child support matters, shall adjudicate the financial obligation, including health insurance, of the child's parents or guardian, and shall enforce the financial obligation as provided in chapter 61. The state's child support enforcement agency shall enforce child support orders under this section in the same manner as child support orders under chapter 61. Placement of the child shall not be contingent upon issuance of a support order.

8.a. If the court does not commit the child to the temporary legal custody of an adult relative, legal custodian, or other adult approved by the court, the disposition order shall include the reasons for such a decision and shall include a determination as to whether diligent efforts were made by the department to locate an adult relative, legal custodian, or other adult willing to care for the child in order to present that placement option to the court instead of placement with the department.

b. If no suitable relative is found and the child is placed with the department or a legal custodian or other adult approved by the court, both the department and the court shall consider transferring temporary legal custody to an adult relative approved by the court at a later date, but neither the department nor the court is obligated to so place the child if it is in the child's best interest to remain in the current placement.

For the purposes of this section, "diligent efforts to locate an adult relative" means a search similar to the diligent search for a parent, but without the continuing obligation to search after an initial adequate search is completed.

9. Other requirements necessary to protect the health, safety, and well-being of the child, to preserve the stability of the child's educational placement, and to promote family preservation or reunification whenever possible.

Section 3. Section 39.6011, Florida Statutes, is amended to read:

(Substantial rewording of section. See

s. 39.6011, F.S., for present text.)

39.6011 Case plan purpose; requirements; procedures.—

(1) PURPOSE.—The purpose of the case plan is to promote and facilitate change in parental behavior and to address the treatment and long-term well-being of children receiving services under this chapter.

(2) GENERAL REQUIREMENTS.—The department shall draft a case plan for each child receiving services under this chapter. The case plan must:

(a) Document that a preplacement assessment of the service needs of the child and family, and preplacement preventive services, if appropriate, have been provided pursuant to s. 409.142, and that reasonable efforts to prevent out-of-home placement have been made.

(b) Be developed in a face-to-face conference with the parent of the child, any court-appointed guardian ad litem, and, if appropriate, the child and the temporary custodian of the child. The parent may receive assistance from any person or social service agency in preparing the case plan. The social service agency, the department, and the court, when applicable, shall inform the parent of the right to receive such assistance, including the right to assistance of counsel.

(c) Be written simply and clearly in English and, if English is not the principal language of the child's parent, in the parent's principal language, to the extent practicable.

(d) Describe a process for making available to all physical custodians and family services counselors the information required by s. 39.6012(2) and for ensuring that this information follows the child until permanency has been achieved.

(e) Specify the period of time for which the case plan is applicable, which must be as short a period as possible for the parent to comply with the terms of the plan. The case plan's compliance period expires no later than 12 months after the date the child was initially removed from the home, the date the child was adjudicated dependent, or the date the case plan was accepted by the court, whichever occurs first.

(f) Be signed by all of the parties, except that the signature of a child may be waived if the child is not of an age or capacity to participate in the case-planning process. Signing the case plan constitutes an acknowledgment by each of the parties that they have been involved in the development of the case plan and that they are in agreement as to the terms and conditions contained in the case plan. The refusal of a parent to sign the case plan does not preclude the court's acceptance of the case plan if it is otherwise acceptable to the court. The parent's signing of the case plan does not constitute an admission to any allegation of abuse, abandonment, or neglect and does not constitute consent to a finding of dependency or termination of parental rights. The department shall explain the provisions of the case plan to all persons involved in its implementation, including, when appropriate, the child, before the signing of the plan.

If the parent's substantial compliance with the case plan requires the department to provide services to the parent or the child and the parent agrees to begin compliance with the case plan before it is accepted by the court, the department shall make appropriate referrals for services which will allow the

parents to immediately begin the agreed-upon tasks and services.

(3) NOTICE TO PARENTS.—The case plan must document that each parent has been advised of the following by written notice:

(a) That he or she may not be coerced or threatened with the loss of custody or parental rights for failing to admit the abuse, neglect, or abandonment of the child in the case plan. Participation in the development of a case plan is not an admission to any allegation of abuse, abandonment, or neglect, and does not constitute consent to a finding of dependency or termination of parental rights.

(b) That the department must document a parent's unwillingness or inability to participate in developing a case plan and must provide such documentation in writing to the parent when it becomes available for the court record. In such event, the department will prepare a case plan that, to the extent possible, conforms with the requirements of this section. The parent must also be advised that his or her unwillingness or inability to participate in developing a case plan does not preclude the filing of a petition for dependency or for termination of parental rights. If the parent is available, the department shall provide a copy of the case plan to the parent and advise him or her that, at any time before the filing of a petition for termination of parental rights, he or she may enter into a case plan and that he or she may request judicial review of any provision of the case plan with which he or she disagrees at any court hearing set for the child.

(c) That his or her failure to substantially comply with the case plan may result in the termination of parental rights, and that a material breach of the case plan may result in the

filing of a petition for termination of parental rights before the scheduled completion date.

(4) DISTRIBUTION AND FILING WITH THE COURT.—The department shall adhere to the following procedural requirements in developing and distributing a case plan:

(a) After the case plan has been agreed upon and signed by the parties, a copy of the case plan must immediately be given to the parties, including the child if appropriate, and to other persons as directed by the court.

(b) In each case in which a child has been placed in out-of-home care, a case plan must be prepared within 60 days after the department removes the child from the home and must be submitted to the court for review and approval before the disposition hearing.

(c) After jurisdiction attaches, all case plans must be filed with the court, and a copy provided to all of the parties whose whereabouts are known, including the child if appropriate, not less than 3 business days before the disposition hearing. The department shall file with the court, and provide copies of such to all of the parties, all case plans prepared before jurisdiction of the court attached.

(d) A case plan must be prepared, but need not be submitted to the court, for a child who will be in care for 30 days or less unless that child is placed in out-of-home care for a second time within a 12-month period.

Section 4. Section 39.6012, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 39.6012, F.S., for present text.)

