Tab 1	**SB 914** by **Garcia**; (Compare to CS/H 00655) Suicide Prevention

Tab 2	**SB 938** by **Davis**; (Identical to H 00829) Operation and Administration of the Baker Act

Tab 3	**SB 1064** by **Yarborough**; (Identical to H 01007) Children Removed from Caregivers

713300	D	S	RCS	CF, Yarborough	Delete everything after	03/14 10:10 AM

Tab 4	**CS/SB 1098** by **JU, Burton**; (Similar to H 01119) Withholding or Withdrawal of Life-prolonging Procedures

319414	A	S	RCS	CF, Burton	Delete L.42 - 45:	03/14 10:10 AM
940260	A	S	RS	CF, Burton	Delete L.181 - 186:	03/14 10:10 AM
267664	SA	S	RCS	CF, Burton	Delete L.181 - 186:	03/14 10:10 AM

Tab 5	**SB 1146** by **Yarborough**; (Similar to CS/H 00775) Shared Parental Responsibility After the Establishment of Paternity

557318	A	S	RCS	CF, Yarborough	Delete L.41 - 64:	03/14 10:10 AM

Tab 6	**SB 1182** by **Simon (CO-INTRODUCERS) Book**; (Similar to CS/H 00299) Education and Training for Alzheimer's Disease and Related Forms of Dementia

622510	D	S	RCS	CF, Simon	Delete everything after	03/14 10:11 AM

Tab 7	**SB 1190** by **Garcia**; (Similar to H 01337) Step into Success Workforce Education and Internship Pilot Program

265304	A	S	RCS	CF, Garcia	Delete L.192 - 193:	03/14 10:11 AM

Tab 8	**SB 1210** by **Burgess**; (Similar to CS/H 00841) Public Records/Human Trafficking Victims

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Garcia, Chair
Senator Thompson, Vice Chair

MEETING DATE: Tuesday, March 14, 2023
TIME: 8:30—10:30 a.m.
PLACE: *Mallory Horne Committee Room,* 37 Senate Building

MEMBERS: Senator Garcia, Chair; Senator Thompson, Vice Chair; Senators Baxley, Book, Bradley, Brodeur, Ingoglia, and Rouson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 914** Garcia (Compare CS/H 655, S 468)	Suicide Prevention; Authorizing certain diagnoses to be made through telehealth; revising the purposes of the Commission on Mental Health and Substance Abuse to include an assessment of the state's suicide prevention infrastructure; revising the duties of the commission to include duties relating to the state's suicide prevention infrastructure; requiring the commission to submit annual interim reports for a specified timeframe, etc. CF 03/14/2023 Favorable HP RC	Favorable Yeas 8 Nays 0
2	**SB 938** Davis (Identical H 829)	Operation and Administration of the Baker Act; Requiring the Department of Children and Families to provide specified information to certain individuals and organizations; requiring the department to maintain an information handbook and repository of answers to frequently asked questions, etc. CF 03/14/2023 Favorable JU RC	Favorable Yeas 7 Nays 0
3	**SB 1064** Yarborough (Identical H 1007)	Children Removed from Caregivers; Requiring community-based care lead agencies, in coordination with the local managing entity, to provide a trauma-focused assessment within a specified timeframe to children removed from certain caregivers; requiring the Department of Children and Families to require in its contracts with the community-based care lead agencies that such agencies and managing entities provide a trauma-focused assessment within a specified timeframe to children removed from certain caregivers, etc. CF 03/14/2023 Fav/CS AHS FP	Fav/CS Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**CS/SB 1098** Judiciary / Burton (Similar H 1119)	Withholding or Withdrawal of Life-prolonging Procedures; Authorizing the court to delegate the right to consent to the withholding or withdrawal of life-prolonging procedures of incapacitated persons in certain circumstances; requiring initial and annual guardianship plans, respectively, to state whether any power under the ward's preexisting order not to resuscitate or advance directive is revoked, modified, suspended, or transferred to the guardian; authorizing a guardian to petition a court for approval to consent to withhold or withdraw life-prolonging procedures under certain circumstances, etc. JU 03/07/2023 Fav/CS CF 03/14/2023 Fav/CS RC	Fav/CS Yeas 8 Nays 0
5	**SB 1146** Yarborough (Similar CS/H 775)	Shared Parental Responsibility After the Establishment of Paternity; Authorizing a parent to request certain determinations and the creation of a parenting plan and time-sharing schedule; requiring the determination of parental responsibility and the establishment of a parenting plan, a time-sharing schedule, or child support to be done through a certain action; specifying that a mother of a child born out of wedlock and the father of such child are the natural guardians of the child and subject to the rights and responsibilities of being parents if certain conditions are met, etc. CF 03/14/2023 Fav/CS JU RC	Fav/CS Yeas 8 Nays 0
6	**SB 1182** Simon (Similar CS/H 299)	Education and Training for Alzheimer's Disease and Related Forms of Dementia; Designating the "Alzheimer's Disease and Related Forms of Dementia Education and Training Act"; requiring the Department of Elderly Affairs to offer certain education about Alzheimer's disease and related forms of dementia to the general public; providing minimum requirements for the training; authorizing persons to satisfy the training requirements of this act using training curricula approved before the effective date of this act until the department adopts rules for training curricula guidelines, etc. CF 03/14/2023 Fav/CS AHS FP	Fav/CS Yeas 7 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1190** Garcia (Similar H 1337)	Step into Success Workforce Education and Internship Pilot Program; Creating the "Step into Success Act"; requiring the Department of Children and Families to establish the pilot program; requiring the independent living professionalism and workforce education component of the pilot program to culminate in a specified certificate; providing that completion of that component allows former foster youth to participate in the onsite workforce and training internship component; specifying conditions for participation in the onsite workforce internship component, etc. CF 03/14/2023 Fav/CS AHS FP	Fav/CS Yeas 8 Nays 0
8	**SB 1210** Burgess (Similar CS/H 841, S 1428)	Public Records/Human Trafficking Victims; Expanding an existing public records exemption relating to human trafficking victims seeking expunction of certain records related to an offense listed in s. 775.084(1)(b)1., F.S.; providing for the reversion of specified provisions if the exemption is not saved from repeal; providing for future legislative review and repeal of the exemption; providing a statement of public necessity, etc. CF 03/14/2023 Favorable RC	Favorable Yeas 8 Nays 0
	Other Related Meeting Documents		

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR JASON BRODEUR
10th District

COMMITTEES:
Appropriations Committee on Agriculture, Environment, and General Government, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Children, Families, and Elder Affairs
Community Affairs
Regulated Industries
Rules

JOINT COMMITTEE:
Joint Legislative Auditing Committee

March 14, 2023

The Honorable Ileana Garcia, Chair
Children, Families, and Elder Affairs Committee
322 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Garcia,

This morning, I was called out of Children, Families, and Elder Affairs because of a bill I had to present in a different committee. Due to my presentation, I missed the vote on SB 938 and SB 1182. I respectfully request that my vote be recorded affirmative on both of these bills.

If you have any questions or concerns, please do not hesitate to reach out to me or my office.

Sincerely,

Jason Brodeur

Senator Jason Brodeur – District 10

REPLY TO:
❒ 110 Timberlachen Circle, Suite 1012, Lake Mary, Florida 32746 (407) 333-1802
❒ 405 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5010

Senate's Website: *www.flsenate.gov*

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

By Senator Garcia

36-01202B-23 2023914__

A bill to be entitled

An act relating to suicide prevention; amending s. 111.09, F.S.; defining the term "affiliated first responder organization"; revising the definition of the term "first responder peer"; amending s. 112.1815, F.S.; authorizing certain diagnoses to be made through telehealth; amending s. 394.9086, F.S.; revising the purposes of the Commission on Mental Health and Substance Abuse to include an assessment of the state's suicide prevention infrastructure; revising the duties of the commission to include duties relating to the state's suicide prevention infrastructure; requiring the commission to submit annual interim reports for a specified timeframe; revising the date by which the commission must submit its final report; extending the repeal date of the commission; providing an effective date.

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

Section 1. Subsection (1) of section 111.09, Florida Statutes, is amended to read:

111.09 Peer support for first responders.—

(1) For purposes of this section, the term:

(a) "Affiliated first responder organization" includes, but is not limited to, any of the following organizations:

1. Regularly organized volunteer firefighting departments or associations.

2. Regularly organized volunteer ambulance services.

3. Combination fire departments, as that term is defined in s. 633.135(1).

(b) "First responder" has the same meaning as provided in s. 112.1815 and includes 911 public safety telecommunicators as defined in s. 401.465.

(c) ~~(b)~~ "First responder peer" means a person who:

1. Is not a health care practitioner as defined in s. 456.001.

2. Has experience working as or with a first responder, including active, volunteer, and retired first responders, regarding any physical or emotional conditions or issues associated with the first responder's employment.

3. Has been designated by the first responder's employing agency or affiliated first responder organization to provide peer support as provided in this section and has received training for this purpose.

(d) ~~(c)~~ "Peer support" means the provision of physical, moral, or emotional support to a first responder by a first responder peer for the purpose of addressing physical or emotional conditions or other issues associated with being a first responder.

(e) ~~(d)~~ "Peer support communication" means electronic, oral, or written communication, made with a mutual expectation of confidentiality while a first responder peer is providing peer support in his or her official capacity.

Section 2. Paragraph (a) of subsection (5) of section 112.1815, Florida Statutes, is amended to read:

112.1815 Firefighters, paramedics, emergency medical technicians, and law enforcement officers; special provisions

for employment-related accidents and injuries.—

(5)(a) For the purposes of this section and chapter 440, and notwithstanding sub-subparagraph (2)(a)3. and ss. 440.093 and 440.151(2), posttraumatic stress disorder, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association, suffered by a first responder is a compensable occupational disease within the meaning of subsection (4) and s. 440.151 if:

1. The posttraumatic stress disorder resulted from the first responder acting within the course of his or her employment as provided in s. 440.091; and

2. The first responder is examined and subsequently diagnosed with such disorder by a licensed psychiatrist, in person or through telehealth as that term is defined in s. 456.47, who is an authorized treating physician as provided in chapter 440 due to one of the following events:

a. Seeing for oneself a deceased minor;

b. Directly witnessing the death of a minor;

c. Directly witnessing an injury to a minor who subsequently died before or upon arrival at a hospital emergency department;

d. Participating in the physical treatment of an injured minor who subsequently died before or upon arrival at a hospital emergency department;

e. Manually transporting an injured minor who subsequently died before or upon arrival at a hospital emergency department;

f. Seeing for oneself a decedent whose death involved grievous bodily harm of a nature that shocks the conscience;

g. Directly witnessing a death, including suicide, that

involved grievous bodily harm of a nature that shocks the conscience;

h. Directly witnessing a homicide regardless of whether the homicide was criminal or excusable, including murder, mass killing as defined in 28 U.S.C. s. 530C, manslaughter, self-defense, misadventure, and negligence;

i. Directly witnessing an injury, including an attempted suicide, to a person who subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience;

j. Participating in the physical treatment of an injury, including an attempted suicide, to a person who subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience; or

k. Manually transporting a person who was injured, including by attempted suicide, and subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience.

Section 3. Subsection (2), paragraph (a) of subsection (4), and subsections (5) and (6) of section 394.9086, Florida Statutes, are amended to read:

394.9086 Commission on Mental Health and Substance Abuse.—

(2) PURPOSES.—The purposes of the commission are to examine the current methods of providing mental health and substance abuse services in the state and to improve the effectiveness of current practices, procedures, programs, and initiatives in

providing such services; identify any barriers or deficiencies in the delivery of such services; assess the adequacy of the current infrastructure of Florida's National Suicide Prevention Lifeline (NSPL) system and other components of the state's crisis response services; and recommend changes to existing laws, rules, and policies necessary to implement the commission's recommendations.

(4) DUTIES.—

(a) The duties of the Commission on Mental Health and Substance Abuse include the following:

1. Conducting a review and evaluation of the management and functioning of the existing publicly supported mental health and substance abuse systems and services in the department, the Agency for Health Care Administration, and all other departments which administer mental health and substance abuse services. Such review shall include, at a minimum, a review of current goals and objectives, current planning, services strategies, coordination management, purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms.

2. Considering the unique needs of persons who are dually diagnosed.

3. Addressing access to, financing of, and scope of responsibility in the delivery of emergency behavioral health care services.

4. Addressing the quality and effectiveness of current mental health and substance abuse services delivery systems, and professional staffing and clinical structure of services, roles, and responsibilities of public and private providers, such as

community mental health centers; community substance abuse agencies; hospitals, including emergency services departments; law enforcement agencies; and the judicial system.

5. Addressing priority population groups for publicly funded mental health and substance abuse services, identifying the comprehensive mental health and substance abuse services delivery systems, mental health and substance abuse needs assessment and planning activities, and local government funding responsibilities for mental health and substance abuse services.

6. Reviewing the implementation of chapter 2020-107, Laws of Florida.

7. Identifying any gaps in the provision of mental health and substance use disorder services.

8. Providing recommendations on how behavioral health managing entities may fulfill their purpose of promoting service continuity and work with community stakeholders throughout this state in furtherance of supporting the NSPL system and other crisis response services.

9. Conducting an overview of the current infrastructure of the NSPL system.

10. Analyzing the current capacity of crisis response services available throughout this state, including services provided by mobile response teams and centralized receiving facilities. The analysis must include information on the geographic area and the total population served by each mobile response team along with the average response time to each call made to a mobile response team; the number of calls that a mobile response team was unable to respond to due to staff limitations, travel distance, or other factors; and the veteran

status and age groups of individuals served by mobile response teams.

11. Evaluating and making recommendations to improve linkages between the NSPL infrastructure and crisis response services within this state.

12. Identifying available mental health block grant funds that can be used to support the NSPL and crisis response infrastructure within this state, including any available funding through opioid settlements or through the American Rescue Plan Act of 2021, Pub. L. No. 117-2; the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136; or other federal legislation.

13. In consultation with the Agency for Health Care Administration, identifying sources of funding available through the Medicaid program specifically for crisis response services, including funding that may be available by seeking approval of a Section 1115 waiver submitted to the Centers for Medicare and Medicaid Services.

14.~~9.~~ Making recommendations regarding the mission and objectives of state-supported mental health and substance abuse services and the planning, management, staffing, financing, contracting, coordination, and accountability mechanisms which will best foster the recommended mission and objectives.

15.~~10.~~ Evaluating and making recommendations regarding the establishment of a permanent, agency-level entity to manage mental health, substance abuse, and related services statewide. At a minimum, the evaluation must consider and describe the:

a. Specific duties and organizational structure proposed for the entity;

b. Resource needs of the entity and possible sources of funding;

c. Estimated impact on access to and quality of services;

d. Impact on individuals with behavioral health needs and their families, both those currently served through the affected systems providing behavioral health services and those in need of services; and

e. Relation to, integration with, and impact on providers, managing entities, communities, state agencies, and systems which provide mental health and substance abuse services in this state. Such recommendations must ensure that the ability of such other agencies and systems to carry out their missions and responsibilities is not impaired.

(5) REPORTS.—Beginning ~~By~~ January 1, 2023, and annually thereafter through January 1, 2025, the commission shall submit an interim report to the President of the Senate, the Speaker of the House of Representatives, and the Governor containing its findings and recommendations on how to best provide and facilitate mental health and substance abuse services in the state. The commission shall submit its final report to the President of the Senate, the Speaker of the House of Representatives, and the Governor by September 1, 2026 ~~2023~~.

(6) REPEAL.—This section is repealed September 1, 2026 ~~2023~~, unless saved from repeal through reenactment by the Legislature.

Section 4. This act shall take effect July 1, 2023.

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 914
INTRODUCER:	Senator Garcia
SUBJECT:	Suicide Prevention
DATE:	March 13, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Cox	CF	**Favorable**
2.			HP	
3.			RC	

I. Summary:

SB 914 modifies statutory provisions governing confidentiality for peer support communications between a first responder and a first responder peer. The bill allows certain first responder organizations to designate first responder peers and clarifies that first responder peers include active, volunteer, and retired first responders. The bill also permits diagnosis of post-traumatic stress disorder in first responders via telehealth for the purposes of obtaining worker's compensation benefits.

The bill directs the Commission on Mental Health and Substance Abuse (the Commission) adjunct to the Department of Children and Families (the DCF) to conduct a study examining the following services and programs relating to suicide prevention:

- The National Suicide Prevention Lifeline (the NSPL);
- Crisis response services;
- Strategies to improve linkages between NSPL infrastructure and crisis response services;
- Available mental health block grant funds;
- Funding sources available through Medicaid; and
- Strategies to ensure that managing entities work with community stakeholders in furtherance of supporting the NSPL and other crisis response services.

The bill extends the statutory repeal date of the Commission from September 1, 2023 to September 1, 2026.The bill also requires the Commission to submit interim reports, beginning January 1, 2023, annually thereafter through January 1, 2025, and a final report due September 1, 2026, to the Governor; the President of the Senate; and the Speaker of the House of Representatives. The bill requires the Commission to include the findings of the suicide prevention study in the final report due September 1, 2026.

The bill is unlikely to have a significant negative impact on state government and may have an indeterminate impact on certain affiliated first responder organizations as defined in the bill. See Section V. Fiscal Impact Statement.

The bill is effective July 1, 2023.

II. Present Situation:

Suicide Prevention

Suicide is a major public health issue and a leading cause of death nationally.[1] In 2020, 45,979 suicide deaths were reported across the U.S., while an estimated 12.2 million American adults seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide.[2] Suicide rates increased every year from 2000 through 2018.[3] After stable trends from 2000 to 2007, suicide rates for persons aged 10–24 increased 56 percent from 2007 to 2017,[4] before declining 2 percent from 2018 to 2019.[5] Provisional data indicate that both the number and the rate of suicides nationally increased 4 percent from 2020 to 2021, after two consecutive years of decline in 2019 and 2020.[6]

In 2020, 3,113 Floridians died by suicide, representing a 10 percent decrease from the number of deaths in 2019.[7] Over half of suicide deaths in 2019 involved a firearm.[8] According to provisional data, approximately 3,325 Floridians died from suicide in 2021, an increase of approximately 7 percent from 2020.[9]

[1] The Centers for Disease Control and Prevention (The CDC), *Facts About Suicide*, available at https://www.cdc.gov/suicide/facts/index.html (last visited March 7, 2023).
[2] *Id*.
[3] *Id*.
[4] Heron M., Curtin, S., *Death Rates Due to Suicide and Homicide Among Persons Aged 10-24: United States, 2007-2017*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention National Center for Health Statistics, available at https://www.cdc.gov/nchs/data/databriefs/db352-h.pdf (last visited March 7, 2023).
[5] The CDC, *Changes in Suicide Rates – United States, 2018-2019*, available at https://www.cdc.gov/mmwr/volumes/70/wr/mm7008a1.htm (last visited March 7, 2023).
[6] The CDC, *Suicide Increases in 2021 After Two Years in Decline*, available at https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20220930.htm (last visited March 7, 2023).
[7] The DCF, *2022 Suicide Prevention Coordinating Council Annual Report*, January 1, 2023, p. 11 (on file with the Senate Committee on Children, Families, and Elder Affairs).
[8] *Id*.
[9] The Florida Department of Health, *FLHealthCharts – Death Count Query System*, available at https://www.flhealthcharts.gov/FLQUERY_New/Death/Count (last visited March 7, 2023).

First Responders

A first responder is a law enforcement officer,[10] firefighter,[11] or an emergency medical technician or paramedic[12] employed by state or local government.[13] Additionally, a volunteer law enforcement officer, firefighter, or emergency medical technician or paramedic engaged by the state or a local government is considered a first responder of the state or local government.[14]

First responders are often exposed to incidents of death and destruction that can result in post-traumatic stress disorder (PTSD), depression, and suicide. A study by the Ruderman Family Foundation revealed that 35 percent of police officers have suffered from PTSD and 46.8 percent of firefighters have experienced suicidal thoughts.[15] Firefighters and police officers are both more likely to die by suicide than in the line of duty.[16] Further, according to a 2015 article published in the Journal of Emergency Medical Services, a survey of 4,000 first responders found that 6.6 percent had attempted suicide, which is more than 10 times the rate in the general population.[17]

Volunteer Firefighters

A volunteer firefighter is an individual who holds a current and valid Volunteer Firefighter Certificate of Completion issued by the Division of State Fire Marshal under s. 633.408, F.S.[18] Approximately 12 million Florida citizens depend on volunteer firefighters to protect their community.[19] To keep these residents safe, it's critical that individuals volunteer for local

[10] Section 943.10(1), F.S. defines the term "law enforcement officer" to mean "any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. The term includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency."
[11] Section 633.102(9), F.S. defines the term "firefighter" to mean "an individual who holds a current and valid Firefighter Certificate of Compliance or Special Certificate of Compliance issued by the Division of State Fire Marshal within the Department of Financial Services."
[12] Section 401.23(12), F.S. defines the term "emergency medical technician" to mean "a person who is certified by the Department of Health to perform basic life support." Section 401.23(18), F.S., defines the term "paramedic" to mean "a person who is certified by the Department of Health to perform basic and advanced life support."
[13] Section 125.01045, F.S.
[14] *Id.*
[15] Miriam Heyman, Jeff Dill & Robert Douglas, *The Ruderman White Paper on Mental Health and Suicide of First Responders*, at p. 12, available at https://dir.nv.gov/uploadedFiles/dirnvgov/content/WCS/TrainingDocs/First%20Responder%20White%20Paper_Final%20(2).pdf (last visited March 7, 2023).
[16] *Id.* at p. 7.
[17] Fire Rescue News, *Increasing Suicide Rates Among First Responders Spark Concerns*, available at https://www.firerescue1.com/fire-ems/articles/222673018-Increasing-suicide-rates-among-first-responders-spark-concern/ (last visited March 7, 2023).
[18] *See* s. 633.408, F.S.
[19] The Florida Department of Financial Services, Division of State Fire Marshal, *Florida Volunteer Firefighter Information*, available at https://www.myfloridacfo.com/division/sfm/volff#:~:text=More%20than%20200%20departments%20throughout%20Florida%20utilize%20volunteers%20to%20sustain%20operations (last visited March 7, 2023).

departments.[20] More than 200 departments throughout Florida utilize volunteers to sustain operations.[21]

First Responders Suicide Deterrence Task Force

In 2020, the Legislature created the First Responders Suicide Deterrence Task Force within the Statewide Office of Suicide Prevention, which is housed within the DCF and coordinates education and training curricula on suicide prevention efforts for veterans and service members.[22] [23]

The most recent report of the task force, published on July 1, 2022, included the findings of a survey conducted by the 2nd Alarm Project,[24] a nonprofit organization established to offer comprehensive, evidence-based resiliency initiatives in first responder communities. [25] According to the survey, upwards of 24 percent of first responders reported provisional diagnosis of posttraumatic stress disorder, 52.3 percent reported depression; 39.1 percent reported anxiety; 38.3 percent reported harmful levels of drinking; and 15.1 percent are at higher risk for suicide. [26] The findings indicated generally higher rates of these issues among respondents who are single certified EMS professionals and among dual certified/combined Fire/EMS personnel who serve as Advanced Life Support/transport providers.[27]

Peer Support

Research has shown that social support provided by peers is beneficial to those in recovery from a SUD or mental illness. There are four primary types of social support provided by peers:

- Emotional: where a peer demonstrates empathy, caring, or concern to bolster a person's self-esteem (i.e., peer mentoring or peer-led support groups).
- Informational: where a peer shares knowledge and information to provide life or vocational skills training (i.e., parenting classes, job readiness training, or wellness seminars).
- Instrumental: where a peer provides concrete assistance to help others accomplish tasks (i.e., child care, transportation, and help accessing health and human services).
- Affiliational: where a peer facilitates contacts with other people to promote learning of social skills, create a sense of community, and acquire a sense of belonging (i.e., recovery centers, sports league participation, and alcohol or drug free socialization opportunities).[28]

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[20] *Id*.
[21] *Id*.
[22] Section 14.2019, F.S.
[23] Chapter 2020-39, L.O.F.
[24] The 2nd Alarm Project, *Our Services*, available at https://2ndalarmproject.org/ (last visited March 7, 2023).
[25] The DCF, *First Responder Suicide Deterrence Task Force 2022 Annual Report*, available at https://myflfamilies.com/sites/default/files/2022-11/FINAL%202022%20First%20Responder%20Suicide%20Deterrence%20Task%20Force%20Report.pdf (last visited March 7, 2023).
[26] *Id*. at p. 8.
[27] *Id*.
[28] The Substance Abuse and Mental Health Services Administration (The SAMSHA), Center for Substance Abuse Treatment, *What Are Peer Recovery Support Services?,* p. 2, available at https://store.samhsa.gov/system/files/sma09-4454.pdf; *See also* the DCF, *Florida Peer Services Handbook* at p. 4-5, 2016, available at https://www.myflfamilies.com/sites/default/files/2022-11/Peer%20Guidance_2016.pdf (all sites last visited March 7, 2023).

First Responder Peer Support

A survey by the Journal of Emergency Medical Services revealed that first responders were less likely to contemplate suicide when they felt supported and encouraged at work.[29] One study showed that while some firefighters reported positive experiences with professional mental health help, others felt more distressed after such intervention.[30] Alternatively, these firefighters reported benefits from peer support, such as bonding with their fire crew after negative incidents, which can reduce the stigma, scheduling difficulties, lack of access, lack of trust, and fear or repercussions that may prevent first responders from seeking mental health care.[31]

In 2020, the Legislature recognized the need for mental health counseling for first responders by adopting confidentiality provisions intended to encourage peer support programs for law enforcement officers, firefighters, emergency medical technicians, paramedics, and 911 public safety telecommunicators.[32] A "first responder peer" is defined as "a person who:

- Is not a health care practitioner as that term is defined in s. 456.001, F.S.;[33]
- Has experience working as or with a first responder regarding any physical or emotional conditions or issues associated with the first responder's employment; and
- Has been designated by the first responder's employing agency to provide peer support as provided in this section and has received training for this purpose.[34]

First responder peers are prohibited from divulging information from, or testifying about, a peer support communication in a civil, criminal, administrative, or disciplinary proceeding, unless:

- The first responder peer is a defendant in a civil, criminal, administrative, or disciplinary proceeding arising from a complaint filed by the first responder who was a party to the peer support communication, in which case such information may be divulged but is limited to the scope of the proceeding;
- The first responder who was a party to the peer support communication agrees, in writing, to allow the first responder peer to testify about or divulge information related to the peer support communications;
- Based on the peer support communications, the first responder peer suspects that the first responder who was a party to the peer support communications has committed a criminal act or intends to commit a criminal act. There is no liability on the part of, and no cause of action of any nature may arise against, the first responder peer for disclosing relevant information; or

[29] Journal of Emergency Medical Services, *Survey Reveals Alarming Rates of EMS Provider Stress and Thoughts of Suicide*, available at https://www.jems.com/2015/09/28/survey-reveals-alarming-rates-of-ems-provider-stress-and-thoughts-of-suicide/ (last visited March 7 2023).
[30] The SAMSHA, *First Responders: Behavioral Health Concerns, Emergency Response, and Trauma*, (May 2019) at p. 10 and 12, available at https://www.samhsa.gov/sites/default/files/dtac/supplementalresearchbulletin-firstresponders-may2018.pdf (last visited March 7, 2023).
[31] *Id*.
[32] Chapter 2020-104, L.O.F.
[33] Section 456.001, F.S., defines "health care practitioner" to mean "any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I, part II, or part III of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491."
[34] Section 111.09(1)(b), F.S.

- There are articulable facts or circumstances that would lead a reasonable, prudent person to fear for the safety of the first responder who was a party to the peer support communication, another person, or society, and the first responder peer communicates the information only to a potential victim and law enforcement or other appropriate authorities. There is no liability on the part of, and no cause of action of any nature may arise against, the first responder peer for disclosing relevant information.[35]

Currently, the infrastructure for peer support teams is varied across Florida depending on the agency or department.[36] Many larger agencies contain high-functioning, sustainable peer support models, and will often share these peer support teams with smaller departments throughout the state.[37] The Orlando Fire Department houses the oldest peer support model in the state and operates within a best practice model.[38]Training for peer support teams is often provided by reputable behavioral health organizations (i.e. the 2nd Alarm Project) or within an agency's behavioral health unit (i.e., Ft. Lauderdale Police Department; Tallahassee Fire Mental Health Wellness Program).[39]

Commission on Mental Health and Substance Abuse

In 2021, the Legislature created the Commission, adjunct to the DCF, in response to recommendations of the 20th Statewide Grand Jury.[40] The DCF is required to provide administrative staff and support services for the Commission.[41]

The purposes of the Commission include:
- Examining the current methods of providing mental health and substance abuse services in the state;
- Improving the effectiveness of current practices, procedures, programs, and initiatives in providing such services;
- Identifying any barriers or deficiencies in the delivery of such services; and
- Recommending changes to existing laws, rules, and policies necessary to implement the Commission's recommendations.[42]

The Commission is comprised of 19 members, including the Secretaries of AHCA and DCF.[43] Membership of the Commission also includes:
- Seven members appointed by the Governor, including:
  - A psychologist licensed under ch. 490, F.S., practicing within the mental health delivery system;

[35] Section 111.09(2), F.S.
[36] The DCF, *First Responder Suicide Deterrence Task Force 2021 Annual Report*, p. 6, available at https://www.myflfamilies.com/sites/default/files/2022-11/First%20Responder%20Task%20Force%202021%20Report%20-%20Final%20-%208-4-21.pdf (last visited March 7, 2023),
[37] *Id*.
[38] *Id*.
[39] *Id*.
[40] Chapter 2021-170, L.O.F.
[41] Section 394.9086(1), F.S.
[42] Section 394.9086(2), F.S.
[43] Section 394.9086(3)(a), F.S.

  - A mental health professional licensed under ch. 491, F.S.;
  - A representative of mental health courts;
  - An emergency room physician;
  - A representative from the field of law enforcement;
  - A representative from the criminal justice system; and
  - A representative of a child welfare agency involved in the delivery of behavioral health services.
- Five members appointed by the President of the Senate, including:
  - A member of the Senate;
  - A person living with a mental health disorder;
  - A family member of a consumer of publicly funded mental health services;
  - A representative of the Louis de la Parte Mental Health Institute within the University of South Florida; and
  - A representative of a county school district.
- Five members appointed by the Speaker of the House of Representatives, including:
  - A member of the House of Representatives;
  - A representative of a treatment facility;
  - A representative of a managing entity;
  - A representative of a community substance abuse provider; and
  - A psychiatrist licensed under chs. 458 or 459, F.S., practicing within the mental health delivery system.[44]

The Governor appoints the Commission chair from among its members, and members serve at the pleasure of the officer who appointed the member.[45] A vacancy on the Commission is required to be filled in the same manner as the original appointment.[46]

The duties of the Commission include:
- Conducting a review and evaluation of the management and functioning of existing publicly supported mental health and substance abuse systems in the DCF, AHCA, and all other relevant state departments;
  - At a minimum, such review must include a review of current goals and objectives, current planning, service strategies, coordination management, purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms.
- Considering the unique needs of people who are dually diagnosed;
- Addressing access to, financing of, and scope of responsibility in the delivery of emergency behavioral health care services;
- Addressing the quality and effectiveness of current service delivery systems and professional staffing and clinical structure of services, roles, and responsibilities of public and private providers;
- Addressing priority population groups for publicly funded services, identifying the comprehensive delivery systems, needs assessment and planning activities, and local government responsibilities for funding services;

[44] *Id*.
[45] Section 394.9086(3)(b), F.S.
[46] *Id*.

- Reviewing the implementation of ch. 2020-107, L.O.F.;[47]
- Identifying gaps in the provision of mental health and substance abuse services;
- Providing recommendations on how managing entities may promote service continuity;
- Making recommendations about the mission and objectives of state-supported mental health and substance abuse services and the planning, management, staffing, financing, contracting, coordination, and accountability of mechanisms best suited for the recommended mission and objectives; and
- Evaluating and making recommendations regarding the establishment of a permanent, agency-level entity to manage mental health, behavioral health, substance abuse, and related services statewide, including the:
  - Duties and organizational structure;
  - Resource needs and possible sources of funding;
  - Impact on access to and the quality of services;
  - Impact on individuals with behavioral health needs, and their families, who are currently receiving services and those who are in need of services; and
  - Relation to and integration with service providers, managing entities, communities, state agencies, and provider systems.[48]

The Commission is required to submit an initial report by January 1, 2023, and a final report by September 1, 2023, to the Governor, President of the Senate, and Speaker of the House of Representatives on its findings and recommendations on how to best provide and facilitate mental health and substance abuse services.[49] The Commission issued its initial report, containing ten preliminary recommendations, on January 1, 2023.[50]

National Suicide Prevention Lifeline

The NSPL is a suicide prevention network of over 180 crisis centers that provides 24/7 service to anyone in a suicidal crisis or emotional distress via a toll-free hotline.[51] The U.S. Substance Abuse and Mental Health Services Administration (the SAMHSA) and Vibrant Emotional Health launched the Lifeline on January 1, 2005.[52]

The NSPL is independently evaluated by the Columbia University's Research Foundation for Mental Hygiene, and receives ongoing consultation and guidance from national suicide prevention experts, consumer advocates, and other stakeholders through the NSPL's Steering

[47] HB 945 (2020) required managing entities to implement the features of a coordinated system of mental health care for children and expands the use of mobile response teams (MRT) across the state. It required the Florida Mental Health Institute within the University of South Florida to develop a model protocol for school use of MRTs. The bill also required the AHCA and DCF to identify children and adolescents who are the highest users of crisis stabilization services and take action to meet the needs of such children. Lastly, the bill required the AHCA to continually test the Medicaid managed care provider network databases to ensure behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.
[48] Section 394.9086(4)(a), F.S.
[49] Section 394.9086(5), F.S.
[50] The DCF, Commission on Mental Health and Substance Abuse, *Legislative Report, January 1, 2023*, pp. 11-25 (on file with the Senate Committee on Children, Families, and Elder Affairs).
[51] The National Suicide Prevention Lifeline, *About*, available at https://suicidepreventionlifeline.org/about/ (last visited March 7, 2023).
[52] *Id*.

Committee; Consumer/Survivor Committee; and Standards, Training, and Practices Committee.[53] The NSPL grant is one component of the National Suicide Prevention Initiative, a multi-project effort to reduce suicide, led by the SAMSHA's Center for Mental Health Services.[54]

Managing Entities (MEs)

The DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[55]

In 2001, the Legislature authorized the DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.[56] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[57] Full implementation of the statewide ME system occurred in 2013 and all geographic regions are now served by a managing entity.[58]

Mobile Response Teams

A mental health crisis can be can be caused by a variety of factors at any hour of the day.[59] Family members and caregivers of an individual experiencing a mental health crisis are often ill-equipped to handle these situations and need the advice and support of professionals.[60] Law enforcement or emergency medical technicians (EMTs) are frequently called to respond to mental health crises and they may lack the training and experience to effectively handle the situation.[61] Mobile crisis response teams (MRTs) can be beneficial in such instances.

MRTs provide readily available crisis care in a community-based setting and increase opportunities to stabilize individuals in the least restrictive setting, thereby avoiding the need for jail or hospital emergency department utilization.[62] Early intervention services are critical to reducing involuntary examinations in minors and there are areas across the state where options

[53] *Id*.
[54] The SAMSHA, *National Suicide Prevention Initiative*, available at https://web.archive.org/web/20080201122133/http://mentalhealth.samhsa.gov/cmhs/nspi/ (last visited March 7, 2023).
[55] *See* s. 394.674(1), F.S., for a complete list of priority populations.
[56] Chapter 2001-191, L.O.F.
[57] Chapter 2008-243, L.O.F.
[58] Florida Tax Watch, *Analysis of Florida's Behavioral Health Managing Entity Models*, p. 4, March 2015, available at https://floridataxwatch.org/Research/Full-Library/ArtMID/34407/ArticleID/15758/Analysis-of-Floridas-Behavioral-Health-Managing-Entities-Model (last visited March 7, 2023).
[59] The DCF, *Mobile Response Teams Framework*, (August 29, 2018), p. 4, available at https://www.lsfnet.org/wp-content/uploads/2018/10/Solicitation-2018-007-Mobile-Response-Team-APPEN-B-Mobile-Response-Framework.pdf (last visited March 7, 2023) (hereinafter cited as "MRT Framework").
[60] *Id*.
[61] *Id*.
[62] MRT Framework, p. 2

short of involuntary examination under the Baker Act are limited or nonexistent.[63] MRTs are available to individuals under age 25 years of age, regardless of their ability to pay, and must be ready to respond to any mental health emergency.[64] Telehealth can be used to provide direct services to individuals via video-conferencing systems, mobile phones, and remote monitoring.[65] It can also be used to provide initial triage to determine if an in-person visit is needed to respond to the crisis, assessments, and follow-up consultation.[66]

The DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:

- Be conducted with the collaboration of local Sheriff's Offices and public schools in the procurement planning, development, evaluation, and selection process;
- Be designed to ensure reasonable access to services among all counties in the ME's service region, taking into consideration the geographic location of existing mobile crisis teams;
- Require services be available 24 hours per day, seven days per week with on-site response time to the location of referred crises within 60 minutes of the request for services;
- Require the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents;
- Require access to a board-certified or board-eligible Psychiatrist or Psychiatric Nurse Practitioner; and
- Provide for an array of crisis response services that are responsive to the individual and the family needs, including screening, standardized assessments, early identification, or linkage to community services as necessary to address the immediate crisis event.[67]

Florida Medicaid

Medicaid provides medical coverage to low-income individuals and families.[68] The state and federal government share the cost of the Medicaid program, and Medicaid services for Floridians are administered by the Agency for Health Care Administration (the AHCA).[69] Medicaid eligibility in Florida is determined either by the DCF or the Social Security Administration for SSI recipients.[70]

Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) program.[71] Within the SMMC, the Managed Medical Assistance (MMA) program provides acute health care services through managed care plans contracted with the AHCA in the 11 regions across the

[63] MRT Framework, p. 4.
[64] *Id*.
[65] MRT Framework, p. 7.
[66] *Id*.
[67] MDT Framework, p. 2-3.
[68] The DCF, Office of Economic Self-Sufficiency, *Medicaid*, available at https://www.myflfamilies.com/Medicaid (last visited March 7, 2023).
[69] *Id*.
[70] *Id*.
[71] Section 409.964, F.S.

state.[72] Coverage includes preventive care, acute care, therapeutics, pharmacy, transportation services, and behavioral health services.[73]

Current law requires each managed care plan to have an accurate and complete online database of the providers in their networks, including information about their credentials, licensure, hours of operation, and location.[74]

Federal Assistance Related to COVID-19

CARES Act Funding

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law "to provide emergency assistance and health care response for individuals, families, and businesses affected by the 2020 coronavirus pandemic."[75] The CARES Act included multiple resources for services and supports intended to benefit individuals with issues related to mental health or substance use disorder, including:

- $425 million for the SAMHSA, including:
  - $250 million to Certified Community Behavioral Health Clinics (CCBHCs);
  - $50 million for suicide prevention programs;
  - $100 million for emergency-response spending that can target support where it is most needed, such as outreach to those experiencing homelessness; and
  - $15 million for tribal communities.[76]

American Rescue Plan Act Funding

On March 11, 2021, the American Rescue Plan Act (the Rescue Act) was signed into law.[77] Under the Rescue Act, the SAMSHA distributed an additional $3 billion in funding for mental health and substance abuse services, comprising the largest ever aggregate amount of funding for mental health and substance use block grant programs.[78, 79] Specifically, the Community Mental

[72] *See* The Agency for Health Care Administration, *A Snapshot of the Florida Statewide Medicaid Managed Care Program*, https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf (last visited March 7, 2023).
[73] *Id*.
[74] Section 409.967(2)(c)1., F.S.
[75] Pub. L. No. 116-136 (2020).
[76] The National Alliance on Mental Illness (NAMI), *Information on the CARES Act for People with Mental Illness*, available at https://www.nami.org/About-NAMI/NAMI-News/2020/Information-on-the-CARES-Act-for-People-with-Mental-Illness (last visited March 7, 2023).
[77] Pub. L. No. 117-2 (2021).
[78] A block grant is a noncompetitive, formula grant mandated by the U.S. Congress where eligible entities must submit an annual application to demonstrate statutory and regulatory compliance in order to receive the formula-based funding by Congress. The SAMHSA's block grants provide funding for substance abuse and mental health services, including the Substance Abuse Prevention and Treatment Block Grant (Funds may be used to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health) and the Community Mental Health Services Block Grant (Funds may be used to provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system). *See* The SAMSHA, *Substance Abuse and Mental Health Block Grants*, available at https://www.samhsa.gov/grants/block-grants (last visited March 7, 2023).
[79] The U.S. Department of Health and Human Services, *HHS Announces $3 Billion in American Rescue Plan Funding for SAMHSA Block Grants to Address Addiction, Mental Health Crisis*, available at https://www.samhsa.gov/newsroom/press-announcements/202105181200#:~:text=The%20Substance%20Abuse%20and%20Mental,substance%20use%20block%20grant%20programs (last visited March 7, 2023).

Health Services Block Grant (MHBG) Program and Substance Abuse Prevention and Treatment Block Grant Program (SABG) dispersed $1.5 billion each to states and territories.[80]

III. Effect of Proposed Changes:

First Responder Peer Support

The bill amends s. 111.09, F.S., permitting affiliated first responder organizations, in addition to a first responder employing agency, to designate first responder peers for the purpose of providing peer support. The bill amends s. 111.09, F.S., defining "affiliated first responder organization" to mean an organization including, but not limited to:

- Regularly organized volunteer firefighting departments or associations;
- Regularly organized ambulance services; and
- Combination fire departments, as that term is defined in s. 633.135(1), F.S.[81]

The bill also clarifies that a person is eligible to serve as a first responder peer if he or she has experience working as or with a first responder, including as:

- An active first responder;
- A volunteer first responder; or
- A retired first responders.

The bill amends s. 112.1815, F.S., to permit diagnosis of post-traumatic stress disorder in first responders via telehealth for the purposes of obtaining worker's compensation benefits.

The bill amends s. 394.9086, F.S., requiring the Commission to study the following services and programs relating to suicide prevention:

- An overview of the National Suicide Prevention Lifeline (the NSPL);
- An analysis of the current capacity of crisis response services, including services provided by mobile response teams and centralized receiving facilities, including specifically an analysis of:
  - The geographic area and total population served by each mobile response team;
  - The average response time to each call made to the mobile response team;
  - The number of calls each mobile response team could not respond to due to staffing issues, travel distance, or other factors; and
  - The veteran status and age groups of individuals receiving services from mobile response teams.
- Strategies to improve linkages between NSPL infrastructure and crisis response services;
- Available mental health block grant funds which can be used to support the state's NSPL infrastructure, including potential funding available through opioid settlements, the CARES Act, the American Rescue Plan Act, or other federal legislation;
- Funding sources available through Medicaid, including potential funding available via approval of a section 1115 waiver; and

[80] *Id.*

[81] Section 633.135, F.S., defines "combination fire department" to mean "a fire department composed of a combination of career and volunteer firefighters."

- Strategies to ensure that managing entities work with community stakeholders in furtherance of supporting the NSPL and other crisis response services.

The bill also amends s. 394.9086, F.S., requiring the Commission to submit interim reports, beginning January 1, 2023, annually thereafter through January 1, 2025, and a final report due September 1, 2026, to:

- The Governor;
- The President of the Senate; and
- The Speaker of the House of Representatives.

This will require the Commission to submit a total of two additional interim reports and moves the due date of the final report from September 1, 2023 to September 1, 2026. The bill also extends the statutory repeal date of the Commission from September 1, 2023 to September 1, 2026.

The bill requires that information on the overview of the state's current suicide prevention infrastructure be included in the Commission's final report due to the Speaker, Senate President, and Governor on September 1, 2026.

The bill is effective July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DCF states that expenditures for the bill can be absorbed within existing resources.[82] The bill may have a positive impact on affiliated first responder organizations who wish to designate first responder peers, however because the decision to engage in this process is voluntary, the fiscal impact on these organizations is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 111.09, 112.1815, and 394.9086 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.

