Florida

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

FY 2025
PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS
Short Title: 2025 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	CherieH@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)	1000 Ashley Drive, Suite 640
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	Cherie Hall
Mailing Address	2473 Care Dr Suite 200
City	Tallahassee
Zip Code	32308
Phone Number & Extension	850-617-9716
E-mail Address	CherieH@DisabilityRightsFlorida.org

5. PPR Preparer Contact Information

Name	Aaron Victoria
Title	PAIMI Program Coordinator
Phone Number & Extension	850-617-9777
Email Address	AaronV@disabilityrightsflorida.org

6. Governing Board President/Chair Name

Name	Katherine DeBriere, Esquire
Mailing Address	[redacted]
City	[redacted]
Zip Code	[redacted]
County of Residence	[redacted]
Email Address	[redacted]
Current Term Started	10/1/2020 12:00:00 AM
Current Term Expires	9/30/2024 11:59:00 PM

7. PAIMI Advisory Council President/Chair Name

Name	Lindsey Betterman
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	Julien Sautie
Title	Director of Finance

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

9. Governor's Liaison

Name	Leda Williams Kelly
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	Leda.Kelly@laspbs.state.fl.us

10. Commissioner/Director of the State Mental Health Agency

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

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Footnotes:

For item #6, the Governing Board President/Chair, Katherine DeBriere's term ended on 09/30/2024, but she agreed to serve beyond her term until the Board found a replacement.

A. PAIMI Program Information

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

		Governing Board	Advisory Council	Program Staff
Ethnicity				
	Hispanic/Latino	2	2	6
	Non-Hispanic/Latino	12	8	39
	Ethnicity Unknown	0	0	0
Race				
	American Indian/Alaska Native	0	0	0
	Asian	0	0	1
	Black/African American	2	3	8
	Native Hawaiian/Pacific Islander	0	0	0
	White	12	6	36
	Two or more races	0	1	0
	Some other race	0	0	0
	Race Unknown	0	0	0
Sex				
	Female	5	7	34
	Male	9	3	11

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Footnotes:

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 9/30/2025	14
Total vacancies on 9/30/2025	1
Term of appointment (number of years)	4
Term maximum	2
Meeting Frequency	4
Number of meetings held this fiscal year (2025)	5
Percentage of members present at meetings during the 2025	79 %

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 (CR/FR) of mental health services or have been eligible for services.	1
Number of family members of individuals with mental illness who are (CR/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	13
Total	**14**

Footnotes:

A. PAIMI Program Information

Executive Director

Intial Appointment Date	02/03/2025 (mm/dd/yyyy)
Recent performance evaluation completed	06/03/2024 (mm/dd/yyyy)
Date of previous performance evaluation	09/08/2023 (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:

DRF's current Executive Director was hired during FY 2024-2025. Their first performance evaluation is scheduled for Q2 of FY 2025-2026, one year after their current appointment.

The dates recorded for Recent Performance Evaluation Completed and Date of Previous Performance Evaluation reflect DRF's previous Executive Director's--Peter Sleasman--performance evaluations.

A. PAIMI Program Information

Number of Mental Health Professionals On the Advisory Council

Professional Category	Number On Advisory Council
Social Worker	1
Psychologist	1
Psychiatric Nurse	0
Psychiatrist	0
Psychiatric Nurse Practitioner	0
Peer Support Specialist	1
Other (Identify the Professional in the Footnotes)	2
Total	**5**

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Footnotes:

2 PAC members serve as Rehabilitation Specialists at a Clubhouse.

A. PAIMI Program Information

PAIMI Advisory Council (PAC)/Assigned Staff

PAIMI Advisory Council (PAC)	
Sits on the governing board?*	(•) Yes ( ) No
Appointment Date	08/30/2024
Other PAC member(s) sit on the governing board?	( ) Yes (•) No
If yes, number serving	

** 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	2	2	0	0	2
Non-Hispanic/Latino	11	11	0	4	7	8	8	0	3	5
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	4	4	0	0	4
Native Hawaiian/Pacific Islander	0	0	0	0	0	0	0	0	0	0
White	9	9	0	4	5	5	5	0	3	2
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	1
6-10	7
11-22	45
23-64	126
65+	14
Prefer not to say	2
Total	**195**

Sex of PAIMI-eligible Individuals Served

Sex	Number
Female	60
Male	135
Total	**195**

Ethnicity and Race of Individuals Served

Ethnicity	Number	PAIMI %	State %
Hispanic/Latino (of any race)	16	8.20	27.40
Non-Hispanic/Latino	126	64.61	72.60
Ethnicity Unknown	53	27.17	0.00
Total	**195**		

Race	Number	PAIMI %	State %
American Indian/Alaska Native	2	1.02	0.40

Asian	3	1.53	3.00
Black/African American	72	36.92	14.90
Native Hawaiian/Other Pacific Islander	0	0.00	0.10
White	101	51.79	55.50
Two or more races	8	4.10	19.30
Some other race	0	0.00	6.80
Race unknown	9	4.61	0.00
Total	**195**		

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Footnotes:

Ethnicity and Race: State data for ethnicity and race in Florida was obtained from the United States Census Bureau's American Community Survey 2023: ACS 1-Year Estimates Date Profile for Demographic and Housing Estimates. Data can be found at the following location: https://data.census.gov/table/ACSDP1Y2023.DP05?q=DP05&g=040XX00US12

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.		61
2. Number of new PAIMI-eligible individuals served during the reporting year.		134
3. Total number of PAIMI-eligible individuals served during this FY (Add lines 1 and 2).		195
4. Individuals with more than one (1) intervention opened/closed during the reporting year.		20
5. Individuals with a co-occurring mental illness and Intellectual and Developmental Disability (IDD).		7
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).		44

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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.	0
Community Residential Home for Adults	0
Non-Medical Community-Based Residential Facility for Children/Youth	0
Foster Care	1
Nursing homes, including skilled nursing facilities	1
Intermediate care facilities	0
Public and Private general hospitals including Emergency Rooms	0
Public Institutional living arrangement	0
Private Institutional living arrangement	18
Psychiatric Hospitals (Public or Private)	
a. Public/State	97
b. Private	13
Jails	11
State Prison	53
Federal Detention Center	0
Federal Prison	0
Veterans' administration hospital/Clinic	0
Other Federal Facility	0
Homeless	1
Independent (in the community & PAIMI-eligible)	8
Parental or Other Family Home & PAIMI-eligible	21
Unknown	0
Total	224

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	0	1	0	0	0	0	0	0	0	0	0	1
b. Inappropriate or excessive restraint and seclusion	2	0	4	0	0	0	0	0	0	0	0	6
c. Involuntary medication	1	1	1	0	0	0	0	0	0	0	0	3
d. Involuntary Electric Convulsive Therapy (ECT)	0	0	0	0	0	0	0	0	0	0	0	0
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	22	5	11	2	1	1	1	0	1	0	0	44
h. Sexual assault	0	0	1	0	0	1	0	0	0	0	0	2
i. Threats of retaliation or verbal abuse by facility staff	0	1	3	0	0	0	0	0	1	0	0	5
j. Coercion	0	0	0	0	0	0	0	0	0	0	0	0
k. Financial exploitation	0	0	0	0	0	0	0	0	0	0	0	0
l. Suspicious death	1	0	4	0	2	0	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.]*	2	0	1	0	0	0	0	0	0	0	0	3

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	28

B. Number of complaints/problems withdrawn or terminated by client	8
C. Number of complaints/problems resolved in the client's favor	25
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	3
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	2
J. Outcome Unknown	0
K. Lack of Resources	0
Total number of Abuse complaints/problem addressed from closed cases	**71**

At least 1 case required.

Case of Alleged Abuse

HA is an adult female with a significant mental illness who was residing in a State Mental Health Treatment Facility at the time of their initial request for assistance from Disability Rights Florida (DRF). HA contacted DRF to request assistance with a complaint of physical abuse. Specifically, she alleged that two female staff dragged her down the hallway during an Emergency Treatment Order (ETO) incident. To investigate this service request, DRF staff held an in-person interview with HA. They also requested and reviewed video and clinical records associated with HA's allegation. As a result of their records review, DRF found evidence supporting the following conclusions: 1) the facility permitted Advanced Practice Registered Nurses (APRN) and/or Psychiatric Mental Health Nurse Practitioners (PMHNP) to approve ETOs instead of a physician, as required by Florida law at the time of the incident; 2) staff used physical restraints on HA without documenting the Use of Force in an incident report; and 3) staff engaged in physical abuse of HA during the administration of an ETO by dragging HA down the hallway for about 15 seconds. DRF subsequently requested the following response from the facility related to the above investigative findings: 1) clarification of the facility's authority to permit ARPNs to order ETOs without physician oversight; 2) review of the identified problems within the incident and production of any/all disciplinary or corrective action plans related to those incidents; 3) implementation of training/re-training for staff on de-escalation techniques, non-violent crisis intervention, proper use of physical restraints, and proper documentation of physical restraint incidents; 4) development of policies and procedures for handling situations where individuals may be resistant to medication. During the investigation, Florida revised the regulations on the ordering of ETOs, permitting Psychiatric APRNs to order ETOs as long as the facility maintains a Framework of Established Protocol (FEP) that includes the ordering of ETOs. As a result, DRF only requested and reviewed the FEP for the Psychiatric Mental Health Nurse Practitioner that administered the ETO. Overall, the facility completed the following corrective action in response to DRF's requests: 1) implemented disciplinary action against the two staff involved in the physical abuse; 2) administered staff training/retraining on the use and proper documentation of ETOs, de-escalation techniques, non-violent crisis intervention, proper use of physical restraints, and proper documentation of physical restraint incidents; 3) revised their policies OP 14-06-01 Management of Psychotherapeutic Medications and 16-01-02 Use of Physical Restraints, including the use of physical holds; 4) trained/re-trained all staff on the revised policies. DRF provided input towards the policy revisions and monitored the progress of staff trainings/re-trainings. Ultimately, DRF confirmed that the facility successfully published the revised policies and trained/re-trained 96.7% of their staff. As a result, DRF closed this case as issues resolved in

the client's favor through Administrative Remedies due to the facility revising policies, implementing corrective action plans, and conducting staff training/re-trainings. The outcomes of this case, specifically the policy changes, enhance the safety of all current and future residents of this State Hospital.

Case of Alleged Abuse

NB is a youth male with serious emotional disturbance (Disruptive Mood Dysregulation disorder; PTSD unspecified; ADHD combined type) who was housed at a Residential Treatment Facility (RTF) when Disability Rights Florida (DRF) was contacted by Disability Rights California (DRC) with an abuse allegation involving NB. According to DRC, NB was an out-of-State placement at a RTF in Florida who had complained of an abusive restraint within a few days of his arrival at the facility. NB told DRC that staff bent his leg to the point that it felt like it was breaking. DRC sought assistance from DRF to investigate the allegation. To investigate this abuse allegation, DRF met with NB who acknowledged that he gave consent to DRC to contact DRF and gave expressed voluntary consent for DRF to investigate on his behalf as well as to get signed consent from his Guardian to do same. DRF communicated the allegation with NB's guardian (father), who agreed to DRF's investigative services. DRF then requested and received medical records and other documentary and video evidence and interviewed all members of the RTF who were named as part of the restraint incident. DRF concluded that the RTF violated NB's right to be free of restraint and that there was no evidence to justify the facility's use of restraint of NB. DRF requested and received corrective actions taken by RTF, which include: 1.) retraining of lead staff for each shift on debriefing requirements in accordance with Florida Administrative Code (FAC); 2.) conducting random Quality Assurance reviews of incident debriefings; 3.) retraining of staff on facility procedure for signing debriefings; 4.) counseling sessions related to the aforementioned issues for the specific staff identified in NB's abuse incident. NB's case is part of a systemic issue of abusive restraint carried out on youths in this particular RTF. NB's case has been linked to the project, which DRF opened to investigate similar abuses and will be ongoing throughout FY 2024-2025. For NB's case, NB and their guardian agreed that DRF's investigative resolutions sufficiently achieved the case objective. As a result, DRF closed this case due to the client's objective being fully met.

