Florida

Department of Health and Human Services
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

FY 2023
PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS
Short Title: 2023 PAIMI Progress Report

Funding Opportuntity Announcement (FOA)
No. SM-17-F2

Catalog of Federal Domestic Assistance (CFDA)
No.: 93-138

A. PAIMI Program Information

General Information

1. P &A Identification

Name of state or jurisdiction	Florida
Name of P&A systems	Disability Rights Florida
Unique Entity ID	H4YLJSF4JXN4

2. Main Office

Agency Name of Main Office	Disability Rights Florida
Mailing Address of Main Office	2473 Care Drive Suite 200
City	Tallahassee
Zip Code	32308
Phone Number of Main Office	850-488-9071
Toll Free Number	800-342-0823
Email address	Peters@disabilityrightsflorida.org
Website address	http://www.disabilityrightsflorida.org
TTY phone number	800-346-4127
County of Main Office	Leon

3. Other Offices (if any)

Agency Name of Other Office	DRF - South Florida Office
Mailing Address (Each Statellite Office)	2400 East Commercial Blvd. #525
City	Ft. Lauderdale
Zip Code	33308
County of Each Satellite Office (Location)	Broward
Agency Name of Other Office	DRF - Tampa Office
Mailing Address (Each Statellite Office)	Times Building, Suite 640 1000 Ashley Drive
City	Tampa
Zip Code	33602
County of Each Satellite Office (Location)	Hillsborough
Agency Name of Other Office	DRF - Gainesville Office
Mailing Address (Each Statellite Office)	4723 NW 53rd Ave., Suite B
City	Gainesville

Zip Code	32653
County of Each Satellite Office (Location)	Alachua

4. Executive Director/Chief Executive Officer Contact Information

Name	Peter Sleasman
Mailing Address	2473 Care Dr Suite 200
City	Tallahassee
Zip Code	32308
Phone Number & Extension	850-617-9775
E-mail Address	Peters@DisabilityRightsFlorida.org

5. PPR Preparer Contact Information

Name	Kathryn Strobach
Title	Director of Investigations
Phone Number & Extension	850-617-9796
Email Address	Kathryns@disabilityrightsflorida.org

6. Governing Board President/Chair Name

Name	Virginia Daire, Esq.
Mailing Address	[redacted]
City	[redacted]
Zip Code	[redacted]
County of Residence	[redacted]
Email Address	[redacted]
Current Term Started	7/1/2021 12:00:00 AM
Current Term Expires	12/1/2023 11:59:00 PM

7. PAIMI Advisory Council President/Chair Name

Name	Aleya Siegel
Mailing Address	[redacted]
City	[redacted]
Zip Code	[redacted]
County of Residence	[redacted]
Email Address	[redacted]
Current Term Started	9/8/2022 12:00:00 AM
Current Term Expires	9/7/2026 12:00:00 AM

8. Name Of P&A Chief Financial Officer/Accountant

Name	Cherie Hall
Title	Director of Operations

Phone Number/Extension	850-488-9071
Email Address	cherieh@disabilityrightsflorida.org

9. Governor's Liaison

Name	Chris Spencer
Official Title	Director of Policy & Budget
Mailing Address	EOG #1701, The Capitol, 400 S. Monroe St.
City	Tallahassee
Zip Code	32399
County of Residence	Leon
Phone Number/Extension	
Email Address	Chris.Spencer@laspbs.state.fl.us

10. Commissioner/Director of the State Mental Health Agency

Name	Erica Floyd Thomas
Mailing Address	2415 North Monroe Street, Suite 400
City	Tallahassee, FL
Zip Code	32303
Phone Number/Extension	850-487-1111
Email Address	erica.floydthomas@myflfamilies.com

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Footnotes:

A. PAIMI Program Information

Demographic Composition of PAIMI Governing Board, Advisory Council, and Program Staff

		Governing Board	Advisory Council	Program Staff
Ethnicity				
	Hispanic/Latino	5	3	11
	Non-Hispanic/Latino	10	8	87
	Ethnicity Unknown	0	0	0
Race				
	American Indian/Alaskan Native	0	0	0
	Asian	0	0	3
	Black/African American	2	4	19
	Native Hawaiian/Pacific Islander	0	0	0
	White	12	7	76
	Two or more races	1	0	0
	Some other race	0	0	0
	Race Unknown	0	0	0
Gender				
	Female	0	0	0
	Male	0	0	0
	Transgender (Trans Woman)	0	0	0
	Transgender (Trans Man)	0	0	0
	Two-Spirit (if Client is AIAN)	0	0	0
	Gender Non-Conforming	0	0	0
	Other (if use a different term)	0	0	0
	Prefer not to say	0	0	0
Sexual Orientation				

	Lesbian or gay	0	0	0
	Straight (not lesbian or gay)	0	0	0
	Bisexual	0	0	0
	Other (if use a different term)	0	0	0
	Prefer not to say	0	0	0

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Footnotes:

Disability Rights Florida is not reporting on the new information requested by the PPR in this section related to gender identity or sexual orientation of our governing board, advisory council, or staff because we do not collect this information. In the past, we have reported on gender as to “male” or “female” only. In light of the new categories sought in this PPR, we believe that reporting only on these two gender categories would be inaccurate and misleading. Therefore, we are not reporting on any gender categories at this time. Regarding the questions on sexual orientation of staff, we will not be gathering this information from our staff until we have determined how certain Florida state laws limit or impact how, or if, DRF can gather such information.

A. PAIMI Program Information

Governing Board Information

Governing Board (GB) Type and Number of Members Included in Governing Board Information

Governing Board	Minimum # of Members	Maximum # of Members
Private, non-profit with multi-member	13	15
State-operated with governing board	0	0
State-operated with no governing board	0	0

Governing Board Information

In the following table, please provide the requested information for the GB members

	Number
Total seats available	15
Total members serving as of 9/30/2023	15
Total vacancies on 9/30/2023	0
Term of appointment (number of years)	4
Term maximum	2
Meeting Frequency	4
Number of meetings held this fiscal year (2023)	5
Percentage of members present at meetings during the 2023	89 %

Governing Board Composition

The governing board shall be composed of members who broadly represent or are knowledgable about the needs of clients served by the P&A System (count each GB member only once)

	Number
Number of individuals with mental illness who are recipients/former recipients (R/FR) of mental health services or have been eligible for services.	1
Number of family members of individuals with mental illness who are (R/FR) of mental health services, guardians, advocates or authorized representatives or other persons who broadly represent or are knowledgeable about the needs of clients served by the P&A system	14
Total	**15**

Footnotes:

A. PAIMI Program Information

Executive Director

Intial Appointment Date	06/12/2020 (mm/dd/yyyy)
Recent performance evaluation completed	09/08/2023 (mm/dd/yyyy)
Date of previous performance evaluation	02/24/2022 (mm/dd/yyyy)

Agency has written policy and procedures to guide the ED's evaluation process? Yes ◉ No ○

Input on ED's performance evaluation obtained from the following (check all that apply)	
All agency employees/staff	Yes ○ No ◉
Senior managers	Yes ○ No ◉
All board directors	Yes ◉ No ○
All PAIMI Advisory Council members	Yes ○ No ◉
Stakeholders	Yes ○ No ◉
Consumers	Yes ○ No ◉
Family members of consumers	Yes ○ No ◉
State mental health providers	Yes ○ No ◉
Private mental health providers	Yes ○ No ◉
Other	Yes ○ No ◉

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Footnotes:

A. PAIMI Program Information

Number of Mental Health Professionals On the Advisory Council

Professional Category	Number On Advisory Council
Social Worker	0
Psychologist	2
Psychiatric Nurse	0
Psychiatrist	0
Psychiatric Nurse Practitioner	0
Peer Support Specialist	1
Other (Identify the Professional in the Footnotes)	0
Total	**3**

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Footnotes:

DRF's PAC has two psychologists on the PAC: One is a mental health professional who teaches college-level courses in the field of psychology. The second is a provider who recently obtained her doctorate degree in psychology and is providing mental health services under the supervision of a licensed psychologist.

A. PAIMI Program Information

PAIMI Advisory Council (PAC)/Assigned Staff

PAIMI Advisory Council (PAC)	
Sits on the governing board?*	(●) Yes ( ) No
Appointment Date	09/21/2023
Other PAC member(s) sit on the governing board?	(●) Yes ( ) No
If yes, number serving	1

** If no please explain in Footnotes*

Assigned PAIMI Staff

	Attorneys					Advocates				
	#	Full-time	Part-time	Male	Female	#	Full-time	Part-time	Male	Female
Ethnicity										
Hispanic/Latino (of any race)	0	0	0	0	0	4	4	0	0	4
Non-Hispanic/Latino	21	21	0	7	14	21	20	1	6	15
Race										
American Indian/Alaska Native	0	0	0	0	0	0	0	0	0	0
Asian	0	0	0	0	0	1	1	0	0	1
Black/African American	2	2	0	0	2	8	8	0	1	7
Native Hawaiian/Pacific Islander	0	0	0	0	0	0	0	0	0	0
White	19	19	0	7	12	16	15	1	5	11
Two or more races	0	0	0	0	0	0	0	0	0	0
Some other race	0	0	0	0	0	0	0	0	0	0
Race Unknown	0	0	0	0	0	0	0	0	0	0

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Footnotes:

B. Demographics - Interventions on Behalf of PAIMI Individuals

Population Information

Age of PAIMI-eligible Individuals Served

Age	Number
0-2	0
3-5	2
6-10	11
11-22	62
23-64	209
65+	16
Prefer not to say	0
Total	**300**

Gender and Sexual Orientation of PAIMI-eligible Individuals Served

Gender	Number
Female	60
Male	239
Transgender (Trans Woman)	0
Transgender (Trans Man)	0
Two-Spirit (if Client is AIAN)	0
Gender Non-Conforming	0
Other (if use a different term)	1
Prefer not to say	0
Total	**300**

Sexual Orientation	Number
Lesbian or Gay	0

Straight (not lesbian or gay)	0
Bisexual	0
Other (if use a different term)	0
Prefer not to say	0
Total	**0**

Ethnicity and Race of Individuals Served

Ethnicity	Number	PAIMI %	State %
Hispanic/Latino (of any race)	37	12.33	27.10
Non-Hispanic/Latino	246	82.00	72.90
Ethnicity Unknown	17	5.66	0.00
Total	**300**		

Race	Number	PAIMI %	State %
American Indian/Alaska Native	1	0.33	0.50
Asian	5	1.66	3.10
Black/African American	131	43.66	17.00
Native Hawaiian/Other Pacific Islander	0	0.00	0.10
White	142	47.33	76.80
Two or more races	17	5.66	2.40
Some other race	0	0.00	0.00
Race unknown	4	1.33	0.00
Total	**300**		

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Footnotes:

Gender Identity: Disability Rights Florida only collected this information using a binary “male” or “female” option during FY 2022-2023. The options of “Transgender (Trans Woman),” “Transgender (Trans Man),” “Two-Spirit (if Client is AIAN),” “Gender Non-Conforming,” “Other (if use a different term),” or “Prefer not to say” were added after the end of FY 2022-2023.

Sexual Orientation: Disability Rights Florida did not collect this information for FY 2023-2023. This is a new category of demographic data added after the end of FY 2022-2023.

Ethnicity and Race: State data for ethnicity and race in Florida was obtained from the United States Census Bureau's April 1, 2020 Population Data. Data can be found at the following location: https://www.census.gov/quickfacts/fact/table/FL/POP010210

B. Demographics - Interventions on Behalf of PAIMI Individuals

PAIMI-Eligible Individuals served with PAIMI Program Funds

Count individual once per fiscal year (FY). Multiple counts not permitted for lines 1-2.

		Enter Number
1. Number of PAIMI-eligible individuals continued to be served with PAIMI program funds, including any program income resulting from legal actions supported by PAIMI program funds as of October 1, from the previous FY into the reporting year.		126
2. Number of new PAIMI-eligible individuals served during the reporting year.		174
3. Total number of PAIMI-eligible individuals served during this FY (Add lines 1 and 2).		300
4. Individuals with more than one (1) intervention opened/closed during the reporting year.		27
5. Individuals with a co-occurring mental illness and Intellectual and Developmental Disability (IDD).		11
6. Total number of PAIMI-eligible individuals who requested program related advocacy services during the reporting year, but were not served within 30-days of initial contact due to:		
	a. insufficient PAIMI Program resources.	0
	b. non-priority areas.	0
7. Individuals served as of September 30 and will be carried over to next reporting year (This should equal ≤ item 3 above).		119

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Footnotes:

B. Demographics - Interventions on Behalf of PAIMI Individuals

Living Arrangements of PAIMI-eligible Individuals at Intake

Living Arrangements	Number
Community Residential Home for Children/Youth up to age 18 Yrs.	1
Community Residential Home for Adults	3
Non-Medical Community-Based Residential Facility for Children/Youth	0
Foster Care	0
Nursing homes, including skilled nursing facilities	0
Intermediate care facilities	0
Public and Private general hospitals including Emergency Rooms	1
Public Institutional living arrangement	74
Private Institutional living arrangement	0
Psychiatric Hospitals (Public or Private)	
a. Public/State	20
b. Private	28
Jails	17
State Prison	101
Federal Detention Center	0
Federal Prison	0
Veterans' administration hospital/Clinic	0
Other Federal Facility	0
Homeless	4
Independent (in the community & PAIMI-eligible)	0
Parental or Other Family Home & PAIMI-eligible	51
Unknown	0
Total	300

Footnotes:

C. Complaints/Problems of PAIMI Individuals

Areas of Alleged Abuse

Number of complaints/problems – Make every effort to report within the following categories:

Areas of Alleged Abuse	Outcomes											Number from Closed Cases Only
	A	B	C	D	E	F	G	H	I	J	K	Total
a. Inappropriate or excessive medication	3	0	1	0	0	0	0	0	0	0	0	4
b. Inappropriate or excessive restraint and seclusion	3	3	2	0	0	0	0	0	0	0	0	8
c. Involuntary medication	0	0	0	0	0	0	0	0	0	0	0	0
d. Involuntary Electric Convulsive Therapy (ECT)	1	0	2	0	0	0	0	0	0	0	0	3
e. Involuntary aversive behavioral therapy	0	0	0	0	0	0	0	0	0	0	0	0
f. Involuntary sterilization	0	0	0	0	0	0	0	0	0	0	0	0
g. Physical assault	33	11	15	2	0	1	3	0	4	0	0	69
h. Sexual assault	0	0	1	0	0	0	0	0	0	0	0	1
i. Threats of retaliation or verbal abuse by facility staff	0	2	1	0	0	0	0	0	0	0	0	3
j. Coercion	0	0	1	0	0	0	0	0	0	0	0	1
k. Financial exploitation	1	0	2	0	0	0	0	0	0	0	0	3
l. Suspicious death	3	0	2	0	0	2	0	0	0	0	0	7
m. Other *Specify types of complaints. Please describe below. [This number should be less than 1% of the total number of total complaints.]*	0	0	0	0	0	0	0	0	0	0	0	0

Abuse Complaints Disposition	
For total closed cases listed in Table C.1., provide the number of abuse complaints/problems for each disposition category.	
A. Number of complaints/problems determined after investigation not to have merit	44

B. Number of complaints/problems withdrawn or terminated by client	16
C. Number of complaints/problems resolved in the client's favor	27
D. Number of complaints/problems not resolved in the client's favor	2
E. Other Indicators of success or outcomes that resulted from P&A involvement	0
F. Other Representation found	3
G. Services not needed due to client death or relocation	3
H. P&A withdrew due to conflict of interest or other reasons	0
I. Lost Contact	4
J. Outcome Unknown	0
K. Lack of Resources	0
Total number of Abuse complaints/problem addressed from closed cases	**99**

At least 1 case required.

Case of Alleged Abuse

MG is an adult with significant mental illness (Major Depressive Disorder and Major Neurocognitive Disorder) who resided at a state mental health treatment facility at the time of intake. In the previous FY, Disability Rights Florida (DRF) received a report of alleged abuse and neglect involving MG, who uses a wheelchair. MG allegedly was involved in a verbal altercation with staff members while eating lunch, during which he was shoved by staff and then his wheelchair was pushed into another room, denying him his meal. Staff members at the facility that witnessed the incident reported it to DRF. Facility resident advocacy staff also reported the incident to Florida's Department of Children and Families (DCF) Adult Protective Services (APS) abuse hotline. Upon receipt of the abuse report, DRF also reported the incident to APS. APS, however, declined to investigate the incident following the reports by facility staff and DRF. DRF accepted the case for investigation. DRF staff interviewed MG along with facility staff. They also reviewed video of the incident in question, which confirmed the abuse allegations. Additionally, DRF staff reviewed the facility's internal investigation of the incident. The facility informed DRF that the alleged perpetrator had received a formal reprimand in their personnel file and that no other actions were taken. After reviewing documents and footage from the facility, DRF drafted an investigative report to the facility outlining their findings related to this case. Specifically, that (1) MG was physically abused by staff in their treatment and rough handling of him, (2) MG was neglected both when staff pushed him into another room without supervision and when staff denied him food as punishment, and (3) that multiple facility staff members failed to intervene or report these incidents, instead making multiple deceptive statements to minimize the apparent harm of their actions. DRF attorneys met with the facility's administrator, hospital counsel, and chief of nursing. The facility committed to providing additional training to staff about denial of food and mandatory reporting requirements. The facility administrator also promised to personally intervene to ensure staff on MG's unit do not cause further issues. Additionally, DCF appointed a nurse risk manager at another state hospital to conduct independent reviews of incidents and staff responses on MG's unit. DRF staff conducted a site visit to interview MG and tour his living area. MG has not had any further issues with the associated staff members that he can recall and reported no additional problems or concerns with his treatment. Prior to case closing, MG was discharged from the hospital to a nursing home. As a result of the above steps, DRF closed this case as complaint/problem resolved in the client's favor through negotiation/mediation due to the facility implementing additional training and policies related to the client's case.

Case of Alleged Abuse

AA is an adult male diagnosed with a significant mental illness (SMI) (psychosis, repeated self-injuries behavior) who was residing on a mental health unit at a county jail at the time of intake. Due to AA's SMI, a family member is appointed as plenary guardian and AA was adjudicated incompetent to proceed and committed to a forensic state mental health treatment facility for competency restoration services. Disability Rights Florida (DRF) was contacted by AA's family member/plenary guardian with concerns about potential abuse (excessive use restraint, taser, and chemical agents [pepper spray]) experienced by AA while housed at the county jail. After communicating directly with AA, DRF requested and reviewed records from the county jail, the probate court, and the criminal court. DRF's records review determined that AA may have been the victim of excessive use of force as the jail struggled to manage behavior stemming from AA's diagnosed SMIs and routinely used force to resolve mental health crises in place of other, non-forceful tactics, such as Crisis Intervention and De-escalation. As a result of this records review, along with other cases presenting similar concerns at this same jail system, DRF staff decided to monitor the county jail to obtain more information about whether the county jail is properly equipped to manage detainees with SMIs. DRF staff communicated the conclusions of their records review with the AA, who granted DRF permission to share their case details with an expert in their monitoring efforts to help advocate for systemic improvements. DRF subsequently reviewed AA's case with an outside expert, who confirmed DRF's concerns about the county jail's tactics for managing mental health crises. During their monitoring, DRF staff discussed their concerns with jail administrators and successfully negotiated amendments to the jail's policies and procedures related to the care and management of detainees with SMIs. DRF monitored these changes for a period of time to confirm implementation. These outcomes were communicated to AA and the plenary guardian who confirmed that they were satisfied with this resolution. At the time of case closure, AA had been released from jail and was residing with their plenary guardian. As a result of the above, DRF closed AA's case as partially/completely resolved in the client's favor through negotiation, resulting in changes in the policies and procedures related to the county jail's care and management of detainees with SMIs.

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Footnotes:

C. Complaints/Problems of PAIMI Individuals

Areas of Alleged Neglect

Number of complaints/problems	Outcomes											Number from closed cases only
	A	B	C	D	E	F	G	H	I	J	K	TOTAL
a. Failure to provide necessary or appropriate medical (other than psychiatric) treatment.	1	0	2	0	1	0	1	0	0	0	0	5
b. Failure to provide necessary or appropriate mental health treatment, including access to prescribed medication	1	2	13	1	0	0	1	0	0	0	0	18
c. Failure to provide necessary or appropriate personal care and safety	10	4	12	0	0	1	4	0	0	0	0	31
d. Failure to provide appropriate discharge planning or release from a residential care or treatment facility	0	0	2	0	0	0	0	0	0	0	0	2
e. Mental health diagnostic or other evaluation (does not include treatment)	0	0	2	0	0	0	0	0	0	0	0	2
f. Medical (non-mental health related) diagnostic physical examination	0	0	3	0	0	0	0	0	1	0	0	4
g. Other *[Describe and make every effort to report within the above categories].*	0	0	0	0	0	0	0	0	0	0	0	0

Neglect Complaints Disposition

For total closed cases listed in Table C.3., provide the numbers of neglect complaints or problem areas for each disposition category.	
A. Number of complaints/problems determined after investigation not to have merit	12
B. Number of complaints/problems withdrawn or terminated by client	6
C. Number of complaints/problems resolved in the client's favor	34
D. Number of complaints/problems not resolved in the client's favor	1
E. Other Indicators of success or outcomes that resulted from P&A involvement	1
F. Other Representation found	1
G. Services not needed due to client death or relocation	6
H. P&A withdrew due to conflict of interest or other reasons	0
I. Lost Contact	1
J. Outcome Unknown	0

K. Lack of Resources	0
Total	**62**

Case of Alleged Neglect

DB is an adult male with significant mental illness (Schizoaffective Disorder, Bipolar Type) who is a forensic patient at a state mental health treatment facility committed pursuant a court order finding him not guilty by reason of insanity and requiring inpatient care due to symptoms of mental illness. DRF received a request from the Resident Advocate Attorney at DB's facility regarding concerns about the physical condition of DB upon arrival at the State Hospital from a County Jail. Specifically, the Resident Advocate noted that DB –who had been at the same SMHTF prior to being sent to the county jail—arrived with signs of physical decompensation potentially as a result of neglect at the county jail. To follow up on the above communication, DRF staff scheduled an on-site visit with DB where they discussed the above concerns with DB and observed his severe physical decline. After observing that DB had lost approximately 80 lbs while at the jail, demonstrated mobility issues, and verbalized increased frequency of seizures and confirming with staff that DB's severe physical decline occurred while DB was at the county jail, DRF determined that an investigation into DB's care and treatment while at the County Jail was necessary to determine the cause of his severe physical decline and determine if it was the result of abuse/neglect. DRF staff reviewed DB's records from the county jail and determined that DB's severe medical decline was the result of progressing pre-existing medical conditions—specifically trouble regulating sodium in his blood, hypertension, and a history of epilepsy—combined with his diagnosed mental illnesses. These conditions were exacerbated by DB's numerous medication refusals, even after medical staff educated him on the consequences of medication refusal. The medical records indicated that, if left untreated, DB's medical conditions would present themselves through severe symptoms, such as weakness, confusion, nausea, and seizures, all of which were observed by DRF staff during their visit with DB and were documented by Jail medical staff. As a result of the above information, DRF staff determined that DB's severe physical decline while at the County Jail was not the result of neglect and that medical staff at the Jail were providing DB with consistent medical care while he was housed at their facility.

Case of Alleged Neglect

WP is an adult male with significant mental illness (Schizophrenia) who was residing in a state mental health treatment facility while receiving assistance from Disability Rights Florida (DRF). Another resident contacted DRF on behalf of WP because WP had difficulty speaking over the phone due to WP being edentulous. WP's friend requested assistance with helping WP receive proper food, alleging WP was not receiving enough food throughout the day due to having a pureed diet, was hungry, and sometimes received non-pureed food items shared by other residents. DRF investigated the complaint and interviewed WP in person at the facility. During the investigation WP confirmed that he does not eat enough and sometimes receives non-pureed food from other residents. He also stated that, even though this problem is not consistent, the protein is often missing from his tray or was simply not enough for WP to not be hungry all the time. DRF educated WP about the safety risks of eating non-pureed foods and received WP's permission to discuss his concerns with his treatment team. DRF spoke with WP's treatment team staff and made them aware of the issues presented. The treatment team addressed the concerns in a treatment team meeting. The clinical dietician also observed WP during mealtime and then spoke with several direct care staff and his medical provider. The clinical dietician reported to DRF that WP was very sleepy and had difficulty opening the lids on his food containers. Staff also had to wake WP up to go to meal time. Consequently, the facility placed WP on 1:1 meal observation for a 3-day trial basis to determine if he required 1:1 meal observation for all meals to ensure he was getting sufficient food and to ensure that other residents were not sharing food. DRF followed-up with WP to determine if the food issues were resolved and WP stated everything was fine. DRF also spoke with the Clinical Dietician who confirmed that the doctor and psychiatry team reevaluated WP's medications and changed them, therefore allowing WP to be more alert and stay up longer during mealtimes. They also assured DRF that staff wakes up WP prior to meals if he is sleeping. This allows WP to now eat the majority of his meals and, as a result, 1:1 meal observation is no longer needed. DRF confirmed that residents are no longer sharing their non-pureed food with WP. As a result of the above steps, DRF closed this case as complaint/problem resolved in client's favor through limited advocacy.

Footnotes:

C. Complaints/Problems of PAIMI Individuals

Areas of Alleged Rights Violations

Number of Complaints/Problems	Outcomes											Number from Closed Cases only
	A	B	C	D	E	F	G	H	I	J	K	TOTAL
a. Failure to provide individualized written treatment or service plan	0	0	0	0	0	0	0	0	0	0	0	0
b. Failure to provide written discharge plan including a description of mental health services needed upon discharged from such program or facility	0	0	3	0	0	0	0	0	1	0	0	4
c. Failure to allow ongoing participation, in a manner appropriate to such person's capabilities, in the planning of mental health services to be provided such person (including the right to participate in the development and periodic revision of the plan)	1	1	3	0	0	0	1	0	0	0	0	6
d. The right to refuse treatment	0	0	0	0	0	0	0	0	0	0	0	0
e. The right to refuse to take prescribed medications	0	0	0	0	0	0	0	0	0	0	0	0
f. The denial of financial benefits/entitlements (e.g., SSI, SSDI, Insurance)	0	0	0	0	0	0	0	0	0	0	0	0
g. Guardianship/Conservator problems	0	1	0	0	0	0	0	0	0	0	0	1
h. The denial of rights protection information or legal assistance, including adequate and appropriate representation during commitment hearings	2	1	1	0	0	1	0	0	0	0	0	5
i. The denial of privacy rights (e.g., congregation, telephone calls, receiving mail)	1	1	2	0	0	0	0	0	0	0	0	4
j. The denial of recreational opportunities (e.g., grounds access, television, and smoking)	0	0	0	0	0	0	0	0	0	0	0	0
k. The denial of visitors	1	0	0	0	0	0	0	0	0	0	0	1
l. The denial of access to or correction of records	0	0	1	0	0	0	0	0	0	0	0	1
m. Breach of confidentiality of records (e.g., failure to obtain consent before disclosure)	0	0	0	0	0	0	0	0	0	0	0	0
n. Failure to obtain informed consent	0	0	0	0	0	0	0	0	0	0	0	0
o. Advance directives issues	0	0	0	0	0	0	0	0	0	0	0	0
p. The denial of parental/family rights	0	0	0	0	0	0	0	0	0	0	0	0
q. Housing Discrimination	0	0	1	1	0	0	0	0	0	0	0	2
r. The denial of access to administrative or judicial process	0	0	3	0	0	0	0	0	0	0	0	3
s. Failure to provide educational services in the least restricted environment for PAIMI-eligible individuals	2	1	20	0	0	1	0	0	1	0	0	25
t. The denial of access to community-based rehabilitation services and/or treatment	0	1	5	0	0	0	0	0	0	0	0	6

u. The denial of access to transportation	0	0	1	0	0	0	0	0	0	0	0	1
v. Employment Discrimination	0	0	1	0	0	0	0	0	0	0	0	1
w. The denial of access to personal possessions	0	0	0	0	0	0	0	0	0	0	0	0
x. Failure to comply with commitment regulations	0	0	0	0	0	0	0	0	0	0	0	0
y. Failure to comply with commitment time frames	0	0	0	0	0	0	0	0	0	0	0	0
z. Other *[Please make every effort to report within the above categories].*	0	0	0	0	0	0	0	0	1	0	0	1

Rights Violations Disposition

For closed cases listed in this Table, provide the number of rights complaints or problem areas for each disposition category.	
A. Number of complaints/problems determined after investigation not to have merit	7
B. Number of complaints/problems withdrawn or terminated by client	6
C. Number of complaints/problems resolved in the client's favor	41
D. Number of complaints/problems not resolved in the client's favor	1
E. Other Indicators of success or outcomes that resulted from P&A involvement	0
F. Other Representation found	2
G. Services not needed due to client death or relocation	1
H. P&A withdrew due to conflict of interest or other reasons	0
I. Lost Contact	3
J. Outcome Unknown	0
K. Lack of Resources	0
Total number of Rights Violation complaints/problems addressed from closed cases	**61**

Cases of Alleged Rights Violations

RH is an adult male with a significant mental illness (adjudicated NGI with Major Depressive Disorder) who was residing on a forensic unit at a state mental health treatment hospital at the time of his initial request for assistance from Disability Rights Florida (DRF). RH contacted DRF to request assistance with accessing his medical and mental health records after being continually denied access by staff at their facility. Specifically, RH wanted to review his records to better understand his status within the forensic program, as he had expected to be transferred to a step-down civil facility a few months prior to their communication with DRF. However, facility staff informed him that they had a general policy stating that they do not provide records to any patient until after discharge to avoid potential security and safety risks. Therefore, RH could not access records until after discharge from the program. To investigate this service request, DRF staff conducted an on-site interview with RH to obtain more information. Additionally, DRF staff

recommended that RH continue to consult his treatment team about options for reviewing records while DRF requested and reviewed RH's records and the facility's records access policy to confirm the reason for RH's denial of records. The records review confirmed RH's allegation along with the reason that facility staff provided to DRF. DRF had concerns that this policy was not in compliance with forensic patient rights as outlined in the Florida Administrative Code and Florida Mental Health Act. In short, while patients may be denied access on an individual basis due to potential patient safety issues, the facility should not employ a general policy that denies all patients access without review of potential safety issues on an individual basis. DRF communicated these concerns to administrative staff at the facility who reviewed their policy alongside DRF's statement of concerns. As a result, the facility agreed to change their policy on patient access to records to require that records requests be reviewed on an individual basis while also training relevant staff on the new policy. They confirmed that the agreed upon changes would be implemented by the end of August 2023. As a result of the above steps, DRF closed this case as issues resolved partially/completely in the client's favor as a result of negotiation that resulted in the facility bringing their records access policy into compliance with Florida Administrative Code and the Florida Mental Health Act.

Cases of Alleged Rights Violations

JM is an adult diagnosed with significant mental illness who contacted Disability Rights Florida (DRF) while inpatient at a forensic state mental health treatment facility to report concerns with the resident telephone system. JM requested assistance with residents being able to call their attorney and leave a message if the attorney does not answer, as well as permission to call toll-free numbers, free local calls, and collect calls. DRF staff agreed to assist JM by communicating JM's concerns to the facility with the goals of providing JM with accurate information about the facility's phone system and ensuring that JM had use of the phone to contact legal counsel when needed. DRF staff met with the facility administrator and several other facility staff to discuss the resident telephone system. DRF and the facility exchanged information about resident needs and experiences regarding phone use, and how the phone system operates including what kinds of restrictions were being imposed for what reasons. This allowed DRF to confirm that phone restrictions as implemented by the facility did not infringe on residents' right to communicate as provided in Florida law. DRF relayed information obtained through these meetings with JM. Specifically, DRF informed JM that that facilities are permitted to establish rules regarding the phone system and that they can charge for local calls and collect calls in this forensic setting. Indigent clients receive a monthly phone allowance and can receive additional phone time with staff assistance if needed. They also informed JM that residents are able to call their attorneys themselves via the resident telephone and, if they require additional assistance due to not being able to leave a message for their attorney if the attorney does not answer, they can contact the Resident Advocate and/or their Social Worker to assist. With regard to calling toll -free numbers, DRF staff told JM that residents can make the request to their treatment team and, if they require additional assistance, they can contact the Resident Advocate and/or their Social Worker to assist with the call. As a result, JM was better able to understand how to use the phone system and who to contact at the facility to resolve future difficulties. As a result of the above steps, DRF staff closed this case as issues resolved partially or completely in individual's favor through limited advocacy.