[82] The DCF, *Agency Analysis of SB 478 (2022 Session)* at p. 5 (on file with the Senate Committee on Children, Families, and Elder Affairs).

By Senator Davis

5-01099-23 2023938__

A bill to be entitled

An act relating to the operation and administration of the Baker Act; amending s. 394.457, F.S.; requiring the Department of Children and Families to provide specified information to certain individuals and organizations; requiring the department to maintain an information handbook and repository of answers to frequently asked questions; providing requirements for such handbook and repository; providing an effective date.

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

Section 1. Paragraph (b) of subsection (2) of section 394.457, Florida Statutes, is amended to read:

394.457 Operation and administration.—

(2) RESPONSIBILITIES OF THE DEPARTMENT.—The department is responsible for:

(b)1. Informing individuals and organizations involved in implementing this part, including, but not limited to, law enforcement officers, qualified professionals, and service providers, ~~The publication and distribution of an information handbook to facilitate understanding~~ of the provisions of this part;~~,~~ the policies and procedures related to its effective ~~involved in the~~ implementation; their roles and ~~of this part, and the~~ responsibilities; and any other information necessary for its effective implementation. The department shall maintain: ~~of the various providers of services under this part.~~

a. An information handbook, which must be published and

updated on the department's website annually by October 1.

b. A repository of answers to frequently asked questions, which must be published on the department's website and continually revised and expanded as necessary.

2. Supporting and facilitating ~~It shall stimulate~~ research by public and private agencies, institutions of higher learning, and hospitals in the interest of the elimination and amelioration of mental illness.

Section 2. This act shall take effect July 1, 2023.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR JASON BRODEUR
10th District

COMMITTEES:
Appropriations Committee on Agriculture, Environment, and General Government, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Children, Families, and Elder Affairs
Community Affairs
Regulated Industries
Rules

JOINT COMMITTEE:
Joint Legislative Auditing Committee

March 14, 2023

The Honorable Ileana Garcia, Chair
Children, Families, and Elder Affairs Committee
322 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Garcia,

This morning, I was called out of Children, Families, and Elder Affairs because of a bill I had to present in a different committee. Due to my presentation, I missed the vote on SB 938 and SB 1182. I respectfully request that my vote be recorded affirmative on both of these bills.

If you have any questions or concerns, please do not hesitate to reach out to me or my office.

Sincerely,

Jason Brodeur

Senator Jason Brodeur – District 10

REPLY TO:
❒ 110 Timberlachen Circle, Suite 1012, Lake Mary, Florida 32746 (407) 333-1802
❒ 405 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5010

Senate's Website: *www.flsenate.gov*

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

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 938
INTRODUCER:	Senator Davis
SUBJECT:	Operation and Administration of the Baker Act
DATE:	March 13, 2023 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Cox	CF	**Favorable**
2.			JU	
3.			RC	

I. Summary:

SB 938 directs the Department of Children and Families (the DCF) to update and publish an informational Baker Act handbook annually and post the updated handbook on the agency's website every year by October 1. The bill also directs the DCF to maintain a repository of frequently asked questions (FAQs) on the agency's website, and continually revise and expand the repository as necessary.

The bill requires the DCF to inform certain stakeholders of their role in the Baker Act process and support their effective implementation of the Act. The DCF must support and facilitate research conducted by public and private agencies, institutions of higher learning, and hospitals in the interest of the elimination and amelioration of mental illness.

The DCF anticipates that the bill will not have a significant fiscal impact. See Section V. Fiscal Impact Statement.

The bill is effective July 1, 2023.

II. Present Situation:

The Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[1] The Baker Act deals with Florida's mental health commitment laws, and includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations.[2]

[1] Chapter 71-131, L.O.F..; The Baker Act is contained in ch. 394, F.S.
[2] Sections 394.451 through 394.47891, F.S.

The Baker Act also protects the rights of all individuals examined or treated for mental illness in Florida.[3]

Involuntary Examination

Individuals suffering from an acute mental health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[4] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; and
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.[5]

The involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[6]
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;[7] or
- A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion.[8]

Involuntary patients must be taken to either a public or private facility which has been designated by the DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold, or refer, as appropriate, involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment or transportation to the appropriate service provider.[9] The patient must be examined by the receiving facility within 72 hours of the initiation of the involuntary examination and specified actions must be taken within that time frame to address the individual needs of the patient.[10]

[3] Section 394.459, F.S.
[4] Sections 394.4625 and 394.463, F.S., respectively.
[5] Section 394.463(1), F.S.
[6] Section 394.463(2)(a)1., F.S. Additionally, the order of the court must be made a part of the patient's clinical record.
[7] Section 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.
[8] Section 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record
[9] Section 394.455(40), F.S.
[10] Section 394.463(2)(g), F.S.

Education and Training on Mental Health for Law Enforcement and School Personnel

As of 2021, there were 43,876 law enforcement officers in Florida's police departments, sheriffs' offices, schools and ports who could initiate an involuntary exam under Baker Act.[11] Some portion of these officers receive training on working with individuals with mental illness through approaches such as Crisis Intervention Team training.[12] Of the state's law enforcement agencies, 94% initiated at least one involuntary exam in FY 20-21.[13]

In FY 2022-23, there were 343,238 full-time staff in Florida's public schools.[14] Many receive training through Youth Mental Health First Aid, which helps school personnel identify and understand the signs of mental health concerns and substance use disorders, and provide such personnel with the next steps to find help for a person who is developing or experiencing mental health concerns or a substance use disorder.[15]

Education and Training on the Baker Act by the DCF

Chapter 394, F.S., assigns the DCF statutory responsibility for the planning, evaluation, and implementation of a complete and comprehensive statewide program of mental health, including community services, receiving and treatment facilities, child services, research, and training.[16] The DCF reports that it has created webinars on the Baker Act and provides informational community presentations.[17] A Baker Act user reference guide and frequently asked question repository are other sources of information maintained by the DCF.[18]

Webinars and Community Presentations on the Baker Act

The DCF has worked with a contracted vendor to produce the following four webinars regarding the Baker Act:

- Introduction to the Baker Act (revised effective 2016).
- Law enforcement and the Baker Act.
- Minors and the Baker Act (revised effective 2016).

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[11] *See* the Florida Department of Law Enforcement, *Criminal Justice Agency Profile (CJAP) Report-Statewide Ratios*, available at https://www.fdle.state.fl.us/CJSTC/Publications/CJAP/Statewide-Ratios.aspx (last visited March 9, 2023).
[12] *See generally* the Florida Sheriff's Association, *Crisis Intervention Team Training*, available at https://www.flsheriffs.org/law-enforcement-programs/crisis-intervention-team (last visited March 9, 2023).
[13] The University of South Florida Baker Act Reporting Center, *The Baker Act Fiscal Year 2020/2021 Annual Report*, p. 3, available at https://www.usf.edu/cbcs/baker-act/documents/usf_barc_fy_20_21_annual_report.pdf (last visited March 9, 2023).
[14] The Florida Department of Education (The DOE), *PK-12 Public School Data Publications and Reports: Staff*, available at https://www.fldoe.org/accountability/data-sys/edu-info-accountability-services/pk-12-public-school-data-pubs-reports/staff.stml (last visited March 9, 2023).
[15] The DOE, *Youth Mental Health Awareness Training*, available at https://www.fldoe.org/schools/k-12-public-schools/sss/ymhat.stml (last visited March 8, 2023). Rule 6A-1.094120, F.A.C., requires an annual certification that at least 80% of school personnel in required job codes in a school district, including school personnel at charter schools, have completed the approved training (last visited March 9, 2023).
[16] The Department of Children and Families (The DCF), *Agency Analysis of 2023 HB 829*, p. 2, (February 21, 2023 (on file with the Senate Committee on Children, Families, and Elder Affairs) (hereinafter cited as, "The DCF HB 829 Analysis").
[17] *Id*.
[18] *Id*.

- Long-term Care and the Baker Act.[19]

Baker Act Handbook

Section 394.457, F.S., requires the DCF to publish and distribute an information handbook to facilitate understanding of the Baker Act. The DCF last published an updated version of the handbook, known as the *Baker Act User Reference Guide*, in 2014.[20] The 2014 volume is 496 pages long and includes:

- Overviews and historical background;
- Maps of judicial circuits, DCF regions, and managing entity service areas;
- Contact information for managing entities;
- Statutes linked to associated rules;
- Flow charts;
- Quick reference guides;
- Charts depicting authority granted to various mental health professionals under different situations;
- Comparison of the Baker and Marchman Act provisions;
- Resources, such as information about helplines, service providers, patient groups, and online training; and
- Forms.[21]

Since then, the Baker Act has been amended by the Legislature multiple times.[22] Some changes that have been made since 2014 include:

- Identifying the components of a coordinated system of care to be provided for individuals with mental illness or substance use disorder and defining a "No Wrong Door" model for accessing care;[23]
- Encouraging school districts to adopt a standardized suicide assessment tool that school-based mental health professionals may implement prior to initiation of an involuntary examination;[24]
- Requiring that when a patient communicates a specific threat against an identifiable individual to a mental health service provider, the provider must notify law enforcement of the potential threat;[25]
- Requiring patients subject to an involuntary Baker Act examination who do not meet the criteria for a petition for involuntary services to be released at the end of 72 hours, regardless of whether the examination period ends on a weekend or holiday, as long as certain discharge criteria are met;[26]

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[19] *Id*.
[20] The DCF, *2014 Baker Act: the Florida Mental Health Act User Reference Guide*, available at https://www.myflfamilies.com/sites/default/files/2023-03/2014%20Baker%20Act%20Manual_0.pdf (last visited March 9, 2023) (hereinafter cited as, "The Baker Act Handbook").
[21] The Baker Act Handbook at pp. i-iv.
[22] For example, including SB 12 (2016), SB 1418 (2019), and SB 1262 and SB 1844 (2022).
[23] Chapter 2016-241, L.O.F.
[24] Chapter 2019-134, L.O.F.
[25] *Id*.
[26] Chapter 2022-36, L.O.F.

- Requiring law enforcement officers to search certain electronic databases for Emergency Contact Information (ECI) of Baker and Marchman Act patients being transported to a receiving facility and expanding the entities who can access the ECI to specifically include receiving facilities, hospitals, and licensed detoxification and addictions receiving facilities;[27] and
- Revising the voluntariness provision under the Baker Act to allow a minor's voluntary admission to a receiving facility or hospital after a clinical review of the minor's assent has been conducted, rather than a hearing on the minor's consent.[28]

The handbook has not been amended to address any of these changes.

Frequently Asked Questions Repository

The DCF maintains a repository of FAQs and responses on its website.[29] These FAQs address issues that arise in the field in the day-to-day administration of the Baker Act by the hundreds of thousands of individuals working in law enforcement, schools, mental health providers, hospitals, nursing homes and ALF's, and jails, as well as individual clinicians, who may come in contact with someone who might meet criteria for an involuntary exam under the Baker Act. The FAQs are the DCF staff's responses to public questions received from stakeholders.[30] At this time, the manual revisions normally occur after new statutory requirements are enacted and rules are formally adopted.[31]

Topics in the DCF FAQ list with accessible content include all of the following:
- Baker Act Forms.
- Long-term Care Facilities.
- Clinical Records and Confidentiality.
- Marchman Act.
- Discharge Planning.
- Minors.
- Emergency Medical Conditions.
- Professional Credentials.
- Emergency Treatment Orders.
- Receiving Facilities.
- Express and Informed Consent.
- Involuntary Examination.
- Involuntary Inpatient Placement.
- Transportation.
- Involuntary Outpatient Placement.
- Voluntary Admissions.
- Weapons & Contraband.

[27] *Id*.
[28] Chapter 2022-41, L.O.F.
[29] The DCF, *Baker Act Frequently Asked Questions*, available at https://www.myflfamilies.com/crisis-services/baker-act/baker-act-frequently-asked-questions (last visited March 8, 2023).
[30] The DCF HB 829 Analysis, p. 2.
[31] *Id*.

- Law Enforcement.
- Telehealth.[32]

III. Effect of Proposed Changes:

The bill amends s. 394.457, F.S., requiring the DCF to inform law enforcement officers, qualified professionals, and service providers of:
- The provisions of the Baker Act;
- Policies and procedures relating to effective implementation;
- Roles and responsibilities of those individuals as they relate to the Baker Act, and;
- Any other information necessary for the effective implementation of the Baker Act.

The bill requires the DCF to update and publish the Baker Act handbook annually and post the handbook on the agency's website by October 1 of each year. The bill also requires the DCF to maintain a repository of frequently asked questions related to the Baker Act, publish the repository on the agency's website, and continually revise and expand it as necessary.

The bill also directs the DCF to support and facilitate research in the interest of the elimination and amelioration of mental illness by:
- Public and private agencies;
- Institutions of higher learning; and
- Hospitals.

The bill is effective July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

[32] *Id.*

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DCF anticipates that the bill will have no fiscal impact on state government.[33]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 394.457 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.

[33] The DCF HB 829 Analysis, p. 4.

By Senator Yarborough

4-01207A-23 20231064__

A bill to be entitled

An act relating to children removed from caregivers; amending s. 409.988, F.S.; requiring community-based care lead agencies, in coordination with the local managing entity, to provide a trauma-focused assessment within a specified timeframe to children removed from certain caregivers; specifying requirements of the assessment and therapy, if recommended; requiring community-based care lead agencies to offer voluntary trauma services under certain circumstances; amending s. 409.996, F.S.; requiring the Department of Children and Families to require in its contracts with the community-based care lead agencies that such agencies and managing entities provide a trauma-focused assessment within a specified timeframe to children removed from certain caregivers; conforming a cross-reference; providing an effective date.

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

Section 1. Present paragraphs (b) through (n) of subsection (1) of section 409.988, Florida Statutes, are redesignated as paragraphs (c) through (o), respectively, and a new paragraph (b) is added to that subsection, to read:

409.988 Community-based care lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(b)1. Shall, in coordination with the local managing

entity, provide a trauma-focused assessment to a child removed from his or her parent, legal custodian, or caregiver to ensure that the child is referred promptly to appropriate trauma services, including clinical evaluation and intervention if needed. The trauma-focused assessment must occur as soon as practicable subsequent to the child's removal but no later than 14 days after the shelter hearing. The assessment and therapy, if recommended, must evaluate and address the impact of the removal to the child.

2. Shall offer voluntary trauma services to a child and his or her family in the event that a shelter petition is denied and the child is returned to his or her parent, legal custodian, or caregiver.

Section 2. Present paragraphs (b) through (f) of subsection (1) of section 409.996, Florida Statutes, are redesignated as paragraphs (c) through (g), respectively, a new paragraph (b) is added to that subsection, and paragraph (b) of subsection (4) of that section is amended, to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration, or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility for the quality of contracted services and programs and shall ensure that, at a minimum, services are delivered in accordance with applicable federal and state statutes and regulations and the performance standards and metrics specified in the strategic plan created under s. 20.19(1).

(1) The department shall enter into contracts with lead

agencies for the performance of the duties by the lead agencies established in s. 409.988. At a minimum, the contracts must do all of the following:

(b) Require lead agencies and managing entities to coordinate to provide a trauma-focused assessment to a child removed from his or her parent, legal custodian, or caregiver to ensure that the child is referred promptly to appropriate trauma services, including clinical evaluation and intervention if needed as required by s. 409.988(1)(b).

(4)

(b) The department shall collect and publish on its website, and update monthly, the information required under s. 409.988(1)(l) ~~s. 409.988(1)(k)~~.

Section 3. This act shall take effect July 1, 2023.

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:	CS/SB 1064
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Yarborough
SUBJECT:	Children Removed from Caregivers
DATE:	March 14, 2023 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Tuszynski	Cox	CF	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1064 expands the duties of a lead agency under s. 409.988, F.S., and the contract requirements of the Department of Children and Families under s. 409.996, F.S., to require a lead agency, in coordination with the local managing entity, to provide a validated trauma-focused screening to a child removed from his or her parent, legal custodian, or caregiver as soon as practicable but no later than 14 days after the shelter hearing. The screening must ensure prompt referral for a child to appropriate trauma services, to include clinical evaluation and intervention if needed, and must address the impact of the removal of the child from his or her home.

The bill also requires a lead agency to offer voluntary trauma screening and appropriate trauma services to a child and his or her family in the event that a court denies the shelter petition and the child is returned to his or her parent, legal custodian, or caregiver.

The bill will have an indeterminate negative fiscal impact on the private sector. See Section V. Fiscal Impact Statement.

The bill has an effective date of July 1, 2023.

II. Present Situation:

Florida's Child Welfare System

The child welfare system identifies families whose children are in danger of suffering or have suffered abuse, abandonment, or neglect and works with those families to address the problems that are endangering children, if possible. If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children. Out-of-home placements can include a temporary placement with a family member, family foster home, residential child-caring agency, a permanent adoptive placement with a family previously unknown to the child.[1]

Community-Based Care Organizations and Services

The DCF contracts for case management, out-of-home care (foster care), adoption, and other related services with lead agencies, also known as community-based care organizations (CBCs). The CBC model is designed to increase local community ownership of service delivery and design of child welfare services.[2]

The DCF, through the CBCs, administers a system of care[3] for children that is directed toward:
- Prevention of separation of children from their families;
- Intervention to allow children to remain safely in their own homes;
- Reunification of families who have had children removed from their care;
- Safety for children who are separated from their families;
- Promoting the well-being of children through emphasis on educational stability and timely health care;
- Permanency; and
- Transition to independence and self-sufficiency.[4]

The CBCs must give priority to services that are evidence-based and trauma informed.[5] The CBCs contract with a number of subcontractors for case management and direct care services to children and their families. There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.[6] The CBCs employ case managers that serve as the primary link between the child welfare system and families with children under the DCF's supervision. These case managers work with affected families to ensure that a child reaches his or her permanency goal in a timely fashion.[7]

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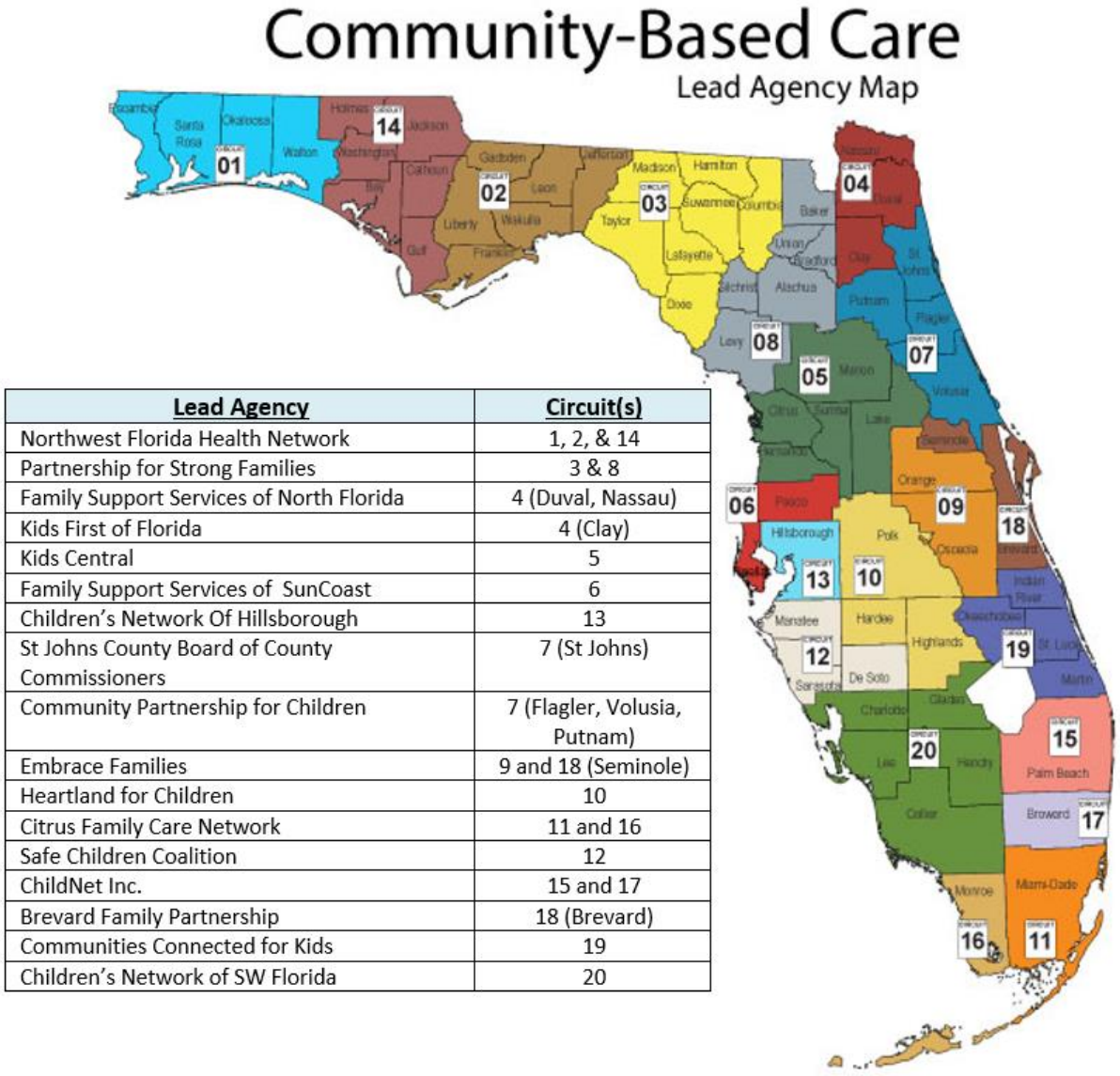
[1] Section 409.175, F.S.
[2] The Department of Children and Families, *About Community-Based Care*, available at https://www.myflfamilies.com/services/child-family/child-and-family-well-being/community-based-care/about-community-based-care (last visited March 7, 2023) (hereinafter cited as "DCF").
[3] *Id.*
[4] *Id.*; *Also see generally* s. 409.988, F.S.
[5] Section 409.988(3), F.S.
[6] The DCF, *Lead Agency Information*, available at https://www.myflfamilies.com/services/child-family/child-and-family-well-being/community-based-care/lead-agency-information (last visited March 7, 2023).
[7] Section 409.988(1), F.S.

The DCF contracts with the following lead agencies as illustrated in the table and map below:



Lead Agency	Circuit(s)
Northwest Florida Health Network	1, 2, & 14
Partnership for Strong Families	3 & 8
Family Support Services of North Florida	4 (Duval, Nassau)
Kids First of Florida	4 (Clay)
Kids Central	5
Family Support Services of SunCoast	6
Children's Network Of Hillsborough	13
St Johns County Board of County Commissioners	7 (St Johns)
Community Partnership for Children	7 (Flagler, Volusia, Putnam)
Embrace Families	9 and 18 (Seminole)
Heartland for Children	10
Citrus Family Care Network	11 and 16
Safe Children Coalition	12
ChildNet Inc.	15 and 17
Brevard Family Partnership	18 (Brevard)
Communities Connected for Kids	19
Children's Network of SW Florida	20

Dependency Process

Current law requires any person who knows or suspects that a child has been abused, abandoned, or neglected to report such knowledge or suspicion to the Florida's central abuse hotline (hotline), including incidents of domestic violence.[8] A child protective investigation begins if the

[8] Section 39.201(1), F.S.

hotline determines the allegations meet the statutory definition of abuse,[9] abandonment,[10] or neglect.[11] A child protective investigator investigates the situation either immediately, or within 24 hours after the report is received, depending on the nature of the allegation.[12]

After conducting an investigation, if the child protective investigator determines that the child is in need of protection and supervision that necessitates removal, the investigator may initiate formal proceedings to remove the child from his or her home.[13] When the DCF removes a child from the home, a series of dependency court proceedings must occur before a child may be adjudicated dependent.[14] The dependency court process is summarized in the table below.

The Dependency Court Process

Dependency Proceeding	Description of Process	Controlling Statute
Removal	A child protective investigation determines a child is unsafe in his or her home and the child is removed.	s. 39.401, F.S.
Shelter Hearing	A shelter hearing occurs within 24 hours after removal. The judge determines whether to keep the child out-of-home.	s. 39.401, F.S.
Petition for Dependency	A petition for dependency occurs within 21 days of the shelter hearing. This petition seeks to find the child dependent.	s. 39.501, F.S.
Arraignment Hearing and Shelter Review	An arraignment and shelter review occurs within 28 days of the shelter hearing. This allows the parent to admit, deny, or consent to the allegations within the petition for dependency and allows the court to review any shelter placement.	s. 39.506, F.S.
Adjudicatory Trial	An adjudicatory trial is held within 30 days of arraignment. The judge determines whether a child is dependent during trial.	s. 39.507, F.S.

[9] Section 39.01(2), F.S. The term "abuse" means any willful act or threatened act that results in any physical, mental, or sexual abuse, injury, or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes the birth of a new child into a family during the course of an open dependency case when the parent or caregiver has been determined to lack the protective capacity to safely care for the children in the home and has not substantially complied with the case plan towards successful reunification or met the conditions for return of the children into the home. Abuse of a child includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.

[10] Section 39.01(1), F.S. The term "abandoned" or "abandonment" means a situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child, or both.

[11] Sections 39.01(50) and 39.201(2)(a), F.S. "Neglect" occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired. The foregoing circumstances shall not be considered neglect if caused primarily by financial inability unless actual services for relief have been offered to and rejected by such person. A parent or legal custodian legitimately practicing religious beliefs in accordance with a recognized church or religious organization who thereby does not provide specific medical treatment for a child may not, for that reason alone, be considered a negligent parent or legal custodian; however, such an exception does not preclude a court from ordering necessary services.

[12] Section 39.101(2), F.S.

[13] *See generally* ss. 39.401 through 39.4024, F.S.

[14] *See* s. 39.01(14), F.S., for the definition of "child who is found to be dependent."

Dependency Proceeding	Description of Process	Controlling Statute
Disposition Hearing	If the child is found dependent, disposition occurs within 15 days of arraignment or 30 days of adjudication. The judge reviews the case plan and placement of the child. The judge orders the case plan for the family and the appropriate placement of the child.	s. 39.506, F.S. s. 39.521, F.S.
Post-disposition hearing	The court may change temporary placement at a post disposition hearing any time after disposition but before the child is residing in the permanent placement approved at a permanency hearing.	s. 39.522, F.S.
Judicial Review Hearings	The court must review the case plan and placement every 6 months, or upon motion of a party.	s. 39.701, F.S.
Petition for Termination of Parental Rights	Once the child has been out-of-home for 12 months, if DCF determines that reunification is no longer a viable goal, termination of parental rights is in the best interest of the child, and other requirements are met, a petition for termination of parental rights is filed.	s. 39.802, F.S. s. 39.8055, F.S. s. 39.806, F.S. s. 39.810, F.S.
Advisory Hearing	This hearing is set as soon as possible after all parties have been served with the petition for termination of parental rights. The hearing allows the parent to admit, deny, or consent to the allegations within the petition for termination of parental rights.	s. 39.808, F.S.
Adjudicatory Hearing	An adjudicatory trial shall be set within 45 days after the advisory hearing. The judge determines whether to terminate parental rights to the child at this trial.	s. 39.809, F.S.

In-Home and Out-of-Home Care

The DCF is required to administer a system of care that endeavors to keep children with their families and provides interventions to allow children to remain safely in their own homes.[15] Protective investigators and CBC case managers can refer families for in-home services to allow children who would otherwise be unsafe to remain in their own homes.

When a child protective investigator determines that in-home services are not enough to allow a child to safely remain in his or her home, the investigator removes and places the child with a safe and appropriate temporary placement.[16] These temporary placements, referred to as out-of-home care, provide housing and services to children until they can return home to their families or achieve permanency with other families through adoption or guardianship.[17]

The CBCs must place all children in out-of-home care in the most appropriate available setting after conducting an assessment using child-specific factors.[18] Legislative intent is to place a

[15] *See* s. 39.001, F.S.
[16] Sections 39.401 through 39.4022, F.S.
[17] The Office of Program Policy and Government Accountability, *Program Summary*, available at https://oppaga.fl.gov/ProgramSummary/ProgramDetail?programNumber=5053 (last visited March 7, 2023).
[18] Rule 65C-28.004, F.A.C., provides that the child-specific factors include age, sex, sibling status, physical, educational, emotional, and developmental needs, maltreatment, community ties, and school placement.

child in the least restrictive, most family-like environment in close proximity to parents when removed from his or her home.[19] The DCF is required to follow an enumerated priority list for out-of-home placement, which includes the below-mentioned specified placements in descending order:

- Nonoffending parent;
- Relative caregiver;
- Adoptive parent of the child's sibling;
- Fictive kin with a close relationship to the child;
- Nonrelative caregiver without an existing relationship to the child;
- Licensed foster care; and then
- Licensed group or congregate care.[20]

Trauma and Trauma-informed Care

Trauma is a widespread, harmful, and costly public health problem.[21] Children and adolescents are particularly affected by trauma.[22] A growing body of research points to the effects of trauma on mental and physical health, family functioning, academic outcomes, housing stability, and employment.[23] For many youth, exposure to childhood adversity increases the likelihood of involvement with multiple systems, including health care, behavioral health, child welfare, and juvenile justice.[24]

The term trauma is used to describe an event, series of events, or set of circumstances that is experienced as physically or emotionally harmful or life-threatening, overwhelms one's ability to cope, and has adverse effects on a person's mental, physical, social, emotional, or spiritual well-being.[25] Exposure to traumatic experiences can alter how people view themselves and others by challenging their beliefs that the world is a safe place, that other people can be trusted, and that they are worthy of care and protection.[26] Whether an event or set of circumstances is experienced as traumatic is influenced by many factors, including our internal coping resources, our external supports, and broader community, cultural, and societal factors that shape how we understand and respond to our experiences.[27]

The term trauma-informed care refers to a universal approach to addressing trauma and promoting resilience through policies, procedures, practices, and programs adopted by the entire workforce, at all levels or roles, and in all parts of the system, for all people receiving services.[28]

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[19] Sections 39.001(1) and 39.4021(1), F.S.
[20] Section 39.4021(2)(a), F.S.
[21] Chapin Hall at the University of Chicago, Building a Multi-System Trauma-informed Collaborative, 2020, p. V, available at https://www.chapinhall.org/wp-content/uploads/PDF/Multi-System-Trauma-Informed-Care-MSTIC-Guide.pdf (last viewed March 7, 2023) (hereinafter cited as "Chapin Hall").
[22] *Id.*
[23] *Id.* at p. 1
[24] *Id.*
[25] Substance Abuse and Mental Health Services Administration, *SAMHSA's concept of trauma and guidance for a trauma-informed approach*, HHS Publication SMA14-4884, 2014, p. 7, available at https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf (last viewed March 7, 2023).
[26] Chapin Hall at p. 3
[27] *Id.*
[28] *Id.* at p. 4

The term trauma-informed care is often mistakenly used interchangeably with trauma-specific clinical interventions.[29] However, a trauma-informed approach encompasses a much more comprehensive model within and across systems that often requires that systems engage in certain fiscal, policy, and workforce development reform efforts.[30]

Service systems designed to help people who have experienced trauma can sometimes re-traumatize the people they serve.[31] This results from recreating situations or experiences that mirror or replicate past trauma, causing survivors to experience a similar level of distress in the present.[32] Research has shown that the removal incident by child welfare services to protect the immediate safety and well-being of a child is often a traumatic experience.[33] Trauma is traditionally examined through the lens of what happened to a child before removal and sometimes what occurred to the child after removal; however, it is critical to consider how a child may experience trauma due to the removal.[34] Research, policy, and practice all indicate that child removal and entry into foster care evokes emotional and psychological trauma and is the most drastic safety intervention utilized by a child welfare agency.[35] Significant gaps exist in policy and practice, which fail to address the impact of child removal on children and their parents. The practice of removal, intended to mitigate serious, imminent harm, has the potential to cause serious, imminent harm itself.[36]

Trauma screening and assessment

Trauma screening and assessment is designed to be able to be administered to every child within a given system (such as child welfare) to determine whether he or she has experienced trauma, displays symptoms related to trauma exposure, and/or should be referred for a comprehensive trauma-informed mental health assessment.[37] Trauma screening should evaluate the presence of two critical elements:

- Exposure to potentially traumatic events and experiences, including traumatic loss; and
- Traumatic stress symptoms and reactions.[38]

Not all children who experience negative events suffer posttraumatic or trauma-specific reactions as a result.[39] Trauma screening should measure a wide range of experiences and identify common reactions and symptoms of trauma as well as other commonly reported difficulties.[40]

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[29] *Id.*
[30] *Id.*
[31] Chapin Hall at p. 10
[32] *Id.*
[33] *See* Sankaran, V., Church, et al., *A Cure Worse Than the Disease? The Impact of Removal on Children and Their Families*, University of Michigan Law School Scholarship Repository, 2019, available at https://repository.law.umich.edu/articles/2055/ (last viewed March 7, 2023) (hereinafter cited as "A Cure").
[34] *Id.* at p. 1166
[35] *Id.* at p. 1167
[36] *Id.* at p. 1168
[37] The National Child Traumatic Stress Network, *Trauma Screening, What is a Trauma Screening Tool or Process?*, available at https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening (last viewed March 7, 2023) (hereinafter cited as "NCTSN").
[38] *Id.*
[39] *Id.*
[40] *Id.*

With proper training, various professionals or paraprofessionals from child-serving systems can administer trauma screening tools or instruments.[41]

There are multiple requirements throughout law for specific screenings within the child welfare system; however there is not a requirement for a trauma specific screening or assessment.[42]

Comprehensive Assessment

Current law defines a "comprehensive assessment" as the gathering of information to evaluate a child and caregiver's physical, psychiatric, psychological, or mental health; developmental delays or challenges; and educational, vocational, and social condition and family environment.[43] This assessment is to evaluate the need for services, including substance abuse, mental health, developmental, literacy, medical, family, and other specialized services.[44]

Comprehensive Behavioral Health Assessment (CBHA)

The DCF requires a CBHA for all children entering out-of-home care who are Medicaid eligible.[45] Any needs identified through the CBHA and recommendations for services must be included in the family's case plan.[46] The CBHA is a Medicaid funded assessment with the following goals:

- Provide assessment of areas where no other information exists;
- Update pertinent information;
- Provide functional information;
- Provide specific information and recommendations to accomplish family preservation, reunification, or permanency planning;
- Provide data to promote the most appropriate out-of-home placement; and
- Provide information for development of an effective individualized treatment plan.[47]

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[41] *Id.*

[42] *See generally* s. 39.0016(2)(b)3.a., F.S., requiring a referral for screening for a child who has or is suspected of having a disability; s. 39.0(65), F.S., defining "preliminary screening" to mean the gathering of information to be used to determine a child's need for substance abuse services; s. 39.407(1), F.S., authorizing the DCF to perform a medical screening on a child to examine a child for injury, illness, and communicable diseases; s. 39.407(4)(c), F.S., allowing a judge to order a screening for learning disabilities, other handicaps, and the need for alternative education; s. 39.4085, F.S., finding that a goal of the child welfare system is to have a full risk, health, educational, medical, and psychological screening; ss. 39.524 and 409.1754, F.S., requiring an assessment and screening for a child that is suspected of being or found to be a victim of commercial sexual exploitation; and s. 409.996(16), F.S., requiring the DCF to work with the Agency for Health Care Administration to provide a Medicaid-eligible child with a 72-hour screening under the Medicaid early and periodic screening, diagnosis, and treatment requirements.

[43] Section 39.01(17), F.S.

[44] *Id.*

[45] The DCF, Children and Families Operating Procedure (CFOP) 170-18 ch. 2-1, August 21, 2020, available at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_170-18_chapter_02_comprehensive_behavioral_health_assessments.pdf (last viewed March 7, 2023).

[46] *Id.*

[47] Agency for Health Care Administration, *Specialized Therapeutic Services Coverage and Limitations Handbook*, 2-10, March 2014, available at https://ahca.myflorida.com/medicaid/review/Specific/59G-4.295_Specialized_Therapeutic_Services_and_Limitations_Handbook_Adoption.pdf (last viewed March 7, 2023).

The CBHA requires information gathering in many components related to the child and the child's family, including the following:

- Personal and family history;
- Placement history;
- Cognitive functioning;
- Medications;
- Substance use and abuse history;
- Mental health treatment history;
- Educational analysis;
- Cultural analysis;
- Present function; and
- Strengths.[48]

A child protective investigator or dependency case manager must refer a child that has been removed from his or her home for a CBHA within seven calendar days of removal.[49] The CBHA provider must complete the assessment and send the report of the findings within 24 calendar days of receipt of the referral.[50] If at any point during the CBHA process a dependency case manager determines a child has an urgent need for immediate behavioral health treatment, the case manager will see appropriate services for the child.[51]

Trauma, including trauma specifically related to the child's removal, is not specifically referenced in the CBHA component requirements or process.

Managing Entities

The DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[52]

In 2001, the Legislature authorized the DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.[53] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[54] Full implementation of the

[48] *Id.* at 2-6 through 2-9.
[49] CFOP 170-18 at ch. 2-5a.
[50] *Id.* at d.
[51] *Id.* at g.
[52] *See* chs. 394 and 397, F.S.
[53] Chapter 2001-191, L.O.F.
[54] Chapter 2008-243, L.O.F.

statewide managing entity system occurred in 2013 and all geographic regions are now served by a managing entity.[55]

Contracted MEs

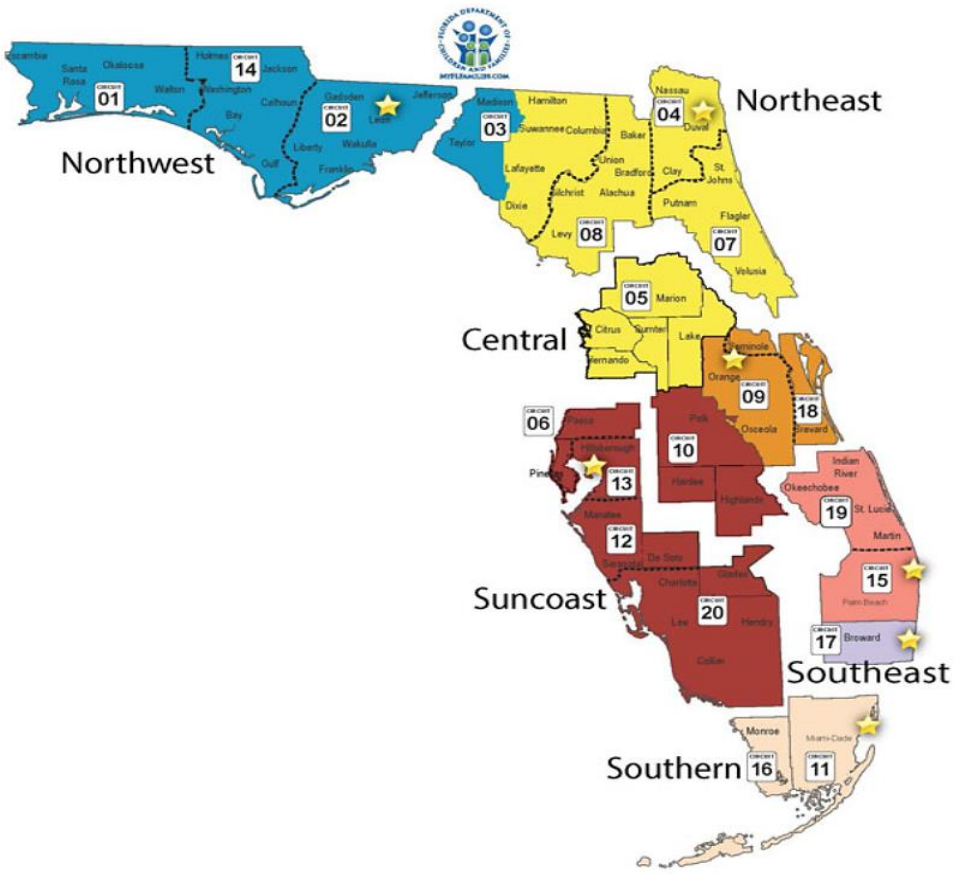
The MEs are required to comply with various statutory duties, including, in part, to:

- Maintain a governing board;
- Promote and support care coordination;[56]
- Develop a comprehensive list of qualified providers;
- Monitor network providers' performances;
- Manage and allocate funds for services in accordance with federal and state laws, rules, regulations and grant requirements; and
- Operate in a transparent manner, providing access to information, notice of meetings, and opportunities for public participation in ME decision making.[57]

The DCF contracts with seven MEs as shown in the map below and summarized as follows:

- Big Bend Community Based Care, Inc. d/b/a NWF Health Network (blue);
- Lutheran Services Florida (yellow);
- Central Florida Cares Health System (orange);
- Central Florida Behavioral Health Network, Inc. (red);
- Southeast Florida Behavioral Health Network (pink);
- Broward Behavioral Health Network, Inc. (purple); and
- Thriving Mind South Florida (South Florida Behavioral Health Network, Inc.) (beige).[58]

[55] Florida Tax Watch, *Analysis of Florida's Behavioral Health Managing Entity Models*, p. 4, March 2015, available at https://floridataxwatch.org/Research/Full-Library/ArtMID/34407/ArticleID/15758/Analysis-of-Floridas-Behavioral-Health-Managing-Entities-Model (last visited March 14, 2023).
[56] Section 394.9082(6), F.S., sets out the network accreditation and systems coordination agreement requirements.
[57] Section 394.9082(5), F.S.
[58] The DCF, *Managing Entities*, https://www.myflfamilies.com/services/substance-abuse-and-mental-health/samh-providers/managing-entities (last visited March 14, 2023).



The MEs in turn contract with local service providers for the delivery of mental health and substance abuse services.[59]

III. Effect of Proposed Changes:

The bill expands the duties of a lead agency under s. 409.988, F.S., and the contract requirements of the Department of Children and Families under s. 409.996, F.S., to require a lead agency, in coordination with the local managing entity, to provide a validated trauma-focused screening to a child removed from his or her parent, legal custodian, or caregiver as soon as practicable but no later than 14 days after the shelter hearing. The screening must ensure prompt referral for a child to appropriate trauma services, to include clinical evaluation and intervention if needed, and must address the impact of the removal of the child from his or her home.

The bill also requires a lead agency to offer voluntary trauma screening and appropriate trauma services to a child and his or her family in the event that a court denies the shelter petition and the child is returned to his or her parent, legal custodian, or caregiver.

The bill has an effective date of July 1, 2023

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will likely have an indeterminate negative fiscal impact on the private sector as a lead agency may need to change operations, increase support, or increase contract amounts to meet the requirements of the bill.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 409.988 and 409.996 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.)

CS by Children, Families, and Elder Affairs on March 14, 2023:
The committee substitute specifies that a lead agency must administer a "validated trauma-focused screening" to a child removed from his or her home, replacing the more general "trauma assessment."

B. Amendments:

None.

713300

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/14/2023	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Present paragraphs (b) through (n) of subsection (1) of section 409.988, Florida Statutes, are redesignated as paragraphs (c) through (o), respectively, and a new paragraph (b) is added to that subsection, to read:

409.988 Community-based care lead agency duties; general provisions.—

713300

(1) DUTIES.—A lead agency:

(b)1. Shall, in coordination with the local managing entity, administer a validated trauma-focused screening to a child removed from his or her parent, legal custodian, or caregiver to ensure any trauma related to the child's removal is timely identified, if present, and that the child is referred promptly to appropriate trauma services, including clinical evaluation and intervention if needed. The trauma-focused screening must occur as soon as practicable subsequent to the child’s removal but no later than 14 days after the shelter hearing. The screening and therapy, if recommended, must evaluate and address the impact of the removal to the child.

2. Shall offer voluntary trauma screening and appropriate trauma services to a child and his or her family in the event that a shelter petition is denied and the child is returned to his or her parent, legal custodian, or caregiver.

Section 2. Present paragraphs (b) through (f) of subsection (1) of section 409.996, Florida Statutes, are redesignated as paragraphs (c) through (g), respectively, a new paragraph (b) is added to that subsection, and paragraph (b) of subsection (4) of that section is amended, to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration, or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility for the quality of contracted services and programs and shall ensure that, at a minimum, services are delivered in accordance with applicable federal and state statutes and regulations and the performance standards and

713300

metrics specified in the strategic plan created under s. 20.19(1).