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Footnotes:

For the 3 cases of "Other" Abuse, 2 cases were related to withholding of food by staff and 1 case was related to verbal abuse by another facility resident.

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.	4	2	5	0	0	0	1	0	0	0	0	12
b. Failure to provide necessary or appropriate mental health treatment, including access to prescribed medication	1	0	11	0	6	0	0	1	0	0	0	19
c. Failure to provide necessary or appropriate personal care and safety	6	2	12	0	1	0	0	0	0	0	0	21
d. Failure to provide appropriate discharge planning or release from a residential care or treatment facility	0	0	0	0	0	0	0	0	0	0	0	0
e. Mental health diagnostic or other evaluation (does not include treatment)	0	0	1	0	4	0	0	0	0	0	0	5
f. Medical (non-mental health related) diagnostic physical examination	0	0	0	0	0	0	0	0	0	0	0	0
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	11
B. Number of complaints/problems withdrawn or terminated by client	4
C. Number of complaints/problems resolved in the client's favor	29
D. Number of complaints/problems not resolved in the client's favor	0
E. Other Indicators of success or outcomes that resulted from P&A involvement	11
F. Other Representation found	0
G. Services not needed due to client death or relocation	1
H. P&A withdrew due to conflict of interest or other reasons	1
I. Lost Contact	0
J. Outcome Unknown	0
K. Lack of Resources	0

Total number of Neglect complaints/problem addressed from closed cases	57

Case of Alleged Neglect

SL is an adult male with significant mental illness who was housed at a State Mental Health Treatment Facility (SMHTF) when they contacted Disability Rights Florida (DRF) for assistance with a neglect allegation. Specifically, SL uses a wheelchair and alerted DRF to physical accessibility issues throughout his current facility, most notably that the access buttons that automatically open doors for wheelchair users were broken in a number of separate units. These issues interfered with his ability to move freely around his living area and attend therapeutic classes and programming. To investigate this case, DRF visited the facility and tested the doors to the specific buildings the SL identified. DRF notified the facility of broken automatic doors on both sides of SL's dorm, one unit, and the entrance to the building where residents attend their classes. After testing additional doors while on site, DRF also alerted the facility about broken doors in additional units and building entrances. In the following weeks, the facility confirmed with DRF that they had repaired all of the broken doors—which DRF confirmed in-person. Finally, DRF reviewed the case outcomes with SL, who confirmed that he no longer had issues accessing buildings/units and that he has not heard of any other broken doors from other residents. DRF closed this case due to the primary issues being resolved in the client's favor. DRF sent a case closing letter with a DRF client satisfaction survey and DRF's grievance procedure to SL at their current address.

Case of Alleged Neglect

BK is an adult female with significant mental illness (schizophrenia) who was residing at a State Mental Health Treatment Facility (State Hospital) when Disability Rights Florida (DRF) received a third-party complaint alleging neglect against BK. Specifically, the complaint alleged that BK, a patient in Forensic Admissions at a State Hospital, was being kept secluded in her room in squalid conditions and denied basic necessities, such as clean clothing. DRF agreed to investigate the complaint. They conducted an immediate and unannounced visit to the dormitory to meet with BK, who DRF observed as being visibly dirty, with an unclean and unpleasant smelling room, and observably in bad shape. Throughout DRF's interview, BK was extremely symptomatic and delusional and, although she did allege that she was being locked in her room and denied necessities, BK was unable to provide consent for DRF to further investigate the allegation. In response, DRF immediately alerted facility administrators to their concerns about the conditions of BK's living area. A few weeks later, DRF returned to BK's living area, unannounced, to assess any changes to her living conditions. They observed that she appeared in better condition, with clean clothes, a clean-living area, and generally none of the concerning conditions that DRF previously witnessed. Although, her behavior was still highly confused and delusional and incapable of providing consent to DRF's investigation. DRF met with BK a third time in her living area, unannounced. At that time, she was walking around her unit and very happy to see DRF. She was dressed in clean clothes with a clean living area and a generally improved mood. While she still presented some statements of confusion, she was less delusional and able to understand DRF's conversation along with the investigative services offered to her. As a result, she was able to consent for DRF to investigate recent incidents with security, particularly an incident involving a mechanical restraint. To investigate this incident, DRF requested and reviewed records, which documented extreme behavioral difficulties with BK from the time of admission. While records did indicate that she had several interactions with security, all were in the context of her either attacking other patients or behaving in incredibly disruptive ways (e.g.: nude, running through the hallways, screaming at people). For the most significant incident, she was mechanically restrained for being violent towards staff and peers and attempting to charge at a recovery team member. Records thus confirmed that a series of significant behavioral incidents occurred, which most commonly resulted in Emergency Treatment Orders and occasionally resulted in relatively brief restraints. The records, however, did not contain overt signs of neglect, as all significant incidents are in response to dangerous behavior from BK. DRF concluded that the allegations of neglect by security staff were not substantiated due to lack of evidence. DRF closed this case due to the problems being resolved in the client's favor through limited advocacy. DRF mailed a closing letter with a client satisfaction survey, DRF grievance procedures and self-addressed stamped envelope to BK.

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	1	0	0	0	0	0	0	0	0	1
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)	0	0	0	0	0	0	0	0	0	0	0	0
d. The right to refuse treatment	1	0	0	0	0	0	0	0	0	0	0	1
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	0	0	0	0	0	0	0	0	0	0	0
h. The denial of rights protection information or legal assistance, including adequate and appropriate representation during commitment hearings	0	0	1	0	0	0	0	0	0	0	0	1
i. The denial of privacy rights (e.g., congregation, telephone calls, receiving mail)	0	0	0	0	0	0	0	0	0	0	0	0
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	0	0	0	0	0	0	0	0	0	0	0	0
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	1	0	0	0	0	0	0	0	0	1
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	1	0	0	0	0	3
r. The denial of access to administrative or judicial process	0	0	2	0	0	0	0	0	0	0	0	2
s. Failure to provide educational services in the least restricted environment for PAIMI-eligible individuals	0	1	13	0	2	0	0	0	0	2	0	18
t. The denial of access to community-based rehabilitation services and/or treatment	0	0	0	0	1	0	0	0	0	0	0	1

u. The denial of access to transportation	0	0	0	0	0	0	0	0	0	0	0	0
v. Employment Discrimination	0	0	0	0	0	0	0	0	0	0	0	0
w. The denial of access to personal possessions	0	0	0	1	0	0	0	0	0	0	0	1
x. Failure to comply with commitment regulations	1	1	0	0	0	0	0	0	0	0	0	2
y. Failure to comply with commitment time frames	6	0	0	0	1	0	0	0	0	0	0	7
z. Other *[Please make every effort to report within the above categories].*	3	1	8	0	1	0	0	0	0	0	0	13

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	11
B. Number of complaints/problems withdrawn or terminated by client	3
C. Number of complaints/problems resolved in the client's favor	28
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	5
F. Other Representation found	0
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	0
J. Outcome Unknown	2
K. Lack of Resources	0
Total number of Rights Violation complaints/problems addressed from closed cases	**52**

Cases of Alleged Rights Violations

FB is an adult female with a significant mental illness (Schizophrenia Disorder, Bipolar Type) who was residing in a State Mental Health Treatment Facility (State Hospital) at the time of their initial request for assistance from Disability Rights Florida (DRF). FB contacted DRF to request assistance with a rights violation allegation. Specifically, she alleged that her recovery team was refusing to provide her with appropriate information about her treatment progress and discharge plan by: 1.) making the decision to discharge her to another State Hospital without explanation; 2.) refusing her request for discharge to her daughter's house without explanation; 3.) delaying her discharge after placing her on discharge status. To investigate this service request, DRF staff met with FB at her facility to gather more information about her service request. DRF also reviewed FB's clinical records to determine if the facility had made decisions about FB's treatment and discharge without informing her. After reviewing FB's records, DRF

confirmed that: 1.) FB's recovery team had not recommended nor approved her discharge to another State Hospital; 2.) FB's recovery team informed her that she could not be discharged to her daughter's house because her original charges stemmed from FB entering into her daughter's house with a firearm and discharging that firearm in the house as well as because FB refused to sign a release allowing her recovery team to speak with the family; 3.) FB had not yet been placed on discharge status. DRF communicated these findings to FB in an investigative findings letter while also providing her with self-advocacy information for obtaining treatment and discharge-related information from her recovery team. As a result of these investigative findings, DRF concluded that FB's request for assistance with a rights violation had been resolved in the client's favor, as DRF was able to obtain treatment and discharge information that FB believed was being withheld from her. DRF mailed a case closing letter with a DRF satisfaction survey, DRF grievance procedure, and SASE to FB at her current facility.

Cases of Alleged Rights Violations

AK is an adult with significant mental illness who was committed at a State Mental Health Treatment Facility (State Hospital) after being adjudicated Incompetent to Proceed at the time of their request for service with Disability Rights Florida. During a rights training by Disability Rights Florida staff, AK approached staff to discuss concerns regarding discharge barriers. Specifically, AK stated that he was having an issue with discharge because the psychiatrist is not submitting his documents to the court in a timely manner. To investigate this case, DRF requested and reviewed AK's records, which documented that AK was admitted to facility on 6/9/2022. Most notably, the court docket has nearly no entries between commitment on 3/22/2022 and the evaluation finding AK competent submitted on 1/27/2025. For this nearly three -year stretch, there is only minor administrative correspondence and there is no indication that the facility submitted any status updates or that competency was re-considered at any point during this stretch. AK's recovery team first writes that he was "opined competent" and awaiting transport back to his committing court in July 2023, but that actual court finding and transport takes 18 additional months. DRF staff met with the facility's Head of Psychology regarding the discharge delays involving AK. After the meeting, DRF identified two, overlapping, sets of problems contributing to the delay. First, the facility failed to supervise psychology practicum students properly (which they relied on due to post-Covid staffing shortages). Second, the facility's most senior psychologist and evaluator had been on leave for 4 months due to a serious chronic medical issue. The Head of Psychology acknowledged that, during the time the Evaluator was out, some cases fell through the cracks. Since then, and since administration has changed, Head of Psychology hired 3 new clinical staff and has two more positions to be filled. She believes that they now have sufficient psychology staff that if a Senior Clinician had to take abrupt medical leave, they would be able to cover it adequately now and this would not re-occur. She has also stated she has corrected the error with the practicum students and their procedures. AK's allegations of neglect due to delays by the facility were admitted by the facility and substantiated. AK has since been discharged from the facility and, as a result, DRF closed this case due to the issue being favorably resolved through Negotiation. Additionally, DRF will be continuing to monitor similar discharge delays through future case work.