39.6012 Services and parental tasks under the case plan; safety, permanency, and well-being of the child.—The case plan must include a description of the identified problem that is being addressed, including the parent's behavior or acts that have resulted in a threat to the safety of the child and the reason for the department's intervention. The case plan must be designed to improve conditions in the child's home to facilitate the child's safe return and ensure proper care of the child, or to facilitate the child's permanent placement. The services offered must be as unobtrusive as possible in the lives of the parent and the child, must focus on clearly defined objectives, and must provide the most timely and efficient path to reunification or permanent placement, given the circumstances of the case and the child's need for safe and proper care.

(1) CASE PLAN SERVICES AND TASKS.—The case plan must be based upon an assessment of the circumstances that required intervention by the child welfare system. The case plan must describe the role of the foster parents or legal custodians which must be developed in conjunction with the determination of the services that are to be provided under the case plan to the child, foster parents, or legal custodians. The child must be involved in developing the case plan as is age and developmentally appropriate.

(a) *Itemization in the case plan.*—The case plan must describe each of the tasks which the parent must complete and the services that will be provided to the parent, in the context of the identified problem, including:

1. The type of services or treatment which will be provided.

2. If the service is being provided by the department or its agent, the date the department will provide each service or referral for service.

3. The date by which the parent must complete each task.

4. The frequency of services or treatment to be provided, which shall be determined by the professionals providing the services and may be adjusted as needed based on the best professional judgment of the provider.

5. The location of the delivery of the services.

6. Identification of the staff of the department or the service provider who are responsible for the delivery of services or treatment.

7. A description of measurable outcomes, including the timeframes specified for achieving the objectives of the case plan and addressing the identified problem.

(b) *Meetings with case manager.*—The case plan must include a schedule of the minimum number of face-to-face meetings to be held each month between the parent and the case manager to review the progress of the case plan, eliminate barriers to completion of the plan, and resolve conflicts or disagreements.

(c) *Request for notification from relative.*—The case manager shall advise the attorney for the department of a relative's request to receive notification of proceedings and hearings submitted pursuant to s. 39.301(14)(b).

(d) *Financial support.*—The case plan must specify the parent's responsibility for the financial support of the child, including, but not limited to, health insurance and child support. The case plan must list the costs associated with any services or treatment that the parent and child are expected to

receive which are the financial responsibility of the parent. The determination of child support and other financial support must be made independently of any determination of dependency under s. 39.013.

(2) SAFETY, PERMANENCY, AND WELL-BEING OF THE CHILD.—The case plan must include all available information that is relevant to the child's care, including a detailed description of the identified needs of the child while in care and a description of the plan for ensuring that the child receives safe and proper care that is appropriate to his or her needs. A child must be given a meaningful opportunity to participate in the development of the case plan and state his or her preference for foster care placement. A child who is 12 years of age or older and in a permanent placement must also be given the opportunity to review the case plan, sign the case plan, and receive a copy of the case plan.

(a) *Placement.*—To comply with federal law, the department must ensure that the placement of a child in foster care be in the least restrictive, most family-like environment; must review the family assessment, safety plan, and case plan for the child to assess the necessity for and the appropriateness of the placement; must assess the progress that has been made toward case plan outcomes; and must project a likely date by which the child can be safely reunified or placed for adoption or legal guardianship. The family assessment must indicate the type of placement to which the child has been assigned and must document the following:

1. That the child has undergone the placement assessments required pursuant to s. 409.143.

2. That the child has been placed in the least restrictive and most family-like setting available consistent with the best interest and special needs of the child, and in as close proximity as possible to the child's home.

3. If the child is placed in a setting that is more restrictive than recommended by the placement assessments or is placed a substantial distance from the child's home, the reasons why the placement is necessary and in the best interest of the child and the steps required to place the child in the placement recommended by the assessment.

4. If residential group care is recommended for the child, the needs of the child that necessitate such placement, the plan for transitioning the child to a family setting, and the projected timeline for the child's transition to a less restrictive environment. If the child is placed in residential group care, his or her case plan shall be reviewed and updated within 90 days after the child's admission to the residential group care facility and at least every 60 days thereafter.

(b) *Permanency.*—If reunifying a child with his or her family is not possible, the department shall make every effort to provide other forms of permanency, such as adoption or guardianship. If a child is placed in an out-of-home placement, the case plan, in addition to any other requirements imposed by law or department rule, must include:

1. If concurrent planning is being used, a description of the permanency goal of reunification with the parent or legal custodian and a description of one of the remaining permanency goals defined in s. 39.01; or, if concurrent case planning is not being used, an explanation as to why it is not being used.

2. If the case plan has as its goal the adoption of the child or his or her placement in another permanent home, a statement of the child's wishes regarding his or her permanent placement plan and an assessment of those stated wishes. The case plan must also include documentation of the steps the agency is taking to find an adoptive family or other permanent living arrangements for the child; to place the child with an adoptive family, an appropriate and willing relative, or a legal guardian; and to finalize the adoption or legal guardianship. At a minimum, the documentation must include child-specific recruitment efforts, such as the use of state, regional, and national adoption exchanges, including electronic exchange systems, after he or she has become legally eligible for adoption.

3. If the child has been in out-of-home care for at least 12 months and the permanency goal is not adoptive placement, the documentation of the compelling reason for a finding that termination of parental rights is not in the child's best interest.

(c) *Education.*—A case plan must ensure the educational stability of the child while in foster care. To the extent available and accessible, the names and addresses of the child's educational providers, a record of his or her grade level performance, and his or her school record must be attached to the case plan and updated throughout the judicial review process. The case plan must also include documentation that the placement:

1. Takes into account the appropriateness of the current educational setting and the proximity to the school in which the

child is enrolled at the time of placement.

2. Has been coordinated with appropriate local educational agencies to ensure that the child remains in the school in which the child is enrolled at the time of placement, or, if remaining in that school is not in the best interest of the child, assurances by the department and the local education agency to provide immediate and appropriate enrollment in a new school and to provide all of the child's educational records to the new school.