Cases of Alleged Rights Violations

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Footnotes:

"Other" case dealt with multiple Rights Violations including discharge planning, voting rights, and access to the facility's grievance procedure.

C. Complaints/Problems of PAIMI Individuals

Reasons for Closing Individual Advocacy Case Files

	Number
1. Client's objective was partially or fully met.	102
2. Case or investigation lacked merit.	63
3. Case withdrawn or terminated by the client.	28
4. Issue favorably resolved.	0
5. Issue not favorably resolved.	4
6. Other success or outcomes due to P&A involvement (i.e., provided self-advocacy assistance)	1
7. Other representation found.	6
8. Services not needed due to client's death or relocation.	10
9. P&A withdrew due to conflict of interest or other reasons (i.e., client would not cooperate).	0
10. Appeal(s) unsuccessful.	0
11. Other appropriate entity investigating.	0
12. Lost Contact.	8
13. Lack of Resources.	0
Total	**222**

At least 1 case required.

Case of Closing an Individual Advocacy Case File

AJ is an adult male diagnosed with a significant mental illness (Delusional Disorder, Persecutory Type) who is a forensic resident of a state mental health treatment facility (SMHTF). AJ contacted DRF with allegations of physical abuse, specifically alleging that security staff came to his room and beat him up during the administration of an Emergency Treatment Order (ETO). DRF staff interviewed AJ, reviewed video of the incident, and reviewed records and notes from AJ's residence at the facility. During an in-person interview, AJ showed DRF staff marks on his hands and feet consistent with being placed in restraints but did not have any other signs of physical abuse. He was guarded and reticent about details, first mentioning that nurses said he was being sexually inappropriate, then later denying any knowledge of why the ETO was ordered. Facility records allege that AJ was being combative, aggressive, and making threats towards nursing staff. He was given an ETO and placed into restraints until he calmed down. They also detail previous history of "frequent" physically and verbally sexually aggressive behavior towards staff. DRF staff found the video footage of the incident to be inconclusive, as no footage of the room itself exists. However, the camera outside of AJ's room shows AJ walking around, in and out of his room, until security showed up and escorted him (without any significant resistance, or any visible excessive force) back to his room. DRF staff observed nurses and facility staff

standing outside AJ's room for a while as security entered the room. They removed his possessions from the room and wheel in a restraint chair. After he was restrained, he was immediately placed on one-to-one observation and security leaves his room. Staff outside do not appear alarmed or show any signs of a serious altercation happening within the room. As a result of this investigation DRF determined that they cannot substantiate AJ's claims with the available evidence, as neither video nor written records show any indication of excessive use of force. DRF closed AJ's case as Complaint/Problem Determined after Investigation Not to Have Merit, due to lack of evidence.

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Footnotes:

C. Complaints/Problems of PAIMI Individuals

Intervention Strategies

The totals reported for the Abuse, Neglect, and Rights Violations Outcomes in this table **should be** the same as the totals reported in the Areas of Alleged Abuse, Areas of Alleged Neglect, and Areas of Alleged Rights Violations tables.

Outcomes												
Abuse	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**Total**
1. Self Advocacy Assistance	26	13	8	1	0	1	2	0	1	0	0	52
2. Limited Advocacy	17	3	9	1	0	2	0	0	3	0	0	35
3. Administrative Remedies	0	0	1	0	0	0	0	0	0	0	0	1
4. Litigation	0	0	1	0	0	0	0	0	0	0	0	1
5. Abuse/Neglect Investigations	0	0	0	0	0	0	0	0	0	0	0	0
6. Mediation	0	0	0	0	0	0	0	0	0	0	0	0
7. Negotiation	1	0	8	0	0	0	1	0	0	0	0	10
Total	**44**	**16**	**27**	**2**	**0**	**3**	**3**	**0**	**4**	**0**	**0**	**99**
Neglect	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	
1. Self Advocacy Assistance	3	6	9	1	1	0	5	0	1	0	0	26
2. Limited Advocacy	8	0	21	0	0	1	1	0	0	0	0	31
3. Administrative Remedies	0	0	0	0	0	0	0	0	0	0	0	0
4. Litigation	0	0	0	0	0	0	0	0	0	0	0	0
5. Abuse/Neglect Investigations	0	0	0	0	0	0	0	0	0	0	0	0
6. Mediation	0	0	0	0	0	0	0	0	0	0	0	0
7. Negotiation	1	0	4	0	0	0	0	0	0	0	0	5
Total	**12**	**6**	**34**	**1**	**1**	**1**	**6**	**0**	**1**	**0**	**0**	**62**
Rights Violations	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	
1. Self Advocacy Assistance	4	3	7	0	0	0	0	0	2	0	0	16
2. Limited Advocacy	3	3	11	0	0	2	0	0	1	0	0	20
3. Administrative Remedies	0	0	1	0	0	0	0	0	0	0	0	1

4. Litigation	0	0	1	0	0	0	0	0	0	0	0	1
5. Abuse/Neglect Investigations	0	0	0	0	0	0	0	0	0	0	0	0
6. Mediation	0	0	1	0	0	0	0	0	0	0	0	1
7. Negotiation	0	0	20	1	0	0	1	0	0	0	0	22
Total	**7**	**6**	**41**	**1**	**0**	**2**	**1**	**0**	**3**	**0**	**0**	**61**

At least 1 case required.

Case of Intervention

As an example of an individual case using the intervention strategy of Limited Advocacy, TS is a forensic patient (adjudicated incompetent to proceed) who resides in a state forensic mental health treatment facility. In addition to significant mental illness, TS was diagnosed with unspecified hearing loss. TS contacted DRF seeking assistance with obtaining his hearing device which he alleged was lost when he transferred to a different forensic facility. DRF investigated TS's concern by reviewing medical records, including social work notes, hearing assessments, evaluations and other relevant reports from the prior facility. DRF staff then communicated with staff at TS's current facility and requested that TS be provided a pocket talker. As a result of DRF's advocacy, TS was provided a pocket talker. In addition, TS's current facility developed a plan that includes all staff to ensure that TS receive effective communication while at the facility. As a result, this case was closed as partially/completely resolved in TS's favor.

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Footnotes:

C. Complaints/Problems of PAIMI Individuals

Death Investigation Activities

A. The number of deaths reported to the P&A for investigation by the following entities:	
1. State	22
2. The Center for Medicaid & Medicare Services (Regional Offices). If zero means the P&A did not receive any death reports from CMS for investigation, please note this in the Footnotes.	0
3. Other Sources. Briefly list the source for each death reported in this category (e.g., newspaper, concerned citizen, relative, etc.). Media reports, other inmates/facility residents, family members, third party referrals.	11
Total Number of deaths investigated	**33**

If the information requested in this section was not available please explain

B. All death investigations conducted involving PAIMI-eligible individuals related to the following:	
a. Number of deaths investigated involving incidents of seclusion (S).	0
b. Number of deaths investigated involving incidents of abuse (A).	4
c. Number of deaths investigated involving incidents of restraint (R).	0
d. Number of deaths investigated NOT related to incidents of S&R, (e.g., suicides.).	19
e. Death investigations with a finding of determination.	8
f. Provision in policy added or prevented as a result of a death investigation.	1
Total Number of deaths investigated [Sum of 9b 1-6]	**32**

C. Provide a brief summary example of an individual's death, P&A involvement, and outcome.
If you reported deaths in categories B.9.b., please provide the following information on one death from each category, as appropriate:

A brief summary of the circumstances about the death.

A brief description of P&A involvement in the death investigation.

A summary of the outcome(s) resulting from the P&A death investigation.

As an example of an incident of abuse, Disability Rights Florida (DRF) received information about the death of KD, an adult with significant mental illness (Bipolar Disorder), who was detained in the North Broward Bureau of the Broward County Jail where detainees who require mental health treatment are housed. The death was alleged to have occurred as the result of a use of force that included chemical and physical restraints. DRF conducted a preliminary review of publicly available information and requested preservation of video evidence. During DRF's initial investigation, DRF learned that the state attorney conducted a criminal investigation in conjunction with local law enforcement. This delayed the release of information to DRF. Subsequently, DRF learned that the National Police Accountability Project, a project of the National Lawyer's Guild, brought a case in the Southern District of Florida alleging excessive force, deliberate indifference, wrongful death, and violations of the Americans with Disabilities Act. DRF, therefore, closed this death investigation due to Other Representation Obtained.

As an example of an incident not related to S&R, Disability Rights Florida (DRF) was contacted by JN's family member with concern about the cause of JN's death as JN was on suicide watch and did not have any prior health impairments prior to their death. JN was incarcerated in a County Jail for less than three (3) months before passing away. A case was opened to conduct a confidential P&A investigation into the death of JN. DRF reviewed records provided by the Medical Examiner and Trauma Services – Investigation Report, Final Toxicology Report, and an Autopsy Report. There was no video in or

around the area of JN's cell. JN was found in the jail cell around 9:15 am on the date of death, unresponsive, and not breathing. Records indicate that facility staff called 911 and started CPR. Fire/Rescue personnel arrived on scene and transported JN from the jail to a local hospital. Emergency Room staff took over CPR, but all efforts to revive JN failed. Hospital staff reported that nothing could be done for JN upon arrival as JN was already deceased. Medical Examiner's reports concluded that the death was sudden and unexplained, potentially related to epilepsy, a cardiovascular issue, or higher baseline mortality levels and higher levels of unexplained deaths for individuals diagnosed with schizophrenia. Reports do not indicate that JN was on suicide watch or otherwise being observed for self-harm and there is no available physiological or circumstantial evidence pointing towards suicide. DRF determined that there was not probable cause to continue the death investigation further due to their investigation being unable to substantiate allegations that JN's death was related to abuse or neglect by the facility. As a result, DRF closed this death investigation.

As an example of a case with a finding or determination, DRF investigated the death of SK, an adult male with significant mental illness (Unspecified Schizophrenia Spectrum and Other Psychotic Disorder) who was admitted to a state mental health treatment facility (SMHTF) pursuant to a court order adjudicating him Incompetent to Proceed. Disability Rights Florida (DRF) reviewed a report of SK's death at the facility. SK was found unresponsive in his room with a plastic bag over his head and pronounced dead after unsuccessful CPR and AED efforts. The medical examiner concluded the probable cause of death was suicide by asphyxiation with plastic bag. During DRF's review of video and clinical records, they observed that supervision of patients was highly inadequate. As it pertains to SK, multiple interviewees attested that SK had been displaying significant changes in behavior. Furthermore, DRF uncovered during their investigation that staff was made aware of a choking sound coming from SK's room the night prior to his death. This report made to staff was not logged in any records received. Additionally, staff had previous knowledge that SK hoarded contraband, dangerous materials, and his medication while also being non-compliant with his medication. In their review of video, DRF observed SK take a plastic bag from the trash can into his room. DRF determined that the facility had overlooked a number of significant warning signs that should have resulted in increased observation levels for SK. As a result of their investigation, DRF found preponderance of evidence of neglect. DRF requested a corrective action plan to improve facility monitoring and oversight of residents who may engage in self-harming behaviors. Following DRF's investigation of the death of SK, the facility conducted a mortality review, a root cause analysis, and a psychological autopsy. Two workers who failed to properly conduct safety checks of clients were terminated and one resigned prior to termination. The facility conducted additional training with nursing and direct care staff on the topics of medications and meal refusals along with staff roles and responsibilities. Supervisors were also trained in how to audit and monitor employees' face checks. Additional noteworthy actions taken by the facility include changes to several operating procedures, such as how the facility handles/manages plastic bags on the units, stricter monitoring of how room checks are done to look for signs of life, supervisors close auditing of room checks done by staff, inspecting patients for contraband and reporting of patients with contrabands, enhanced controls of the use of cleaning products and other materials patients may need to use when cleaning. DRF staff conducted a follow up visit to meet with facility administrators, staff, and residents about the policy changes implemented as a result of the corrective action. Residents confirmed that the changes have taken place. Staff were also interviewed about the new audit system for face checks. DRF staff viewed a random selection of videos and observed that there is room for improvement in the way that direct care staff conduct face checks. DRF will continue to monitor with periodic check-ins as part of our efforts related to this systemic issue being addressed as part of a project designed to improve patient safety checks at SMHTFs. As a result of the above steps, DRF closed this case as favorably resolved through negotiation/mediation due to the facility adopting DRF's corrective action plan.

As an example of a provision in policy added or prevented as a result of a death investigation, DRF received a report of the death at a state mental health treatment facility (SMHTF) of RI—an adult with serious mental illness committed to the facility—resulting from an altercation with his roommate. DRF initiated a death investigation to determine whether action or inaction, such as inadequate supervision, by facility staff contributed to RI's death. DRF requested and reviewed medical records, security records, incident reports, and all other available records related to RI's treatment at the facility and the incident that resulted in his death. DRF requested and reviewed extensive video footage of the period prior to RI's death in order to determine whether facility staff properly conducted patient safety checks. DRF's investigation concluded that facility staff failed to make multiple 30-minute patient safety checks in the hours prior to the death, along with several checks that were partial or inadequate. These checks, if properly conducted, could have potentially resulted in staff intervening to protect RI, or discovering him and being able to provide life-saving emergency care sooner. DRF also concluded that staff falsely signed records indicating that they had made these checks. After DRF presented their findings to facility staff, the facility provided DRF with a corrective action plan, which included terminating employees who falsified safety checks, increasing pay for nursing and direct care positions, hiring additional staff, retraining all staff on conducting safety checks, and adding new layers of supervisory monitoring/audits to ensure that checks are properly made in the future. DRF met with senior staff at the facility to verify that the changes discussed above were made and to discuss their progress and findings. DRF determined that the facility complied with the steps they agreed to take, along with making further revisions to the process intended to avoid future incidents like this happening. DRF also used this death investigation as the basis for a larger project (Project 7008) that focuses on enacted improvements to patient safety checks at SMHTFs throughout the state.

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Footnotes:

A2. Disability Rights Florida does not receive death reports from The Center for Medicaid & Medicare Services.

B. For one death investigation, Disability Rights Florida is currently unaware of the cause of death. Therefore, we are unable to speculate regarding what the death was related to. This one death accounts for the discrepancy between the numbers in Section A (33) and Section B (32).

C. Complaints/Problems of PAIMI Individuals

Number of Interventions on behalf of Groups of PAIMI Eligible Individuals - Individuals Impacted

Multiple counts not permitted for lines 1 –3 and 6.

What to Count	
1. Group cases/projects still open on October 1, 2022. (Carried over from prior FY (s))	53
2. New group cases/projects opened during the year.	44
3. Total group cases/projects worked on during the year (Add lines 1 & 2)	97
4. Total group cases/projects as of September 30, 2023. (Carry over to next FY)	61
5. Group cases/projects targeted at serving the following special populations:	
a. Ethnicity	5
b. Racial Minorities	5
c. Homeless	2
d. Veterans	2
e. Urban	25
f. Rural/Frontier	7
g. Older Adults/geriatric	4
6. Total # of individuals potentially impacted by line 3	51,672,718

Only the number of cases are needed for the last three columns, not the number of individuals

Intervention Types (See the Instructions for Guidance)	Potential # of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	On-going
Group Advocacy (non-Litigation)	11,561,983	4	2	12
Abuse and Neglect Investigations (non-death related)	1,053	0	1	2
Facility Monitoring Services	6,238	16	6	9
Community Based Monitoring Services	0	0	0	0
Court Ordered Monitoring	0	0	0	0
Systemic Litigation	11,179,491	1	0	8

Educating Policy Makers	9,637,751	0	0	13
Other Systemic Advocacy	19,286,202	7	0	15
Total	**51,672,718**	**28**	**9**	**59**

Case of Intervention on Behalf of a Group

During FY 2022-2023, Disability Rights Florida (DRF) continued monitoring compliance with a court-ordered settlement obtained in the case of Disability Rights Florida v. Jones and the Florida Department of Corrections (FDC). (See Case No. 3:18-cv- 179-J-20JRK, M.D. Fla.). The settlement agreement addresses the constitutionally deficient treatment of patients in the custody of the FDC that reside on the inpatient mental health units (MHUs) for inmates with significant mental illness that requiring the highest level of care. The original agreement required two periods of compliance monitoring to be conducted by the Correctional Medical Authority (CMA), acting as a neutral monitoring authority. The second monitoring period was completed in FY 2021-2022 and revealed significant deficiencies in the FDC's compliance at six of their eight MHUs. As a result, DRF prepared to file a motion for contempt regarding the FDC's continued non-compliance with the settlement agreement. However, after multiple negotiation meetings and a court hearing, the parties ultimately agreed to extend jurisdiction for two additional years (until July 1, 2024) to provide the FDC additional time to come into compliance and to allow the CMA to conduct a third round of limited settlement monitoring at the six non-compliant institutions to verify compliance. During FY 2022-2023, the FDC continued corrective action efforts to bring its six non-compliant institutions into compliance with the terms of the settlement agreement. The CMA monitored four of the six institutions and issued reports indicating compliance with the terms of the settlement agreement at issue during the third round of monitoring. The two remaining institutions that require a third round of compliance monitoring are scheduled to occur during FY 2023-2024.

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Footnotes:

C. Complaints/Problems of PAIMI Individuals

Performance Measures of P&A Activities

Outcomes	Number from Closed Cases Only
a) PAIMI-eligible individuals who access community-based mental health or health care services that resulted in community integration and independence or are better able to advocate to do so;	7
b) PAIMI-eligible individuals who access benefits or services or are better able to advocate to do so;	280
c) PAIMI-eligible individuals who live in a healthier, safer, improved, or more integrated settings or are better able to advocate to do so;	1,331
d) PAIMI-eligible individuals are able to stay in their own home or better able to advocate to do so;	1
e) PAIMI-eligible individuals who can secure or maintain employment and/or are not subject to workplace discrimination or are better able to advocate for to do so;	1
f) PAIMI-eligible individuals who receive appropriate educational services and supports and/or are not subject to discrimination in educational settings or are better able to advocate for those outcomes;	5
g) PAIMI-eligible individuals who go to school in safe and more humane conditions;	2,502
h) PAIMI-eligible children (individuals) who receive appropriate services in the most integrated settings;	47
i) PAIMI-eligible individuals who were not subject to discrimination in government benefits/services, housing, public accommodations, etc. or are better able to advocate for such outcomes;	0
j) PAIMI-eligible individuals who were not subject to abuse, neglect, or rights violations or are better able to advocate for to do so;	0
k) PAIMI-eligible individuals who can make their own decisions to the maximum extent feasible or are better able to advocate to do so;	0
l) PAIMI-eligible individuals who had their rights enforced, retained, restored and/or expanded or are better able to advocate for to do so; and	467
m) PAIMI-eligible individuals who were more able to participate in the voting process or are better able to advocate for to do so.	0

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Footnotes:

D. Non-Client Directed Advocacy Activities

Non-client Directed Advocacy Activities

1. Individual Information and Referral (I&R).	Total
Provide the number of PAIMI Program I&R services.	1,436
2. State Mental Health planning activities	
DRF's Director of Public Policy serves as a voting member of the Florida SAMHSA Block Grant Planning Council. This seat is designated for an advocacy organization, and DRF keeps the Planning Council appraised of our relevant work, gathers information from members regarding initiatives and service delivery across the state, and reviews and comments on the state's relevant block grants as a part of the Council. Additionally, DRF's representative on the Planning Council is a member of both the Legislative/Advocacy and Nominating/Membership Committees.	
3. Education, Public Awareness Activities, and Events	
1. Number of public awareness activities or events.	41
2. Number of education/training activities undertaken.	54
3. Number (approximate) of persons trained in 2.	3,400
4. Technical Assistance	
Provide the number of PAIMI Program TA services.	2

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Footnotes:

E. Grievance Procedures

Grievance Procedures 42 CFR § 51.25 (a)(1)(2)

}

1. Do you have a systemic/program assurance grievance policy as mandated 42 CFR 51.25 (a)(2)?	(●) Yes ( ) No
If Yes please upload your organizations Grievance Policy using the attachment tab	
2. The number of grievances filed by PAIMI-eligible clients, including representatives or family member of such individuals receiving services during this fiscal year. Total	5
3. The number of grievances filed by prospective PAIMI-eligible clients (those who were not served due to limited PAIMI Program resources or because of non-priority issues). 42 CFR § 51.25 (a)(1)(2)	0
4. The number of grievances appealed to : a. The Governing Authority/Board b. The Executive Director	 0 5
Total 4.a & 4.b	5
5. The number of reports sent to the Governing Board and the Advisory Board. Total	4
6. Please IDENTIFY ALL INDIVIDUALS, by name & title, responsible for grievance reviews (maximum 5): Name:Peter Sleasman Title:Executive Director Name:Eurica Ketant Title:Chair, BOD Client Grievance Committee	
7. What is the timetable (in days) used to ensure prompt notification of the grievance procedure process to clients, prospective clients or persons derided representation, and ensure prompt resolution? Total # of days	30
8. Were written responses sent to each grievant? *If no, explain below*	(●) Yes ( ) No
9. Was client confidentiality protected? *If no, explain below*	(●) Yes ( ) No

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Footnotes:

Notice to Individuals about Disability Rights Florida Grievance Procedure

How to File a Grievance

You may file a grievance if:

- You asked for help from Disability Rights Florida but were told you could not get help;
- You currently are getting help from Disability Rights Florida but are unhappy with the help; or
- The help you were receiving ended and Disability Rights Florida denied further help.

To file a grievance you may do the following:

Step 1 (optional): Discuss the Disagreement with the Disability Rights Florida Employee.

You may want to talk about the problem with the Disability Rights Florida staff person. You do not have to do this.

Step 2: Disability Rights Florida Executive Director

You may file a grievance with Disability Rights Florida's Executive Director within 30 days of when Disability Rights Florida made the decision you do not like.

You may file a grievance using the attached form, by writing your grievance on another piece of paper, or by calling Disability Rights Florida for assistance in preparing your grievance.

Updated 4/27/15

Send your grievance:

- **Via mail**
  Executive Director
  Disability Rights Florida
  2473 Care Drive, Suite 200
  Tallahassee, FL 32308
- **Via fax**
  (850) 488-8640
- **Via e-mail**
  executivedirector@disabilityrightsflorida.org
- **Via phone or TDD (if assistance is required)**
  (800) 342-0823
  TDD (800) 346-4127

The Executive Director will review your grievance and give you a written decision within 30 days unless the Director tells you that he/she needs more time.

Step 3: Disability Rights Florida Board of Directors

If you disagree with the Executive Director's decision, you may request a review by Disability Rights Florida's Board Grievance Committee within 30 days of the Executive Director's decision.

You may request a review by using the attached form, by writing your request on another piece of paper, or by calling Disability Rights Florida for assistance in preparing your grievance.

Send your request:

- **Via mail**
  Grievance Committee of the Board of Directors
  Disability Rights Florida
  2473 Care Drive, Suite 200
  Tallahassee, FL 32308
- **Via fax**
  (850) 488-8640
- **Via e-mail**
  clientgrievancecommittee@disabilityrightsflorida.org

Updated 4/27/15

- **Via phone or TDD (if assistance is required)**
  (800) 342-0823
  TDD (800) 346-4127

The Board Grievance Committee will review your request and issue a written decision within 30 days unless the Grievance Committee Chair tells you that he/she needs more time. The Grievance Committee's decision is Disability Rights Florida's final decision.

Updated 4/27/15

Client Grievance Form

To file a grievance, you may use this form, write your grievance on another piece of paper or call (800) 342-0823 and ask a Disability Rights Florida staff person to assist you in writing your grievance. You may also call us on the TDD line at (800) 346-4127, send us a fax at (850) 488-8640, or send an e-mail to executivedirector@disabilityrightsflorida.org

Your name:

Your address:

Your daytime telephone number: ( )

Your e-mail:

If you are helping someone file a grievance, their name:

Please explain why you are filing a grievance:

What do you want Disability Rights Florida to do differently?

Updated 4/27/15

Disability Rights Florida
PAIMI Assurance Grievance Procedure

Disability Rights Florida, Inc., is required by the Protection and Advocacy for Individuals with Mental Illnesses (PAIMI) Act to establish a grievance procedure for individuals who have received or are receiving mental health services, family members of such individuals with mental illnesses, or representatives of such individuals or family members to assure that Disability Rights Florida is operating in compliance with the PAIMI Act, 42 U.S.C. Sec. 10805(a) (9).

Any individuals identified above may file a PAIMI Assurance Grievance if s/he believes that Disability Rights Florida has violated any of the following federal assurances:

1. Be independent of service providers;
2. Have the capacity to protect and advocate for the rights of individuals with mental illnesses;
3. Have trained staff;
4. Have the authority to investigate allegations of abuse and neglect;
5. Have the authority to pursue legal, administrative, and other appropriate remedies;
6. Have access to individuals with mental illnesses, records and facilities;
7. Maintain confidentiality of records;
8. Not take action on behalf of individuals with mental illnesses which are duplicative of actions taken by the individual's legal guardian, conservator, or representative other than the State, unless such legal representatives request assistance from Disability Rights Florida;
9. Exhaust administrative remedies prior to initiating legal action, except in an emergency;
10. Have a multi-member governing board which develops priorities and includes members who are broadly representative of people who receive services

Updated 4/27/15

from Disability Rights Florida and includes the Disability Rights Florida PAIMI Advisory Council Chair;

11. Have a Disability Rights Florida PAIMI Advisory Council that has 60% of membership composed of service recipients, former recipients, or family members, that offers advice on policies and priorities and completes an Advisory Council Report on an annual basis.
12. Provide the public with an opportunity to comment on priorities;
13. Use court judgments to further purposes of federal laws; and
14. Use federal allotments to supplement, not supplant, non-federal funds.

Any individual who is receiving or has received mental health services, their family member or representative may file a written complaint with Disability Rights Florida's Executive Director. The complaint should specify which Assurance the individual believes Disability Rights Florida is violating and the reason(s) the individual believes the Assurances are being violated.

The complaint form should be sent:

- **Via mail**
  Executive Director
  Disability Rights Florida
  2473 Care Drive, Suite 200
  Tallahassee, FL 32308

- **Via fax**
  (850) 488-8640

- **Via e-mail**
  executivedirector@disabilityrightsflorida.org

- **Via phone or TDD (if assistance is required)**
  (800) 342-0823
  TDD (800) 346-4127

The Executive Director will review the Assurance Grievance and issue a written decision within 30 days of receiving the complaint, unless the Director notifies the individual that s/he requires additional time.

The Executive Director shall advise Disability Rights Florida's Board of Directors and PAIMI Advisory Council of all Assurance Grievances and the outcome of those grievances at their next regularly scheduled meetings. If the assurance grievance includes confidential information, the Assurance Grievance will be discussed in a session that is closed to the public.

Updated 4/27/15

Disability Rights Florida
PAIMI Assurance Grievance Form

Thank you for contacting Disability Rights Florida. We are providing this notice to file a grievance if you believe Disability Rights Florida is in violation of the assurances in the Protection and Advocacy for Individuals with Mental Illnesses (PAIMI) Act, 42 U.S.C. Sec. 10805(a)(9).

Please indicate if you are:

___ An individual who is receiving or has received mental health services.

___ A family member of an individual who is receiving or has received mental health services

___ A representative of either an individual who is receiving or has received mental health services or of the family member of such an individual.

Please explain why you believe Disability Rights Florida is in violation of the PAIMI Act (please be as specific as possible and use additional paper if needed):

Signature: Date:

Updated 4/27/15

Name:

Mailing Address:

Daytime phone number:

Email address:

Please send the completed form:

- **Via mail**
  Executive Director
  Disability Rights Florida
  2473 Care Drive, Suite 200
  Tallahassee, FL 32308
- **Via fax**
  (850) 488-8640
- **Via e-mail**
  executivedirector@disabilityrightsflorida.org
- **Via phone or TDD (if assistance is required)**
  (800) 342-0823
  TDD (800) 346-4127

The Executive Director will investigate your complaint and respond to you in writing within 30 working days, unless the Director notifies you that s/he requires additional time.

Updated 4/27/15

F. Other Services & Activities

Public Comment

1. Does the P&A have procedures established for public comment?

a. (●) Yes, briefly describe how the notice is used to reach persons with mental health illness and their families.

In FY 2022-2023, Disability Rights Florida (DRF) collected public input by requesting comments to the draft Goals, Priorities, Objectives that were posted to our website, as well as by collecting public comments through completion of a public input survey. Notice of the public comment period was posted on the DRF website and input was collected at in-person events held during the input period. DRF also promoted completion of GPO comments and/or a survey on all social media pages, including Facebook, e-newsletter to the organization's email list, and by letter to the governing Board and PAC. Additionally, our Intake and Information Referral Team provided notice of the DRF's collection of GPO comments and public input surveys along with a link to each on all electronic communications, and provided electronic copies of the survey to individuals, including individuals in facilities who contact us and provide an email as part of the general Information and Referral packet. Surveys were made available in English, Spanish, Haitian Creole, and American Sign Language. The PAC also provided notice at outreach events during the input period.

b. ( ) No, (if no, briefly explain, limit to 500 characters).

2. Were the notices provided to the following persons:

a. Individuals with mental illness in residential facilities? (●) Yes ( ) No

b. Family members and representatives of such individuals? (●) Yes ( ) No

c. Other individuals with disabilities? (●) Yes ( ) No

d. Brief explanation is required for each no answer in 2.a., b., or c.

3. Do the procedures provide for receipt of the comments in writing or in person?

3a. (●) Yes, attach a copy of the agency's Policies & Procedures pertaining to public comment.

3b. ( ) If no to 2 a, b, c., explain why the agency does not have such procedures in place

4. Was the public provided an opportunity for public comment. (●) Yes ( ) No

5. If you answered Yes to 4 briefly describe the activities used to obtain public comment.

Throughout the input period, in addition to electronic reminders to access DRF's website to complete the GPO comments or the Survey Monkey electronic survey tool to complete the public input survey, staff, Board and PAC were encouraged to make personal contact with family, friends and colleagues asking them to participate and share the link to the comment page and survey. There are several well attended statewide conferences for individuals with disabilities during the input period. Staff, in addition to distributing surveys at these events, conducted workshops and solicited additional input and feedback from participants. Additionally, in FY 2022-2023, DRF hosted a public forum at which public input was received via written surveys and verbal comments at roundtable discussions led by DRF staff and members of DRF's PAC and Board of Directors.

6. What formats and languages (as applicable) were used in materials to solicit public comment?

Written surveys were available in electronic and paper versions in English, Spanish, Haitian Creole, and an electronic version in American Sign Language. DRF has bilingual Spanish/English staff available to accept verbal input. DRF also uses a service to assist with interpretation/translation and can assist with completion of the survey in other languages upon request, including American Sign Language.

7. If you answered No to 4, briefly explain why the public was not provided an opportunity to comment.

8. List groups (e.g., states, consumer advocacy, service providers, professional organizations and others, including groups of current and former mental health consumers or family members of such individuals) with whom the PAIMI Program coordinated systems, activities and mechanisms. [42 CFR 51.21 (a) (D)]

SA/MH Planning Council, Trauma Informed Care Workgroup, Florida Supportive Housing Coalition, FADAA, Family Café/Governor's Summit on Disabilities, Guardian Ad Litem, Florida Bar, Florida Supreme Court Taskforce on Substance Abuse and Mental Health, the Public Interest Law Section of the Florida Bar, state and local NAMI, DD Act organizations and AHCA ALF Workgroup.