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Footnotes:

For the 13 case of "Other" Rights Violations:
- 5 cases involved multiple co-occurring rights violations;
- 2 cases involved rights violations related to post-secondary education;
- 2 cases involved rights violations related to service animals;
- 1 case involved rights violations related to an inpatient mental health treatment facility's refusal to provide ADA accommodations to a resident who also had a documented visual impairment;
- 1 case involved rights violations by a public library refusing to provide reasonable accommodations to an individual with mental illness to ensure that they were able to access the libraries services and programs;
- 1 case involved rights violations related to an inpatient mental health treatment facility's failure to provide a special diet; and
- 1 case involved rights violations related to an inpatient mental health treatment facility's failure to provide access to functioning phones.

C. Complaints/Problems of PAIMI Individuals

Reasons for Closing Individual Advocacy Case Files

	Number
1. Client's objective was partially or fully met.	56
2. Case or investigation lacked merit.	51
3. Case withdrawn or terminated by the client.	13
4. Issue favorably resolved.	33
5. Issue not favorably resolved.	2
6. Other success or outcomes due to P&A involvement (i.e., provided self-advocacy assistance)	16
7. Other representation found.	1
8. Services not needed due to client's death or relocation.	3
9. P&A withdrew due to conflict of interest or other reasons (i.e., client would not cooperate).	1
10. Appeal(s) unsuccessful.	0
11. Other appropriate entity investigating.	2
12. Lost Contact.	2
13. Lack of Resources.	0
Total	**180**

At least 1 case required.

Case of Closing an Individual Advocacy Case File

As an example of a case that DRF closed due to other indicators of success or outcomes that resulted in P&A involvement, MH is a 21-year-old female with significant mental illness (Oppositional Defiant Disorder) who was housed in a Detention Facility at the time of referral to Disability Rights Florida (DRF). MH had felony charges for battery on LEO and was waiting for hospital placement for competency training. MH's parents/plenary guardians contacted DRF to request assistance with finding appropriate placement for MH after they had applied for Agency for Persons with Disabilities (APD) Eligibility multiple times and appealed to Fair Hearing, both unsuccessfully. MH has a history of elopement, trespassing, aggression, self-harm, at least 40 Baker Act holds, as well as a history of inpatient and outpatient mental health treatment. DRF agreed to assist with obtaining information about APD waiver eligibility along with other appropriate community services. During this case, MH was found to be competent to stand trial and was immediately released to her guardians. She was subsequently placed in a hospital under Baker Act. Her parents, with assistance from the Baker Act facility, were able to place MH in a privately paid residential program but they needed options for when she completes the program. DRF provided MH's parents with self-advocacy information for how to apply for the Long-Term Care (LTC) waiver through Medicaid, for which MH's parents hired a private attorney to assist.

Additionally, DRF successfully located an Assisted Living Facility that accepts young adults with significant mental illness under the LTC waiver and provided that information to MH's parents for when MH completes the residential program. As a result of the above steps, DRF closed this case as Other Successes or Outcomes Due to P&A Involvement through Self-advocacy Assistance. DRF emailed a case closing letter with DRF Client Procedure and Client Satisfaction Survey to MH's parents.

Case of Closing an Individual Advocacy Case File

As an example of a case that DRF closed with the problem resolved in the client's favor, RJ is a student with serious emotional disturbance (Schizoaffective Disorder, ADHD, and Disruptive Mood Dysregulation Disorder (DMDD). RJ's parent contacted Disability Rights Florida (DRF) seeking assistance with appealing a Manifestation Determination Review decision (MDR) and preventing expulsion. These issues surfaced after RJ committed a zero-tolerance offense and their school determined that the offense was not a manifestation of their disability. Furthermore, RJ's only diagnosed disability at the time of the incident was ADHD. As a result, the school district moved to expel RJ. DRF conducted a review of the RJ's records and concluded that RJ needed to be evaluated to determine if she was experiencing the sudden onset of symptoms related to possible schizophrenia or bipolar disorder. In response, RJ's parent disenrolled RJ from the school district, had RJ comprehensively evaluated privately, and RJ received a diagnosis of schizoaffective disorder. DRF negotiated a mitigated expulsion with the school district where, instead of expelling and excluding RJ from school, she would receive a therapeutic 45-day Interim Alternative Education Placement (IAES) through which RJ could receive all needed therapeutic interventions throughout their school day in a small student-teacher ratio setting. At the end of RJ's 45-day IAES, her IEP team reconvened and determined that RJ's current therapeutic placement provides her Free and Appropriate Public Education (FAPE), she is making great gains and is very happy in her current placement, and RJ continues to receive all needed therapeutic and medicinal interventions in the school, community, and home placement. DRF closed this case due to the primary objectives of this case being resolved in the client's favor.

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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	9	6	2	0	1	2	1	0	2	0	0	23
2. Limited Advocacy	0	0	1	0	0	0	0	0	0	0	0	1
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	19	2	22	2	2	0	0	0	0	0	0	47
6. Mediation	0	0	0	0	0	0	0	0	0	0	0	0
7. Negotiation	0	0	0	0	0	0	0	0	0	0	0	0
Total	**28**	**8**	**25**	**2**	**3**	**2**	**1**	**0**	**2**	**0**	**0**	**71**
Neglect	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	
1. Self Advocacy Assistance	1	2	3	0	0	0	1	1	0	0	0	8
2. Limited Advocacy	1	2	14	0	10	0	0	0	0	0	0	27
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	9	0	11	0	1	0	0	0	0	0	0	21
6. Mediation	0	0	0	0	0	0	0	0	0	0	0	0
7. Negotiation	0	0	1	0	0	0	0	0	0	0	0	1
Total	**11**	**4**	**29**	**0**	**11**	**0**	**1**	**1**	**0**	**0**	**0**	**57**
Rights Violations	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	
1. Self Advocacy Assistance	5	2	3	0	3	0	0	0	0	2	0	15
2. Limited Advocacy	0	0	10	2	1	0	1	0	0	0	0	14
3. Administrative Remedies	0	0	1	0	0	0	0	0	0	0	0	1

4. Litigation	0	0	0	0	0	0	0	0	0	0	0	0
5. Abuse/Neglect Investigations	6	0	3	0	0	0	0	0	0	0	0	9
6. Mediation	0	0	0	0	0	0	0	0	0	0	0	0
7. Negotiation	0	1	11	0	1	0	0	0	0	0	0	13
Total	**11**	**3**	**28**	**2**	**5**	**0**	**1**	**0**	**0**	**2**	**0**	**52**

At least 1 case required.

Case of Intervention

As an example of DRF resolving a case through negotiation, JW is an adult female with significant mental illness (Borderline Personality Disorder, Bi-polar Disorder) who was residing in a County Jail at the time of their initial request for assistance from Disability Rights Florida (DRF). JW contacted DRF to request assistance with an allegation of neglect from jail staff. Specifically, she alleged that, while housed on the jail's Suicide Precaution unit, jail staff verbally abused her, sprayed her twice with chemical agents, stripped her of her clothes, and did not intervene during prolonged incidents of self-injurious behavior. To investigate this service request, DRF staff requested and reviewed video surveillance records, clinical records, and jail policies and procedures associated with the incident. DRF developed the following conclusions as a result of their records review: 1.) jail staff failed to conduct required 15-minute checks of JW while she was on Suicide Precaution, resulting in JW banging her head against the cell door for at least 5 hours without intervention; 2.) jail staff discharged chemical agents, twice, without first taking appropriate efforts to de-escalate the situation, as is required by jail policy; 3.) jail staff training materials did not include de-escalation techniques, Crisis Intervention Techniques, and mental health-related training modules; 4.) jail staff stripped JW of her Suicide Precaution gown—as a legitimate safety precaution—and left her naked in her cell for over 5 hours without intervention. DRF presented their investigative conclusions to the jail and worked with jail administrators and General Counsel to resolve the presented issues. As a result of these communications, DRF achieved the following case outcomes: 1.) jail administrators reviewed internal audits of 15-minute checks of inmates on the Suicide Precaution and determined that the jail's internal auditor failed to complete their task of auditing 15-minute checks for the time associated with this case. At the time of this case closing, the internal auditor position is vacant as the jail continues its search for a candidate to fill the position; 2.) jail administrators developed and implemented additional required staff training modules that focus on mental health-related topics, such as de-escalation and Crisis Intervention Techniques; 3.) jail administrators revised jail policies and procedures related to the care and treatment of individuals with significant mental illness, particularly by including language to provide more comprehensive assessments of inmates who demonstrate continued self-injurious behavior and developing a procedure to intermittently assess inmates who have had their Suicide Precaution gowns confiscated to ensure that gowns are returned as soon as the immediate risk of harm is resolved. As a result of the above steps, DRF closed this case as issues resolved in the client's favor through Negotiation due to DRF working with the jail to develop additional training modules and revise jail policies and procedures to better provide care and treatment to inmates with significant mental illness. DRF mailed a case closing letter with a DRF satisfaction survey, and SASE to JW at her current facility.

Case of Intervention

As an example of DRF resolving a case through Administrative Remedies, BS is an adult female with a significant mental illness who was residing in a State Mental Health Treatment Facility at the time of their initial request for assistance from Disability Rights Florida (DRF). BS contacted DRF to request assistance with a complaint of a rights violation. Specifically, she alleged that facility staff were violating her right to access abuse reporting via the patient telephones by not posting the required phone numbers for the Department of Children and Families (DCF) Abuse Hotline and DRF above the resident phones in her living area, refusing her access to the phones to call DRF, and requesting details about the specific complaints that she was reporting the DCF and DRF. To investigate this service request, DRF staff held an in-person interview with BS. During that visit, DRF staff visited BS' living area and inspected the patient phones. They confirmed that phone numbers for the DCF Abuse Hotline and DRF were not posted above patient phones, as required by state regulations. Furthermore, they spoke with facility staff who

demonstrated a lack of awareness about patients' rights to access to the unit telephones according to state regulations. To resolve BS' complaints, DRF contacted the facility's Customer Relations department to request that: 1.) they post the contact information for the DCF Abuse Hotline and DRF above all patient phones in the facility; 2.) re-train all direct care staff on the state regulations regarding patients' access to abuse reporting (most notably that staff cannot restrict phone calls to the DCF Abuse Hotline or DRF and that staff cannot request that patients explain their reason for contacting those agencies). The facility's Customer Relations department agreed to implement DRF's request. DRF held this case open while they confirmed that the facility completed the requested actions. As a result of the above steps, DRF closed this case as issues resolved in the client's favor through Administrative Remedies due to the facility posting the required phone numbers above all patient phones and conducting staff training/re-trainings on patients' right to report abuse. DRF mailed a closing letter with a DRF satisfaction survey, DRF grievance procedure, and SASE to BS at her at current facility.

Case of Intervention

As an example of DRF resolving a case through Limited Advocacy, FB is an adult male with a significant mental illness who was residing in a forensic State Mental Health Treatment Facility at the time of their initial request for assistance from Disability Rights Florida (DRF). FB contacted DRF to request assistance with 1.) gaining more efficient access to their legal documents, which the facility was storing in FB's personal property after they determined that the large volume of papers that FB was keeping in his room were a safety risk; 2.) submitting a change in counselor request; 3.) submitting requests for accommodations—specifically, an extra mattress. To investigate this service request, DRF staff met with FB at his facility to gather more information about his service request. While on-site, DRF staff spoke with the Risk Management Department, FB's counselors, and other facility staff who are involved with the aforementioned issues. After speaking with facility staff, DRF communicated self-advocacy information to FB to address each of the three issues related to their service request. They then held FB's case open to ensure that FB did not have problems accessing their documents, change of counselor requests, or accommodations requests. Upon follow up with FB, he alleged that staff were not providing him with immediate access to his legal documents. DRF contacted FB's counselor a second time to get more information about FB's allegation. The counselor explained that FB submits an egregious number of legal filings and is, therefore, constantly requesting access to his legal documents—almost daily. Also, FB becomes upset if staff do not immediately provide him access to his documents. While facility staff can accommodate FB, they may not always have the staff or room availability to provide him with immediate access but the counselor ensured that they would continue to provide FB with reasonable access. DRF reviewed this information with FB, who confirmed that he understood and had no further questions related to their initial request for service. As a result, DRF closed this case as issues resolved in the client's favor through Limited Advocacy due to FB receiving accurate self-advocacy instructions to address his primary needs associated with this case. DRF mailed a case closing letter with a DRF satisfaction survey, DRF grievance procedure, and SASE to FB at his current facility.