(d) *Health care.*—To the extent that they are available and accessible, the names and addresses of the child's health and mental health providers, a record of the child's immunizations, the child's known medical history, including any known health issues, the child's medications, and any other relevant health and mental health information must be attached to the case plan and updated throughout the judicial review process.

(e) *Contact with family.*—When out-of-home placement is made, the case plan must include provisions for the development and maintenance of sibling relationships and visitation, if the child has siblings and is separated from them, and a description of the parent's visitation rights and obligations. As soon as possible after a court order is entered the following must be provided to the child's out-of-home caregiver:

1. Information regarding any court-ordered visitation between the child and the parents, and the terms and conditions necessary to facilitate such visits and protect the safety of the child.

2. Information regarding the schedule and frequency of the visits between the child and his or her siblings, as well as any

court-ordered terms and conditions necessary to facilitate the visits and protect the safety of the child.

(f) *Independent living.*—

1. When appropriate, the case plan for a child who is 13 years of age or older, must include a written description of the programs and services that will assist the child, consistent with his or her best interests, in preparing for the transition from foster care to independent living. The case plan must be developed with the child and individuals identified as important to the child, and must include the steps the agency is taking to ensure that the child has a connection to a caring adult.

2. During the 180-day period after a child reaches 17 years of age, the department and the community-based care provider, in collaboration with the caregiver and any other individual whom the child would like to include, shall assist the child in developing a transition plan pursuant to s. 39.6035, which is in addition to standard case management requirements. The transition plan must address specific options that the child may use in obtaining services, including housing, health insurance, education, and workforce support and employment services. The transition plan must also consider establishing and maintaining naturally occurring mentoring relationships and other personal support services. The transition plan may be as detailed as the child chooses and must be attached to the case plan and updated before each judicial review.

Section 5. Subsection (4) of section 39.6035, Florida Statutes, is amended to read:

39.6035 Transition plan.—

(4) ~~If a child is planning to leave care upon reaching 18~~

~~years of age,~~ The transition plan must be approved by the court before the child's 18th birthday ~~child leaves care and the court terminates jurisdiction~~.

Section 6. Subsection (2) of section 39.621, Florida Statutes, is amended, present subsections (3) through (11) of that section are redesignated as subsections (4) through (12), respectively, and new subsection (3) is added to that section, to read:

39.621 Permanency determination by the court.—

(2) Except as provided in subsection (3), the permanency goals available under this chapter, listed in order of preference, are:

(a) Reunification;

(b) Adoption, if a petition for termination of parental rights has been or will be filed;

(c) Permanent guardianship of a dependent child under s. 39.6221; or

~~(d) Permanent placement with a fit and willing relative under s. 39.6231; or~~

(d)~~(c)~~ Placement in another planned permanent living arrangement under s. 39.6241.

(3) The permanency goal of maintaining and strengthening the placement with a parent may be used in the following circumstances:

(a) If a child has not been removed from a parent but is found to be dependent, even if adjudication of dependency is withheld, the court may leave the child in the current placement with maintaining and strengthening the placement as a permanency option.

(b) If a child has been removed from a parent and is placed with the parent from whom the child was not removed, the court may leave the child in the placement with the parent from whom the child was not removed with maintaining and strengthening the placement as a permanency option.

(c) If a child has been removed from a parent and is subsequently reunified with that parent, the court may leave the child with that parent with maintaining and strengthening the placement as a permanency option.

Section 7. Paragraphs (a) and (d) of subsection (2) of section 39.701, Florida Statutes, are amended to read:

39.701 Judicial review.—

(2) REVIEW HEARINGS FOR CHILDREN YOUNGER THAN 18 YEARS OF AGE.—

(a) *Social study report for judicial review.*—Before every judicial review hearing or citizen review panel hearing, the social service agency shall make an investigation and social study concerning all pertinent details relating to the child and shall furnish to the court or citizen review panel a written report that includes, but is not limited to:

1. A description of the type of placement the child is in at the time of the hearing, including the safety of the child, ~~and~~ the continuing necessity for ~~and appropriateness of~~ the placement, and that the placement is in the least restrictive and most family-like setting that meets the needs of the child as determined by the assessment completed pursuant to s. 409.143.

2. Documentation of the diligent efforts made by all parties to the case plan to comply with each applicable

provision of the case plan.

3. The amount of fees assessed and collected during the period of time being reported.

4. The services provided to the foster family or legal custodian in an effort to address the needs of the child as indicated in the case plan.

5. A statement that either:

a. The parent, though able to do so, did not comply substantially with the case plan, and the agency recommendations;

b. The parent did substantially comply with the case plan; or

c. The parent has partially complied with the case plan, with a summary of additional progress needed and the agency recommendations.

6. A statement from the foster parent or legal custodian providing any material evidence concerning the return of the child to the parent or parents.

7. A statement concerning the frequency, duration, and results of the parent-child visitation, if any, and the agency recommendations for an expansion or restriction of future visitation.

8. The number of times a child has been removed from his or her home and placed elsewhere, the number and types of placements that have occurred, and the reason for the changes in placement.

9. The number of times a child's educational placement has been changed, the number and types of educational placements which have occurred, and the reason for any change in placement.

10. If the child has reached 13 years of age but is not yet 18 years of age, a statement from the caregiver on the progress the child has made in acquiring independent living skills.

11. Copies of all medical, psychological, and educational records that support the terms of the case plan and that have been produced concerning the parents or any caregiver since the last judicial review hearing.