(1) The department shall enter into contracts with lead agencies for the performance of the duties by the lead agencies established in s. 409.988. At a minimum, the contracts must do all of the following:

(b) Require lead agencies and managing entities to coordinate to administer a validated trauma-focused screening to a child removed from his or her parent, legal custodian, or caregiver to ensure any trauma related to the child's removal is timely identified, if present, and that the child is referred promptly to appropriate trauma services, including clinical evaluation and intervention if needed as required by s. 409.988(1)(b).

(4)

(b) The department shall collect and publish on its website, and update monthly, the information required under s. 409.988(1)(l) ~~s. 409.988(1)(k)~~.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to children removed from caregivers; amending s. 409.988, F.S.; requiring community-based care lead agencies, in coordination with the local managing entity, to administer a trauma-focused screening within a specified timeframe to children removed from certain caregivers; specifying

requirements of the screening and therapy, if recommended; requiring community-based care lead agencies to offer voluntary trauma screening and services under certain circumstances; amending s. 409.996, F.S.; requiring the Department of Children and Families to require in its contracts with the community-based care lead agencies that such agencies and managing entities administer a trauma-focused screening within a specified timeframe to children removed from certain caregivers; conforming a cross-reference; providing an effective date.

By the Committee on Judiciary; and Senator Burton

590-02349-23 20231098c1

A bill to be entitled

An act relating to withholding or withdrawal of life-prolonging procedures; amending s. 744.3215, F.S.; authorizing the court to delegate the right to consent to the withholding or withdrawal of life-prolonging procedures of incapacitated persons in certain circumstances; amending ss. 744.363 and 744.3675, F.S.; making technical changes; requiring initial and annual guardianship plans, respectively, to state whether any power under the ward's preexisting order not to resuscitate or advance directive is revoked, modified, suspended, or transferred to the guardian; requiring such plans to state the date of such action; establishing certain authority without additional court approval; requiring a guardian to obtain court approval to exercise transferred power to execute an order not to resuscitate or consent to withhold or withdraw life-prolonging procedures under certain circumstances; creating s. 744.4431, F.S.; authorizing a guardian to petition a court for approval to consent to withhold or withdraw life-prolonging procedures under certain circumstances; specifying requirements for the petition; requiring the guardian to serve certain notices; specifying procedures that must be followed by the court in acting on the petition; authorizing the guardian to withhold or withdraw life-prolonging procedures without a hearing or court approval under certain circumstances; amending s. 744.441, F.S.; making technical changes; deleting

provisions regarding the authority of certain guardians to sign an order not to resuscitate; providing an effective date.

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

Section 1. Paragraph (h) is added to subsection (3) of section 744.3215, Florida Statutes, to read:

744.3215 Rights of persons determined incapacitated.—

(3) Rights that may be removed from a person by an order determining incapacity and which may be delegated to the guardian include the right:

(h) To consent to the withholding or withdrawal of life-prolonging procedures as defined in s. 765.101, subject to court approval as provided in s. 744.4431 if there is a conflict over or objection to the proposed exercise of that authority.

Section 2. Present subsections (2) through (6) of section 744.363, Florida Statutes, are redesignated as subsections (3) through (7), respectively, paragraph (g) is added to subsection (1) and a new subsection (2) is added to that section, and paragraph (f) of subsection (1) of that section is amended, to read:

744.363 Initial guardianship plan.—

(1) The initial guardianship plan shall include all of the following:

(f)1. A list of any preexisting:

a. Orders not to resuscitate as described in ~~executed under~~ s. 401.45(3) and the date such orders were signed; or

b. ~~Preexisting~~ Advance directives~~,~~ as defined in s. 765.101

and~~,~~ the date such directives were signed. ~~an order or directive was signed,~~

2. For each item listed under subparagraph 1., the plan must state whether the ~~such~~ order or directive has been revoked, modified, or suspended by the court or the extent to which authority under an order or directive has been transferred by the court to the guardian. The plan must also state the date of such action by the court.

(g) ~~, and~~ A description of the steps taken to identify and locate a ~~the~~ preexisting order not to resuscitate or advance directive.

(2) A surrogate designated by the ward in an advance directive or an agent designated by the ward in a durable power of attorney who retains authority to make health care decisions under the guardianship plan may exercise retained authority without additional approval by the court. Any authority of the surrogate to carry out the instructions in the advance directive or authority of the agent under a durable power of attorney which is transferred to the guardian may be exercised by the guardian, consistent with the advance directive or durable power of attorney, without additional approval by the court. Any authority transferred to the guardian to execute an order not to resuscitate or to consent to withhold or withdraw life-prolonging procedures is subject to court approval pursuant to s. 744.4431 if there is a conflict over or objection to a proposed exercise of that authority.

Section 3. Present subsections (2), (3), and (4) of section 744.3675, Florida Statutes, are redesignated as subsections (3), (4), and (5), respectively, paragraph (e) is added to subsection

(1) and a new subsection (2) is added to that section, and paragraph (d) of subsection (1) of that section is amended, to read:

744.3675 Annual guardianship plan.—Each guardian of the person must file with the court an annual guardianship plan which updates information about the condition of the ward. The annual plan must specify the current needs of the ward and how those needs are proposed to be met in the coming year.

(1) Each plan for an adult ward must, if applicable, include:

(d) 1. A list of any preexisting:

a. Orders not to resuscitate as described in ~~executed under~~ s. 401.45(3) and the date such orders were signed; or

b. ~~Preexisting~~ Advance directives~~,~~ as defined in s. 765.101 and~~,~~ the date such directives were signed. ~~an order or directive was signed,~~

2. For each item listed under subparagraph 1., the plan must state whether the ~~such~~ order or directive has been revoked, modified, or suspended by the court or the extent to which authority under an order or directive has been transferred by the court to the guardian. The plan must also state the date of any revocation, modification, or suspension by the court.

(e) ~~, and~~ A description of the steps taken to identify and locate a ~~the~~ preexisting order not to resuscitate or advance directive.

(2) A surrogate designated by the ward in an advance directive or an agent designated by the ward in a durable power of attorney who retains authority to make health care decisions under the guardianship plan may exercise retained authority

without additional approval by the court. Any authority of the surrogate to carry out the instructions in the advance directive or authority of the agent under a durable power of attorney which is transferred to the guardian may be exercised by the guardian, consistent with the advance directive or durable power of attorney, without additional approval by the court. Any authority transferred to the guardian to execute an order not to resuscitate or to consent to withhold or withdraw life-prolonging procedures is subject to court approval pursuant to s. 744.4431 if there is a conflict over or objection to a proposed exercise of that authority.

Section 4. Section 744.4431, Florida Statutes, is created to read:

744.4431 Guardianship power regarding life-prolonging procedures.—

(1) A guardian of a ward's person may petition a court pursuant to the Florida Probate Rules for authority to consent to withhold or withdraw life-prolonging procedures for any of the following reasons:

(a) The right to consent to withhold or withdraw life-prolonging procedures has not been delegated to the guardian in the order appointing the guardian.

(b) Sufficient authority under the ward's preexisting advance directive or durable power of attorney has not been transferred to the guardian.

(c) The proposed withholding or withdrawal of life-prolonging procedures is in conflict with the wishes, as presently or previously expressed, of the ward, the ward's next of kin, or any interested person.

(2) The petition by the guardian must contain all of the following:

(a) A description of the proposed action for which court approval is sought and documentation of any existing authority for the guardian to make health care decisions for the ward.

(b) A statement regarding any known objections to the proposed action or of conflicts between the guardian's proposed action to withhold or withdraw life-prolonging procedures and the wishes, presently or previously expressed, of the ward, the ward's next of kin, or any interested person.

(c) A description of the circumstances or evidence and affidavits or supporting documentation showing that the proposed action satisfies the applicable criteria in s. 765.401 or s. 765.404.

(3) The guardian must serve notice of the petition, and of any hearing, upon interested persons and the ward's next of kin, unless waived by the court.

(4) The court must hold a hearing on the petition if the court has been notified of an objection or conflict or if the court has insufficient information to determine whether the criteria for granting the requested authority has been met.

(5) If a hearing is required and exigent circumstances are alleged, the court must hold a preliminary hearing within 72 hours after the petition is filed and do one of the following:

(a) Rule on the relief requested immediately after the preliminary hearing.

(b) Conduct an evidentiary hearing within 4 days after the preliminary hearing and rule on the relief requested immediately after the evidentiary hearing.

(6) Notwithstanding the requirements for court approval imposed under this section, and if authority to withhold or withdraw life-prolonging procedures has not been vested in another person, the guardian may, without a hearing or prior court approval, consent to the withholding or withdrawal of life-prolonging procedures if all of the following apply:

(a) The ward is in a hospital and at least two of the ward's treating physicians state in writing that there is a substantial likelihood that the ward's death will occur within the next 72 hours.

(b) There is no known objection to the granting of a petition to withhold or withdraw life-prolonging procedures.

(c) The hospital ethics committee has met and agrees with the guardian's proposal to withhold or withdraw life-prolonging procedures. If the hospital does not have an ethics committee, it may seek approval by the ethics committee of another facility or a community-based ethics committee approved by the Florida Bioethics Network.

Section 5. Section 744.441, Florida Statutes, is amended to read:

744.441 Powers of guardian upon court approval.—After obtaining approval of the court pursuant to a petition for authorization to act, ~~:~~

~~(1)~~ a plenary guardian of the property, or a limited guardian of the property within the powers granted by the order appointing the guardian or an approved annual or amended guardianship report, may do all of the following:

(1) ~~(a)~~ Perform, compromise, or refuse performance of a ward's contracts that continue as obligations of the estate, as

he or she may determine under the circumstances.

(2) ~~(b)~~ Execute, exercise, or release any powers as trustee, personal representative, custodian for minors, conservator, or donee of any power of appointment or other power that the ward might have lawfully exercised, consummated, or executed if not incapacitated, if the best interest of the ward requires such execution, exercise, or release.

(3) ~~(c)~~ Make ordinary or extraordinary repairs or alterations in buildings or other structures; demolish any improvements; or raze existing, or erect new, party walls or buildings.

(4) ~~(d)~~ Subdivide, develop, or dedicate land to public use; make or obtain the vacation of plats and adjust boundaries; adjust differences in valuation on exchange or partition by giving or receiving consideration; or dedicate easements to public use without consideration.

(5) ~~(e)~~ Enter into a lease as lessor or lessee for any purpose, with or without option to purchase or renew, for a term within, or extending beyond, the period of guardianship.

(6) ~~(f)~~ Enter into a lease or arrangement for exploration and removal of minerals or other natural resources or enter into a pooling or unitization agreement.

(7) ~~(g)~~ Abandon property when, in the opinion of the guardian, it is valueless or is so encumbered or in such condition that it is of no benefit to the estate.

(8) ~~(h)~~ Pay calls, assessments, and other sums chargeable or accruing against, or on account of, securities.

(9) ~~(i)~~ Borrow money, with or without security, to be repaid from the property or otherwise and advance money for the

protection of the estate.

(10) ~~(j)~~ Effect a fair and reasonable compromise with any debtor or obligor or extend, renew, or in any manner modify the terms of any obligation owing to the estate.

(11) ~~(k)~~ Prosecute or defend claims or proceedings in any jurisdiction for the protection of the estate and of the guardian in the performance of his or her duties. Before authorizing a guardian to bring an action described in s. 736.0207, the court shall first find that the action appears to be in the ward's best interests during the ward's probable lifetime. There shall be a rebuttable presumption that an action challenging the ward's revocation of all or part of a trust is not in the ward's best interests if the revocation relates solely to a devise. This subsection ~~paragraph~~ does not preclude a challenge after the ward's death. If the court denies a request that a guardian be authorized to bring an action described in s. 736.0207, the court must ~~shall~~ review the continued need for a guardian and the extent of the need for delegation of the ward's rights.

(12) ~~(l)~~ Sell, mortgage, or lease any real or personal property of the estate, including homestead property, or any interest therein for cash or credit, or for part cash and part credit, and with or without security for unpaid balances.

(13) ~~(m)~~ Continue any unincorporated business or venture in which the ward was engaged.

(14) ~~(n)~~ Purchase the entire fee simple title to real estate in this state in which the guardian has no interest, but the purchase may be made only for a home for the ward, to protect the home of the ward or the ward's interest, or as a home for

the ward's dependent family. If the ward is a married person and the home of the ward or of the dependent family of the ward is owned by the ward and spouse as an estate by the entirety and the home is sold pursuant to the authority of subsection (12) ~~paragraph (l)~~, the court may authorize the investment of any part or all of the proceeds from the sale toward the purchase of a fee simple title to real estate in this state for a home for the ward or the dependent family of the ward as an estate by the entirety owned by the ward and spouse. If the guardian is authorized to acquire title to real estate for the ward or dependent family of the ward as an estate by the entirety in accordance with the preceding provisions, the conveyance must ~~shall~~ be in the name of the ward and spouse and ~~shall~~ be effective to create an estate by the entirety in the ward and spouse.

(15) ~~(o)~~ Exercise any option contained in any policy of insurance payable to, or inuring to the benefit of, the ward.

(16) ~~(p)~~ Pay reasonable funeral, interment, and grave marker expenses for the ward from the ward's estate.

(17) ~~(q)~~ Make gifts of the ward's property to members of the ward's family in estate and income tax planning procedures.

(18) ~~(r)~~ When the ward's will evinces an objective to obtain a United States estate tax charitable deduction by use of a split interest trust (as that term is defined in s. 736.1201), but the maximum charitable deduction otherwise allowable will not be achieved in whole or in part, execute a codicil on the ward's behalf amending said will to obtain the maximum charitable deduction allowable without diminishing the aggregate value of the benefits of any beneficiary under such will.

(19) ~~(s)~~ Create or amend revocable trusts or create irrevocable trusts of property of the ward's estate which may extend beyond the disability or life of the ward in connection with estate, gift, income, or other tax planning or in connection with estate planning. The court shall retain oversight of the assets transferred to a trust, unless otherwise ordered by the court.

(20) ~~(t)~~ Renounce or disclaim any interest by testate or intestate succession or by inter vivos transfer.

(21) ~~(u)~~ Enter into contracts that are appropriate for, and in the best interest of, the ward.

(22) ~~(v)~~ As to a minor ward, pay expenses of the ward's support, health, maintenance, and education, if the ward's parents, or either of them, are alive.

~~(2) A plenary guardian or a limited guardian of a ward may sign an order not to resuscitate as provided in s. 401.45(3). When a plenary guardian or a limited guardian of a ward seeks to obtain approval of the court to sign an order not to resuscitate, if required by exigent circumstances, the court must hold a preliminary hearing within 72 hours after the petition is filed, and:~~

~~(a) Rule on the relief requested immediately after the preliminary hearing; or~~

~~(b) Conduct an evidentiary hearing not later than 4 days after the preliminary hearing and rule on the relief requested immediately after the evidentiary hearing.~~

Section 6. This act shall take effect July 1, 2023.

OFFICE OF THE STATE COURTS ADMINISTRATOR
2023 JUDICIAL IMPACT STATEMENT

DATE: March 6, 2023

BILL NUMBER: SB 1098

SPONSOR(S): Senator Burton

STATUTE(S) AFFECTED: ss. 744.3215, 744.363, 744.3675, 744.4431, 744.441, F.S.

COMPANION BILL(S): HB 1119 (Representative Berfield)

AGENCY CONTACT: Tashiba Robinson, Legislative Affairs

TELEPHONE: (850) 922-5692

ASSIGNED OSCA STAFF: MEH

I. **SUMMARY:**

The bill relates to the withholding or withdrawal of life-prolonging procedures. Specifically, the bill authorizes a court to delegate the right to consent to the withholding or withdrawal of life-prolonging procedures of incapacitated persons in certain circumstances. The bill requires initial and annual guardianship plans, respectively, to state whether any power under the ward's preexisting order not to resuscitate or advance directive is revoked, modified, suspended, or transferred to the guardian. The bill also authorizes a guardian to petition a court for approval to consent to withhold or withdraw life-prolonging procedures under certain circumstances.

The bill takes effect July 1, 2023.

II. **ANALYSIS**:

Delegation of Rights to a Guardian Regarding Consent to Withhold or Withdraw Life-Prolonging Procedures

Section 1: Amends s. 744.3215, F.S., to provide that rights that may be removed from a person by an order determining incapacity and which may be delegated to the guardian include the right to consent to the withholding or withdrawal of life-prolonging procedures as defined in s. 765.101, F.S., subject to court approval as provided in s. 744.4431, F.S., if there is a conflict over or objection to the proposed exercise of the authority.

Guardianship Plan Requirements for Life-Prolonging Procedure Directives

Sections 2 and 3: Amends ss. 744.363 and 744.3675, F.S., to revise requirements of initial and annual guardianship plans. Specifically, guardianship plans must include a list of any preexisting orders not to resuscitate as described in s. 401.45(3), F.S., and the date such orders were signed; or advance directives, as defined in s. 765.101, F.S., and the date such directives were signed. The bill provides that the initial plan must state whether such order or directive has been revoked, modified, or suspended by the court or the extent to which authority under an order or directive has been transferred by the court to the guardian, and the plan must also state the date of such action by the court. The bill also provides that a surrogate designated by the ward in an advance directive, or an agent designated by the ward in a durable power of attorney, who retains authority to make health care decisions under the guardianship plan may exercise retained authority without additional approval by the court. Any authority of the surrogate to carry out the instructions in the advance directive or authority of the agent under a durable power of attorney which is transferred to the guardian may be exercised by the guardian, consistent with the advance directive or durable power of attorney, without additional approval by the court. Any authority transferred to the guardian to execute an order not to resuscitate or to consent to withhold or withdraw life-prolonging procedures is subject to court approval pursuant to s. 744.441, F.S., if there is a conflict over or objection to a proposed exercise of that authority.

Guardian's Power Regarding Life-Prolonging Procedures

Section 4: Creates s. 744.4431, F.S., to specify the powers of a guardian regarding life-prolonging procedures. Specifically, the bill authorizes a guardian to petition a court for approval to consent to withhold or withdraw life-prolonging procedures for specified reasons, and with specific requirements demonstrated. Under this bill, the guardian must serve notice of the petition, and of any hearing, upon interested persons and the ward's next of kin, unless waived by the court. The court must hold a hearing on the petition if the court has been notified of an objection or conflict or if the court has insufficient information to determine whether the criteria for granting the requested authority has been met. If a hearing is required and exigent circumstances are alleged, the court must hold a preliminary hearing within 72 hours after the petition is filed and do one of the following: rule on the relief requested immediately after the preliminary hearing; conduct an evidentiary hearing within 4 days after the preliminary hearing and rule on the relief requested immediately after the evidentiary hearing. Additionally, notwithstanding the requirements for court approval imposed under this section, and if authority to withhold or withdraw life-prolonging procedures has not been vested in another person, the guardian may, without a hearing or prior court approval, consent to the withholding or withdrawal of life-prolonging procedures if

all of the following apply: the ward is in a hospital and at least two of the ward's treating physicians state in writing that there is a substantial likelihood that the ward's death will occur within the next 72 hours; there is no known objection to the granting of a petition to withhold or withdraw life-prolonging procedures; and the hospital ethics committee has met and agrees with the guardian's proposal to withhold or withdraw life-prolonging procedures. If the hospital does not have an ethics committee, it may seek approval by the ethics committee of another facility or a community-based ethics committee approved by the Florida Bioethics Network.

Conforming Changes
Section 5: Amends s. 744.441, F.S., to make technical changes and to delete provisions regarding the authority of plenary guardians or limited guardians to sign an order not to resuscitate.

The bill takes effect July 1, 2023.

III. **ANTICIPATED JUDICIAL OR COURT WORKLOAD IMPACT:** Indeterminate. While the specific extent of the effect is difficult to determine, the bill is likely to create an increase in judicial workload, as it creates new judicial processes and hearing requirements.

IV. **IMPACT TO COURT RULES/JURY INSTRUCTIONS:** The Florida Probate Rules may need to be reviewed to ensure that they accommodate the new statutory procedures.

V. **ESTIMATED FISCAL IMPACTS ON THE JUDICIARY**:

A. **Revenues:** The State Courts System receives $115 from filing fees collected in probate matters into the State Courts Revenue Trust Fund. The fiscal impact of this legislation on revenues cannot be accurately determined due to the unavailability of data needed to establish impacts resulting from the filing of petitions related to life prolonging procedures of incapacitate persons established in the bill.

B. **Expenditures:** The fiscal impact of this legislation is indeterminate due to the unavailability of data needed to quantifiably establish the increase in judicial time and workload as a result of new judicial processes and hearing requirements related to petitions for withholding or withdrawal of life-prolonging procedures of incapacitated persons, as discussed in Section III, above.

Trial court judicial workload is measured using a case weighting system that calculates the amount of time that it takes for a judge to dispose of a case. Passage of this bill may impact the case weighting system. The

number of case filings using the case weighting system is used to determine the needs for additional judicial resources each year. Any judicial workload increases in the future as a result of this bill will be reflected in the Supreme Court's annual opinion *In re: Certification of Need for Additional Judges*.

Commission on Mental Health and Substance Abuse
Legislative Report
January 1, 2023

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Acknowledgments

Commission Members

Sheriff Bill Prummell
Chair, Governor Appointee

Senator Darryl Rouson
President of the Senate Appointee

Ray Gadd
President of the Senate Appointee

Wes Evans
President of the Senate Appointee

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Message from the Chair

As a society, we do not view behavioral health crisis services as an essential community service, as we view police, fire, emergency medical services (EMS) and emergency medical care. Communities are further recognizing that failure to respond properly to these crises is dramatic in its personal, social, and economic cost, resulting in incarceration, devastation, homelessness, and death. When people are in a mental health crisis, what to expect at the basic level of treatment and services before, during and after the crisis should not be a mystery.

Many individuals are unable to access care in the community. Some are unable to access care due to financial limitations, travel time and distance to available services, and/or no available space. There are not enough resources (services) for all who need it, and many find themselves on a waiting list for services (see Appendix 6).

Not only is there a shortage of MH professionals, but community-based organizations cannot attract MH clinicians and compete with the private sector. The only option is to access care through some of the most costly and inefficient points of entry into the health care delivery system including emergency rooms, acute crisis services and, often, the juvenile and criminal justice systems.

There is an equally if not more compelling need to invest in prevention and treatment at the front end so that the demand for more inefficient services will be reduced.

- Programs to prevent individuals from inappropriately entering the justice and forensic mental health systems.
- Programs to stabilize these individuals and link them to recovery-oriented services in the community that are responsive to their unique needs.
- Mechanisms to quickly identify individuals with mental illnesses who do become inappropriately involved in the justice system.
- Lack of community/based care for reentry. It is imperative that the efforts being undertaken to enhance community re-entry from jails and prisons include the establishment of comprehensive and competent services in the community targeted toward the needs of this high-risk population.

18% (1 in 5) of the population in the U.S. has a diagnosable mental illness. 1 in 17, or 6% of the population, suffer from a serious mental illness (Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health, 2020). An estimated 20 million Americans have a substance use disorder and 8 million suffer from both Mental Health and Substance Use disorders.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), last year alone, more than 56% of all adults living with serious mental illness and about 62% of all children living with severe emotional disturbances in need of treatment in the public mental health system had no access to care. Our geriatric population is also lacking in providers, needed care, and medication.

It is estimated that somewhere between 13%-20% of adolescents suffer from a mental health disorder, most starting around age 14. It is said that 37 out of 100 children suffer from Acute Childhood Experiences (ACE's). Trauma affects the brain. It is important that those who work

with children, such as school officials, have training in ACEs, calming techniques, and de-escalation. The earlier the diagnoses, and treatment is provided, the better the outcome for the individual.

As identified in the Marjory Stoneman Douglas High School Public Safety Commission, there are issues transitioning from the juvenile system of care into the adult system. Many reaching adulthood are left out on their own and/or now can just choose to stop treatment, which can have devastating effects. Those who find themselves in the criminal justice system will receive services through the Department of Juvenile Justice (DJJ), but once released from their supervision, there are no referrals and/or follow up care.

There are six state mental health hospitals and three private facilities in Florida. In fiscal year 2021 the Department of Children and Families (Department) funded 2,677 beds through the state mental health treatment facilities. Additional beds are contracted annually through the managing entities, including residential programs, in patient programs and psychiatric hospitals. The number varies and only represents patients paid for by the Department. Using the 2020 provisional population numbers for adults in Florida, 17,358,504, the ratio of beds per 1,000 adults is 0.154. There are just not enough long-term and short-term residential treatment beds in the State to address the need. In addition, counties in the State are not created equal and lack access to care for their residents.

In FY 2021, the Department's clients presented with 997 different mental health diagnoses in FY2021. These were the top 10 most common.

ICD10	Dx	Number of clients
F32.9	Major depressive disorder, single episode, unspecified	14,923
F33.1	Major depressive disorder, recurrent, moderate	14,055
F11.20	Opioid dependence, uncomplicated	10,389
Z91.89	Other specified personal risk factors, not elsewhere classified	10,336
F41.1	Generalized anxiety disorder	9,919
F31.9	Bipolar disorder, unspecified	9,724
F43.10	Post-traumatic stress disorder, unspecified	9,554
F25.0	Schizoaffective disorder, bipolar type	9,236
F20.9	Schizophrenia, unspecified	9,147
F10.20	Alcohol dependence, uncomplicated	8,624

Below is a breakdown of Department clients served in FY2021 by program area. This only represents the clients paid for through Department funding and does not represent the entire population of individuals with mental health and substance abuse disorders.

Program Area	Number of clients
Adult Mental Health	152,565
Adult Substance Abuse	43,470
Child Mental Health	34,595
Child Substance Abuse	6,976

Here are the number of admissions meeting criteria for Baker Act and Marchman Act for the last five years.

	Baker Act Admissions	Marchman Act Admissions
FY 2020-2021	14,043	1,125
FY 2019-2020	27,576	2,235
FY 2018-2019	37,722	2,907
FY 2017-2018	38,385	2,995
FY 2016-2017	36,676	2,639
Note: FY 2016-2017 and 2017-2018 are from SAMHIS; FY 2018-2019, 2019-2020, and 2020-2021 are from FASAMS.		

It is not possible to go to one specific source to obtain this data. There is no interoperability between various systems (public providers, private providers, primary care, DCF, DJJ, DOH, DOE, DJJ, VA, criminal justice system). Deinstitutionalization has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, and systems; leaving enormous gaps in treatment and disparities in access to care.

Individuals can and do, move through community-based providers, the criminal justice system, private providers, emergency rooms, schools, etc., receiving a diagnosis, treatment, and medications in each without anyone being the wiser. Not even our state organizations (DFC, AHCA, DOH, DOC, DJJ, DVA, etc.) share information. We must connect the dots between all the service providers, both public and private, to make sure everyone is sharing information about a single client and preventing silos of information from existing.

While a portion of crises are unpredictable and unavoidable even in the perfect overall behavioral health delivery system, many behavioral health crises are a direct result of inadequate performance by the rest of the behavioral health delivery system and other human service systems such as justice, housing, immigration and child or adult protective services. Common behavioral health system causes of behavioral health crises include inadequate access to routine services, premature discharge from treatment programs and inadequate attention to patient engagement.

In many communities, it is difficult for individuals to flow smoothly to higher or lower levels of service intensity as their needs change. Even more problematic, many individuals in crisis, their families and support systems, experience multiple disjunctions and transitions in care during the crisis episode at a time when they are most vulnerable and distressed. These transitions are often associated with multiple repetitive assessments, changes in diagnosis and variations in treatment plan from one day to the next or one program to the next. This lack of continuity through the crisis episode results not only in diminished experience of care for primary customers but can lead to poorer outcomes because the information often does not flow efficiently as the client moves through the continuum.

For these reasons, continuity of care through the crisis episode and facilitation of smooth transition through different levels of service intensity in the crisis continuum are both essential elements of an ideal crisis system. In Florida's system of care, the money follows individual

programs and not the individual. As the needs of the individual change, protocols and funding should be in place that make it easy for them to be transitioned through the appropriate levels of care in the crisis continuum. These vertical transitions through the continuum should occur as smoothly as possible to meet individual needs and be associated with continuity of care by a crisis intervention team or crisis intervention coordinator that is usually based in the crisis hub and has a care coordination function throughout the continuum of services.

In addition, we sperate mental health and substance abuse disorders (SUD). SUDs are included in the DSM V manual as a mental health disorder. There is a need for seamless flow between various types of co-occurring capable mental health and SUD services for individuals with co-occurring mental health and SUD. Many crisis programs and crisis systems create distinct detox capacity and crisis bed capacity. This often results in impediments to both individual client flow and flexible utilization of limited resources. Individuals with co-occurring conditions in crisis who need help with withdrawal management can receive such support in a crisis bed. Individuals who present with requests for assistance with SUD often have co-occurring mental health conditions as well.

Further, individuals with active SUD who need a safe place to stop using, to address mental health and social concerns and to consider the next steps in recovery should not be required to present with intoxication to access the support services labeled as detox. Therefore, within the bounds of state regulations, efforts in the ideal crisis system should be made to eliminate the artificial distinction between crisis beds and detox beds in favor of a more fluid system that meets the needs of all individuals with any combination of mental health and substance use needs.

Our system is complicated and administratively burdensome, not just for the individual and their families, but the providers. MH/SUD clinicians are inundated with paperwork for various funding sources and programs. Where does this paperwork go and what is it used for? Hours of paperwork equals time a MH/SUD professional could be working with clients. Reporting is necessary in tracking outcomes but can be streamlined to what data is necessary for treatment and for guiding the system of care throughout the State of Florida.

Community providers often find it difficult to meet mandatory performance standards. These high standards disincentivize providers from taking on those high-risk individuals, who are harder to treat, and are more likely to provide services to those not requiring acute care. There are financial deterrents for programs to take on those requiring acute care services. Behavioral health systems cannot meet the mandatory performance standards by taking on those who need the services the most. There are also no protections for the community-based providers and all liability falls on them and premiums continue to rise.

A continuum of services is needed as an individual navigates through the MH/SUD system. Case workers and peer support members are also paramount to keep the individual on track and circumnavigate through this very complex system, assuring they receive the care they need and the funding to support the treatment. The individual should navigate through the system based on their needs not by what the funding source dictates.

In the level of expenditures on front-end community-based services intended to promote recovery, resiliency, and adaptive life in the community, Florida is often ranked near the bottom. In 2021, $769,723,025 was allocated to the managing entities. $61,483,010 was unexpended due to unused ***program*** funds. This is just funding provided through the managing entities. There are also funds from other local and private entities that are returned for this same reason.

The Funding is not flexible. Rules are very strict and cannot be used universally. It was indicated that there is not enough funding, but if funding was more portable, it might address the areas where funding is short, making the system more effective and efficient.

In this first report, you will find recommendations the Commission believes will begin to make the system better. But we still have much work to do as we continue to take a deeper dive into all aspects of our system of care. We are tracking the funding, where it's going, how it's being expended, and the reporting and accountability requirements. We are looking at data collection and sharing, how to make this happen among all stakeholders, and most importantly, how to make Florida's system of care work for all.

William Prummell, Sheriff
Commission on Mental Health and Substance Abuse, Chair

Executive Summary

In 2021, the Florida Legislature passed legislation, which Governor Ron DeSantis subsequently signed into law, to establish the Commission on Mental Health and Substance Abuse (Commission). Composed of 19 members, the Commission's tasks are to review and evaluate the current effectiveness of such services in the state, identify barriers to care, and make recommendations regarding policy and legislative action to implement improvements. In addition to conducting a review of the State's behavioral health and substance abuse systems of care, the Commission is also responsible for assessing priority population groups that can benefit from publicly funded care and proposing recommendations for the creation of a single, permanent State agency that will manage the delivery of these services. Other tasks the Commission must perform include identifying gaps in behavioral health care and assessing current staffing levels and availability of services across Florida. Also, the Commission is responsible for submitting two reports to the Governor, President of the Senate, and Speaker of the House of Representatives. The first, which is due on January 1, 2023, is an interim report that precedes a final one due on September 1, 2023. This is the Commission's interim report on the status and recommendations for Florida's mental health and substance abuse services.

To complete its review, the Commission established four subcommittees and tasked them with evaluating specific aspects of the State's behavioral health and substance abuse systems of care. In addition to holding regular meetings, each prepared reports proposing recommendations. Focusing on their assigned areas, the following subcommittees developed strategies and ideas based on their assessments of how Florida delivers behavioral health services:

- **Subcommittee on Business Operations:** This team dedicated itself to evaluating how Florida's State agencies approached behavioral health services and where they could implement improvements to streamline delivery and reduce wasteful practices.
- **Subcommittee on Criminal Justice:** Tasked with reviewing the Baker and Marchman Acts, this subcommittee worked on recommendations to improve services related to restoring competency, jail diversion, and reducing recidivism.
- **Subcommittee on Data Analysis:** All State agencies and entities engaged in delivering behavioral health services perform data collection. This team focused on methods to improve and enhance data collection and reporting, and devised strategies for alignment and storage.
- **Subcommittee on Finance:** Funding for behavioral health services comes from myriad payers, including Medicaid, federal grants, private insurance, and state and local revenues. This subcommittee explored current obstacles to funding, in addition to identifying potential new sources.

These recommendations correlated to the subcommittees' respective areas and included proposals to improve access to care, divert those with behavioral health needs from the criminal justice system, gather and report data, and discover novel means to fund these services. Each recommendation builds upon existing State programs and will enhance behavioral health care across Florida, if implemented. It is important to note that while the recommendations in this report were agreed upon by the majority of the Commission members, there are some recommendations for which there was not consensus, specifically in the Access to Care section.

As the Commission continues its work, these subcommittees will refine their proposals in the final report.

Focusing on how to improve access to behavioral health services, the Subcommittee on Business Operations identified several approaches that can connect individuals to appropriate care when necessary. These consist of the following measures:

- Establishing a master client index that will collect demographic and diagnosis information: If implemented, such an index can identify those who would benefit the most from enhanced care coordination to reduce the likelihood of utilizing higher levels of services (e.g., crisis stabilization units, inpatient hospitals).
- Conducting an explorative study to better understand the perceived gaps in behavioral health care to determine if modifying Medicaid eligibility criteria would make a difference.
- Initiating uniform quality metrics for all publicly funded behavioral health and substance abuse care in Florida: Currently, programs such as Medicaid and the Department use similar but varying metrics that can prevent accurate measures of performance. A uniform set will provide a more accurate account on the effectiveness of services delivered statewide.
- Creating a coordinated community behavioral health approach for public school students utilizing a single organization, and amending Section 1006.05, F.S

The above recommendations can increase access to behavioral health care for individuals of all ages. Having the ability to see the right provider at the right time can help reduce overutilization of intense services, as well as mental health and substance abuse crises. Among the most intense behavioral health services in Florida that result in heavy costs for the State are involuntary examinations conducted under the Baker and Marchman Acts. In addition, competency restoration following arrest and indictment compounds these costs. Furthermore, the State's jails and prisons have become residences for those who would be better served by behavioral health and substance abuse service providers. To improve these issues, the Subcommittee on Criminal Justice proposed modernizing the Baker and Marchman Acts, making improvements to how Florida approaches competency restoration, and implementing jail diversion programs. Regarding the two acts, the subcommittee recommended legislative action that will amend the existing statutes to better serve the populations that require them and reduce unnecessary involuntary examinations. For competency restoration, proposed actions consist of reducing the number of offenses where such action is necessary for an individual to stand trial. This is needed to alleviate the burden on state mental health hospitals, which have insufficient capacity to meet this demand. The subcommittee also cited jail diversion programs as critical in reducing the number of inmates contending with serious mental illness who would benefit from behavioral health interventions. All of these recommendations can contribute to reducing costs by lowering recidivism rates and utilization of intense levels of care.

Measuring the outcomes of new measures and programs is impossible without data. To determine actions to improve this area, the Subcommittee on Data Analysis proposed the following three goals that will align and centralize Florida's behavioral health and substance abuse data:

- Goal One: Create a coalition of key stakeholders to identify the best data sources across the state and determine outcomes for their use.
- Goal Two: Establish a single repository for behavioral health and substance abuse data which can allow for accurate collation and reporting. The subcommittee proposed establishing one point for all state agencies to submit their data.
- Goal Three: Use collected data to provide information on behavioral health provider availability to aid individuals with the highest risks.

These improvements can aid the State in increasing access to services, achieving better outcomes, and ensuring appropriate levels of care are utilized. Regarding funding opportunities, the Subcommittee on Finance is in the process of reviewing whether there are untapped sources of revenue or areas that could generate additional funds. As the subcommittee completes its evaluations, it will prepare its recommendations for the final report in September 2023.

Data Transparency

Having data available upon which to make informed decisions and address persistent behavioral health problems is critical to having a robust and effective system of care. On that basis, the Commission has composed several recommendations to improve data collection, storage, and transparency that will improve how the State uses information when evaluating performance, individual outcomes, and identifying issues. The Commission proposes the development of a master client index to reduce duplication of effort and better integrate delivery of care between various public funders of behavioral health services. The Commission further proposes the development of a de-identified data warehouse to analyze trends, prevalence, and outcomes in behavioral healthcare in Florida. The following outlines the Commission's proposed actions to make these improvements.

Recommendation 1

Develop a pilot Master Client Index to yield the following results:

1. Public Funders of Behavioral Health Services would be required to upload limited scope, client specific information and service type or program into a non-transactional data warehouse/repository at a specified frequency.
2. The data would be submitted in a universal file format
3. The data fields would be limited to the most commonly collected information. For example:
    a. First Name
    b. Middle Initial
    c. Last Name
    d. Date of Birth
    e. Social Security Number
    f. Procedure code or Healthcare Common procedure coding system
    g. DSM-5 Diagnosis
    h. First date of behavioral health service or entry into a treatment program
    i. Setting of service – i.e., jail, school, Department of Juvenile Justice (DJJ) commitment program, provider facility, state psychiatric hospital, etc.
    j. Last day of a publicly funded behavioral health service or exit from a treatment program
4. The Master Client Index would sort/match records based on a combination of the demographic fields, including partial matches, so that a significant level of confidence is achieved when two distinct individuals are identified as actually the same person.
5. Access to a patient's record in the repository would be limited to matches between the specific public funder's roster and a corresponding demographic record match from another public funder's submission. Access will be guided by adherence to federal and state privacy protections.

Rationale
Individuals whose behavioral health care needs go unmet become the high utilizers of acute care and encounters across systems. They are frequently bounced between social service systems, including the Department of Education (DOE), the Department of Juvenile Justice (DJJ), the Department of Children and Families (DCF), law enforcement agencies, the Agency for Persons with Disabilities (APD), and the Agency for Health Care Administration (AHCA), Department of Housing and Urban development (HUD). By developing a standard methodology for building a Master Client Index that cross-checks certain demographic values with an advanced algorithm to include partial matches, the potential for a truly integrated and informed behavioral health care system is attainable. The effects of successfully identifying those who would most benefit from a targeted care coordination strategy would be a reduction in duplicative or conflicting services, more effective resource allocations by informed funders of behavioral health services, and better outcomes for the complex individuals served.

Recommendation 2

Create a Florida behavioral health data repository or comparable effective data system that includes data harmonization and cleaning of identified data sources.

Following creation of a statewide data collaborative and development of information sharing guidelines, then a behavioral health repository can be formed to include various data from organizations such as (but not limited to):

- Department of Children and Families (DCF)
- Agency for Health Care Administration (AHCA)
- Department of Juvenile Justice (DJJ)
- Department of Education (DOE)
- Department of Housing and Urban Development (HUD)
- Florida Department of Law Enforcement (FDLE)
- Agency for Persons with Disabilities (APD)

In order to mobilize this recommendation, the Commission proposes the following steps:

1. Secure the administrative authority and commitment from stakeholders/agencies (DCF, AHCA, etc., to establish the state-wide Florida Behavioral Healthcare Data Repository (FBHDR)).
2. Due to the sensitivity of this data, the legalities of Health Information Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), and SAMHSA must be addressed.
3. Determine structure of the repository (centralized, federated, etc.), as well as policies and protocols for data standardization, security, and access.
4. Determine a process to identify and partner with parties responsible for creation and maintenance of a data repository.
5. Implement innovative technology to address privacy concerns and make the data more accessible with fewer data sharing consequences (e.g., personally identifiable information and protected health information).
6. Incorporate technological and data science innovations to improve data collection, upload, cleaning, harmonization, and statistical analyses.

7. Budget appropriate initial funding for the initiative, including a fiscal analysis of elements/components (associated costs) of establishing and maintaining the repository and the possible addition of a qualitative component and analysis.

Rationale
The overall goal is to provide information on access, prevalence, quality, costs, and outcomes of the behavioral health system in Florida. Key questions have been developed based on national standards and guidance relating to understanding and improving statewide health systems aimed at effectiveness, efficiency, and fairness. In addition, states that have embarked on characterizing and optimizing behavioral health care and outcomes have provided guidance on initial questions that inform policy, spending, and clinical capacity. Initial research questions will evaluate major behavioral health outcomes and evaluation of current performance metrics to provide detailed information defining what they are and what outcomes they are achieving.

Recommendation 3

Provide information on behavioral health data sources in Florida for high-risk individuals. The Commission's Data Strategy for improving outcomes is included in Appendix 2.

In order to mobilize this recommendation, the Commission proposes the following steps:

1. Establish an FBHDR oversight steering committee that will identify appropriate behavioral health data sources and will guide and prioritize analytic direction and initiatives. Membership should include representatives from major stakeholders.
2. Initially, this level of research will focus on people served by public-funded services and supports. Specifically, the research will descriptively report on people served within each public service and across departments (e.g., DCF, AHCA, DOJ, etc.). Specific research questions will include, but not be limited to:
    - Demographic and diagnostic characteristics.
    - Prevalence of specific psychiatric and medical diagnoses.
    - Specific behavioral health and medical services.
    - Client outcomes, using available direct and proxy outcome measures, based on the above client and service characteristics.

    In a later exploration, comparisons of the above outputs will be made among people covered by Medicaid versus Medicare versus private insurance versus uninsured. Some recommendations for additional analyses may be proposed.
3. Additional considerations:
    a. Implement a mixed-method or qualitative component to inform/contextualize the data:
        i. Focus on the following questions: (1) what services are being provided, (2) how services are being provided, and (3) how effective services are for different populations.
        ii. Prioritize consumer voices (e.g., advocacy groups focusing on housed individuals, individuals with a criminal record, etc.).

For more information on national data frameworks, refer to Appendix 3.

Rationale
States that have embarked on integration of behavioral health information from multiple agency sources have found significant improvements in accuracy of information on**:**

1. Personal characteristics (e.g., age, sex, gender, race, ethnicity, geographic location).
2. Diagnoses, including co-morbidities (e.g., DSM-5 ICD-10 dx, multiple diagnoses, screening tool results, medical dx).
3. Service use types and intensity/frequency (e.g., visit types- assessment, intake, medication management, psychotherapy and counseling, crisis intervention, individual, group treatment, provider type).
4. Person outcomes and health care quality (e.g., clinical severity scores, such as PHQ9, functioning outcomes, outcome measures, such as follow up with care, medical screening for patients with psychotic disorders, etc.).
5. Collect data on individuals receiving services and start collecting a 'catalogue' of mental health and behavioral health resources that are available.
    a. Identify all existing statewide behavioral health service directories (e.g., Hope for Healing and 211 services).
    b. Compare county level resource differences (i.e., organizations, providers, practitioners, etc.) between DCF and AHCA systems.
6. Identify information that is not being collected through publicly funded care that should be collected for outcomes.

Recommendation 4

Develop a workgroup to establish a statewide core set of metrics that will provide a comprehensive, standardized, and transparent approach to assessing and evaluating quality of care and health outcomes. These metrics will address the following domains:

- Preventive care and screening.
- Referrals and care coordination.
- Treatment and follow up.
- Risk factors and health outcomes.