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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	17
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 (4), other inmates/facility residents (2), managing entity staff (1).	7
Total Number of deaths investigated	**24**

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

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

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).	2
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.).	16
e. Death investigations with a finding of determination.	4
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]	**23**

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 a death investigation involving incidents of abuse, a State Mental Health Treatment Facility (State Hospital) sent Disability Rights Florida (DRF) reports of substantiated abuse and neglect against MD, a patient committed to their facility for treatment of serious mental illness. MD's condition declined while at the facility and he was ultimately placed on hospice care, before being discharged to his family and dying shortly thereafter. In addition to the substantiated abuse/neglect allegations prior to his death, the notice of death included several alarming details, such as that his family asked the State Hospital to discontinue feeding "because he is very severely mentally ill, we look at this as a gift to allow him to die." This ethical issue was exacerbated by the fact that the courts had committed MD for charges of domestic violence against the same family members and that some of the family seeking to become his decisionmakers had an active restraining order against him. To investigate this case, DRF reviewed extensive records for the time period leading up to MD's death. DRF concluded that the State Hospital could have potentially averted the ethical issue involving MD's family if it had taken more appropriate steps to allow MD to determine his own end-of-life care, including advanced directives. Though the State Hospital offered these forms to MD at admission, his records indicate that he was not in a state of mind where he understood what was being offered. When he was later more stable, the State Hospital never re-offered them. DRF also concluded that, when the State Hospital became aware of the need for end-of-life decision making, it failed to take appropriate steps to obtain a surrogate decisionmaker or guardian, allowing it to default to MD's family in an ethically dubious

situation. DRF sent a letter to the State Hospital summarizing the above issues. DRF met with the facility's Risk Manager and Chief Nursing Officer about these issues. DRF received a response from the new administrator which stated that the State Hospital had completed the following corrective actions: (1) re-instituted the hospital's Ethics Committee, (2) retrained all providers on rules for advanced directives and other end-of-life processes, and (3) implemented a new protocol that requires these documents to be re-offered at each monthly Recovery Team meeting, rather than only at admission, and that they also be offered again at every annual review. The State Hospital noted that their new electronic medical records system will also require that teams confirm they've been offered at every monthly meeting. Upon review, DRF agreed that the State Hospital's corrective action plan was sufficient, and they agreed to close the individual death investigation. DRF will continue to monitor the State Hospital for issues akin to this, particularly in quarterly notices of deaths.

As an example of a death investigation not related to Seclusion and Restraint, TC is an adult male with significant mental illness who was housed on the inpatient mental health unit of a State Prison at the time of their death. Disability Rights Florida (DRF) learned of TC's death during their litigation against the Florida Department of Corrections (FDC) related to care and treatment being provided to inmates residing on inpatient mental health units (MHUs) within the FDC. Since TC was assigned to an inpatient level of mental health care at the time of their death, DRF conducted a death investigation to determine if abuse, neglect, or rights violations contributed to TC's death. To investigate this case, DRF requested and reviewed various records related to TC's treatment on the inpatient mental health unit (e.g. FDC Classification, Medical and Mental Health Records, and Inspector General Records). According to the records, TC had engaged in repeated instances of self-harm requiring transfer to an outside hospital and continued care while at the State Prison. Additionally, DRF identified shortfalls in the prison's medical staff's diagnosis and treatment of severe medical symptoms resulting from TC's self-injurious behavior. Specifically: 1) nursing staff did not consult with medical providers during TC's multiple self-harm incidents after TC returned from the outside hospital; 2) prison staff allowed TC to return to their cell after self-harming multiple times and remained on 15-minutes checks even though they demonstrated high-risk behavior (as opposed to being placed on continuous observation); 3) mental health staff failed to take precautions to keep TC safe (such as placing them on continuous observation or being placed in an Isolation Management Room (IMR), providing Emergency Treatment Orders, placing them in restraints to prevent further self-harm, etc.). DRF used the information gathered during their records review to communicate with the FDC regarding ongoing systemic issues on their inpatient mental health units, which DRF feels may have contributed to TC's death—most notably, the FDC's policies for monitoring inmates actively engaging in self-harm behaviors. DRF provided these concerns along with their investigative findings to the FDC via written letter and in meetings as part of DRF's ongoing systemic death investigation work, with acknowledgement from FDC. In response, FDC confirmed that their Mortality Review of TC's death had identified the above issues and that they had implemented and completed a corrective action plan with staff training to address the problems. Furthermore, the FDC hired an outside consultant to complete a thorough review of all policies related to care of inmates located on their inpatient mental health units. DRF concluded that the FDC's corrective actions sufficiently addressed the problems associated with TC's death. As a result of the above or this reason, DRF closed this due to "other success or outcomes due to P&A involvement" after the FDC completed their Mortality Review and implemented a Corrective Action Plan. No closing letter or satisfaction survey sent, as client is deceased.

As an example of a death investigation with a finding or determination, TW was and adult male with significant mental illness who was housed at a County Jail at the time of their death in Q4 of FY 2023-2024. Prior to TW's death, he had been adjudicated Incompetent to Proceed as a result of his significant mental illness, committed to housing in a State Mental Health Treatment Facility (State Hospital), and was awaiting transfer from the jail to the State Hospital. Disability Rights Florida (DRF) learned about TW's death through a local newspaper report. To investigate this case, DRF reviewed the Medical Examiner's (ME) report and, under their Access Authority, requested TW's records from County Jail. According to the ME's report, the cause of death for TW was hypernatremic dehydration and that TW commonly refused to eat, take prescribed medication, and maintain personal hygiene in the month prior to his death. As a result, DRF had concerns that TW's behavior may have been symptoms of his mental health diagnoses. Furthermore, County Jail staff neglected TW by failing to appropriately identify and treat his worsening mental health symptoms. Based on the above investigative findings, DRF concluded that the County Jail's negligent supervision contributed to TW's death. Following the conclusion of the individual investigation of TW's death, DRF engaged in discussions with the County Jail's General Counsel. DRF presented the following concerns: 1) TW's history of risk for deterioration without appropriate treatment; 2) TW's consistent refusal of mental health treatment and medications; 3) the jail staff's failure to effectively intervene or engage in TW's care; 4) TW's psychiatric assessment when Baker Acted; 5) any corrective actions taken as a result of TW's death. Although not in direct connection with TW's death, the jail presented DRF with the following policy changes implemented after the death of TW: 1) Revised the procedure for conducting medication distribution; 2) Implemented "huddles" between the jail's mental health team and jail staff working in specific dorm areas every morning; 3) Initiated a mental health-tiered-housing model, e.g. Isolation Housing, Closed-Mental Health Housing and Open-Mental Health Housing; 4) Completed refresher trainings on how to conduct medical/mental health evaluations, make observations of dehydration and malnutrition, and document medical/mental health information; 5) Instituted a process for providing involuntary psychotropic medication; 6) Ensured that a medical provider is on site twenty-hours a day and seven days a week, except on Sunday nights when a physician is on-call. As a result of the above steps, DRF closed this case as issues resolved in the client's favor through Negotiation due to DRF discussing their investigative findings with the County Jail and the County Jail confirming changes in the procedure for managing detainees with medical/mental health needs. DRF could not mail a closing letter to the client because this was a death investigation.

As an example of a death investigation with a provision in policy, SK was an adult female with a significant mental illness who was residing in a State Mental Health Treatment Facility (State Hospital) at the time of her death. Disability Rights Florida (DRF) received notice of SK's passing as part of their review of the Florida Department of Children and Families' (DCF) Facility Incident Tracking System (FITS) reports of serious incidents that occur in Florida's State Hospitals. As a result, DRF conducted a death investigation to determine if abuse, neglect, or rights violations contributed to SK's death. During the investigation, DRF staff interviewed facility staff, inspected SK's living area and bedroom, and reviewed records associated with SK's death. They also consulted a medical expert for an expert opinion on the facility's management of SK in the time leading to her death. As a result of their records review and the medical expert opinion, DRF found evidence supporting the following conclusions: 1) nursing staff failed to properly perform and document face checks; 2) nursing and direct care staff falsified documentation or failed to document details related to injuries sustained by SK; 3) facility staff failed to qualify SK's previous injury leading to hospitalization outside of the facility as a "critical event"; 4) facility staff failed to complete a Special Observation

Order upon SK's return to the medical unit, as required by facility Operating Procedures (OP); 5) facility staff demonstrated a lack of consistency in how they conduct face checks. DRF subsequently requested the following from the facility related to the above investigative findings: 1) amend the definition of "critical event" to comply with DCF CFOP 155-25 and retrain staff on the policy amendment; 2) retrain staff on Special Observation Orders (SOO); 3) coordinate with DCF to revise policy CFOP 155-06: Safe and Supportive Observations of Residents, to include a minimum required distance for conducting 15-minute face checks to better ensure staff consistency when monitoring residents on 15-minute checks. DRF maintained communication with the facility as they addressed each of DRF's requests. Overall, the facility completed the following in response to DRF's requests: 1) confirmed that they previously completed an investigation into staff violations and implemented disciplinary action against the staff involved in the cited violations, including termination of one staff member and re-training requirements for three others; 2) revised the Special Observation Flowsheet to include a required distance that face checks must be completed; 3) trained staff on the updated Special Observation Flowsheet; 4) clarified their definition of a "critical event" and their reasoning for not requiring a SOO upon SK's return to the facility, satisfying DRF's concerns regarding this issue. As a result of the above steps, DRF closed this case as issues resolved in the client's favor through Administrative Remedies due to the facility revising policies, implementing corrective action plans, and conducting staff training/re-trainings. DRF could not mail a closing letter to the client because this was a death investigation.

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Footnotes:

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 (24) and Section B (23).

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, 2023 to 2024. (Carried over from prior FY (s))	51
2. New group cases/projects opened during the year.	29
3. Total group cases/projects worked on during the year (Add lines 1 & 2)	80
4. Total group cases/projects as of September 30, 2024 to 2025. (Carry over to next FY)	57
5. Group cases/projects targeted at serving the following special populations:	
a. Ethnicity	0
b. Racial Minorities	0
c. Homeless	3
d. Veterans	3
e. Urban	13
f. Rural/Frontier	1
g. Older Adults/geriatric	2
6. Total # of individuals potentially impacted by line 3	28,209,249

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)	12,437,633	4	1	11
Abuse and Neglect Investigations (non-death related)	1,012	1	0	6
Facility Monitoring Services	8,880	7	0	12
Community Based Monitoring Services	6	1	0	0
Court Ordered Monitoring	0	0	0	0
Systemic Litigation	2,852,614	3	0	5

Educating Policy Makers	9,057,439	2	2	11
Other Systemic Advocacy	3,851,665	3	0	11
Total	**28,209,249**	**21**	**3**	**56**

In the second form, the Potential # of Individuals Impacted should match the number for Question 3. Total group cases/projects worked on during the year (Add lines 1 & 2). The total number of cases Concluded Successfully, Concluded Unsuccessfully, and On-going should match the number for Question 6. Total # of individuals potentially impacted by line 3.