12. Copies of the child's current health, mental health, and education records as identified in s. 39.6012.

(d) *Orders.*—

1. Based upon the criteria ~~set forth~~ in paragraph (c) and the recommended order of the citizen review panel, if any, the court shall determine whether ~~or not~~ the social service agency shall initiate proceedings to have a child declared a dependent child, return the child to the parent, continue the child in out-of-home care for a specified period ~~of time~~, or initiate termination of parental rights proceedings for subsequent placement in an adoptive home. Amendments to the case plan must be prepared as prescribed in s. 39.6013. If the court finds that the conditions for return have been met and ~~prevention or reunification efforts of the department~~ will allow the child to remain safely at home or be safely returned to the home with an in-home safety plan, the court shall allow the child to remain in or return to the home after making a specific finding of fact that the reasons for the out-of-home safety ~~creation of the case~~ plan have been remedied to the extent that the child's safety, well-being, and physical, mental, and emotional health can be ensured with an in-home safety plan and appropriate in-home safety services while the parent continues to work toward case

outcomes ~~will not be endangered~~.

2. The court shall return the child to the custody of the parents with an in-home safety plan at any time it determines that they have met conditions for return ~~substantially complied with the case plan~~, and if the court is satisfied that reunification will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health.

3. If, in the opinion of the court, the social service agency has not complied with its obligations as specified in the written case plan, the court may find the social service agency in contempt, shall order the social service agency to submit its plans for compliance with the agreement, and shall require the social service agency to show why the child could not safely be returned to the home of the parents.

4. If possible, the court shall order the department and the community-based care lead agency to file a written notification before a child changes placements or living arrangements. If such notification is not possible before the change, the department and the community-based care lead agency must file a notification immediately following a change.

5.~~4.~~ If, at any judicial review, the court finds that the parents have failed to substantially comply with the case plan to the degree that further reunification efforts are without merit and not in the best interest of the child, on its own motion, the court may order the filing of a petition for termination of parental rights, whether or not the time period as contained in the case plan for substantial compliance has expired.

6.~~5.~~ Within 6 months after the date that the child was

placed in shelter care, the court shall conduct a judicial review hearing to review the child's permanency goal as identified in the case plan. At the hearing the court shall make findings regarding the likelihood of the child's reunification with the parent or legal custodian within 12 months after the removal of the child from the home. If the court makes a written finding that it is not likely that the child will be reunified with the parent or legal custodian within 12 months after the child was removed from the home, the department must file with the court, and serve on all parties, a motion to amend the case plan under s. 39.6013 and declare that it will use concurrent planning for the case plan. The department must file the motion within 10 business days after receiving the written finding of the court. The department must attach the proposed amended case plan to the motion. If concurrent planning is already being used, the case plan must document the efforts the department is taking to complete the concurrent goal.

7.~~6.~~ The court may issue a protective order in assistance, or as a condition, of any other order made under this part. In addition to the requirements included in the case plan, the protective order may set forth requirements relating to reasonable conditions of behavior to be observed for a specified period of time by a person or agency who is before the court; and the order may require any person or agency to make periodic reports to the court containing such information as the court in its discretion may prescribe.

Section 8. Section 409.142, Florida Statutes, is created to read:

409.142 Intervention services for unsafe children.—

(1) LEGISLATIVE FINDINGS AND INTENT.—The Legislature finds that intervention services and supports are designed to strengthen and support families in order to keep them safely together and to prevent children from entering foster care. Therefore, it is the intent of the Legislature for the department to identify evidence-based intervention programs that remedy child abuse and neglect, reduce the likelihood of foster care placement by supporting parents and relative or nonrelative caregivers, increase family reunification with parents or other relatives, and promote placement stability for children living with relatives or nonrelative caregivers.

(2) DEFINITION.—As used in this section the term "intervention services and supports" means assistance provided to a child or to the parents or relative and nonrelative caregivers of a child determined by a child protection investigation to be in present or impending danger.

(3) SERVICES AND SUPPORTS.—Intervention services and supports that shall be made available to eligible individuals include, but are not limited to:

(a) Safety management services provided to unsafe children which immediately and actively protect the child from dangerous threats if the parent or other caregiver cannot, as part of a safety plan.

(b) Parenting skills training, including parent advocates, peer-to-peer mentoring, and support groups for parents and relative caregivers.

(c) Individual, group, and family counseling, mentoring, and therapy.

(d) Behavioral health care needs, domestic violence, and

substance abuse services.

(e) Crisis assistance or services to stabilize families in times of crisis or to facilitate relative placement, such as transportation, clothing, household goods, assistance with housing and utility payments, child care, respite care, and assistance connecting families with other community-based services.

(4) ELIGIBILITY FOR SERVICES.—The following individuals are eligible for services and supports under this section:

(a) A child who is unsafe but can remain safely at home or in a relative or nonrelative placement with receipt of specified services and supports.

(b) A parent or relative caregiver of an unsafe child.

(5) GENERAL REQUIREMENTS.—The community-based care lead agency shall prepare a case plan for each child and his or her family receiving services and support under this section which includes:

(a) The safety services and supports necessary to prevent the child's entry into foster care.

(b) The services and supports that will enable the child to return home with an in-home safety plan.

(6) ASSESSMENT AND REPORTING.—

(a) By October 1, 2016, each community-based care lead agency shall submit a monitoring plan to the department describing how the lead agency will monitor and oversee the safety of children who receive intervention services and supports. The monitoring plan shall include a description of training and support for caseworkers handling intervention cases, including how caseload size and type will be determined,

managed, and overseen.

(b) Beginning October 1, 2016, each community-based care lead agency shall collect and report annually to the department, as part of the child welfare Results Oriented Accountability Program required under s. 409.997, the following with respect to each child for whom, or on whose behalf, intervention services and supports are provided during a 12-month period:

1. The number of children and families served;

2. The specific services provided and the total expenditures for each such service;

3. The child's placement status at the beginning and at the end of the period; and

4. The child's placement status 1 year after the end of the period.

(c) Outcomes for this subsection shall be included in the annual report required under s. 409.997.

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

Section 9. Section 409.143, Florida Statutes, is created to read:

409.143 Assessment and determination of appropriate placement.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that it is a basic tenet of child welfare practice and the law that children be placed in the least restrictive, most family-like setting available in close proximity to the home of their parents, consistent with the best interests and needs of the child, and that children be placed in permanent homes in a timely manner.