Rationale
Health surveillance is the process of continuously monitoring attitudes, behaviors, quality of care, and health outcomes over time. Statewide surveillance is important for monitoring the achievement of overall program goals. Evaluation is used to assess the implementation and outcomes of a program, increase efficiency and impact over time, and demonstrate accountability. Standardized and comprehensive data to accurately assess and monitor substance abuse and mental health related metrics are currently not available at a state level. Development of a comprehensive approach to substance abuse and mental health quality metrics will provide a source of reliable and valid information for use in developing, implementing, and evaluating efforts to improve the health and safety of all Floridians and visitors. A detailed collaboration roadmap is provided in Appendix 1.

Access to Care

Considering that Florida's population is rapidly expanding, timely access to behavioral health services when needed is critical to preventing crisis situations that result in admissions to crisis stabilization units or inpatient facilities. As one of the State's main priorities, improving access to care is not only essential to improving individual outcomes, but also to reducing the financial and human costs of behavioral health crises that involve intense levels of care or law enforcement. Because of this need, the Commission has made several recommendations that will improve access to behavioral health care so that more individuals will have their first encounter with a provider at the community level rather than the emergency department or local jail.

Recommendation 5

In partnership with AHCA, conduct an explorative study to assess the potential impact of adjusting the Medicaid income eligibility criteria for young adults ages 18-26 years, in the coverage gap whose parents are not insured. The results of this study will be used to meet the following goals:

- Assess the data to ascertain the behavioral health needs of uninsured or underinsured youth
- Identify evidence-based interventions to address their specific needs and increase access to care (e.g., pilot)
- Develop a strategic, data-driven approach to addressing behavioral health care access and costs for a targeted population at risk that will benefit from early intervention.

Rationale

An estimated **415,000 Floridians** are in the **coverage gap**. They do not have health insurance through an employer, possibly because they work at a small business, work part-time or seasonally, or they are self-employed. They earn too much to qualify for Medicaid, but not enough to qualify for subsidies to purchase health insurance in the Marketplace.

Coverage for Behavioral Health

In 2019-2020, over 1,000,000 adults in Florida reported needing, but not receiving, mental health treatment, and 51.9% cited cost as the barrier.

In Florida, behavioral health care can be covered by commercial insurance, Medicare, Medicaid, state or federal funding, or self-pay. An estimated 14.9 percent of adults in Florida who reported a mental health disorder were covered by Medicaid, while 54.9 percent were covered by private insurance. Because the Managed Medical Assistance (MMA) plans are paid on a capitated basis, determining how much is spent specifically to treat mental or substance use disorders is difficult and requires analysis of encounter data for each plan.

However, it is worth noting that behavioral health care costs are not limited to behavioral health treatment. A recent 2020 study found that people with behavioral health disorders also had higher utilization and costs for physical health care. This study included 21 million individuals covered by employer health plans. The study also found that 27 percent had a behavioral health diagnosis or treatment but accounted for **56.5 percent of the total health care costs** for the entire study population. More than 95 percent of their health care spending was for physical treatment and only 4 percent was used

for behavioral health. Better care coordination and integrated services would appear to be important tools to reduce health care costs, regardless of payer source. (Davenport et al, 2020)

Young adults ages 19 to 26 account for 8.3 percent of Florida's total population, but 14.1 percent of the uninsured population. This percentage has improved since young adults up to age 26 became eligible to remain on a parent's health insurance plan. Youth ,who age out of foster care are also permitted to remain on Medicaid until age 26, if income requirements are met. Adjusting the income eligibility criteria for Medicaid for young adults in the coverage gap whose parents are not insured would improve access to care for behavioral health and for primary and preventive care that could promote better long-term physical health outcomes. The study would include a comprehensive system of qualitative and quantitative data analysis to assess utilization and results. This approach allows for a better understanding of gaps in behavioral health services that exist for young adults whose families are not able to afford health insurance, and for youth pursuing technical education without access to college health clinics and those who are living independently and working, but in jobs that do not offer affordable health coverage.

Recommendation 6

Implement a three-year pilot in which one agency level entity manages all public, behavioral health funding in a geographic area, minimally including:

- Department of Children and Families (DCF) safety net funding.
- DCF child welfare prevention funds related to substance use and mental health.
- Criminal justice funding (Department of Corrections and DJJ).
- Medicaid managed care funding.
- Private Insurers.
- Medicaid fee-for-service funding (including Florida Assertive Community Treatment).
- Local funding (county, city, Children's Services Councils, independent tax districts, etc.).
- Department of Education and Local School Boards mental health funding.

To ensure the community has access to timely, quality, and comprehensive services, it is further recommended that the pilot must provide a minimum of nine types of services through contract with partner organizations, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with community partners, integration with physical health care, and provider payment through a prospective payment system or other payment systems, regardless of the patient's payer source.

Based on a comprehensive assessment, individuals would have access to the entire service array. The agency level entity would be responsible for billing the responsible entity, blending and braiding funding to ensure comprehensive, equitable care for all. The following topics will require development and definitions.

- Independent care coordination.
- Prospective payments based on cost.

- CCBHC certification criteria in addition to the federal minimum standards.
- Contracts with the various funders.
- Uniform performance measures to satisfy federal Medicaid and Substance Abuse and Mental Health Services (SAMHSA) reporting requirements.
- Coverage policies for individuals who have commercial or federal coverage (i.e., Medicare, Tricare, etc.), but are not able to access the services they need under these plans because the service is not covered, or co-payments/deductibles are so high that the individuals cannot afford care.

Rationale

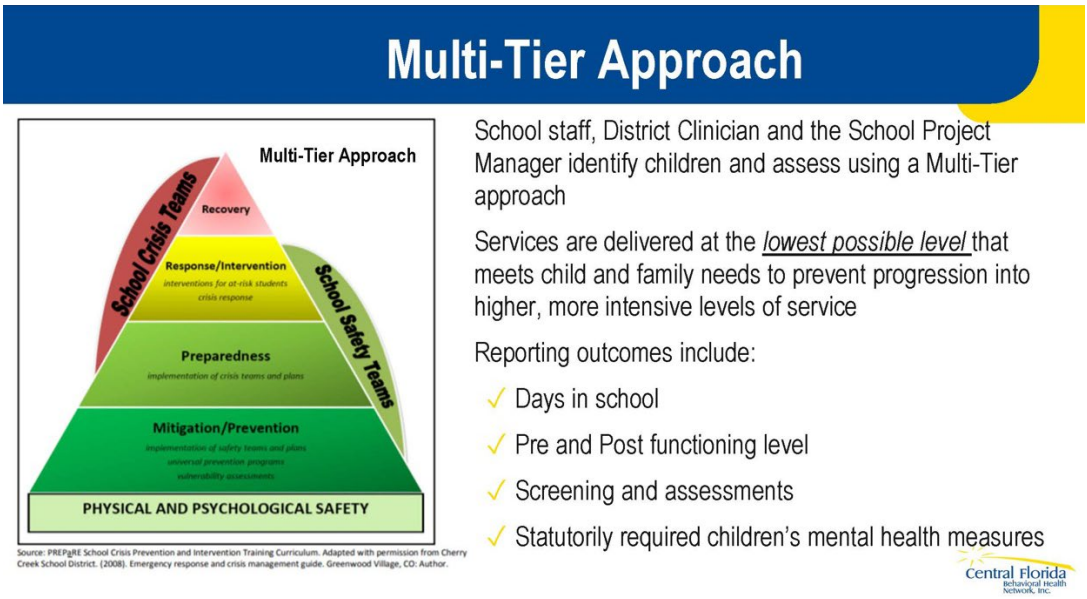
Florida's current payment structure for publicly funded behavioral healthcare has resulted in a fragmented and siloed service system. The services a person with mental health and/or substance use disorders receives is often dependent on how their services are funded, rather than their individualized needs. The system of care is a patchwork of programs, care delivery, and oversight that is complex, disjointed, and inequitable. Because each payor has differing covered services, reporting requirements, and eligibility, it is challenging to provide individualized care or maintain needed service levels when insurance/fund source changes occur. The recommended approach would allow providers of behavioral healthcare to serve individuals with the flexibility necessary to provide person and family-centered care. Provider time would be spent on what they do best – provision of prevention, recovery, and treatment services instead of complicated billing processes and reporting that differs for each funder. A predictable, stable payment structure based on actual costs will allow providers to hire and retain the workforce necessary to manage the challenging needs of the target population. The entity would function as the single point of accountability for payment, oversight, and care-system management with the ability to leverage resources and reduce duplication. Another advantage to this approach is that one entity would have all the behavioral health care history for the person served in one place, including service encounters, assessments completed, multiple provider involvement, and service intensity. This will allow the agency level entity to identify high utilizers, duplication of care, and care coordination needs through data surveillance. The agency level entity would also have the necessary data on service provision, cost, and performance outcomes across the system of care to effectively identify gaps, scale best practices, and plan system improvements.

Recommendation 7

Create a coordinated community behavioral health approach for public school students utilizing a single organization and amend section 1006.05, F.S., as indicated in Appendix 4.

The need for a uniform system to assure access to care, reduce fragmentation caused by siloed systems of care, care coordination, and uniform reporting of outcomes was identified by the Marjory Stoneman Douglas Commission.

A successful model has been replicated by three major school systems (Broward, Hillsborough, and Pasco) to assure the appropriate identification, referral, and care coordination of children and families with complex and co-occurring behavioral health needs. The model standardizes the process for referral, care coordination, feedback, and outcomes through contracts with Managing Entities, and will be evaluated for potential replication across the State.



Merging school and community behavioral health process

Similar to the model above, the single organization will contract with the school district to assess student needs and gaps in services, identify providers and additional services needed, and report needs and outcomes. The entity will also organize a system of care to ensure mental health services are delivered to all children and families, regardless of insurance type, identified by the school system.

The single organization would be responsible for ensuring there is an expansive network of providers with both the expertise and capacity to provide timely access to services for these high-risk children and their families. The model would include a Care Coordinator within each district to ensure students are receiving necessary services and to assure that appropriate funds are used to support the cost of treatment (including Medicaid and private or commercial insurance) prior to accessing school based mental health funding to purchase community-based services. In addition, school districts may choose to contract for the management of onsite community-based services designated to meet the students' needs in high needs schools within the district.

Single organization responsibilities include the following:

- Identification of gaps to expand and enhance services.
- Provide onsite services for high-risk schools (upon request).
- Track and report outcomes.
- Ensure community education about the availability of wraparound services.
- Identification of unique behavioral health needs for students.
- Assure that the provider network has the capacity to meet the need.
- Maintain and enhance relationship building and communication with school districts and community providers.
- Collaborate with public and private funders.

- Develop or utilize youth at risk staffing when necessary for children involved in multiple systems (Child Welfare, DJJ, students with three or more admissions to a crisis unit within 90 days, etc.).

Rationale

School districts' expertise is in the delivery of high-quality education and services to maximize each student's potential. The single organization would possess expertise in the delivery and coordination of behavioral health services (mental health, substance use, and recovery supports) for children and their families with complex and severe behavioral health needs. School districts utilize a variety of methods and services within the school system to offer mental health well-being, screen and identify youth with behavioral health needs. The majority of students identified with behavioral health services can be appropriately served within current school-based prevention and counseling services to support the student's well-being. However, there is no uniform system in place throughout Florida to assure timely access to the appropriate level of community based behavioral health services and care coordination for children identified at the highest level of risk that cannot be mitigated with school-based counseling and supports. Although school systems may have referral agreements and/or contracts with community providers, there is no mechanism to assure that linkage and care coordination feedback loops are in place to assure students' unique needs are addressed across the various systems providing services to high-risk youth and their families, or uniform reporting of outcomes for children referred to community services.

Gaps in Care

To better ensure access to care, the Commission recognizes the need to identify and fill the gaps in behavioral health services. Many of the gaps exist due to outdated processes that will require systematic change. Currently in the system, there are wait lists for services that are highly utilized. In Appendix 6, wait list data by Managing Entity is presented. This section puts forth recommendations that will improve the State's capacity to address behavioral health comprehensively.

Recommendation 8

Limit the use of Competency Restoration process to cases that are inappropriate for dismissal or diversion using the following:

1) Divert cases inappropriate for competency restoration (misdemeanor/low level felonies) from the criminal justice system through the expansion and funding or specialty courts and programs.
2) Restrict which cases are referred for competency evaluations.
3) Expand and fund section 916.185, F.S. – Competency Alternative Programs

Rationale

Competency to stand trial (CST), refers to the constitutional requirement that people facing criminal charges must be able to assist in their own defense. A criminal case cannot be adjudicated unless this requirement is met. The U.S. Supreme Court considers someone competent to stand trial if that person is rationally able to consult with an attorney and holds a clear understanding of the charges against him or her. Some people view competency restoration as a way to connect a person with mental health treatment. The reality, however, is that competency restoration services have a narrow focus on stabilization, symptom management, and required legal education. This is not the same as providing access to a fully developed treatment plan and treatment services with the goal of long-term recovery and rejoining the community.

In Florida, once an individual is adjudicated incompetent to stand trial on a felony charge, DCF must transfer the individual from jail to a competency restoration facility within 15 days of the finding. Individuals adjudicated incompetent to stand trial on a misdemeanor charge may be restored in the community, but more likely would be released to the community without access to treatment. If they remain incompetent to stand trial after one year, the charges are dismissed. Florida spends nearly 20 percent of all adult mental health dollars and half of all state mental health treatment facility dollars (approximately $198 million) annually on 1,600 forensic and forensic step-down beds serving roughly 3,300 individuals under forensic commitment. Admissions for competency restoration in state forensic treatment facilities last almost six months, at a cost to taxpayers of over $50,000 per admission. Roughly 70 percent of people restored will have their charges dropped, or they will accept a plea to credit time served or probation and will be released back to the community; in many cases there is no provision for follow-up services or access to basic necessities such as food, clothing, housing, or medication.

Individuals subject to forensic commitments are now the fastest growing segment of mental health consumers. Forensic commitments have increased by 72 percent since 1999, including an unprecedented 16 percent increase between 2005 and 2006, far exceeding existing forensic treatment bed capacity. At the same time, prison sentences of a year and a day have increased by 25 percent. On November 30, 2006, a judge in West Florida fined the Secretary of DCF

$80,000, and found her in criminal contempt of court for failing to comply with an order to transfer inmates with mental illnesses adjudicated incompetent to proceed to trial from the Pinellas County jail to state forensic hospitals in a timely manner, as required by law. This ruling followed months of controversy and high-profile media attention surrounding DCF's inability, due to lack of resources, to abide by statutory requirements to place defendants, who were found incompetent to proceed to trial or not guilty by reason of insanity, in forensic mental health treatment facilities within 15 days of adjudication.

Recommendation 9

Modernize the Baker and Marchman Acts statutes by including proposals that include the following changes in the existing laws: The recommendations represent a comprehensive modernization of Florida's civil commitment system for mental health and substance abuse treatment. The changes reflect case law and scientific developments and will conserve state resources while ensuring that care is more efficiently provided.

Baker Act Changes (Involuntary Mental Health Care):

- Defines the elements of the law's "self-neglect" criteria.
- Allows DCF to establish rules regarding a person's care after post-discharge and make recommendations to reduce high utilizer readmission based on facility data.
- Further protects minors from being forced into "voluntary treatment" by requiring they have a mental illness and be suitable for treatment.
- Grants the police same discretion the courts and medical professionals have to initiate Baker Act examinations, which should reduce number of unnecessary Baker Acts.
- Streamlines procedures to allow the court the opinion of ordering inpatient or outpatient treatment depending on individual's needs. Outpatient is less costly and respects individual liberty more than inpatient hospitalization, and grants court continuing jurisdiction to enforce its treatment orders.
- Modernizes Baker Act's Dangerousness Criteria and conforms Florida law to majority of other states which address harm on a "totality of the circumstances" basis and not just the threat of serious bodily harm.
- Enables witnesses to appear remotely if there is good cause.
- Grants State Attorney limited record access & continuance; allows appointment of public defender, regardless of respondent's indigency status.

Marchman Act Changes (Involuntary Substance Abuse Treatment):
(Note: given the overlap between mental illness and addiction, many of the above changes are made to the Marchman Act so that the laws mirror each other as much as possible.)

- Updates definition of substance abuse impaired so that Marchman Act can better address prescription drug abuse and substance abuse disorders and requires DCF to create annual reports on Marchman cases statewide.

- Makes the State Attorney the real party of interest except if private counsel retained.

- Streamlines Marchman procedures by eliminating the need to file two separate petitions (assessment and treatment).

- Modernizes Marchman Court's authority to incorporate drug court best practices, which are scientifically proven to be more effective at treating addiction.

Rationale

In 1971, the Florida Legislature passed into law the Florida Mental Health Act, which went into effect July 1, 1972. This Act brought about a dramatic and comprehensive revision of Florida's 97-year-old mental health laws. It substantially strengthened the due process and civil rights of persons in mental health facilities and those alleged to be in need of emergency evaluation and treatment.

The Act, usually referred to as the "Baker Act," was named after Maxine Baker, former state Representative from Miami, who sponsored the legislation after serving as chairperson of the House Committee on Mental Health. When the Baker Act was passed, it created a legal process to involuntarily hospitalize individuals primarily in state psychiatric hospitals. At the time, Florida had significantly more psychiatric hospital beds than it has today, serving a state population of approximately 6.8 million people. Today, there are a little over 2,600 state hospital beds. Two-thirds of admissions are forensic and 69 percent of bed capacity is occupied by individuals, with forensic involvement serving a state population of approximately 21.3 million people. In a study by three authors affiliated with the Department of Mental Health Law and Policy at the University of South Florida, they found that involuntary examinations under the Baker Act "are associated with increased risk of arrest." They concluded that "an involuntary examination" is a significant signal that individuals with serious mental illness are at risk of arrest. In fact, each involuntary examination was associated with a 12 percent increase in the risk of arrest. An individual who is Baker Acted four times in a year has almost a 50% chance of being arrested in the near future.

Based on data from the Florida Mental Health Institute at USF, there were over 205,000 involuntary examinations under the Baker Act in 2019. Involuntary Baker Act examinations more than doubled (115.31 percent increase) in the last 17 years. More than 50 percent (106,327) were initiated by law enforcement. More than half (55.84 percent) of all involuntary examinations were based on evidence of *harm to self only.* One in five (21.52 percent) were based on *both harm to self and harm to others. Harm to others only* was the evidence for 5.55 percent of all involuntary examinations. In a one-year period, it is typical for 21 percent of people with an involuntary (Baker Act) examination to have two or more. While the people with two or more involuntary exams in a year account for 21 percent of the people with involuntary exams in that year, their involuntary exams account for 44% of the total involuntary exams for the year. While the people with five or more involuntary exams account for two percent of people with exams in that year, their exams account for 12 percent of the total involuntary exams. Florida ranks 43rd nationally in access to mental health care and has the 4th highest rate of adults with mental illnesses who are uninsured. At $39.55 per capita, spending for community-based treatment ranks 49th among all states and the District of Columbia. However, Florida is spending inordinate resources on acute mental health services. Improving access to treatment under this proposal will help Florida avoid unnecessary acute care spending and will afford those with serious mental illnesses an opportunity for hope and recovery.

Modernizing the Baker Act will prevent individuals from entering the justice system, and will respond quickly to individuals who do become involved in the justice system to effectively link them to appropriate services and prevent recidivism. By designing an appropriate and responsive system of care for individuals with serious mental illnesses, severe emotional disturbances, and/or co-occurring substance use disorders, people who otherwise would continue to recycle through the justice system will be served more effectively and efficiently. Public safety will be improved and the rate of individuals accessing more costly services in forensic mental health and criminal justice systems will be reduced.

Recommendation 10

Establish pre and post diversion programs in every circuit throughout Florida for individuals with serious mental illnesses who are at risk of an arrest or charged with a non-violent offense.

Rationale

Pre-Arrest Diversion Program

Over the last several years, mental health units have been developed by law enforcement agencies across the nation to address MH/SUD calls for service. Crisis Intervention Teams, co-responder models, or MH response teams help redirect individuals with mental illness from the judicial system and other high-cost health care systems to lower cost health care interventions. The purpose of these programs is to address the growing issues surrounding mental health, homelessness, and substance abuse challenges each community faces. To deliver quality professional services to the community while minimizing the abuse of 911 and diverting emergency services response. The target population are people who contact 911, or by other means come in to contact with law enforcement and are presenting with a mental health or substance use concern. Teams will assist persons and families in crisis in the community and attempt to restore the person to a pre-crisis level. They will be able to provide direct follow up until the crisis is diverted or resolved. Outcomes of such interventions include:

1. Improving officer and client safety.
2. Redirecting clients with mental health or substance use crisis from the judicial system and other high-cost healthcare systems to lower cost of health care interventions.
3. Improve outcomes of police interactions with people with mental health or substance use concerns.
4. Reducing the number of repeat calls for service for persons with mental illness.
5. Reduction in arrests, reducing contact with an already over-burdened criminal justice system.
6. Reducing emergency room visits, thus reducing costs and drain to an overworked healthcare system.

These response teams are often funded through local county or municipal budgets and are often found in counties and cities that are able to afford to budget for such a team. There are mobile response teams divided among regions, but often response times are much too long, and law enforcement is left to handle the case, often resulting in arrest of a subject suffering from a MH and SUD. All counties and cities should have access to a response team that can respond quickly.

Post-Arrest Diversion

Florida Statutes 394.47891, 394.47892, and 397.334 all provide the ability for each jurisdiction to create a veteran's court, mental health court, and drug court. The issue is that it is optional, and counties must secure funding from sources other than the state to operate. This is achievable by those jurisdictions that can afford to operate them but is often unachievable for those fiscally constrained counties.

Misdemeanor Diversion

All defendants booked into jail should be screened for signs and symptoms of mental illnesses. Individuals charged with misdemeanors who meet involuntary examination criteria should be transferred from the jail to a community-based crisis stabilization unit, as soon as possible. Individuals that do not meet involuntary eligibility should be screened, assessed, and, if necessary, provided with treatment while incarcerated. Eligible defendants who voluntarily agree to participate in a diversion program, should have their legal charges dismissed or modified upon successful completion, in accordance with treatment engagement. Individuals who agree to services should be assisted with linkages to a comprehensive array of community-based treatment, support, and housing services that are essential for successful community re-entry and recovery outcomes. Program participants should be monitored for up to one year following community re-entry to ensure ongoing linkage to necessary supports and services. Eligible participants are likely to be homeless at the time of arrest and are likely to be the most severely psychiatrically impaired. Assisted Out-Patient Treatment (AOT) should be expanded to every circuit and county court criminal division in Florida.

Assisted Out-Patient Treatment (AOT)

Florida Senate Bill 12 went into effect July 1, 2016, and it provides the authority for County Court Criminal Judges to use AOT for individuals charged with misdemeanor offenses. AOT serves to identify individuals with histories of repeated admissions to mental health treatment services in the criminal justice and acute care treatment systems that may benefit from court ordered outpatient treatment services. These individuals will have histories of treatment noncompliance and/or refusal to engage in treatment and are unlikely to survive safely in the community without supervision. Individuals that complete AOT can be transitioned into misdemeanor jail diversion to resolve misdemeanor cases. In Miami-Dade (detailed in Appendix 5) the misdemeanor diversion program receives approximately 300 referrals annually. Recidivism rates among program participants have decreased from roughly 75 percent to 20 percent annually.

Felony Diversion

Participants in a felony jail diversion program should be referred for mental health treatment and should meet diagnostic and legal criteria. When a person is accepted into the felony jail diversion program, the State Attorney's Office should inform the court of the plea the defendant will be offered, contingent upon successful program completion. The State Attorney weighs all of the equities involved in a case and determines whether a charge is dismissed, pled to a lesser offense, or will utilize some other appropriate sanction. Like the misdemeanor program, upon successful completion, legal charges should be dismissed or modified based on treatment engagement. All program participants should be assisted in accessing community-based services and supports, and their progress should be monitored and reported back to the court

by program staff. In Miami-Dade, individuals participating in the felony jail diversion program demonstrate reductions in jail bookings and jail days of more than 75 percent, with those who successfully complete the program demonstrating a recidivism rate of just 6 percent. Since 2008, the felony jail program alone is estimated to have saved Miami-Dade County over 31,000 jail days, more than 84 years in jail bed days.

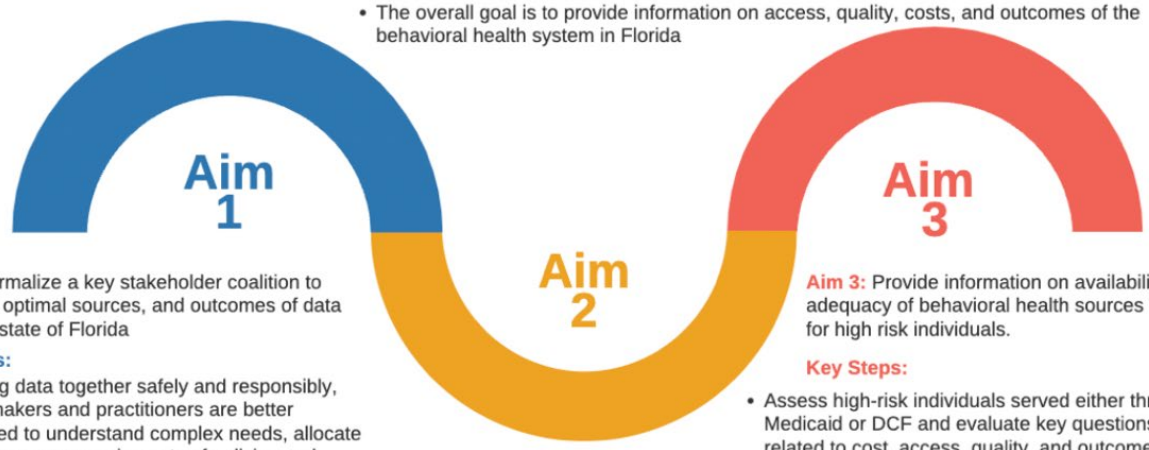
Conclusion

The Commission is honored to serve in the capacity to address the needs of the people of Florida. The ultimate goal is to ensure individuals facing behavioral health issues have access to high quality, affordable, person-centered care. To effectively and efficiently meet the most pressing needs currently facing the mental health system in Florida, it is recommended that the state invest in a redesigned and transformed system of care oriented around ensuring adequate access to appropriate prevention and treatment services in the community, minimizing unnecessary involvement of people with mental illnesses in the criminal justice system, and developing collaborative cross-systems relationships that will facilitate continuous, integrated service delivery across levels of care and treatment settings. In order to have sustainable and pervasive impact, the Commission recognizes that this work cannot happen overnight, and will require systematic changes and improvements. The Commission stands ready to partner with stakeholders across the state in order to achieve the aforementioned recommendations and utilize data to reach those most in need.

Appendix 1

Recommended Data Collaboration Roadmap

The Data Analysis Subcommittee of the Commission on Mental Health and Substance Abuse have designed the following phased approach roadmap for data sharing, collaboration, and analysis in the state of Florida.



Aim 1: Formalize a key stakeholder coalition to determine optimal sources, and outcomes of data within the state of Florida

Key Steps:

- Bringing data together safely and responsibly, policymakers and practitioners are better equipped to understand complex needs, allocate resources, measure impacts of policies and programs, engage in shared decision-making about data use, and institutionalize regulatory compliance.
- Assess county- and state-level data collaboratives to account for specified approaches related to the creation of Memorandum of Understanding (MOU) documents, linking resources across agencies, and assignment of unique identification numbers.

Aim 2: Create a Florida behavioral health data repository or comparable effective system that includes harmonization and cleaning of identified data sources for analyses.

Key Steps:

- Once a statewide data collaborative has been created and information sharing guidelines have been developed, then a behavioral health repository can be formed to include various data from organizations such as (but not limited to) DCF, AHCA, DJJ, and FDLE.
- The overall goal is to provide information on access, quality, costs, and outcomes of the behavioral health system in Florida

Aim 3: Provide information on availability and adequacy of behavioral health sources in Florida for high risk individuals.

Key Steps:

- Assess high-risk individuals served either through Medicaid or DCF and evaluate key questions related to cost, access, quality, and outcomes.
- Integration of behavioral health information from multiple sources have significant improvements in accuracy of personal demographics, diagnoses (including co-morbidities), service use types and frequency of use, and personal outcomes and health care quality
- Establishing a Florida Behavioral Health Data Repository (FBHDR) oversight steering committee can identify appropriate data sources and can guide and prioritize analytic direction and initiatives.

Appendix 2

Improving Outcomes

The Commission's Data Strategy for improving outcomes will include the following aims aligned to statute direction (§394.9086, F.S.):

Outcome 1: Describe the continuum of services available for Floridians' mental health and substance use disorders. Descriptive statistics will be used to report on the number of people and rates of utilization for the continuum of mental health and substance use services spanning from disease prevention to screening and detection, and from treatment to recovery support services that maintain sobriety and prevent relapse. Comparisons will be made among geographic areas, payers, Managing Entities, health systems, facility, or provider classifications. Claims-based methods will be used to estimate health care expenditures per service and per sub-classification. Particular emphasis will be made to quantifying the utilization of telehealth services for people with mental illnesses and/or substance use disorders. The number and trend of prescribing providers for medication-assisted therapy (MAT) will be reported, with respect to changes in certification requirements and clinical sub-specialty (e.g., primary care, obstetric, addiction medicine). The number and trend of mental health providers will be reported, including, but not limited to, psychiatrists, nurse psychiatrists, licensed certified social workers, licensed mental health counselors, and psychologists. The number and trend of certified community health workers as peer supports or targeted case managers for mental health will be presented. Trend data will be presented spanning before 2020, when available, to compensate for exacerbating effects of COVID-19 on mental health and substance use.

Outcome 2: Quantify the effectiveness of mental health care in Florida. The Commission will define a list of benchmarked performance measures that the Commission should use to evaluate the quality of mental health care delivery (process measures) and mental health outcomes (outcome measures). We recommend the development of a statewide behavioral health dashboard. For example, the percentage of children in a clinical practice who have documented evidence of mental health screening using the PSC-17 survey or similar instrument is measured and indicative of high-quality practice. The number of suicides or near-suicides would be a late-stage disease outcome measure. Employment or housing would be positive outcome measures of interest. Descriptive statistics will be used to show the trends of these performance measures. These performance measures, when possible, will be analyzed by subgrouping according to geographic distribution, payer, Managing Entity, intervention, health system, facility, or attributable provider classification.

Outcome 3: Identify barriers and deficiencies in the delivery of mental health services in Florida. Performance measures from Recommendation 8 that fall below national medians will be highlighted as opportunities for improvement, and will indicate either ineffective programs, systems of programs, or lack of programs. In addition, the Subcommittee will identify data sources to inform the Commission's examination of prevention services; hotline access and utilization; integration of mental health services within settings of physical health care delivery; telehealth access and reimbursement to providers; workforce training sites, faculty number, and trainee slots; access to MAT providers for pregnant women with substance use disorder; number and variety of school-based programs for preventing bullying, promoting mental health, and diverting from need for involuntary examination; number and rate of drug court utilization and referrals; and number, funding, and outcomes of community re-entry programs for justice-involved people with mental illness and/or substance use disorder.

Outcome 4: Modeling of proposed service changes. Modeling and sensitivity analyses will be performed for the Commission on programs or rule changes, with impacts calculated at least on expected health outcomes and expenditures.

Outcome 5: Surveillance of Mental Health. The Commission will develop and maintain a directory of currently available data sources related to the status of population mental health in Florida. This directory will include national, state, and local data sources. The primary purpose of this directory is to make data sources readily accessible to the Commissioners and other policy decisionmakers. To protect privacy and confidentiality, the specific datasets will still be housed and maintained by the respective data sources. The directory itself does not contain specific datasets but instead provides the Commissioners and other policy decisionmakers information on: (1) the appropriate data sources that can potentially address research questions and policy concerns, and (2) how to access those relevant datasets. The directory, at a minimum, will include the following information about the data sources: a brief description of the source, what specific type of data is included in the source, who owns and/or maintains the source, when the source is updated (i.e., its periodicity), how it is benchmarked, and how to access the data.

Appendix 3

National Frameworks

There are many national frameworks that may provide useful guidance in developing core categories or domains of quality care metrics. The following represent just a handful of examples that the workgroup may consider:

- Institute of Medicine (IOM) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Outlines the six aims of high-quality health care: (1) Safe, (2) Effective, (3) Patient-centered, (4) Timely, (5) Efficient, and (6) Equitable, and provides recommendations on improving the quality of health care for mental and substance use conditions. https://www.ncbi.nlm.nih.gov/books/NBK19823/

- National Committee for Quality Assurance (NCQA) Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care. Provides a potential framework encouraging a shift from administrative metrics to quality focused metrics and focuses on three levels of management: (1) State & Federal (Macro level) to set priorities and direct resources through regulations and financial support, (2) Managed Care (Meso level) – manage delivery of evidence-based care, and (3) Facility/Provider (Micro level) – provide evidence-based treatment and services to support whole-person care.
  https://www.ncqa.org/wp-content/uploads/2021/07/20210701_Behavioral_Health_Quality_Framework_NCQA_White_Paper.pdf

- American Society of Addiction Medicine (ASAM) Standards of Care for the Addiction Specialist Physician. The Standards identify six practice domains: (1) Assessment and Diagnosis, (2) Withdrawal Management, (3) Treatment Planning, (4) Treatment Management, (5) Care Transitions and Care Coordination, and (6) Continuing Care Management. Reference: https://www.asam.org/docs/default-source/advocacy/performance-measures-for-the-addiction-specialist-physician.pdf

- Centers for Disease Control and Prevention (CDC) Four Domains of Chronic Disease Prevention. These key areas are: (1) Epidemiology and Surveillance, (2) Environmental Approaches, (3) Health Care System Interventions, and (4) Community Programs Linked to Clinical Services. Reference: https://www.cdc.gov/chronicdisease/center/nccdphp/how.htm

- Association of State and Territorial Health Officials (ASTHO) and National Association of State Alcohol and Drug Abuse Directors (NASADAD) Preventing Opioid Misuse and Overdose in the States and Territories: A Comprehensive Public Health Framework to Address the Opioid Crisis. This framework recognizes the need for a comprehensive, cross-sector response to the opioid crisis leveraging leadership and cross-sector partnerships across four strategies: (1) Training and Education, (2) Monitoring and Surveillance, (3) Treatment, Recovery and Harm Reduction, and (4) Primary and Overdose Prevention.
  Reference: https://my.astho.org/opioids/home

There are also existing national standards for tracking quality of care and health outcomes that should be considered for inclusion in the Florida substance abuse and mental health metrics. This section references metrics that would provide a national reference for benchmarking and monitoring improvement at the state and local levels. Sample topics and measures are listed below, but the list is not exhaustive. Please note that some measures are included in more than one national standard described below.

- NCQA Healthcare Effectiveness Data and Information Set (HEDIS): https://www.ncqa.org/hedis/

Domain	Sample Measures
Effectiveness of Care	• Follow-Up After Emergency Department Visit for Mental Illness. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. • Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder. • Adherence to Antipsychotic Medications for Individuals with Schizophrenia. • Pharmacotherapy for Opioid Use Disorder.
Access/Availability of Care	• Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.
Utilization	• Identification of Alcohol and Other Drug Services. • Mental Health Utilization.
Measures Reported Using Electronic Clinical Data Systems	• Depression Screening and Follow-Up for Adolescents and Adults. • Depression Remission or Response for Adolescents and Adults. • Unhealthy Alcohol Use Screening and Follow-Up.

- Centers for Medicare and Medicaid Services: Core Quality Measures Collaborative (CQMC) Behavioral Health Dataset: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures

Topic	Sample Measures
Depression	• Depression Response at Six Months. • Depression Response at Twelve Months.
Serious Mental Illness	• Adherence to Antipsychotic Medications for Individuals with Schizophrenia. • Metabolic Monitoring for Children and Adolescents on Antipsychotics. • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

Tobacco, Alcohol, and Other Substance Use	• --Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. • --Pharmacotherapy for Opioid Use Disorder.
Other	• --Follow-Up After Hospitalization for Mental Illness. • --Follow-Up After Emergency Department Visit for Mental Illness.

Healthy People 2030: https://health.gov/healthypeople

Domain	**Sample Indicators**
Addiction	• --Increase the proportion of people with a substance use disorder who got treatment in the past year. • --Reduce the proportion of people who had drug use disorder in the past year. • --Increase the proportion of people who get a referral for substance use treatment after an emergency department visit.

Mental Health and Mental Disorders	• --Increase the proportion of people with substance use and mental health disorders who get treatment for both.
	  ■ Increase the proportion of primary care visits where adolescents and adults are screened for depression.
	  ■ Increase the proportion of children and adolescents with symptoms of trauma who get treatment.
	  ■ Increase the proportion of adults with serious mental illness who get treatment.
	• -- Reduce emergency department visits related to nonmedical use of prescription opioids

Appendix 4

Section 1006.05, Florida Statutes, Amendment to Recommendation 6

1006.05 Section 1. Subsection (1) to be added. Pursuant to section 394.491 and to further promote the effective implementation of a coordinated system of care pursuant to 394.4573 and 394.495 each school district that provides mental health assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance use diagnosis and students at high risk of such diagnoses shall be guided by and adhere to the principles of the child and adolescent mental health treatment and support system.
1006.05 Section 1. Subsection (2) (a) to be added. School districts shall contract with Managing Entities to provide children's care coordination for students with complex behavioral health needs who continue to experience adverse outcomes due to their unmet needs or inability to engage. Care coordination is as defined in 394.573(1)(a).

1006.05 Section 1. Section (2) (b) to be added. School districts shall address recommendations from the Managing Entity children's care coordinator whenever a student is identified as having experienced an involuntary admission to an acute care psychiatric facility upon the return of the student to the school setting.

1006.05 Section 1. Subsection (2) to be added. Pursuant to s. 394.494(1) Each school district shall meet the general performance outcomes for the child and adolescent mental health treatment and support system.
(This recommendation would connect school districts with the mental health system of care and reads:
394.494 General performance outcomes for the child and adolescent mental health treatment and support system.—
(1) It is the intent of the Legislature that the child and adolescent mental health treatment and support system achieve the following performance outcomes within the target populations who are eligible for services:
(a) Stabilization or improvement of the emotional condition or behavior of the child or adolescent, as evidenced by resolving the presented problems and symptoms of the serious emotional disturbance recorded in the initial assessment.
(b) Stabilization or improvement of the behavior or condition of the child or adolescent with respect to the family, so that the child or adolescent can function in the family with minimum appropriate supports.
(c) Stabilization or improvement of the behavior or condition of the child or adolescent with respect to school, so that the child can function in the school with minimum appropriate supports.
(d) Stabilization or improvement of the behavior or condition of the child or adolescent with respect to the way he or she interacts in the community, so that the child or adolescent can avoid behaviors that may be attributable to the emotional disturbance, such as substance abuse, unintended pregnancy, delinquency, sexually transmitted diseases, and other negative consequences.)

Revise 397.96 Case management for complex substance abuse cases.— Change case management to care coordination as defined in 394.573(1)(a).
397.96 Section (1) Replace case management with care coordination.
397.96 Section (2) Replace case manager with care coordinator.
397.96 Section (3) Replace case management with care coordination.
397.96 Section (4) Replace case manager with care coordinator.
397.96 Section (5) Replace case manager with care coordinator.

Appendix 5

MIAMI-DADE FORENSIC ALTERNATIVE CENTER (MD-FAC) PROGRAM

Since August 2009, the Miami-Dade Criminal Mental Health Project has been diverting individuals with mental illnesses committed to the Florida Department of Children and Families from placement in state forensic facilities to placement in community-based treatment and forensic services. Participants include individuals charged with 2nd and 3rd degree felonies that do not have significant histories of violent felony offenses and are not likely to face incarceration if convicted of their alleged offenses. Participants are adjudicated incompetent to proceed to trial or not guilty by reason of insanity.

Unlike individuals admitted to state forensic treatment facilities, individuals served by MD-FAC are not returned to jail upon restoration of competency, thereby decreasing burdens on the jail and eliminating the possibility that a person may decompensate while in jail and require readmission to a state facility. To date, the project has demonstrated more cost-effective delivery of forensic mental health services, reduced burdens on the county jail in terms of housing and transporting defendants with forensic mental health needs, and more effective community re-entry and monitoring of individuals who, historically, have been at high risk for recidivism to the justice system and other acute care settings. Individuals admitted to the MD-FAC program are identified as ready for discharge from forensic commitment an average of 52 days (35 percent) sooner than individuals who complete competency restoration services in forensic treatment facilities and spend an average of 31 fewer days (18 percent) under forensic commitment. The average cost to provide services in the MD-FAC program is roughly 32 percent less expensive than services provided in state forensic treatment facilities.

4) Revise restoration protocols.
5) Address operational inefficiencies.
    a. Evaluator training, availability, and speed.
    b. Evaluation templates.
    c. Limit multiple evaluations
    d. Case managers and court liaisons.
    e. Court case management – centralized calendars, frequent reviews, and teams.
        i. Centralized calendars
        ii. Frequent reviews
        iii. Teams
6) Address training, recruitment, and retention of staff.
7) Coordinate and use data.
8) Develop robust community-based treatment and supports for diversion and re-entry.

Appendix 6

FISCAL YEAR 20-21 Individuals Served Each Month – Unduplicated Monthly

Clients Served	Column Labels												
Row Labels	July	August	September	October	November	December	January	February	March	April	May	June	Grand Total
AMH	**51,207**	**50,373**	**49,769**	**49,854**	**46,511**	**47,316**	**48,441**	**48,222**	**49,600**	**50,698**	**49,929**	**49,345**	**591,265**
CSU/Inpatient	2,852	2,898	2,784	2,733	2,556	2,575	2,715	2,611	2,883	2,725	2,789	2,517	32,638
Outpatient	47,106	46,251	45,736	45,855	42,708	43,422	44,454	44,273	45,363	46,653	45,636	45,343	542,800
Residential	1,249	1,224	1,249	1,266	1,247	1,319	1,272	1,338	1,354	1,320	1,504	1,485	15,827
ASA	**22,699**	**23,014**	**23,060**	**23,563**	**22,474**	**21,490**	**22,628**	**22,512**	**23,125**	**23,140**	**24,273**	**23,500**	**275,478**
Inpatient Detoxification	1,216	1,330	1,282	1,359	1,294	1,218	1,317	1,266	1,313	1,320	1,470	1,247	15,632
Outpatient	19,715	19,899	19,903	20,260	19,310	18,449	19,507	19,517	19,900	19,885	20,597	20,040	236,982
Residential	1,343	1,340	1,430	1,486	1,456	1,427	1,471	1,426	1,552	1,559	1,837	1,774	18,101
Detox	425	445	445	458	414	396	333	303	360	376	369	439	4,763
CMH	**9,094**	**8,981**	**9,485**	**9,556**	**8,619**	**9,132**	**9,425**	**9,817**	**10,457**	**10,440**	**10,657**	**10,379**	**116,042**
CSU/Inpatient	358	418	549	531	478	494	596	697	631	589	496	362	6,199
Outpatient	8,689	8,524	8,900	8,996	8,122	8,614	8,792	9,082	9,803	9,832	10,143	9,999	109,496
Residential	47	39	36	29	19	24	37	38	23	19	18	18	347
CSA	**2,447**	**2,419**	**2,520**	**2,572**	**2,520**	**2,684**	**2,597**	**2,691**	**2,840**	**2,935**	**3,235**	**2,757**	**32,217**
Inpatient Detoxification	2						2	1		1			6
Outpatient	2,303	2,277	2,375	2,427	2,373	2,533	2,461	2,552	2,713	2,810	3,097	2,620	30,541
Residential	142	142	145	145	147	151	134	138	127	124	138	137	1,670
Grand Total	**85,447**	**84,787**	**84,834**	**85,545**	**80,124**	**80,622**	**83,091**	**83,242**	**86,022**	**87,213**	**88,094**	**85,981**	**1,015,002**

FISCAL YEAR 20-21 Individuals Added to the Waitlist

Clients added to wait list	Sum of Added To Wait List
AMH	**1,315**
CAT	27
CCT	204
CSU/Inpatient	70
FACT	222
Outpatient	382
Residential	388
Forensic MT	22
ASA	**5,117**
Care Coordination	8
Inpatient Detoxification	21
Outpatient	411
Residential	4,677
CMH	**809**
CAT	681
Outpatient	128
CSA	**9**
Residential	9
Grand Total	**7,250**

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:	CS/CS/SB 1098
INTRODUCER:	Children, Families, and Elder Affairs Committee, Judiciary Committee and Senator Burton
SUBJECT:	Withholding or Withdrawal of Life-prolonging Procedures
DATE:	March 14, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Collazo	Cibula	JU	**Fav/CS**
2.	Delia	Cox	CF	**Fav/CS**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1098 regulates the authority of a court-appointed guardian to consent to withhold or withdraw life-prolonging procedures, or sign an order not to resuscitate, on behalf of a ward. The bill allows the ward's wishes to be followed without delay, but still requires court approval to withhold or withdraw life-prolonging procedures in some cases.