Case of Intervention on Behalf of a Group

Throughout FY 2024-2025, Disability Rights Florida (DRF) worked on and produced an amicus brief related to fair treatment of veterans with significant mental illness during criminal proceedings. In Q3 of FY 2024-2025, attorneys from the Florida Association of Public Defenders and the Capital Habeas Unit of the Federal Public Defender contacted Disability Rights Florida (DRF) about participating in an Amicus Brief in the United States Supreme Court, seeking a stay of execution for Sgt. J. Huchinson, an Army veteran sentenced to death for the murder of his partner and her two children. Hutchinson is a Gulf war veteran with disabling conditions, including significant mental illness (PTSD and Gulf War Syndrome) and Traumatic Brain Injury from his combat experience. The Amici—DRF and Veterans groups—sought a stay of execution and new sentencing hearing to allow the court to hear about additional mitigating factors related to the effects of his military service. The legal argument is that Sgt. Hutchinson has lasting physical and psychological scars that his capital jury or sentencing judge never heard about—in part because Congress itself had not yet recognized those scars—rendering his death sentence constitutionally impermissible. The Amicus brief arguing the points above was successfully filed in the US Supreme Court. DRF was represented in the Amicus brief by John R. Mills, Principal Attorney at Phillips Black, Inc., which is a Non-Profit, Public Interest Law Practice in Oakland CA. Unfortunately, but not unexpectedly, the stay of execution was denied. However, DRF will continue to raise these issues in the courts to increase awareness on the how the actions of the criminal justice system discriminates against those with significant mental illness. This project impacted a group 10 individuals who are veterans with significant mental illness sentenced to death in Florida. Of the 273 inmates sentenced to death in Florida, approximately 5% identify as veterans and may be impacted by greater recognition of military service-related disabilities.

Case of Intervention on Behalf of a Group

In FY 2024-2025, Disability Rights Florida (DRF) created a litigation project in response to the Florida Department of Children and Families' (DCF) failure to collect and report data as required by § 394.461(4), Fla. Stat. At the onset, DRF, in collaboration with attorneys at Southern Poverty Law Center (SPLC), submitted a public records request for annual reports and associated data that DCF is required by law to collect, maintain, and report on. The goal of the initial records request was to investigate the accuracy of anecdotal reports received by DRF alleging that some receiving facilities were holding patients for involuntary examinations under the Baker Act longer depending on their payor class. DRF's primary concern was that individuals whose insurance offered higher reimbursement rates were being held longer to increase profits for the receiving facility. Upon request, however, DCF informed DRF and SPLC that their agency did not have the data because the receiving facilities refused to provide it, arguing that it is "proprietary" information. Further discussions with DCF's General Counsel Office confirmed they have no intention of pursuing any path to obtain this data without outside pressure. As a result of DCF failing to collect and report on Baker Act data according to law, DRF shifted their focus to filing a lawsuit against DCF for their failure to comply with the law. SPLC, along with Florida Health Justice Project, have offered to co-counsel and represent DRF as plaintiff in a civil suit to enforce the legislative mandate that DCF collect and report this data. The ultimate goal of the lawsuit is to ensure DCF follows the law and to obtain the data in question so we can determine whether the receiving facilities are illegally and unconstitutionally holding individuals under the Baker Act longer than necessary to improve their profits. During FY 2024-2025, DRF filed the lawsuit and commenced negotiations with DCF. Throughout FY 2024-2025, DCF provided the majority of the data previously requested and denied. After DCF asserted that it had provided all data available, DRF and partners decided to dismiss the lawsuit. DRF sent a letter to DCF outlining the expectations for future statutory compliance with data collection and reporting requirements. This project will remain open into the next FY as DRF finalizes negotiations with DCF. Overall, this project impacts a group of 111,803 Floridians who receive involuntary examinations under

the Baker Act--a statistic which comes from the Florida's Baker Act Reporting Center report for FY 2022-2024.

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;	1
b) PAIMI-eligible individuals who access benefits or services or are better able to advocate to do so;	33
c) PAIMI-eligible individuals who live in a healthier, safer, improved, or more integrated settings or are better able to advocate to do so;	11,575
d) PAIMI-eligible individuals are able to stay in their own home or better able to advocate to do so;	2
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;	0
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
h) PAIMI-eligible children (individuals) who receive appropriate services in the most integrated settings;	428
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;	1
j) PAIMI-eligible individuals who were not subject to abuse, neglect, or rights violations or are better able to advocate for to do so;	107
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	776
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.	1,298
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.	40
2. Number of education/training activities undertaken.	67
3. Number (approximate) of persons trained in 2.	3,976
4. Technical Assistance	
Provide the number of PAIMI Program TA services.	2

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Footnotes:

E. Grievance Procedures

Grievance Procedures

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:Dr. Beth Boone Title:Chair, DRF Board of Directors Grievance Committee Name:Cherie Hall Title:DRF Executive Director	
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 2024-2025, Disability Rights Florida (DRF) collected public input by requesting comments to the draft Goals, Priorities, Objectives that were posted to the DRF 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, DRF's Frontline Intake and Referral Services Team (FIRST) 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. 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. (●) If **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 members 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 2024-2025, 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]
N/A per current Executive Orders and SAMHSA Strategic Priorities

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.

N/A per current Executive Orders and SAMHSA Strategic Priorities

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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.

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 2024-2025
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 2024-2025

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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.
In the context of outreach, Disability Rights Florida (DRF) staff produced the Disability Deep Dive Podcast—a bi-weekly interview-based podcast. Each episode focuses on issues of importance to people with disabilities, such as accessibility, identity, discrimination, rights protections, and voting. In FY 2024-2025, they hosted Katie Hasson, Associate Director of the Center for Genetics and Society, who discussed the documentary "Fixed: The Science/Fiction of Human Enhancement." The episode covered PAIMI-related topics such as such as the impact of the promotion of ableism through new science technologies, e.g. embryo screening to predict mental health conditions like bi-polar disorder or schizophrenia (see attachment 1 for a link to the podcast episode).
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)].
Training Needs
Please identify any training and technical assistance requests. [42 U.S.C. 10825]

Upload supporting documents for Accomplishments here

DRF's FY 2024-2025 PAIMI-focused Disability Deep Dive Podcast Episodes

The following are links to the DRF Disability Deep Dive podcast episodes The Ethics of Innovation: Disability, Technology, and Reproductive Justice with Katie Hasson Disability, Pop Culture, and Higher Education with Kyle Romano, as outlined in paragraphs one and two of DRF's statement of accomplishments:

The Ethics of Innovation: Disability, Technology, and Reproductive Justice – with Katie Hasson

https://disabilityrightsflorida.org/podcast/story/episode_76

Disability, Pop Culture, and Higher Education – with Kyle Romano

https://disabilityrightsflorida.org/podcast/story/episode_75

The Palm Beach Post

STATE

Disability group sues Florida, saying it's not releasing public records on Baker Act

'The Department's ongoing refusal to provide the requested records will harm DRF's ability to advance its mission of monitoring the use of involuntary psychiatric care in Florida,' the suit says.

Ana Goñi-Lessan
USA TODAY NETWORK - Florida

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An advocacy group is suing the state of Florida for not releasing what it says is public information about how many times mentally ill people are involuntarily taken into custody.

Disability Rights Florida (DRF) filed suit this week in Leon Circuit Civil court against the Florida Department of Children and Families (DCF).

The complaint alleges the department did not publish a required annual report on the Baker Act – the state law allowing for the involuntary examination and treatment of those who may pose a risk to themselves or others – and did not collect data from receiving and treatment facilities.

According to the lawsuit, the organization filed a public records request Oct. 4 for information about each public receiving and treatment facility designated by DCF, including five years of previous annual reports, but the department didn't comply with the request.

DRF says in its complaint that a 2007 law passed by lawmakers requires the state to track Baker Acts and the state has not kept track of this information, nor has it compelled facilities to turn over the information or publish reports.

According to state law, the state has reporting requirements for receiving and treatment facilities and is supposed to report data including the following: the number of licensed beds, the number of contract days and the number of admissions by diagnosis.

"The department shall issue an annual report based on the data required pursuant to this subsection. The report shall include individual facilities' data, as well as statewide totals. The report shall be posted on the department's website," the law states.

The lawsuit says DCF responded to the request with a link and said the reports could be found there, but DRF argues the information required by law was not there.

"The Department's ongoing refusal to provide the requested records will harm DRF's ability to advance its mission of monitoring the use of involuntary psychiatric care in Florida," the suit says.

The lawyers representing DRF are Sam Boyd with the Southern Poverty Law Center and Katy DeBriere with the Florida Health Justice Project. The case has been assigned to Circuit Judge Jonathan Sjostrom.

A complaint in a lawsuit tells one side of a story. A request for comment from the department is pending, though state agencies generally decline to do so on pending litigation.

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Disability rights organization sues Florida DCF, says it has not gathered Baker Act data

The lawsuit alleges, in part, that the department has not complied with a 2007 law that requires publishing reports and data about use of the Baker Act.

By News Service of Florida • Published December 13, 2024 • Updated on December 13, 2024 at 8:26 am

An organization that advocates for people with disabilities filed a lawsuit this week alleging that the Florida Department of Children and Families has not gathered data and issued required reports about use of a law known as the Baker Act.

Disability Rights Florida wants a Leon County circuit judge to order the department to collect Baker Act data from mental-health facilities and produce reports.

The Baker Act allows for people with mental illness to be involuntarily held and treated at such facilities under certain circumstances. The lawsuit alleges, in part, that the department has not complied with a 2007 law that requires publishing reports and data about use of the Baker Act.

The lawsuit, filed Wednesday, said the information, if collected, would “answer a number of important questions about use of the Baker Act such as how long an average patient is held, what conditions lead to shorter or longer stays, whether insured patients are being held longer than others, and whether patients insured by the state are being held for longer, costing the state more money, than others.”

The lawsuit said the data would help the non-profit Disability Rights Florida in monitoring psychiatric hospitals. It said the organization on Oct. 4 made a public-records request but that the department did not provide the requested information.

IN THE DISTRICT COURT OF APPEAL
OF THE STATE OF FLORIDA
FIFTH DISTRICT

CASE NO. 5D2024-1853
L.T. CASE NO. 16-2021-CA-004707

SHAMYLIA MURPHY, as Personal Representative for the Estate of SHERITA SHAVON MURPHY-GRAY,
Appellant,

-vs-

HERITAGE II HOLDINGS, LLC, and HERITAGE FLORIDA PROPERTY HOLDINGS, INC.,
Appellees.

ON APPEAL FROM THE CIRCUIT COURT
IN THE FOURTH JUDICIAL CIRCUIT
IN AND FOR DUVAL COUNTY, FLORIDA

BRIEF OF *AMICUS CURIAE* FLORIDA HOUSING UMBRELLA GROUP IN SUPPORT OF APPELLANT

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INTEREST OF AMICUS CURIAE

Amicus Curiae Florida Housing Umbrella Group (hereinafter "HUG") is an unincorporated statewide association of approximately 250 lawyers, legal professionals, advocates, faculty, and researchers employed by legal services and civil legal aid organizations, universities, and nonprofit organizations. Founded in the 1980s, HUG focuses on legal issues and practical problems in rental housing, foreclosure, and homelessness. The majority of its members provide no-cost civil legal services to indigent communities across Florida, representing people at risk of losing housing or experiencing homelessness. Many of the persons served by HUG's members are people with disabilities, and many of its members litigate on behalf of persons with disabilities and families with minor children. HUG has regularly appeared as amicus curiae and offered public comments to aid Florida appellate courts better understand rental housing issues, as well as to protect and advance the rights of tenants in Florida.