(b) The Legislature also finds that behavior problems can create difficulties in a child's placement and ultimately lead to multiple placements, which have been linked to negative outcomes for children.

(c) The Legislature further finds that given the harm associated with multiple placements, the ideal is connecting children to the most appropriate setting at the time they come into care.

(d) Therefore, it is the intent of the Legislature that through the use of a standardized assessment process and the availability of an adequate array of appropriate placement options, that the first placement be the best placement for every child entering care.

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

(a) "Comprehensive behavioral health assessment" means an in-depth and detailed assessment of the child's emotional, social, behavioral, and developmental functioning within the family home, school, and community that must include direct observation of the child in the home, school, and community, as well as in the clinical setting.

(b) "Level of care" means a tiered approach to the types of placement used and the acuity and intensity of intervention services provided to meet the severity of a dependent child's specific physical, emotional, psychological, and social needs.

(3) INITIAL PLACEMENT ASSESSMENT.—

(a) Each child that has been determined by the department, a sheriff's office conducting protective investigations, or a community-based care provider to require an out-of-home placement must be assessed prior to placement selection to

determine the best placement option to meet the child's immediate and ongoing intervention and services and supports needs. The department shall develop and adopt by rule a preplacement assessment tool that must include an analysis of the child's age, maturity level, known behavioral health diagnosis, behaviors, prior placement arrangements, physical and medical needs, and educational commitments.

(b) If it is determined during the preplacement evaluation that a child may be suitable for residential treatment as defined in s. 39.407, the procedures in that section must be followed.

(c) A decision to place a child in group care with a residential child care agency may not be made by any individual or entity who has an actual or perceived conflict of interest with any agency being considered for placement.

(d) The department shall document initial placement assessments in the Florida Safe Families Network.

(4) COMPREHENSIVE ASSESSMENT.—

(a) Each child placed in out-of-home care shall be referred by the department for a comprehensive behavioral health assessment. The comprehensive assessment is intended to support the family assessment, which will guide the case plan outcomes and treatment and well-being service provisions for a child in out-of-home care, in addition to providing information to help determine if the child's initial placement was the most appropriate out-of-home care setting for the child.

(b) The referral for the comprehensive behavioral health assessment shall be made within 7 calendars days of the child entering out-of-home care.

(c) The comprehensive assessment will measure the strengths and needs of the child and the services and supports that are necessary to maintain the child in the least restrictive out-of-home care setting. In developing the assessment, consideration must be given to:

1. Current and historical information from any psychological testing or evaluation of the child;

2. Current behaviors exhibited by the child which interfere with or limit the child's role or ability to function in a less restrictive, family-like setting;

3. Current and historical information from the guardian ad litem, if one has been appointed;

4. Current and historical information from any current therapist, teacher, or other professional who has knowledge of the child or has worked with the child;

5. Information related to the placement of any siblings of the child; and

6. If the child has been moved more than once, the circumstances necessitating the moves and the recommendations of the former foster families or other caregivers, if available.

(d) Completion of the comprehensive assessment must occur within 30 calendar days after the child entering out-of-home care.

(e) The department must use the results of the comprehensive assessment and any additional information gathered to determine the child's functioning level and the level of care needed for continued placement.

(f) Upon receipt of a child's completed comprehensive assessment, the child's case manager will review the assessment,

and document whether a less restrictive, more family-like setting for the child is recommended and available. The department must document determinations resulting from the comprehensive assessment in the Florida Safe Families Network to include identified needs of the child, specified services and supports to be provided by the out-of-home care placement setting to meet the needs of the child, and diligent efforts to transition the child to a less restrictive, family-like setting.

(5) PERMANENCY TEAMS.—The department or community-based care lead agency that places children pursuant to this section shall establish special permanency teams dedicated to overcoming the permanency challenges occurring for children in out-of-home care. The special permanency team shall convene a multidisciplinary staffing every 180 calendar days, to coincide with the judicial review, to reassess the appropriateness of the child's current placement. At a minimum, the staffing shall be attended by the community-based care lead agency, the caseworker for the child, out-of-home care provider, guardian ad litem, and any other agency or provider of services to the child. The multidisciplinary staffing shall consider, at a minimum, the current level of the child's functioning, whether recommended services are being provided effectively, any services that would enable transition to a less restrictive family-like setting, and diligent search efforts to find other permanent living arrangements for the child.

(6) ANNUAL REPORT.—By October 1 of each year, the department shall report to the Governor, President of the Senate, and Speaker of the House of Representatives on the placement of children in licensed out-of-home care, including

family foster homes and residential group care, during the year. At a minimum, the report should include the number of children placed in family foster homes and residential group care, the number of children placed more than 50 miles from their parents, the number of children who had to change schools as a result of a placement decision; use of this form of placement on a local, regional, and statewide level; and the available services array to serve children in the least restrictive settings.

Section 10. Section 409.144, Florida Statutes, is created to read:

409.144 Continuum of care for children.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that permanency, well-being, and safety are critical goals for all children, especially for those in care, and that children in foster care or at risk of entering foster care are best supported through a continuum of care that provides appropriate ongoing services, supports and place to live from entry to exit.

(b) The Legislature also finds that federal law requires that out-of-home placements for children are to be in the least restrictive, most family-like setting available that is in close proximity to the home of their parents and consistent with the best interests and needs of the child, and that children be transitioned from out-of-home care to a permanent home in a timely manner.

(c) The Legislature further finds that permanency can be achieved through preservation of the family, reunification with the birth family, or through legal guardianship or adoption by relatives or other caring and committed adults. Planning for

permanency should begin at entry into care and should be child-driven, family-focused, culturally appropriate, continuous, and approached with the highest degree of urgency.

(d) It is, therefore, the intent of the Legislature that the department and the larger child welfare community establish and maintain a continuum of care that affords every child the opportunity to benefit from the most appropriate and least restrictive interventions, both in or out of the home, while ensuring that well-being and safety are addressed.

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

(a) "Continuum of care" means the complete range of programs and services for children served by, or at risk of being served by, the dependency system.