9. Briefly describe the outreach efforts/activities used to increase the number of ethnic and racial minority clients served or educated about the PAIMI program [this information will be evaluated by using the demographic/state profile information contained in the PAIMI application for the same FY]

During FY 2022-2023, DRF designated staff for the explicit purpose of conducting community outreach, education, and training events to

underserved populations across the state of Florida. 39 of the events conducted this year aimed to provide underserved populations with information about DRF and the PAIMI program. Of these 39 events, 4 events focused on areas of the state that serve racially and ethnically diverse populations, including individuals who speak languages other than English (Spanish and Haitian Creole). DRF also held events targeting the following groups: older adults, Veterans and Military personnel, the LGBTQ community, economically disadvantaged areas, and rural/urban areas. PAC members attended and participated in 2 of these outreach events.

10. Did the activities described in question 9 result in an increase of ethnic and/or minorities in the following categories?

a. Staff ○ Yes ◉ No

b. Advisory Council ○ Yes ◉ No

c. Governing Board ○ Yes ◉ No

d. Clients ◉ Yes ○ No

If you answer no to any item (10.a-d), please provide a brief explanation, such as 10.a, b., or c. – no vacancies.
10a-c. Board, PAC, and staff vacancies are filled through other recruitments methods.

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Footnotes:

Public Comment Procedure Memo

Disability Rights Florida annually updates our goals survey for public input and annually distributes our goals survey via our website and Facebook page, provided electronically through Constant Contact to the organization's email list, by letter to the governing Board and PAC, and notice and survey are made available at outreach events. Additionally, our Intake and Information & Referral Team provides notice of the public input survey along with a link on all electronic communications and provides electronic and hard copies of the survey to individuals, including individuals in facilities who contact us and provide an email or physical address as part of the general Information and Referral packet. The PAC also provides notice at on-site outreach events during the input period including outreach visits at facilities. Surveys are made available in English, Spanish, Haitian-Creole, and American Sign Language.

F. Other Services & Activities

Impediments

External Impediments
Describe any problems with implementation of mandated PAIMI activities, including those activities required by Parts H and I of the Children's Heath Act of 2000 that pertain to requirements related to incidents involving seclusion and restraint and related deaths and serious injuries (e.g., access issues, delays in receiving records and documents, etc.).
None identified during FY 2022-2023.
Internal Impediments
Describe any problems with implementation of mandated PAIMI activities, including any identified annual priorities and objectives (e.g., lack of sufficient resources, necessary expertise, etc.).
None identified during FY 2022-2023.

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Footnotes:

F. Other Services & Activities

Accomplishments/Recommendations/Training Needs

Accomplishments
For this fiscal year, briefly describe the most important accomplishment(s) that resulted from PAIMI Program activities. Provide copies of supporting documents, e.g., case law, news, articles, legislation, etc.
During FY 2022-2023, DRF successfully served PAIMI-eligible individuals in a variety of contexts. In the facility monitoring context, Disability Rights Florida concluded a multi-year monitoring project in our State Mental Health Treatment Facilities (SMHTFs or "state hospitals"). The goal of this project was to monitor the three primary civil facilities (Florida State Hospital (FSH), Northeast Florida State Hospital (NEFSH) and South Florida State Hospital (SFSH)) with a focus on discharge planning and community placement issues in addition to the abuse, neglect and safety issues present in the facilities. The project originated in FY 2018-2019 with extensive research and record review followed by on-site monitoring at the two largest and oldest facilities, FSH and NEFSH. During the summer of 2021, DRF and an epidemiologist expert again monitored FSH and NEFSH to address specific, ongoing concerns related to the immediate health and safety concerns of residents surrounding the COVID-19 pandemic. Recommendations were provided to these facilities onsite during the summer 2021 monitoring. Following the COVID-19 monitoring, DRF pivoted back to the general monitoring of all three civil facilities with the above-noted focus on discharge to the community. As the focus of the investigation shifted more toward discharge concerns in addition to health and safety, DRF leadership engaged a team of experts suited for this role. In the summer of 2022, a team of monitors and consulting experts monitored NEFSH, FSH, and SFSH. Our goal was to provide an independent, expert opinion related to discharge planning and community placement issues, in addition to monitoring any identifiable abuse, neglect, and safety issues present in the facilities. In particular, DRF focused on individuals under involuntary status by court order for inpatient mental health treatment that have not made significant progress towards being discharged after an extended period of hospitalization. All three facilities were visited by a team consisting of three DRF staff members and two outside experts – one who is an Master of Science in Nursing and a Registered nurse, and the other who is a Licensed Clinical Social Worker. Our team conducted direct observations and physical inspections of all units at SFSH and NEFSH (which operate with a mix of civil and forensic individuals), and all civil units at FSH. We also conducted formal and informal interviews and discussions with executives, management, department heads, support staff, and direct care staff. We both formally interviewed and informally interacted with numerous patients, and, after obtaining written consent, reviewed the charts of certain specific individuals at each facility. Additionally, we reviewed the Department of Children and Families (DCF) and facility-specific operating procedures for each institution. The consulting experts, along with DRF staff, drafted a comprehensive report to DCF about the effects of extended hospitalization, identify systemic, community, and facility specific discharge barriers, and recommend strategies to DCF to advocate for increased opportunities for community reintegration and placement. The report includes the background of DRF's involvement in these discharge planning issues along with some specific case studies that are indicative of the larger discharge-related problems these individuals face, observations from the facilities and the barriers to discharge that various residents and staff members told us about, and recommendations about several topics that emerged from these visits, including clinical care, safety, technology, and discharge planning. The report was provided to the DCF Hospital Administrator, along with the administration at the three facilities, with a request to implement targeted strategies by DCF and other stakeholders and to create a task force oriented at removing barriers to discharge and finding appropriate placements for individuals that have been at these institutions the longest. A new project has been opened by DRF to oversee implementation of the recommendations

with fidelity at the institutions.

In the corrections context, Disability Rights Florida (DRF) filed a class action lawsuit in the case of Cody Barnett et al and Disability Rights Florida v. Gregory Tony (Case No. 20-cv-61113-WPD) ("Barnett"), along with the American Civil Liberties Union (ACLU) National Prison Project, the national ACLU Foundation, the ACLU Foundation of Florida, and Sullivan and Cromwell, LLP. This lawsuit challenged the Broward County Jail's (BCJ) response to the COVID-19 pandemic as applied to medically vulnerable inmates, which included those with mental illness who are at a higher risk of transmission and serious illness due to their disability according to CDC criteria. The lawsuit alleged that the medical care being provided violated the ADA, the Rehabilitation Act, and the Eighth and Fourteenth Amendments to the United States Constitution.

The parties in Barnett entered into a settlement agreement that was approved by the court in May of 2021. The settlement agreement's requirements included that the BCJ conduct temperature and COVID-19 symptom checks of inmates in accordance with CDC guidelines upon booking at the jail; maintain social distancing between inmates during booking; provide face coverings to inmates during booking and prior to contact with other inmates; require staff to wear face coverings when processing newly booked inmates; display information about COVID-19 and how to reduce transmission in all areas accessible by inmates; identify all persons who are vulnerable to serious illness or death because of COVID-19 infection, including medically vulnerable persons; provide socially distant housing accommodations to high risk inmates; implement a plan to allow and encourage inmates to socially distance when going about daily activities such as eating and showering, including the use of floor markers at 6-foot increments in key areas such as medication lines; house inmates who are positive for COVID-19 in medical isolation; restrict transfers of inmates from and to other facilities; implement procedures to allow for virtual attendance at court hearings; and test symptomatic inmates and staff or those who are exposed to a known positive individual, as well as medically vulnerable inmates who have been incarcerated for at least 3 days.

The Barnett settlement agreement allowed Plaintiffs to conduct monitoring of the BCJ's compliance with the assistance of an expert. Monitoring was conducted at all four BCJ facilities over the course of 2 days with the assistance of DRF staff and a medical expert. That monitoring revealed many areas in which the BCJ was not compliant with the terms of the settlement agreement. This resulted in the filing of a Motion for Enforcement and Modification of the settlement ("Motion for Enforcement.") After an evidentiary hearing, the magistrate judge entered a report and recommendations granting the Motion for Enforcement in part by requiring BSO to do the following: conduct COVID-19 tests at certain times that are critical to controlling infection, including at intake, when leaving the jail (e.g. to attend court), and while in quarantine; conduct temperature and COVID-19 symptom checks prior to transferring detainees to different facilities; maintain a list of medically vulnerable detainees and routinely conduct temperature and COVID-19 symptoms screenings on these individuals; track the housing location of medically vulnerable detainees; and ensure detainees possess two face coverings in usable condition at all times. The magistrate's report and recommendations were affirmed in an order entered by the Court.

In FY 2021-2022, DRF and co-counsel conducted another on-site monitoring at all four facilities in the BCJ system that, along with written documentation provided as part of the settlement agreement, revealed ongoing violations of the agreement. DRF and co-counsel subsequently filed a Motion for Order to Show Cause and a Motion to Modify the Consent Decree to request court intervention to ensure enforcement of key provisions of the consent decree and additional time for the court to oversee the needed enforcement. An example of a key provision Plaintiffs sought to enforce is COVID-19 testing of detainees at key points during their incarceration to reduce the spread of infection among medically vulnerable and disabled individuals.

In October of FY 2022-2023, the court held a hearing on Plaintiffs' Motion to Modify and Motion for an Order to Show Cause. The court granted Plaintiffs' Motion and issued an Order to Show Cause against the Sheriff. A hearing on the Order to Show Cause took place in February 2023 before a magistrate judge. The purpose of the hearing was for the Sheriff to present evidence as to why he should not be held in contempt for violating the consent decree (the settlement agreement which was adopted as an order of the court). The judge heard 7 hours of legal argument and testimony from an incarcerated person, the jail's chief administrator, and the jail's medical director. Following the hearing, the magistrate judge issued a Report and Recommendations (R&R) for the court. The magistrate's R&R to the presiding judge included findings that the Sheriff had not entirely complied with all provisions of the consent decree but that the Sheriff had provided sufficient evidence demonstrating a legal basis to not be held in contempt of court and recommended termination of the consent decree. DRF joined its co-counsel in filing of written objections to the R&R. In August of 2023, the presiding judge issued the final ruling in the case and upheld the magistrate judge's R&R, thereby concluding litigation in this case.

Throughout the pendency of this case, DRF and co-counsel continued to receive and analyze data provided by BSO in accordance with the consent decree, which helped with monitoring jail compliance and supported Plaintiffs' arguments for ongoing court enforcement. DRF and co-counsel also continued to use this data to identify and provide enhanced monitoring of medically vulnerable individuals, including individuals with disabilities who required individual advocacy services.

Based on the foregoing, this litigation project was concluded successfully.

In both the education and corrections contexts, DRF litigated a due process hearing on behalf of a student with disabilities who is in the custody of Florida's Department of Corrections (FDC) to enforce his rights under the IDEA. Specifically, DRF alleged that FDC predetermined the student's educational program, denied him access to secondary school education, and denied him appropriate behavioral and mental-health supports. The student prevailed in the hearing, with the Administrative Law Judge issuing a decision that struck down an FDC policy that negatively impacts all students with disabilities in FDC custody. FDC is now in the process of appealing the decision, and DRF is litigating the appeal, as well as an action to enforce the decision. The appeal and enforcement action will are continuing through the next fiscal year. In addition to litigating the due process hearing, DRF filed a systemic complaint with the Department of Justice to address FDC's policy. DRF is awaiting action from FDC.

In the education context, DRF concluded litigation in the case of D.P. et al, Disability Rights Florida, Florida State Conference of the National Association for the Advancement of Colored People v. School Board of Palm Beach County et al. (Case No. 9:21-cv-81099, filed in the Southern District of Florida, West Palm Beach Division). In this case, Disability Rights Florida (DRF), the Florida State Conference of the NAACP, and a group of Palm Beach County parents and students sued the School Board of Palm Beach County and its officials and employees for illegally initiating involuntary psychiatric examinations on students. DRF partners in the subject litigation are Southern Poverty Law Center, National Center for Youth Law and the law firm of King & Spalding.

The students who were plaintiffs in this case were taken from their classrooms and transported—handcuffed and in the back of police cars—to Baker Act receiving facilities, where they waited hours or days for a psychiatric evaluation to be completed. The lawsuit described how police employed by the School District of Palm Beach County illegally use the Florida Mental Health Act, also known as the Baker Act, to subject hundreds of students each year to involuntary psychiatric evaluation and treatment. The officers transport these children, some as young as five years old, to psychiatric facilities without their parents' input, consent and, sometimes, over their objections. Records show that district officers knowingly use the Baker Act on children whose behavior is due to autism, even though the law does not permit psychiatric evaluation and treatment on this basis. They also failed to consult mental health resources, including mobile crisis teams and the children's own therapists, prior to initiating an involuntary evaluation. The lawsuit alleged that these actions violate the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Florida Educational Equity Act, as well as parents' and students' rights under the Fourth and Fourteenth Amendments.

DRF and co-counsel attempted to settle the lawsuit through mediation, but these efforts were unsuccessful. As a result, Discovery, including the exchange of written documentation and taking depositions, was conducted throughout FY 2021-2022 and 2022-2023. Both Plaintiffs and Defendants filed summary judgment motions.

In June of 2023, the Department of Justice filed a Statement of Interest in support of the Plaintiff's claims based on the DOJ's interest in support the proper and uniform application of the ADA. Shortly thereafter, litigation on this case concluded at the hearing on the parties' summary judgment motions. On the eve of the summary judgment hearing, all remaining individual plaintiffs accepted Offers of Judgment. Based on the resolution of all individual claims filed in this case, the presiding judge heard arguments from plaintiffs' counsel on whether DRF as a named plaintiff in the suit had standing to pursue the remaining claims for injunctive relief. The court later entered orders confirming the Offers of Judgment and an order dismissing the remaining claims by plaintiff DRF for lack of jurisdiction and closed the case. DRF's litigation of this case before the court is therefore concluded; however, this case will remain open into FY 2023-2024 to facilitate the distribution of settlement funds in accordance with the Orders of Judgement in the case.

In the context of education and educating key stakeholders about the impact of their decisions on students with disabilities, the Florida Governor appointed a Disability Rights Florida (DRF) staff member to a state workgroup to develop a replacement survey after the Governor rescinded Florida's participation in the Youth Risk Behavior Survey (YRBS) in FY 2022-2023. The new survey is called the Florida-Specific Youth Survey (FSYS) and was administered in Q3 of FY 2022-2023. DRF participated in workgroup meetings and provided input in multiple areas, such as the use of "resiliency terms" which will be used to guide topics/questions on the FSYS and the inclusion of questions related to actual behavior versus content of behavior education. DRF drafted and submitted a letter to the Florida Department of Education (DOE) addressing DRF's concerns about the process and final outcome of the FSYS. One major concern that DRF communicated to the DOE was their new mental health education requirements that focus on "resiliency" and related character traits. Specifically, DRF discussed how the shift of focus towards "resiliency" implies that mental health issues are a character flaw as opposed to biological/situational and that the shift may increase stigma leading to fewer students wanting to acknowledge or seek treatment for mental health concerns. DRF also expressed concerns about the FSYS seriously paring down the number of questions related to mental health in favor of questions about resiliency characteristics and the failure to include important demographic questions relating to disability and members of gender and orientation diverse populations, making it more difficult to monitor trends or changes in the mental health of Florida's students in a meaningful way.

In order to bring awareness of DRF's concerns about the FSYS to the public, DRF recorded Episode 49: Who's Missing in Florida's New Youth Survey for its You First Podcast. The podcast centered on a discussion with the DRF staff involved in the FSYS project. The podcast first aired on July 6, 2023 and remains available on the DRF website, DRF's YouTube channel and other platforms where podcasts are aired for android and iOS users.

Finally, DRF helped enforce the Protection and Advocacy system's exercise of access authority in facilities that provide care and treatment to PAIMI-eligible individuals by drafting an amicus brief in the case of Disability Rights Texas v. Hollis, pending before the Federal Fifth Circuit Court of Appeals. The amici curiae in the case were the NDRN network and Disability Rights Louisiana, a P&A system located in the Fifth Circuit. The issue on appeal is a PAIMI Act access authority issue that concerns the entire P&A network, summarized as follows:

Disability Rights Texas succeeded in the district court in obtaining an order for recorded videos as part of an abuse and neglect investigation into abuse by staff at the Houston Behavioral Psychiatric Intensive Care Unit. Staff allegedly restrained a patient and administered involuntary injectable medications in the absence of a psychiatric emergency. The district court issued an injunction for the video recording to the patient subject of the investigation, and reserved the right to amend its order to include other patients if the Defendant did not release records in accordance with its order. Defendant appealed to the Fifth Circuit.

DRF attorneys drafted the amicus brief in support of Disability Rights Texas's position and the importance of this case to the entire P&A network. The amici curiae's arguments included educating the appellate court on the history of the P&A system, the right of P&As to investigate incidents of abuse and neglect and access records during the course of those investigations, and the importance of P&As being able to quickly obtain access to video records when conducting an investigation.

The amicus brief was filed on October 2, 2023 by Disability Rights Louisiana on behalf of the amici curiae. This project will remain open in FY 2023-2024 to provide any additional needed support to the amici curiae and follow the appellate decision to conclusion.

Recommendations

Please provide recommendations for activities and services to improve the PAIMI Program. Include a brief description of why such activities and services are needed. [42 U.S.C. 10824(a)(4)].
None identified at this time.
Training Needs
Please identify any training and technical assistance requests. [42 U.S.C. 10825]
None identified at this time.

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Footnotes:

REQUEST FOR DUE PROCESS HEARING AND MEDIATION

Date of Request: October 14, 2022

Educational Agency: Florida Department of Corrections

Student's Name: [redacted]

Student's Current School: [redacted]

Address of Student: [redacted]

Home Phone Number [redacted]

Name of Person(s) Completing the Form:

Karem Castane-Blanco
Kevin A. Golembiewski
Attorneys for Petitioner
Disability Rights Florida
2400 E. Commerce Blvd.
Suite 525
Fort Lauderdale, FL 33308
karemc@disabilityrightsflorida.org
1-800-342-0823
FBN: 1008070
FBN:1002339

As provided under the procedural safeguards of the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 *et seq.*, [redacted] ("[redacted]") files this request for a Due Process Hearing and formal mediation pursuant to 34 CFR § 300.532(a) and (c). [redacted] is a student with a disability who qualifies for special-education services and is currently receiving services from the Florida Department of Corrections ("FLDOC"). [redacted] has an Individualized Education Plan ("IEP") under the eligibility of [redacted]

FLDOC has violated [redacted]'s rights under the IDEA; Section 504 of the Rehabilitation Act, as amended, 29 U.S.C. §794 et seq., and its implementing regulations ("Section 504"); and the Americans with Disabilities Act, 42 U.S.C. §12131-12134 ("ADA"). As an educational agency, a recipient of federal funds, and a state entity, FLDOC is subject to the IDEA, Section 504, and the ADA.

The IDEA and Section 504 require states receiving federal funds to provide students with disabilities a free appropriate public education ("FAPE"). 20 U.S.C. § 1412(a)(1)(A). And Section 504 and the ADA prohibit discrimination on the basis of disability. FLDOC violated [redacted]'s right to FAPE, and it discriminated against [redacted] when it:

1. Failed to provide [redacted] an IEP with appropriate supports and services to meet [redacted] unique needs;
2. Refused to provide [redacted] access to the general education curriculum; and
3. Limited [redacted]'s education to only General Education Diploma ("GED") preparatory instruction.

STATEMENT OF FACTS

In support of the allegations above, [redacted] provides the following facts:

1. [redacted] is [redacted] years old. FLDOC has identified [redacted] as being in [redacted].

2. [redacted] is housed, and receives educational services, at [redacted], which is part of FLDOC.

3. FLDOC is responsible for providing [redacted] FAPE under the IDEA.

4. FLDOC is currently providing [redacted] instruction to prepare [redacted] for the GED exam.

5. Before [redacted] transfer to FLDOC, including while [redacted] was housed in a local jail, [redacted] was enrolled in the 18 credit general education curriculum, and [redacted] had an IEP designed to allow [redacted] to access and make progress in the general education curriculum.

6. [redacted] is formally [redacted] with [redacted], [redacted] and [redacted] has been on a number of [redacted] over the years and also receives [redacted]

7. [redacted] first became eligible for an IEP on [redacted], under the category of [redacted] is significantly delayed in all areas of adaptive behavior functioning.

8. [redacted] currently has an IEP and receives specially designed instruction and related services under the eligibility category [redacted]

9. Since [redacted], [redacted] has received Exceptional Student Education ("ESE") services from FLDOC. Prior to [redacted] transfer to [redacted] received ESE services from the [redacted] while enrolled in the District's schools and while at the [redacted].

10. Services from [redacted] while at [redacted] were provided through Odysseyware, a distance learning program, and twice weekly phone conferences with a district ESE teacher.

11. [redacted]'s IEP provided for specially designed direct instruction in Language Arts, instruction on Independent Life Skills and Employment Skills, and Handwriting Practice and Guidance. The IEP also included related services in behavior support.

12. [redacted]'s post-secondary goal is to become a [redacted]

13. On [redacted], around the time of [redacted]'s transfer to [redacted] FLDOC held an IEP meeting. During the meeting, FLDOC unilaterally removed [redacted] from the general education curriculum and determined that [redacted] will receive only GED exam prep. Referrals were also made to [redacted] and [redacted].

14. FLDOC did not perform any individualized assessment of [redacted] in deciding to remove [redacted] from the general education curriculum and provide [redacted] only GED exam prep. Instead, FLDOC has a general policy of providing all students only GED exam prep. It simply implemented that policy at the IEP meeting.

15. On [redacted], Disability Rights Florida ("DRF") contacted FLDOC and provided a memorandum explaining FLDOC's obligation to offer [redacted] access to the general curriculum and instruction that allows [redacted] to work towards obtaining a high school diploma. *See* Ex. A (attached). DRF highlighted *Letter to Duncan*, issued by the Office of Special Education Programs ("OSEP"), in which OSEP determined that "IEP teams must make individualized determinations regarding IEP content for students who are serving time in adult prisons, including by providing services they need to earn a regular diploma." 73 IDELR 264. The only exception to this requirement is when "a state demonstrates that a student cannot receive a regular high school diploma because of a bona fide security or compelling penological interest." *Id.*

16. On [redacted], a follow-up IEP meeting was held, and during the meeting, counsel for FLDOC informed the team that [redacted] would only be offered GED exam prep because FLDOC does not offer access to the general education curriculum, regardless of the student's disabilities and unique needs.

17. The IEP explicitly states "The student will be placed in either an adult basic education or GED Preparatory course where the student will be assessed using the TABE, AZTEC, or GED to demonstrate proficiency on the GED exam. FDC does not offer [a] Standard High School Diploma Option in accordance with s.1003.4282."

18. At the meeting, [redacted] also signed consent for an [redacted]

19. [redacted]'s IEP is not reasonably calculated to enable [redacted] to make progress appropriate in light of his circumstances. The data produced and gathered by FLDOC is by way of the Test for Adult Basic Education ("TABE"), which is a pre-GED assessment, and the GED itself is not developed in light of an ESE student's individual needs. Due to this, FLDOC is unable to accurately take data on [redacted]'s individual needs and deficits and unable to write goals specifically tailored to meet [redacted] needs.

20. DRF requested a prior written notice ("PWN") explaining FLDOC's refusal to provide [redacted] access to the general education curriculum and instruction that allows [redacted] to work towards a high school diploma.

21. On [redacted], FLDOC provided the requested PWN. The PWN states that [redacted] will be provided a "course of study towards a high school diploma via GED," however, the GED is not a high school diploma. Further, FLDOC still failed to explain why they will not afford [redacted] access to, and the opportunity to make progress in, the general education curriculum. Instead, the PWN simply stated that "the team considered prior course of study towards a Florida High School Diploma at a public school system as listed in the student's IEP upon incarceration in a state Correctional Facility."

22. FLDOC has refused to consider a general education curriculum for [redacted] even though the IDEA requires that students with disabilities "be involved in and make progress in the general education curriculum" (*see* 34 C.F.R. § 300.320(a)(4)), and even though OSER has provided direct guidance to FLDOC on this issue in *Letter to Duncan*. Moreover, FLDOC has not alleged, much less demonstrated, that there is a bona fide security or compelling penological interest exempting it from this obligation.

23. FLDOC is currently providing [redacted] instruction only to improve his TABE score. Before [redacted] takes the GED, [redacted] needs a qualifying TABE score. [redacted] does not have such a score.

PROPOSED RESOLUTION

Petitioner respectfully requests that FLDOC provide [redacted]

1. Access to, and specially designed instruction and IEP goals that allow [redacted] to progress in, the general education curriculum;

2. An opportunity to receive a high school diploma;

3. An appropriate IEP that is aligned with [redacted] unique needs;

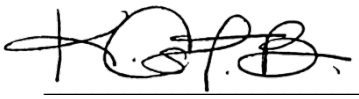
4. Compensatory education;

5. Reasonable attorney fees and costs; and

6. Any and all other relief this tribunal deems appropriate.

We anticipate that the trial of this matter will take at least 1 day.

Very truly yours,



10/14/2022

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 21-81099-CIV-CANNON

D.P. et al.,

Plaintiffs,

v.

SCHOOL BOARD OF PALM BEACH COUNTY,

Defendant.

STATEMENT OF INTEREST OF THE UNITED STATES

STATEMENT OF INTEREST OF THE UNITED STATES

The United States submits this Statement of Interest[1] to address the application of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131-34, to a public entity's response to young children with disabilities experiencing behavioral challenges. Congress charged the Department of Justice with enforcement and implementation of Title II of the ADA. *Id.* §§ 12133-34. The Department therefore has an interest in supporting the proper and uniform application of the ADA, in furthering Congress's intent to create "clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities," as well as Congress's intent to reserve a "central role" for the federal government in enforcing the ADA. *Id.* § 12101(b)(2)-(3).

This case involves the involuntary seizure of young children by law enforcement officers in their schools. Plaintiffs are children with disabilities who attend elementary and middle schools in Palm Beach County, Florida, and receive services and modifications related to those disabilities. Without their guardians or parents' consent, each child was removed from their classroom, handcuffed, and driven away in the back of a police car to a locked facility to be psychiatrically examined. In some cases, the children were separated from their families for not just a few hours, but days. The police were not acting in response to any suspected criminal activity. Rather, they took the children into their custody in response to behavioral health episodes. In doing so, the officers invoked a Florida law known as the Baker Act, which allows police to seize a person for involuntary psychiatric examination under specific circumstances.

[1] The Attorney General is authorized "to attend to the interests of the United States" in any case pending in federal court. 28 U.S.C. § 517.

The young children and their guardians have asserted several claims arising out of these incidents against Defendant School Board of Palm Beach County, including claims of disability discrimination under Title II of the ADA and Section 504 of the Rehabilitation Act of 1973. Plaintiffs allege that Defendant violated these statutes by failing to provide them with reasonable modifications that could prevent unnecessary police interactions and hospitalization.

Defendant now moves for summary judgment, arguing that its duty to provide reasonable modifications was not triggered because Plaintiffs did not specifically demand them on the day in question. ECF No. 183 at 53, Def. Mot'n for S.J. Defendant also asserts that the proposed modifications are not reasonable because they would fundamentally alter what it views to be the program or activity at issue in this case, police seizures under the Baker Act. *Id.* at 58.

The Department respectfully submits this Statement of Interest to clarify two legal principles: (1) a public entity is obligated to provide reasonable modifications where it knows or reasonably should know of the disability-based need for modifications; and (2) reasonably modifying Defendant's response to children experiencing behavioral health challenges to utilize known strategies and interventions is not a fundamental alteration.

INTEREST OF THE UNITED STATES

The Department of Justice implements and enforces Title II, which prohibits disability discrimination by public entities in the provision of their services, programs, or activities. 42 U.S.C. §§ 12132–34; 28 C.F.R. pt. 35. Under the ADA, the Department is the designated agency that implements Title II as to "[a]ll programs, services, and regulatory activities relating to law enforcement . . . ." 28 C.F.R. § 35.190(b)(6). The United States therefore has a strong interest in the proper interpretation of Title II and its corresponding regulations in this context.

BACKGROUND

I. Legal Framework

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Title II obligates public entities to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7)(i).

II. Factual Background[2]

The following facts are relevant to Plaintiffs' reasonable modification claims.

D.P., a nine-year-old student with Autism

At the time of his removal from school, D.P. was a nine-year-old child with Autism Spectrum Disorder (ASD). ECF No. 177, Joint Statement of Undisputed Fact (JSUF) ¶¶ 2-3. D.P. attended a classroom exclusively for children with ASD, *id.* ¶ 12, and his educational records showed that he had impaired judgment and difficulty communicating, including when he became upset. ECF No. 181, Plaintiffs' Statement of Material Facts (PSF) ¶¶ 1-2; JSUF Ex. 5 at 12, 15, 20. Defendant not only had experience de-escalating D.P. during behavioral episodes, it had also documented successful strategies like giving him a "safe place" and "an opportunity to

[2] The following facts are from the parties' Joint Statement of Undisputed Facts and the Plaintiffs' Statement of Facts, as to the three children for whom Plaintiffs move for summary judgment. At the summary judgment stage, factual inferences are drawn and reasonable doubts about the facts are resolved in the nonmovant's favor. *Denney v. City of Albany*, 247 F.3d 1172, 1181 (11th Cir. 2001).

calm down." PSF ¶¶ 3-4. D.P. became upset on the day in question, but he was able to calm down. JSUF ¶¶ 16, 20. School administrators requested, and then decided to cancel, a call to a mobile crisis team. *Id.* ¶ 17. Mobile crisis teams are behavioral health professionals who help de-escalate and evaluate children. After D.P. "was back to his normal self," an officer who was stationed at the school under a contract between Defendant and a local police department decided to Baker Act[3] D.P. based on statements he made while he was upset. *Id.* ¶¶ 7-8, 20. Plaintiffs contend that school employees who were present knew that D.P. had Autism. PSF ¶ 7. The officer was aware that a mobile crisis team was available to respond to the school and evaluate D.P. JSUF ¶ 17. Plaintiffs contend that prior to being placed in police custody, neither D.P.'s guardian nor his counselor had a chance to speak with him. PSF ¶¶ 5, 10.

E.S., a nine-year-old student with Autism

At the time of his removal from school, E.S. was a nine-year-old child with ASD. JSUF ¶¶ 28-29. E.S. attended school in a classroom designated for children with Autism, and he had a behavioral aide who was privately retained by his mother to provide support in the classroom. *Id.* ¶¶ 36, 41, 43. According to E.S.'s educational records, he had "outbursts and tantrums a few times a week." *Id.* ¶ 46. Prior to his removal, E.S.'s school principal was aware that that E.S.'s. disability-related behaviors included "outbursts and reacting negatively to non-preferred tasks." *Id.* ¶ 47. The principal had "sometimes been able to deescalate E.S. by providing him with Marvel superhero books or by trying to talk about some of the things he was going to be doing over the weekend." *Id.* ¶ 50. Prior to the date of his removal, school staff "had experience

[3] In this Statement of Interest, the United States uses "Baker Act" as both a noun ("the Baker Act") and verb ("the person was Baker Acted"). When used as a verb, it means that an individual was seized by law enforcement for an involuntarily examination under the Florida Mental Health Act, Fla. Stat §§ 394.451–.47892 (2022), known as the Baker Act.

deescalating E.S. when he was agitated" and had "contacted [E.S.'s mother] when they needed additional behavioral supports for E.S." *Id.* ¶¶ 49, 51.

On the day in question, "E.S. became agitated in his classroom" and was escorted to the school's office by his behavioral aide. *Id.* ¶¶ 58-59. The principal and a school behavioral health specialist attempted to deescalate E.S. verbally, and E.S. hit his behavioral aide, whose only observable injury was a red mark on the aide's chest. *Id.* ¶¶ 61-63. E.S. then hit a thick glass window but did not injure himself or break the window. *Id.* ¶¶ 65-66.

A police officer employed by Defendant, who knew that E.S. had Autism before the day in question, arrived and "decided to initiate an involuntary examination under the Baker Act" upon seeing E.S. hitting the window. *Id.* ¶¶ 32, 57, 67. The officer handcuffed E.S, who remained calm while he was removed from school in police custody. *Id.* ¶¶ 76-77, 85-87. Neither the officer nor the principal contacted E.S.'s mother until after the involuntary examination was initiated, nor gave her the option to calm her son down. *Id.* ¶¶ 88-92.