Specifically, the bill creates a statute that:

- Authorizes a guardian of a ward's person to petition a court for authority to consent to withhold or withdraw life-prolonging procedures, if the guardian lacks sufficient authority to consent or if the proposal is in conflict with the wishes of the ward or the ward's next of kin.
- Requires the court to hold a hearing on the petition if it has been notified of an objection or conflict, or if the court has insufficient information to determine whether the criteria for granting the requested authority has been met.
- Requires the court to hold a preliminary hearing within 72 hours after the petition is filed, if a hearing is required and exigent circumstances are alleged, and either rule on the requested relief immediately or conduct an evidentiary hearing within 4 days.
- Allows a guardian without vested authority to consent to the withholding or withdrawal of life-prolonging procedures, without a hearing or prior court approval, if:
  - The ward is in a hospital and the ward's primary physician and at least one other consulting physician document that the ward's death is imminent;

- The guardian has notified known next of kin as to the intent to withhold or withdraw life-prolonging procedures and there is no known objection to the withholding or withdrawing of life-prolonging procedures by the ward, the next of kin, or any other interested person, and the hospital ethics committee has met and agrees with the guardian's proposal.

The bill also amends existing statutes to:

- Require initial and annual guardianship plans to state whether an advance directive or an order to not resuscitate listed therein remains in effect, or state the extent to which their authority to make health care decisions has been transferred by the court to the guardian.
- Provide that a surrogate under an advance directive, or an agent under a durable power of attorney, who has retained the authority to make health care decisions under the initial and annual guardianship plans may exercise that authority without additional approval by the court.
- Provide that any authority to make health care decisions that has been transferred by the court to the guardian may be exercised by the guardian, consistent with the advance directive or the durable power of attorney, and without additional approval by the court, unless there is a conflict over or objection to the guardian's proposed exercise of that authority.

The bill takes effect on July 1, 2023.

II. Present Situation:

Guardians and Guardianship

A "guardian" is someone who has been given the legal duty and authority to care for another person or his or her property because of that person's infancy, disability, or incapacity.[1] A "guardianship" is a trust relationship designed to protect vulnerable members of society who do not have the ability to protect themselves.[2] The person for whom a guardian is appointed in a guardianship is called a "ward."[3]

Once a guardian is appointed by the court, the guardian serves as a surrogate decision-maker and makes personal or financial decisions, or both, for the ward.[4] Guardianships are generally disfavored because the ward loses his or her individual and civil rights; a guardian may be appointed only if the court finds there is no less restrictive alternative to a guardianship.[5]

There are two main forms of guardianship: guardianship over the person, and guardianship over the property – each of which may be limited or plenary. For adults, a guardianship may be established when a person has demonstrated that he or she is unable to manage some or all of his

[1] BLACK'S LAW DICTIONARY (11th ed., 2019).
[2] *See* Id.
[3] Section 744.102(22), F.S.
[4] *See* s. 744.102(9), F.S.
[5] Section 744.1012(1)-(2), F.S.; *see also* Disability Rights Florida, *Types of Guardianship*, available at https://disabilityrightsflorida.org/disability-topics/disability_topic_info/types_of_guardianship (last visited March 11, 2023).

or her own affairs.[6] If the adult is competent, this can be accomplished voluntarily. However, if an individual's mental competence is in question, an involuntary guardianship may be established through an adjudication of incompetence, which is determined by a court-appointed examination committee.[7]

A guardianship must be specific to the abilities and needs of the individual and should never be more restrictive than necessary.[8] Consequently, state law recognizes different types of guardians and guardianship arrangements, including[9] preneed guardians;[10] voluntary guardianship;[11] emergency temporary guardianship;[12] limited guardianship;[13] guardian advocates for individuals who have a developmental disability[14] or for individuals receiving mental health treatment;[15] and full (*i.e.* plenary) guardianship.[16]

Powers and Duties of Court-Appointed Guardians

The powers and duties of a court-appointed guardian may include:

- Filing an initial plan and annual reports.[17]
- Making provision for the medical, mental, rehabilitative, and personal care of the person.[18]
- Making residential decisions on behalf of the person.[19]
- Advocating on behalf of the person in institutional and other residential settings.[20]
- Making financial decisions on behalf of the person.[21]

On the other hand, certain actions require specific authority from the court before a guardian may take them.[22] In particular, a guardian may not:

- Commit the ward to a facility, institution, or licensed service provider without formal placement proceedings pursuant to state law.
- Consent on behalf of the ward to the performance on the ward of any experimental biomedical or behavioral procedure, or to the participation by the ward in any biomedical or behavioral experiment. The court may permit such performance or participation only if it is:
    - Of direct benefit to, and is intended to preserve the life of or prevent serious impairment to, the mental or physical health of the ward; or

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[6] *See generally*, s. 744.102(9), F.S. A plenary guardian exercises all delegable rights and powers of the ward after a court has determined that the ward lacks the capacity to perform all of the tasks necessary to care for his or her person or property. Section 744.102(9)(b), F.S.

[7] *See generally*, s. 744.102(12), F.S.; *see also* ch. 744, pt. V, F.S. (regarding the adjudication of incapacity and appointment of guardians).

[8] Section 744.1012(2), F.S.; *see also* Disability Rights Florida, *supra* note 5.

[9] *See generally* Disability Rights Florida, *supra* note 5.

[10] Sections 744.3045 and 744.3046, F.S.

[11] Section 744.341, F.S.

[12] Section 744.3031, F.S.

[13] Section 744.441(1), F.S.; *see also* s. 744.102(9)(a), F.S. (defining "limited guardian").

[14] Sections 744.3085 and 393.12, F.S.

[15] Sections 744.3085 and 394.4598, F.S.

[16] Section 744.441(1), F.S.; *see also* s. 744.102(9)(b), F.S. (defining "plenary guardian").

[17] Section 744.361(6)-(7), F.S.

[18] Section 744.361(13)(f), F.S.

[19] *See* s. 744.361(13)(h), F.S.

[20] Section 744.361(13)(i), F.S.

[21] *See* s. 744.361(12), F.S.

[22] *See* ss. 744.3725 and 744.3215(4), F.S.

- Intended to assist the ward with developing or regaining his or her abilities.
- Initiate a petition for dissolution of marriage for the ward.
- Consent on behalf of the ward to termination of the ward's parental rights.
- Consent on behalf of the ward to the performance of a sterilization or abortion procedure on the ward.[23]

State courts have long recognized the relationship between a guardian and his or her ward is a fiduciary one.[24] A fiduciary relationship exists between two persons when one of them is under a duty to act or to give advice for the benefit of the other, upon matters within the scope of that relationship.[25] Such duties include, but are not limited to, duties to refrain from self-dealing, of loyalty, to not take unfair advantage of the ward and to act in the best interest of the ward, and to disclose material facts.[26]

State law also imposes specific duties upon guardians consistent with the basic duties of a fiduciary, including protecting and preserving the property of the ward as well as his or her overall physical and social health.[27] For example, as noted above, guardians must file initial[28] and annual guardianship reports,[29] and an annual accounting of the ward's property, with the court;[30] such reports may be deemed evidence of a guardian's faithful execution of his or her fiduciary duties.[31]

An overriding concern of reviewing courts is that guardian fiduciaries not breach their duties to their wards or abuse their positions. If a guardian breaches his or her fiduciary duty, the court must take action to protect the ward and the ward's assets.[32]

Initial and Annual Guardianship Plans

Guardians must file an initial guardianship report with the court. It must be filed within 60 days after appointment and, for a guardian of the person, include an initial guardianship plan.[33] Initial guardian plans must contain certain specified information regarding the ward. Among other things, the initial plan must include information regarding the provision of medical, mental, or personal care services for the welfare of the ward; the kind of residential setting best suited for the needs of the ward; the provision of social and personal services for the welfare of the ward; and a list of any preexisting orders not to resuscitate or advance directives.[34]

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[23] *Id.*
[24] *See, e.g., In re Guardianship of Lawrence v. Norris,* 563 So. 2d 195, 197 (Fla. 1st DCA 1990) (noting that the guardian in that case was found to have violated his fiduciary duty as a guardian); *Denarii Systems, LLC v. Tellez,* 2011 WL 13322664 (S.D. Fla. 2011) (recognizing that fiduciary duties may be created by legal proceedings, such as in the case of a guardian and ward).
[25] *Doe v. Evans,* 814 So. 2d 370, 374 (Fla. 2002) (internal citations omitted).
[26] *Capital Bank v. MVP, Inc.* 644 So. 2d 515, 520 (Fla. 3d DCA 1994).
[27] *See generally* s. 744.361, F.S.
[28] Section 744.362, F.S.
[29] Section 744.367, F.S.
[30] Section 744.3678, F.S.
[31] *See generally* s. 744.368, F.S. (directing the clerk of the circuit court to review each initial and annual guardianship report to ensure it contains specified information about the ward).
[32] Section 744.446(5), F.S.
[33] Sections 744.361(6) and 744.362(1), F.S.
[34] *See* s. 744.363(1)(a)-(f), F.S.

Guardians must also file an annual guardianship report with the court. The annual guardianship report must be filed within 90 days after the last day of the anniversary month of appointment. The annual plan must cover the coming fiscal year, ending on the last day in the anniversary month.[35] Similar to the initial guardianship report, the annual guardianship report for a guardian of the person must include an annual guardianship plan[36] containing information regarding the medical and mental health conditions, treatment, and rehabilitation needs of the ward; the residence of the ward; the social condition of the ward; and a list of any preexisting orders not to resuscitate or advance directives.[37]

Determining Incapacity

The process to determine incapacity and appoint a guardian begins with the filing of a petition in the appropriate circuit court. The petition must be served on, and read to, the allegedly incapacitated person. Notice and copies of the petition must also be provided to the attorney for the allegedly incapacitated person and served on all next of kin identified in the petition.[38]

At hearing, the partial or total incapacity of the person must be established by clear and convincing evidence.[39] After finding that a person is incapacitated with respect to the potential exercise of one or more rights, the court must enter a written order of incapacity. A person is deemed incapacitated only as to those rights specified in the court's order.[40] If the order provides that the person is incapable of exercising delegable rights (described below), the court must next consider whether there are any alternatives to guardianship which will sufficiently address the incapacitated person's problems. If not, a guardian will be appointed.[41]

Rights of Incapacitated Persons

A person who has been determined to be incapacitated retains certain rights, regardless of the determination of incapacity, including the right to be treated humanely and with dignity and respect; the right to be protected against abuse, neglect, and exploitation; the right to receive visitors and communicate with others; and the right to privacy.[42]

Certain rights may be removed from a person by an order determining incapacity, but not delegated to a guardian. They include the right to marry (if the right to enter into a contract has been removed, the right to marry is subject to court approval); the right to vote; the right to personally apply for government benefits; the right to have a driver license; the right to travel; and the right to seek or retain employment.[43]

[35] Section 744.367(1), F.S.
[36] Section 744.367(1) and (3)(a), F.S.
[37] Section 744.3675, F.S.
[38] Section 744.331(1), F.S.
[39] Section 744.331(5)(c), F.S.
[40] Section 744.331(6), F.S.
[41] Section 744.331(6)(b), F.S.
[42] *See* s. 744.3215(1)(a)-(o), F.S. (specifying all retained rights).
[43] Section 744.3215(2)(a)-(f), F.S.

Additionally, certain other "delegable" rights may be removed from a person by an order determining incapacity, and also delegated to a guardian. They include the rights to:

- Contract.
- Sue and defend lawsuits.
- Apply for government benefits.
- Manage property or to make any gift or disposition of property.
- Determine his or her residence.
- Consent to medical and mental health treatment.
- Make decisions about his or her social environment or other social aspects of his or her life.[44]

Advance Directives

State law defines an advance directive as a witnessed, oral statement or written instruction that expresses a person's desires about any aspect of his or her future health care, including the designation of a health care surrogate, a living will, or an anatomical gift.[45] Designation of each of these can serve different purposes and have their own unique requirements and specifications under the law.[46]

One type of advance directive, an "order not to resuscitate" or a "do not resuscitate order," results in the withholding of cardiopulmonary resuscitation from an individual if the order is presented to the health care professional treating the patient.[47] For the order to be valid, it must be on the yellow form adopted by the Department of Health, signed by the patient's physician and by the patient, or if the patient is incapacitated, the patient's health care surrogate or proxy, court-appointed guardian, or agent under a durable power of attorney.[48]

It is the responsibility of the Emergency Medical Services provider to ensure that the order form or the patient identification device, which is a miniature version of the form, accompanies the patient.[49] An order not to resuscitate may be revoked by the patient at any time, if signed by the patient, or the patient's health care surrogate, proxy, court-appointed guardian or a person acting under a durable power of attorney.[50]

A power of attorney is a writing that grants authority to an agent to act in the place of the principal.[51] A "durable" power of attorney is a kind of power of attorney that cannot be terminated by the principal's incapacity.[52] Among many other things, a durable power of

[44] Section 744.3215(3)(a)-(g), F.S.
[45] Section 765.101(1), F.S.
[46] *See id.*
[47] *See* Fla. Admin. Code R. 64J-2.018(1).
[48] Section 401.45(3), F.S.; *see also* Fla. Admin. Code R. 64J-2.018(1)-(3).
[49] Fla. Admin. Code R. 64J-2.018(2)(b) and (4).
[50] Fla. Admin. Code R. 64J-2.018(6).
[51] Section 709.2102(9), F.S.
[52] Section 709.2102(4), F.S.; *see also* s. 709.2104 (specifying that a power of attorney is durable if it contains the words: "This durable power of attorney is not terminated by subsequent incapacity of the principal except as provided in chapter 709, Florida Statutes," or similar words that show the principal's intent that the authority conferred is exercisable notwithstanding the principal's subsequent incapacity).

attorney may be used to allow another person to make health care decisions on behalf of an incapacitated principal.[53]

Hospital Ethics Committees

Hospital ethics committees discuss and make recommendations about clinical ethical issues in a hospital.[54] Such committees are a resource for medical staff and administrators in addressing the difficult ethical questions and compliance issues that arise in patient care, including the proper respect for patient confidentiality or concerns about a patient's refusal of life-saving treatment.[55] They are typically multi-disciplinary in nature, consisting of representatives from different departments of the facility, including medicine, nursing, law, pastoral care, and social work.[56]

The Florida Bioethics Network is an organization dedicated to the understanding and resolution of ethical and legal problems arising in health care and research in the state's hospitals, hospices, nursing homes, managed care organizations and teaching institutions.[57]

III. Effect of Proposed Changes:

In 2020, in response to reports that a professional guardian had signed an order not to resuscitate against her ward's wishes, the Legislature began requiring guardians to obtain court approval to sign orders not to resuscitate.[58] Some courts went even further, also requiring court approval for a guardian to consent to withhold or withdraw life-prolonging procedures. These requirements, however, may result in prolonged suffering and be inconsistent with the ward's wishes.

The bill creates or amends several sections within the state's guardianship statutes[59] to regulate the authority of a court-appointed guardian to consent to withhold or withdraw life-prolonging procedures, or to sign an order not to resuscitate, on behalf of his or her ward. The bill allows a ward's wishes to be followed without delay, but still requires court approval to withhold or withdraw life-prolonging procedures in some cases.

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[53] *See id.; see also* The Florida Bar, *Consumer Pamphlet: Florida Power of Attorney, About the Power of Attorney,* available at https://www.floridabar.org/public/consumer/pamphlet13/#about (last visited March 11, 2023).
[54] Alaska Regional Hospital, *Alaska Regional Hospital's Ethics Committee* (Apr. 16, 2018), available at https://www.alaskaregional.com/blog/entry/alaska-regional-hospital-s-ethics-committee; *see also* F. Hajibabaee et al., *Hospital/clinical ethics committees' notion: an overview,* 9 J. MED. ETHICS HIST. MED. 17 (Dec. 18, 2016) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5432947/ (explaining that a healthcare ethics committee or hospital ethics committee is a body of persons established by a hospital or health care institution for the purpose of considering, debating, studying, taking action on, or reporting on ethical issues that arise in patient care) (all sites last visited March 11, 2023).
[55] Alaska Regional Hospital, *supra* note 54.
[56] Thaddeus Mason Pope, *The Growing Power of Healthcare Ethics Committees Heightens Due Process Concerns,* 15 CARDOZO JOURNAL OF CONFLICT RESOLUTION 425 (2014), available at https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1278&context=facsch (last visited March 11, 2023).
[57] Florida Bioethics Network, *About Us*, available at https://fbn.miami.edu/about-us/index.html (last visited March 11, 2023).
[58] Ch. 2020-35, s. 6, Laws of Fla.; *see also* Greg Angel, *DeSantis Signs Florida Guardianship Bill Into Law, Expanding Oversight of Program* (Jun. 19, 2020), Spectrum News 13, available at https://www.mynews13.com/fl/orlando/news/2020/06/19/desantis-signs-florida-guardianship-bill-into-law (last visited March 11, 2023).
[59] Chapter 744, F.S.

Guardianship Powers Regarding Life-Prolonging Procedures

The bill creates s. 744.4431, F.S., entitled "Guardianship power regarding life-prolonging procedures."

The bill authorizes a guardian of a ward's person to petition a court pursuant to the Florida Probate Rules for authority to consent to withhold or withdraw life-prolonging procedures if:

- The right to consent to withhold or withdraw life-prolonging procedures has not been delegated to the guardian in the order appointing the guardian.
- Sufficient authority under the ward's preexisting advance directive or durable power of attorney has not been transferred to the guardian.
- The proposed withholding or withdrawal of life-prolonging procedures is in conflict with the wishes, as presently or previously expressed, of the ward, the ward's next of kin, or any interested person.

The bill requires the petition by the guardian to:

- Describe the proposed action for which court approval is sought and supply documentation of any existing authority for the guardian to make health care decisions for the ward.
- Notify the court of any known objections to the proposed action or of conflicts between the guardian's proposed action to withhold or withdraw life-prolonging procedures and the wishes, presently or previously expressed, of the ward, the ward's next of kin, or any interested person.
- Describe the circumstances or evidence and include affidavits or supporting documentation showing that the proposed action satisfies the applicable criteria in the statutes providing for health care decision proxies[60] or governing individuals who are in a persistent vegetative state.[61]

The bill requires the guardian to serve notice of the petition, and of any hearing, upon interested persons and the ward's next of kin, unless waived by the court.

The bill requires the court to hold a hearing on the petition if it has been notified of an objection or conflict, or if the court has insufficient information to determine whether the criteria for granting the requested authority has been met. If a hearing is required and exigent circumstances are alleged, the court must hold a preliminary hearing within 72 hours after the petition is filed and do one of the following:

- Rule on the relief requested immediately after the preliminary hearing.
- Conduct an evidentiary hearing within 4 days after the preliminary hearing and rule on the relief requested immediately after the evidentiary hearing.

The bill provides that notwithstanding the requirements for court approval described in the bill, and if authority to withhold or withdraw life-prolonging procedures has not been vested in

[60] *See generally* s. 765.401, F.S.
[61] *See generally* s. 765.404, F.S.

another person, the guardian may, without a hearing or prior court approval, consent to the withholding or withdrawal of life-prolonging procedures if:

- The ward is in a hospital and the ward's primary physician and at least one other consulting physician document that the ward's death is imminent;
- The guardian has notified known next of kin as to the intent to withhold life-prolonging procedures and there is no known objection to the withholding or withdrawing life-prolonging procedures by the ward, the next of kin, or any other interested person; and
- The hospital ethics committee has met and agrees with the guardian's proposal to withhold or withdraw life prolonging procedures. If the hospital does not have an ethics committee, it may arrange for this requirement to be satisfied by an ethics committee of another facility or a community-based ethics committee approved by the Florida Bioethics Network.

Rights of Persons Determined Incapacitated

State law includes a list of rights that may be removed from a person by an order determining incapacity and which may be delegated to a guardian.[62] The bill amends this list to include the right to consent to the withholding or withdrawal of life-prolonging procedures[63] and subject to court approval as provided in the bill, if there are not valid advance directives, as defined in s. 765.101, and no valid alternative to guardianship that will sufficiently address the withholding or withdrawal of life-prolonging procedures.

Initial and Annual Guardianship Plans

The bill amends the statutes regulating the contents of initial[64] and annual[65] guardianship plans. Specifically, with respect to any signed orders not to resuscitate[66] or preexisting advance directives identified in the plans,[67] the bill requires the plan to state whether the order or the directive has been revoked, modified, or suspended by the court, or the extent to which authority under an order or directive has been transferred by the court to the guardian. The plan must also state the date of any revocation, modification, or suspension by the court.

The bill provides that either a surrogate designated by the ward in an advance directive, or an agent designated by the ward in a durable power of attorney, who retains authority to make health care decisions under the guardianship plan, may exercise that authority without additional approval by the court. Any authority of a surrogate or agent that has been transferred to a guardian may be exercised by the guardian, consistent with the advance directive or durable power of attorney, without additional approval by the court. And any power transferred to a

[62] Section 744.3215(3), F.S.
[63] Section 765.101(12), F.S., defines "life-prolonging procedure" to mean any medical procedure, treatment, or intervention, including artificially provided sustenance and hydration, which sustains, restores, or supplants a spontaneous vital function. The term does not include the administration of medication or performance of medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.
[64] Section 744.363, F.S.
[65] Section 744.3675, F.S.
[66] *See* s. 401.45(3), F.S., for a full description of the requirements for issuance of a valid order not to resuscitate.
[67] *See* s. 765.101(1), F.S., defines "advance directive" to mean a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care or health information, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V of this chapter..

guardian to execute an order not to resuscitate or to consent to withhold or withdraw life-prolonging procedures is subject to court approval pursuant to the new statute created by the bill (s. 744.4431, F.S.) if there is a conflict over or objection to a proposed exercise of that power.

Guardian Powers upon Court Approval

The bill also implements conforming changes to the statute providing for the powers of guardians upon court approval.[68]

Effective Date

The bill takes effect July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under the bill, a surrogate under an advance directive, or an agent under a durable power of attorney, who has retained the authority to make health care decisions under the initial and annual guardianship plans may exercise that authority without additional approval by the court. Similarly, a guardian to whom the authority to make health care decisions has

[68] Section 744.441, F.S.

been transferred by the court may exercise that authority, consistent with the advance directive or the durable power of attorney and without additional approval by the court, unless there is a conflict over or objection to the guardian's proposed exercise of that authority. Accordingly, surrogates, agents, and guardians will in many cases be able to consent to the withholding or withdrawing of life-prolonging procedures, and sign orders to not resuscitate, without incurring the legal costs associated with seeking and obtaining court approval.

C. Government Sector Impact:

For the reasons stated above in the private sector impact, the bill will allow surrogates, agents, and guardians to in certain circumstances consent to the withholding or withdrawing of life-prolonging procedures, and sign orders to not resuscitate, without court approval. As a result, the bill may result in a positive fiscal impact to the courts from the reduction in workload as a result of less status and evidentiary hearings related to such decisions.

The Office of the State Courts Administrator states that the fiscal impact of the bill is indeterminate due to the unavailability of data needed to quantifiably establish the increase in judicial time and workload as a result of new judicial processes and hearing requirements related to petitions for withholding or withdrawal of life-prolonging procedures of incapacitated persons.[69]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 744.3215, 744.363, 744.3675, and 744.441.

This bill creates section 744.4431 of the Florida Statutes.

IX. Additional Information:

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

CS by Children, Families, and Elder Affairs on March 14, 2023:
The committee substitute:

[69] The Office of the State Courts Administrator, *Agency Analysis of SB 1098*, March 6, 2023 (on file with the Senate Committee on Children, Families, and Elder Affairs).

- Delegates the right to consent to the withholding or withdrawal of life prolonging procedures, as defined in s. 765.101, subject to court-approval, only if there are not valid advance directives, as defined in s. 765.101, and there is also no valid alternative to guardianship that will sufficiently address the withholding or withdrawal of life-prolonging procedures.
- Modifies the conditions under which consent to the withholding or withdrawing of life-prolonging procedures may occur if the authority to withhold or withdraw life-prolonging procedures has not been vested in another person.
- Specifically, a guardian may, with or without court approval, consent to the withholding or withdrawing of life-prolonging procedures only if:
  - The ward is in a hospital and the ward's primary physician and at least one other consulting physician document that the ward's death is imminent;
  - The guardian has notified the next of kin as to the intent to withhold or withdraw life-prolonging procedures and there is no known objection to the withholding or withdrawing of life-prolonging procedures by the ward, the next of kin, or any other interested person; and
  - The hospital ethics committee has met and agrees with the guardian's proposal to withhold or withdraw life-prolonging procedures.

CS by Judiciary on March 7, 2023:
The committee substitute corrects two cross-references.

B. Amendments:

None.

319414

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/14/2023	.	
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The Committee on Children, Families, and Elder Affairs (Burton) recommended the following:

Senate Amendment

Delete lines 42 - 45
and insert:
(h) To consent to the withholding or withdrawal of life-prolonging procedures, as defined in s. 765.101, subject to court-approval, if there are not valid advance directives as defined in s. 765.101 and no valid alternative to guardianship that will sufficiently address the withholding or withdrawal of life-prolonging procedures.

940260

LEGISLATIVE ACTION

Senate	.	House
Comm: RS	.	
03/14/2023	.	
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The Committee on Children, Families, and Elder Affairs (Burton) recommended the following:

Senate Amendment

Delete lines 181 - 186
and insert:
(a) The ward is in a hospital and the ward's primary physician and at least one other consulting physician document that the ward's death is imminent.
(b) The guardian has notified the next of kin as to the intent to withhold or withdraw life-prolonging procedures and there is no known objection to the withholding or withdrawing of

940260

life-prolonging procedures by the ward, the next of kin, or any other interested person.

267664

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/14/2023	.	
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The Committee on Children, Families, and Elder Affairs (Burton) recommended the following:

Senate Substitute for Amendment (940260)

Delete lines 181 - 186
and insert:
(a) The ward is in a hospital and the ward's primary physician and at least one other consulting physician document that the ward's death is imminent.
(b) The guardian has notified known next of kin as to the intent to withhold or withdraw life-prolonging procedures and there is no known objection to the withholding or withdrawing of

267664

life-prolonging procedures by the ward, the next of kin, or any other interested person.

By Senator Yarborough

4-01618A-23 20231146__

A bill to be entitled

An act relating to shared parental responsibility after the establishment of paternity; amending s. 742.011, F.S.; authorizing a parent to request certain determinations and the creation of a parenting plan and time-sharing schedule; amending s. 742.10, F.S.; requiring the determination of parental responsibility and the establishment of a parenting plan, a time-sharing schedule, or child support to be done through a certain action; deleting a provision regarding unchallenged acknowledgment of paternity; amending s. 744.301, F.S.; specifying that a mother of a child born out of wedlock and the father of such child are the natural guardians of the child and subject to the rights and responsibilities of being parents if certain conditions are met; providing an effective date.

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

Section 1. Section 742.011, Florida Statutes, is amended to read:

742.011 Proceedings for determination of paternity, rights, and responsibilities ~~proceedings~~; jurisdiction.—Any woman who is pregnant or has a child, any man who has reason to believe that he is the father of a child, or any child may bring proceedings in the circuit court, in chancery, to determine the paternity of the child when paternity has not been established by law or otherwise. After the birth of the child, a parent may request a

determination of parental responsibility and child support and for the creation of a parenting plan and time-sharing schedule pursuant to chapter 61.

Section 2. Subsection (5) of section 742.10, Florida Statutes, is amended to read:

742.10 Establishment of paternity for children born out of wedlock.—

(5) Regardless of whether paternity is established in an action under s. 742.011 or this section, the determination of parental responsibility and a parenting plan, a time-sharing schedule, or child support must be established in an action brought under s. 742.011 ~~Judicial or administrative proceedings are not required or permitted to ratify an unchallenged acknowledgment of paternity~~.

Section 3. Subsection (1) of section 744.301, Florida Statutes, is amended to read:

744.301 Natural guardians.—

(1) The parents jointly are the natural guardians of their own children and of their adopted children, during minority, unless the parents' parental rights have been terminated pursuant to chapter 39. If a child is the subject of any proceeding under chapter 39, the parents may act as natural guardians under this section unless the court division with jurisdiction over guardianship matters finds that it is not in the child's best interests. If one parent dies, the surviving parent remains the sole natural guardian even if he or she remarries. If the marriage between the parents is dissolved, the natural guardianship belongs to the parent to whom sole parental responsibility has been granted, or if the parents have been

granted shared parental responsibility, both continue as natural guardians. If the marriage is dissolved and neither parent is given parental responsibility for the child, neither may act as natural guardian of the child. The mother of a child born out of wedlock and a father who has signed a voluntary acknowledgment of paternity or established paternity under s. 742.011 or s. 742.10 are the natural guardians of the child and are entitled and subject to the rights and responsibilities of parents. If a father has not established paternity under s. 742.011 or s. 742.10, the mother of a child born out of wedlock is the natural guardian of the child and is entitled to primary residential care and custody of the child unless the court enters an order stating otherwise.

Section 4. This act shall take effect July 1, 2023.

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:	CS/SB 1146
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Yarborough
SUBJECT:	Shared Parental Responsibility After the Establishment of Paternity
DATE:	March 14, 2023 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Tuszynski	Cox	CF	**Fav/CS**
2.			JU	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1146 amends s. 742.011, F.S., to clarify that after the birth of a child a parent may request a determination of parental responsibility and child support and for the creation of a parenting plan and timesharing schedule pursuant to ch. 61, F.S. Absent such a determination of parental responsibility and child support, a mother retains sole parental responsibility and no requirement for timesharing.

The bill amends s. 742.10, F.S., to require that any action to establish paternity must include a determination of parental responsibility and a parenting plan, establish a timesharing schedule, and child support. The bill attaches determinations of parental responsibility and timesharing to the establishment of paternity for a father under ch. 742, F.S.

The bill also amends s. 744.301, F.S., to clarify that an unwed mother and a father who sign a voluntary acknowledgment of paternity or have established paternity through a court judgment are the natural guardians of the child. As such, they are subject to the rights and responsibilities of parents that a married parent would enjoy. If a father has not established paternity, the mother is the natural parent and is entitled to primary residential care and custody of the child.

The bill does not appear to have a fiscal impact to state government or the private sector. See Section V. Fiscal Impact Statement.

The bill is effective July 1, 2023.

II. Present Situation:

Rights and Responsibilities of a Parent

In a dissolution of marriage with children or in a paternity case, issues of parenting must be worked out between the parties. The United States Supreme Court and Florida courts have consistently ruled that a parent's desire and right to the companionship, care, custody, and management of his or her children is an important interest that warrants deference and, absent a powerful countervailing interest, protection.[1] Further, a parent has general responsibilities owed to his or her children, including supervision, health and safety, education, care, and protection. In Florida, parenting is broken down into two distinct components: parental responsibility (decision-making) and timesharing (physical visitation with the child based on a parenting plan).

Under current law, issues related to timesharing and parental responsibility do not have to be addressed in a final judgment of paternity; a court is only required to address child support in such a paternity action.[2]

Child Support

Under s. 61.29, F.S., each parent has a fundamental obligation to support his or her minor or legally dependent child. A court must order either or both parents owing a duty of support to the child to pay support pursuant to s. 61.30, F.S. A parent's child support obligation is calculated based on the child support guidelines established in s. 61.30, F.S. These guidelines use a mathematical formula to develop the basic child support obligation of each parent. The court may not deviate from the basic child support obligation provided under the guidelines by more than five percent when establishing the child support award except in very limited circumstances, such as when the court orders substantial time-sharing.

Timesharing and Parental Responsibility

Section 61.13, F.S., provides guidelines to assist courts in determining matters related to parenting[3] and time-sharing[4] of minor children in actions under ch. 61, F.S., in accordance with the best interests of the child while balancing the rights of parents. As a threshold consideration, the Legislature has declared that:[5]

> It is the public policy of this state that each minor child has frequent and continuing contact with both parents after the parents separate or the marriage of the parties is dissolved and to encourage parents to share the rights and responsibilities, and joys, of childrearing. There is no

[1] *See* Lassiter v. Dep't of Soc. Services of Durham Cnty., N. C., 452 U.S. 18 (1981) (calling the right "plain beyond the need for multiple citation" and quoting Stanley v. Illinois, 405 U.S. 645 (1972)); I.T. v. Dep't of Children & Families, 338 So. 3d 6 (Fla. 3d DCA 2022); D.M.T. v. T.M.H., 129 So. 3d 320 (Fla. 2013); F.R. v. Adoption of Baby Boy Born November 2, 2010, 135 So. 3d 301 (Fla. 1st DCA 2012); In Interest of J.D., 510 So. 2d 623 (Fla. 1st DCA 1987).
[2] Section 742.031(1), F.S.
[3] Parenting or parental responsibility refers to the responsibility and right to make important decisions about the child's welfare, such as education and medical care after the parents separate.
[4] Time-sharing refers to the time, including overnights and holidays, which the child spends with each parent. Section 61.046(23), F.S.
[5] Section 61.13(2)(c)1., F.S.

> presumption for or against the father or mother of the child or for or against any specific time-sharing schedule when creating or modifying the parenting plan of the child.

Therefore, current law does not provide a presumption in favor of a specific time-sharing schedule, and the court sets a time-sharing schedule when the parties are unable to agree. In establishing time-sharing, the court must consider the best interests of the child[6] as the primary consideration and evaluate all factors affecting the welfare and interests of the child and the circumstances of the family, including, but not limited to the:

- Demonstrated capacity and disposition of each parent to facilitate and encourage a continuing parent-child relationship, honor the time-sharing schedule, and accommodate necessary changes.
- Anticipated division of parental responsibilities after the litigation, including the extent to which parental responsibilities will be delegated to third parties.
- Demonstrated capacity and disposition of each parent to determine, consider, and act upon the needs of the child.
- Length of time the child has lived in a stable environment and the desirability of maintaining continuity.
- Geographic viability of the parenting plan, with special attention paid to the needs of school-age children, and the amount of time to be spent traveling to effectuate the parenting plan.
- Mental health, physical health, and moral fitness of the parents.
- Home, school, and community record of the child.
- Reasonable preference of the child.
- Demonstrated knowledge, capacity, and disposition of each parent to be informed of the circumstances of the minor child, including, the child's friends, teachers, and daily activities.
- Demonstrated capacity and disposition of each parent to provide a consistent routine and communicate with and keep the other parent informed of issues and activities regarding the minor child.
- Evidence of domestic violence, sexual violence, child abuse, child abandonment, or child neglect, or that either parent has ever knowingly provided false information about such matters.
- Particular parenting tasks customarily performed by each parent, including the extent to which parenting responsibilities were undertaken by third parties.
- Demonstrated capacity and disposition of each parent to participate and be involved in the child's school and extracurricular activities.
- Demonstrated capacity and disposition of each parent to maintain an environment for the child which is free from substance abuse.
- Capacity and disposition of each parent to protect the child from the ongoing litigation regarding child custody.
- Developmental stages and needs of the child and the demonstrated capacity and disposition of each parent to meet the child's developmental needs.[7]

[6] Section 61.13(2)(c), F.S.
[7] Section 61.13(3), F.S.

A court may prescribe a "parenting plan"[8] by which the parents are ordered to share decision-making and physical custody of the minor child. The parenting plan may order parents to exercise shared parental responsibility, it may delegate decision-making authority over specific matters to one parent, or it may grant a parent sole parental responsibility over the minor child. Common issues concerning a minor child may include education, healthcare, and social or emotional wellbeing. Further, once a court has established parental responsibility, a parenting plan, or a time-sharing schedule, such plan may not be modified without a showing of a substantial, material, and unanticipated change in circumstances and a determination that the modification is in the best interests of the child.[9]

Establishment of Paternity

Pursuant to ch. 742, F.S., paternity of a child born to an unmarried mother may be established by adjudicatory hearing, voluntary acknowledgement, by the Department of Revenue,[10] or by court order in response to a Petition to Establish Paternity.[11] Shared parental responsibility under ch. 61, F.S., does not apply until an order adjudicating paternity is entered. Without a court order specifically establishing a timesharing schedule and parental responsibility, putative fathers whose paternity is established through ch. 742, F.S., are left without defined rights relating to his relationship with the child.

Adjudicatory Hearing

If paternity has been raised and determined as a matter of law within an adjudicatory hearing brought under the statutes governing inheritance, or dependency under workers' compensation or a similar compensation program, such adjudication establishes the paternity of the father.[12] When paternity is established through an adjudicatory hearing, the court is not required to establish parental responsibilities or a timesharing schedule.

Affidavit or Voluntary Acknowledgment

Parents may also establish paternity by agreement and both parents may sign an affidavit of voluntary acknowledgement of paternity under oath in the presence of a notary or under oath in the presence of two witnesses.[13] This establishes a rebuttable presumption of paternity and a sixty-day revocation period is triggered. During the sixty-day revocation period, either the mother or the alleged father may rescind the acknowledgement of paternity.[14] After the sixty-day period, the signed voluntary acknowledgement of paternity constitutes an establishment of paternity and a court may only allow a collateral challenge based on fraud, duress, or material mistake of fact.[15] Alternatively, both parents may establish paternity by executing an affidavit of

[8] A "parenting plan" is a document created to govern the relationship between the parents relating to decisions which must be made regarding the child and must contain a timesharing schedule for the parents and child. Section 61.046(14), F.S. If a parenting plan is agreed to by the parties, it must be approved by the court.
[9] Section 61.13.(3), F.S.
[10] A request for timesharing or visitation may not be filed in a DOR action for paternity. *See* s. 409.2564, F.S.
[11] Section 742.011, F.S.
[12] Section 742.10, F.S.
[13] *Id.*
[14] Section 742.10(1), F.S.
[15] Section 742.10(4), F.S.

paternity or a stipulation of paternity and filing it with the clerk of court.[16] If both parents sign the affidavit or stipulation of paternity, paternity is established at the time the affidavit is filed with the clerk of court.

Department of Revenue

In the absence of an acknowledgement or affidavit of paternity, the Department of Revenue (DOR) may also establish paternity under s. 409.256, F.S. The DOR may commence a paternity proceeding or a paternity and child support proceeding when:

- Paternity has not otherwise been established;
- No one is named as the father on the child's birth certificate or the person named as the father is the putative father named in an affidavit;
- The mother was unmarried at the time of the child's conception and birth; or
- The DOR is providing services under Title IV-D.[17]

Court Order

Section 742.011, F.S., permits a woman who is pregnant or has a child, any man who has reason to believe that he is the father of a child, or any child, to bring proceedings in court to determine the paternity of the child when paternity has not been established by law or otherwise. Section 742.031, F.S., requires the court to conduct a hearing on the complaint and establish paternity if the court finds the alleged father is the father of the child. Upon a determination of paternity, the court must decide on the ability of the parents to support the child.[18] In a matter brought under ch. 742, F.S., the court is not required to decide on an appropriate parenting plan or time-sharing schedule.[19] This can result in the establishment of paternity and a child support order issued without providing a specific timesharing schedule with the child.

The mother of a child born out of wedlock is the natural guardian of the child and is entitled to primary residential care and custody unless a court enters an order stating otherwise.[20] If an order establishing paternity includes a child support award but does not provide a parenting plan or timesharing schedule, the parent receiving the child support (obligee) is deemed to have all of the timesharing and sole parental responsibility without prejudice to the other parent (obligor).[21] Similarly, if a paternity judgment makes no child support award and does not provide a parenting plan, the mother is presumed to have all of the timesharing over the child as well as sole parental responsibility. As such, an order simply establishing paternity and nothing more, can leave a father with no decision-making authority or timesharing with the child.

III. Effect of Proposed Changes:

The bill amends s. 742.011, F.S., to clarify that after the birth of a child a parent may request a determination of parental responsibility and child support and for the creation of a parenting plan

[16] Section 742.10(1), F.S.
[17] Section 409.256(2), F.S.
[18] Section 742.031(1), F.S.
[19] *Id*.
[20] Section 744.301(1), F.S.
[21] Section 742.031(2), F.S.

and timesharing schedule pursuant to ch. 61, F.S. Absent such a determination, a mother retains sole parental responsibility and no requirement for timesharing.

The bill amends s. 742.10, F.S., to require that any action to establish paternity must include a determination of parental responsibility and a parenting plan, establish a timesharing schedule, and child support. The bill requires that parental responsibility and timesharing must be established in addition to the establishment of paternity for a father.

The bill also amends s. 744.301, F.S., to clarify that an unwed mother and a father who sign a voluntary acknowledgment of paternity or have established paternity through a court judgment are the natural guardians of the child. As such, they are subject to the rights and responsibilities of parents that a married parent would enjoy. If a father has not established paternity, the mother is the natural parent and is entitled to primary residential care and custody of the child.

The bill is effective July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 742.011, 742.10, and 744.301 of the Florida Statutes.

IX. Additional Information:

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

CS by Children, Families, and Elder Affairs on March 14, 2023:
The committee substitute reinserts inadvertently deleted language that is federally required to receive certain federal grants related to the operation of child support programs and removes a phrase for clarity and concision made unnecessary by a subsequent cross-reference.

B. Amendments:

None.

557318

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/14/2023	.	
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The Committee on Children, Families, and Elder Affairs (Yarborough) recommended the following:

Senate Amendment (with title amendment)

Delete lines 41 - 64
and insert:
brought under s. 742.011. Judicial or administrative proceedings are not required or permitted to ratify an unchallenged acknowledgment of paternity.

Section 3. Subsection (1) of section 744.301, Florida Statutes, is amended to read:

744.301 Natural guardians.—

557318

(1) The parents jointly are the natural guardians of their own children and of their adopted children, during minority, unless the parents' parental rights have been terminated pursuant to chapter 39. If a child is the subject of any proceeding under chapter 39, the parents may act as natural guardians under this section unless the court division with jurisdiction over guardianship matters finds that it is not in the child's best interests. If one parent dies, the surviving parent remains the sole natural guardian even if he or she remarries. If the marriage between the parents is dissolved, the natural guardianship belongs to the parent to whom sole parental responsibility has been granted, or if the parents have been granted shared parental responsibility, both continue as natural guardians. If the marriage is dissolved and neither parent is given parental responsibility for the child, neither may act as natural guardian of the child. The mother of a child born out of wedlock and a father who has paternity established under s. 742.011 or s.

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

And the title is amended as follows:

Delete lines 10 - 11

and insert:

a certain action; amending s.