(b) "Family foster care" means a family foster home as defined in s. 409.175.

(c) "Level of care" means a tiered approach to the type of placements used and the acuity and intensity of intervention services provided to meet the severity of a dependent child's specific physical, emotional, psychological, and social needs.

(d) "Out-of-home care" means the placement of a child in licensed and nonlicensed settings, arranged and supervised by the department or contracted service provider, outside the home of the parent.

(e) "Residential group care" means a 24-hour, live-in environment that provides supervision, care, and intervention services to meet the physical, emotional, social, and life skills needs of children served by the dependency system. Intervention services may either be provided by residential group care staff who are qualified to perform the needed

service, or a community-based service provider with clinical expertise, credentials, and training to provide services to the children being served.

(3) DEVELOPMENT OF CONTINUUM.—The department, in collaboration with the Florida Institute for Child Welfare and the Quality Parenting Initiative, shall develop a continuum of care for the placement of children in care, including but not limited to, both family foster care and residential group care. To implement the continuum of care, the department must by December 31, 2017:

1. Establish levels of care in the continuum that are clearly and concisely defined with the qualifying criteria for placement for each level identified.

2. Revise licensure standards and rules to reflect both the supports and services provided by a placement at each level of care as well as the complexity of the needs of the children served. This must include attention to the need for a particular category of provider in a community before licensure can be considered; numbers and qualifications of staff that are adequate to effectively serve children with the issues the facility seeks to serve; and a well-defined process tied to specific criteria that lead to licensure suspension or revocation.

3. Develop policies and procedures necessary to ensure that placement in any level of care is appropriate for each specific child, is determined by the required assessments and staffings, and lasts only as long as necessary to resolve the issue that required the placement.

(4) REPORTING REQUIREMENT.—The department shall submit a

report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1 of each year, with the first report due October 1, 2016. At a minimum, the report must include the following:

(a) An update on the development of the continuum of care required by this section.

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

(c) An inventory of existing services available by community-based care lead agency and a plan for filling any identified gap, as well as a determination of what services are available that can be provided to children in family foster care without having to move the child to a more restrictive placement.

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

(e) For every placement of a child made that is contrary to an appropriate placement as determined by the assessment process in s. 409.142, an explanation from the community-based care lead agency as to why the placement was made.

(f) The strategies being used by the community-based care lead agencies to reduce the high percentage of turnover in caseworkers.

(g) A plan for oversight by the department over the implementation of the continuum by the community-based care lead agencies.

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

Section 11. Subsection (3) of section 409.1451, Florida Statutes, is amended, and a new subsection (11) is added to that section, to read:

409.1451 The Road-to-Independence Program.—

(3) AFTERCARE SERVICES.—

(a) Aftercare services are available to a young adult who was living in licensed care on his or her 18th birthday, who ~~has reached 18 years of age but~~ is not yet 23 years of age, and is:

1. Not in foster care.

2. Temporarily not receiving financial assistance under subsection (2) to pursue postsecondary education.

(11) EDUCATION TRAINING VOUCHERS.—The department shall make available education training vouchers.

(a) A child or young adult is eligible for services and support under this subsection if he or she is ineligible for services under subsection (2) and:

1. Was living in licensed care on his or her 18th birthday, is currently living in licensed care, or is at least 16 years of age and has been adopted from foster care or placed with a court-approved dependency guardian.

2. Has earned a standard high school diploma pursuant to s. 1002.3105(5), s. 1003.4281, or s. 1003.4282, or its equivalent pursuant to former s. 1003.435, Florida Statutes.

3. Has been admitted for enrollment as a student in a postsecondary educational institution.

4. Has made the initial application to participate prior to age 21 and is not yet 23 years of age.

5. Has applied, with assistance from his or her caregiver and the community-based lead agency, for any other grants and

scholarships for which he or she is qualified.

6. Has submitted a Free Application for Federal Student Aid which is complete and error free.

7. Has signed an agreement to allow the department and the community-based care lead agency access to school records.

8. Has maintained satisfactory academic progress as determined by the postsecondary institution.

(b) The voucher provided for an individual under this subsection may not exceed the lesser of $5,000 per year or the total cost of attendance as defined in 42 U.S.C. s. 672.

(c) The department may adopt rules concerning the payment of financial assistance that considers the applicant's requests concerning disbursement. The rules must include an appeals process.

Section 12. Subsection (3) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(3) SERVICES.—

(a) A lead agency must provide dependent children with services that are supported by research or that are recognized as best practices in the child welfare field. The agency shall give priority to the use of services that are evidence-based and trauma-informed and may also provide other innovative services, including, but not limited to, family-centered and cognitive-behavioral interventions designed to mitigate out-of-home placements.

(b) Lead agencies shall ensure the availability of a full array of services, including family support and family preservation services, which encompasses safety management

services, treatment services, and child well-being services to address the complex needs of all children, including teens, and caregivers served within their local system of care. Lead agencies shall ensure that sufficient flexibility exists within the service array to adequately match services to the unique characteristics of families served, including ages of children, cultural considerations, and parental choice.

(c) The department shall annually complete an evaluation of the service array adequacies, engagement of trauma-informed and evidenced-based programming, and the impact of available services to the outcomes of children served by lead agencies and subcontracted providers of lead agencies. The evaluation report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each year.

Section 13. Paragraph (s) of subsection (2) of section 39.202, Florida Statutes, is amended to read:

39.202 Confidentiality of reports and records in cases of child abuse or neglect.—

(2) Except as provided in subsection (4), access to such records, excluding the name of the reporter which shall be released only as provided in subsection (5), shall be granted only to the following persons, officials, and agencies:

(s) Persons with whom the department is seeking to place the child or to whom placement has been granted, including foster parents for whom an approved home study has been conducted, the designee of a licensed residential child caring agency defined ~~group home described~~ in s. 409.175 ~~s. 39.523~~, an approved relative or nonrelative with whom a child is placed

pursuant to s. 39.402, preadoptive parents for whom a favorable preliminary adoptive home study has been conducted, adoptive parents, or an adoption entity acting on behalf of preadoptive or adoptive parents.