The officer later testified that before initiating E.S.'s involuntary examination, he did not: (1) "think about strategies that might have prevented E.S. from hurting himself other than use of the Baker Act"; (2) ask about E.S.'s disabilities; (3) ask if E.S.'s mother had been contacted; (4) ask what anybody had done to calm E.S. down in the past; (5) ask whether there were adults E.S. trusted who could help calm E.S. down; or (6) discuss contacting any other mental health resources or the mobile crisis response team. *Id.* ¶¶ 68-69, 71-75. The officer also testified that there was time to wait for the mobile crisis response team to evaluate E.S. because E.S. was calm and not hurting himself. *Id.* ¶ 95 (Ex. 7 at 143:19-144:2).

W.B., a ten-year-old student with an emotional/behavioral disability

At the time of his removal from school, W.B. was a ten-year-old child with a disability attending a classroom exclusively for children with emotional/behavioral disabilities. *Id.* ¶¶ 108-09, 118. W.B.'s educational records contained modifications such as offering a safe place or person when W.B. felt frustrated and remaining non-reactive in the face of negative behaviors. PSF ¶ 22. Records also reflected that W.B. did not like to be touched by males, JSUF ¶ 123, and school staff testified in deposition that they had successfully used intervention strategies such as giving W.B. time and space to calm down, walking with him, doing breathing exercises, and allowing his mother to come to school and talk with him. *Id.* ¶¶ 124-25, 129. Staff also testified that although W.B. made threats to others, because he frequently did so as "just . . . part of his vocabulary," they did not believe he was actually going to harm anyone. *Id.* ¶¶ 126-28. W.B. became upset on the day in question and threw chairs in his classroom. *Id.* ¶ 131. He then ran outside and began to climb a fence. *Id.* ¶ 132. School staff were able to stop him from jumping the fence. *Id.* ¶ 133. Shortly after, a school police officer employed by Defendant placed W.B. in handcuffs. *Id.* ¶ 134-35. W.B. was transported for inpatient examination without the officer speaking to his mother, PSF ¶ 24, the school therapist who W.B. met with weekly, or any school staff about de-escalation strategies that could help W.B. JSUF ¶¶ 136-38. The officer later testified that he did not think a student's disability was relevant to his decision to Baker Act a child. PSF ¶ 25.

DISCUSSION

This Statement of Interest clarifies two legal principles. First, a public entity is obligated to provide reasonable modifications to qualified individuals with disabilities where it knows or reasonably should know of the disability-based need for modifications. Second, modifications to

a public entity's behavioral response that utilize known strategies and interventions are reasonable and not a fundamental alteration.

I. Plaintiffs' known and documented need for reasonable modifications put Defendant on sufficient notice to trigger Defendant's duty to modify on the day in question.

Defendant argues that its obligation to provide reasonable modifications was not triggered because Plaintiffs, young children (some with disabilities that impact communication), and their guardians (who were not present or even aware of the incidents), did not make specific demands for modifications on the days in question. ECF No. 183 at 53. This argument is unavailing. Although reasonable modifications may follow a request from a person with a disability, nothing in the Title II regulation limits a public entity's obligation to provide modifications only in those situations where it receives a request. To the contrary, the plain language of the regulation makes no mention of a request requirement when it states that a public entity "shall make" such reasonable modifications, indicating an affirmative obligation. 28 C.F.R. § 35.130(b)(7)(i).

Accordingly, several circuit courts have held that public entities must provide reasonable modifications regardless of a request where the need to modify is apparent and obvious. *See Robertson v. Las Animas Cnty. Sheriff's Dep't*, 500 F.3d 1185, 1196 (10th Cir. 2007) (holding that a public "entity must have knowledge that the individual is disabled, either because that disability is obvious or because the individual (or someone else) has informed the entity of the disability."); *Greer v. Richardson Indep. Sch. Dist.*, 472 F. App'x 287, 296 (5th Cir. 2012) (holding that a "failure to expressly 'request' an accommodation is not fatal to an ADA claim where the defendant otherwise had knowledge of the individual's disability and needs but took no action"); *Duvall v. Cnty. of Kitsap*, 260 F.3d 1124, 1139 (9th Cir. 2001) ("When the plaintiff has alerted the public entity to his need for accommodation or where the need for

accommodation is obvious . . . the public entity is on notice that an accommodation is required . . . ") (internal brackets omitted); *see also Bennett-Nelson v. Louisiana Bd. of Regents*, 431 F.3d 448, 454-55 (5th Cir. 2005) (public entities have "an affirmative obligation to make reasonable accommodations for disabled individuals. Where a defendant fails to meet this affirmative obligation, the cause of that failure is irrelevant.").

In *Rylee v. Chapman*, the Eleventh Circuit stated that a "defendant's duty to provide a reasonable accommodation is not triggered until the plaintiff makes a specific demand for an accommodation." 316 F. App'x 901, 906 (11th Cir. 2009) (internal citation and quotation omitted). Relying on *Rylee*, Defendant argues that because Plaintiff children failed to make a specific demand on the day they were seized under the Baker Act, they were not entitled to reasonable modifications. *See* ECF No. 183 at 53, 61. But *Rylee* does not foreclose Plaintiffs' claim.

In *Rylee*, the plaintiff, who was deaf, brought an ADA claim against a county for failing to provide him with a sign language interpreter during his arrest, booking, and first court appearance. 316 F. App'x at 905 n.5. He was arrested at his home by county police after his son called 911 to report that his father was abusing his mother. *Id.* at 903. During the 911 call, Rylee's wife got on the phone and told police that Rylee was deaf and did not know sign language, but he could read lips if someone spoke slowly. *Id.* The dispatcher relayed this information to the responding officer, and Rylee did not request any other form of communication assistance during his discussions with the officers. *Id.* While he was being booked at the local jail, Rylee requested that the officer hand-write her questions and statements, and the officer complied with this request. *Id.* at 904. Rylee also acknowledged later in the booking process that he could read lips and conceded during litigation that he did not know sign

language. *Id.* at 904, 905 n.5. Based on these facts, the Eleventh Circuit held that Rylee's reasonable modification claim failed where his wife had told officers he could read lips, and there was no evidence that he needed an interpreter during his arrest and booking. *Id.* at 906. The court also concluded that Rylee would not have benefitted from the services of an interpreter because he did not know sign language. *Id.* at 905 n.5.

Although the court's holding in *Rylee* turned on the fact that the plaintiff had not made a request for the specific modification that was the basis for his claim, it also noted the lack of evidence that would have allowed officers to become aware of his need for the modification: "Rylee has presented no evidence *from which one could infer* that the deputies *knew or believed* that Rylee could not read lips or that Rylee requested an interpreter or the aid of a family member." *Id.* at 906 (emphasis added). By discussing facts from which the defendant could have inferred that modifications were necessary, the Eleventh Circuit left open the possibility that the failure (or inability) to make a demand at the very moment a modification is sought is not fatal in every case. *See id.*

The facts of this case are materially different, and there is ample evidence from which to infer the need for reasonable modifications. Unlike the officers in *Rylee*, who had no reason to know or even infer that the plaintiff needed reasonable modifications based on his and his wife's statements, it is undisputed here that Defendant was aware of the children's disabilities. JSUF ¶¶ 12, 36, 117. Even more telling, Defendant concedes it knew that de-escalation strategies, including calling a parent to help with de-escalation, were effective in the past. *See, e.g.*, ECF No. 183 at 59-61 (describing "known" de-escalation strategies that employees "were aware of—and typically utilized"); *see also id.* at 60-61 ("The parties agree that District staff had contacted [the child's mother] when they needed additional behavioral supports for E.S." and "school staff

understood [the child's mother] was capable of calming W.B. down"). Indeed, this Court has pointed out that such strategies were well-known. *See D.P. et al., v. Sch. Bd. of Palm Beach Cnty.*, No. 21-81099-CIV 2023, WL 2178384, *1, *32 ("alternative de-escalation tactics before Baker Acting" were "already known to them and known to be successful"). Thus, unlike the record in *Rylee,* where the defendant provided the modifications that were specifically requested and where there was nothing to suggest any other modification was needed or would have helped, here there is ample evidence in the record that Defendant was aware of modifications that would have helped Plaintiffs during their behavioral episodes. Accordingly, any failure by the children to make a specific request for those modifications should not be deemed fatal to their claim.

But even if a request were necessary in this case, the Eleventh Circuit has considered a request to be made when a covered entity has been sufficiently put on notice of the need for a modification. In *United States v. Hialeah Housing Authority*, decided two years after *Rylee*, the court held that providing enough information about a need for a modification can sufficiently put a covered entity on notice and thus constitute a "specific demand" for disability-based modifications. 418 F. App'x 872, 876-77 (11th Cir. 2011) (Fair Housing Act); *see also Hunt v. Amico Properties, L.P.*, 814 F.3d 1213, 1226 (11th Cir. 2016) (holding that "a plaintiff can be said to have made a request for accommodation under the Fair Housing Act when the defendant has enough information to know of both the disability and desire for an accommodation.") (internal citations and quotations omitted).[4] *Hialeah* involved a claim that the defendant housing

[4] For purposes of determining what constitutes a "specific demand" to trigger an entity's reasonable accommodation obligation under the Fair Housing Act, the Eleventh Circuit has looked to cases interpreting ADA and Rehabilitation Act reasonable modification claims. *See, e.g.*, *Hialeah*, 418 F. App'x at 876 ("We have previously recognized that we look to case law

authority failed to provide a tenant with a reasonable modification in the form of accessible housing that would allow him to use the bathroom without climbing stairs. 418 F. App'x at 873-75. The *Hialeah* court stated that a specific demand is required but that the Eleventh Circuit had "not 'determined precisely what form the request must take.'" *Id.* at 876 (citing *Holly v. Clairson Indus., L.L.C.*, 492 F.3d 1247, 1261 n.14 (11th Cir. 2007)). Cautioning against requiring "magic words," the court held that "for a demand to be specific enough to trigger the duty to provide a reasonable accommodation, *the defendant must have enough information to know of both the disability and desire for an accommodation*," or alternatively that "*circumstances must at least be sufficient to cause a reasonable* [*defendant*] *to make appropriate inquiries about the possible need for an accommodation*." *Hialeah*, 418 F. App'x at 876-77 (internal quotations and citation omitted) (emphasis added). The Eleventh Circuit ultimately reversed the district court's grant of summary judgment for the defendant, concluding that the tenant could have been deemed to have "made a specific demand for an accommodation" during a prior mediation where his attorney told the housing authority that the tenant "was disabled due to hip and back problems and could not constantly go up and down stairs to use a bathroom." *Id.* at 877.

Here, as in *Hialeah*, there is no dispute that Defendant had sufficient information about the Plaintiffs' disabilities and reasonable modification needs to satisfy a request. This information was not only a part of Plaintiffs' educational records, *see* JUSF ¶¶ 11-12, 15, 46, 48, 120-24, but Defendant used these very modifications in the past, *see, e.g.*, *id.* ¶¶ 49-51, 125; PSF ¶¶ 3-4. Likewise, in *A.V. through Hanson v. Douglas County School District RE-1, et al.*, the

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under the Rehabilitation Act and the Americans with Disabilities Act . . . for guidance in evaluating reasonable accommodation claims under the FHA."); *Hunt*, 814 F.3d at 1226 (citing ADA cases).

court rejected arguments, similar to the ones Defendant makes here, that a ten-year-old child with Autism needed to make a request for reasonable modifications during an encounter with a police officer at school. 586 F.Supp.3d 1053, 1056 (D. Colo. 2022). The court concluded that facts pled showed "an obvious need of an accommodation" and school police officers "failed to reasonably accommodate [the child]" by ignoring those apparent signs. *Id.* at 1065. The court relied in part on allegations that the officers received "advisements and warnings" from a school official and a family member explaining how the child's disability related to his challenging behavior, and that law enforcement also observed obvious signs, such as the child "repeatedly banging his head on the plexiglass and window of the patrol car while handcuffed." *Id*.

Defendant's insistence that on each day in question the children (or their guardians) were required to re-request reasonable modifications before police removed the children from school runs counter to Title II's affirmative obligation and to common sense. Requiring nine- and ten-year-old children with disabilities to request modifications their school already knew they needed in the midst of behavioral outbursts is "baffling as a matter of law and logic." *Pierce v. District of Columbia*, 128 F. Supp. 3d 250, 269 (D.D.C. 2015) (rejecting argument that a request was necessary to provide reasonable modifications to incarcerated person with "known communications-related difficulties"). By that logic, a school employee who relies on a service animal would have to ask permission every time she brings her service dog inside. Such an arrangement would be "untenable" because "[n]othing in the disability discrimination statutes even remotely suggests that covered entities have the option of being passive in their approach to disabled individuals as far as the provision of accommodations is concerned." *Id.*

II. Modifying Defendant's behavioral health response to incorporate known strategies and interventions is reasonable and not a fundamental alteration.

In a Title II reasonable modification case, the defendant bears the burden of "establish[ing] that the requested relief would require . . . [a] fundamental alteration" of its service, program, or activity. *Frederick L. v. Dep't of Public Welfare*, 364 F.3d 487, 492 n.4 (3d Cir. 2004); *see also Haddad v. Arnold*, 784 F. Supp. 2d 1284, 1304 (M.D. Fla. 2010) (declining to recognize fundamental alteration defense where "Defendant provided no *evidence* to support these arguments") (emphasis in original); *Henrietta D. v. Bloomberg*, 331 F.3d 261, 280 (2d Cir. 2003); 28 C.F.R. § 35.130(b)(7). Here, Defendant attempts to meet this burden by arguing that modifications such as de-escalation, involving parents/guardians, contacting mental health professionals, or calling mobile crisis would work a fundamental alteration to seizures under the Baker Act. ECF No. 183 at 58. This argument fails for three reasons.

First, in denying Defendant's motion to dismiss, this court held, "all three of the proposed modifications are reasonable." *D.P.*, 2023 WL 2178384 at *32. Second, the Title II service at issue in this case is not simply the Baker Act seizure, as Defendant would have it. Instead, the service at issue is Defendant's behavioral health response, which includes a range of tools and strategies, of which the Baker Act is but one intervention. In fact, Defendant's narrow framing does not account for Defendant's documented record of reasonably modifying its behavioral health response in previous episodes where it utilized strategies short of placing a child in police custody. And critically, Defendant ignores this Court's prior ruling, which understood the program or service at issue here to be broader than a police seizure: "I fail to see how asking school staff members to employ alternative de-escalation tactics before Baker Acting, especially when those tactics are already known to them and known to be successful . . . would require a fundamental alteration in the nature of the program." *Id.* (internal quotation marks omitted)

(holding that other modifications were also reasonable). By referring to tactics that could have been used prior to seizing a child as reasonable and not a fundamental alteration, this Court indicated that the Title II service at issue here begins before the moment an officer decides to seize a child.

Third, the reasonableness of Plaintiffs' proposed modifications is further underscored by the fact that they are consistent with the Baker Act's statutory scheme. In *Henrietta D.*, the Second Circuit upheld modifications where they were "designed to effectuate [the] goal" of the defendant "perform[ing] its statutory mandate." 331 F.3d at 280. Here, the proposed modifications help Defendants perform their obligations under the Baker Act. The Baker Act is not a criminal statute; it is a mental health law with specific procedures to guide an officer or other authorized individual in determining whether an involuntary examination is necessary for a person who they believe has mental illness. Fla. Stat. § 394.463(1) (2022). If suspected or actual mental illness is present, the Baker Act only supports an involuntary examination under two narrow circumstances: 1) where there is "threat of substantial harm" that cannot "be avoided through help of willing family members or friends or the provision of other services"; or 2) where "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." *Id.* § 394.463(1)(b)1-2. Reasonable modifications such as engaging a child's parent, their behavioral health provider, or mobile crisis do not alter these procedures. To the contrary, they help officers effectuate the law's purposes of avoiding future harm and taking action only where a child's recent behavior is indicative of future serious bodily harm.

Moreover, the Baker Act excludes developmental disability from the definition of mental illness. *Id.* § 394.455(29). Thus, declining to refer a child with Autism to law enforcement to

initiate the Baker Act's procedures, and instead using known de-escalation strategies or other interventions, would be entirely consistent with the law. And even where it may not be known at the outset that a child has Autism, reasonable modifications such as consulting with behavioral health professionals who are familiar with a child, or a mobile crisis team trained in evaluating mental states, would allow both school staff and officers to assess whether mental illness or another disability-related factor, such as Autism-related behavior, is at play, before proceeding further with the Baker Act.

The modifications proposed here are also similar to those found reasonable in other cases involving police encounters with individuals experiencing behavioral health episodes. In *Vos v. City of Newport Beach*, the Ninth Circuit reversed a district court's summary judgment ruling dismissing plaintiffs' ADA claim, holding that officers attempting to apprehend a mentally ill man running around a convenience store with scissors in his hand, "had the time and the opportunity to assess the situation and potentially employ . . . accommodations . . . including de-escalation, communication, or specialized help" prior to using deadly force. 892 F.3d 1024, 1037 (9th Cir. 2018); *see also Brunette v. City of Burlington, Vermont*, No. 2:15-CV-00061, 2018 WL 4146598, at *35 (D. Vt. Aug. 30, 2018) (denying defendant summary judgment because "Plaintiffs have adduced sufficient evidence from which a rational jury could find that the officers failed to reasonably accommodate [plaintiffs' deceased relative's] mental illness" by "wait[ing] for backup" and "employ[ing] less confrontational tactics") (internal citations omitted). Courts have also recognized the obligation to provide reasonable modifications in school police interactions. In *A.G. v. Fattaleh*, a district court denied summary judgment and allowed the case to proceed to trial on plaintiffs' claim that defendants violated the ADA by failing to provide reasonable modifications to a student with Autism when he was sitting calmly

with school staff after a behavior incident. 614 F.Supp.3d 204, 242 (W.D.N.C. 2022) (relying in part on evidence that defendants had no policies or specialized trainings on how to interact with students with disabilities); *see also S.R. v. Kenton Cnty. Sheriff's Ofc.*, No. 2:15–cv–143, 2015 WL 9462973 1, *8 (E.D. Ky. Dec. 28, 2015) (holding that plaintiffs plausibly alleged defendant "failed to modify its practices with respect to disabled students" by declining to take "less severe measures such as crisis intervention, de-escalation, etc. to address their behavioral problems").

Notwithstanding the weight of case law supporting the reasonableness of Plaintiffs' proposed modifications, Defendants rely on a single case to argue fundamental alteration, *Rebalko v. City of Coral Springs*, 552 F.Supp.3d 1285 (S.D. Fla. 2020). *Rebalko* is simply not analogous to the facts and the ADA theory of liability here. In *Rebalko*, the plaintiff, who was not experiencing a behavioral health crisis or episode of any kind, alleged that he was unlawfully detained by officers on the road. *Id.* at 1298. After officers had handcuffed plaintiff, his wife mentioned his "health issues" in appealing to the police to issue him a summons to court rather than arrest him. *Id.* at 1300. The court held that this request to be "unarrested" was a fundamental alteration. *Id* at 1330. Unlike the plaintiff in *Rebalko*, the children here do not seek to undo a seizure or to change the Baker Act's procedures. They seek modifications through the course of their interactions with school staff, including police, that would prevent the need for involuntary psychiatric examination. These modifications are not only available to Defendant, but they also have a documented track record of working to resolve Plaintiffs' behavioral health challenges. Thus, Defendant's fundamental alteration argument should be rejected.

CONCLUSION

For the foregoing reasons, the United States respectfully requests that the Court consider this Statement of Interest in this litigation.

Date: June 26, 2023

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In Florida, showing mental health struggles could get a child detained

Advocates say the Baker Act, designed as a measure of last resort, is not used that way. The result: Kindergarteners can be forcibly committed to psych centers for exams.

By Donna St. George

March 16, 2023 at 10:01 a.m. EDT

When a fourth-grader in Florida was frustrated about having to sit out his afternoon recess, he penciled a word on an outdoor bench: kill. A teacher asked him about it, and he said it was what he wanted God to do to him.

His mother, Marah Marino, guessed he was hurt and angry. “He’s not a mature 10-year-old,” she said.

But soon, a sheriff’s deputy who was working in the school stepped in, using a controversial state law to order an involuntary psychiatric evaluation and confinement for up three days in a mental health facility. Marino, who rushed to the school after getting a call about the incident, was stunned, pleading with the officer and asking to be with her son.

The deputy drove away with the terrified boy, and Marino followed closely behind them in her car, watching her son stare out the back window, sobbing, his hand on the glass.

Every day in Florida, children and adolescents are involuntarily committed for psychiatric assessments under the Baker Act, a 1971 law. In fiscal year 2020-21, involuntary exams happened more than 38,000 times to children under 18 — an average of more than 100 a day and a nearly 80 percent increase in the past decade, according to the most recent data. The law is so deeply enmeshed into the state's culture that it is widely used as a verb, as in: The 6-year-old was "Baker Acted."

Some children have been taken away in handcuffs.

Florida's reliance on forced psych exams is rising amid a national mental health crisis among school-aged children. The percentage of girls who reported depressive symptoms and suicidal thoughts climbed in 2021, according to the Centers for Disease Control and Prevention. There are too few clinicians for the expanding need for mental health care. And in Florida, Baker Act intakes hit a high. By contrast, the number for adults dropped, according to a report by the Baker Act Reporting Center at University of South Florida.

While the law is useful for the most serious cases, critics say, it is too often used with kids who have behavioral issues, students with disabilities and those who say something they don't mean. Children as young as 5 or 6 have been temporarily committed, and opponents contend that some mental health facilities are profit-driven and substandard and fail to keep parents informed about their children.

Supporters say that the longtime Florida law has helped keep people from hurting themselves or others — and that it can force a family to reckon with a child's need for professional care. When police and others involved are sufficiently trained, the process can work well "as one strategy for intervention," says Stephen Roggenbaum, chair of the Florida Suicide Prevention Coalition.

Florida is not alone in detaining children this way. But of the six states that keep publicly available data on the practice — including California, Colorado, Connecticut, Virginia and Wisconsin — Florida is an outlier, said David Cohen, a professor at the University of California at Los Angeles who studies the issue. In 2018, the state committed children nearly 16 times more often than Wisconsin, one of the less zealous users of its provision.

"The public has no clue how much involuntary commitment and coercion are going on right now," Cohen said.

By law, the Baker Act can be used when a person is thought to be mentally ill and poses a "substantial likelihood" of serious harm to themselves or others in the near future if they don't have care or treatment. Police, mental health clinicians and others with the power to invoke the law used it more than 5,000 times in school settings in Florida during the 2021-22 fiscal year, according to data collected by school districts.

This school year, a 16-year-old who made a joke about running into traffic, a 6-year-old who made an unspecified threat in class and a 15-year-old who spoke of self-harm when the school declined to recognize their gender identity all found themselves Baker Acted.

The most recent data showed a commitment rate of 1,231 per 100,000 minors, compared to 740 per 100,000 a decade ago.

The Florida Department of Children and Families did not provide comment — in response to repeated inquiries by The Washington Post — on the law's benefits and challenges, including oversight and lack of parent involvement.

Elizabeth McGill, a mother of two in northeastern Florida, watched her 6-year-old be led away in handcuffs last year for allegedly saying he would shoot others or harm himself — words she was certain he did not fully understand. School officials could not be reached for comment this week.

McGill and the boy's father were not allowed to visit him at the mental health facility where he spent three nights, she said, but she called frequently. Each time, McGill said, the kindergartner pleaded: "Mama, when are you getting me out?"

In the early 1970s, when lawmakers crafted the Florida Mental Health Act, commonly called the Baker Act, support was growing for community-based mental health efforts that would reduce long-term psychiatric hospitalizations. Fifty years later, those hospitalizations are no longer the norm.

But the law has no age parameters and, critics contend, little oversight, and sometimes children or adolescents are kept longer than the 72 hours permitted by the statute, according to parents and advocates.

One problem is that not everyone using the law is equally trained. April Lott, chief executive of a Florida mental health nonprofit called Directions for Living, sat on a statewide task force convened to study the Baker Act in 2017**.** Some police officers get training in crisis intervention, she said, but it is not comparable to the expertise of mental health or medical practitioners. "It should require extensive training," she said.

Sixty percent of cases for people under age 18 were initiated by police, and 40 percent were made by health professionals, according to state data. Florida has mobile mental health response teams that get involved in cases, but "there's just not enough of them," Lott said.

In 2020, just weeks before the pandemic, 6-year-old Nadia King was sent for a compulsory psychiatric exam for being "a threat to herself and others" and "out of control." But body-camera footage from that day shows a calm child as she is led away from her school by sheriff's deputies. Later, as the officers confer, one is heard saying that nothing seems to be wrong with the girl.

"She's been actually very pleasant," the officer said. The other agreed. "I think it's more of them just not knowing how to deal with it," he said, appearing to refer to the school.

School officials said at the time of the episode that the decision was made by a mental health professional sent by a nonprofit, according to a story by The Washington Post. It was not clear whether school officials considered other ways to resolve the incident.

The law's detractors say even a night of psychiatric detainment is traumatic in the life of a child. Some had never slept away from home. Some interpret it as being jailed or punished. And after the ordeal, some parents move their children into new schools, scared it will happen again.

Adding to the toll, some families are saddled with medical bills for the time their children spent in psychiatric facilities. The tab may be several thousand dollars, depending on insurance and other factors, several parents and lawyers said.

Critics say the process is traumatic without being helpful. "Kids leave there with recommendations for treatment but no way to get it," said Robert Latham, associate director of the Children & Youth Law Clinic at the University of Miami Law School. Standing in the way, he said, are waiting lists for therapy, insurance limitations, access problems and geographical barriers. Most of the time, nothing changes afterward, he said.

Florida newspapers have often pressed the issue. In 2019, a Tampa Bay Times investigation found cases of children being housed with adults in mental health centers, or being physically or sexually abused there. It cited instances of children being Baker Acted after saying something on Snapchat, scribbling about death in a textbook or crying in a counselor's office.

Efforts to change the law have been mixed. One change in 2021: Parents must now be notified before a child is removed from a school. But their consent is not needed. Other changes from 2022 require each school system to designate a mental health coordinator and police to restrain people in the least restrictive manner "available and appropriate under the circumstances."

Caitlyn Clibbon, a public policy analyst with Disability Rights Florida, said that the change to police practices could reduce the use of handcuffs on children but that the wording leaves room for interpretation. "We should not be treating them like criminals," she said.

While revisions from 2017 say psych exams on minors must start within 12 hours of arrival at a facility, the wording is vague and parents report children detained for days.

Some argue for more scrutiny of the Baker Act process as it begins, so that children are not pulled into facilities unnecessarily. "I wish there were an intermediate step where the facility that they're brought to can sort of reevaluate and see that they really need to be admitted or not," said Michael Shapiro, a Florida psychiatrist.

For Latham, the most important issue is that the Baker Act solves little in the lives of children. They may get some medication management and possibly some group sessions while detained, but they typically don't receive therapy or other services, he said. "If it was the front door to something that would help, that would be different," he said. But "it traumatizes and puts a kid through all of this with nothing on the other end."

Superintendent Bill Husfelt of Bay District Schools on the Gulf Coast makes no apologies for supporting the Baker Act. His students have been pummeled by Hurricane Michael — a Category 5 storm that ripped away houses, paychecks, stability and hope — and then a pandemic that brought more stress and chaos. Some are immigrants from Honduras, Guatemala and Ukraine who experienced hideous traumas before they arrived.

During the previous school year, children were Baker Acted 121 times in school settings, district data show. This year appears to be similar.

But Husfelt said that in his district of 27,000 students, the Baker Act is not used lightly. Well-trained mental health staff conduct a thorough examination, he said, in a process that could take "an hour or two easy before that decision is made." Usually, he said, parents are there.

Still, he said, "there are more Baker Acts of elementary school students than I've ever seen."

State data on use of the Baker Act in 2020-21 shows a majority of students ages 5 to 10 were boys, while a majority of those ages 11 to 17 were girls. More than 60 percent of students were White, 23 percent Black and 11 percent other races, with 20 percent identifying as Hispanic. The racial makeup largely reflects the population.

Husfelt cites examples: A 9-year-old said she was hearing voices that were telling her to hurt herself and who planned to turn on the oven and climb inside. A 16-year-old with a history of self-harm who needed counseling but was hamstrung by her family's disapproval and now wanted to hurt herself.

"I would rather every child get counseling, and nobody get Baker Acted," he said. "But I also don't want to be the one that finds out that one of our students committed suicide because we didn't do anything about it."

On the other side of Florida, on another side of the debate, advocates assert that the best way to apply the Baker Act is sparingly. The better-safe-than-sorry approach presumes that the risks of not using the Baker Act are greater than the trauma children experience from commitment, they say.

In Palm Beach County, the nonprofit Disability Rights Florida and several families sued the school system in 2021 for allegedly overusing the law, an action that followed a report by the Southern Poverty Law Center detailing the "costly and cruel" practice.

More than 1,200 students went from district schools to psychiatric facilities from 2016 to 2020, the suit said, including more than 250 students in elementary school. The suit also accuses the county of having "seized Black children for involuntary examination at twice the rate of white children, a disparity that worsens for young children: 40 of 59 children under age eight examined under the Act in that period were Black."

Those students did not get the benefit of de-escalation strategies, and they instead were taken into custody by police officers working for the district — often without parental input or over parents' fierce objections, the suit alleged.

Palm Beach County school officials said in a statement that the case points to the need for student mental health support. Each student involved in the suit was experiencing a mental health crisis, they said, and "the appropriate individuals, acting in good faith … made the decision that these children should be transported to the hospital for the appropriate medical personnel to evaluate them and provide them with help."

The legal team behind the case said that de-escalation strategies should precede a referral and that parents should be involved in decision-making. They want handcuffs used in only the most severe circumstances and cases to receive after-action reviews to see whether they were preventable.

Brian Martinez's son was 10 years old when he was caught up in the Baker Act. The boy was part of a special program for children with autism in a public school in the Orange County school district in Orlando. After students teased him one April day in 2018, he said he wanted to hurt himself, the father said.

Teachers and principals can't order a student's psychiatric removal through the Baker Act, but they can involve police officers or mental health personnel who have the authority to do so.

In the Martinez case, a school administrator alerted police, who beat Martinez and the boy's mother to the school, he said. The decision had already been made by the time they arrived. Martinez recalls pleading that his son not be handcuffed. He dropped to his knees to tell his son it would be okay.

Once at the psychiatric facility, the 10-year-old refused to eat or shower. He shared quarters with teenagers as old as 17, the family said. Martinez hired a lawyer who won the boy's release the next day. "He had a developmental disability, not a mental illness," said attorney Kendra Parris, who argues that teachers and police need more training on how to use the law.

But for the boy, the experience was not over, Martinez said. He had nightmares for two years. He worried more. At 14, he still struggles with "saying the wrong thing" and facing detention again, Martinez said.

"Kids say stupid things all the time," he said. "It doesn't mean they're going to go kill themselves. You're telling me, with all the advances and all the science and all of the education, we can't diagnose this and know the difference?"

School officials in Orange County said that they could not speak directly on the case because of student privacy protections, but that the district has threat assessment teams set up at each school, and centrally, and relies on law enforcement to determine when a Baker Act is needed.

Nev Jones, a University of Pittsburgh professor who interviewed dozens of affected teenagers and young adults in Florida, said a substantial number reported feeling worse after their psychiatric stay than before it — more despondent, depressed and hopeless. None had received therapy during a Baker Act commitment.

Families have reported that children have trouble sleeping after they come home. Some lose faith in adults at school. Some children of color, who already fear interactions with police, feel even more frightened. Many children and adolescents vow to protect themselves by never disclosing their mental health difficulties.

“I don’t want to share my feelings, even with people I trust,” said a 16-year old from Melbourne who was Baker Acted during the 2022-23 school year and spoke on the condition of anonymity to protect her privacy.