By Senator Simon

3-00592-23 20231182__

A bill to be entitled

An act relating to education and training for Alzheimer's disease and related forms of dementia; creating s. 430.5025, F.S.; providing a short title; defining terms; requiring the Department of Elderly Affairs to offer certain education about Alzheimer's disease and related forms of dementia to the general public; specifying uniform dementia-related education and training for employees of covered providers; requiring the department to provide certain dementia-related employee training in an online format and at no cost; providing minimum requirements for the training; requiring the department to make a record of the completion of the training; providing requirements for the record; requiring covered providers to maintain such records of training completion for their employees; providing that an employee does not have to repeat such training after changing employment to another covered provider; providing additional training and continuing education requirements for certain employees who provide direct care to patients with Alzheimer's disease or related forms of dementia; authorizing the department to establish training curriculum guidelines; authorizing the department to approve training providers and curricula and maintain a list of approved providers; authorizing training to be offered in a variety of formats; providing that certain continuing education does not require the adoption of curriculum guidelines by the department or

provider or curriculum approval by the department; providing qualifications and requirements for training providers; providing that training curricula approved before the effective date of this act remain in effect until their respective expiration dates; authorizing the department to adopt rules related to qualified training providers and compliance monitoring procedures; authorizing certified nursing assistants to count the dementia-related training toward their annual certification training requirements; authorizing health care practitioners to count the dementia-related training requirements toward their continuing education requirements for licensure; authorizing persons employed, contracted, or referred to provide services before the effective date of this act to complete the required training by a specified date; providing for the substitution of equivalent training for training required by this act; authorizing persons to satisfy the training requirements of this act using training curricula approved before the effective date of this act until the department adopts rules for training curricula guidelines; amending ss. 400.0239, 400.1755, 400.4785, and 400.6045, F.S.; conforming provisions to changes made by the act; creating s. 400.51, F.S.; requiring a person employed, contracted, or referred by a nurse registry or a person registered with the Agency for Health Care Administration to provide companion or homemaker services to complete specified training;

amending ss. 429.178, 429.52, 429.83, 429.917, and 429.918, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Section 430.5025, Florida Statutes, is created to read:

430.5025 Alzheimer's disease and related forms of dementia; education and training.—

(1) This section may be cited as the "Alzheimer's Disease and Related Forms of Dementia Education and Training Act."

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

(a) "Covered provider" means a nursing home, a home health agency, a nurse registry, a companion or homemaker service provider, an assisted living facility, an adult family-care home, or an adult day care center licensed or registered under chapter 400 or chapter 429.

(b) "Department" means the Department of Elderly Affairs or its designee.

(c) "Employee" means a person, contracted staff, or an independent contractor employed or referred by a covered provider who is required to undergo a level 2 background screening under s. 408.809 and chapter 435.

(d) "Personal care" means providing, through in-person contact, assistance with activities of daily living, assistance with self-administration of medication, homemaker or companion services, nursing services, or other services that promote the physical, mental, and psychosocial well-being of participants,

patients, and residents of covered providers. The term does not include duties involving administrative functions or maintaining the physical environment of a licensed facility, including grounds maintenance, building maintenance, housekeeping, laundry, or food preparation.

(e) "Regular contact" means the performance of duties other than personal care which may require employees to interact in person on a daily basis with participants, patients, or residents.

(3) The department shall offer to the general public education about Alzheimer's disease and related forms of dementia. Such education must provide basic information about the most common forms of dementia, how to identify the signs and symptoms of dementia, coping skills, how to respond to changes, planning for the future, and how to access additional resources about dementia.

(4) Covered providers must provide employees the following training for Alzheimer's disease and related forms of dementia:

(a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have Alzheimer's disease or related forms of dementia.

(b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department.

1. The department shall provide the training in an online format at no cost. The 1-hour training program must contain information on understanding the basics about the most common forms of dementia, how to identify the signs and symptoms of

dementia, and skills for communicating and interacting with persons with Alzheimer's disease or related forms of dementia. A record of the training program must be made available to the covered provider which includes the training, the name of the employee, and the date of completion.

2. A covered provider must maintain a record of the employee's completion of the training and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies.

3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider.

(c) Within 7 months after beginning employment with a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care for persons who have Alzheimer's disease or related forms of dementia must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, and skills for working with families and caregivers.

(d) Within 7 months after beginning employment with a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care for persons with Alzheimer's disease or related forms of dementia must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in

activities of daily living, skills for working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.

(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with Alzheimer's disease, in addition to the training specified in paragraphs (a) and (b), each employee must receive the following training:

1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).

2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of dementia-specific training. Such training must include, but is not limited to, understanding Alzheimer's disease and related forms of dementia, the stages of Alzheimer's disease, communication strategies, medical information, and stress management.

3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning technology. For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or hands-on experience to help develop and refine the employee's skills for caring for a person with Alzheimer's disease or a

related form of dementia. The continuing education must cover at least one of the topics included in the dementia-specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning technology chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year.

(5) The department may establish training curricula guidelines for the training required in paragraphs (4)(c), (d), and (e). The department may approve training providers and training curricula and maintain a list of approved providers. Approved training may be offered in a variety of formats, including, but not limited to, in person, electronically, or on-the-job by a facility administrator or his or her designee. Continuing education under this section does not require the adoption of training curricula guidelines by the department or approval of the training provider and curricula by the department.

(a) A training provider meeting one of the following qualifications may offer training in compliance with the training curricula guidelines without prior approval of the department:

1. A person approved by an applicable board or the Department of Health to provide training who is registered with the electronic continuing education tracking system under s. 456.025;

2. A person with a master's or doctoral degree in health care, social services, or gerontology from an accredited college or university; or

3. A person approved by the department before July 1, 2023.

(b) Training providers qualified under subparagraphs (a)1. and 2. must also have:

1. At least 1 year of teaching experience as an educator for caregivers of persons with Alzheimer's disease or related forms of dementia;

2. At least 1 year of practical experience in a program providing care to persons with Alzheimer's disease or related forms of dementia; or

3. Completed a specialized training program in the subject matter of Alzheimer's disease and related forms of dementia from an accredited health care, human services, or gerontology education provider.

(c) Upon an employee's completion of the training specified in paragraphs (4)(c), (d), and (e), the training provider must provide a record of the completion of the training which includes the name of the employee, the name of the training provider, the topics covered, and the date of completion. The training record is evidence of completion of training in the identified topic, and the employee is not required to repeat training in that topic if the employee changes employment to a different covered provider.

(d) Any Alzheimer's disease and related forms of dementia training curriculum approved by the department before July 1, 2023, remain in effect until the curriculum's expiration date.

(6) The department may adopt rules to establish

requirements for the approval of other qualified training providers and a process for conducting a sampling of training or training curriculum as necessary to monitor for compliance with curricula guidelines.

(7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant.

(8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board.

(9) Each person employed, contracted, or referred to provide services before July 1, 2023, must complete the training required in this section before July 1, 2026. Proof of completion of equivalent training completed before July 1, 2023, may substitute for the training required in subsection (4). Each person employed, contracted, or referred to provide services on or after July 1, 2023, may satisfy training requirements by completing training curricula approved under subparagraph (5)(d) until the effective date of the rules adopted by the department under subsection (6).

Section 2. Paragraph (b) of subsection (2) of section 400.0239, Florida Statutes, is amended to read:

400.0239 Quality of Long-Term Care Facility Improvement Trust Fund.—

(2) Expenditures from the trust fund shall be allowable for direct support of the following:

(b) Development and implementation of specialized training

programs for long-term care facility personnel who provide direct care for residents with Alzheimer's disease and other dementias as provided under s. 430.5025, residents at risk of developing pressure sores, and residents with special nutrition and hydration needs.

Section 3. Section 400.1755, Florida Statutes, is amended to read:

400.1755 Care for persons with Alzheimer's disease or related disorders; staff training requirements.—

~~(1)~~ As a condition of licensure, the employees of facilities licensed under this part must complete the training required under s. 430.5025 ~~provide to each of their employees, upon beginning employment, basic written information about interacting with persons with Alzheimer's disease or a related disorder~~.

~~(2) All employees who are expected to, or whose responsibilities require them to, have direct contact with residents with Alzheimer's disease or a related disorder must, in addition to being provided the information required in subsection (1), also have an initial training of at least 1 hour completed in the first 3 months after beginning employment. This training must include, but is not limited to, an overview of dementias and must provide basic skills in communicating with persons with dementia.~~

~~(3) An individual who provides direct care shall be considered a direct caregiver and must complete the required initial training and an additional 3 hours of training within 9 months after beginning employment. This training shall include, but is not limited to, managing problem behaviors, promoting the~~

~~resident's independence in activities of daily living, and skills in working with families and caregivers.~~

~~(a) The required 4 hours of training for certified nursing assistants are part of the total hours of training required annually.~~

~~(b) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward this total of 4 hours.~~

~~(4) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.~~

~~(5) The Department of Elderly Affairs or its designee must approve the initial and continuing training provided in the facilities. The department must approve training offered in a variety of formats, including, but not limited to, Internet-based training, videos, teleconferencing, and classroom instruction. The department shall keep a list of current providers who are approved to provide initial and continuing training. The department shall adopt rules to establish standards for the trainers and the training required in this section.~~

~~(6) Upon completing any training listed in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not~~

~~required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility or to an assisted living facility, home health agency, adult day care center, or adult family-care home. The direct caregiver must comply with other applicable continuing education requirements.~~

Section 4. Section 400.4785, Florida Statutes, is amended to read:

400.4785 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.—

(1) The employees of a home health agency must complete the training required under s. 430.5025 ~~A home health agency must provide the following staff training:~~

~~(a) Upon beginning employment with the agency, each employee must receive basic written information about interacting with participants who have Alzheimer's disease or dementia-related disorders.~~

~~(b) In addition to the information provided under paragraph (a), newly hired home health agency personnel who will be providing direct care to patients must complete 2 hours of training in Alzheimer's disease and dementia-related disorders within 9 months after beginning employment with the agency. This training must include, but is not limited to, an overview of dementia, a demonstration of basic skills in communicating with persons who have dementia, the management of problem behaviors, information about promoting the client's independence in activities of daily living, and instruction in skills for working with families and caregivers.~~

~~(c) For certified nursing assistants, the required 2 hours~~

~~of training shall be part of the total hours of training required annually.~~

~~(d) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 2 hours.~~

~~(e) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.~~

~~(f) The Department of Elderly Affairs, or its designee, must approve the required training. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 2-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.~~

~~(g) Upon completing the training listed in this section, the employee shall be issued a certificate that states that the training mandated under this section has been received. The certificate shall be dated and signed by the training provider. The certificate is evidence of completion of this training, and the employee is not required to repeat this training if the employee changes employment to a different home health agency~~.

(2) ~~(h)~~ A licensed home health agency whose unduplicated census during the most recent calendar year was composed ~~comprised~~ of at least 90 percent of individuals aged 21 years or younger at the date of admission is exempt from the training

requirements in this section.

(3) ~~(2)~~ An agency licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The agency must give a copy of all such advertisements or a copy of the document to each person who requests information about the agency and must maintain a copy of all such advertisements and documents in its records. The Agency for Health Care Administration shall examine all such advertisements and documents in the agency's records as part of the license renewal procedure.

Section 5. Section 400.6045, Florida Statutes, is amended to read:

400.6045 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.—

(1) The employees of a home health agency must complete the training required under s. 430.5025 ~~A hospice licensed under this part must provide the following staff training:~~

~~(a) Upon beginning employment with the agency, each employee must receive basic written information about interacting with persons who have Alzheimer's disease or dementia-related disorders~~.

~~(b) In addition to the information provided under paragraph (a), employees who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer's disease or dementia-related disorders must complete initial training of at least 1 hour within the first 3 months~~

~~after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.~~

~~(c) In addition to the requirements of paragraphs (a) and (b), an employee who will be providing direct care to a participant who has Alzheimer's disease or a dementia-related disorder must complete an additional 3 hours of training within 9 months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the patient's independence in activities of daily living, and instruction in skills for working with families and caregivers.~~

~~(d) For certified nursing assistants, the required 4 hours of training shall be part of the total hours of training required annually.~~

~~(e) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 4 hours.~~

~~(f) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.~~

~~(g) The Department of Elderly Affairs or its designee must approve the required 1-hour and 3-hour training provided to employees or direct caregivers under this section. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 1-hour and 3-hour~~

~~training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.~~

~~(h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different hospice or to a home health agency, assisted living facility, nursing home, or adult day care center.~~

(2) A hospice licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The hospice must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the hospice and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the hospice's records as part of the license renewal procedure.

Section 6. Section 400.51, Florida Statutes, is created to read:

400.51 Patients with Alzheimer's disease or other related

disorders; staff training requirements.—A person employed, contracted, or referred by a nurse registry or a person registered with the agency to provide companion or homemaker services must complete the training required under s. 430.5025.

Section 7. Section 429.178, Florida Statutes, is amended to read:

429.178 Special care for persons with Alzheimer's disease or other related disorders.—

~~(1)~~ A facility which advertises that it provides special care for persons with Alzheimer's disease or other related disorders must meet the following standards of operation:

(1)(a)~~1.~~ If the facility has 17 or more residents, have an awake staff member on duty at all hours of the day and night.~~;~~ ~~or~~

(b)~~2.~~ If the facility has fewer than 17 residents, have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the facility's residents.

(2)~~(b)~~ Offer activities specifically designed for persons who are cognitively impaired.

(3)~~(c)~~ Have a physical environment that provides for the safety and welfare of the facility's residents.

(4)~~(d)~~ Employ staff who have completed the training and continuing education required under s. 430.5025 ~~in subsection (2)~~.

~~(2)(a) An individual who is employed by a facility that provides special care for residents who have Alzheimer's disease or other related disorders, and who has regular contact with such residents, must complete up to 4 hours of initial dementia-~~

~~specific training developed or approved by the department. The training must be completed within 3 months after beginning employment and satisfy the core training requirements of s. 429.52(3)(g).~~

~~(b) A direct caregiver who is employed by a facility that provides special care for residents who have Alzheimer's disease or other related disorders and provides direct care to such residents must complete the required initial training and 4 additional hours of training developed or approved by the department. The training must be completed within 9 months after beginning employment and satisfy the core training requirements of s. 429.52(3)(g).~~

~~(c)An individual who is employed by a facility that provides special care for residents with Alzheimer's disease or other related disorders, but who only has incidental contact with such residents, must be given, at a minimum, general information on interacting with individuals with Alzheimer's disease or other related disorders, within 3 months after beginning employment.~~

~~(3) In addition to the training required under subsection (2), a direct caregiver must participate in a minimum of 4 contact hours of continuing education each calendar year. The continuing education must include one or more topics included in the dementia-specific training developed or approved by the department, in which the caregiver has not received previous training.~~

~~(4) Upon completing any training listed in subsection (2), the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic~~

~~covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility. The employee or direct caregiver must comply with other applicable continuing education requirements.~~

~~(5) The department, or its designee, shall approve the initial and continuing education courses and providers.~~

~~(6) The department shall keep a current list of providers who are approved to provide initial and continuing education for staff of facilities that provide special care for persons with Alzheimer's disease or other related disorders.~~

~~(7) Any facility more than 90 percent of whose residents receive monthly optional supplementation payments is not required to pay for the training and education programs required under this section. A facility that has one or more such residents shall pay a reduced fee that is proportional to the percentage of such residents in the facility. A facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the department, for such training and education programs.~~

~~(8) The department shall adopt rules to establish standards for trainers and training and to implement this section.~~

Section 8. Paragraph (g) of subsection (3) of section 429.52, Florida Statutes, is amended to read:

429.52 Staff training and educational requirements.—

(3) The agency, in conjunction with providers, shall

develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics:

(g) Care of persons with Alzheimer's disease and related disorders as provided under s. 430.5025.

Section 9. Section 429.83, Florida Statutes, is amended to read:

429.83 Residents with Alzheimer's disease or other related disorders; training; certain disclosures.—

(1) The employees of an adult family-care home must complete the training required under s. 430.5025.

(2) An adult family-care home licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The home must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the home and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the home's records as part of the license renewal procedure.

Section 10. Subsection (1) of section 429.917, Florida Statutes, is amended to read:

429.917 Patients with Alzheimer's disease or other related

disorders; staff training requirements; certain disclosures.—

(1) The employees of an adult day care center licensed under this part must complete the training required under s. 430.5025 ~~provide the following staff training:~~

~~(a) Upon beginning employment with the facility, each employee must receive basic written information about interacting with participants who have Alzheimer's disease or dementia-related disorders.~~

~~(b) In addition to the information provided under paragraph (a), newly hired adult day care center personnel who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer's disease or dementia-related disorders must complete initial training of at least 1 hour within the first 3 months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.~~

~~(c) In addition to the requirements of paragraphs (a) and (b), an employee who will be providing direct care to a participant who has Alzheimer's disease or a dementia-related disorder must complete an additional 3 hours of training within 9 months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the participant's independence in activities of daily living, and instruction in skills for working with families and caregivers.~~

~~(d) For certified nursing assistants, the required 4 hours of training shall be part of the total hours of training required annually.~~

~~(e) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 4 hours.~~

~~(f) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.~~

~~(g) The Department of Elderly Affairs or its designee must approve the 1-hour and 3-hour training provided to employees and direct caregivers under this section. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 1-hour and 3-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.~~

~~(h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different adult day care center or to an assisted living facility, nursing home, home health agency, or hospice. The direct caregiver must comply with other applicable continuing education requirements.~~

~~(i) An employee who is hired on or after July 1, 2004, must~~

~~complete the training required by this section~~.

Section 11. Subsection (6) of section 429.918, Florida Statutes, is amended to read:

429.918 Licensure designation as a specialized Alzheimer's services adult day care center; training.—

(6)~~(a)~~ An adult day care center having a license designated under this section must provide the following staff training and supervision:

(a)~~1.~~ A registered nurse or licensed practical nurse must be on site daily for at least 75 percent of the time that the center is open to ADRD participants. Each licensed practical nurse who works at the center must be supervised in accordance with chapter 464.

(b) Each employee must complete the training and continuing education required under s. 430.5025

~~2. Upon beginning employment with the center, each employee must receive and review basic written information about interacting with ADRD participants.~~

~~3. In addition to the information provided in subparagraph 2., every employee hired on or after July 1, 2012, who has direct contact with ADRD participants shall complete 4 hours of dementia-specific training within 3 months after employment.~~

~~4. In addition to the requirements of subparagraphs 2. and 3., each employee hired on or after July 1, 2012, who provides direct care to ADRD participants shall complete an additional 4 hours of dementia-specific training within 6 months after employment.~~

~~(b) The Department of Elderly Affairs or its designee shall approve the training required under this section. The department~~

~~shall adopt rules to establish standards for employees who are subject to this training, for trainers, and for the training required in this section.~~

~~(c) Upon completing any training described in this section, the employee shall be issued a certificate that includes the name of the training provider, the topics covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topics, and the employee is not required to repeat training in those topics if the employee changes employment to a different adult day care center~~.

(c) ~~(d)~~ Each employee hired on or after July 1, 2012, who provides direct care to ADRD participants, must receive and review an orientation plan that includes, at a minimum:

1. Procedures to locate an ADRD participant who has wandered from the center. These procedures must ~~shall~~ be reviewed regularly with all direct care staff.

2. Information on the Silver Alert program in this state.

3. Information regarding available products or programs used to identify ADRD participants or prevent them from wandering away from the center, their home, or other locations.

Section 12. This act shall take effect July 1, 2023.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR JASON BRODEUR
10th District

COMMITTEES:
Appropriations Committee on Agriculture, Environment, and General Government, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Children, Families, and Elder Affairs
Community Affairs
Regulated Industries
Rules

JOINT COMMITTEE:
Joint Legislative Auditing Committee

March 14, 2023

The Honorable Ileana Garcia, Chair
Children, Families, and Elder Affairs Committee
322 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Garcia,

This morning, I was called out of Children, Families, and Elder Affairs because of a bill I had to present in a different committee. Due to my presentation, I missed the vote on SB 938 and SB 1182. I respectfully request that my vote be recorded affirmative on both of these bills.

If you have any questions or concerns, please do not hesitate to reach out to me or my office.

Sincerely,

Jason Brodeur

Senator Jason Brodeur – District 10

REPLY TO:
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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:	CS/SB 1182
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Simon
SUBJECT:	Education and Training for Alzheimer's Disease and Related Forms of Dementia
DATE:	March 14, 2023 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Cox	CF	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1182 creates s. 430.5025, F.S., to establish the Florida Alzheimer's Disease and Dementia Training Act. The bill establishes universal Alzheimer's disease and related disorder (ADRD) training requirements to be used by nursing homes, home health agencies, nurse registries, companion or homemaker service providers, assisted living facilities (ALFs), adult family-care homes (AFCHs), adult day care centers (ADCCs), and specialized Alzheimer's services ADCCs to replace each license type's individual training requirements on that topic.

The bill defines a number of terms, including "covered provider", "department", "employee", "personal care", and "regular contact".

The bill requires specified employees of covered providers who provide personal care to or have regular contact with patients, participants, or residents, with one hour of dementia-related training within 30 days of his or her initial employment. All employees must also receive basic written information about interacting with persons who have ADRD upon beginning employment.

Within the first seven months of employment, the bill requires each employee of a home health agency, nurse registry, or companion or homemaker service provider who provides personal care to receive two hours of additional; and each employee of a nursing home, ALF, AFCH or ADCC who provides personal care for persons with ADRD to receive three hours of additional training.

Additionally, employees of ALFs, AFCHs, and ADCCs which advertise and provide specialized care for persons with Alzheimer's disease must also receive the following additional training:

- Three hours of additional training within the first three months of employment, rather than the first seven months;
- Four hours of dementia-specific training within the first six months of employment; and
- Four hours of continuing education each calendar year through:
  - Contact hours;
  - On-the-job training, limited to a certain amount of credit in each calendar year; or
  - Electronic learning technology.

The bill directs the DOEA to provide the initial one hour of dementia-related training. The training must be provided in an online format at no cost, and must contain information on the following topics:

- Understanding the basics about the most common forms of dementia;
- How to identify the signs and symptoms of dementia; and
- Skills for communicating and interacting with persons with ADRD.

The bill requires the DOEA to make a record of the completion of the training program available to covered providers, and the record must include the training, the name of the employee, and the date of completion. The bill also requires covered providers to maintain a record of each employee's completion of the training and provide the employee with a copy of the completion record consistent with the employer's written policies upon request.

Employees hired, contracted, or referred to provide services before July 1, 2023 must complete the training before July 1, 2026. Further, proof of completion of equivalent training that has been completed prior to July 1, 2023 may substitute for the training. Employees hired, contracted, or referred to provide services on or after July 1, 2023 may satisfy training requirements by completing training curricula approved by the DOEA until the effective date of rules adopted by the DOEA under the bill.

The bill also requires the Department of Elder Affairs (DOEA) to offer education to the general public about ADRD. The education must provide basic information about:

- The most common forms of dementia;
- How to identify the signs and symptoms of dementia;
- Coping skills;
- How to respond to changes;
- Planning for the future; and
- How to access additional resources about dementia.

The bill will likely have a negative fiscal impact on private sector health care providers and an insignificant negative fiscal impact on the DOEA. See Section V. Fiscal Impact Statement.

The bill is effective July 1, 2023.

II. Present Situation:

Dementia and Alzheimer's Disease

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—and behavioral abilities to such an extent that it interferes with a person's daily life and activities. These functions include memory, language skills, visual perception, problem solving, self-management, and the ability to focus and pay attention. Some people with dementia cannot control their emotions, and their personalities may change. Dementia ranges in severity from the mildest stage, when it is just beginning to affect a person's functioning, to the most severe stage, when the person must depend completely on others for basic activities of living.[1]

Alzheimer's disease is the most common type of dementia. It is a progressive disease that begins with mild memory loss and can lead to loss of the ability to carry on a conversation and respond to one's environment. Alzheimer's disease affects parts of the brain that control thought, memory, and language. It can seriously affect a person's ability to carry out daily activities. Although scientists are studying the disease, what causes Alzheimer's disease is unknown.[2]

There are an estimated 580,000 individuals living with Alzheimer's disease in the state of Florida.[3] By 2025, it is projected that 720,000 Floridians will have Alzheimer's disease. More than 6 million Americans are living with Alzheimer's and the cost of caring for ADRD patients is estimated to total nearly $1 trillion by mid-century.[4]

[1] National Institute on Aging, *What is Dementia? Symptoms, Types, and Diagnosis*, available at https://www.nia.nih.gov/health/what-dementia-symptoms-types-and-diagnosis, (last visited on March 11, 2023).
[2] Centers for Disease Control and Prevention, *Alzheimer's Disease and Healthy Aging*, available at https://www.cdc.gov/aging/aginginfo/alzheimers.htm#AlzheimersDisease, (last visited March 11, 2023).
[3] Alzheimer's Association, *Alzheimer's Statistics Florida*, available at https://www.alz.org/media/Documents/florida-alzheimers-facts-figures-2022.pdf (last visited March 11, 2023).
[4] *Id*.

Dementia and Alzheimer's Disease Training

Overview by Facility/Agency Type

	All Employees	Employees with Expected or Required Direct Contact	Employees Providing Direct Care	Health Care Practitioner Continuing Education Sufficient?	Training Approved?	Additional Reqs.
Nursing Homes	Provided with basic written information about interacting with persons with ADRD upon beginning employment.	1 hour of training within the first 3 months of employment.	Additional 3 hours of training within the first 9 months of employment.	Yes	By DOEA.	
Home Health Agencies		Not specified.	2 hours of training within the first 9 months of employment.	Yes	By DOEA.	HHA's that serve 90% individuals under age 21 are exempt.
Hospice Providers	ADRD upon beginning employment.	1 hour of training within the first 3 months of employment.	Additional 3 hours of training within the first 9 months of employment.	Yes	By DOEA.	
Special Care ALFs[5]	Employees with incidental contact must be given information within 3 months.	4 hours within 3 months of employment	4 additional hours within 9 months of employment + 4 hours CE annually	Not specified.	By DOEA	
Adult Day Care Centers	Same as nursing homes, home health agencies, and Hospice.	1 hour of training within the first 3 months of employment.	Additional 3 hours of training within the first 9 months of employment.	Yes	By DOEA	
Specialized Alzheimer's Services Adult Day Care Centers	Same as nursing homes, home health agencies, and Hospice.	4 hours of training within the first 3 months of employment.	Additional 4 hours of training within the first 6 months of employment.	Yes	By DOEA	
Adult Family-Care Homes	None	None	None	Not Specified.	By the Agency for Health Care	

[5] Training is required if the ALF advertises that it provides special care for persons with Alzheimer's disease or related disorders. Section 429.178, F.S.

					Administration (AHCA)	
Nurse Registries/ Companion or Homemaker Services	None	None	None	Not specified.		

Specific details for each facility/agency type are below:

Nursing Homes

A nursing home is a facility that provides 24-hour nursing care, personal care, or custodial care to individuals who are ill or physically infirm.[6] Nursing homes are licensed and regulated by the Agency for Health Care Administration (AHCA) under part II of ch. 400, F.S.

Section 400.1755, F.S., requires each nursing home to provide the following training:

- Provide each of its employee's basic written information about interacting with persons with ADRD upon beginning employment.
- All employees who are expected to, or whose responsibilities require them to, have direct contact with residents with ADRD must also have an initial training of at least one hour completed in the first three months after beginning employment. This training must include, but is not limited to, an overview of dementias and must provide basic skills in communicating with persons with dementia.
- An individual who provides direct care must complete the required initial training and an additional three hours of training within nine months after beginning employment. This training must include, but is not limited to, managing problem behaviors, promoting the resident's independence in activities of daily living, and skills in working with families and caregivers. Health care practitioners' continuing education can be counted toward the required training hours.
- The DOEA or its designee must approve the initial and continuing training provided in the facilities. The DOEA must approve training offered in a variety of formats, including, but not limited to, Internet-based training, videos, teleconferencing, and classroom instruction. The DOEA must keep a list of current providers who are approved to provide initial and continuing training. The DOEA must adopt rules to establish standards for the trainers and the training required in this section of statute.
- Upon completing any training listed in the section, the employee or direct caregiver must be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility or to an assisted living facility, home health agency, adult day care center, or adult family-care home. The direct caregiver must comply with other applicable continuing education requirements.

[6] Section 400.021(7), F.S.

Home Health Agencies

A home health agency provides one or more of the following home health services: nursing care; therapy; home health aide services; dietetics and nutrition; or medical supplies.[7] Home health agencies are licensed and regulated by the AHCA under part III of ch. 400, F.S.

Section 400.4785, F.S., requires a home health agency to provide the following staff training:

- Upon beginning employment with the agency, each employee must receive basic written information about interacting with participants who have ADRD.
- Newly-hired home health agency personnel who will be providing direct care to patients must complete two hours of training in ADRD within nine months after beginning employment with the agency. This training must include, but is not limited to, an overview of dementia, a demonstration of basic skills in communicating with persons who have dementia, the management of problem behaviors, information about promoting the client's independence in activities of daily living, and instruction in skills for working with families and caregivers.
- For certified nursing assistants, the required two hours of training are part of the total hours of training required annually.
- For a health care practitioner, as defined in s. 456.001, F.S.,[8] continuing education hours taken as required by that practitioner's licensing board are counted toward the total of two hours.
- For an employee who is a licensed health care practitioner, training that is sanctioned by that practitioner's licensing board must be considered to be approved by the DOEA.
- The DOEA, or its designee, must approve the required training. The DOEA must consider for approval training offered in a variety of formats. The DOEA must keep a list of current providers who are approved to provide the two-hour training. The DOEA must adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section of statute.
- Upon completing the training listed in the section, the employee must be issued a certificate that states that the training mandated under the section has been received. The certificate must be dated and signed by the training provider. The certificate is evidence of completion of this training, and the employee is not required to repeat this training if the employee changes employment to a different home health agency.
- A licensed home health agency whose unduplicated census during the most recent calendar year was composed of at least 90 percent of individuals aged 21 years or younger at the date of admission, is exempt from the training requirements in this section of statute.

Assisted Living Facilities

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[9] ALFs are licensed and

[7] Section 400.462(12) and (14), F.S.
[8] Section 456.001(4), F.S., defines "health care practitioner" as any person licensed under ch. 457, F.S.; ch. 458, F.S.; ch. 459, F.S.; ch. 460, F.S.; ch. 461, F.S.; ch. 462, F.S.; ch. 463, F.S.; ch. 464, F.S.; ch. 465, F.S.; ch. 466, F.S.; ch. 467, F.S.; part I, part II, part III, part V, part X, part XII, or part XIV of ch. 468, F.S.; ch. 478, F.S.; ch. 480, F.S.; part I or part II of ch. 483, F.S.; ch. 484, F.S.; ch. 486, F.S.; ch. 490, F.S.; or ch. 491, F.S.
[9] Section 429.02(5), F.S.

regulated by the AHCA under part I of ch. 429, F.S. An ALF that advertises that it provides special care for individuals with ADRD is required to meet certain staffing and ADRD training requirements that are not required of other ALFs.[10]

All ALF employees are required to attend a preservice orientation provided by the facility prior to interacting with residents. The preservice orientation must be at least two hours and must cover certain topics, including resident's rights and the services offered by the facility.[11] ADRD training is only required for employees of ALFs that provide special care for residents with ADRD.[12] Further, s. 429.178, F.S., requires an ALF that advertises it provides special care for persons with ADRD to provide the following training:

- An employee who has regular contact with such residents must complete up to four hours of initial dementia-specific training developed or approved by the DOEA. The training must be completed within three months after beginning employment and satisfy the core training requirements of s. 429.52(3)(g), F.S.
- A direct caregiver who provides direct care to such residents must complete the required initial training and four additional hours of training developed or approved by the DOEA. The training must be completed within nine months after beginning employment and satisfy the core training requirements of s. 429.52(3)(g), F.S.
- An individual who is employed by a facility that provides special care for residents with ADRD, but who only has incidental contact with such residents, must be given, at a minimum, general information on interacting with individuals with ADRD, within three months after beginning employment.
- A direct caregiver must also participate in a minimum of four contact hours of continuing education each calendar year. The continuing education must include one or more topics included in the dementia-specific training, developed or approved by the DOEA, in which the caregiver has not received previous training.
- Upon completing any specified training, the employee or direct caregiver must be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility. The employee or direct caregiver must comply with other applicable continuing education requirements.
- The DOEA, or its designee, must approve the initial and continuing education courses and providers.
- The DOEA must keep a current list of providers who are approved to provide initial and continuing education for staff of facilities that provide special care for persons with ADRD.

[10] Sections 429.177 and 429.178(1), F.S.
[11] Section 429.52(1), F.S., and Rule 59A-36.011(2), F.A.C.
[12] Section 429.178(1), F.S., requires an ALF that advertises that it provides special care for persons with ADRD to meet certain standards of operation that are not required of other ALFs. This is not a separate licensure category. The additional standards of operation include: have an awake staff member on duty 24 hours a day, if the facility has 17 or more residents; if the facility has fewer than 17 residents, the facility may have mechanisms in place to monitor residents instead of having an awake staff member on duty 24 hours a day; offer activities specifically designed for persons who are cognitively impaired; have a physical environment that provides for the safety and welfare of the residents; and employ staff who have completed the required training and continuing education.

Adult Family-Care Homes

An adult family-care home is a private home, under which a person who owns or rents the home provides room, board, and personal care in a family-like living arrangement, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives of the homeowner.[13] AFCHs are licensed and regulated by the AHCA under part II of ch. 429, F.S.

AFCH providers are required to undergo 12 hours of training some of which must be related to Identifying and meeting the special needs of disabled adults and frail elders. However, providers are not currently required to undergo training specific to ADRD.[14]

Adult Day Care Centers

Adult day care centers provide therapeutic services and activities for adults in a non-institutional setting.[15] Participants may utilize a variety of services offered during any part of a day totaling less than 24-hours. Basic services provided by ADCCs include leisure activities, self-care training, nutritional services, and respite care.[16]

Section 429.917, F.S., requires an ADCC to provide the following staff training:

- Upon beginning employment with the facility, each employee must receive basic written information about interacting with participants who have ADRD.
- In addition to the information provided, newly-hired adult day care center personnel who are expected to, or whose responsibilities require them to, have direct contact with participants who have ADRD must complete initial training of at least one hour within the first three months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.
- In addition to the previous requirements, an employee who will be providing direct care to a participant who has ADRD must complete an additional three hours of training within nine months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the participant's independence in activities of daily living, and instruction in skills for working with families and caregivers.
- For certified nursing assistants, the required four hours of training is part of the total hours of training required annually.
- For a health care practitioner as defined in s. 456.001, F.S., continuing education hours taken as required by that practitioner's licensing board are counted toward the total of four hours.
- For an employee who is a licensed health care practitioner as defined in s. 456.001, F.S., training that is sanctioned by that practitioner's licensing board is considered to be approved by the DOEA.
- The DOEA or its designee must approve the one-hour and three-hour training provided to employees and direct caregivers under this section of statute. The DOEA must consider for approval training offered in a variety of formats. The DOEA must keep a list of current

[13] Section 429.65(2), F.S.
[14] *See* s. 429.75, F.S., and Fla. Admin. Code R. 59A-37.007 (2020).
[15] Section 429.901(3), F.S.
[16] *Id.*

providers who are approved to provide the one-hour and three-hour training. The DOEA must adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section of statute.

- Upon completing any training described in the section, the employee or direct caregiver must be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different ADCC or to an ALF, nursing home, home health agency, or hospice. The direct caregiver must comply with other applicable continuing education requirements.

Specialized Alzheimer's Services Adult Day Care Centers

An ADCC may hold a license designated by the AHCA as a specialized Alzheimer's services adult day care center if it meets certain requirements.[17] Employees of specialized Alzheimer's services ADCCs, who have direct contact with, or provide direct care to, individuals with ADRD are required to receive four hours of ADRD training within three months of beginning employment.[18] Employees of specialized Alzheimer's services ADCCs who provide direct care to participants with ADRD are required to receive an additional four hours of training within six months of beginning employment. The curriculum for the additional four hours of training must address the following subject areas:

- Understanding brain disease;
- Normal brain functions and normal aging;
- Understanding treatable and irreversible dementia;
- Mental status tests;
- Communication and the effects of damage to brain cells;
- Influences on behavior and brain deterioration;
- Interventions;
- Physical causes and pain indications;
- Common ADRD medications and side effects;
- Malnutrition and dehydration;
- Activities of daily living;
- Validation therapy;
- Safety; and
- Caregiver stress management.[19]

Employees of specialized Alzheimer's services ADCCs who provide direct care to participants with ADRD are also required to receive 4-hours of continuing education annually in topics related to ADRD.[20]

[17] Section 429.918(4), F.S.
[18] Rule 59A-16.111(2), F.A.C.
[19] Rule 59A-16.111(3), F.A.C.
[20] Rule 59A-16.111(5), F.A.C.

Nurse Registries and Companion and Homemaker Services

A nurse registry is an agency licensed to secure employment for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, and homemakers, who are compensated by fees as independent contractors to provide services in a patient's home or with health care facilities or other entities.[21] Nurse registries are governed by part II of chapter 408, F.S., and the nurse registry rules in Chapter 59A-18, F.A.C. A nurse registry must be licensed by the AHCA to offer contracts in Florida.[22] Current law does not require contracted personnel of nurse registries to complete training on ADRD.

Companions spend time with and care for elderly, handicapped, or convalescent individuals, prepare and serve meals to such individuals, and accompany such individuals on trips and outings. Companions are prohibited from providing hands-on personal care to a client.[23] Homemakers perform household chores that include housekeeping, meal planning and preparation, shopping assistance, and routine household activities for elderly, handicapped, or convalescent individuals. Homemakers are prohibited from providing hands-on personal care to a client.[24] Current law does not require companions or homemakers to complete training on ADRD.

ADRD Training Providers and Curricula

The DOEA or its designee is responsible for approving ADRD training providers and curricula for employees of nursing homes, home health agencies, ALFs, and adult day care centers.[25] The University of South Florida (USF) administers the Program through a contract with DOEA.[26] To be approved as a training provider, an applicant must provide proof of certain educational and experience requirements, including:

- A Master's degree from an accredited college in health care, human services, or gerontology; or
- A Bachelor's degree from an accredited college, or licensure as a registered nurse; and
- One year of experience as an educator of caregivers for individuals with ADRD; or
- Completion of a specialized training program relating to ADRD, and a minimum of two years of practical experience in a program providing direct care to individuals with ADRD; or
- Three years of practical experience in a program providing direct care to individuals with ADRD.[27]

Upon successful completion of training, the trainer is required to issue the trainee a certificate of completion.[28] Training curricula is certified for a period of three years and must be resubmitted

[21] Section 400.462(21), F.S.
[22] Section 400.506(1), F.S.
[23] Section 400.462(7), F.S.
[24] Section 400.462(18), F.S.
[25] Sections 400.1755(5), 400.4785(1)(f), 429.178(5), and 429.917(1)(g), F.S.
[26] The University of South Florida, College of Behavioral & Community Sciences, USF's Training Academy on Aging, *Alzheimer's Disease and Related Disorders Frequently Asked Questions*, available at http://www.trainingonaging.usf.edu/products/faq.cfm (last visited March 11, 2023).
[27] Rule 58A-5.0194(1)(a), F.A.C.
[28] Rule 58A-5.0194(3), F.A.C.

for approval.[29] Approval of training curricula is based on how well it addresses the required subject areas.[30]

The table below depicts the number of approved trainers and training curricula by facility/provider type.[31]

Facility/Provider Type	Approved Training Providers	Approved Training Curricula
Nursing Home	1,865	24
ALF	800	66
Home Health Agency	750	22
Adult Day Care Center	133	17
Total	**3,548**	**129**

Quality of Long-Term Care Facility Improvement Trust Fund

The Quality of Long-Term Care Facility Improvement Trust Fund ("Trust Fund"), created in 2001,[32] supports innovative ideas that directly impact quality of care or quality of life of nursing home residents beyond minimum standards.[33] Section 400.0239, F.S., places the Trust Fund within the AHCA.[34] Trust Fund expenditures can be made for:

- Development and operation of a mentoring program for increasing the competence, professionalism, and career preparation of long-term care facility direct care staff, including nurses, nursing assistances, and social service and dietary personnel;
- Development and implementation of specialized training programs for long-term care facility personnel who provide direct care of residents:
  - With ADRD;
  - At risk of developing pressure sores; and
  - With special nutrition and hydration needs.
- Provision of economic and other incentives to enhance the stability and career development of the nursing home direct care workforce, including paid sabbaticals for exemplary direct care career staff to visit facilities throughout the state to train and motivate younger workers to commit to long-term care careers; and
- Promotion and support for the formation and active involvement of resident and family councils in the improvement of nursing home care.[35]

The Trust Fund is funded through a combination of:

- General Revenue;

[29] Rule 58A-5.0194(1)(b), F.A.C.
[30] *Id*.
[31] The University of South Florida's Training Academy on Aging, *Find Approved Applications*, available at https://usfweb.usf.edu/trainingonAging/default.aspx, (last visited March 11, 2023).
[32] Ch. 2001-205, L.O.F.
[33] The AHCA, *Quality of Long-Term Care Facility Improvement Trust Fund*, available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Long_Term_Care/Trust_Fund.shtml (last visited March 11, 2023).
[34] Section 400.0239(1), F.S.
[35] Section 400.0239(2), F.S.

- The Civil Money Penalty Fund; and
- Fifty percent of any punitive damages awarded in lawsuits against a nursing home or ALF.[36]

III. Effect of Proposed Changes:

ADRD Training Requirements

SB 1182, which may be cited as the "Florida Alzheimer's Disease and Dementia Training Act", creates s. 430.5025, F.S., to establish universal ADRD training requirements for nursing homes, home health agencies, nurse registries, companion and homemaker service providers, ALFs, AFCHs, and ADCCs with limited exception.

The bill makes the following changes (indicated by red font) to the ADRD training requirements for employees of nursing homes, home health agencies, nurse registries, ALFs, and adult day care centers to increase uniformity of training requirements across the long-term care industry.

		Initial Training for all "Employees"			
		Basic Written Info		Hours	
		Current	Effect of the Bill	Current	Effect of the Bill
Nursing Homes		Basic written info upon beginning employment	Basic written info upon beginning employment	None.	1 hr w/in 1st 30 days
Home Health Agencies		Basic written info upon beginning employment	Basic written info upon beginning employment	None.	1 hr w/in 1st 30 days
Nurse Registry Companion or Homemaker Service		None.	Basic written info upon beginning employment	None.	1 hr w/in 1st 30 days
ALFs	**Generally**	None.	Basic written info upon beginning employment	None.	1 hr w/in 1st 30 days
	Special Care	Basic written info w/in 1st 3 months	Basic written info upon beginning employment	None.	1 hr w/in 1st 30 days
Adult Family-Care Home	**Generally**	None.	Basic written info upon beginning employment	None.	1 hr w/in 1st 30 days
	Special Care	None.	Basic written info upon beginning employment	None.	1 hr w/in 1st 30 days
Adult Day Care Centers	**Generally**	Basic written info upon beginning employment	Basic written info upon beginning employment	None.	1 hr w/in 1st 30 days
	Special Care	Basic written info upon beginning employment	Basic written info upon beginning employment	None.	1 hr w/in 1st 30 days

[36] Section 400.0238(4), F.S.

		Direct Care Workers Providing Personal Care to Individuals with ADRD[37]					
		Initial Training[38]		Additional 1st Year Training		Continuing	
		Current	Effect of the Bill	Current	Effect of the Bill	Current	Effect of the Bill
Nursing Homes		1 hr. w/in 1st 3 months	1 hr w/in 1st 30 days	3 hrs. w/in 1st 9 months	3 hrs. w/in 1st 7 months	None.	No change.
Home Health Agencies		None.	1 hr w/in 1st 30 days	2 hrs. w/in 1st 9 months	2 hrs. w/in 1st 7 months	None.	No change.
Nurse Registry Companion or Homemaker Service		None.	1 hr w/in 1st 30 days	None.	2 hrs. w/in 1st 7 months	None.	No change.
ALFs	Generally	None.	1 hr w/in 1st 30 days	None.	3 hrs. w/in 1st 7 months	None.	No change.
	Special Care	4 hrs. w/in 1st 3 months	1 hr w/in 1st 30 days	4 hrs. w/in 1st 9 months	3 hrs. w/in 1st 3 months plus 4 hrs. w/in 1st 6 months	4 hrs., annually	No change.
Adult Family-Care Home	Generally	None.	1 hr w/in 1st 30 days	None.	3 hrs. w/in 1st 7 months	None.	No change.
	Special Care	None.	1 hr w/in 1st 30 days	None.	3 hrs. w/in 1st 3 months plus 4 hrs. w/in 1st 6 months	None.	4 hrs., annually
Adult Day Care Centers	Generally	1 hr. w/in 1st 3 months	1 hr w/in 1st 30 days	3 hrs. w/in 1st 9 months	3 hrs. w/in 1st 7 months	None.	No change.
	Special Care	4 hrs. w/in 1st 3 months	1 hr w/in 1st 30 days	4 hrs. w/in 1st 6 months	3 hrs. w/in 1st 3 months plus 4 hrs. w/in 1st 6 months	4 hrs., annually, per rule	4 hrs., annually, per statute

The bill defines the following terms:

- "Covered provider" means a nursing home, a home health agency, a nurse registry, a companion or homemaker service provider, an ALF, an AFCH, or an ADCC licensed or registered under ch. 400, F.S., or ch. 429, F.S.