This appeal features important questions for tenants across Florida regarding the application of the Impact Rule in a case brought on behalf of a tenant's estate against the tenant's former landlord.

The trial court's misapplication of the Impact Rule in the judgment on appeal threatens to upset the policy balance between landlord and tenant set forth within the Florida Residential Landlord and Tenant Act (hereinafter "FRLTA"). Specifically, the trial court's narrowing of what constitutes an impact for the purposes of the Impact Rule could immunize a landlord from its obligations to maintain certain structures, condition, or elements of a residential dwelling unit and deprive tenants of remedies afforded by FRLTA for such noncompliance, in addition to the implications for tortious conduct actionable at common law.

The outcome of this appeal will greatly affect the work of HUG's members and their housing litigation across Florida. The combined experience of the HUG's members in litigating landlord/tenant cases across both federal and state court will aid this Court in understanding the troubling implications of the trial court's version of the Impact Rule. HUG can help this Court better understand these broader impacts of the trial court's ruling, and the accordant chilling effects on exercising protected rental housing rights.

SUMMARY OF ARGUMENT

Florida's Impact Rule is designed to curtail fictitious and expansive claims for emotional distress damages where no impact upon the claimant has occurred. However, the Impact Rule does not apply to any tort claim in which there is an impact or contact with a claimant's person, no matter how large or small, visible or invisible, or immediate or delayed in harm. The Impact Rule, properly understood, is a threshold claims processing mechanism to determine whether a claimant has been contacted or impacted by something that later causes emotional distress.

However, the trial court diverged from the proper understanding of the Impact Rule in its ruling granting summary judgment to Appellees. By engaging in a quantitative assessment into the nature and extent of Appellant's injury and by focusing too narrowly on the nature and extent of the impact upon Appellant, the trial court improperly transformed the Impact Rule into a tool of claim preclusion. Worse, the trial court engaged in impermissible weighing of the evidence and usurped the role of the jury in determining critical questions of fact regarding the breach of Appellees' duty to Appellant, the proximate cause of Appellant's injuries, and the damages

sustained by Appellant. The trial court's ruling threatens to disrupt FRLTA's balance of duties between a landlord and tenant, and effectively insulate a landlord from duties owed by law to their tenant. The effects would be far reaching, especially given the state of the rental housing market in Florida, the number of unsafe and unhealthy rental housing units, and the widespread population with disabilities that may be greatly exacerbated by a ruling extending the Impact Rule in this erroneous way.

The Court should grant the relief sought by Appellant on appeal, reverse the trial court's grant of summary judgment, and remand this case to the trial court for proceedings consistent with the Court's opinion and mandate. In doing so, the Court would protect the balance of interests expressed in FRLTA and ensure that tenants across Florida have access to a needed remedy for unsafe and unhealthy housing.

ARGUMENT

I. The trial court's flawed interpretation of Florida's Impact Rule is contrary to well-established law and, if left undisturbed, will have collateral implications for the enforcement of a landlord's duties set forth within the Florida Residential Landlord and Tenant Act.

The trial court, while correctly identifying and discussing the broad strokes of Florida's Impact Rule, twisted that same rule to insulate a landlord from liability for emotional distress despite evidence of clear and obvious physical impacts upon a tenant. The trial court found the connection between these impacts on Appellant in her rental dwelling, which resulted from a breached duty to maintain the rental dwelling in a reasonably safe manner, and the emotional distress sustained by Appellant to be too attenuated to sustain a viable negligence claim. In granting summary judgment to Appellees, the trial court impermissibly intruded into the jury's role to determine the ultimate questions of fact regarding breach, proximate causation, and damages. Moreover, the trial court's ruling, broad in its conclusion that tenant claims of emotional distress connected to unsafe rental housing conditions should be scarce, threatens collateral harm to Florida's specific statutory balance of repairing and maintaining rental housing within FRLTA.

Florida's Impact Rule, as the trial court rightly summarizes, "requires that before a plaintiff can recover damages for emotional distress caused by the negligence of another, the emotional distress suffered must flow from physical injuries sustained in an impact." R. at 2617 (quoting Rowell v. Holt, 850 So. 2d 474, 477 – 79 (Fla. 2003) (internal quotation omitted)). Concerned with "open[ing] the floodgates for fictitious or speculative claims," Rowell, 850 So. 2d at 478, the Impact Rule applies to limit recovery only where there has been no impact upon a claimant. However, the Impact Rule has nuance and is not a strict dichotomy clothed in absolutes. Id. at 478.

As a threshold matter, the Impact Rule "does not apply and has never applied to torts which involve impact to or contact with the claimant's person." Willis v. Gami Golden Glades, LLC, 967 So. 2d 846, 851 (Fla. 2007) (Lewis, J., concurring). A plaintiff can rather easily meet the "slight requirements" to demonstrate an impact, since all that is required is a showing that "the outside force or substance, *no matter how large or small*, visible or invisible, and no matter that the *effects are not immediately deleterious*, touch[ed] or enter[ed] into the plaintiff's body." Eagle-Picher Indus., Inc. v. Cox, 481 So. 2d 517, 527 (Fla. 3d DCA 1985) (cited with approval in Zell v. Meek, 665 So.

2d 1048, 1050 n.1 (Fla. 1995) (emphasis added). Misapplications, misunderstandings, and "erroneous extensions" of the Impact Rule into cases where there is a clear but small impact can and often do lead to summary denials of meritorious claims, and transform the legal injury analysis of whether a physical impact or contact occurred into an impermissible quantitative assessment into the nature or extent of an injury. See Willis, 967 So. 2d at 854 – 55 (Lewis, J., concurring) (cautioning on how judicial overreach can lead to distortions of the Impact Rule); see also id. at 863 ("[t]his Court has never attempted to determine the application of the [Impact Rule] *based on the nature or extent of* the physical impact.") (Quince, J., concurring) (emphasis added). The inhalation of a substance or an electric shock are classic examples of contact that satisfy the requirement of impact. Eagle-Picher Indus., Inc., 481 So. 2d at 527 – 28.

If there is no impact, only then does the Impact Rule prevent recovery albeit with a notable exception. Even without impact, recovery for emotional distress may still occur where emotional distress is "manifested by physical injury," where the claimant is "involved" in the incident by proximity to the traumatizing event, and

where the claimant suffers the complained-of emotional distress and accompanying physical impairment "within a short time" of the incident. Id. at 526 (quoted with approval in Zell, 665 So. 2d at 1050 n. 1). This exception can be broad in practice, such as recognizing that a bystander to a traumatizing event can state an adequate claim and that there is no requirement that the impact be applied directly by the defendant. See Willis, 967 So. 2d at 848 – 50 (recognizing that a touching by an unknown assailant in a neighboring parking lot to the property owned by the defendant satisfied as an impact); see also T.V. v. Grindr, LLC, No. 3:22-cv-864-MMH-PDB, 2024 WL 4128796 at * 42 – 43 (M.D. Fla. 2024) (recommending rejection of a strict use of the "impact rule" where a minor's download and use of an online app "resulted in [the claimant's] exposure to, and engagement in, sexual relationships and activities with adults"). There are numerous other narrow exceptions to the Impact Rule not germane to this appeal, and the Impact Rule has never extended into the realm of intentional torts. See, e.g. Florida BC Holding, LLC v. Reese, 376 So. 3d 109, 114 – 15 (Fla. 6th DCA 2023) (citing examples).

Regrettably, when trial courts are faced with the interpretation of the Impact Rule, many courts engage in the precise type of

quantitative assessment divorced from the narrow contact or impact question that Justice Lewis forewarned. Many courts conflate the Impact Rule with proximate causation or damages, and especially at the summary judgment phase, impermissibly weigh the evidence as if the ultimate trier of fact on the elements of the negligence claim itself. The trial court fell victim to this error, conflating questions reserved for the jury into the Impact Rule analysis and improperly weighing the evidence of causation and damages in its grant of summary judgment. R. at 2619 – 20, Am. Order Granting Defs.' Mot. for Summ. J. at Pg. 4 – 5. Despite clear and unrebutted evidence of impact from inhaling fumes from faulty wiring in the walls of Appellant's rental dwelling, feeling excessive heat exuding through the walls of the rental dwelling due to the faulty wiring, inhaling fumes from sewage via the pipes in the rental dwelling, and touching sand and other sediment in the water supplied to the rental dwelling through its pipes, the trial court impermissibly weighed the evidence in lieu of assessing solely whether an impact occurred. Id.; compare R. at 1497 – 1534, Pl.'s Opp. To Defs. Mot. for Summ. J. on Impact Rule (summarizing supporting factual positions for impacts on Appellant from actual contact with rental dwelling) with R. at 888 -

920, Defs.' Mot. for Summ. J. on Impact Rule, Pg. 21 (focusing on whether the impact was the sole cause of emotional distress rather than rather an impact occurred). The trial court minimized the critical importance of the contacts Appellant sustained, "doubt[ing]" whether emotional harm from merely feeling or touching sand in water or heat from faulty wiring behind a wall could or "should ever be sufficient" to satisfy the Impact Rule. R. at 2619. The trial court's reluctance to find the contact sufficient appears grounded in prudential concerns regarding whether Appellant's emotional distress sustained was foreseeably connected to Appellees' duty to maintain the rental dwelling and whether the damages sustained were of any material consequence. R. at 2620 – 21. The trial court's analysis diverted from the Impact Rule's focus on an impact, no matter how small, and instead weighed the evidence of causation and harm reserved for the jury. Eagle-Picher Indus., Inc., 481 So. 2d at 527 (quoted with approval in Zell, 665 So. 2d at 1050 n. 1); see also Seybold v. Clapis, 966 F. Supp. 2d 1312, 1315 (M.D. Fla. 2013) (holding that impact by "an invisible force" that shook children inside a car was sufficient for the Impact Rule).

The trial court's Impact Rule error is compounded by its further removal from the jury the critical factual questions of breach, causation, and damages. The Impact Rule, used in this manner as a broad shield from jury trial, will have severe collateral consequences for tenants across Florida. The trial court's ruling significantly diminishes a landlord's legal duties to their tenant to maintain their rental dwelling, and the collateral effects of such a ruling could prevent a future tenant from exercising any material remedy for personal injuries stemming from unsafe and unhealthy rental housing conditions.

Section 83.51, Florida Statutes (2019) provides, in pertinent part, that a landlord of a residential dwelling is required to:

> (a) Comply with the requirements of applicable building, housing, and health codes; or
> (b) Where there are no applicable building, housing, or health codes, maintain the roofs, windows, doors, floors, steps, porches, exterior walls, foundations, and all other structural components in good repair and capable of resisting normal forces and loads and the plumbing in reasonable working condition. The landlord, at commencement of the tenancy, must ensure that screens are installed in a reasonable condition. Thereafter, the landlord must repair damage to screens once annually, when necessary, until termination of the rental agreement.