Foster kids are especially vulnerable to Baker Acts, said Latham, of the Children & Youth Law Clinic. Many lose their placements after being sent away, he added, and then are harder to place because of the stigma that attaches to them.

“I’ve had kids held in Baker Acts for way longer than they should be,” Latham said. “No placements would take them, so they wound up getting stuck there for months.”

The 10-year-old who wrote “kill” on the bench at his public charter school — which said it could not comment because of student privacy laws — was one of the lucky ones. He was taken to a hospital where a doctor saw the boy quickly and decided he had been wrongly Baker Acted. According to Marino, the doctor called it a “grave overreaction.”

Together, mother and son headed home.

If you or someone you know needs help, visit 988lifeline.org or call or text the Suicide & Crisis Lifeline at 988.

Disability Rights FLORIDA

May 17, 2023

Dr. Peggy Aune, Vice Chancellor for Strategic Improvement
Florida Department of Education
Peggy.Aune@fldoe.org

Re: Florida-Specific Youth Survey Workgroup

Dear Dr. Aune,

I am a member of the workgroup selected to assist in development of the Florida Specific Youth Survey. While I appreciate being selected to provide input on the survey, I am writing to express my concerns with the workgroup process and the result.

Overall, the process felt very rushed. I was informed I was selected in December. We had only one in-person meeting, in January, and despite being assured there would be at least one more in-person meeting for all workgroup members, there were only two additional virtual meetings, lasting less than one hour each, prior to the survey administration.

At the in-person meeting in January, workgroup members were given our first opportunity to ask questions of the survey developers from USF. I asked whether the survey would be made accessible to students with disabilities, specifically whether it would be compatible with screen reading software and whether children who received testing accommodations through IEPs would be allowed those accommodations when participating in the FSYS. I was told that accessibility for students with disabilities had not been considered and that, due to the short timeframe in which the survey was to be developed, no effort would be made to ensure students with disabilities would be accommodated. As a result, the data gleaned from this year's FSYS will not be representative of Florida's student population because they will not include the perspectives of students with disabilities requiring accommodation.

The rushed nature of this project also minimized workgroup members' opportunity to provide meaningful input. And at our only in-person meeting, our work was limited by the things that had not yet been done:

- We discussed parental consent and decided that parents should be provided with detailed notification about the survey prior to its administration and be given the option to opt their child out of participation. We were told we would have the ability to provide input on the parental notification and opt-out language. However, workgroup members were not provided with this language until after the survey administration began, providing no opportunity for input.

- The majority of the January meeting was spent dickering over the definitions for terms related to Florida's new resiliency standards, which we were later told were actually in the process of being developed and defined by another, separate workgroup. The definitions of these terms were again dickered over at a virtual meeting in February.
- Workgroup members, including myself, expressed the importance of maintaining the longitudinal data provided by prior YRBS results in order to be able to determine changes in trends in youth behavior. We were assured by the survey developers that they were working to ensure consistency between the YRBS and FSYS but no sample questions were available at that time. It was only when we were provided the draft questions in March that it was clear the FSYS questions were not similar enough to YRBS questions to preserve the ability to compare longitudinal data from prior administrations of the YRBS to current and future administrations of the FSYS.

When we received the draft questions in March, via email, we were told someone from DOE would be in contact soon to schedule another workgroup meeting. Personally, I hoped this would be an in-person meeting, or at least scheduled for more than one hour, to give workgroup members a meaningful opportunity to discuss the questions with each other, "in the Sunshine," and provide input. Instead, the next communication workgroup members received was in April notifying us that the survey administration was underway. Had I not been led to believe there would be another meeting prior to the survey administration, I would have provided feedback on the draft questions via email prior to the survey administration. But even this would have been a less meaningful option because, due to Sunshine Law, I would be unable to understand and discuss the concerns and suggestions of other workgroup members and incorporate those into my own feedback.

However, having had the chance to review the full set of questions on this year's FSYS, I wanted to take this opportunity to share my feedback. My main concerns are about the loss of utility of any longitudinal data, the reduction of demographic information as compared to the YRBS, and the focus on measuring how well the students have been taught the resiliency standards as opposed to actual youth behavior.

As explained above, I expressed the importance of maintaining enough consistency between the YRBS and the FSYS to ensure that the data sets could be compared in a meaningful way. When longitudinal data is preserved, one can learn not just what students are reporting today, but also how that compares to the past. For example, the YRBS asks a series of questions about school safety including questions such as "During the past 30 days, on how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school?" There are no questions on the FSYS on this topic and there are several other topics, such as teen dating violence and weapons on campus, that have been completely eliminated. Longitudinal data on these topics would be invaluable to evaluate the effectiveness of changes in policy and law meant to address student safety. Without this data, Florida is set back to square one.

My concern with the reduction of demographic information in the FSYS as compared to the YRBS is for similar reasons. By failing to ask whether students identify as a person with a disability or a member of the LGBTQ+ community, we can learn far less about any differences or changes in the

behaviors and mental health status of these groups of students. Each year, laws and policies affecting these groups are changed and we have now lost a valuable tool in measuring the impact and effectiveness of those changes. I cannot think of a single situation where less information is better as far as evaluating outcomes. I realize some might feel these are sensitive topics, but that is all the more reason to want to know how our laws and policies are affecting these students.

Finally, I am deeply worried about the change in focus on resiliency standards as opposed to actual youth behaviors that may cause disease or disability – the intended purpose of the YRBS. The vast majority of the questions on the FSYS are aimed at the resiliency standards, with only a few about student behavior that might affect their health, mental or otherwise. Questions about drug use other than marijuana or prescription drugs have been eliminated in the FSYS. All but one question about sexual activity have been eliminated. Questions about concussions, fighting, sexual assault have all been eliminated. And among the topics from the YRBS that do appear on the FSYS, the questions about individual student behavior and experiences are seriously limited in the FSYS.

My concern with these changes is two-fold. It is not uncommon for young people to know that something is bad for them but still do it anyway. By limiting the amount of information about actual student behavior and experiences relating to disease, disability, and safety, we are taking away valuable information that guides all sorts of professionals who work with and on behalf of these students. For example, if a doctor doesn't know that the rate of serious drug use among teens has tripled in the last few years, they don't know they may need change their practice or advice to parents on the topic.

More importantly, I worry about the message that the focus on resiliency and related traits sends the wrong message about mental health. While character development skills such as perseverance, critical thinking, and citizenship are incredibly important, building and measuring these skills is not a proper alternative to mental health education and monitoring. Shifting mental health instruction to resiliency education implies that mental health issues that students experience are somehow a character flaw. In reality, we know that many mental health issues are caused either by uncontrollable chemical imbalances, external factors such as a difficult home environment, or a combination of these factors. This shift in perspective is likely to increase the stigma of acknowledging and seeking appropriate treatment for mental health issues which will negatively impact student outcomes and safety. I certainly hope that the focus on resiliency characteristics is in addition to, not in lieu of, mental health education and assistance. However, the balance of questions in the FSYS leads me to believe otherwise. Just 8 of the 223 questions on the FSYS relate to mental health while 161 of the questions relate to resiliency characteristics.

While I feel it is my responsibility as a workgroup member to express my concerns, I look forward to continued participation in the FSYS development process. I believe that all of the workgroup members and agencies involved share the goal of improving the lives of all of Florida's students. Thank you for taking the time to hear out these concerns. I would welcome any opportunity to discuss with the other workgroup members or any appropriate agency personnel and can be reached at the contact information below.

Sincerely,

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No. 23-20171

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

Disability Rights Texas,

Plaintiff–Appellee v.

Roy Hollis, in his official capacity as the Chief Executive Officer of Houston Behavioral Healthcare Hospital, LLC,

Defendant–Appellant

On Appeal from United States District Court for the Southern District of Texas
4:22-CV-121

BRIEF FOR *AMICI CURIAE* NATIONAL DISABILITY RIGHTS NETWORK AND DISABILITY RIGHTS LOUISIANA IN SUPPORT OF PLAINTIFF-APPELLEE AND AFFIRMANCE OF THE COURT'S ORDER BELOW

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No. 23-20171

IN THE
UNITED STATES COURT OF
APPEALS FOR THE FIFTH CIRCUIT

Disability Rights Texas,

Plaintiff–Appellee v.

Roy Hollis, in his official capacity as the Chief Executive Officer of Houston Behavioral Healthcare Hospital, LLC,

Defendant–Appellant

On Appeal from
United States District Court for the Southern District of
Texas 4:22-CV-121

BRIEF FOR *AMICI CURIAE* NATIONAL DISABILITY RIGHTS NETWORK AND DISABILITY RIGHTS LOUISIANA IN SUPPORT OF PLAINTIFF-APPELLEE AND AFFIRMANCE OF THE COURT'S ORDER BELOW

SUPPLEMENTAL CERTIFICATE OF
INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of 5TH CIR. R. 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges

of this court may evaluate possible disqualification or recusal.

A. Amici Curiae for Plaintiff-Appellee

National Disability Rights Network
Rule 26.1 Disclosure Statement: National Disability Rights Network, Inc., is a Florida Not for Profit Corporation whose corporate office is located in the District of Columbia. National Disability Rights Network is the national membership organization for the Protection and Advocacy network. National Disability Rights Network does not have a parent corporation or publicly traded stock.

Disability Rights Louisiana
Rule 26.1 Disclosure Statement: Disability Rights Louisiana was authorized and is designated as the Protection and Advocacy (P&A) system for individuals with disabilities in the State of Louisiana pursuant to a series of federal statutes that authorized and created a P&A entity in each state and territory charged with protecting and advocating for the rights of individuals with disabilities. The relevant federal statutes include the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. §§ 10801 et seq.; the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.; and the Protection and Advocacy of Individual Rights Program, 29 U.S.C. § 794e. Founded in 1977, Disability Rights Louisiana is a non-profit that provides legal representation, information and referral, educational services, and other systemic advocacy on issues related to disability. Our practice areas focus on the rights of individuals with disabilities living in institutions, special education rights, access to home- and community-based care services, and what can broadly be described as "anti- discrimination" advocacy—i.e., the rights of people with disabilities to physical and programmatic access to publicly available programs and services.

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STATEMENT OF CONSENT

Disability Rights Louisiana sought consent of the parties to the filing of this amicus. The Appellants and Appellees have consented.

INTEREST OF THE *AMICI CURIAE*[1]

The National Disability Rights Network (NDRN) is the non-profit membership organization for the federally mandated Protection and Advocacy (P&A) and Client Assistance Program (CAP) agencies for individuals with disabilities. The P&A and CAP agencies were established by the United States Congress to protect the rights of people with disabilities and their families through legal support, advocacy, referral, and education. There are P&As and CAPs in all 50 states, as well as the District of Columbia, Puerto Rico, and the U.S. Territories (American Samoa, Guam, Northern Mariana Islands, and the US Virgin Islands), and there is a P&A and CAP affiliated with the Native American Consortium which includes the Hopi, Navajo and San Juan Southern Paiute Nations in the Four Corners region of the Southwest. Collectively, the P&A and CAP agencies are the largest provider of legally based advocacy services to people with disabilities in the United States.

Disability Rights Louisiana (DRLA) is the designated Protection and Advocacy organization for Louisiana. DRLA was founded pursuant to federal law establishing

[1] All parties consented to the filing of this brief. Pursuant to Fed. R. app. 29(a)(4)(A)-(E), counsel for *amici curiae* states that no counsel for a party authored the brief in whole or in part, and no person other than *amici curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

P&A systems in each state and territory, and as such, have been charged with the responsibility to advocate for individuals with disabilities for decades—DRLA since 1977. Each of these P&As is currently authorized by law to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of individuals with mental illness, which is the most relevant authority to this matter. 42 U.S.C. § 10805(a)(1)(B). DRLA possesses the same statutory authority as Disability Rights Texas (DRTx). As *Amici*, NDRN and DRLA have a strong interest in ensuring that P&As can carry out their statutory duty to represent the rights of people with disabilities including their established practice of receiving video records of alleged abuse and neglect.

The P&A network was established by Congress in response to wide-spread abuse and neglect of people with disabilities. One important component of this Congressional mandate was assigning P&As the responsibility of investigating abuse and neglect of people with disabilities. *See* 42 U.S.C. § 15043(a)(2)(B), 42 CFR § 51.2. To fulfill that mandate, these organizations were provided with extensive access, including the authority to request and review various records that relate to their investigation. *Alabama Disabilities Advocacy Program v. J.S. Tarwater Developmental Center*, 97 F.3d. 492, 497 (11th Cir. 1996); *Center for Legal Advocacy v. Hammons*, 323 F.3d 1262, 1270 (10th Cir. 2003).

Overturning the District Court's Order[2] granting an injunction allowing DRTx access to video records pertaining to a client would negatively impact the ability of P&As to access records and conduct meaningful investigations. Limiting a P&A's investigative authority could likely result in the inability to mitigate abuse and neglect of people with disabilities in locked, restricted settings. Because the ability to effectively investigate and mitigate harm is critical to a P&A's ability to protect the legal rights of persons with disabilities, NDRN and its members, including the *Amici*, have an interest in this case and believe that their views may assist the Court in resolving the issues before it.

SUMMARY OF THE ARGUMENT

The District Court properly ruled that Plaintiff–Appellee was entitled to access video records capturing the involuntary administration of medication to its client who was inpatient in a psychiatric hospital. As a P&A organization, DRTx is charged with a federal mandate to protect and advocate for the rights of individuals with disabilities, including those with mental illness. This authority is broad, and the investigative authority granted to P&As provides a layer of independent oversight to prevent and address the abuse and neglect of people with mental illness while

[2] The lower court's decision at issue in the instant appeal that is addressed in this *Amici Curiae* brief is the Memorandum and Order entered by US District Court Judge Keith P. Ellison on February 28, 2023, in *Disability Rights Texas v. Roy Hollis*, Civil Action No. 4:22-CV-00121, ECF No. 32, ROA page range 23.20171.249-23.20171.260. (Referred to herein as "the Order".)

receiving care and treatment. The timely ability of P&As to access video records is a critical part of conducting a thorough investigation. Concerns regarding confidentiality of residents who are not clients of the P&A would not be a justification to restrict access to video, because (1) access to video would not permit the P&A to view anything that they are not already entitled to view under the P&A Acts, and (2) P&As are required to maintain the confidentiality of investigative information to the same degree as the facility itself. For these reasons, this Court should uphold the District Court's Order.

ARGUMENT

I. The history of the P&A system provides context for unique federal access authority afforded by Congress.

The history of mistreatment, abuse, and neglect of persons with psychiatric, developmental, and other disabilities within public and private institutions and facilities in the United States is well documented. *See, e.g.*, Stanley S. Herr, The New Clients: Legal Services for Mentally Retarded Persons, 31 Stan. L. Rev. 553, 558 (1979); Michael Perlin, International Human Rights Law and Comparative Mental Disability Law: The Universal Factors, 34 Syracuse J. Int'l L & Com. 333, 335 (2007). In 1958, the president of the American Psychiatric Association categorized state psychiatric hospitals as "bankrupt beyond remedy." *See* Perlin at 335. During a Congressional hearing in 1961, a witness testified that he had interviewed physicians

at state hospitals who "frankly admitted that the animals of nearby piggeries were better housed, fed and treated than many of the patients on their wards." *Id.*

During the decades of nearly complete reliance on public and private institutions established to house and ostensibly treat persons with developmental, intellectual, and mental health disabilities, institutes such as the Pennhurst School and Hospital in Pennsylvania, Forest Haven in Maryland, Partlow State School in Alabama, and the Willowbrook and Suffolk Developmental Centers in New York became notorious for the horrible conditions and treatment of residents. During the 1970's and early 1980's, advocates brought to light the widespread neglect and mistreatment of people with disabilities in these facilities. Willowbrook was exposed to the public in 1972 through an investigative report by Geraldo Rivera who testified to Congress about his experience. *See* S. Rep. No. 94-160, at 28-32 (May 22, 1975). The inhumane conditions at the Partlow School also played a prominent role in Congressional investigations regarding the treatment of persons with intellectual disabilities in facilities at that time. *Id.*

Several high-profile cases connected to the horrendous treatment of persons with intellectual and developmental disabilities at the Pennhurst School eventually reached the Supreme Court, who analyzed the Constitutional parameters of the rights of residents in such facilities. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981). The Supreme Court noted that "conditions at Pennhurst are not only dangerous, with the residents often physically abused or drugged by staff members,

but also inadequate for […] habilitation[.] Indeed, the [district] court found that the physical, intellectual, and emotional skills of some residents have deteriorated at Pennhurst." *Id.* at 7; *see also Youngberg v. Romero*, 457 U.S. 307 (1982) (holding that a resident with intellectual disability involuntarily confined to Pennhurst enjoys constitutionally protected interests in conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests).

In 1975, in response to these conditions and highly publicized incidents, Congress created the P&A system through what is now known as the Developmental Disabilities Assistance and Bill of Rights Act (the "DD Act"). Pub. L. No. 94-103, 89 Stat. 486 (1975) (originally codified at 42 U.S.C. §§ 6041-6043 and currently codified at 42 U.S.C. §§ 15041-15045). The DD Act's purpose is "to provide for allotments to support a protection and advocacy system […] in each State to protect the legal and human rights of individuals with developmental disabilities[.]" 42 U.S.C. § 15041. The DD Act provides that to receive allotments under the Act, a state must put "in effect a system to protect and advocate the rights of individuals with developmental disabilities[.]" 42 U.S.C. § 15043(a)(1). NDRN's member P&As were created pursuant to this provision. And as the "system to protect and advocate the rights of individuals with developmental disabilities," P&As are granted numerous authorities under the DD Act, including the ability to have on-site access to service providers and to receive records of individuals with developmental disabilities. 42 U.S.C. §§15043(a)(2)(H)&(I).

A decade after the passage of the DD Act, Congress expanded the P&As' responsibilities by enacting what is now the Protection and Advocacy for Individuals with Mental Illness Act (the "PAIMI Act"), Pub. L. No. 99-319, 100 Stat. 478 (1986), codified at 42 U.S.C. § 10801, *et seq.* Through the PAIMI Act, P&As were tasked with protecting and advocating for those with mental illness, in addition to those with developmental disabilities under the DD Act. P&As' responsibilities were again expanded in 1993 with the enactment of the Protection & Advocacy of Individual Rights ("PAIR"), designed to protect the legal and human rights of all other persons with disabilities not covered by the DD and PAIMI Acts (e.g., individuals with physical disabilities). 29 U.S.C. § 794e. Currently, P&As are granted similar authorities under the PAIMI and PAIR Acts with respect to the populations covered by those Acts as they are to the developmentally disabled population covered by the DD Act. *See, e.g.*, 42 U.S.C. § 10805(a)(4) (P&As have access to records of individuals with mental illness); *see also* 29 U.S.C. § 794e(f)(2) (a P&A under the PAIR Act shall "have the same general authorities, including the authority to access records and program income, as are set forth in [the DD Act]"). It should also be noted that the PAIMI, PADD, and PAIR Acts are to be read coextensively. *See* S. Rep. 454, 100th Cong., 2d Sess. 10 (1988); S. Rep. 109, 99th Cong., 1st Sess. 2-3 (1985); S. Rep. 113, 100th Cong, 1st Sess. 24 (1987); *see also* 29 U.S.C § 794e(f)(2). Therefore, the case law and regulations interpreting the scope of one P&A's access authority is equally applicable with respect to the interpretation of the counterpart provisions for any other P&A.

To ensure that the P&As can carry out their mandates, Congress established a baseline of authority a P&A must have for the state to qualify to receive funding under the DD Act, the PAIMI Act, or the PAIR Act (collectively, the "P&A Acts"). The critical required features of all P&As, explained in part *infra*, include independence from state agencies that provide treatment, services, and/or habilitation to individuals covered by the P&A Acts; rights to access the records of individuals with disabilities under various circumstances; and the right to pursue legal, administrative, and other appropriate remedies to protect the rights of those covered by the P&A Acts. *See generally* 42 U.S.C. § 15043; 42 U.S.C. § 10805 (DD and PAIMI Act statutes containing many of the P&A authorities). Consequently, a P&A's exercise of its authority to access records of individuals with disabilities and facilities where they receive treatment is a mandatory requirement under the P&A Acts. For example, in 2018, Disability Rights Oregon (DRO) used its access authority to review video footage of a police canine attacking a person with a disability.[3] Through the use of their access authority, DRO was able to work with the local sheriff's office to investigate the incident and resulted in statewide ban.

II. P&As have the right under the P&A Acts to investigate incidents of abuse and neglect as well as access to records of individuals with disabilities, including video records.

[3] "You are Going to Get Bitten: Columbia County Jail's Use of Canines to Intimidate or Control Inmates" available at https://www.droregon.org/successes/banning-the-use-of-canines-in-jail-to-control-inmates

Investigating allegations of abuse and neglect of individuals in psychiatric treatment facilities, such as the one reviewed by the court in the instant case (*see* ROA.250), is a cornerstone activity of P&As. Because Congress developed both the DD and PAIMI Acts in response to widespread abuse and neglect in facilities and the lack of effective state-run systems to monitor compliance, all P&A Acts authorize the P&As to conduct such investigations. *See* S. Rep 109, 99th Cong., 1st Sess. 2-3 (1985); 42 U.S.C. § 15043(a)(2)(B); and 42 U.S.C. § 10805(a)(1)(A).

The District Court correctly determined that the case before the Court is governed by the PAIMI Act because it involves DRTx's efforts to obtain video records of an individual with a mental illness. (*See* ROA.250). Like all P&A Acts, the PAIMI Act authorizes the P&A to conduct investigations, specifically to "investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred[.]" 42 U.S.C. § 10805(a)(1)(A). As part of this investigatory power, Congress intended the P&A system to "have the fullest possible access to client records with appropriate authorization and access to facilities where a complaint has been received on behalf of" a person with mental illness. S. Rep 109, 99th Cong., 1st Sess. 10 (1985). Whenever a P&A receives a report or has determined that there is probable cause of abuse or neglect it "shall" have access to "all records" of an individual with mental illness to carry out its investigation. *See* 42 U.S.C. § 10805(a)(4).

A P&A may access "all records…of any individual" with mental illness when the individual "has authorized the system to have such access," as the District Court found occurred in the underlying case. 42 U.S.C. § 10805(a)(4)(A); (ROA.252). Such access to records explicitly includes access to "video or audio tape records." 42 C.F.R. § 51.41(c). Even though a facility's video records are not made or maintained as part of an individual patient's chart, the PAIMI Act requires a facility to release them to a P&A when related to an abuse or neglect investigation and when the patient has authorized the P&A to obtain "all" of their records. *See* 42 U.S.C. § 10805(a)(4)(A).

Courts have held in analogous situations that the PAIMI Act requires the disclosure of facility records maintained outside of a patient's chart, namely peer review or quality assurance records, because those records are related to the care and treatment of individuals who were the subject of an authorized P&A investigation. *See Pennsylvania Protection & Advocacy, Inc. v. Houstoun*, 228 F.3d 423, 427 (3d Cir. 2000) (Alito, J.) (finding that peer reviewed reports are "records" accessible under the PAIMI Act because records "of any individual" includes those records that are "connect[ed] or associate[ed]" to the individual); *Center for Legal Advocacy v. Hammons*, 323 F. Ed 1262, 1272 (10th Cir. 2003) (agreeing with the Third Circuit's opinion in *Houstoun*, that the PAIMI Act required a facility to disclose peer review and other quality assurance records to a P&A).

Courts have consistently held that P&As have a federal mandate to "broad access to records, facilities, and residents to ensure that the Act's mandates can be

effectively pursued." *Alabama Disabilities Advocacy Program v. J.S. Tarwater Developmental Center*, 97 F.3d. 492, 497 (11th Cir. 1996) (referring in this instance to the DD Act). Several courts have noted that a P&A's access to records is fundamental to the exercise of its Congressional mandate. *See Alabama Disabilities Advocacy Program v. J.S. Tarwater Developmental Ctr.*, 894 F. Supp. 424, 429 (M.D. Ala. 1995), *aff'd* 97 F.3d 492 (11th Cir. 1996) ("The authority to investigate would mean nothing and advocacy in the form of investigation would be ineffective without access to records."); *Robbins v. Budke*, 739 F. Supp. 1479, 1488 (D.N.M. 1990) (mem.) ("Access to patient records is necessary for [a] P&A to serve its clients, evaluate its clients' concerns, and determine whether a client has a legal claim.").

Contrary to Defendant's "sweeping arguments" below (ROA.254), the Health Insurance Portability and Accountability Act (HIPAA) does not preempt DRTx, as the state's P&A, from accessing Houston Behavioral Healthcare Hospital's video footage of patients. HIPAA states that "a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law." 45 C.F.R. § 164.152(a)(1).

Congress' commentary on HIPAA specifically mentions that it does not impede a P&A's access to an individual's identifiable health information, stating that "covered entities may make these disclosures under § 164.512(a) without first obtaining an individual's authorization, except in those circumstances in which the

[Developmental Disabilities] Act requires the individual's authorization. Therefore, the rules below will not impede the functioning of the existing Protection and Advocacy System." 65 Fed. Reg. 82462, 82594 (Dec. 28, 2000); *see also Ohio Legal Rights Service v. Buckeye Ranch, Inc.*, 365 F. Supp. 2d 877, 890 (S.D. Ohio 2005).

The United States Department of Health and Human Services (HHS) also has commented on this issue, providing that "[t]he Privacy Rule permits a covered entity to disclose protected health information (PHI) without the authorization of the individual to the state-designated Protection and Advocacy system to the extent that such disclosure is required by law and the disclosure complies with the requirements of that law. 45 C.F.R. § 164.512(a)." Health Information Privacy, U.S. DEPT'T OF HEALTH AND HUMAN SVCS, https://www.hhs.gov/hipaa/for-professionals/faq/909/may-a-covered-entity-disclose-information-to-a-protection-system/index.html (last visited September 26, 2023).

Once a P&A requests records, it is entitled to receive prompt access to those records:

> If a P&A system's access to facilities, programs, residents or records covered by the Act or this part is delayed or denied, the P&A system shall be provided promptly with a written statement of reasons, including, in the case of a denial for alleged lack of authorization, the name, address and telephone number of the legal guardian, conservator, or other legal representative of an individual with mental illness. Access to facilities, records or residents shall not be delayed or denied without the prompt provision of written statements of the reasons for the denial.

42 C.F.R. § 51.43; *see also id.* 42 C.F.R. § 51.41(a) ("Access to records shall be extended promptly to all authorized agents of a P&A system."); 42 U.S.C. § 15043(A)(2)(J)(i) (under the DD Act, a P&A shall have access to records "not later than 3 business days after the system makes a written request for the records involved"). Courts have found that timely access to records by a P&A is so important that denial of this access constitutes irreparable harm to the P&A sufficient to allow for preliminary or permanent injunctive relief. *See Connecticut Office of Protection and Advocacy v. Hartford Bd. of Ed.*, 464 F.3d 229 (2nd Cir. 2006); *Indiana Prot. & Advoc. Servs. v. Indiana Fam. & Soc. Servs. Admin.*, 603 F.3d 365 (7th Cir. 2010).

Some courts have gone further and found that even tardy access to records presents the same irreparable harm to a P&A's ability to investigate under its Congressional mandate. *See The Advocacy Center v. Stalder*, 128 F. Supp. 2d 358, 364 (M.D. La. 1999) ("Prompt access to records is necessary [. . .] [T]he defendants maintain that, under state law and departmental policy, the Advocacy Center needs a court order. However, it cannot be disputed that the delay in getting a court order frustrates the goal of the [PAIMI] Act."); *Robbins*, 739 F. Supp. at 1488 (holding that "[t]imely access to records is essential for effective communication" and that delays may "preclude[] [a] P&A from evaluating and acting on a patient's concerns in a timely manner" and "prevent P&A from acting within prescribed deadlines or may cause a violation of rights to go unaddressed until it is too late to remedy"). Moreover, any delay in the process gives "facilities the time to conceal evidence, change medical

records, coordinate stories among witnesses and/or impose a code of silence upon staff." National Association of Protection & Advocacy Systems, Inc., Annual Report of the P&A System 1995-1996 (1996), at 8.

III. A P&A's confidentiality obligations address any privacy concerns.

Once a P&A obtains records through its federal authority, it is not free to do whatever it pleases with them: the P&A Acts generally, and the PAIMI Act specifically, place guardrails on how the P&A can utilize the records it obtains. In fact, P&As are required to maintain the confidentiality of the records obtained "to the same extent as is required of the provider of such services." 42 U.S.C. § 10806(a); *see also* 42 C.F.R. § 51.45(a)[4]. In other words, if a P&A receives records from a facility that is bound to maintain the confidentiality of that record, the P&A must also maintain that same level of confidentiality.

The district courts have been active and persistent in their interpretation of the PAIMI Act's duty of confidentiality. *See, e.g.*, *Protection & Advocacy Sys., Inc. v. Freudenthal*, 412 F.Supp.2d 1211, 1215-16 (D.Wyo.2006); *State of Conn. Office of Prot. &*

[4] "The P&A must: (1) Except as provided elsewhere in this section, keep confidential all records and information, including information contained in any automated electronic database pertaining to:
(i) Clients to the same extent as is required under Federal or State laws for a provider of mental health services;
(ii) Individuals who have been provided general information or technical assistance on a particular matter;
(iii) Identity of individuals who report incidents of abuse or neglect or furnish information that forms the basis for a determination that probable cause exists; and
(iv) Names of individuals who are residents and provide information for the record."

Advocacy for Persons with Disabilities v. Hartford Bd. of Educ., 355 F.Supp.2d 649, 663-64 (D.Conn.2005); *Advocacy Ctr. v. Stalder*, 128 F.Supp.2d 358, 366 (M.D.La.1999); *Ala. Disabilities Advocacy Prog.*, 97 F.3d at 497, 499. Furthermore, this duty of confidentiality is "especially significant" because P&A organizations have a "special function [. . .] to serve individuals with disabilities or mental illness." *Disability Rts. Wis., Inc. v. State of Wis. Dep't of Pub. Instruction*, 603 F.3d 365, 728 (7th Cir. 2006).

This is particularly relevant in the present case where Defendant is concerned about producing video records to DRTx due to its assertion that it must protect the confidentiality of the individuals who have not signed releases to DRTx. (*See* ROA.254). Defendant's concern is unfounded, because as the District Court explained in detail, DRTx is required by federal law to maintain the same confidentiality that binds Defendant. *See id.* Accordingly, Defendant's contention that DRTx is not entitled to video records due to confidentiality concerns is a violation of DRTx's broad authority under federal law and ignores the fact that the same exact confidentiality restrictions bind DRTx in an identical manner. As noted *supra*, the duty of confidentiality imposed on P&A organizations prevents the disclosure of unredacted records and third-party information without additional consent.

Based on the foregoing, P&As have long been held to the stringent requirement that confidentiality be maintained to the same extent as is required of the provider of such services. 42 U.S.C. § 10806(a); 42 C.F.R. § 51.45; 45 C.F.R. § 1386.22(e); *Robbins*, 739 F. Supp. at 1488; *Houstoun*, 228 F.3d at 427. Such rulings

affirm that the duty of confidentiality is a core principle within the P&A and further emphasize the need for P&A organizations to access unredacted records to effectively carry out their mandates.

IV. The District Court's Order allowing P&A access to video is consistent with the P&As' otherwise broad authority to physically access facilities.

The District Court's Order permitting DRTx to access video recordings of the administration of involuntary medication to their client should be upheld because it allows the P&A system to view something that they would have been able to view had they happened to be on-site when it occurred. During an abuse or neglect investigation, a P&A system is permitted "reasonable unaccompanied access…to all areas of the facility which are used by residents or are accessible to residents…at all times necessary to conduct a full investigation." 42 C.F.R. § 51.42 (b). A P&A's authority to conduct a "full investigation" of possible abuse and neglect includes access to records, as well as physical locations, service recipients, and staff. *See* 42 C.F.R. § 51.2; 42 C.F.R. § 51.41(b); 42 C.F.R. § 51.42(b).