[37] Note: New training requirements only apply to employees providing direct care to patients/residents with ADRD, as compared to training requirements in current law which apply to employees providing direct care to any patient/resident.
[38] Current law only provides an initial hour-based training requirement for the direct care workers of certain provider types. The proposed initial hourly training requirement applicable to all "employees" is repeated here since all "direct care workers" will have to complete this training. This initial training requirement is not in addition to the initial hour-based training that is currently applicable.

- "Department" means the Department of Elderly Affairs.[39]
- "Employee" means a person, contracted staff, or independent contractor employed or referred by a covered provider who is required to have a level 2 background screening as required by s. 408.809, F.S., and ch. 435, F.S.
- "Personal care" means providing, through in-person contact, assistance with activities of daily living, assistance with self-administration of medication, homemaker or companion services, nursing services, or other services that promote the physical, mental, and psychosocial well-being of participants, patients, and residents of covered providers. The term does not include duties involving administrative functions or maintaining the physical environment of an ALF, including grounds maintenance, building maintenance, housekeeping, laundry, or food preparation.
- "Regular contact" means the performance of duties other than personal care which may require employees to interact in person on a daily basis with participants, patients, or residents.

The bill also requires the Department of Elder Affairs (DOEA) to offer education to the general public about ADRD. The education must provide basic information about:
- The most common forms of dementia;
- How to identify the signs and symptoms of dementia;
- Coping skills;
- How to respond to changes;
- Planning for the future; and
- How to access additional resources about dementia.

The bill requires employees of covered providers who provide personal care to or have regular contact with patients, participants, or residents, one hour of dementia-related training within 30 days of his or her employment. All employees must also receive basic written information about interacting with persons who have ADRD upon beginning employment.

The bill directs the DOEA to provide the initial one hour of dementia-related training. The training must be provided in an online format at no cost, and must contain information on the following topics:
- Understanding the basics about the most common forms of dementia;
- How to identify the signs and symptoms of dementia; and
- Skills for communicating and interacting with persons with ADRD.

Additionally, the bill requires each employee of a home health agency, nurse registry, or companion or homemaker service provider who provides personal care to receive two hours of additional training within the first seven months of employment. For employees of home health agencies, nurse registries, or companion or homemakers services, the additional training must include, but is not limited to:
- Behavior management;
- Promoting the person's independence in activities of daily living;
- Skills for working with families and caregivers.

[39] Also known as the Department of Elder Affairs (DOEA).

Each employee of a nursing home, ALF, AFCH or ADCC who provides personal care must receive three hours of additional training within the first seven months of employment. For employees of ALFs, AFCHs, and ADCCs, the additional training must include the three above-mentioned topics and also include, but not be limited to:

- Group and individual activities;
- Maintaining an appropriate environment; and
- Ethical issues.

Employees of ALFs, AFCHs, and ADCCs which advertise and provide specialized care for persons with Alzheimer's disease must also receive the following additional training if such employees provide personal care, as defined in the bill:

- Three hours of additional training within the first three months of employment, rather than the first seven months;
- Four hours of dementia-specific training within the first six months of employment; and
- Four hours of continuing education each calendar year through:
  - Contact hours;
  - On-the-job training[40] which can account for no more than 2 hours of continuing education credit each calendar year; or
  - Electronic learning technology.

The bill requires the continuing education to cover at least one of the topics included in the dementia-specific training in which the employee has not received previous training within the last calendar year.

The bill allows ADRD training hours required under the bill to count toward the total hours of training required for certified nursing assistants to maintain certification. The bill also allows ADRD training hours to count toward the total hours of continuing education required for health care practitioners, as defined in s. 456.001, F.S.

ADRD Training Providers and Curricula

For the post-initial training and continuing education, the bill authorizes the DOEA to develop training curriculum guidelines and allows training providers who meet certain qualifications to offer training without prior approval, including:

- An individual who is approved by a board of the Department of Health (DOH) to provide training and is registered with the DOH electronic continuing education tracking system; or
- A person approved by the DOEA or its designee before July 1, 2023.

The individuals above, other than those approved by the DOEA or its designee before July 1, 2023, must also meet one of the following experience requirements:

- At least one year of teaching experience as an educator for caregivers of persons with ADRD;

[40] The bill defines "on-the-job training" to mean a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or hands-on experience to help develop and refine the employee's skills for caring for a person with ADRD.

- At least one year of practical experience in a program providing care to persons with ADRD; or
- Completion of a specialized ADRD training program from an accredited health care, human services, or gerontology education provider.

Current law authorizes DOEA or its designee to approve the initial 1-hour training curricula, the additional training (post-initial training) curricula, and the continuing education curricula for nursing homes, ALFs, adult family-care homes, home health agencies, and adult day care centers. The bill adds the authority for DOEA to approve such training curricula for nurse registries and homemaker and companion services.

For the initial 1-hour training requirement, the bill requires the DOEA to provide ADRD training for free and make it available online.

The bill provides that any ADRD training and curriculum that has been approved before July 1, 2023 remains in effect until the curriculum's expiration date. The bill authorizes the DOEA to create training curricula guidelines and adopt rules to establish requirements for the approval of other qualified training providers, and to conduct samplings of training curricula as necessary to monitor for compliance with curriculum guidelines. The bill also permits the DOEA to develop or provide continuing education training or curricula as an option for covered providers and employees.

Training Records

Under the bill, employees are not required to repeat any of the training requirements in the bill upon a change of employment to a different covered provider. To facilitate this, the bill addresses employee access to their own training records.

For the initial training, the bill requires trainers to provide a record of an employee's completion of training to the covered provider. The bill requires the covered provider to maintain a record of the employee's completion of the training, and upon written request by the employee, provide a copy of the record of completion to the employee.

For post-initial training and continuing education, the bill requires trainers to provide a record of an employee's completion of training and continuing education, but it does not specify who the record must be provided to (covered provider or employee). Further, the bill does not require a covered provider to maintain the record of completion or provide a copy of the record of completion like it does for records of completion of initial training.

Implementation

The bill requires all employees hired before July 1, 2023, to complete the training requirements of the bill by July 1, 2026. Individuals newly employed, contracted, or referred to provide services on or after the effective date of the bill may complete training using any existing training curriculum approved by DOEA. The bill provides a grandfather clause for an employee who shows proof of completion of training that is equivalent to the training requirements of the bill. However, it is unlikely that many employees have received training that is equivalent to the enhanced training requirements of the bill.

The bill amends s. 400.0239, F.S., to allow funds from the Quality of Long-Term Care Facility Improvement Trust Fund to be allocated for direct support of the development and implementation of specialized training programs for long-term care facility personnel who provide direct care for residents with ADRD as provided under the bill.

The bill also amends ss. 400.1755, 400.4785, 400.6045, 429.178, 429.917, and 429.918 F.S., respectively, to cross-reference the ADRD training section created by the bill and repeal the individual ADRD training requirements in the licensure statutes for nursing homes, home health agencies, ALFs, ADCCs, and specialized Alzheimer's services ADCCs in favor of the uniform training requirements established by the bill.

The bill creates s. 400.51, implementing the training requirements established by the bill for persons employed, contracted, or referred by a nurse registry or a person registered with an agency to provide companion or homemaker services.

The bill amends s. 429.52 to require all ALF employees to complete the training requirements established by the bill. The bill also allows the 1-hour training requirement for ALF employees to count toward an existing mandatory 2-hour preservice orientation, if completed before interacting with residents.

The bill amends s. 429.83, F.S., to require all adult family-care homes to provide ADRD staff training pursuant to the requirements established in the bill. Currently, no adult family-care homes are required to provide such training.

The bill is effective date July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill is likely to have a negative fiscal impact on health care facilities and providers as a result of the increased training requirements of the bill. The level of fiscal impact is indeterminate.

C. Government Sector Impact:

The DOEA states that there are potential expenditures to develop and distribute informational materials beyond what is currently provided, potential expenditures for developed training curricula, approval and monitoring beyond what is currently provided, and potential expenditures to develop a database to store training participant information.[41] The DOEA anticipates that any expenditures generated by the bill can be absorbed by existing resources.[42]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 400.0239, 400.1755, 400.4785, 429.178, 429.52, 429.83, 429.917, and 429.918 of the Florida Statutes.

This bill creates sections 430.5025 and 400.51 of the Florida Statutes.

IX. Additional Information:

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

CS by Children, Families, and Elder Affairs on March 14, 2023:

- Removes authority for the DOEA to delegate the administration of any of the bill provisions;

[41] E-mail from Tyler Jefferson, Legislative Affairs Director, the DOEA, *RE: SB 1182 - Education and Training for Alzheimer's Disease and Related Forms of Dementia*, March 11, 2023 (on file with the Senate Committee on Children, Families, and Elder Affairs).
[42] *Id*.

- Makes employees responsible for compliance with the training requirements instead of employers;
- Requires the DOEA to provide a record of the completion of the 1-hour training program to the covered provider, rather than a record of the training program;
- Makes the training requirements apply to employees who provide personal care to any resident of a facility, instead of only to residents with Alzheimer's disease.
- Authorizes the DOEA to develop or provide continuing education training or curricula;
- Removes authority for a person with a master's or doctoral degree in health care, social services, or gerontology to act as a training provider;
- Authorizes the DOEA to adopt rules to create training curriculum guidelines;
- Retains current law relating to training requirements on Alzheimer's disease for hospice employees;
- Clarifies that all ALF employees must complete ADRD training under the bill, rather than adding training as a topic on the core competency test for ALF administrators; and
- Allows the 1-hour training requirement for ALF employees to count toward the 2-hour preservice orientation, if completed before interacting with residents.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/14/2023	.	
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	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 430.5025, Florida Statutes, is created to read:

430.5025 Alzheimer's disease and related forms of dementia; education and training.—

(1) This section may be cited as the "Alzheimer's Disease and Related Forms of Dementia Education and Training Act."

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

(a) "Covered provider" means a nursing home, a home health agency, a nurse registry, a companion or homemaker service provider, an assisted living facility, an adult family-care home, or an adult day care center licensed or registered under chapter 400 or chapter 429.

(b) "Department" means the Department of Elderly Affairs.

(c) "Employee" means a person, contracted staff, or an independent contractor employed or referred by a covered provider who is required to undergo a level 2 background screening under s. 408.809 and chapter 435.

(d) "Personal care" means providing, through in-person contact, assistance with activities of daily living, assistance with self-administration of medication, homemaker or companion services, nursing services, or other services that promote the physical, mental, and psychosocial well-being of participants, patients, and residents of covered providers. The term does not include duties involving administrative functions or maintaining the physical environment of a licensed facility, including grounds maintenance, building maintenance, housekeeping, laundry, or food preparation.

(e) "Regular contact" means the performance of duties other than personal care which may require employees to interact in person on a daily basis with participants, patients, or residents.

(3) The department shall offer to the general public education about Alzheimer's disease and related forms of dementia. Such education must provide basic information about the most common forms of dementia, how to identify the signs and

symptoms of dementia, coping skills, how to respond to changes, planning for the future, and how to access additional resources about dementia.

(4) Employees of covered providers must complete the following training for Alzheimer's disease and related forms of dementia:

(a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have Alzheimer's disease or related forms of dementia.

(b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department.

1. The department shall provide the training in an online format at no cost. The 1-hour training program must contain information on understanding the basics about the most common forms of dementia, how to identify the signs and symptoms of dementia, and skills for communicating and interacting with persons with Alzheimer's disease or related forms of dementia. A record of the completion of the training program must be made available to the covered provider which identifies the training course, the name of the employee, and the date of completion.

2. A covered provider must maintain a record of the employee's completion of the training and, upon written request of the employee, must provide the employee with a copy of the record of completion consistent with the employer's written policies.

3. An employee who has completed the training required in this subsection is not required to repeat the program upon

changing employment to a different covered provider.

(c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, and skills in working with families and caregivers.

(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.

(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with Alzheimer's disease or related forms of dementia, in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:

1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).

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2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of dementia-specific training. Such training must include, but is not limited to, understanding Alzheimer's disease and related forms of dementia, the stages of Alzheimer's disease, communication strategies, medical information, and stress management.

3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning technology. For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or hands-on experience to help develop and refine the employee's skills for caring for a person with Alzheimer's disease or a related form of dementia. The continuing education must cover at least one of the topics included in the dementia-specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning technology chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year.

(5) The department may establish training curricula guidelines for the training required in paragraphs (4)(c), (d), and (e). The department may approve training providers and

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training curricula and maintain a list of approved providers. Approved training may be offered in a variety of formats, including, but not limited to, in person, electronically, or on-the-job by a facility administrator or his or her designee. Continuing education under this section does not require the adoption of training curricula guidelines by the department or approval of the training provider and curricula by the department. The department may develop or provide continuing education training or curricula as an option for covered providers and employees.

(a) A training provider meeting one of the following qualifications may offer training in compliance with the training curricula guidelines without prior approval of the department:

1. A person approved by an applicable board or the Department of Health to provide training who is registered with the electronic continuing education tracking system under s. 456.025; or

2. A training provider approved by the department or its designee before July 1, 2023.

(b) Training providers qualified under subparagraph (a)1. must also have:

1. At least 1 year of teaching experience as an educator for caregivers of persons with Alzheimer’s disease or related forms of dementia;

2. At least 1 year of practical experience in a program providing care to persons with Alzheimer’s disease or related forms of dementia; or

3. Completed a specialized training program in the subject

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matter of Alzheimer's disease and related forms of dementia from an accredited health care, human services, or gerontology education provider.

(c) Upon an employee's completion of the training specified in paragraphs (4)(c), (d), and (e), the training provider must provide a record of the completion of the training which includes the name of the employee, the name of the training provider, the topics covered, and the date of completion. The training record is evidence of completion of training in the identified topic and the employee is not required to repeat training in that topic if the employee changes employment to a different covered provider.

(d) Any Alzheimer's disease and related forms of dementia training curriculum approved by the department or its designee before July 1, 2023, remains in effect until the curriculum's expiration date.

(6) The department may adopt rules to establish training curriculum guidelines, requirements for the approval of other qualified training providers, and a process for conducting a sampling of training or training curricula as necessary to monitor for compliance with curricula guidelines.

(7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant.

(8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board.

(9) Each person employed, contracted, or referred to provide services before July 1, 2023, must complete the training required in this section before July 1, 2026. Proof of completion of equivalent training completed before July 1, 2023, shall substitute for the training required in subsection (4). Each person employed, contracted, or referred to provide services on or after July 1, 2023, may satisfy the training requirements by completing training using approved curricula as specified in paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6).

Section 2. Paragraph (b) of subsection (2) of section 400.0239, Florida Statutes, is amended to read:

400.0239 Quality of Long-Term Care Facility Improvement Trust Fund.—

(2) Expenditures from the trust fund shall be allowable for direct support of the following:

(b) Development and implementation of specialized training programs for long-term care facility personnel who provide direct care for residents with Alzheimer's disease and other dementias, including training provided under s. 430.5025, residents at risk of developing pressure sores, and residents with special nutrition and hydration needs.

Section 3. Section 400.1755, Florida Statutes, is amended to read:

400.1755 Care for persons with Alzheimer's disease or related disorders; staff training requirements.—

~~(1)~~ As a condition of licensure, the employees of facilities licensed under this part must complete the training required under s. 430.5025 ~~provide to each of their employees,~~

~~upon beginning employment, basic written information about interacting with persons with Alzheimer's disease or a related disorder~~.

~~(2) All employees who are expected to, or whose responsibilities require them to, have direct contact with residents with Alzheimer's disease or a related disorder must, in addition to being provided the information required in subsection (1), also have an initial training of at least 1 hour completed in the first 3 months after beginning employment. This training must include, but is not limited to, an overview of dementias and must provide basic skills in communicating with persons with dementia.~~

~~(3) An individual who provides direct care shall be considered a direct caregiver and must complete the required initial training and an additional 3 hours of training within 9 months after beginning employment. This training shall include, but is not limited to, managing problem behaviors, promoting the resident's independence in activities of daily living, and skills in working with families and caregivers.~~

~~(a) The required 4 hours of training for certified nursing assistants are part of the total hours of training required annually.~~

~~(b) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward this total of 4 hours.~~

~~(4) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be~~

~~considered to be approved by the Department of Elderly Affairs.~~

~~(5) The Department of Elderly Affairs or its designee must approve the initial and continuing training provided in the facilities. The department must approve training offered in a variety of formats, including, but not limited to, Internet-based training, videos, teleconferencing, and classroom instruction. The department shall keep a list of current providers who are approved to provide initial and continuing training. The department shall adopt rules to establish standards for the trainers and the training required in this section.~~

~~(6) Upon completing any training listed in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility or to an assisted living facility, home health agency, adult day care center, or adult family-care home. The direct caregiver must comply with other applicable continuing education requirements.~~

Section 4. Section 400.4785, Florida Statutes, is amended to read:

400.4785 Patients with Alzheimer’s disease or other related disorders; staff training requirements; certain disclosures.—

(1) The employees of a home health agency must complete the training required under s. 430.5025 ~~A home health agency must~~

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~~provide the following staff training:~~

~~(a) Upon beginning employment with the agency, each employee must receive basic written information about interacting with participants who have Alzheimer's disease or dementia-related disorders.~~

~~(b) In addition to the information provided under paragraph (a), newly hired home health agency personnel who will be providing direct care to patients must complete 2 hours of training in Alzheimer's disease and dementia-related disorders within 9 months after beginning employment with the agency. This training must include, but is not limited to, an overview of dementia, a demonstration of basic skills in communicating with persons who have dementia, the management of problem behaviors, information about promoting the client's independence in activities of daily living, and instruction in skills for working with families and caregivers.~~

~~(c) For certified nursing assistants, the required 2 hours of training shall be part of the total hours of training required annually.~~

~~(d) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 2 hours.~~

~~(e) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.~~

~~(f) The Department of Elderly Affairs, or its designee, must approve the required training. The department must consider~~

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~~for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 2-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.~~

~~(g) Upon completing the training listed in this section, the employee shall be issued a certificate that states that the training mandated under this section has been received. The certificate shall be dated and signed by the training provider. The certificate is evidence of completion of this training, and the employee is not required to repeat this training if the employee changes employment to a different home health agency~~.

(2) ~~(h)~~ A licensed home health agency whose unduplicated census during the most recent calendar year was composed ~~comprised~~ of at least 90 percent of individuals aged 21 years or younger at the date of admission is exempt from the training requirements in this section.

(3) ~~(2)~~ An agency licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The agency must give a copy of all such advertisements or a copy of the document to each person who requests information about the agency and must maintain a copy of all such advertisements and documents in its records. The Agency for Health Care Administration shall examine all such advertisements and documents in the agency's records as part of

the license renewal procedure.

Section 5. Section 400.510, Florida Statutes, is created to read:

400.510 Patients with Alzheimer's disease or other related disorders; staff training requirements.—A person employed, contracted, or referred by a nurse registry or a person registered with the agency to provide companion or homemaker services must complete the training required under s. 430.5025.

Section 6. Section 429.178, Florida Statutes, is amended to read:

429.178 Special care for persons with Alzheimer's disease or other related disorders.—

~~(1)~~ A facility that ~~which~~ advertises that it provides special care for persons with Alzheimer's disease or other related disorders must meet the following standards of operation:

(1)(a)~~1.~~ If the facility has 17 or more residents, have an awake staff member on duty at all hours of the day and night; or

(b)~~2.~~ If the facility has fewer than 17 residents, have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the facility's residents.

(2)~~(b)~~ Offer activities specifically designed for persons who are cognitively impaired.

(3)~~(c)~~ Have a physical environment that provides for the safety and welfare of the facility's residents.

(4)~~(d)~~ Require employed ~~Employ~~ staff to complete ~~who have completed~~ the training and continuing education required under s. 430.5025 ~~in subsection (2)~~.

~~(2)(a) An individual who is employed by a facility that provides special care for residents who have Alzheimer's disease or other related disorders, and who has regular contact with such residents, must complete up to 4 hours of initial dementia-specific training developed or approved by the department. The training must be completed within 3 months after beginning employment and satisfy the core training requirements of s. 429.52(3)(g).~~

~~(b) A direct caregiver who is employed by a facility that provides special care for residents who have Alzheimer's disease or other related disorders and provides direct care to such residents must complete the required initial training and 4 additional hours of training developed or approved by the department. The training must be completed within 9 months after beginning employment and satisfy the core training requirements of s. 429.52(3)(g).~~

~~(c) An individual who is employed by a facility that provides special care for residents with Alzheimer's disease or other related disorders, but who only has incidental contact with such residents, must be given, at a minimum, general information on interacting with individuals with Alzheimer's disease or other related disorders, within 3 months after beginning employment.~~

~~(3) In addition to the training required under subsection (2), a direct caregiver must participate in a minimum of 4 contact hours of continuing education each calendar year. The continuing education must include one or more topics included in the dementia-specific training developed or approved by the department, in which the caregiver has not received previous~~

~~training.~~

~~(4) Upon completing any training listed in subsection (2), the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility. The employee or direct caregiver must comply with other applicable continuing education requirements.~~

~~(5) The department, or its designee, shall approve the initial and continuing education courses and providers.~~

~~(6) The department shall keep a current list of providers who are approved to provide initial and continuing education for staff of facilities that provide special care for persons with Alzheimer's disease or other related disorders.~~

~~(7) Any facility more than 90 percent of whose residents receive monthly optional supplementation payments is not required to pay for the training and education programs required under this section. A facility that has one or more such residents shall pay a reduced fee that is proportional to the percentage of such residents in the facility. A facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the department, for such training and education programs.~~

~~(8) The department shall adopt rules to establish standards for trainers and training and to implement this section.~~

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Section 7. Subsection (1) of section 429.52, Florida Statutes, is amended to read:

429.52 Staff training and educational requirements.—

(1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.

(b) Each employee must complete the training required under s. 430.5025.

(c) If completed before interacting with residents, the 1-hour training required in s. 430.5025 concerning information on Alzheimer's disease and related forms of dementia may count toward the 2 hours of preservice orientation required under paragraph (a).

Section 8. Section 429.83, Florida Statutes, is amended to read:

429.83 Residents with Alzheimer's disease or other related disorders; training; certain disclosures.—

(1) The employees of an adult family-care home must complete the training required under s. 430.5025.

(2) An adult family-care home licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in

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its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The home must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the home and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the home's records as part of the license renewal procedure.

Section 9. Subsection (1) of section 429.917, Florida Statutes, is amended to read:

429.917 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.—

(1) The employees of an adult day care center licensed under this part must complete the training required under s. 430.5025 ~~provide the following staff training:~~

~~(a) Upon beginning employment with the facility, each employee must receive basic written information about interacting with participants who have Alzheimer's disease or dementia-related disorders.~~

~~(b) In addition to the information provided under paragraph (a), newly hired adult day care center personnel who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer's disease or dementia-related disorders must complete initial training of at least 1 hour within the first 3 months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating~~

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~~with persons who have dementia.~~

~~(c) In addition to the requirements of paragraphs (a) and (b), an employee who will be providing direct care to a participant who has Alzheimer's disease or a dementia-related disorder must complete an additional 3 hours of training within 9 months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the participant's independence in activities of daily living, and instruction in skills for working with families and caregivers.~~

~~(d) For certified nursing assistants, the required 4 hours of training shall be part of the total hours of training required annually.~~

~~(e) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 4 hours.~~

~~(f) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.~~

~~(g) The Department of Elderly Affairs or its designee must approve the 1-hour and 3-hour training provided to employees and direct caregivers under this section. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 1-hour and 3-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers,~~

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~~and for the training required in this section.~~

~~(h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different adult day care center or to an assisted living facility, nursing home, home health agency, or hospice. The direct caregiver must comply with other applicable continuing education requirements.~~

~~(i) An employee who is hired on or after July 1, 2004, must complete the training required by this section~~.

Section 10. Subsection (6) of section 429.918, Florida Statutes, is amended to read:

429.918 Licensure designation as a specialized Alzheimer's services adult day care center; training.—

(6)~~(a)~~ An adult day care center having a license designated under this section must provide the following staff training and supervision:

(a)~~1.~~ A registered nurse or licensed practical nurse must be on site daily for at least 75 percent of the time that the center is open to ADRD participants. Each licensed practical nurse who works at the center must be supervised in accordance with chapter 464.

(b) Each employee must complete the training and continuing education required under s. 430.5025.

~~2. Upon beginning employment with the center, each employee~~

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~~must receive and review basic written information about interacting with ADRD participants.~~

~~3. In addition to the information provided in subparagraph 2., every employee hired on or after July 1, 2012, who has direct contact with ADRD participants shall complete 4 hours of dementia-specific training within 3 months after employment.~~

~~4. In addition to the requirements of subparagraphs 2. and 3., each employee hired on or after July 1, 2012, who provides direct care to ADRD participants shall complete an additional 4 hours of dementia-specific training within 6 months after employment.~~

~~(b) The Department of Elderly Affairs or its designee shall approve the training required under this section. The department shall adopt rules to establish standards for employees who are subject to this training, for trainers, and for the training required in this section.~~

~~(c) Upon completing any training described in this section, the employee shall be issued a certificate that includes the name of the training provider, the topics covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topics, and the employee is not required to repeat training in those topics if the employee changes employment to a different adult day care center.~~

(c) ~~(d)~~ Each employee hired on or after July 1, 2012, who provides direct care to ADRD participants, must receive and review an orientation plan that includes, at a minimum:

1. Procedures to locate an ADRD participant who has wandered from the center. These procedures must ~~shall~~ be

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reviewed regularly with all direct care staff.

2. Information on the Silver Alert program in this state.

3. Information regarding available products or programs used to identify ADRD participants or prevent them from wandering away from the center, their home, or other locations.

Section 11. This act shall take effect July 1, 2023.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to education and training for Alzheimer's disease and related forms of dementia; creating s. 430.5025, F.S.; providing a short title; defining terms; requiring the Department of Elderly Affairs to offer certain education about Alzheimer's disease and related forms of dementia to the general public; specifying uniform dementia-related education and training for employees of covered providers; requiring the department to provide certain dementia-related employee training in an online format and at no cost; providing minimum requirements for the training; requiring the department to make a record of the completion of the training; providing requirements for the record; requiring covered providers to maintain such records of training completion for their employees; providing that an employee does not have to repeat such training after changing employment to

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another covered provider; providing additional training and continuing education requirements for certain employees who provide direct care to patients with Alzheimer's disease or related forms of dementia; authorizing the department to establish training curriculum guidelines; authorizing the department to approve training providers and curricula and maintain a list of approved providers; authorizing training to be offered in a variety of formats; providing that certain continuing education does not require the adoption of curriculum guidelines by the department or provider or curriculum approval by the department; authorizing the department to develop or provide continuing education training or curricula as an option for covered providers and their employees; providing qualifications and requirements for training providers; providing that training curricula approved before the effective date of this act remain in effect until their respective expiration dates; authorizing the department to adopt rules related to training curriculum guidelines, qualified training providers, and compliance monitoring procedures; authorizing certified nursing assistants to count the dementia-related training toward their annual certification training requirements; authorizing health care practitioners to count the dementia-related training requirements toward their continuing education requirements for licensure; authorizing persons employed, contracted, or referred to provide services


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before the effective date of this act to complete the required training by a specified date; providing for the substitution of equivalent training for training required by this act; authorizing persons to satisfy the training requirements of this act using training curricula approved before the effective date of this act until the department adopts rules for training curricula guidelines; amending ss. 400.0239, 400.1755, and 400.4785, F.S.; conforming provisions to changes made by the act; creating s. 400.510, F.S.; requiring a person employed, contracted, or referred by a nurse registry or a person registered with the Agency for Health Care Administration to provide companion or homemaker services to complete specified training; amending ss. 429.178, 429.52, 429.83, 429.917, and 429.918, F.S.; conforming provisions to changes made by the act; providing an effective date.

By Senator Garcia

36-00558A-23 20231190__

A bill to be entitled

An act relating to the Step into Success Workforce Education and Internship Pilot Program; creating s. 409.1455, F.S.; providing a short title; requiring the Department of Children and Families to establish the pilot program; specifying the purposes and components of the program; requiring the department's Office of Continuing Care, in consultation with certain entities, to develop and administer the program; authorizing the department to contract with certain entities to collaborate with the office on development and administration of the pilot program; requiring the independent living professionalism and workforce education component of the pilot program to culminate in a specified certificate; providing that completion of that component allows former foster youth to participate in the onsite workforce and training internship component; defining terms; providing requirements for the administration of the pilot program; requiring the office to initiate the respective components of the pilot program by specified dates; specifying the duties of the office related to the two components; requiring the components to address specified topics; providing requirements for organizations participating in the onsite workforce training internship component; specifying time limitations for former foster youth participating in the onsite workforce training internship component; requiring the Board of Governors

and the State Board of Education to adopt certain regulations and rules, respectively; specifying conditions for participation in the onsite workforce internship component; requiring the department to include a section on the pilot program in a specified annual report which must include specified information; requiring the department to adopt rules; amending s. 414.56, F.S.; conforming a provision to changes made by the act; providing an effective date.

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

Section 1. Section 409.1455, Florida Statutes, is created to read:

409.1455 Step into Success Workforce Education and Internship Pilot Program for foster youth and former foster youth.—

(1) SHORT TITLE.—This section may be cited as the "Step into Success Act."

(2) CREATION.—The department shall establish the 3-year Step into Success Workforce Education and Internship Pilot Program to give eligible foster youth and former foster youth an opportunity to learn and develop essential workforce and professional skills, to transition from the custody of the department to independent living, and to become better prepared for an independent and successful future. The pilot program must consist of an independent living professionalism and workforce education component and, for youth who complete that component, an onsite workforce training internship component. In

consultation with subject-matter experts and the community-based care lead agencies, the office shall develop and administer the pilot program for interested foster youth and former foster youth; however, the department may contract with entities that have demonstrable subject-matter expertise in the transition to adulthood for foster youth, workforce training and preparedness, professional skills, and related subjects to collaborate with the office in the development and administration of the pilot program. The independent living professionalism and workforce education component of the program must culminate in a certificate that allows a former foster youth to participate in the onsite workforce training internship.

(3) DEFINITIONS.—For purposes of this section, the term:

(a) "Community-based care lead agency" has the same meaning as in s. 409.986(3).

(b) "Former foster youth" means an individual 18 years of age or older but younger than 26 years of age who is currently or was previously placed in licensed care, excluding Level I licensed placements pursuant to s. 409.175(5)(a)1., for at least 60 days within this state.

(c) "Foster youth" means an individual older than 16 years of age but younger than 18 years of age who is currently in licensed care, excluding Level I licensed placements pursuant to s. 409.175(5)(a)1.

(d) "Office" means the department's Office of Continuing Care.

(e) "Participating organization" means a state agency, a corporation under chapter 607 or chapter 617, or another relevant entity that has agreed to collaborate with the office

in the development and implementation of a trauma-informed onsite workforce training internship program pursuant to subsections (6) and (7).

(4) REQUIREMENTS OF THE DEPARTMENT AND OFFICE.—The department shall establish and the office shall develop and administer the pilot program for eligible foster youth and former foster youth. The pilot program must be administered as part of an eligible foster youth's regular transition planning under s. 39.6035 or as a post-transition service for eligible former foster youth. The office must begin the professionalism and workforce education component of the program on or before January 1, 2024, and the onsite workforce training internship component of the program on or before July 1, 2024.

(5) INDEPENDENT LIVING PROFESSIONALISM AND WORKFORCE EDUCATION COMPONENT REQUIREMENTS.—The office shall do all of the following in connection with the independent living professionalism and workforce education component for eligible foster youth and former foster youth:

(a) Designate and ensure that the number of qualified staff is sufficient to implement and administer the component, which may be part of a larger independent living or life skills training program if the larger program meets the requirements of this subsection.

(b) Develop all workshops, presentations, and curricula for the component, including, but not limited to, all written educational and training materials for foster youth and former foster youth. Resources may include, but are not limited to, workshops and materials to assist with preparing resumes, mock interviews, experiential training, and assistance with securing

an internship or employment. The office must review and update these materials as necessary. The training materials must address, but are not limited to, the following:

1. Interview skills;

2. Professionalism;

3. Teamwork;

4. Leadership;

5. Problem solving; and

6. Conflict resolution in the workplace.

(c) Require that the training provided be in addition to any other life skills or employment training required by law. The training may be developed or administered by the department, community-based care lead agencies, or the lead agencies' subcontracted providers, or in collaboration with colleges or universities or other nonprofit organizations in the community with workforce education and training resources.

(d) Provide relevant written materials from the component and any relevant tools developed to ensure participants' successful transition to internships to all participating organizations that offer workforce training internship opportunities.

(e) Provide materials to inform eligible foster youth and former foster youth of the program, the requirements for participation, and contact information for enrollment. The community-based care lead agencies shall ensure that any subcontracted providers that directly serve youth receive this information.

(f) Advertise and promote the availability of the education and internship program to engage as many eligible foster youth

and former foster youth as possible.

(g) Assess the career interests of each eligible foster youth and former foster youth who expresses interest in participating in the program and determine the most appropriate internship and post-internship opportunities for that youth based on his or her expressed interests.

(6) ONSITE WORKFORCE TRAINING INTERNSHIP COMPONENT REQUIREMENTS.—The office shall do all of the following in connection with the onsite workforce training internship program for eligible former foster youth:

(a) Develop processes and procedures to implement a trauma-informed onsite workforce training internship component. The processes and procedures of the internship component must be designed so that they can be replicated and scaled to meet various organizational structures and sizes. The component must include:

1. Recruitment of agencies, corporations, and other entities to host interns as participating organizations;

2. Assisting participating organizations with mentor recruitment, training, and matching;

3. Mentor-led performance reviews, including a review of the intern’s work product, professionalism, time management, communication style, and stress-management strategies;

4. Daily mentorship and coaching on topics such as:

a. Professionalism;

b. Teamwork;

c. Leadership;

d. Problem solving; and

e. Conflict resolution in the workplace;

5. Development of opportunities for interns to become employees of the participating organization; and

6. Reporting requirements specified in subsection (11).

(b) Develop a minimum of 1 hour of required trauma-informed training for mentors to teach the skills necessary to engage with participating eligible former foster youth.

(c) Provide assistance to eligible foster youth and former foster youth interested in participating in the internship component, including, but not limited to, identifying and monitoring internship opportunities, being knowledgeable of the training and skills needed to match eligible foster youth and former foster youth with appropriate internships, and assisting eligible foster youth and former foster youth with applying for post-internship employment opportunities.

(d) Publicize specific internship positions in an easily accessible manner and inform eligible foster youth and former foster youth of where to locate such information.

(e) Develop a process and schedule for the distribution of stipends to former foster youth participating in the component, subject to the availability of funds.

(f) Distribute funds appropriated for the compensation of mentors who are participating in the component as provided in paragraph (7)(b).

(g) By May 1, 2024, provide to the Board of Governors and the State Board of Education all relevant internship information necessary to support the award of postsecondary credit or career education clock hours for internship positions held by former foster youth participating in the onsite workforce training internship component.

(h) Develop and conduct follow-up surveys with:

1. Former foster youth within 3 months after their internship start date to ensure successful transition into the work environment and to gather feedback on how to improve the experience for future participants.

2. Mentors assigned to participating former foster youth.

Such data must be collected by October 1, 2024, and by October 1 annually thereafter, for inclusion in the independent living services annual report.

3. Any other persons the office deems relevant for purposes of continued improvement of the internship component.

(7) REQUIREMENTS FOR PARTICIPATING ORGANIZATIONS.—Each organization participating in the onsite workforce training internship component shall:

(a) Collaborate with the office to implement a trauma-informed approach to mentoring and training former foster youth.

(b) Recruit employees to serve as mentors for former foster youth interning with such organizations.

1. To serve as a mentor, an employee must:

a. Have worked for the participating organization for at least 1 year;

b. Have experience relevant to the job and task responsibilities of the intern;

c. Sign a monthly hour statement for the intern;

d. Allocate at least 1 hour per month to conduct mentor-led performance reviews, to include a review of the intern’s work product, professionalism, time management, communication style, and stress-management strategies; and

e. Complete a minimum of 1 hour of trauma-informed training

to gain skills critical for successfully engaging former foster youth.

2. Subject to available funding, an employee who serves as a mentor and receives the required trauma-informed training is eligible for a maximum payment of $1,200 per intern per fiscal year, to be issued as a $100 monthly payment for every month of service as a mentor.

3. An employee may serve as a mentor for a maximum of three interns at one time and may not receive more than $3,600 in compensation per fiscal year for serving as a mentor. Any time spent serving as a mentor to an intern under this section counts toward the minimum service required for eligibility for payments pursuant to subparagraph 2. and this subparagraph.

(c) When necessary, have a discussion with an intern's assigned mentor, the participating organization's internship program liaison, and the office about the creation of a corrective action plan to address issues related to the intern's professionalism, work product, or performance and, if applicable, after giving the intern a reasonable opportunity to comply with the corrective action plan, document the intern's failure to do so before discharging him or her.

(d) Provide relevant feedback to the office at least annually for the office to comply with paragraph (6)(h).

(e) Collaborate with the department to provide any requested information necessary to prepare the annual report required under subsection (11).

(8) TIME LIMITATIONS FOR PARTICIPATION.—A former foster youth who obtains an internship with a participating organization may participate in the internship component for no

more than 1 year, calculated as 12 monthly stipend periods. The year begins on his or her start date with a participating organization. A former foster youth may intern under the internship program with more than one participating organization, but may not intern with more than one participating organization at the same time. A participating organization may hire the intern as an employee, but the hiring of a former foster youth may not be for an internship under this section.

(9) AWARD OF POSTSECONDARY CREDIT.—The Board of Governors and the State Board of Education shall adopt regulations and rules, respectively, to award postsecondary credit or career education clock hours for eligible former foster youth participating in the internship component pursuant to subsection (4). The regulations and rules must include procedures for the award of postsecondary credit or career education clock hours, including, but not limited to, equivalency and alignment of the internship component with appropriate postsecondary courses and course descriptions.

(10) CONDITIONS OF PARTICIPATION IN THE INTERNSHIP COMPONENT.—

(a) To become a participant in the internship component of the program, the applicant must be a foster youth or a former foster youth as those terms are defined in subsection (3) at the time such youth applies for an internship position with a participating organization. A foster youth or former foster youth who has completed the training component with the department may apply for a position with a participating organization but may not begin an internship until attaining the

age of 18 years.

(b) If offered an internship, a former foster youth must be classified as an intern and must work 80 hours per month to be eligible for the stipend payment.

(c) A former foster youth must spend any stipend funds specified for clothing on clothing that is in compliance with the dress code requirements of the participating organization with which the former foster youth is interning. Notwithstanding any limitation on funds provided to purchase clothing, the former foster youth must comply with any dress code requirements of the participating organization with which he or she is interning.

(d) Stipend money earned pursuant to the internship component may not be considered earned income for purposes of computing eligibility for federal or state benefits, including, but not limited to, the Supplemental Nutrition Assistance Program, a housing choice assistance voucher program, the Temporary Cash Assistance Program, the Medicaid program, or the school readiness program. Notwithstanding this paragraph, any reduction in the amount of benefits or loss of benefits due to receipt of the Step into Success stipend may be offset by an additional stipend payment equal to the value of the maximum benefit amount for a single person allowed under the Supplemental Nutrition Assistance Program.

(e) A former foster youth may, at the discretion of a postsecondary educational institution within this state in which such youth is enrolled, earn postsecondary credit or career education clock hours for work performed as an intern under the internship component. Postsecondary credit and career education

clock hours earned for work performed under the internship component may be in addition to any compensation earned for the same work performed under the internship component and may be awarded for completion of all or any part of the internship component. Participating organizations shall cooperate with postsecondary educational institutions to provide any information about internship positions which is necessary to enable the institutions to determine whether to grant the participating former foster youth postsecondary credit or career education clock hours toward his or her degree.

(f) A former foster youth who accepts an internship with a participating organization pursuant to this section may only be discharged from the internship component after the participating organization engages the intern's assigned mentor and the participating organization's internship program staff to assist the intern in performing the duties of the internship. Before discharging the former foster youth, the participating organization must also document the intern's failure to comply with a corrective action plan after being given a reasonable opportunity to do so.

(11) REPORT.—The department shall include a section on the Step into Success Workforce Education and Internship Program in the independent living annual report prepared pursuant to s. 409.1451(6) which includes, but is not limited to, all of the following:

(a) Whether the pilot program is in compliance with this section, and if not, barriers to compliance.

(b) A list of participating organizations and the number of interns.

(c) A summary of recruitment efforts to increase the number of participating organizations.

(d) A summary of the feedback and surveys received pursuant to paragraph (6)(h) from participating former foster youth, mentors, and others who have participated in the program.

(e) Recommendations, if any, for actions necessary to improve the quality, effectiveness, and outcomes of the pilot program.

(f) Employment outcomes of former foster youth who participated in the pilot program, including employment status after completion of the program, whether he or she is employed by the participating organization in which he or she interned or by another entity, and job description and salary information, if available.

(12) RULEMAKING.—The department shall adopt rules to implement this section.

Section 2. Subsection (5) is added to section 414.56, Florida Statutes, to read:

414.56 Office of Continuing Care.—The department shall establish an Office of Continuing Care to ensure young adults who age out of the foster care system between 18 and 21 years of age, or 22 years of age with a documented disability, have a point of contact until the young adult reaches the age of 26 in order to receive ongoing support and care coordination needed to achieve self-sufficiency. Duties of the office include, but are not limited to:

(5) Developing and administering the Step into Success Workforce Education and Internship Pilot Program for foster youth and former foster youth as required under s. 409.1455.

Section 3. This act shall take effect July 1, 2023.

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:	CS/SB 1190
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Garcia
SUBJECT:	Step into Success Workforce Education and Internship Pilot Program
DATE:	March 15, 2023 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Tuszynski	Cox	CF	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1190 creates s. 409.1455, F.S., cited as the "Step into Success Act," establishing the Step into Success Workforce Education and Internship Program (program) as a three-year pilot administered by the Department of Children and Families' (DCF) Office of Continuing Care (OCC). The program must consist of an independent living professionalism and workforce education component and, for youth that complete that component, an onsite workforce training internship component that uses employees of participating organizations as mentors. The purpose of the program is to assist foster youth transitioning to adulthood to:

- Develop essential workforce and professional skills;
- Transition from the custody of the DCF to independent living; and
- Become best prepared for an independent and successful future.

The bill specifies and details numerous requirements for the operation of each component of the program as well as for participating organizations, mentors, and foster and former foster youth who participate. Some of the specific requirements are:

- The program is available to foster and former foster youth between the ages of 16 and 25 who are currently or were previously in foster care. A foster youth may participate in the education component at age 16 years of age or older, but a former foster youth may not begin the internship portion until turning 18 years of age.
- The program must match mentors in participating organizations with the youth participating to ensure that the youth acquire as many skills as possible and provide a $1,200 per year

payment to mentors with a limitation on the number of interns a mentor may be paired with in a given year.
- The DCF must perform follow-up surveys with foster and former foster youth, mentors, and other persons to include specific information about the program and recommendations for improvement in an annual report.
- The DCF must implement the workforce education component on or before January 1, 2024 and the internship component on or before July 1, 2024.

The bill provides for a monthly financial assistance payment of $1,517 to former foster youth participating in the internship component and ensures that the stipend does not count toward income in the determination of self-sufficiency benefit eligibility. Further, the bill provides a specified increase in the stipend payment amount if the youth does have a loss or reduction of any benefits.

The bill requires the Board of Governors and State Board of Education to adopt rules and regulations to award postsecondary credit or career education clock hours to program participants.

The bill requires the DCF to adopt rules to implement the program.

The bill will have significant negative fiscal impact on state government. See Section V. Fiscal Impact Statement.

The bill takes effect July 1, 2023.