The duty of the landlord pursuant to FRLTA is two-fold: (1) prior to possession by the tenant, the landlord has a duty to inspect the residential dwelling and to make necessary repairs to transfer possession to the tenant a reasonably safe dwelling,[1] and (2) after possession commences by the tenant, the landlord as a continuing duty to exercise reasonable care in repairing dangerous defective conditions upon notice of their existence by the tenant. Youngblood v. Pasadena at Pembroke Lakes South, Ltd., 882 So. 2d 1097, 1098 (Fla. 4th DCA 2004) (citing Mansur v. Eubanks, 401 So. 2d 1328, 1329 – 30 (Fla. 1981)); see also Perez v. Belmont at Ryals Chase Condo. Ass'n, Inc., 393 So. 3d 859, 862 (Fla. 2d DCA 2024) (making

[1] While not currently before the Court in this appeal, the existence of a waiver of warranty or exculpatory clause in Appellee's rental agreement, R. at 341, Pl.'s Second Am. Compl., Ex. "A" at Pg. 4, is likely insufficient as a matter of law to waive Appellant's claims for obvious or apparent defects or hazardous conditions. See Casasanta v. Sailshare 296, LLC, 274 So. 3d 418, 420 – 21 (Fla. 1st DCA 2019) (Thomas, J., concurring) (discussing that the exculpatory clause was insufficiently clear in separating financial liability for repairs from personal injury claims); see also § 83.47, Fla. Stat. (2019) (forbidding rental agreement clauses "limit[ing] or preclud[ing] any liability of the landlord to the tenant" arising under law). Assuming it remains enforceable on that ground, it is also substantively unconscionable absent evidence Appellant had a meaningful, substantial, and actual opportunity to inspect the rental dwelling utilizing a person sufficiently trained to identify latent defects and hazards invisible to the ordinary person. See § 83.45, Fla. Stat. (2019).

clear that there is no insulation from liability for a landlord just because inherently unsafe or dangerous conditions were readily apparent to the tenant).[2] Any injury resulting from a failure to maintain the rental dwelling is cognizable, both in common law and by FRLTA. § 83.55, Fla. Stat. (1973).

Typically, the questions of breach of duty, damages, and most importantly, proximate causation are to be resolved by the trier of fact. Smith v. Grove Apts., LLC, 976 So. 2d 582, 586 – 87 (Fla. 3d DCA 2007). At the summary judgment stage, the trial court was limited in how far it could inquire into whether the breach alleged by Appellant was tied to the Appellees' statutory maintenance duties, whether the injuries Appellant suffered are of a type that FRLTA is intended to prevent, and whether the Appellees' violations were the

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[2] Just as in Perez, Appellees' rental agreement specifically forbids any "painting, installing fixtures, *making alterations*, additions and/or improvements" without prior written consent by Appellees, along with "[n]o financial restitution" for "such items" except where prior written consent is given and where a writing agreed to by the parties exists. Compare R. at 340, Pl.'s Second Am. Compl., Ex. "A" at Pg. 3 (emphasis added) with Perez, 393 So. 3d at 863 n. 2. While the term of the rental agreement likely violates section 83.47, Florida Statutes (2019) in part, it also demonstrates that Appellees had reserved unto themselves the duty of structural alterations, inclusive of plumbing and electrical wiring.

proximate cause of Appellant's injuries. Id.; see, e.g., Cold Storage Café, Inc. v. Barone, 779 So. 2d 371 (Fla. 2d DCA 2000) (reversing summary judgment because whether the condition of the window on the leased premises on the date of the accident was dangerous is an unresolved issue of fact); Grant v. Thornton, 749 So. 2d 529 (Fla. 2d DCA 1999) (reversing summary judgment because tenant was injured while exiting through front window of apartment during fire and alleged that landlord had violated county building and fire codes by maintaining front door with a deadbolt that required key to be used to exit); Bosket v. Broward County Hous. Auth., 676 So. 2d 72 (Fla. 4th DCA 1996) (reversing summary judgment because the issues of whether landlord breached duty to provide tenant with readable stove knobs allegedly requested by tenant, as well as duty to maintain fire extinguisher in safe working condition, were for jury to decide); Bean v. Carey's Rental Agency, Inc., 532 So. 2d 685 (Fla. 3d DCA 1988) (reversing summary judgment because action brought by father of deceased child who died as a result of inhaling noxious fumes from mineral spirits supplied by apartment manager to child's mother who was painting apartment upon the landlord's refusal to do so). A trial court may only decide these issues as a matter of law

where reasonable people could not differ, or where the harm resulting from the tortfeasor's actions or omissions are so bizarre or happen so infrequently that it could not have been reasonably anticipated. Bennett M. Lifter, Inc. v. Varnado, 480 So. 2d 1336, 1339 (Fla. 3d DCA 1985) (discussing that an appropriate jury instruction is vastly preferrable to judicial overreach).

Despite finding that the Appellant had multiple impacts with substances in the rental dwelling from faulty wiring or plumbing, R. at 2619 – 20, the trial court elected to decide the foreseeability of Appellant's emotional distress from those impacts as a matter of law. R. at 2621. The trial court considered that the "foreseeability or gravity of emotional harm from a landlord failing to correct unsafe or unsanitary conditions does not outweigh the need to prevent potential claims which are fictitious, speculative or difficult to prove." R. at 2621. Implicit in its ruling is that touching sediment in water or heat from faulty wiring behind a wall that led to emotional distress was not a foreseeable injury resulting from the landlord's failure to maintain the rental dwelling. See id. However, FRLTA expressly contemplates that such noncompliance by a landlord may be continuous and rise to such a degree that damages flowing from the

failures to make repair are actionable. See § 83.56(1), Fla. Stat. (2019) (rent withholding remedy and diminution in rental value); § 83.63, Fla. Stat. (2019) (tenant casualty damage remedies); cf. McCready v. Booth, 398 So. 2d 1000 (Fla. 5th DCA 1981) (recognizing residential tenant wrongful eviction remedy against landlord). It is eminently foreseeable that a failure to maintain a residential dwelling in safe and sanitary conditions would lead to possibilities like dispossession, diminished value, personal property damage, and emotional distress associated with living in indignity and squalor. In ruling otherwise, the trial court improperly deprived a jury from its proper role of weighing the question of proximate cause.

In deciding that a pattern of similar impacts to Appellant were not sufficient and in depriving Appellant of access to a jury to decide breach, proximate causation and foreseeability, damages, and the credibility of the disputed factual questions in this action, the trial court erred. By engaging in the exact mistake of which Justice Lewis warned, see Willis, 967 So. 2d at 854 – 55 (Lewis, J., concurring), the trial court's view on the Impact Rule effectively shields landlords from most negligence claims in which there is not property damage or immediate bodily injury, undermining Florida's imposed duty on

landlords to maintain safe and habitable housing in compliance with FRLTA. The trial court's error should be corrected in this appeal, and the action remanded for jury trial.

II. The incorrect Impact Rule interpretation will worsen the options available for tenants facing increased exposure to unsafe and unhealthy rental housing, and will exacerbate harms experienced by tenants with disabilities.

Apart from the effects on Appellant, the trial court's incorrect understanding of the Impact Rule operates as a deterrent to other tenants seeking damages as a remedy to landlord noncompliance with FRLTA's duties of maintenance. Much of the existing rental housing supply available in Florida and beyond threatens the health, safety, and wellbeing of those residing within it. Where rental housing affordability remains a myth more than reality, tenants' options to seek needed repairs, maintenance, damages for harms suffered, or alternatives for safer and healthier housing are made scarcer by a narrow view of how unsafe and unhealthy rental housing impacts a tenant. The downstream effects of summary judgment in favor of Appellees on the rental housing rights of other tenants could be pernicious, and this Court should consider those effects as part of its review.

One of the most prevalent concerns for tenants in rental housing is that their rental housing negatively affects their or another occupant's health, safety, or wellbeing. See Abbe Will, New survey finds many renters are concerned about the impact of home on health, Joint Ctr. for Hous. Studies of Harvard Univ. (Mar. 31, 2022), https://www.jchs.harvard.edu/blog/new-survey-finds-many-renters-are-concerned-about-impact-home-health. In the Joint Center for Housing Studies of Harvard University's study, indoor air quality, structural safety, moisture intrusion, and chemical exposure[3] each ranked highly in the chief concerns expressed by tenants regarding their existing rental housing. Id. 37% of tenants surveyed indicated that their concerns for their own health or the other occupants in their household led the tenant to either move or consider moving to another rental dwelling. Id. However, practical considerations, including the broad unaffordability of rental housing across the

[3] These common tenant concerns mirror the impacts that Appellant experienced, including inhaling fumes from arcing wires behind the drywall in Appellant's rental dwelling, feeling excessive heat exuding through the walls of the rental dwelling due to the electrical wiring, inhaling fumes from sewage via the pipes in the rental dwelling, and touching sand and other sediment in the water supplied to the rental dwelling through its pipes. R. at 2532 – 50, Pl.'s Notice of Record Evidence of Impact.

country, limit both the mobility of these tenants to move or to find housing that is in better condition. Id. As the survey respondents noted, many tenants also forego bringing complaints or legal claims against landlords for fear of eviction, rent increases, or other types of retaliation. Id.

Tenants do not have the same level of control over their living conditions given the nature of their possessory interest in their rental dwellings. Tenants are often beholden to their landlord's decisions, from whether to repair certain structures or how the method of living within a dwelling will be regulated. This dynamic places tenants at a comparative disadvantage, as they also have fewer resources and access to representation to challenge unlawful practices. Tenants are also much more likely to be cost-burdened than homeowners, spending a larger proportion of their income on housing acquisition costs alone. Across the nation, almost 50% of all tenant households, compared to around 25% of homeowner households, are cost burdened, spending more than 30% of their income on housing and utility costs. Joint Ctr. for Hous. Studies of Harvard Univ., The State of the Nation's Housing 2024, Harvard College (2024), https://www.jchs.harvard.edu/sites/default/files/interactive-item/

files/Harvard_JCHS_State_Nations_Housing_2024_Figures.pptx at 23, Fig. 22. Duval County, like many large municipalities in Florida, has a large share of low-income tenant households with even greater cost burdens. In 2023, 29% of Duval County tenants had considerably insufficient income to meet their rental housing needs. Shimberg Ctr. For Hous. Studies of the Univ. of Fla., 2023 Annual Report, Univ. of Fla. (2023), http://www.shimberg.ufl.edu/publications/Shimberg_annual_report_Dec_2023.pdf at 13, Table 10.

The impact on tenants is greatest for those with disabilities or for those with disabilities who occupy the rental dwelling alongside tenants. More than five million Floridians live with a disability. Ctrs. for Disease Control and Prevention, U.S. State Profile Data: Adults 18+ years of age, https://www.cdc.gov/dhds/impacts/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/index.html. In particular, respiratory disabilities are common across the United States, with more than 34 million American adults reporting diagnosis with respiratory diseases including chronic obstructive pulmonary disorder, emphysema, chronic bronchitis, and asthma. Ctrs. for Disease Control and Prevention, Interactive

Summary Health Statistics for Adults (2019-2023), https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html. More than one million adult Floridians are diagnosed with chronic obstructive pulmonary disease and more than 1.6 million Floridian children are diagnosed with asthma. American Lung Ass'n, COPD Prevalence Rates and Counts by State and Gender (2021), https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/data-tables/copd-prevalence-rates-by-state-gender; American Lung Ass'n, Current Asthma by State (2022), https://www.lung.org/research/trends-in-lung-disease/asthma-trends-brief/data-tables/asthma-current-state.