Not only do P&As have the right to unaccompanied access to facilities as part of their investigatory powers, the P&A Acts also grant them access to "facilities in the State providing care or treatment" to individuals with mental illness for certain other federally authorized purposes. *See* 42 U.S.C. § 10805(a)(3). It is through this authority that many P&As frequently conduct "monitoring" of facilities that serve individuals with mental illness, which includes inspecting and photographing areas of the facility

accessible to residents, unaccompanied access to the residents to conduct interviews and welfare checks, and generally ensuring patient rights and safety. *See* 42 C.F.R. § 51.42(c) & (d). All of these activities may occur routinely, without any need for a triggering report or probable cause of abuse and neglect sufficient to conduct an investigation.

Any time P&A staff is on site at a facility—whether to conduct an abuse or neglect investigation, to monitor patient rights and safety, or to provide information and training to residents—P&As encounter a majority, if not all, of the residents and often make efforts to speak with as many of the residents as possible. In fact, as part of the PAIMI Act's regulations, it is envisioned that the P&A shall be given "the opportunity to meet and communicate privately with individuals [at facilities] regularly, both formally and informally, by telephone, mail and in person." 42 C.F.R. § 51.42(d). However, as with records obtained by a P&A, it should be noted that any resident names must be kept confidential by the P&A. 42 C.F.R. § 51.45(a)(1)(iv).

Given the P&As' broad authority to unaccompanied access to investigate and monitor facilities that provide care or treatment to individuals with mental illness, P&As routinely encounter confidential or HIPAA-protected information while on-site. P&A staff may witness active medical treatment, hear therapeutic activities being provided to residents, or view information such as residents' names on their rooms, posted allergies by kitchen staff, or other information relating to patient care,

treatment, and safety that the P&A must keep confidential. *See* 42 C.F.R. § 51.42 (c); 42 C.F.R. § 51.45.

While the Defendant expressed concerns that video footage sought by DRTx contains images of residents for whom DRTx does not have releases, (*see* ROA.254), this concern is unfounded given that DRTx could access Defendant's facility at any time that may be "necessary" to conduct another abuse or neglect investigation, or at any "reasonable time" to monitor the facility or provide residents with information and training services. 42 C.F.R. § 42(b) & (c). In any of these visits, DRTx would have the right to unaccompanied access to the residents of the facility regardless of whether they signed a release or not. 42 C.F.R. § 51.42(c). It would therefore be illogical to restrict DRTx's authority to obtain and view video related to an abuse or neglect investigation that captures facility activities P&A staff could have viewed had they been present when the incident occurred.

V. Access to records, including video records, is a crucial part of a P&As' operations.

Access to records, specifically video records, is a crucial part of any P&A's operations. Congress did not intend for facilities serving people with disabilities to operate in the dark. Quite the contrary: one court, analyzing a restriction on P&A access to records, noted that "[t]o shield from independent review valuable records of this type of appraisal would directly contradict the expressly stated public policy of Congress." *Iowa Prot. & Advoc. Servs., Inc. v. Rasmussen*, 521 F. Supp. 2d 895, 902 (S.D.

Iowa 2002). Placing any limits on reasonable P&A access shields facility staff from appraisal and creates a more dangerous situation for people with disabilities as any potential abuse or neglect may go unchecked. Further, accessing video records is often the first step in investigating a claim of abuse or neglect. When a P&A receives a report of abuse or neglect, or otherwise develops probable cause to believe abuse or neglect occurred, it begins an investigation. 42 U.S.C. § 10805(a)(1)(A). Once this report is obtained, the P&A quickly works to obtain a release for that individual so that they can begin determining the veracity of the allegation, which typically involves obtaining records. By reviewing an individual's records, including any video of an alleged incident, the P&A can typically determine whether the claim has veracity and whether immediate action is needed to protect the rights and safety of a person with a disability.

Reviewing video of an alleged incident is crucial to a P&A's mandate to investigate abuse and neglect. It would be devastating to a P&A's capacity to investigate abuse or neglect if the ability to review video was limited. Because paper records and files are created by the very facility that is the subject of an abuse or neglect allegation, video records often provide the most salient information in helping a P&A determine the veracity of an allegation. Even seemingly minor alterations to a P&A's broad authority to access video records would directly harm its ability to fulfill its statutory duties. For example, if a P&A were only able to receive video where all individuals who did not sign a release to the P&A had their faces blurred, it would

significantly hamper a P&A's ability to identify witnesses. Instead, the P&A would have to rely on the facility to provide an accounting of who was present during an incident; again, the same facility that the individual alleged caused them abuse or neglect.

Moreover, courts that have interpreted P&A's broad federal authority to review all records have included video recordings as subject to PAIMI's records-access provisions. *See e.g. Disability Rights Texax v. Bishop*, 615 F.Supp. 3d 454, 467 (2022)(citing to *Disability Rights Pennsylvania v. Pennsylvania Department of Human Services,* 2020 WL 1491186; *Disability Rights Ohio v. Buckeye Ranch, Inc.,* 375 F. Supp. 3d 873, 878 (S.D. Ohio 2019).

The federal enforcement agency that oversees the provisions of the PAIMI Act also issued a rule the specifies that "electronic files, photographs or video or audio tape records" are subject to the records-access authority of the P&A systems under Section 10805(a)(4). *See* 42 C.F.R. § 51.41(c). As the *Bishop* court just held last year, this regulation helps address any conflicting policies including confidentiality provisions. *Bishop,* 615 F. Supp at 469.

Finally, P&As often receive abuse or neglect reports after another entity has already investigated the same allegation. In these instances, P&As may conduct what is commonly referred to by the P&A system as a "secondary investigation," wherein a P&A gathers facts and reviews records that include "reports prepared by an agency charged with investigating reports of incidents of abuse and neglect, and injury

occurring at such facility that describes the incidents of abuse, neglect and injury occurring at such facility and the steps taken to investigate such incidents." 42 U.S.C. § 10806(b)(3)(A). Due to the passage of time, P&As conducting secondary investigations are typically less focused on the immediate health and safety of the affected individual and more focused on evaluating the quality of the primary investigation. Such work is critical to P&As' ability to verify that the person with a disability received adequate protections and to further advance rights and safety protections for present and future facility residents.

For the above reasons, unencumbered access to records, especially video recordings, is critical to P&As' ability to provide independent oversight to facilities as envisioned by Congress.

CONCLUSION

Congress intended P&As to be independent, non-State actors to protect and advocate for individuals with disabilities, including those individuals with mental illness who receive care and treatment from psychiatric facilities. To effectuate that purpose, Congress imbued P&As with broad authority to ensure that individuals' rights were being complied with, and to investigate any incidents of abuse and neglect that were alleged by individuals with disabilities. To conduct these investigations, and to ensure patient safety, and to ensure that we do not find ourselves with the same kinds of facilities that were exposed in the 1970s, one of the tools given to P&As was

the ability to obtain and review video footage. To restrict use of that tool in this case would be contrary to the Congressional authority granted to the P&As. For the foregoing reasons, the *Amici* respectfully request that this Court uphold the District Court's Order.

October 2, 2023

Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE

This document complies with the type-volume limitations of Fed. R. App. P. 27(d)(2) because, excluding the parts of the motion exempted by Fed. R. App. P. 32(f), it contains 5,437 words. This document complies with the typeface requirements under Fed. R. App. P. 32(a)(5) and the type-face style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Garamond.

/s/ Melanie A. Bray
Melanie A. Bray

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s/ Melanie A. Bray
Melanie A. Bray

Counsel for Amici Curiae

G. PAIMI Budget - Actual

PAIMI Expenditures and Revenues

PAIMI Expenditures	
1. Does your P&A have an approved Federal indirect cost rate? If yes, what is the approved rate?	○ Yes ◉ No 0.05% %
2. Total indirect costs	$0
3. Total of all PAIMI program costs listed in **I - VIII** in the Budget	$1,427,838
Total	**$1,427,838**

Income sources and other resources (PAIMI program only)			
1. PAIMI program carryover of grant funds identified by FY.			
Enter the last two digits of the Fiscal Year	FY	2022	$925,869
2. Program income (PAIMI only)			$250,161
3. State			$0
4. Other funding sources [identify each source]			
Total of all PAIMI Program resources.			**$1,176,030**

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Footnotes:

H. Statement of Priorities & Objectives

PAIMI Program Statement of Priorities and Objectives - Report

The PAIMI Program Statement of Priorities and Objectives (SPOs) **must be specific** to individuals with significant mental illness (adults) and/or significant emotional impairment (children/youth), as determined by a mental health professional qualified under the laws and regulations of the state in accordance with 42 U.S.C.A. § 10802(4) (A). The SPOs in the PPR **must match** the same format and order approved in the FY 2023 PAIMI Application.

Priority/Goal Description: REDUCE THE INCIDENCE OF ABUSE, NEGLECT, AND RIGHTS VIOLATIONS OF INDIVIDUALS WITH SIGNIFICANT MENTAL ILLNESS OR SIGNIFICANT EMOTIONAL DISTURBANCE

Objective: Investigate individual complaints of abuse or neglect violations of adults with significant mental illness and youth with significant emotional disturbance in facilities, including civil and forensic state mental health treatment facilities, psychiatric (Baker Act) receiving facilities, crisis stabilization units, psychiatric residential treatment facilities, residential treatment facilities, assisted living facilities, group homes, jails, Florida Department of Juvenile Justice detention and commitment centers, and prisons. Take further action as indicated.

Strategies Used: Investigations of Abuse and Neglect

Target Measures

Target Population:	PAIMI eligible adults and youth in facilities.
Expected Target:	50
Expected Outcome:	50
Actual Outcome:	99
Achieved: (●) **Not Achieved:** ( )	

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

As an example of an abuse investigation, FV is an adult male with significant mental illness (Major Depressive Disorder) who was residing at a Baker Act Receiving Facility, after being court-ordered to received continued inpatient treatment. FV's sister contacted Disability Rights Florida (DRF) to express concerns about FV being placed under the Baker Act after a domestic dispute with his ex-wife, his subsequent indefinite extension of inpatient treatment, and the administration of Electroconvulsive Therapy (ECT) as an alternative treatment option. FV's sister asked DRF to assist in protecting FV's individual rights, as she was unclear about the Baker Act process and whether FV was receiving ECT against his will.

DRF staff traveled to the Baker Act Receiving Facility to interview FV and to obtain more information regarding the facility's ECT procedures. Upon completion of DRF's interview with FV, he did not reveal that any procedure had been forced upon him, specifically ECT. FV felt that he was doing better as a result of the ECT sessions and that being at the facility was helping him with his mental health issues. FV explained that, before every ECT session, the facility nurse counseled him and asked him if he would like to proceed with the procedure. While in the procedure room, the doctor, anesthesiologist, and nurse ensured that FV was ready for the procedure prior to administering it. FV confirmed that he is never left alone in the room after a procedure and that the medical staff keep him for observation/vital checks for at least 45 minutes prior to being returned to his room. FV noted that, if he had any concerns regarding the procedure, he was always able to speak to the nurse.

DRF staff followed up with FV's Social Worker and reviewed facility policies and procedures related to ECT along with FV's treatment records. DRF's investigation determined that there were no rights violations related to FV's treatment plan, that FV was satisfied with his treatment plan and quality of care, and that FV was properly informed about any recommended treatment along with the processes for requesting information and/or voicing complaints about any treatment, specifically ECT. Furthermore, the facility provided treatment information (including an overview of the procedure, purpose, side effects, and risks) to all patients prior to consent to perform the treatment, consent is obtained through the patient, guardian, or court order, patient can report any issues directly to staff verbally or in written form and risk management will follow up with the patient, employees receive ECT training provided by internal training (including ECT overview and patients' rights), and ECT sessions are administered onsite at the facility, which is hospital-based.

DRF's follow up with FV's sister revealed that, after receiving more information regarding FV's case, she has no longer has concerns about potential rights violations or FV receiving treatment against his will. Additionally, she informed DRF that FV was released from the Baker Act Receiving Facility and transferred to an Assisted Living Facility. DRF closed this case as Issues Resolved Partially/Completely in the Client's Favor as a result of the investigation.

As an example of a neglect investigation, TH is a minor male with significant emotional disturbance (Bipolar Disorder with ADHD) who was housed in a county jail when his mother contacted Disability Rights Florida (DRF) for assistance on his behalf. TH's mother requested assistance with his placement in the jail, access to disability-related medication, access to proper mental health treatment, and access to educational services. Since this case involved issues related to access to mental health care and education while in the county jail, the initial service request was split into two separate cases with DRF's Advocacy, Education, and Outreach Team (AEO) handling the education component and the DRF's Investigations Team (IT) handling the mental health care component discussed here.

To investigate the mental-health related portion of this service request, DRF staff communicated with TH to verify his need for assistance and obtain clarification about the type of assistance required. DRF staff also maintained contact with TH's mother to provide updates and obtain relevant information about TH's mental health care history and up-to-date status. After obtaining signed releases from TH and TH's mother, DRF staff also requested, received, and reviewed the county jail's policies and procedures regarding Suicide Prevention and Detainee Access to Mental Health Services along with TH's medical and mental health records. DRF also interviewed TH's Junior Parole Officer to determine what types of mental health services TH was required by court to receive, better understand TH's medical and mental health history, and make sense of the TH's status as a student of the school district while also being a detainee at the county jail. With this information, DRF staff verified that TH was in age-appropriate housing and receiving mental health care and medication from mental health counselors provided by the school district while at the county jail. DRF staff continued to monitor TH's access to mental health and education programs after the school year to ensure that TH maintained access to necessary mental health care.

During the course of its investigation, DRF staff determined that TH had and maintained access to appropriate levels of mental health care while at the county jail and therefore concluded that this service request has been resolved completely in the client's favor. DRF staff also followed-up with TH and TH's mother to discuss the above information but left this case open for several months to monitor TH's access to continued care while at the county jail until he was transferred to Florida Department of Corrections (FDC) custody. Once in FDC custody, DRF staff followed-up with TH to confirm that he was receiving the care that he required and to provide self-advocacy instructions for resolving disability-related matters that he may encounter while in FDC. TH confirmed that he is satisfied with the final resolution of DRF's investigation and understood how to request assistance while in FDC custody.

Objective: Investigate individual complaints of rights violations of adults with significant mental illness and youth with significant emotional disturbance in facilities, including civil and forensic state mental health treatment facilities, psychiatric (Baker Act) receiving facilities, crisis stabilization units, psychiatric residential treatment facilities, residential treatment facilities, assisted living facilities, group homes, jails, Florida Department of Juvenile Justice detention and commitment centers, and prisons. Take further action as indicated.

Strategies Used: Collaboration,Rights-Based Individual Advocacy Services

Target Measures

Target Population:	PAIMI eligible adults and youth in facilities
Expected Target:	30
Expected Outcome:	30
Actual Outcome:	61
Achieved: (●) **Not Achieved:** ( )	

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

AS an example of a rights violation, TS is an adult male with significant mental illness (Bipolar Disorder, PTSD, and ADHD), as well as other co-occurring developmental disabilities.. TS' Case Manager at a community-based social services program that integrates medical and social service provision for children and youth with co-occurring disabilities contacted Disability Rights Florida (DRF) on behalf of TS. TS was having a

psychotic episode at home when his mother called the non-emergency line seeking help. Local police arrived at the mother's home, resulting in an altercation with TS. TS had a pitchfork in his hand and attempted to throw a propane tank at the officers. TS was arrested and taken to the County Jail.

DRF accepted TS' case for further investigation and advocacy with the goal of assisting TS with accessing diversion from the criminal justice system after his arrest during an active mental health crisis. The secondary goal was to ensure that TS receives appropriate care and treatment while incarcerated to ensure a smooth discharge to a community-based setting. Over the course of their investigation, DRF visited the County Jail to meet with TS, where he described a variety of mental health and physical health concerns related to medication he was taking. He also expressed having unmanaged mental health symptoms. DRF communicated TS' concerns to nursing staff at the Jail.

DRF then spoke to TS' Case Manager/Social Worker at the community-based program to discuss TS' mental health background. They confirmed that they had also provided information about TS' mental and medical treatment needs during incarceration to County Jail staff, including a copy of TS' medications. They explained that the program had been working with TS for a couple of years and that TS had several behavioral problems at his school, resulting in being Baker Acted recently at the local public receiving facility. The incident that led to TS' current arrest occurred when he was trying to adjust to the new medication he received from the public receiving facility. They stated that they have been advocating for TS and trying to find a good team to work with him. They had also been trying to get TS into a Statewide Inpatient Psychiatric Program before he turned 18 but were unsuccessful. The Case Manager had been in contact with the jail to ensure that TS was receiving his mental health and other medications, and would continue to work with TS upon release to ensure continuity of care.

DRF also spoke with TS' criminal defense attorney. They informed DRF of the status of TS' criminal case, in which the court ordered an evaluation for competency and determined that TS was incompetent. The criminal attorney welcomed DRF's assistance in the goal of securing TS's release on a conditional release plan with appropriate services in place as a way of avoiding future prosecution and further time in custody. DRF staff attended TS' court hearing and met with TS' mom and TS' Public Defender prior to the hearing. The Public Defender explained that court-appointed evaluators had recommended a conditional release for TS to which the State Attorney had agreed, so this recommendation would be presented to the judge for approval during the hearing. The judge then granted conditional release.

As a result of TS' release, DRF closed this case with the issues resolved partially or completely in TS's favor due to TS' release from the County Jail and receiving appropriate and desired services on conditional release.

Objective: Investigate individual complaints regarding the violation of the right of students with significant emotional disturbance or significant mental illness to a Free and Appropriate Public Education (FAPE). Advocate for appropriate remedies as indicated.

Strategies Used: Rights-Based Individual Advocacy Services

Target Measures

Target Population:	PAIMI eligible students in public schools, alternative schools, segregated settings, and Department of Juvenile Justice detention and commitment centers.
Expected Target:	4
Expected Outcome:	4
Actual Outcome:	25
Achieved: ◉	**Not Achieved:** ○

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

As an example of a case involving advocacy on behalf of a PAIMI-eligible student to FAPE, RJ is a student with disruptive mood dysregulation disorder (DMDD), post-traumatic stress disorder (PTSD), and attention deficit hyperactivity disorder (ADHD). With the support of RJ's group home support staff, RJ contacted Disability Right Florida (DRF) for assistance with accessing their education and special education services. The DRF Investigated RJ's concerns and found that the District inappropriately changed RJ's placement to home instruction due to RJ's social-emotional and behavioral needs, which violated RJ's Least Restrictive Environment (LRE) rights and denied FAPE. In addition, the District failed to evaluate and explore all suspected needs upon RJ's transfer into the district, thereby preventing it from developing a reasonably calculated individualized education plan (IEP) for RJ.

DRF attempted to collaborate with the District to secure for RJ necessary special-education services in a brick-and-mortar school and comprehensive educational evaluations. DRF's advocacy efforts were not successful and as a result, it filed a due process complaint against the District. DRF and the District went to mediation and entered into an agreement that required the District to sponsor independent education evaluations (IEEs) and allow RJ to attend a brick-and-mortar school with 1:1 paraprofessional support. The District failed to comply with the agreement, however, resulting in a breach of contract. DRF filed a complaint in federal court to enforce the mediation agreement, and the Court ultimately entered a Consent Decree.

Through DRF's efforts, RJ returned to a brick-and-mortar school with 1:1 paraprofessional support; a tailored educational program with the necessary behavioral, academic, and transition services; language therapy; and mental health counseling. DRF also negotiated a robust compensatory education services agreement in which the district agreed to provide RJ with 183.75 hours of instruction via a specialized reading program, 140.75 hours of instruction via a specialized math program, 38 hours of Speech therapy, 76 hours of Language therapy, and 98 hours of transition services via community-based instruction. Finally, DRF negotiated for the District to pay DRF's attorney's fees and costs that it incurred as a result of having to enforce the mediation agreement in federal court.

Objective: Monitor facilities that provide residential care and treatment to adults with significant mental illness and youth with significant emotional disturbance regarding compliance with rights protections requirements per statute and rule and quality of service provided, including civil and forensic state mental health treatment facilities, psychiatric (Baker Act) receiving facilities, crisis stabilization units, psychiatric residential treatment facilities, residential treatment facilities, assisted living facilities, group homes, jails, Florida Department of Juvenile Justice detention and commitment centers, and prisons. Take further action as indicated.

Strategies Used: Monitoring

Target Measures

Target Population:	PAIMI eligible adults and youth in facilities.
Expected Target:	10
Expected Outcome:	10
Actual Outcome:	25
Achieved: (●)	**Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

In FY 2022- 2023, Disability Rights Florida (DRF) continued efforts to monitor facilities that provide residential care and treatment to adults with significant mental illness and youth with significant emotional disturbance. DRF worked on monitoring projects at a total of 25 facilities in the current fiscal year. The facilities monitored include: 10 Baker Act Receiving Facilities ; 2 Psychiatric Residential Treatment Facility; 3 State Mental Health Treatment Facilities; 3 County Jails; 2 Department of Juvenile Justice Facilities; 4 Group Homes; 1 Juvenile Incompetent to Proceed Program. Narratives for DRF's monitoring efforts by facility type are listed below.

BAKER ACT RECEIVING FACILITIES

In FY 2022 – 2023, DRF worked on monitoring projects at 10 Baker Act Receiving Facilities. In one example, DRF opened a monitoring project for one Baker Act Receiving Facility that serves up to 18 senior adults with significant mental illness and is the only Senior Baker Act unit in its area of the state. DRF selected this facility as a result of an individual service request that presented systemic concerns about the facility being non-compliant with Baker Act patient rights. DRF completed both a virtual pre-monitoring interview with facility administrators along with on-site monitoring of the facility. DRF staff interviewed facility staff, talked to residents, provided information about patient rights, and viewed all areas of the facility where residents reside and receive care and treatment. DRF also requested and reviewed records relating to facility accreditation, policies and procedures relating to patient care and treatment, staffing, and instances of restraint and seclusion.

During the course of the monitoring process, facility administrators informed DRF that they would not be renewing their certification as a Baker Act Receiving Facility through the Department of Children and Families (DCF). Their certification was scheduled to expire on July 1st. While no longer being a certified Baker Act Receiving Facility, DRF continued their standard process of communicating their recommendations for improvement to the facility administrators given that patients were still at the facility. These recommendations included concerns about patients' lack of access to outdoor recreation time, mounted telephones on the Baker Act unit, and access to activities and programs.

DRF tracked the facility's certification status and confirmed that DCF formally decertified their facility on July 1, 2023. DRF also sent a letter to

the Managing Entity with oversight of this facility with DRF's monitoring conclusions and concerns about the void left by the facility's decertification. Finally, DRF drafted an internal report on all virtual and on-site monitoring activities.

In a second example, DRF completed a monitoring that began in FY 2021-2022 of a facility that serves up to 61 adults with significant mental illness receiving evaluation and treatment under Florida's Baker Act. DRF conducted its initial monitoring via virtual interview followed by an on-site visit to the facility. During the in-person facility visit, DRF staff interviewed facility staff, talked to residents, provided information about patient rights, and viewed all areas of the facility where residents reside and receive care and treatment. DRF also requested and reviewed records relating to facility accreditation, policies and procedures relating to patient care and treatment, staffing, and instances of restraint and seclusion.

The project was carried over into FY 2022-2023 to complete follow-up with facility. In FY 2022-2023, DRF staff completed another on-site follow-up monitoring visit during which they requested additional records, reviewed previously identified areas of concern, and interviewed residents. Later in FY 2022-2023, DRF conducted an additional on-site follow-up monitoring visit to interview patients and confirm implementation of the facility's agreed upon corrective action for facility repairs and improvements. Ongoing concerns about the facility grievance process were identified during the second follow-up monitoring visit. DRF communicated these concerns to the facility along with recommended improvements to the facility grievance process. Subsequently, the facility sent DRF a new patient handbook with their updated grievance process. DRF reviewed the new grievance process and confirmed that the facility had resolved all of DRF's post-monitoring recommendations for improvement. DRF drafted internal reports on the virtual and on-site monitoring activities conducted.

In a third example, DRF's monitored of a Baker Act receiving facility that was selected due to DRF receiving calls on their inpatient mental health intake line from patients voicing complaints about abuse, neglect, and rights violations. The purpose of monitoring this facility was to identify occurrences of possible abuse/neglect related to the health and wellbeing of residents who suffer from a mental or physical disability and reside in facilities and to take appropriate action to prevent, reduce, or otherwise address these occurrences.

DRF conducted a virtual monitoring interview with facility staff and administrators followed by an on-site monitoring visit of the facility. During the monitoring, DRF staff reviewed the Baker Act Receiving Unit and the Electro-convulsive Therapy Unit. DRF staff identified that the facility lacked a formalized patient grievance process, did not have patient rights posters and required advocacy agency contact information near the patient phones, and did not provide clear details of accommodations provided for D/HOH patients in restraint. They communicated these issues in a letter to the facility administrator. Subsequently, DRF staff confirmed that the facility adequately revised their grievance policy to comply with Florida law, posted grievance instructions on the unit, posted patient rights posters next to the patient phones, and clarified that accommodations are provided for D/HOH patients in restraint.

DRF received a response from the facility that addressed the concerns identified during the initial on-site monitoring. DRF then conducted an on-site follow-up monitoring visit to interview patients and confirm implementation of the facility's written response. During the visit, DRF confirmed that the facility had complied with changes that the facility had communicated to DRF. However, DRF determined that the facility still had not fully resolved the issues related to their grievance policy. As a result, DRF communicated the ongoing grievance-related issues to the facility. DRF concluded this monitoring after confirming that the facility had amended their patient grievance process and, therefore, resolved DRF's concerns related to this matter. DRF drafted internal reports about the virtual and on-site monitoring activities.

PSYCHIATRIC RECEIVING FACILITIES

In FY 2022 – 2023, DRF worked on monitoring projects at 2 Psychiatric Residential Treatment Facilities that provide services to youth with significant emotional disturbance. In one example, Disability Rights Florida (DRF) selected a residential treatment center for children because of a report received from AHCA regarding a child who was allegedly improperly and fraudulently prescribed prescription medication at this facility prior to his transfer to another facility. During the prior FY, DRF staff investigated this individual case and determined that the alleged fraud appears to have been caused by a clerical error resulting in use of an electronic form that populated the prior doctor's signature.

During FY 2022-2023, DRF staff completed monitoring of the facility. During the monitoring, DRF staff identified three potential areas of improvement related to the facility's provision of DRF's contact information to their residents, availability of specific programs requested by residents during monitoring interviews, and staff training on appropriate interaction with residents. They communicated recommendations for changes to the identified areas of potential improvement and confirmed that the facility had implemented the recommended changes. DRF staff drafted an internal report and provided feedback and recommendations to the facility administrator.

STATE MENTAL HEALTH TREATMENT FACILITIES

In FY 2022 – 2023, DRF worked on monitoring 3 State Mental Health Treatment facilities. In one example, DRF opened a project to address nutrition issues at Florida State Hospital. This facility was selected after DRF received frequent resident complaints about a lack of food during mealtime and the absence of food options during medication administration. DRF staff conducted a targeted monitoring of Florida State Hospital that focused on food and nutrition issues. As part of the targeted monitoring, DRF staff developed nutrition-centered questionnaires

that they used during interviews with staff and residents, and requested and reviewed facility policies, procedures, and records on residents' diets and nutrition options. DRF staff communicated their recommendations for improvements to resident nutrition plans.

Subsequently, DRF received a response from the facility indicating certain key improvements based on DRF's recommendations, including the provision of additional snacks during evening hours, improvements to the tracking and delivery of food to residents, and efforts to improve the quality of food. DRF continued communications with the facility about improvements to their nutritional programs and confirmed that the facility started implementing new policies and procedures in trial phase one unit. Specifically, they added more snack options, updated policies for monitoring meal delivery times, projected renovations to the kitchen, and started research on new food items and ways to improve food quality. The facility also secured additional legislative funding to allow for facility-wide implementation of DRF's recommendations. This project will remain open while DRF monitors the implementation of the new nutrition programs and confirms that the facility has met the goals of the new program.

COUNTY JAILS

In FY 2022-2023, DRF worked on monitoring projects at 3 county jails that provide services to individuals with significant mental illness. In one example, DRF opened the project for a jail located in Florida's panhandle to monitor the jail's compliance with rights protections requirements of inmates with significant mental illness and other co-occurring disabilities per statute and rule. DRF completed both virtual and on-site monitoring activities that allowed DRF to interview jail staff and administrators, talk to detainees, and view all areas of the facility where detainees with disabilities reside and receive care and treatment. Following the monitoring, DRF made numerous recommendations to the facility, including making more areas accessible for detainees with disabilities, working towards better conditions for juvenile inmates, and, most significantly, changes to policies and procedures affecting individuals with disabilities, including individuals with mental illness. The jail made numerous changes to their policies and procedures in response to DRF's monitoring and follow-up. For the areas where they have yet to implement DRF's recommended changes, they provided detailed explanations as to issues they encountered when attempting to adopt the changes or plans to implement the changes in the future. DRF drafted internal reports about the virtual and on-site monitoring activities.

DEPARTMENT OF JUVENILE JUSTICE FACILITIES

In FY 2022-2023, DRF worked on monitoring projects at 2 Department of Juvenile Justice (DJJ) facilities that provide services to youth with significant emotional disturbance. In one example, DRF opened a project for a DJJ Detention facility to monitor compliance with rights protections of juveniles with significant emotional disturbance and other co-occurring disabilities who are detained in this 50-bed pre-trial detention center for juveniles. DRF conducted a virtual monitoring interview with facility administrators followed by an on-site monitoring visit to the facility. DRF staff interviewed facility administrators, staff, and treatment providers during the virtual and on-site monitoring visits. DRF's site visit allowed for inspection of those areas of the facility where juveniles with disabilities reside and receive care and treatment activities, including those areas devoted to mental health care. While on site, DRF also spoke with juvenile detainees about their experiences at the facility and provided information about their rights as detainees with disabilities. In addition, DRF collected and reviewed records, policies, and procedures on a variety of information, including assessment and classification of symptoms of significant mental illness upon intake to the detention center, identifying and monitoring of self-injurious and suicidal thoughts and behaviors, use of seclusion and restraint on individuals with disabilities, and assessment and classification of detainees with physical disabilities.

DRF staff drafted an internal report and made recommendations to the facility regarding a lack of accessible facilities for individuals who use wheelchairs or other mobility devices, individualized Exception Student Education (ESE) services and gaps in the curricula, and improvements needed to educated detained youth about abuse and grievance reporting procedures. DRF received and approved a response from the facility regarding their post-monitoring recommendations with outlines of planned improvements to accessibility for youth with physical disabilities, individualized ESE services, grade-level-appropriate curriculum, and the structure of the grievance policy. Subsequently, DRF followed-up with the facility and confirmed that the facility had started implementing the following improvements: 1.) put in place new policies to identify, screen, and ensure that any necessary assistive devices are provided to any youth that need them; 2.) hire a new full-time instructor for ESE students and science classes, add an additional paraprofessional full-time employee to assist in ESE work, make other changes to better document and track accommodations provided to ESE students, and provide additional training and education to all educational staff about individualized instruction for ESE students; 3.) add informational postings and additional review with youth about grievance and abuse reporting.

GROUP HOMES

In FY 2022 – 2023, DRF worked on monitoring projects at 4 Group Homes that provide services to individuals with significant mental illness. In one example, DRF opened a monitoring project for a Group Home with the primary purpose of ensuring that people with significant mental illness are living free of neglect and abuse and to monitor the implementation of the Home and Community Based Services (HCBS) Settings Rule. This project is also part of DRF's overall work towards monitoring group homes that house adults with disabilities, including those with medically complex cases to assess whether these community-based facilities allow for community integration and if the residents are at risk for institutionalization because of policy or funding. DRF completed on-site monitoring of the Group Home, which allowed DRF to interview

facility administrators and staff, view all areas of the Group Home, and interact with residents. Subsequently, DRF sent a post-monitoring follow-up letter to the Group Home owner with a summary of their monitoring efforts along with recommendations for increasing opportunities under the Settings Rule. Furthermore, DRF advised the Group Home owner to continue to work with the State to address the potential areas of concern. DRF completed this monitoring project after they confirmed that the Group Home received their post-monitoring follow-up letter.