Section 14. Subsection (11) of section 1002.3305, Florida Statutes, is amended to read:

1002.3305 College-Preparatory Boarding Academy Pilot Program for at-risk students.—

(11) STUDENT HOUSING.—Notwithstanding s. 409.176 ~~ss. 409.1677(3)(d) and 409.176~~ or any other provision of law, an operator may house and educate dependent, at-risk youth in its residential school for the purpose of facilitating the mission of the program and encouraging innovative practices.

Section 15. Section 39.523, Florida Statutes, is repealed.

Section 16. Section 409.141, Florida Statutes, is repealed.

Section 17. Section 409.1676, Florida Statutes, is repealed.

Section 18. Section 409.1677, Florida Statutes, is repealed.

Section 19. Section 409.1679, Florida Statutes, is repealed.

Section 20. This act shall take effect July 1, 2016.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

FOR

10-22-15
Meeting Date

7018
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Child Welfare

Name Christina Spudeas

Job Title Exec. Dir.

Address 1801 N. University Dr., Ste 3B
Street
Coral Springs, FL 33071
City *State* *Zip*

Phone 954-796-0860

Email Christina.Spudeas@floridaschoolchoice.org

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

(Wishes to submit written support)

Representing Florida Children First

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

#1

10/22/15
Meeting Date

SB 7018
Bill Number (if applicable)

Topic Child Welfare

Amendment Barcode (if applicable)

Name Victoria Vangelis Zepp

Job Title Exec. Dir. Govt Affairs, FCC

Address ~~121~~ 411 E. College Ave
Street

Phone 850.241.6309

TLH, FL 32301
City *State* *Zip*

Email VICTORIA@FLChildren.org

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA COALITION for CHILDREN

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

10.22.15 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) SB 7018

Meeting Date *Bill Number (if applicable)*

#184684

Amendment Barcode (if applicable)

Topic _____

Name Victoria Vangalis Zepp

Job Title Exec. Dir. Govt Affairs

Address 411 E. College Phone 850.241.6389

Street

32301 Email Victoria

City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against

(The Chair will read this information into the record.)

Representing FL Coalition For Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

amendment

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

10/22/15
Meeting Date

SB 7018
Bill Number (if applicable)

#255158
#304418
#792830
Amendment Barcode (if applicable)

Topic _____

Name Victoria Vangalis Zepp

Job Title Exec. Dir Govt Affairs

Address 411 E. College
Street

Phone 850.241.6305

_____ 32301
City *State* *Zip*

Email _____

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Coalition For Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

#2

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

October 22
Meeting Date

SP 7018
Bill Number (if applicable)

Topic Child Welfare

Amendment Barcode (if applicable)

Name Jim Carlson

Job Title Senior Executive for Administration

Address 2301 East Gallic Blvd
Street

Phone 321-752-4650

Melbourne Florida 32935
City *State* *Zip*

Email james.carlson@brevard fp.org

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Brevard Family Partnerships

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

#3

10-23-15
Meeting Date

SB 7018
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Child Welfare

Name Lucia Brunton

Job Title Director of External Affairs

Address 1500 Independence Blvd
Street
Sarasota FL 34238
City *State* *Zip*

Phone 941-371-4799 x103

Email lbrunton@TheSarasotaY.org

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Safe Children Coalition - Sarasota YMCA

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SPB 7018
FINAL ACTION: Submitted as Committee Bill
MEETING DATE: Thursday, October 22, 2015
TIME: 12:30—2:30 p.m.
PLACE: 301 Senate Office Building

FINAL VOTE			10/22/2015 1 Amendment 184684 Detert		10/22/2015 2 Amendment 917038 Detert		10/22/2015 3 Amendment 206734 Detert	
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Dean						
X		Detert						
X		Garcia						
X		Hutson						
		Ring						
X		Altman, VICE CHAIR						
		Sobel, CHAIR						
5	0	**TOTALS**	FAV	-	FAV	-	FAV	-
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SPB 7018
FINAL ACTION: Submitted as Committee Bill
MEETING DATE: Thursday, October 22, 2015
TIME: 12:30—2:30 p.m.
PLACE: 301 Senate Office Building

	10/22/2015 4 Amendment 385888 Detert		10/22/2015 5 Amendment 255158 Detert		10/22/2015 6 Amendment 304418 Detert		10/22/2015 7 Amendment 612830 Detert	
SENATORS	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
Dean								
Detert								
Garcia								
Hutson								
Ring								
Altman, VICE CHAIR								
Sobel, CHAIR								
TOTALS	FAV **Yea**	- **Nay**	FAV **Yea**	- **Nay**	FAV **Yea**	- **Nay**	FAV **Yea**	- **Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SPB 7018
FINAL ACTION: Submitted as Committee Bill
MEETING DATE: Thursday, October 22, 2015
TIME: 12:30—2:30 p.m.
PLACE: 301 Senate Office Building

	10/22/2015 8 Amendment 691122 Detert		10/22/2015 9 Amendment 287242 Detert		10/22/2015 10 Amendment 903328 Detert		10/22/2015 11 Amendment 615066 Detert	
SENATORS	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
Dean								
Detert								
Garcia								
Hutson								
Ring								
Altman, VICE CHAIR								
Sobel, CHAIR								
TOTALS	FAV **Yea**	- **Nay**	FAV **Yea**	- **Nay**	FAV **Yea**	- **Nay**	FAV **Yea**	- **Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SPB 7018
FINAL ACTION: Submitted as Committee Bill
MEETING DATE: Thursday, October 22, 2015
TIME: 12:30—2:30 p.m.
PLACE: 301 Senate Office Building