II. Present Situation:

Florida's Child Welfare System

Florida's child welfare system identifies children and families in need of services through reports to the central abuse hotline and child protective investigations. The DCF and community-based care lead agencies (CBC) work with those families to address the problems endangering children, if possible. If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children until a permanency option can be identified.

Florida Central Abuse Hotline

The DCF operates the Florida central abuse hotline (hotline), which accepts reports 24 hours a day, seven days a week of known or suspected child abuse, abandonment, or neglect.[1] A child protective investigation begins with a report by any person to the hotline. Law requires any person who knows or suspects that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care, shall report such knowledge or suspicion to the hotline.[2]

[1] Section 39.101(1)(a), F.S.
[2] Section 39.201(1)(a), F.S.

Once the hotline obtains information from a reporter, the allegations of the report must meet the statutory definition required to trigger a child protective investigation. For a report to be accepted and initiate an investigation the hotline must have reasonable cause to believe that the child is at risk of or was harmed by abuse, abandonment, or neglect.[3]

Child Protective Investigations

The DCF must conduct a child protective investigation if a hotline report meets the statutory definition of child abuse, abandonment, or neglect. An investigation is commenced immediately or within 24 hours after the report is received, depending on the nature of the allegation.[4] The child protective investigator assesses the safety and perceived needs of the child and family and whether the child should receive in-home services or removed and placed in out-of-home care.

Community-Based Care Organizations and Services

If a child protective investigation results in verified findings of abuse or neglect, the child will receive a case plan and services are provided to the family to address the problems that are endangering the child. The DCF contracts for case management, out-of-home care, and related services with CBCs. The use of CBCs to provide child welfare services is intended to increase local community ownership of service delivery and design.[5]

The DCF contracts for case management, out-of-home care (foster care), adoption, and other related services with lead agencies, also known as community-based care organizations (CBCs). The Legislature designed the CBC model to increase local community ownership of service delivery and design of child welfare services.[6]

The DCF, through the CBCs, administers a system of care[7] for children that is directed toward:
- Prevention of separation of children from their families;
- Intervention to allow children to remain safely in their own homes;
- Reunification of families who have had children removed from their care;
- Safety for children who are separated from their families;
- Promoting the well-being of children through emphasis on educational stability and timely health care;
- Permanency; and
- Transition to independence and self-sufficiency.[8]

The CBCs must give priority to services that are evidence-based and trauma informed.[9] The CBCs contract with a number of subcontractors for case management and direct care services to

[3] *See* ss. 39.101(1)(b) and 39.101(2), F.S.
[4] Section 39.201(2)(a), F.S.
[5] The Department of Children and Families, *About Community-Based Care*, available at https://www.myflfamilies.com/services/child-family/child-and-family-well-being/community-based-care/about-community-based-care (last visited March 7, 2023) (hereinafter cited as "DCF").
[6] *Id.*
[7] *Id.*
[8] *Id.*; *Also see generally* s. 409.988, F.S.
[9] Section 409.988(3), F.S.

children and their families. There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.[10] The CBCs employ case managers that serve as the primary link between the child welfare system and families with children under the DCF's supervision. These case managers work with affected families to ensure that a child reaches his or her permanency goal in a timely fashion.[11]

Transition to Independent Living

Sometimes a child's particular case results in that child not finding permanency through reunification, adoption, or another arrangement and that child transitions to young adulthood while in the care of the DCF. In these instances, the DCF is required to assist children who are transitioning out of foster care to independent living and self-sufficiency, including the requirement to:

- Identify important life skills that children in out-of-home care should acquire;
- Develop a list of age-appropriate activities and responsibilities for children and caregivers;
- Design and disseminate training for caregivers related to building needed life skills;
- Regularly assess the degree of life skills acquired by each child beginning after the child's 13th birthday, and support the caregiver in implementing an updated transition plan as necessary;
- Provide opportunities for children to interact with qualified, trained mentors; and
- Develop and implement procedures for children of sufficient age and understanding to directly access and manage the personal allowance they receive from the DCF.[12]

During the year after a child reaches 16 years of age, the DCF and community-based care lead agency as well as other specified individuals are required to assist the child in developing a transition plan.[13] The plan must include specific resources that the child may use to obtain services, such as housing, health insurance and education, and tasks to establish and maintain naturally occurring mentoring relationships.[14] The DCF and CBC are required to periodically meet with the young adult to review and update the transition plan beyond the young adults 18th birthday if the young adult is participating in Independent Living Services.[15]

Florida provides Independent Living Services to assist young adults in obtaining the skills, education, and support necessary to become self-sufficient after his or her exit from foster care into adulthood.[16] The program comprises three main programs: postsecondary education services and support, extended foster care, and aftercare.[17] The categories of services to assist in the successful transition to adulthood include:

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[10] The DCF, *Lead Agency Information*, available at https://www.myflfamilies.com/services/child-family/child-and-family-well-being/community-based-care/lead-agency-information (last visited March 7, 2023).
[11] Section 409.988(1), F.S.
[12] Section 409.14515, F.S.
[13] Section 39.6035(1), F.S
[14] *Id.*
[15] Section 39.6035(5), F.S.
[16] Section 409.1451, F.S. The Road-to-Independence program was created in statute in 2002. Over the last 21 years the program has been expanded and added to larger initiatives focused on independent living. Today, the independent living services provided under Road-to-Independence are generally referred to as "Independent Living Services" as the overall construction of the program has grown outside of s. 409.1451, F.S., and the term "Road-to-Independence" is rarely used.
[17] *See generally* ss. 409.1451 and 39.6251, F.S.

- Independent living needs assessment;
- Academic support;
- Postsecondary educational support;
- Career preparation;
- Employment programs or vocational training;
- Budget and financial management;
- Housing education and home management training;
- Health education and risk prevention;
- Family support and healthy marriage education;
- Mentoring;
- Supervised independent living;
- Room and board financial assistance;
- Education financial assistance: and
- Other financial assistance.[18]

Postsecondary Education Services and Support (PESS)

PESS is a program that provides monthly financial support for a young adult to secure housing, utilities, and assist with cost of living while attending certain postsecondary educational institutions.[19]

A young adult is eligible for PESS if certain criteria are met, including:

- Specified criteria with respect to when the child was living in foster care;
- Earned a standard high school diploma;[20]
- Has been admitted for enrollment as a full-time[21] student or its equivalent in an eligible postsecondary institution as provided in s. 1009.533, F.S.;[22]
- Has reached 18 years of age, but is not yet 23 years of age;
- Has applied for any other grants and scholarships for which he or she may qualify;
- Submitted a complete and error-free Free Application for Federal Student Aid; and
- Signed an agreement to allow the DCF and the community-based care lead agency to access his or her school records.[23]

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[18] Daniel Kids, *Florida's Independent Living Resource Center*, available at https://www.danielkids.org/our-programs/floridas-i-l-resource-center/ (last visited March 7, 2023) (hereinafter cited as "Daniel").
[19] The DCF, *Postsecondary Education Services and Support (PESS)*, available at https://www.myflfamilies.com/services/child-family/independent-living/youth-young-adults/postsecondary-education-services-and (last visited March 7, 2023).
[20] Pursuant to s. 1002.3105(5), F.S., s. 1003.4281, F.S., or s. 1003.4282, F.S., or its equivalent pursuant to s. 1003.435, F.S.
[21] Section 409.1451(2)(a)4., F.S., defines "full-time" as 9 credit hours or the vocational school equivalent.
[22] Section 1009.533, F.S., provides for eligible postsecondary education institutions, including: (1) a Florida public university, Florida College System institution, or career center; (2) An independent Florida college or university that is accredited by an accrediting association whose standards are comparable to the minimum standards required to operate an institution at that level in Florida and which has operated in the state for at least 3 years; (3) an independent Florida postsecondary education institution that is licensed by the Commission for Independent Education and meets other specified criteria; (4) a Florida independent postsecondary education institution that offers a nursing diploma approved by the Board of Nursing; and (5) A Florida independent postsecondary education institution that is licensed by the Commission for Independent Education.
[23] Section 409.1451(2)(a), F.S.

Extended Foster Care

A child who is living in foster care on his or her 18th birthday and who has not achieved permanency in accordance with s. 39.621, F.S.,[24] is eligible to remain in licensed care under the care of the DCF and the jurisdiction of the court if he or she is:

- Completing secondary education or equivalent program;
- Enrolled in a postsecondary or vocational education institution;
- Participating in a program to eliminate barriers to employment;
- Employed for at least 80 hours per month; or
- Unable to participate in any of the above-listed programs or activities.[25]

A young adult[26] who participates in extended foster care must reside in a DCF-approved supervised living environment. The young adult must live independently in this approved placement, but the DCF and CBC must provide the young adult with supervision, case management, and supportive services.[27]

Aftercare Services

Aftercare services are available for a young adult who has reached 18 years of age but is not yet 23 years of age and is:

- Not in foster care.
- Temporarily not receiving financial assistance to pursue postsecondary education.[28]

The specific aftercare services to be provided are determined by an assessment of an eligible young adult, and may include, in part:

- Mentoring and tutoring;
- Mental health services and substance abuse counseling;
- Life skills classes;
- Parenting classes;
- Job and career skills training;
- Counselor consultations;
- Temporary assistance for necessities and emergency situations; and
- Financial literacy skills training.[29]

[24] Section 39.621(3), F.S., provides that the permanency goals available under ch. 39, F.S., listed in order of preference, are reunification; adoption, if a petition for termination of parental rights has been or will be filed; permanent guardianship of a dependent child under s. 39.6221, F.S.; permanent placement with a fit and willing relative under s. 39.6231, F.S.; or placement in another planned permanent living arrangement under s. 39.6241, F.S.

[25] Section 39.6251(2), F.S.

[26] Section 39.6251(1), F.S., defines "young adult" as an individual who has attained 18 years of age but who has not attained 21 years of age.

[27] Section 39.6251(4)(a), F.S.

[28] Section 409.1451(3)(a), F.S. Additionally, subject to available funding, aftercare services are also available to a young adult who is between the ages of 18 and 22, is receiving financial assistance for postsecondary education, who is experiencing an emergency situation, and whose resources are insufficient to meet the emergency situation.

[29] Section 409.1451(3)(b), F.S.

Office of Continuing Care

In 2021, the Legislature established the Office of Continuing Care (OCC) within the DCF. The Legislature created the OCC to provide ongoing support and care coordination to youth and young adults who age out of the foster care system between 18 and 21 years of age, or 22 years of age with a documented disability.[30] The OCC has specified duties, including, but not limited to:

- Providing young adults who age out of the foster care system with certain information about the office, including its purpose, services offered and contact information;
- Providing assistance in accessing services and supports; and
- Collaborating with community-based care lead agencies to identify local resources and assist young adults in accessing such support services.[31]

The OCC is also part of Hope Florida – A Pathway to Prosperity, a program that assists Floridians to navigate the myriad systems and programs created to stabilize and help families in crisis.[32] Hope Navigators guide, amongst others, foster youth on an individualized path to prosperity, economic self-sufficiency, and hope.[33]

Fostering Success Program

In 2014, the Legislature appropriated $75,000 to fund the Fostering Success Pilot Project for young adults who aged out of foster care to obtain internships/professional shadowing positions.[34] In 2016, the legislature funded an expansion of the pilot program with $100,000 appropriated in recurring general revenue funds to a program known as "Fostering Success Youth Readiness Training and Placement Services" (Fostering Success).[35] The program was designed for young adults ages 18 to 24 to gain employment skills that would enable them to achieve economic self-sufficiency and professional success through a program that provided year-long, part-time, Other Personal Services (OPS) positions with a participating state agency.[36] Funding for Fostering Success ceased in Fiscal Year 2020-2021.[37]

III. Effect of Proposed Changes:

The bill creates s. 409.1455, F.S., cited as the "Step into Success Act," establishing the Step into Success Workforce Education and Internship Program (program) as a three-year pilot administered by the DCF's Office of Continuing Care. The program must consist of an independent living professionalism and workforce education component and, for youth that complete that component, an onsite workforce training internship component that uses

[30] Chapter 2021-169, s. 20, L.O.F., codified as s. 414.56, F.S.
[31] *Id*.
[32] The DCF, *Hope Florida – A Pathway to Prosperity*, available at https://www.myflfamilies.com/services/hope-florida (last visited March 7, 2023).
[33] *Id*.
[34] Chapter 2014-51, Specific Appropriation 1393, L.O.F.
[35] Chapter 2016-66, Specific Appropriation 1351, L.O.F.
[36] Florida Fish and Wildlife Conservation Commission, *Fostering Success*, available at https://myfwc.com/get-involved/internships/fostering-success/ (last visited March 11, 2023).
[37] Governor Ron DeSantis, *2020 Veto List*, p. 8 lines 1384 and 1388, available at https://www.flgov.com/wp-content/uploads/2020/06/2020-Veto-List.pdf (last visited March 7, 2023).

employees of participating organizations as mentors. The purpose of the program is to assist foster youth transitioning to adulthood to:

- Develop essential workforce and professional skills;
- Transition from the custody of the DCF to independent living; and
- Become best prepared for an independent and successful future.

For the purposes of the bill, the term "foster youth" is defined as an individual older than 16 but younger than 18 years of age who is currently in licensed care, excluding Level I licensed placements and the term "former foster youth" is defined as an individual 18 years of age or older but younger than 26 years of age who is currently or was previously placed in licensed care, excluding Level I licensed placements.

A "participating organization" is defined as a state agency; a corporation under ch. 607, F.S., or ch. 617, F.S.; or another relevant entity that has agreed to collaborate with the OCC in the development and implementation of a trauma-informed onsite workforce training internship program.

The DCF must establish and the OCC must develop and administer the program and begin operations on or before January 1, 2024. The program must be provided as part of an eligible foster youth's regular transition planning or as a post-transition service for eligible former foster youth.

Independent Living Professionalism and Workforce Education Component

The OCC must meet the following requirements in development and implementation of the independent living professionalism and workforce education component:

- Designate and ensure that there is sufficient qualified staff to implement and maintain operation of the program, and provide required services to agency liaison personnel and eligible foster youth.
- Develop workshops, presentations, and curricula to educate youth on topics such as interview skills, professionalism, teamwork, leadership, problem solving, and conflict resolution in the workplace.[38]
- Provide relevant written materials from the component and any relevant tools developed to ensure successful transition to internships to all participating organizations.
- Provide written materials to youth to ensure that they are aware of the requirements for participating in the program and contact information for the program office. Community-based care lead agencies must provide any of their subcontracted providers that directly serve youth with such material.
- Advertise and promote the availability of the program.
- Assess each eligible foster youth's career interests and determine the most appropriate internship opportunities.

[38] This component must be provided in addition to any other life skills or employment training required by law and may be developed or administered by the DCF, community-based care lead agencies, or the lead agencies' subcontracted providers or through collaboration with the approved agencies, colleges or universities, or non-profit organizations in the community that have workforce training resources.

Onsite Workforce Training Internship Component

The OCC must meet the following requirements in development and implementation of the onsite workforce training internship component:

- Develop processes and procedures to implement a trauma-informed onsite workforce training internship component, designed to be replicated and scaled to meet various organizational structures and sizes, that includes:
  - Recruitment of agencies, corporations, and other entities to host interns as participating organizations;
  - Assisting participating organizations with mentor recruitment, training, and matching;
  - Mentor-led performance reviews, including the intern's work product, professionalism, time management, communication style, and stress management strategies;
  - Daily mentorship and coaching on professionalism, teamwork, leadership, problem solving, and conflict resolution;
  - Development of employment opportunities for interns; and
  - Reporting requirements.
- Develop a minimum of 1 hour of required trauma-informed training for mentors.
- Provide assistance to eligible youth interested in the internship component.
- Publicize internship positions in an easily accessible manner to inform eligible youth.
- Develop a process and schedule for the distribution of $1,517 monthly financial assistance payments to former foster youth participating in the component, subject to availability.
- Distribute funds appropriated for the compensation of mentors at $1,200 per intern per fiscal year, to be issued as $100 monthly payments for every month of service as a mentor. A mentor may only mentor a maximum of three interns at one time for a maximum of $3,600 in compensation per fiscal year.
- By May 1, 2024, provide the Board of Governors and State Board of Education all relevant internship information necessary to support the award of postsecondary credit or career education clock hours.
- Develop and conduct follow-up surveys with former foster youth, mentors, and any other persons the OCC deems relevant for continued improvement of the internship component.

Requirements for Participating Organizations

The participating organizations must meet the following requirements in implementation of the onsite workforce training internship component:

- Collaborate with the OCC to implement a trauma-informed approach to mentoring former foster youth.
- Recruit employees that meet certain requirements to serve as mentors.
- Have discussions around the creation of corrective action plans, when necessary, and not discharging an intern until he or she is given a reasonable opportunity to comply with the corrective action plan.
- Provide relevant feedback and certain information for reporting purposes to the DCF.

The bill requires that mentors within participating organizations must:

- Have worked for the participating agency for a minimum of one year;
- Have experience relevant to the employment responsibilities of the intern;

- Sign a monthly hour statement for the intern;
- Allocate at least 1 hour per month for performance reviews; and
- Complete a minimum of 1 hour of trauma-informed training.

Requirements for Former Foster Youth Participating in the Internship Component

Former foster youth must complete the training component with the DCF before being eligible to apply for an open internship under the internship component and must have attained the age of 18 years before working as an intern.

If offered an internship, a former foster youth must be classified as an intern and work 80 hours per month to be eligible for the financial assistance payment. Any stipend specified for clothing must be spent on clothing that is in compliance with the dress code requirements of the participating organization and comply with the participating organizations' dress code and can be awarded separate from the monthly financial assistance payment related to the internship component.

If offered an internship, a former foster youth may hold the position for no more than one year. The participating organization may extend the internship beyond the one year or hire the foster youth as a full-time employee, but it may not be as an intern under the program. A foster youth may intern at more than one participating organization but not at the same time.

A former foster youth participating in an internship may only be discharged from the internship component after the participating organization engages the intern's assigned mentor and the internship program staff to assist the intern in performing the duties of the internship. Before discharging the former foster youth, the participating organization must document the intern's failure to comply with a corrective action plan after being given a reasonable opportunity to do so.

Any financial assistance payment money earned pursuant to the internship component may not be considered earned income for the purposes of computing eligibility for federal or state benefit programs. If there is a reduction or loss of benefits due to the receipt of the Step into Success financial payment money, that reduction or loss may be offset by an additional financial assistance payment equal to the value of the maximum benefit amount for a single person allowed under the Supplemental Nutrition Assistance Program.[39]

Postsecondary Credits or Career Education Clock Hours

The Board of Governors and the State Board of Education is required to adopt regulations and rules, respectively, to award postsecondary credit or career education clock hours for eligible former foster youth participating in the internship component.

Additionally, a former foster youth may, at the discretion of the postsecondary institution within Florida in which such youth is enrolled, earn postsecondary credit or career education clock

[39] Currently $250 for a single person household in Florida. The DCF, *Food Assistance Program Fact Sheet*, p. 3, available at https://www.myflfamilies.com/sites/default/files/2022-10/fafactsheet_1.pdf (last visited March 10, 2023).

hours for work performed as an intern under the internship component. Postsecondary credit or career education clock hours earned may be in addition to any financial payment for the same work performed under the internship component and may be awarded for completion of the whole or any part of the internship component. Participating organizations must cooperate with postsecondary educational institutions to provide any information that is necessary for the institution to determine whether to grant the former foster youth postsecondary credit or career education clock hours toward his or her degree.

Reporting Requirement

The bill requires the DCF to include a section on the Step into Success Program in the annual independent living report required by s. 409.1451(6), F.S. The report must include, but is not limited to:

- Whether the pilot program is in compliance with statute, and if not, barriers to compliance.
- A list of participating organizations and interns.
- A summary of recruitment efforts.
- A summary of feedback and surveys received from former foster youth, mentors, and others.
- Recommendations for actions necessary to improve the quality, effectiveness, and outcomes of the pilot program.
- Employment outcomes of former foster youth who participated in the pilot program, including employment status, employment location, job description, and salary information, if available.

The bill also amends s. 414.56, F.S., to add the development and administration of the Step into Success program as one of the enumerated duties of the OCC. The bill requires the DCF to adopt rules to implement the program.

The bill takes effect July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill will have a significant negative fiscal impact on state government. Under the bill, former foster youth are to receive a $1,517 monthly financial assistance payment for participation in the internship component (line 192), an undefined stipend amount for clothing (line 296), and mentors are to receive $1,200 per year per intern (line 235), all subject to available funding. Furthermore, the DCF will need to staff the program with FTE positions and expend other funds to implement the program.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 414.56 of the Florida Statutes.

This bill creates section 409.1455 of the Florida Statutes.

IX. Additional Information:

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

CS by Children, Families, and Elder Affairs on March 14, 2023:
The amendment provides $1,517 as the amount of the monthly financial assistance payment to former foster youth participating in the internship component of the Step into Success Program.

B. Amendments:

None.

265304

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/14/2023	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 192 - 193

and insert:

(e) Provide a participating former foster youth with financial assistance in the amount of $1,517 monthly and develop a process and schedule for the distribution of payments to former foster youth participating in the component,

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 1210
INTRODUCER:	Senator Burgess
SUBJECT:	Public Records/Human Trafficking Victims
DATE:	March 14, 2023
REVISED:	3/14/23

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Tuszynski	Cox	CF	**Favorable**
2.			RC	

I. Summary:

SB 1210 amends s. 943.0583, F.S., expanding the public records exemption authorizing human trafficking victims to expunge a criminal history record related to offenses listed under the habitual violent felony offender designation unless a victim was found guilty of or entered a plea of guilty or nolo contendre to such an offense.

The bill also creates a new exemption from public records disclosure under s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution for any petition filed by a human trafficking victim to expunge a criminal history record and all pleadings and documents related to the petition.

The bill makes findings that the expansion of the exemption and the new exemption from public records disclosure are each a public necessity as required by the State Constitution. Two-thirds vote of both the House and the Senate is required for final passage.

The expansion of the exemption and the new exemption in the bill are subject to the Open Government Sunset Review Act and will be repealed on October 2, 2028 in accordance with s. 119.15, F.S., unless the Legislature reviews and renews the exemptions before that date. If the expansion of the exemption related to the human trafficking victim expunction is not saved from repeal, the provision will revert to the version as it exists on June 30, 2023, except that any amendments to the subsection must be preserved and continue to operate to the extent that such amendments are not dependent upon the portions of the expanded exemption which expire.

There is no anticipated fiscal impact on state, county or municipal governments. Agency costs incurred in responding to public records requests for the specified information should be offset by authorized fees. See Section V. Fiscal Impact Statement.

The bill is effective July 1, 2023.

II. Present Situation:

Access to Public Records - Generally

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[1] The right to inspect or copy applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[2]

Additional requirements and exemptions related to public records are found in various statutes and rules, depending on the branch of government involved. For instance, section 11.0431, F.S., provides public access requirements for legislative records. Relevant exemptions are codified in s. 11.0431(2)-(3), F.S., and adopted in the rules of each house of the legislature.[3] Florida Rule of Judicial Administration 2.420 governs public access to judicial branch records.[4] Lastly, chapter 119, F.S., known as the Public Records Act, provides requirements for public records held by executive agencies.

Executive Agency Records – The Public Records Act

The Public Records Act provides that all state, county and municipal records are open for personal inspection and copying by any person, and that providing access to public records is a duty of each agency.[5]

Section 119.011(12), F.S., defines "public records" to include:

> All documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connections with the transaction of official business by any agency.

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business that are used to "perpetuate, communicate, or formalize knowledge of some type."[6]

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[1] FLA. CONST. art. I, s. 24(a).
[2] *Id*.
[3] *See* Rule 1.48, *Rules and Manual of the Florida Senate*, (2022-2024) and Rule 14.1, *Rules of the Florida House of Representatives*, Edition 1, (2022-2024)
[4] *State v. Wooten*, 260 So. 3d 1060 (Fla. 4th DCA 2018).
[5] Section 119.01(1), F.S. Section 119.011(2), F.S., defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."
[6] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc., Inc*., 379 So. 2d 633, 640 (Fla. 1980).

The Florida Statutes specify conditions under which public access to public records must be provided. The Public Records Act guarantees every person's right to inspect and copy any public record at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.[7] A violation of the Public Records Act may result in civil or criminal liability.[8]

The Legislature may exempt public records from public access requirements by passing a general law by a two-thirds vote of both the House and the Senate.[9] The exemption must state with specificity the public necessity justifying the exemption and must be no broader than necessary to accomplish the stated purpose of the exemption.[10]

General exemptions from the public records requirements are contained in the Public Records Act.[11] Specific exemptions often are placed in the substantive statutes relating to a particular agency or program.[12]

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." There is a difference between records the Legislature has determined to be exempt from the Public Records Act and those which the Legislature has determined to be exempt from the Public Records Act *and confidential*.[13] Records designated as "confidential and exempt" are not subject to inspection by the public and may only be released under the circumstances defined by statute.[14] Records designated as "exempt" may be released at the discretion of the records custodian under certain circumstances.[15]

Open Government Sunset Review Act

The provisions of s. 119.15, F.S., known as the Open Government Sunset Review Act[16] (the Act), prescribe a legislative review process for newly created or substantially amended[17] public records or open meetings exemptions, with specified exceptions.[18] The Act requires the repeal of

[7] Section 119.07(1)(a), F.S.
[8] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[9] FLA. CONST. art. I, s. 24(c).
[10] *Id*. *See, e.g.*, *Halifax Hosp. Medical Center v. News-Journal Corp.*, 724 So. 2d 567 (Fla. 1999) (holding that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption); *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004) (holding that a statutory provision written to bring another party within an existing public records exemption is unconstitutional without a public necessity statement).
[11] *See, e.g.*, s. 119.071(1)(a), F.S. (exempting from public disclosure examination questions and answer sheets of examinations administered by a governmental agency for the purpose of licensure).
[12] *See, e.g.*, s. 213.053(2)(a), F.S. (exempting from public disclosure information contained in tax returns received by the Department of Revenue).
[13] *WFTV, Inc. v. The Sch. Bd. of Seminole County*, 874 So. 2d 48, 53 (Fla. 5th DCA 2004).
[14] *Id*.
[15] *Williams v. City of Minneola*, 575 So. 2d 683 (Fla. 5th DCA 1991).
[16] Section 119.15, F.S.
[17] An exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings as well as records. Section 119.15(4)(b), F.S.
[18] Section 119.15(2)(a) and (b), F.S., provides that exemptions required by federal law or applicable solely to the Legislature or the State Court System are not subject to the Open Government Sunset Review Act.

such exemption on October 2nd of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.[19]

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[20] An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- It allows the state or its political subdivisions to effectively and efficiently administer a governmental program, and administration would be significantly impaired without the exemption;[21]
- It protects sensitive, personal information, the release of which would be defamatory, cause unwarranted damage to the good name or reputation of the individual, or would jeopardize the individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[22] or
- It protects information of a confidential nature concerning entities, such as trade or business secrets.[23]

The Act also requires specified questions to be considered during the review process.[24] In examining an exemption, the Act directs the Legislature to question the purpose and necessity of reenacting the exemption.

If the exemption is continued and expanded, then a public necessity statement and a two-thirds vote for passage are required.[25] If the exemption is continued without substantive changes or if the exemption is continued and narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to expire, the previously exempt records will remain exempt unless otherwise provided by law.[26]

Human Trafficking

Human trafficking is a form of modern-day slavery.[27] Human trafficking victims are young children, teenagers, and adults who may be citizens that are trafficked domestically within the

[19] Section 119.15(3), F.S.
[20] Section 119.15(6)(b), F.S.
[21] Section 119.15(6)(b)1., F.S.
[22] Section 119.15(6)(b)2., F.S.
[23] Section 119.15(6)(b)3., F.S.
[24] Section 119.15(6)(a), F.S. The specified questions are:
- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[25] *See generally* s. 119.15, F.S.
[26] Section 119.15(7), F.S.
[27] Section 787.06(1)(a), F.S.

borders of the United States or smuggled across international borders worldwide.[28] Many human trafficking victims are induced with false promises of financial or emotional security, but are forced or coerced into commercial sex, domestic servitude, or other types of forced labor.[29] Any minor who is younger than 18 years old and who is induced to perform a commercial sex act is a human trafficking victim even if there is no forced fraud or coercion.[30] Increasingly, criminal organizations, such as gangs, are enticing local school children into commercial sexual exploitation or trafficking.[31]

Human Trafficking in Florida

Florida law defines "human trafficking" as transporting, soliciting, recruiting, harboring, providing, enticing, maintaining,[32] purchasing, patronizing, procuring, or obtaining[33] another person for the purpose of exploitation of that person.[34] In Florida, any person who knowingly, or in reckless disregard of the facts, engages in human trafficking, or attempts to engage in human trafficking, or benefits financially by receiving anything of value from participation in a venture that has subjected a person to human trafficking for labor or services, or commercial sexual activity, commits a crime.[35] Florida law sets out several circumstances which give rise to specified penalties including, in part:

- Labor or services of any child under the age of 18 commits a first degree felony;[36]
- Labor or services of any child under the age of 18 who is an unauthorized alien[37] commits a first degree felony;[38]
- Labor or services who does so by the transfer or transport of any child under the age of 18 from outside of Florida to within Florida commits a first degree felony;[39]
- Commercial sexual activity[40] who does so by the transfer or transport of any child under the age of 18 from outside of Florida to within Florida commits a first degree felony;[41] or

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[28] *Id.*
[29] The Department of Education (the DOE), *Healthy Schools – Human Trafficking*, available at http://www.fldoe.org/schools/healthy-schools/human-trafficking.stml (last visited March 7, 2023).
[30] *Id.*
[31] *Id.*
[32] Section 787.06(2)(f), F.S., provides "maintain" means, in relation to labor or services, to secure or make possible continued performance thereof, regardless of any initial agreement on the part of the victim to perform such type service. Section 787.06(2)(h), F.S., defines "services" as any act committed at the behest of, under the supervision of, or for the benefit of another, including forced marriage, servitude, or the removal of organs.
[33] Section 787.06(2)(g), F.S., provides "obtain" means, in relation to labor, commercial sexual activity, or services, to receive, take possession of, or take custody of another person or secure performance thereof. Section 787.06(2)(e), F.S., provides "labor" means work of economic or financial value.
[34] Section 787.06(2)(d), F.S.
[35] Section 787.06(3), F.S.
[36] Section 787.06(3)(a)1., F.S. A first degree felony is punishable by a state prison term not exceeding 30 years, a fine not exceeding $10,000, or both. Sections 775.082 and 775.083, F.S.
[37] Section 787.06(2)(j), F.S., defines "unauthorized alien" as an alien who is not authorized under federal law to be employed in the United States, as provided in 8 U.S.C. s. 1324a(h)(3).
[38] Section 787.06(3)(c)1., F.S.
[39] Section 787.06(3)(e)1., F.S.
[40] Section 787.06(2)(b), F.S., defines "commercial sexual activity" as any violation of ch. 796, F.S., or an attempt to commit any such offense, and includes sexually explicit performances and the production of pornography. Section 787.06(2)(i), F.S., defines "sexual explicit performance" as an act or show, whether public or private, that is live, photographed, recorded, or videotaped and intended to arouse or satisfy the sexual desires or appeal to the prurient interest.
[41] Section 787.06(3)(f)1., F.S., provides that an offense committed under these circumstances is punishable by a term of imprisonment not exceeding life or as provided in ss. 775.082, 775.083, or 775.084, F.S.

- Commercial sexual activity in which any child under the age of 18, or in which any person who is mentally defective[42] or mentally incapacitated[43] is involved commits a life felony.[44]

The above-mentioned first degree felonies are reclassified as a life felony if a person causes great bodily harm, permanent disability, or permanent disfigurement to another person during the commission of the offense.[45] Ignorance of the human trafficking victim's age, the victim's misrepresentation of his or her age, or a bona fide belief of the victim's age cannot be raised as a defense by a defendant.[46]

Florida is ranked the third highest state of reported human trafficking cases in the United States.[47] In 2021, reports of commercially exploited children to the Florida Abuse Hotline remained relatively stable, increasing from 3,181 reports in 2020 to 3,182 reports in 2021.[48]

Public Records Exemption relating to Human Trafficking

In part, current law provides a public record exemption for criminal intelligence[49] and criminal investigative information[50] including:

- Any information that reveals the identity of a person under the age of 18 who is the victim of human trafficking for labor or services;
- Any information that may reveal the identity of a person who is the victim of human trafficking for commercial sexual activity; and
- A photograph, videotape, or image of any part of the body of a victim of human trafficking involving commercial sexual activity.[51]

[42] Section 794.011(1)(b), F.S., defines "mentally defective" as a mental disease or defect which renders a person temporarily or permanently incapable of appraising the nature of his or her conduct.
[43] Section 794.011(1)(c), F.S., defines "mental incapacitated" as temporarily incapable of appraising or controlling a person's own conduct due to the influence of a narcotic, anesthetic, or intoxicating substance administered without his or her consent or due to any other act committed upon that person without his or her consent.
[44] A life felony is punishable by a term of life imprisonment, $15,000 fine, or both as provided in s. 775.082(3)(a)6., F.S., s. 775.083, F.S., or s. 775.084, F.S.
[45] Section 787.06(8)(b), F.S.
[46] Section 787.06(9), F.S.
[47] Florida Alliance to End Human Trafficking, *The Issue*, available at https://floridaallianceendht.com/the-issue/ (last visited March 7, 2023).
[48] The Office of Program Policy Analysis and Government Accountability, *Annual Report on the Commercial Sexual Exploitation of Children in Florida*, 2022, p. 2, July 2022, available at https://oppaga.fl.gov/Documents/Reports/22-05.pdf (last visited March 7, 2023).
[49] Section 119.011(3)(a), F.S., defines "criminal intelligence information" as information with respect to an identifiable person or group of persons collected by a criminal justice agency in an effort to anticipate, prevent, or monitor possible criminal activity.
[50] Section 119.011(3)(b), F.S., defines "criminal investigative information" as information with respect to an identifiable person or group of persons compiled by a criminal justice agency in the course of conducting a criminal investigation of a specific act or omission, including, but not limited to, information derived from laboratory tests, reports of investigators or informants, or any type of surveillance.
[51] Section 119.071(2)(h)1., F.S.

Human Trafficking Victim Expunction

In 2013, the Legislature created a process authorizing a victim of human trafficking to petition a court for the expunction[52] of a criminal history record resulting from his or her arrest or filing of charges for an offense committed or reported to have been committed while he or she was a victim of human trafficking.[53]

For purposes of human trafficking victim expunction, "victim of human trafficking" means a person subjected to coercion[54] for the purpose of being used in human trafficking, a child under 18 years of age subjected to human trafficking, or an individual subjected to human trafficking as defined by federal law.[55]

To be eligible for expunction, the criminal offense must be related to a human trafficking scheme of which the person was a victim or the offense must have been committed at the direction of an operator of the scheme and must not be one of the following offenses under s. 775.084(1)(b)1., related to the designation as a "habitual violent felony offender", including:

- Arson;
- Sexual battery;
- Robbery;
- Kidnapping;
- Aggravated child abuse;
- Aggravated abuse of an elderly person or disabled adult;
- Aggravated assault with a deadly weapon;
- Murder;
- Manslaughter;
- Aggravated manslaughter of an elderly person or disabled adult;
- Aggravated manslaughter of a child;
- Unlawful throwing, placing, or discharging of a destructive device or bomb;
- Armed burglary; or
- Aggravated stalking.[56]

[52] When a criminal history record is ordered to be expunged, the record must be physically destroyed by any criminal justice agency possessing such record, except that any criminal history record in the custody of the Florida Department of Law Enforcement (FDLE) must be retained. *See* s. 943.045(16), F.S.
[53] Section 943.0583(3), F.S.
[54] Section 787.06, F.S., defines "coercion" as "1. Using or threatening to use physical force against any person; 2. Restraining, isolating, or confining or threatening to restrain, isolate, or confine any person without lawful authority against his or her will; 3. Using lending or other credit methods to establish a debt by any person when labor or services are pledged as a security for the debt, if the value of the labor or services as reasonably assessed is not applied toward the liquidation of the debt, the length and nature of the labor or services are not respectively limited and defined; 4. Destroying, concealing removing, confiscating, withholding, or possessing any actual or purported passport, visa, or other immigration document, or any other actual or purported government identification document, of any person; 5. Causing or threatening to cause financial harm to any person; 6. Enticing or luring any person by fraud or deceit; or 7. Providing a controlled substance as outlined in Schedule I or Schedule II of s. 893.03, F.S., to any person for the purpose of exploitation of that person."
[55] Section 943.0583(1)(c), F.S.
[56] Section 943.0583(3), F.S. This subsection provides that expunction is not permitted if the offense is related to an offense enumerated in s. 775.084(1)(b)1., F.S., related to habitual violent felony offenders.

The human trafficking victim is eligible to receive the expunction regardless of the disposition of the arrest or of any charges unless the criminal history record is related to one of the above-listed offenses.

The court with original jurisdiction over the crime that the human trafficking victim seeks to expunge is the court designated to hear the victim's petition.[57] A petition must be initiated by the petitioner with due diligence after he or she is no longer a victim of human trafficking or has sought human trafficking services.[58] The petition must be accompanied by the following:

- A sworn statement attesting that the petitioner is eligible for an expunction to the best of his or her knowledge and does not have other petitions to expunge or seal pending before any court; and
- Official documentation of the petitioner's status as a human trafficking victim, if any exists.[59]

In contrast to other expunctions made under s. 943.0585, F.S., a court is required to treat a petition seeking to expunge more than one eligible case as a single petition.[60] Florida's clerks of court are prohibited from charging a filing fee, service charge, or copy fee or any other charge for a petition for a human trafficking victim expunction.[61]

When a criminal history record is ordered to be expunged, the record must be physically destroyed by any criminal justice agency possessing such record, except that any criminal history record in the custody of the Florida Department of Law Enforcement (FDLE) must be retained.[62] A human trafficking victim may lawfully deny or fail to acknowledge any expunged record unless he or she is applying for a job with a criminal justice agency or is a defendant in a subsequent criminal prosecution.[63] The criminal history record that has been expunged is considered confidential and exempt[64] from public records requirements.[65]

[57] Section 943.0583(2), F.S.
[58] Section 943.0583(4), F.S.
[59] Section 943.0583(6), F.S.
[60] Section 943.0583(2), F.S.
[61] Section 943.0583(2), F.S.
[62] Section 943.045(16), F.S.
[63] Section 943.0583(8)(b), F.S.
[64] Records designated as "confidential and exempt" are not subject to inspection by the public and may only be released under the circumstances defined by statute. *WFTV, Inc. v. The Sch. Bd. of Seminole County*, 874 So. 2d 48, 53 (Fla. 5th DCA 2004). Records designated as "exempt" may be released at the discretion of the records custodian under certain circumstances. *Williams v. City of Minneola*, 575 So. 2d 683 (Fla. 5th DCA 1991).
[65] Section 119.071(2)(h), F.S.

Current law also provides that criminal intelligence[66] and criminal investigative information[67] is confidential and exempt from public records requirements. Such information includes:[68]

- Any information that reveals the identity of a person under the age of 18 who is the victim of human trafficking for labor or services;[69]
- Any information that may reveal the identity of a person who is the victim of human trafficking for commercial sexual activity;[70] and
- A photograph, videotape, or image of any part of the body of a victim of human trafficking involving commercial sexual activity.[71]

Florida law does not currently provide a public records exemption for a human trafficking victim's petition and any accompanying documents for expunction of his or her criminal history record resulting from an offense committed while he or she was a victim of human trafficking.

III. Effect of Proposed Changes:

The bill amends s. 943.0583, F.S., expanding the application of the human trafficking victim expunction provision. A victim of human trafficking will now be authorized to expunge a criminal history record related to any offense listed in s. 775.084(1)(b)1., F.S., unless a victim was found guilty of or entered a plea of guilty or nolo contendre to such an offense. As a result, a victim will now be able to obtain an expunction for an offense related to the designation as a "habitual violent felony offender" when he or she is arrested for such an offense but charges are not filed by the state attorney or a no information is filed, or when the victim is found not guilty by a judge or a jury.

The bill provides that the expansion of the public records exemption related to expunging certain records that are related to offenses listed in s. 775.084(1)(b)1., F.S., is subject to the Open Government Sunset Review Act and will be repealed on October 2, 2028, unless the Legislature reviews and renews the expansion of the exemption before that date. If the expansion is not saved, the subsection will revert to the version in existence at June 30, 2023, except that any amendments to this subsection other than by this act shall be preserved and continued to operate to the extent that they are not dependent upon the portions of this subsection that expire.

The bill amends s. 943.0583, F.S., establishing that any petition filed by a human trafficking victim to expunge a criminal history record and all pleadings and all related documents are confidential and exemption from public records disclosure requirements. The bill provides that the exemption related to the petition and all pleadings and documents related to the expunction

[66] Section 119.011(3)(a), F.S., defines "criminal intelligence information" as information with respect to an identifiable person or group of persons collected by a criminal justice agency in an effort to anticipate, prevent, or monitor possible criminal activity.
[67] Section 119.011(3)(b), F.S., defines "criminal investigative information" as information with respect to an identifiable person or group of persons compiled by a criminal justice agency in the course of conducting a criminal investigation of a specific act or omission, including, but not limited to, information derived from laboratory tests, reports of investigators or informants, or any type of surveillance.
[68] Ch. 2015-146 L.O.F.
[69] *See* s. 787.06(3)(a), F.S.
[70] *See* s. 787.06(3)(b), (d), (f), and (g), F.S.
[71] *Id.*

petition is subject to the Open Government Sunset Review Act and will be repealed on October 2, 2028, unless the Legislature reviews and renews the exemption before that date.

The bill also provides a statement of public necessity as required by the State Constitution, which notes:

> [t]he Legislature finds it is a public necessity that criminal history records of human trafficking victims related to any offense listed in s. 775.084(1)(b)1. that was dismissed or nolle prosequi by the state attorney or statewide prosecutor, or was dismissed by a court of competent jurisdiction or a judgment of acquittal was rendered by a judge, or a verdict of not guilty was rendered by a judge or jury, and that are ordered to be expunged under s. 943.0583, F.S., be made confidential and exempt from 119.07(1), F.S., and s. 24(a), Article I of the State Constitution. Further, the Legislature finds that it is a public necessity that a petition filed under s. 943.0583, F.S., and all pleadings and documents related to the petition be made confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. Persons who are victims of human trafficking and who have been arrested, charged, or convicted of crimes committed at the behest of their traffickers are themselves victims of crimes. These victims face barriers to employment and loss of other life opportunities, and the fact that they are seeking expungement, as well as the information contained in related pleadings and documents, would expose these petitioners to possible discrimination due to details of their past lives becoming public knowledge. Therefore, it is necessary that these specified criminal history records, even though such record is related to certain serious offenses, and these petitions, pleadings, and related documents be made confidential in order for human trafficking victims to have the chance to rebuild their lives and reenter society.

The bill is effective July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Vote Requirement

Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a bill creating or expanding an exemption to the public records requirements. This bill enacts a new exemption for petition for expunction of human trafficking victims and all pleadings and documents related to the petition, as well as expands the current exemption related to the specific criminal history records that can be expunged to new records, thus the bill will require two-thirds vote to be enacted.

Public Necessity Statement

Article I, s. 24(c) of the State Constitution requires a bill creating or expanding an exemption to the public records requirements to state with specificity the public necessity justifying the exemption. Section 2 of the bill contains a statement of public necessity for the exemptions.

Scope of Exemption

Article I, s. 24(c) of the State Constitution requires an exemption to the public records requirements to be no broader than necessary to accomplish the stated purpose of the law. The stated purpose of the law is to protect human trafficking victims from exposure to possible discrimination due to details of their past lives becoming public knowledge. This bill exempts only those persons who are at risk of harm, and their criminal history records and the documents related to petitioning the court for such an expunction, which could pose a harm to them, from the public records requirements. The exemption does not appear to be broader than necessary to accomplish the purpose of the law.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill does not appear to have a fiscal impact on state or local governments. Costs incurred by an agency in responding to public records requests regarding these exemptions should be offset by authorized fees.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 943.0583 of 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.