JUVENILE INCOMPETENCY TO PROCEED PROGRAM

In FY 2022 – 2023, DRF monitored the facility that operates Florida's only Juvenile Incompetent to Proceed Program (JITP). The facility treats children and youth with significant mental illness/significant emotional disturbance who are charged with a delinquent act and require competency restoration services. DRF selected this facility to continue its efforts in monitoring the facility's compliance with rights protections requirements per statute and rule while also providing rights training and education to the facility's patients and staff.

DRF completed its virtual pre-monitoring interview with facility staff along with their on-site monitoring of the facility. DRF then communicated its recommendations for improvement to the facility administrators, including their concerns about cleanliness and physical conditions of the facility and food quality. This project remains open while DRF awaits the facility's response to their post-monitoring recommendations for improvement. DRF drafted an internal report about its findings to date.

ONGOING FOLLOW-UP MONITORING FROM FY 2021-2022

In FY 2022-2023, Disability Rights Florida (DRF) also continued work on monitoring projects that were carried over from the previous FY. This work includes post-monitoring follow-up, such as preparing and communicating post-monitoring reports to the facility administrator, waiting for facilities to respond to DRF's recommendations for improvement, confirming that facilities have implemented DRF's recommendations, or awaiting final approval of project closure. Examples of these monitoring efforts are outlined below.

In the first example, Disability Rights Florida (DRF) conducted on-site monitoring activities at three State Mental Health Treatment Facilities (SMHTFs) with an expert nurse reviewer and a Licensed Clinical Social Worker as part of an ongoing project to monitor Florida's SMHTFs. The three SMHTFs monitored were Florida State Hospital (FSH), Northeast Florida State Hospital (NEFSH), and South Florida State Hospital (SFSH), with a total licensed bed capacity of 2455. FSH and NEFSH are publicly operated by the state, while SFSH is operated by a state-contracted provider (Wellpath Care), but all three provide treatment to patients committed civilly under Florida's Baker Act. The focus of the monitoring efforts at these three SMHTFs was to identify barriers to discharge planning. DRF received extensive documentation pertaining to discharge planning practices and procedures and individual client records from consenting residents that DRF identified as potentially facing barriers to discharge while in the hospital.

DRF worked with the expert nurse reviewer and Licensed Clinical Social Worker to complete a report related to the goals of this project. DRF delivered the report to the DCF Hospital Administrator, along with the administration at the three facilities, with a request to implement targeted strategies by DCF and other stakeholders to remove barriers to discharge and finding appropriate placements for individuals that have been at these institutions the longest. As a result, DRF completed this monitoring project in FY 2022 – 2023 and transitioned to a systemic advocacy project to oversee implementation of the recommendations at the institutions.

In a second example, DRF opened the Monitoring Project of Developmental Disabilities Defendant Program (DDDP) in FY 2019-2020 to monitor the facility and investigate any deficiencies, rights violations, potential abuse and neglect, and any threats to the health, safety and welfare of residents at DDDP. DDDP is a 146-bed secure facility located on the grounds of Florida State Hospital in Chattahoochee. DDDP provides competency training and testing for persons with intellectual/developmental disabilities alleged to have committed a felony and who have been court ordered into the facility. In addition to housing forensic clients, DDDP also operates a civil commitment program for individuals who are not charged with a crime but have been adjudicated as requiring the security provided in a forensic facility. DRF's monitoring activities to date have determined that most of the residents have significant mental illness co-occurring with intellectual/developmental disabilities, and those residents with significant mental illness are more likely to be subject to abuse or neglect or other rights violations occurring at this facility.

During DRF's prior monitoring activities during FY 2019-2020, DRF staff conducted a monitoring of the facility and, at the conclusion of the visit, new facility administrators were in place and agreed to work on recommended improvements. Due to the ongoing COVID-19 pandemic, however, in-person monitoring at the facility was placed on hold until the current FY to identify any improvements in the areas initially identified in DRF's previous monitoring activities.

In FY 2022-2023, DRF completed virtual and on-site monitoring visits with the facility. After the monitoring, DRF reviewed all available facility policies and procedures, requested additional records, and communicated improvement for short-term and long-term concerns that DRF identified during the monitoring. Subsequently, DRF received responses to their previously submitted post-monitoring recommendations for

short-term and long-term improvements. After reviewing the facility's response, DRF still had remaining concerns about the adequacy of competency restoration services, lack of other programming, classes, and therapeutic activities, and heavy usage of seclusion and restraint due to personnel shortages and institutional culture – especially among those residents with significant mental illness. To address these, DRF will continue to monitor the facility and review abuse reports from the facility throughout the remainder of this FY and into the FY 2023 – 2024.

In a third example, DRF monitored a County Jail system FY 2021 - 2022. The primary purpose of the monitoring project was to assess the facility's policies, procedures, and practices of screening, assessing, and treating individuals with significant mental illness, intellectual/developmental disabilities, and/or physical disabilities. DRF conducted this monitoring via virtual monitoring interview followed by an on-site monitoring visit to the facility. DRF interviewed facility administrators, staff, and treatment providers during both monitoring visits. While on site, DRF also spoke with detainees about their experiences and provided information about their rights. DRF's site visit allowed for inspection of those areas of the facility where individuals with disabilities reside and receive care and treatment activities. In addition, DRF collected and reviewed records, policies, and procedures on a variety of information, including assessment and classification of symptoms of serious mental illness upon intake to the jail, identifying and monitoring of self-injurious and suicidal thoughts and behaviors, use of seclusion and restraint on individuals with disabilities, and assessment and classification of detainees with physical disabilities.

DRF engaged a consulting expert on care of inmates with disabilities to assist in identifying and communicating recommendations for improvements to policies, procedures, and practices at the jail. Based on DRF's recommendations, the jail is currently undergoing revisions to several policies and procedures regarding care of inmates with disabilities, which DRF will continue to monitor through completion. The jail has also initiated an investigation into an allegation of abuse of an individual with significant mental illness that DRF identified during the monitoring, which DRF is also investigating. DRF drafted internal reports on its virtual and on-site monitoring activities.

In FY 2022-2023, DRF followed up with the jail to confirm the implementation of the agreed-upon recommendations and the conclusion of the abuse investigation related to an individual with significant mental illness. The results of DRF's monitoring efforts include revision of jail policies related to the use of forced cell extractions in a correctional setting, retraining of all staff on policy revisions, retraining of all staff in crisis intervention with a focus on inmates with significant mental illnesses. In regard to the jail's abuse investigation, DRF confirmed that the jail took appropriate corrective action. As a result, DRF closed this project in FY 2022 - 2023.

In a fourth example, DRF monitored another County Jail facility, an 840-bed county jail located in FY 2021 - 2022. The purpose of this monitoring was to assess the facility's policies, procedures, and practices of screening, assessing, and treating individuals with disabilities, including those with significant mental illness. DRF staff conducted this monitoring via virtual monitoring interview followed by an on-site monitoring visit to the facility. DRF interviewed facility administrators, staff, and treatment providers during both monitoring visits. DRF's site visit allowed for inspection of those areas of the facility where individuals with disabilities reside and receive care and treatment activities, including those areas devoted to mental health care. While on site, DRF also spoke with detainees about their experiences and provided information about their rights. In addition, DRF collected and reviewed records, policies, and procedures on a variety of information, including assessment and classification of symptoms of serious mental illness upon intake to the jail, identifying and monitoring of self-injurious and suicidal thoughts and behaviors, use of seclusion and restraint on individuals with disabilities, and assessment and classification of detainees with physical disabilities.

Based on concerns identified during the monitoring regarding mental health staffing numbers, DRF requested additional information from the jail on anticipated efforts to improve staffing levels, which DRF continued to monitor and take further action on throughout FY 2022-2023.

In FY 2022 - 2023, DRF continued to communicate with the Chief of the County Jail about their efforts to improve their mental health staffing levels. The Corrections Chief confirmed that, while they have made attempts to improve recruitment and hiring by implementing a salary compensation study and employing permanent and temp staff agencies, they have not succeeded in significantly improving their staff levels, noting that a general community shortage of mental health counselors is contributing to staffing shortages at their facility, as well as other health agencies in their area. The Chief confirmed that they continue to receive assistance from qualified staffing agencies. DRF determined that, while unsuccessful, the jail has made sufficient attempts to address DRF's post-monitoring recommendations. As a result, DRF closed this project successfully in FY 2022 - 2023.

In a fifth example, in FY 2021-2022, DRF monitored a secure, residential high risk treatment facility operated by the Department of Juvenile Justice (DJJ). This project originated in FY 2019-2020, but due to the COVID-19 pandemic, DRF was unable to conduct on-site monitoring and continued this project until on-site monitoring was possible in FY 2021-2022. This facility serves youth committed to DJJ after adjudication. The facility has a capacity of 78 youth, but the census at the time of monitoring was 47, 100% of which had a significant emotional disturbance or significant mental illness and/or a substance abuse disorder.

At the time of DRF's monitoring activities, the facility was operated by a private provider that contracted with the DJJ. In the previous FY, DRF conducted an initial virtual interview with administrators and treatment providers as well as an on-site monitoring visit, which allowed DRF to view all areas of the facility where youth reside and receive services. DRF drafted an internal report and provided feedback and recommendations for improvement to the Facility Administrator. DRF intended to monitor the response from the facility in FY 2021-2022.

In Q1 of FY 2022-2023, however, DRF received information that the facility was going to be closed and re-opened by a new operator after DRF provided written feedback and their post-monitoring recommendations for improvement to the facility. DRF continued to track the status of the facility and, in Q1 of FY 2022-2023, confirmed that the facility had closed and would reopen at a later date. As a result, DRF closed this project in FY 2022 – 2023. In the future, DRF may open a new project to monitor the facility under its new service provider.

Objective: Monitor and enforce implementation of court-ordered settlement agreement regarding the systemic lack of care and treatment being provided to inmates with significant mental illness in inpatient mental health units throughout the Florida Department of Corrections. Take further action as indicated.

Strategies Used: Collaboration,Systemic Litigation,Monitoring

Target Measures

Target Population:	PAIMI eligible adults in the inpatient mental health units of the Florida Department of Corrections.
Expected Target:	1
Expected Outcome:	1
Actual Outcome:	1
Achieved: (●) **Not Achieved:** ( )	

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

This priority involves monitoring of a settlement agreement in a lawsuit filed by Disability Rights Florida (DRF) against the Florida Department of Corrections (FDC) alleging that the FDC failed to provide constitutionally adequate mental health care to inmates with significant mental illness housed in prison inpatient mental health units (MHUs) across the state. (See Disability Rights Florida v. Jones and the Florida Department of Corrections (FDC), 3:18-cv-179-J-20JRK, M.D. Fla.) The original settlement agreement was adopted as an order of the court in FY 2018. The settlement agreement appointed a monitoring team (the Correctional Medical Authority or CMA) to review the MHUs using established criteria and monitoring instruments to determine whether FDC was complying with the terms of the agreement over two periods of compliance monitoring.

The first settlement monitoring occurred in FY 2018-2019. It revealed several areas in which the FDC was significantly non-compliant with many terms of the agreement. DRF and the FDC agreed upon corrective action to occur during the second compliance monitoring period, but implementation of the corrective action and continuation of the compliance monitoring were interrupted by the COVID-19 pandemic in March of 2020. DRF negotiated an agreement with the FDC to extend jurisdiction of the agreement until July of 2022 to allow the FDC time to implement correction action measures and for the independent monitors to complete the second period of compliance monitoring.

The second monitoring period was completed during FY 2021-2022 and revealed multiple significant and ongoing deficiencies in the FDC's compliance at six of the eight MHUs. As a result, DRF and co-counsel prepared to file a motion for contempt regarding the FDC's continued non-compliance with the settlement agreement. However, after multiple negotiations and a court hearing, the parties ultimately agreed to extend jurisdiction for two additional years (until July 1, 2024) to provide FDC additional time to come into compliance and to allow the CMA to conduct a third round of limited settlement monitoring at the six non-compliant institutions, with the independent monitors to verify compliance.

During FY 2022-2023, the Florida Department of Corrections (FDC) continued corrective action efforts to bring its six non-compliant institutions into compliance with the terms of the settlement agreement. The CMA monitored four of the six institutions and issued reports indicating compliance with the terms of the settlement agreement at issue during the third round of monitoring. The two remaining institutions that require a third round of compliance monitoring are scheduled to occur during FY 2023-2024.

Objective: Improve protections and/or outcomes related to abuse, neglect, and/or rights protections of individuals with significant mental illness or significant emotional disturbance by analyzing relevant bills, rules, policies, procedures, and practices that affect PAIMI eligible individuals. Take further action as indicated.

Strategies Used: Educating Policy Makers

Target Measures

Target Population:	PAIMI eligible adults and youth in facilities and receiving community-based care and treatment.
Expected Target:	4
Expected Outcome:	4
Actual Outcome:	4
Achieved: (●)	**Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

During FY 2022-2023, the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR) posted a Notice of Proposed Rulemaking on "Nondiscrimination in Health Programs and Activities" under Section 1557 of the Affordable Care Act. Disability Rights Florida (DRF) collaborated with its national partners at the National Disability Rights Network and NHelp and submitted comments in support of the proposed rule because it clarifies and strengthens nondiscrimination protections for people with disabilities and other populations that have experienced discrimination and barriers to receiving equally effective healthcare.

One area of the new rule specifically supported by DRF is the portion extending Section 1557's protections to HHS's non-health programs and activities that support social and economic well-being in children, families, and older adults, emergency and disaster preparation, public health, health and policy research, regulation of food and medical devices, disease control, and many aspects of administrative and legislative coordination. This part of the proposed rule is related to DRF's PAIMI program activities, as this would extend Section 1557's protections to agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), which oversees DRF's use of PAIMI program funds. Although not directly involved in delivering or funding health care, entities like SAMHSA set the framework and priorities for federally funded and conducted health care activities.

DRF also engaged in tracking and analyzing several bills related to abuse, neglect, and/or rights protections of individuals with significant mental illness or significant emotional disturbance during Florida's 2023 legislative session. One of those bills passed by the Florida Legislature and signed into law by the Governor is SB 508 (Problem Solving Courts, Ch. 2023-191, Laws of Florida). SB 508 revised the requirements for treatment-based drug court and mental health court programs to afford more people the opportunity to participate by: (1) eliminating the restriction that people who have previously rejected opportunities to participate cannot participate in the future, and (2) no longer barring people convicted of certain felonies from participation. SB 508 also gave courts more discretion to determine how long a defendant, based upon his or her clinical needs, must remain in a program.

Another example is HB 829 (Operation and Administration of the Baker Act, Ch. 2023-198, Laws of Florida), which requires DCF to annually update the Baker Act handbook and to maintain a FAQ repository. Section 394.457, F.S., already requires the Department of Children and Families (DCF) to publish and distribute an information handbook to facilitate understanding of the Baker Act but the handbook has not been updated for about 10 years despite multiple legislative revisions to the Baker Act during those years. This legislation will ensure that providers, patients and the public have a comprehensive, current Baker Act handbook.

As a final example, HB 1349 (Mental Health Treatment, Ch. 2023-270, Laws of Florida), authorizes DCF to issue a conditional designation for Baker Act receiving and treatment facilities for up to 60 days as an alternative to suspension or withdrawal of a non-conditional designation. A conditional designation will allow facilities to address inspection and minor compliance issues without having to suspend services or reapply for a designation. It also revises the statutory procedures for criminal defendants found incompetent to proceed by (1) Requiring expert evaluators and the courts to consider alternative treatment options before ordering a defendant into a treatment facility, including community-based mental health treatment services, rehabilitative services, support services, and case management services including those provided on an outpatient basis or within conditional release or supportive employment and housing services; (2) requiring sheriffs to either administer or permit DCF to administer psychotropic medication to forensic clients held in jail awaiting admission to a state mental health treatment facility; (3) reducing various timeframes for the mental health treatment facility and the court to take action when a defendant has regained competency or no longer meets the criteria for involuntary commitment; and (4) requiring the forensic treatment facility to transfer the defendant back to the committing jurisdiction with up to 30 days of medication and to assist in discharge planning with medical teams at the receiving jail.

Objective: Investigate the impact of legislative changes made in 2022 knowns as the "School Safe Laws" (SB 7026 and SB 7030) that created a threat assessment process and changes to the rules on restraint and seclusion of school-aged youth. These legislative changes are likely to disproportionately impact students with significant emotional disturbance (SED) or significant mental illness (SMI),

resulting in the denial of a Free and Appropriate Public Education and other federal due process rights and procedural safeguards. This investigation will include a review of school districts' plans to provide mental health services and providers and eliminate seclusion and limit restraints. This investigation will be used to identify and analyze trends of inappropriate use of Baker Acts as a behavioral intervention tool, the overuse of suspensions and expulsions of students with SED/SMI, and schools' inappropriate use of the threat assessment process to remove students from schools which eventually leads to the student to prison pipeline. Appropriate action will be taken on behalf of students with SED/SMI based on the findings of this investigation.

Strategies Used: Other Systemic Advocacy

Target Measures

Target Population:	PAIMI-eligible students in public schools, alternative schools, segregated settings, and Department of Juvenile Justice detention and commitment centers.
Expected Target:	1
Expected Outcome:	1
Actual Outcome:	1
Achieved: (●)	**Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

During FY 2021-2022, Disability Rights Florida (DRF) submitted public records requests to all of Florida's school districts for information about incidents involving the seclusion and restraint of students—including restraint used for the stated purpose of crisis prevention and intervention procedures—that occurred during the FY 2018-2019 and FY 2019-2020 school years. The purpose of these requests was to compile demographic information regarding the students who were subject to seclusion and restraint, the type of seclusion or restraint procedure used, the type of holds used during restraints, the duration of the restraints, the reasons for the restraints, and any injuries resulting from the restraint of students with significant mental illness/emotional disturbance.

DRF's ongoing investigation of these issues includes collaborating with the Southern Poverty Law Center, the National Center for Youth Law and other Florida legal aid and children's rights organizations, which led to the filing of a lawsuit against the Palm Beach County School District for its improper use of the Baker Act on students with disabilities. (See D.P. et al. vs. School Board of Palm Beach County, p:21cv81099, S.D. Fla.) DRF's progress on this lawsuit against the Palm Beach County School District is reported separately in the next objective.

During FY 2022-2023, DRF continued investigating this issue on a systemic level in other parts of the state by continuing to analyze the data received from the school districts. As a result, this project will remain open through FY 2023-2024.

Objective: Systemic advocacy through litigation to stop the inappropriate use of school resource officers in the arrest, initiation of involuntary examinations under the Baker Act, suspension and expulsion, and restraint and seclusion of students with significant emotional disturbance or significant mental illness. DRF is co-counsel and an organizational plaintiff in a case filed by several civil rights organizations and private counsel on behalf of parents of minor school children and two organizational plaintiffs against the Palm Beach County School District, school officials, the School Board police force, and individual members of the police asserting various constitutional, ADA, and Rehabilitation Act claims for unlawful restraint and confinement of school children removed from school for involuntary mental health exams pursuant to the Baker Act.

Strategies Used: Systemic Litigation

Target Measures

Target Population:	PAIMI eligible students in Palm Beach County public schools and alternative schools.
Expected Target:	1
Expected Outcome:	1
Actual Outcome:	1
Achieved: (●)	**Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

In the case of D.P. et al., Disability Rights Florida, Florida State Conference of the National Association for the Advancement of Colored People v. School Board of Palm Beach County et al. (Case No. 9:21-cv-81099, filed in the Southern District of Florida, West Palm Beach Division), Disability Rights Florida (DRF), the Florida State Conference of the NAACP, and a group of Palm Beach County parents and students sued the School Board of Palm Beach County and its officials and employees for illegally initiating involuntary psychiatric examinations on students. DRF partners in the subject litigation are Southern Poverty Law Center, National Center for Youth Law, and the law firm of King & Spalding.

The student plaintiffs in this case were taken from their classrooms and transported—handcuffed and placed in the back of police cars—to Baker Act receiving facilities, where they waited hours or days for a psychiatric evaluation to be completed. The lawsuit described how police by the School District of Palm Beach County illegally use the Florida Mental Health Act, also known as the Baker Act, to subject hundreds of students each year to involuntary psychiatric evaluation and treatment. The officers transported these children, some as young as five years old, to psychiatric facilities without their parents' input or consent and, sometimes, over their objections. Records showed that district officers knowingly use the Baker Act on children whose behavior was due to autism, even though the law does not permit psychiatric evaluation and treatment on this basis. They also failed to consult mental health resources—including mobile crisis teams and the children's own therapists—prior to initiating an involuntary evaluation. The lawsuit alleged that these actions violated the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Florida Educational Equity Act, as well as parents' and students' rights under the Fourth and Fourteenth Amendments.

Litigation in this case concluded during FY 2022-2023 after all individual plaintiffs accepted Offers of Judgment. Based on the resolution of all individual claims filed in this case, the presiding judge heard arguments from plaintiffs' counsel on whether DRF as a named plaintiff in the suit had standing to pursue the remaining claims for injunctive relief. The court later entered an order dismissing the remaining claims by plaintiff DRF for lack of jurisdiction and closed the case.

Objective: Investigate individual complaints regarding housing discrimination occurring against youth with significant emotional disturbance (SED) or adults with significant mental illness (SMI) for reasons related to their SED/SMI diagnosis. Advocate for appropriate remedies as indicated.

Strategies Used: Rights-Based Individual Advocacy Services

Target Measures

Target Population:	PAIMI eligible individuals residing in community-based facilities or their own homes.
Expected Target:	2
Expected Outcome:	2
Actual Outcome:	2
Achieved: (●) **Not Achieved:** ( )	

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

In FY 2022-2023, Disability Rights Florida (DRF) continued to work to investigate housing discrimination complaints against individuals with significant mental illness or significant emotional disturbance. In one example involving housing discrimination of a PAIMI-eligible client, SP contacted DRF after losing their housing assistance due to non-use after an eviction was filed by private landlord. SP is an adult diagnosed with significant mental illness with a co-occurring physical disability whose lease was terminated at a prior apartment after SP threatened management staff. SP's Shelter Plus Care housing assistance was not terminated at that time and SP was asked to move with that assistance but did not do so within the required timeframes and the assistance expired. DRF assisted SP by requesting and reviewing medical records that showed SP had received involuntary evaluation and treatment under Florida's Baker Act near the time they lost their housing. DRF used that information to request a reasonable accommodation for the reinstatement of SP's housing assistance because it was lost as the result of SP's mental health disabilities. Unfortunately, SP demonstrated both an inability to interact in a non-threatening manner with key individuals who were attempting to secure the needed housing assistance, as well as an unwillingness to engage in therapeutic interventions to improve negative behaviors related to significant mental illness. DRF was therefore unable to negotiate a reinstatement of SP's housing assistance prior to case closure and closed this case because SP was uncooperative and repeatedly threatened DRF's staff.

In a second example, JN contacted DRF for assistance with investigating possible disability-related housing discrimination occurring based on the failure of their county's housing staff and managing entity of mental health services to provide a housing certificate or voucher. JN was a returning client and an individual with significant mental illness who was homeless at the time of intake.

DRF investigated JN's concerns by interviewing JN extensively, attending a case staffing with housing and managing entity staff members, and discussing JN's housing needs and other concerns with the county's housing support specialist. DRF advocated for JN to receive a supported housing certificate, which was the only remaining option for housing assistance based on prior behavioral issues that had resulted in eviction and loss of financial housing assistance. This was done in conjunction with advocacy to successfully enroll JN in wrap-around services to address mental health, physical health, and case management needs. DRF also researched and reviewed trespass and no contact orders issued in JN's county to ensure JN was not in violation of any orders based on staying in certain areas while waiting for housing or in obtaining supported housing. Finally, DRF supported JN by helping communicate needs associated with getting their belongings from a prior residence moved and stored until permanent housing could be located.

At case closure, JN was successfully placed on the waiting list for permanent supported housing and will receive a supportive housing certificate once one becomes available. JN had also successfully secured assistance with the homeless Task Force to get their belongings moved and stored pending permanent housing. This case was therefore closed successfully.

Priority/Goal Description: INCREASE PUBLIC AWARENESS OF DISABILITY RIGHTS FLORIDA'S PAIMI PROGRAM WORK AND EDUCATE INDIVIDUALS WITH SIGNIFICANT MENTAL ILLNESS/SIGNIFICANT EMOTIONAL DISTURBANCE, THEIR FAMILIES, AND SUPPORTERS ABOUT THEIR RIGHTS.

Objective: Provide callers to Disability Rights Florida who are individuals with significant mental illness or significant emotional disturbance, or who are seeking to assist someone with significant mental illness or significant emotional disturbance, with direct access to intake specialists trained to provide prompt information, external referral, or internal referral.

Strategies Used: Rights-Based Individual Advocacy Services

Target Measures

Target Population:	PAIMI eligible individuals, their families, and supporters.
Expected Target:	1000
Expected Outcome:	1000
Actual Outcome:	1568
Achieved:	**Not Achieved:**

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

Disability Rights Florida's (DRF) intake staff members are trained to accept requests for service and provide information and referral services to PAIMI-eligible individuals. DRF maintains a specialized intake line for callers from civil and forensic state mental health treatment facilities, Baker Act receiving facilities, and other inpatient forensic facilities. This line is administered and staffed daily by DRF staff who are specially trained in receiving calls from individuals with mental illness, interfacing with institutional facilities, and addressing concerns that arise in institutional settings. DRF also dedicates staff to receiving and responding to mail from individuals residing in correctional settings, including PAIMI-eligible individuals, to provide information and referral services or follow-up on requests for service. Additionally, DRF's Frontline Intake and Referral Service (FIRST) staff members receive and process calls and written intakes (online and via fax) from individuals – including PAIMI-eligible individuals – that reside in various community-based facilities (e.g. Assisted Living Facilities, group homes and nursing homes) inquiring about information and referral services or requesting service.

Objective: Provide quality outreach services to adults with significant mental illness and youth with significant emotional disturbance who are members of underserved populations, as well as their families and supporters.

Strategies Used: Training/Outreach

Target Measures

Target Population:	PAIMI eligible individuals who are members of underserved populations, including cultural, ethnic, and racial minorities, and their families and supporters.
Expected Target:	2
Expected Outcome:	2
Actual Outcome:	39

Achieved: (●) **Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

During FY 2022-2023, Disability Rights Florida (DRF) provided 39 separate outreach events to underserved populations, including older adults, Veterans/active military personnel, individuals who identify as members who identify as identify as members of gender and orientation diverse populations, racial/ethnic minorities - including individuals who speak Spanish as their primary language, and individuals who reside in areas of the state that are underserved by DRF, individuals who reside in rural areas, and individuals who are economically disadvantaged. DRF provided outreach in a variety of ways, including live and virtual presentations in English and Spanish, tabling events, and distribution of DRF materials.

Objective: Provide public awareness activities to include newsletters, podcasts, social media postings, website services, and general distribution of agency brochures.

Strategies Used: Training/Outreach

Target Measures

Target Population: PAIMI eligible individuals, their families, and supporters.

Expected Target: 60

Expected Outcome: 60

Actual Outcome: 207

Achieved: ( ) **Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

Disability Rights Florida (DRF) provided 207 public awareness activities that include E-Newsletters, social media posts on 9 social media platforms, the DRF website, the distribution of DRF brochures and public planning surveys, and news articles about DRF's work or authored by DRF staff. The content focused on resources, rights, and information on a variety of disability topics that are relevant to individuals with significant mental illness/significant emotional disturbance, their families, and their supporters.

Objective: Advocate for the increased use of Supported Decision Making (SDM) through education of state policy makers, school districts, the judiciary, and attorneys on SDM as an effective and less restrictive alternative to guardianship for individuals with significant mental illness and significant emotional disturbance. This objective is particularly important for PAIMI eligible youth transitioning from secondary school into adulthood.

Strategies Used: Collaboration,Educating Policy Makers,Training/Outreach

Target Measures

Target Population: PAIMI eligible individuals, their families, supporters, policy makers, and legal professionals.

Expected Target: 1

Expected Outcome: 1

Actual Outcome: 4

Achieved: (●) **Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

In FY 2022 – 2023 Disability Rights Florida (DRF) staff continued to advocate for the use of Supported Decision Making (SDM) as an effective and less restrictive alternative to guardianship for individuals with significant mental illness and significant emotional disturbance. DRF accomplished this by: 1) conducting training and education programs on the importance and use of SDM agreements; and 2) continuing education of policymakers on the need for formal legal recognition of SDM as an alternative to guardianship.

DRF staff provided training and education to individuals with significant mental illness/emotional disturbance, family members, lawyers, and judges on the appropriate use of SDM as an alternative to guardianship. First, DRF staff provided an SDM training at the 2023 Family Café event—the largest single gathering of individuals with disabilities, self-advocates and family members in the state with an attendance of more than 12,000 individuals. Second, DRF attorneys provided training on SDM to attorneys in State legal aid programs, law school clinics, and continuing legal education programs sponsored by the Florida Bar. Third, DRF attorneys educated state guardians through a presentation on SDM at the annual conference of the Florida State Guardianship Association.

In addition, DRF provided 6 trainings that were funded under DRF's CAP grant and for that reason are not otherwise reported on in this PPR. These trainings bear mention, however, because they were to transition-aged youth – including those with significant mental illness/emotional disturbance – and provided content on the use of SDM to support them in their transition into adulthood.

In regard to SDM-related legislative work, although there was no SDM bill filed during the 2023 Florida legislative session, DRF Public Policy staff continued to advocate for the eventual passage of a SDM bill by collaborating with self-advocacy organizations to develop support for passage of the bill in the 2024 legislative session. DRF staff also met with representatives of the Elder Law Section and Real Property and Probate Sections of the Florida bar on multiple occasions to provide education and address misconceptions about SDM as an alternative to guardianship. These sections are highly influential with key members of the Florida legislature and gaining their support is key to eventual passage of a SDM law. DRF public policy staff also met with key legislators who intend to introduce SDM legislation in the upcoming 2024 legislative session. Moreover, DRF met with representatives from the Florida State Guardianship Association to develop support for passage of a SDM bill in 2024. Finally, DRF continued its work with the Working Interdisciplinary Network of Guardianship Stakeholders (WINGS) of Stetson University Law School to educate and develop support for the passage of a bill formally recognizing SDM as an alternative to guardianship.

Objective: Conduct training events to educate adults with significant mental illness, youth with significant emotional disturbance, and facility staff regarding patient rights in facilities. Take further action as indicated.

Strategies Used: Training/Outreach

Target Measures

Target Population:	PAIMI eligible individuals and their supporters.
Expected Target:	4
Expected Outcome:	4
Actual Outcome:	25
Achieved:	**Not Achieved:**

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

In FY 2022-2023, Disability Rights Florida (DRF) conducted a total of 25 education and training events about rights to PAIMI-eligible individuals that focused on patient rights in facilities, as well as individual rights when accessing mental health care and related services in facilities and the community. These included training events at Baker Act Receiving Facilities, state mental health treatment centers, Drop-in Centers, and Clubhouses. Over the course of the fiscal year, 745 PAIMI-eligible individuals received education and training about their rights in facilities and in a variety of community settings. At these training and education events, DRF staff provided information about DRF (including P&A history and authority, grants, access authority, DRF history and current teams makeup), DRF services (including how to receive DRF services via FIRST and the Mental Health (Inpatient) Intake Line), information about the PAIMI grant and the PAIMI Advisory Council, and information about rights of persons with disabilities for individuals in inpatient settings and in the community. DRF staff also gathered information from participants about their needs, the needs of the mental health community, and how DRF may be able to support them. DRF informational materials—including DRF's "Supporting Individuals with Significant Mental Health Conditions" and our PAIMI Mental Health Resources Guide—were provided in English, Spanish and Haitian-Creole.

As an example of a rights and self-advocacy training to PAIMI-eligible individuals in an inpatient treatment setting, DRF staff conducted a two-day rights training to all residents of South Florida State Hospital, a state mental health treatment facility. During those two days, DRF staff provided 12 total trainings to small groups of residents, reaching 202 adults with significant mental illness persons. DRF staff provided information on the history and description of DRF, PAIMI grant, DRF advocacy work, self-advocacy, mental health rights training, and DRF's MH line. "Supporting Individuals with Significant Mental Health Conditions" brochures were provided during each rights training sessions. After each small group training, DRF staff also met individually with residents who required assistance completing a request for service. At the conclusion of the training, the training team provided "Supporting Individuals with Significant Mental Health Conditions" brochures and DRF's mental health facility posters were provided to the facility's Community Liaison in English, Spanish and Creole for placement on each unit.