	10/22/2015 12 Amendment 792830 Detert		10/22/2015 13 Amendment 868866 Detert		10/22/2015 14 Amendment 208674 Detert		10/22/2015 15 Motion to submit as Committee Bill Detert	
SENATORS	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
Dean								
Detert								
Garcia								
Hutson								
Ring								
Altman, VICE CHAIR								
Sobel, CHAIR								
TOTALS	FAV **Yea**	- **Nay**	FAV **Yea**	- **Nay**	FAV **Yea**	- **Nay**	FAV **Yea**	- **Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR JEREMY RING
29th District

COMMITTEES:
Governmental Oversight and Accountability, *Chair*
Appropriations Subcommittee on Finance and Tax, *Vice Chair*
Appropriations
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Banking and Insurance
Commerce and Tourism
Judiciary
Rules

JOINT COMMITTEES:
Joint Legislative Auditing Committee
Joint Select Committee on Collective Bargaining

October 13, 2015

The Honorable Eleanor Sobel, Chair
Committee on Children, Families and Elder Affairs
520 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Chairwoman Sobel:

Please accept this letter as a formal request to be excused from Children, Familes and Elder Affairs meeting, which is scheduled for 12:30pm on October 23rd. I have to be on the West Coast forbusiness meetings that cannot be changed. I apologize for any inconvenience this may have caused you or the committee.

If you need further information, please do not hesitate to contact me or my staff.

Sincerely,

Jeremy Ring

Senator Jeremy Ring
District 29

cc: Todd McKay, Staff Director
Patty Blackburn, Committee Administrative Assistant

REPLY TO:
☐ 5790 Margate Boulevard, Margate, Florida 33063 (954) 917-1392 FAX: (954) 917-1394
☐ 405 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5029

Senate's Website: *www.flsenate.gov*

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

10/22/15
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Child Welfare

Name Mike Carroll

Job Title Secretary

Address 1317 Winewood Blvd.
Street

Tallahassee FL 32399
City *State* *Zip*

Phone 850 487 1111

Email mike.carroll@myflfamilies.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Department of Children & Families

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

CourtSmart Tag Report

Room: SB 301 **Case No.:** **Type:**
Caption: Senate Children, Families, and Elder Affairs Committee **Judge:**

Started: **10/22/2015 12:31:59 PM**
Ends: 10/22/2015 1:55:05 PM **Length: 01:23:07**

12:32:02 PM	Meeting called to order
12:32:59 PM	Roll Call
12:33:41 PM	Comments by chair regarding news articles
12:34:27 PM	Secretary Mike Carrol, Dept. of Children and Families on recent child deaths
12:50:38 PM	Chair Sobel comments to members to try to find solutions
12:51:24 PM	Senator Detert responds to chair's inquiry
12:55:19 PM	Senator Hutson reponds to chair's inquiry and question to Sec'y Carrol
12:56:35 PM	Secretary Carrol responds to Senator Hutson's question
1:01:43 PM	Senator Dean question to Sec'y Carrol
1:04:14 PM	Sec'y Carrol responds to Sen. Dean
1:05:33 PM	Chair Sobel question to Sec'y Carrol
1:08:04 PM	Senator Altman question to Sec'y Carrol
1:10:34 PM	Sec'y Carrol responds
1:12:04 PM	Tab 1, SB 230, Missing Persons with Special Needs, Senator Dean
1:12:56 PM	Michael Daniels, FAAST
1:14:45 PM	Brian Pitts, Justice-2-Jesus
1:19:55 PM	Sen. Sobel question to Senator Dean & Sen. Dean responds re: pilot project
1:20:42 PM	Max Harmony
1:22:11 PM	Roll call on SB 230
1:22:44 PM	Tab 4, SPB 7018, Child Welfare
1:22:58 PM	Senator Detert to present SPB 7018
1:24:56 PM	Senator Altman for questions
1:27:39 PM	Carol Preston responds
1:27:53 PM	Senator Detert responds
1:29:03 PM	Barcode 184684 by Senator Detert, Carol Preston to explain
1:30:20 PM	Victoria Vangalis Zepp, Florida Coalition for Children
1:31:07 PM	Barcode 917038 by Senator Detert, Carol Preston to explain'
1:31:36 PM	Barcode 206734 by Senator Detert, Carol Preston to explain
1:32:48 PM	Barcode 385888 by Senator Detert, Carol Preston to explain
1:33:04 PM	Barcode 255158 by Senator Detert, Carol Preston to explain
1:33:31 PM	Victoria Vangalis Zepp, representing Florida Coalition for Children
1:34:27 PM	Barcode 304418 by Senator Detert, Carol Preston to explain

1:35:12 PM Victoria Vangalis Zepp, Florida Coalition for Children
1:36:12 PM Carol Preston responds
1:36:30 PM Senator Detert responds
1:36:46 PM Victoria Vangalis Zepp
1:37:07 PM Barcode 612830 by Senator Detert, Carol Preston to explain
1:37:59 PM Barcode 691122 by Senator Detert, Carol Preston explains
1:38:29 PM Barcode 287242 by Senator Detert, Carol Preston explains
1:38:42 PM Barcode 903328 by Senator Detert, Carol Preston explains
1:38:59 PM Barcode 615066 by Senator Detert, Carol Preston explains
1:39:22 PM Barcode 792830 by Senator Detert, Carol Preston to explain
1:40:05 PM Victoria Vangalis Zepp, Florida Coalition for Children
1:41:22 PM Barcode 868866 by Senator Detert, Carol Preston explains
1:41:50 PM Barcode 208674 by Senator Detert, Carol Preston explains
1:43:39 PM Victoria Vangalis Zepp, Florida Coalition for Children
1:46:09 PM Chair Sobel turns chair over to Vice Chair Altman
1:46:33 PM Jim Carlson, Bevard Family Partnerships
1:48:18 PM Lucia Brunton, Safe Children Coalition Sarasota YMCA
1:51:00 PM Senator Detert responds
1:52:10 PM Senator Garcia comment
1:54:12 PM Senator Deterts moves SPB 7018 as amended be submitted as a committee bill
1:54:21 PM Roll call on SPB 7018
1:54:57 PM Senator Garcia moves to rise