As an example of rights and self-advocacy training to PAIMI-eligible individuals in a community-based setting, DRF provided trainings and self-advocacy training to adults that attend A.M.I.G.O.S. Drop-In Center for adults with significant mental illness, which operates in an underserved area of the state. DRF staff trained six groups of Drop-In Center members on three separate dates several months apart, during which a total of 119 members received training. During the course of these trainings, DRF provided information about DRF (including P&A history and authority, grants, access authority, DRF history and current teams makeup), DRF services (including how to receive DRF services via FIRST and our Institutional Intake Line), information about the PAIMI grant and the PAIMI Advisory Council, rights training of persons with disabilities for individuals in inpatient settings and in the community, and self-advocacy training. In addition, at one training, DRF also provided information on hurricane preparedness including the Florida Department of Emergency Management's supply kit checklist and information about what to expect in a hurricane shelter, special needs shelters, how to locate shelters, SA/ESA/pets, making a plan that includes disability-related planning such as having medications and needed medical supplies, and the state assistance information line.

0930-0169 Approved: 07/27/2023 Expires: 07/31/2026

Footnotes:

Advisory Council Report

Advisory Council Report

Advisory Council Report (ACR)

The Advisory Council Report (ACR) section of the annual PAIMI Program Performance Report, to the Secretary of the U.S. Department of Health and Human Services, **is due by January 1**. The ACR is mandated under the PAIMI Act at 42 U.S.C. 10805 (a) (7). The ACR is the PAIMI Advisory's Council's (PAC) **independent assessment** of their protection and advocacy system's for the previous fiscal year. **The ACR must be prepared by the PAC and signed and dated by the PAC Chairperson.**

Please use the box below to indicate areas of technical assistance needed related to this section.

0930-0169 Approved: 07/27/2023 Expires: 07/31/2026

Footnotes:

OMB Approval: 0930-0169
Expiration Date: 07/31/2026

THE ADVISORY COUNCIL REPORT (ACR) SECTION OF THE ANNUAL PAIMI PROGRAM PERFORMANCE REPORT (PPR)

STATE Florida	FISCAL YEAR 2022-2023

The Advisory Council Report (ACR) section of the annual PAIMI Program Performance Report, to the Secretary of the U.S. Department of Health and Human Services, **is due by January 1**. The ACR is mandated under the PAIMI Act at 42 U.S.C. 10805 (a) (7). The ACR is the PAIMI Advisory's Council's (PAC) **independent assessment** of their protection and advocacy systems for the previous fiscal year. **The ACR must be prepared by the PAC and signed and dated by the PAC Chairperson.**

For ACR assistance, please contact the PAIMI Program Coordinator.

Please read and follow the instructions in each section and use the attached glossary in to complete the form.

The ACR Section of the ANNUAL PAIMI PPR

TABLE of CONTENTS

The ACR Section of the Annual PAIMI PPR	
SECTION A. GENERAL INFORMATION	
Fiscal Year:	2022-2023
State:	Florida
Name of P&A system:	Disability Rights Florida
PAC Report Prepared By: Provide the name [Print First, Middle and Last Name] Title of the Preparer: Phone Number:	Aleya Marie Siegel PAC Chair [redacted]
Name of PAC Chair: [Print First, Middle and Last Name] Provide updated contact information if the PAC Chair is different than the person listed on the most recent PAIMI Application.	Aleya Siegel
Telephone Number:	[redacted]
E- Mail Address:	[redacted]
Date Submitted:	11/30/2023
By signing this document, the Chair certifies that this report reflects the consensus of the PAC members.	aleya M Siegel

SECTION B. The PAIMI ADVISORY COUNCIL (PAC)	
*Under Primary ID, select *ONLY ONE* (1) primary identity for each PAC member position **[B.1.b. - B.1.h.] that** is mandated per the PAIMI Act & Rules).	**Primary Identification**
B.1.a. The TOTAL number of seats on the PAC.	**Total**
B.1.b. Individuals who are recipients/former recipients (R/FR) of mental health services.	3
B.1.c. Family members of individuals who are recipients/former recipients (R/FR) of mental health services.	3
At least one (1) PAC member shall be a B.1.d.	
B.1.d. Family members of a minor child or youth (under 18 years old) who has received or is receiving mental health services.	1
B.1.e. Mental health service providers	1
B.1.f. Mental health professionals:	

B.1.f.1. Social Workers	
B.1.f.2. Psychologists	1
B.1.f.3. Psychiatric Nurses	
B.1.f.4. Psychiatrists	
B.1.f.5. Psychiatric Nurse Practitioners	
B.1.f.5. Peer Support Specialists	1
B.1.g. Attorneys.	
B.1.h. Individuals from the public knowledgeable about mental illness.	1
B.1.i. Others (please identify by position held).	
B.1.j. Vacancies as of 9/30. [identify each vacant position & the date it was vacated].	1 (Attorney, 9/21/23)
B.1.k. TOTAL number of PAC members serving on 9/30.	**Total 11**
B.1.l. Number of PAC members who are either R/FR of MH services or family members of these individuals (count each PAC member only once).	7
B.1.m. Percentage of PAC members who are either R/FR of MH services or family members of these individuals [B.1. k. divided by B.1.l.]	63 %

B. 2. REPRESENTATION OF THE PAC CHAIRPERSON		
B.2. Is the PAC Chair an individual who has received or is receiving mental health services, or a family member of an individual who has received or is receiving mental health services?	**Yes** **X**	**No**

B. 3. PAC TERMS of Appointment	
B.3.a. Term of Appointment (number of years)	4
B.3.b. Maximum Number of Terms a Member May Serve	1
B.3.c. Frequency of Meetings	Quarterly
B.3.d. Number of Meetings Held in the FY [3 is the mandated minimum].	6 (4 quarterly meetings and 2 special election meetings)
B.3. e. Number (%Average) of PAC members present at Meeting.	80.75%

SECTION C. PAC ETHNICITY & RACIAL DIVERSITY

Please refer to the **GLOSSARY** for definitions. The following information is self-reported or self-identified and uses two separate questions. The data on race and ethnicity are collected SEPARATELY; provision shall be made to report the number of respondents in each category who are Hispanic or Latino. Collection of greater detail is encouraged; however, any collection that uses more detail shall be organized in such a way, that the additional information can be aggregated into these minimum categories for data on race and ethnicity.

C. A. ETHNICITY	**Number of PAC Members**
C. A. 1. Hispanic or Latino	3
C. A. 2. Not of Hispanic Origin	8

C. A. 3. Ethnicity Unknown	0
(Add C.A.1 through C.A.3., the total should be the same as the one listed in B.1.k. (members serving as of 9/30).	**Total**
C. B. RACE	
C. B. 1. American Indian or Alaska Native	**0**
C. B. 2. Asian	**0**
C. B. 3. Black or African American	**4**
C. B. 4. Native Hawaiian/Other Pacific Islander	**0**
C. B. 5. White	**7**
C. B. 6. Two or more races	**0**
C. B. 7. Some other race	**0**
C. B. 8. Race unknown	**0**
C. B. 9. = C.B.1 through C.B.8.	**Total**
Members may select as many racial identifications as they want.	**11**
C. C.1. Total Number of PAC member vacancies on September 30.	**Total PAC Vacancies**
	1 Attorney vacancy as of 07/30/2023

SECTION D. Gender of PAC Members	
D.1 FEMALE	D.2 MALE
D.3 TRANSGENDER (Trans Woman)	D.4 TRANSGENDER (Trans Man)
D.5 TWO-SPIRIT (if AI or AN)	D.6 GENDER NON-CONFORMING
D.7 OTHER (if use a different term)	D.8 PREFER NOT TO SAY 11
D.3. TOTAL 11	

SECTION E. GOVERNING BOARD INFORMATION		
E. 1. FOR STATE-OPERATED P&A SYSTEMS ONLY:		
E.1.a. Is this a State-operated P&A system?	Yes	No X
E.1.b. Does this State-operated system have a Governing Board/Authority authorized by State statute? If the answer is NO, proceed to Section F.	Yes	No X
E.1.c. If the answer to item E.1.b. is YES, does the PAC Chair sit on the Governing Board/Authority as a full voting member?	Yes	No
E.1.d. If the answer to item E.1.c. is no, briefly explain (e.g., State statute determines Governing Board/Authority composition, etc.).		

E.2. For PRIVATE, Not-for Profit P&A SYSTEMS only		
E. 2.a. Does the P&A system have a multi-member Governing Board?	Yes X	No
If you answered YES to E.2.a., please answer the questions E.2.b. 1. - 3.		
E.2.b.1. Number of Governing Board members.	Total 15	
E.2.b.2. Is the PAC Chair a full voting member of the Governing Board?	Yes X	No
E.2.b.3. If you answered No to E.2.b.2., then explain why the PAC Chair is not a full voting member of the Governing Board as mandated by the PAIMI Rules at 42 CFR 51.22(b)(3).		
E.2.b.4. Do any other PAC members hold seats on the Governing Board? If Yes, how many seats? 1	Yes X	No

SECTION F. PAC ACTIVITIES [See, PAIMI Act - 42 U.S.C. 10805(7)]		
F.1. Are P&A program staff invited to attend PAC meetings?	Yes X	No
F.1.a. Did any of the invited program staff attend?	Yes X	No

F.2.a. If the answer to F.1. is Yes, please identify the positions of staff (e.g., PAIMI Coordinator, Mental health advocate, etc.) usually invited to attend.

At all meetings:

- **Attorney-Director of Investigations (Institutions) Team**
- **PAIMI Program Coordinator**
- **DRF-PAC Liaison**
- **Executive Director**
- **Director of Operations**

Invited as needed:

- **Director of Public Policy**
- **Staff Attorneys on Public Policy Team**
- **Director of Systems Reform**
- **Director of Advocacy, Education, and Outreach**
- **Staff Attorneys on Investigations Team**
- **Advocate/Investigators on Investigations Team**

F.2.b. If the answer to F.1.a. is Yes, please identify the positions of the program staff in attendance (e.g., one advocate, one attorney) and their role at the meetings, e.g., information sharing, etc.

- **Director of Investigations (Institutions) Team: Planning, information sharing**
- **PAIMI Program Coordinator: Planning, information sharing**
- **Executive Director: Information sharing and PAIMI grievances**
- **Director of Operations: PAIMI financials and information sharing**
- **DRF-PAC Liaison: Meeting coordination, minutes, and travel assistance**
- **Team Directors: Training and information sharing**
- **Staff Attorneys: Training and information sharing**
- **Advocate/Investigators: Training and information sharing**

F.2.c. If the answer to F.1. is No, you *MAY* provide a brief explanation.

F. 3. a. Were governing board members, excluding the PAC Chair, invited to PAC meetings?	Yes X	No

F.3.b. If you answered Yes to F.3.a., which governing board members were invited, for what purpose (e.g., informational, etc.) and did they attend?

An open invitation exists between the PAC and the Board to attend each other's meetings. During the FY 2022-2023, the following Board members attended PAC meetings:

- **Kyle Romano, information sharing**
- **Donte' Mickens, information sharing**
- **Virginia Daire, information sharing**
- **Eurica Ketant, information sharing**
- **Enrique Escallon (Board member and PAC member)**

F.3.c. Did any of the invited governing board members attend?	Yes X	No
F.4. Did the PAC work jointly with the governing board to develop the annual PAIMI priorities? [42 CFR 51.23(a) (2)].	Yes X	No*

F.4.a. If Yes, briefly describe these joint activities.

The PAC provided written input and comments to the Board regarding the annual PAIMI Goals, Priorities, and Objectives. In response, the Board provided written comments about how the PAC's input was incorporated into drafting the updated Goals, Priorities, and Objectives. The PAC also presented input at the 3rd Quarter Board meeting through the PAC Chair. A copy of the written exchange between the PAC and the Board is attached.

SECTION F. PAC ACTIVITIES [See, PAIMI Act - 42 U.S.C. 10805(7)]

F.4. b. If No, PAC's affiliated with private, non-profit P&A systems must provide a brief explanation.

F.5. Did PAC members attend any in-state or out-of-state trainings or educational presentations related to PAIMI Program activities? *[42 CFR 51.27 - payments for PAC and Governing board/authority members by a State P&A system are optional].*

F.5.a. In-State Trainings/Educational Activities.		No

If Yes, list each activity by number and provide a brief description of PAC involvement, e.g., Activity 1 – Attendance at local NAMI training. 1. **2023 American Deafness and Rehabilitation Association Virtual Conference: Generation Trauma on February 24, 2023. 1 PAC member attended. Topics covered during the conference include, "Expanding the Lens of Trauma-Informed Care" moderated by Dr. Lori Day and "Adult Child Estrangement: Working the Continuum" moderated by Drs. Damara Paris and Basil Kessler.** 2. **Virtual webinar and training on Anxiety and Depression for Children Teens hosted by the Wellness Institute on December 1, 2022. 1 PAC member attended. This special program was created to help inform parents and educators who are on the front line of dealing with children and teens with mental health issues and can often be among some of the first people to see that a child is struggling. Enhancing the potential for early intervention is important and because educational professionals have relationships with students and their families, they are often the people who guide students and their families to resources. As educational professionals learn more about mental health issues, their ability to make appropriate referrals for evaluation will improve for students and their families.** 3. **The 988 Celebration Webinar hosted by the National Council for Mental Wellbeing on September 12, 2023. 1 PAC member attended. The webinar included discussions with key leaders in the field to discuss the efforts of the National Council for Mental Wellbeing, Vibrant Emotional Health and the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the launch, lessons learned and the vision for 988 moving forward.** 4. **Family Café from June 9 – June 11, 2023. 7 PAC members attended.** 5. **NDRN – P&A/CAP 2023 Annual Virtual Conference from February 27 – March 2, 2023. 3 PAC members attended.**	Yes X	
F.5.b. Out-of-State Trainings/Educational Activities.		No

If yes, list each activity by number and provide a brief description of PAC involvement, e.g., Activity 1 – Attendance at NDRN annual conference. 1. **2022 National Association for Rights Protection and Advocacy (NARPA) Conference on October 26-29, 2022 in Newark, New Jersey. 4 PAC members attended. NARPA hosted a pre-conference institute for PAC members. There were presentations on the history of the PAIMI Act, PAIMI 101 (an overview of PACs), and other important topics. The Institute is one way to welcome PAC members to the world of NARPA, to bring PAIMI Council members together to network, to discuss possibilities for the work of state PACs, to share ideas about systemic advocacy, and to strategize about national connections.** 2. **2023 National Association for Rights Protection and Advocacy (NARPA) Conference on September 6-9, 2023 in New Orleans, Louisiana. 3 PAC members attended. NARPA hosted a pre-conference institute for PAC members. There were presentations on the history of the PAIMI Act, PAIMI 101 (an overview of PACs), and other important topics. The Institute is one way to welcome PAC members to the world of NARPA, to bring PAIMI Council members together to network, to discuss possibilities for the work of state PACs, to share ideas about systemic advocacy, and to strategize about national connections.**	Yes X	

F.6. Does the P&A system have established written policies and procedures for reimbursing PAC members for expenses that takes into account the needs of the individual council members, available resources and applicable restrictions on use of grant funds, including the restrictions cited in and the restrictions in 51.31(e) and 51.6(e)? [See, 42 CFR 51.23 (d) (1)].

F.6.a.1. Yes X	F.6.a.2. No*	F.6.a.3. Don't Know.*

F.6.b. Brief explanation needed for F.6.a.2. or F.6.a.3. responses].

SECTION F. PAC ACTIVITIES [See, PAIMI Act - 42 U.S.C. 10805(7)]

F.7. If the answer to F.6. was Yes, were PAC members reimbursed for expenses incurred for PAIMI Program related activities, consistent with the P&A system's policies and procedures.

F.7.a.	1.Yes X	2. No*	3. Don't Know*

F.7.b. *Brief explanation required for either F.7.a. 2. No *or F.7.a*. 3. Don't Know responses.

F. 8. REIMBURSEMENT OF EXPENSES – If PAC member expenses were reimbursed, please complete the following chart. [42 CFR 51.23(d) (1)]. Under the Activity column, list the activity by the number used in above F.5.a. – In-State or F.5.b. – Out-of-State. Example: F.5.b. Out-of-State activity # 1, – 5 PAC members attended the NDRN annual meeting, 2 members reimbursed by the P&A; 2 self-paid, 1 NDRN scholarship.

a. ACTIVITY	b. # ATTENDING	c. P&A	d. SELF	e. OTHER
NARPA 2022	4	4	0	0
NARPA 2023	4	3	1	0
Family Cafe	7	6	1	0

SECTION F. PAC ACTIVITIES [See PAIMI Act at 10805(7)]

F.9. Did the P&A system provide the PAC with reports, materials, & fiscal data to enable review of the following: [42 CFR 51.23(c)].

F.9.a. Existing program policies, priorities, and performance outcomes.	Yes X	No*
F.9.b. If Yes, were the submissions (of P&A system documents referenced in F.9.a.) made at least annually and (shall) report expenditures for the past two (2) FISCAL *YEARS?*	Yes X	No*
*F.9.c. If the answer to F.9. a. or F.9.b. is 'No", a brief explanation is required.		
F.9.d. If you answered Yes in F.9.a., did the P&A system documents referenced also *INCLUDE THE PROJECTED EXPENSES FOR THE NEXT FISCAL YEAR (FY) IDENTIFIED BY BUDGET CATEGORY*, e.g. salary & wages, contracts for services, administrative expenses, including, the amount allotted for training of the PAC, the governing board and staff?	Yes X	No*

F.9.d.1. If No*, a brief explanation is required].

SECTION F. PAC ACTIVITIES [See, PAIMI Act at 10805(7)]		
F.9.e. The PAIMI Rules mandate that members of the public shall be given an opportunity, on an annual basis, to comment on the priorities established by and the activities of the P&A system. Procedures for public comment must provide for notice in a format accessible to individuals with mental illness, including such individuals who are in residential facilities, to family members and representatives of such individuals with disabilities. [42 CFR at 51.24(b)].		
F.9.e. Does the P&A have procedures established for public comment?		
F.9.e. 1. Yes X	F.9.e. 2. No*	F.9.e.3. Don't Know*
F.9.e.4. *Brief explanation required for F.9.e.2. No or F.9.e.3. Don't know responses.		
F.9.f. Was the PAC provided a copy of these procedures?		
F.9.f.1. Yes X	F.9.f.2. No*	F.9.f.3. Don't Know*
F.9.f.4. *Brief explanation required for F.9.f.2. No or F.9.f.3.Don't know responses.		

SECTION F. PAC ACTIVITIES [See, PAIMI Act at 10805(7)]		
F.9.g. The PAIMI Rules, at 42 CFR 51. 24(b), mandate that the public shall be given an opportunity, on an annual basis, to comment on the priorities established by and the activities of the P&A system. *WAS THE PUBLIC PROVIDED AN OPPORTUNITY FOR PUBLIC COMMENT?*		
F.9.g. 1. Yes# X	F.9.g. 2. No*	F.9.g.3. Don't Know*
F.9.g 4. #If the answer to F.9.g.1. is Yes, briefly describe activities the P&A system used to obtain public comment. **Notice of public comment period is posted on the DRF website, social media platforms (including Facebook), provided electronically to the organization's email list, and provided by letter to the Governing Board and the PAC. DRF's intake and information referral unit provides notice of the public input survey along with a link on all electronic communications and provides electronic or hard copies of the survey to individuals, including individuals in facilities who contact DRF and provide an email address. The PAC provided notice at the on-site outreach event during the input period at the Family CAFÉ event and led small group discussions to solicit input from the public at DRF's Public Forum at Family CAFÉ.**		

F.9.g. 5. *If the answer to F.9.g.2. is NO, explain why public comment was not obtained.
F.9.g. 6. *If the answer to F.9.g.3. is DON'T KNOW, please explain (e.g., PAC needs training, etc.)
F.10. ***COMPLETION OF THIS SECTION (F.10 a. –e.) IS OPTIONAL.*** However, if you choose to respond, please describe in the spaces below any other PAC activities, *other than* mandated PAC membership meetings.
F.10.a. Briefly describe, governing board or PAC committee work.
F.10.b. Briefly describe any training or educational presentations to either constituency groups or the general public.

SECTION F. PAC ACTIVITIES [See, PAIMI Act – 42 U.S.C.10805(7)]
F.10.d. Briefly describe any special projects (e.g., institutional monitoring). PAC members participated in 2 outreach events with DRF staff. The first event was a community resource fair held at a public library in an underserved part of the state. The second event was a back-to-school event held at schools in rural parts of the state. The PAC members who attended this event helped pass out information about DRF services and DRF's Mental Health Resource Guide, and talked to members of the public about the PAC.
F.10.e. Briefly describe any other activities, e.g., fund raising, public relations, etc. A PAC member attended the statewide PTA Leadership Conference and was a member of the Superintendent's Advisory Council for Students with Mental Illness for a large metropolitan school district. The PAC member discussed DRF's services and their role on the PAC during participation in these groups.

SECTION G. PAC ASSESSMENT OF PAIMI PROGRAM OPERATIONS
G.1. ***Please provide a NARRATIVE SUMMARY of the PAC'S ASSESSMENT of the PAIMI priorities (goals) and objectives included in the PPR for this Fiscal Year.***
Include in the narrative an assessment of the following items:
G.1.a. The PAIMI Priorities (Goals) and Objectives selected.
G.1.b. The activities conducted towards achieving these priorities (goals) and objectives.

G.1.c. The outcomes.
G.1.d. Examples of individual or systemic cases, applicable legislative activities, and participation in State mental health planning activities.
G.1.e. Any recommendations regarding future priorities (goals) and objectives.

It is the evaluation of the Council that Disability Rights Florida has taken appropriate steps and measures to ensure the concerns of the Council are reflected in the work performed around the state. Each Objective has been quantified in a goal of individuals who have been assisted in accordance with the particular objective target. These targets have been met and frequently surpassed.

In regard to the PACs concern on the use of Electroconvulsive Treatment ("ECT" also known as "shock treatment"), DRF has ensured the investigations leading to the reduction of abuse, neglect, and right violations of individuals with mental illness and significant emotional disturbances have been expanded by making it a Priority/ Objective. This has resulted in an expected outcome far exceeding the expected target within the target population. This particular objective has been prioritized by the council due to the previous experience of council members, and the current members are appreciative and satisfied with the care taken by staff to provide this oversight to the State's individuals who can be served under the grant.

The target goal for investigations done on behalf of individuals undergoing rights violations have be exceeded and the information provided to the council satisfies the perspective of the council in reference to the goal established.

The advocacy work done on behalf of PAIMI eligible individuals to receive a Free and Appropriate Public Education is able to be quantified in the population outcome laid out in the PPR, this goal was of particular concern to several council members and the work done and described by DRF staff have adequately informed the council as to the progress made on this goal.

The comprehensive and targeted monitoring of facilities directly addresses concerns made by the council on behalf of individuals in these facilities and those who have experienced treatment at these facilities.

The council was informed on the Goal pertaining to the monitoring and enforced implementation of court-orders settlement regarding the lack of care to inmates with significant mental illness, and the progress made.

DRF is on target with the improvement of protections and/or outcomes related to abuse, neglect, and/or rights protections of individuals with significant mental illness. The inclusion of the HB829 Baker Act Handbook updates directly demonstrate the works and progress made following concerns of the council. 2022 legislation impacting PAIMI eligible individuals is being investigated and ongoing updates are keeping the council informed of how the Goals are actively being held in high importance by staff in the work that they do.

The service requests received and explained in the PPR are of continuing importance to the council and have guided the formation of future Goals, priorities, and objectives that the council looks forward to crafting. The outreach to underserved populations that DRF is prioritizing falls in line with the future goals of the council.

SECTION G. PAC ASSESSMENT OF PAIMI PROGRAM OPERATIONS
G.2. OTHER COMMENTS CONCERNING PAIMI SYSTEM OPERATIONS:
G.3. Please list any training & technical assistance needs identified by the PAC.

SECTION H. GRIEVANCE PROCEDURES [42 CFR Section 51.25]		
Pursuant to the PAIMI Rules at 42 CFR 51.25, the P&A systems shall establish procedures to address grievances from: individuals at 42 CFR 51.25*(a)(1) – clients or prospective clients . . . ; and systemic complaints at 42 CFR 51.25(a)(2) – individuals who have received or are receiving mental health services in the state, family members or representatives of such individuals . . . .*		
H.1. Is the PAC aware of and knowledgeable of the above referenced policies and procedures?	Yes X	No*
H.1.a. If you answered No to H.1. provide a brief explanation.		
H.2. The number of grievances filed by PAIMI-eligible clients, including representatives or family-members of such individuals receiving services during this fiscal year.	Total 5	
H.3. The number of grievances filed by prospective PAIMI-eligible clients (those who were not served due to limited PAIMI Program resources or because of non-priority issues).	Total 0	
H.4. Add H.2 & H.3 **[42 CFR Section 51.25(a)(1),(2)]**	Total 5	
H.5. The Number of Grievances Appealed to:		
H.5. a. The Governing Board (the PAC Chair of a private, non-profit P&A system should have this information).	Total 0	
H.5.b. The Executive Director	Total 5	
H.5 c. The number of Grievances appealed [H.5.a. + H.5.B = H.5.c.].	Total 5	
H.6. The number of reports sent to the Governing Board AND the PAC (*at least one annually*) that describe the grievances received, processed, and resolved.	Total 4	

SECTION H. GRIEVANCE PROCEDURES [42 CFR Section 51.25]

H.7. Please identify all individuals, by name & title, responsible for P&A system grievance reviews.

Peter Sleasman, Executive Director

Eurica Ketant, Chair, Board of Directors Client Grievance Committee

H.8. What is the timetable (in days) used to ensure prompt notification of the grievance procedure process to clients, prospective clients or persons denied representation, and ensure prompt resolution. **[42 CFR 51.25(B)(4)]**		Days 30
H.9. Were written responses sent to all grievants?	Yes X	No*
H.9.a. *If you answered No, to H.9, briefly explain.		
H.10. Was client confidentiality protected? ____. If not, explain below. **[42 CFR 51.25(B)(6)]**	Yes X	No*
H.10.a. *If you answered No, to H.10, briefly explain.	Yes	No*

GLOSSARY

Closed Case - is when the advocate/attorney closes the client record or case file after providing advocacy interventions on behalf of a client and determining that the client either has no need of further intervention services or that the agency has no other services available to address the issue(s) or complaint(s) for which the case was initially opened.

Grievance Procedures - are policies and procedures developed by the P&A system to ensure that its clients and prospective PAIMI-eligible clients, their family members, or representatives have full access to the system services and that the system is fully compliant with the provisions of the PAIMI Act and Rules.

Information and Referral (I&R) Services - is the provision of brief written or oral information, such as generic information about the P&A, including information about additional programs and resources external to the P&A that relate to the individual's service needs and statutory or constitutional rights as a person with a disability. I &R services are generally of short duration, typically range from a few minutes to an hour, do not involve direct advocacy intervention by staff, and any type of staff follow-up. I&R services may include mailing generic agency information. Individuals receiving I &R services are not counted as PAIMI clients.

Intervention Strategies:

Abuse/Neglect Investigations - a systemic and thorough examination of information, records, evidence, and circumstances surrounding an allegation of abuse and neglect. Investigations are undertaken to determine if there is a basis for administrative or legal action on behalf of the client. Investigations require a significant allocation of time to interview witnesses, gather factual information, and to issue a written report of findings.

Administrative Remedies - includes the use of any systems for appeal within an agency or facility, or between agencies, which does not involve adjudication by a court of law.

Legal Remedies - the legal representation of clients in litigation in court processes concerned with rights, grievances, or appeals of such rights or grievances.
Legislative/Regulatory Advocacy - activities involve monitoring, evaluating, and commenting upon the development and implementation of Federal, State, and local laws, regulations, plans, budgets, taxes and other actions which may affect individuals with mental illness. [The PAIMI Rules at 42 FCR at 51.24 mandates that legislative activities shall also be addressed in the development of program priorities].

Negotiation/Mediation - is an informal, non-legal intervention by a PAIMI representative, attorney or case manager used to resolve problems with facility staff or other agency representatives; (does not involve a formal appeal).

Objectives - are activities undertaken to achieve annual program priorities (goals). All objectives required to have measurable outcomes and the use of numerical targets is encouraged. Each objective must clearly state why the activity was undertaken, who will benefit from the objective (the target population), how the activity will be accomplished, and what is the expected outcome for the activity? Generally, with the exception of litigation, legislative or regulatory activities, objectives shall be attainable within the fiscal reporting period (within one (1) fiscal year).

Open Case - is when a PAIMI-eligible individual with a complaint is accepted as a client by the P&A system. A case record or case file is opened for that individual. System staff maintain all intervention services provided to the client and other information t are maintained in this case record/file.

Outreach - is an activity that targets information on PAIMI Program activities to specific populations (e.g., cultural, ethnic, and racial minorities, and other underserved or un-served populations, etc. The activity is linked to an objective of a specific annual priority.

PAIMI Clients (for purposes of this report) - are individuals who meet the PAIMI eligibility criteria as defined in the PAIMI Act [42 U.S.C. 10802(4) and its Rules at 42 CFR 51.2 Definitions, who have a complaint, for whom demographic data is collected, and for whom the PAIMI Program, or any of its subcontractors, provides an intervention (as reported under Intervention Strategies in this form).

Priorities (Goals) - are broad general descriptions of short-term activities for the P&A system to accomplish within one (1) fiscal year (FY). [The exceptions are generally regulatory, legislative, and litigation activities]. The priorities must be directly related to the purpose of the enabling Federal legislation and the requirements

of the Federal-funding agency and consistent with the priorities included in the PAIMI Application for the same FY. [See PAIMI Act at 42 U.S.C. 10801, PAIMI Rules at 42 CFR 51.24 (a) – Program Priorities, and the Children's Health Act of 2000 at 42 U.S.C. at 290ii-ii-1 and 290jj-jj-2].

Public Awareness Activities - provide general information on disability rights and the purpose and mission of the P&A system. Public awareness activities include public service announcements, newsletters, radio or television, publications in legal journals, web site services, general distribution of agency brochures, etc.

Public Education and Constituency Training - is the dissemination of information to one or more persons through an interactive event, which often promotes a greater understanding of the constitutional or statutory rights of persons with disabilities. Contrasted to Public Awareness Activities, education and training must be specifically targeted to meet the unique need of the group(s) trained.

Racial/Ethnic Background - The following minimum standards shall be used for all federal administrative reporting and grants reporting or record keeping requirements that include data on race and ethnicity [http://www.whitehouse.gov/omb/fedreg_1997standards/].

CATEGORIES AND DEFINITIONS:

Ethnicity:

Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American descent.

Not of Hispanic Origin.

Race:

American Indian or Alaska Native (include tribal affiliation for the Alaska native when possible) - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Black or African American - A person having origins in any of the Black racial groups of Africa.

Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific islands.

White - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Respondents have the option of selecting one or more racial designations.

Resolution of Complaint/Problem Area – is in a client's favor when (1) the client is satisfied with the result of the intervention or (2) the expressed wish or stated goal of the client is either fully attained or negotiated to an agreeable outcome, or (3) the violation in the stated case complaint/problem area was remedied.

Systemic Advocacy Activities – are the efforts taken to implement changes in policies and practices of systems that impact persons with mental illness. These "systems" include, but are not limited to, State

agencies, various public and private residential care and treatment facilities, and other service providers, etc. [The PAIMI Rules at 42 CFR 51.24 (a) PAIMI Priorities state that systemic activities shall be addressed in the development and implementation of program priorities].

Technical Assistance - assistance provided to family members, non-legal guardians, professionals, or other advocates in consultation regarding an area of the law in which the P&A has expertise. It is considered a non-client directed activity.