Respiratory impairments can be disabling and often result in significant symptoms including labored breathing, fatigue, limited mobility, cardiac function anomalies, and compromised immune response. The contact of noxious odor that the trial court discounts as insufficient, R. at 2619 – 20, may not cause immediate harm to persons without disabilities but for the millions of people with respiratory disabilities, inhalation of smoke, fumes, and vapors can exacerbate their symptoms, cause significant emotional distress associated with exposure, and threaten bodily function or life. See

generally Mayo Clinic, COPD (2025), https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679. People with respiratory disabilities are also more likely to live in poverty, and are more likely to live in the kind of unhealthy and unsafe conditions extant in poorly maintained housing. Nanette Goodman et al., Financial Inequality: Disability, Race and Poverty in America, National Disability Institute (2019-2021), https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf; Paula Braveman, et al., Housing and Health, Robert Wood Johnson Foundation (May 2011), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70451.

In addition to limiting the ability of people with disabilities to recover for harms caused by maintenance failures like those faced by Appellant, the trial court's ruling will also limit options for tenants with disabilities to improve their housing conditions. Tenants with disabilities must often utilize the Fair Housing Act and Florida Fair Housing Act's provisions to force maintenance of their rental property, through requests for reasonable accommodation that identify disability-related reasons why the landlord must remedy

issues like faulty plumbing or dangerous wiring. See 42 U.S.C. § 3604(f)(3) (2018); see also § 760.23(9), Fla. Stat. (2019). The trial court's grant of summary judgment reduces incentives for landlords to accommodate tenants and remedy dangerous conditions by insulating them from the damages such tenants could otherwise claim.

With rental housing scarcity on the rise and the reduced market and economic incentives to maintain rental housing in good, safe, and healthy condition, HUG expects that landlords will only grow more likely to avoid the sizeable expenses of rental housing maintenance and rehabilitation by simply making tenants lump the conditions. The trial court's ruling would make it more difficult for tenants suffering such impacts to seek justice and compensation, and would increase the likelihood of greater harm on those families. HUG respectfully requests that this Court not deviate from the Impact Rule's narrow focus to help ensure those affected may seek relief.

CONCLUSION

The trial court distorted the Impact Rule in a manner that gives Appellees insulation from liability and divests the jury of the factual determinations it should decide. In doing so, the trial court threatens to impair Florida's duty placed upon landlords maintain a safe and healthy rental dwelling for their tenants and will make addressing the effects of unsafe and unhealthy housing on vulnerable tenants much more difficult. Accordingly, HUG respectfully requests that this Court grant the relief sought by Appellant, reverse the trial court's grant of summary judgment to Appellees, and remand this case to the trial court for proceedings consistent with the Court's opinion and mandate.

Respectfully submitted, on January 2, 2025.

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CERTIFICATE OF SERVICE

I **HEREBY CERTIFY** that, on this 2nd day of January, 2025, a true and correct copy of the foregoing has been furnished through email via the Florida Courts E-Filing Portal to:

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CERTIFICATE OF COMPLIANCE

I **HEREBY CERTIFY** that this Amicus Brief was prepared using the Bookman Old Style 14-point font and contains 4,651 words, excluding exempted sections, in accordance with Florida Rules of Appellate Procedure 9.045, 9.210(a)(2), and 9.370(b).

/s/*Kevin S. Rabin*
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Attorney

Footnotes:

DRF's FY 2024-2025 PAIMI-focused Disability Deep Dive Podcast Episodes

The following are links to the DRF Disability Deep Dive podcast episodes The Ethics of Innovation: Disability, Technology, and Reproductive Justice with Katie Hasson Disability, Pop Culture, and Higher Education with Kyle Romano, as outlined in paragraphs one and two of DRF's statement of accomplishments:

The Ethics of Innovation: Disability, Technology, and Reproductive Justice – with Katie Hasson

https://disabilityrightsflorida.org/podcast/story/episode_76

Disability, Pop Culture, and Higher Education – with Kyle Romano

https://disabilityrightsflorida.org/podcast/story/episode_75

The Palm Beach Post

STATE

Disability group sues Florida, saying it's not releasing public records on Baker Act

'The Department's ongoing refusal to provide the requested records will harm DRF's ability to advance its mission of monitoring the use of involuntary psychiatric care in Florida,' the suit says.

Ana Goñi-Lessan
USA TODAY NETWORK - Florida

Dec. 12, 2024, 12:45 p.m. ET

An advocacy group is suing the state of Florida for not releasing what it says is public information about how many times mentally ill people are involuntarily taken into custody.

Disability Rights Florida (DRF) filed suit this week in Leon Circuit Civil court against the Florida Department of Children and Families (DCF).

The complaint alleges the department did not publish a required annual report on the Baker Act – the state law allowing for the involuntary examination and treatment of those who may pose a risk to themselves or others – and did not collect data from receiving and treatment facilities.

According to the lawsuit, the organization filed a public records request Oct. 4 for information about each public receiving and treatment facility designated by DCF, including five years of previous annual reports, but the department didn't comply with the request.

DRF says in its complaint that a 2007 law passed by lawmakers requires the state to track Baker Acts and the state has not kept track of this information, nor has it compelled facilities to turn over the information or publish reports.

According to state law, the state has reporting requirements for receiving and treatment facilities and is supposed to report data including the following: the number of licensed beds, the number of contract days and the number of admissions by diagnosis.

"The department shall issue an annual report based on the data required pursuant to this subsection. The report shall include individual facilities' data, as well as statewide totals. The report shall be posted on the department's website," the law states.

The lawsuit says DCF responded to the request with a link and said the reports could be found there, but DRF argues the information required by law was not there.

"The Department's ongoing refusal to provide the requested records will harm DRF's ability to advance its mission of monitoring the use of involuntary psychiatric care in Florida," the suit says.

The lawyers representing DRF are Sam Boyd with the Southern Poverty Law Center and Katy DeBriere with the Florida Health Justice Project. The case has been assigned to Circuit Judge Jonathan Sjostrom.

A complaint in a lawsuit tells one side of a story. A request for comment from the department is pending, though state agencies generally decline to do so on pending litigation.

Ana Goñi-Lessan is the State Watchdog Reporter for USA TODAY - Florida and can be reached at AGoniLessan@tallahassee.com.

Disability rights organization sues Florida DCF, says it has not gathered Baker Act data

The lawsuit alleges, in part, that the department has not complied with a 2007 law that requires publishing reports and data about use of the Baker Act.

By News Service of Florida • Published December 13, 2024 • Updated on December 13, 2024 at 8:26 am

An organization that advocates for people with disabilities filed a lawsuit this week alleging that the Florida Department of Children and Families has not gathered data and issued required reports about use of a law known as the Baker Act.

Disability Rights Florida wants a Leon County circuit judge to order the department to collect Baker Act data from mental-health facilities and produce reports.

The Baker Act allows for people with mental illness to be involuntarily held and treated at such facilities under certain circumstances. The lawsuit alleges, in part, that the department has not complied with a 2007 law that requires publishing reports and data about use of the Baker Act.

The lawsuit, filed Wednesday, said the information, if collected, would “answer a number of important questions about use of the Baker Act such as how long an average patient is held, what conditions lead to shorter or longer stays, whether insured patients are being held longer than others, and whether patients insured by the state are being held for longer, costing the state more money, than others.”

The lawsuit said the data would help the non-profit Disability Rights Florida in monitoring psychiatric hospitals. It said the organization on Oct. 4 made a public-records request but that the department did not provide the requested information.

IN THE DISTRICT COURT OF APPEAL
OF THE STATE OF FLORIDA
FIFTH DISTRICT

CASE NO. 5D2024-1853
L.T. CASE NO. 16-2021-CA-004707

SHAMYLIA MURPHY, as Personal Representative for the Estate of SHERITA SHAVON MURPHY-GRAY,
Appellant,

-vs-

HERITAGE II HOLDINGS, LLC, and HERITAGE FLORIDA PROPERTY HOLDINGS, INC.,
Appellees.

ON APPEAL FROM THE CIRCUIT COURT
IN THE FOURTH JUDICIAL CIRCUIT
IN AND FOR DUVAL COUNTY, FLORIDA

BRIEF OF *AMICUS CURIAE* FLORIDA HOUSING UMBRELLA GROUP IN SUPPORT OF APPELLANT

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INTEREST OF AMICUS CURIAE

Amicus Curiae Florida Housing Umbrella Group (hereinafter "HUG") is an unincorporated statewide association of approximately 250 lawyers, legal professionals, advocates, faculty, and researchers employed by legal services and civil legal aid organizations, universities, and nonprofit organizations. Founded in the 1980s, HUG focuses on legal issues and practical problems in rental housing, foreclosure, and homelessness. The majority of its members provide no-cost civil legal services to indigent communities across Florida, representing people at risk of losing housing or experiencing homelessness. Many of the persons served by HUG's members are people with disabilities, and many of its members litigate on behalf of persons with disabilities and families with minor children. HUG has regularly appeared as amicus curiae and offered public comments to aid Florida appellate courts better understand rental housing issues, as well as to protect and advance the rights of tenants in Florida.

This appeal features important questions for tenants across Florida regarding the application of the Impact Rule in a case brought on behalf of a tenant's estate against the tenant's former landlord.

The trial court's misapplication of the Impact Rule in the judgment on appeal threatens to upset the policy balance between landlord and tenant set forth within the Florida Residential Landlord and Tenant Act (hereinafter "FRLTA"). Specifically, the trial court's narrowing of what constitutes an impact for the purposes of the Impact Rule could immunize a landlord from its obligations to maintain certain structures, condition, or elements of a residential dwelling unit and deprive tenants of remedies afforded by FRLTA for such noncompliance, in addition to the implications for tortious conduct actionable at common law.

The outcome of this appeal will greatly affect the work of HUG's members and their housing litigation across Florida. The combined experience of the HUG's members in litigating landlord/tenant cases across both federal and state court will aid this Court in understanding the troubling implications of the trial court's version of the Impact Rule. HUG can help this Court better understand these broader impacts of the trial court's ruling, and the accordant chilling effects on exercising protected rental housing rights.

SUMMARY OF ARGUMENT

Florida's Impact Rule is designed to curtail fictitious and expansive claims for emotional distress damages where no impact upon the claimant has occurred. However, the Impact Rule does not apply to any tort claim in which there is an impact or contact with a claimant's person, no matter how large or small, visible or invisible, or immediate or delayed in harm. The Impact Rule, properly understood, is a threshold claims processing mechanism to determine whether a claimant has been contacted or impacted by something that later causes emotional distress.

However, the trial court diverged from the proper understanding of the Impact Rule in its ruling granting summary judgment to Appellees. By engaging in a quantitative assessment into the nature and extent of Appellant's injury and by focusing too narrowly on the nature and extent of the impact upon Appellant, the trial court improperly transformed the Impact Rule into a tool of claim preclusion. Worse, the trial court engaged in impermissible weighing of the evidence and usurped the role of the jury in determining critical questions of fact regarding the breach of Appellees' duty to Appellant, the proximate cause of Appellant's injuries, and the damages

sustained by Appellant. The trial court's ruling threatens to disrupt FRLTA's balance of duties between a landlord and tenant, and effectively insulate a landlord from duties owed by law to their tenant. The effects would be far reaching, especially given the state of the rental housing market in Florida, the number of unsafe and unhealthy rental housing units, and the widespread population with disabilities that may be greatly exacerbated by a ruling extending the Impact Rule in this erroneous way.

The Court should grant the relief sought by Appellant on appeal, reverse the trial court's grant of summary judgment, and remand this case to the trial court for proceedings consistent with the Court's opinion and mandate. In doing so, the Court would protect the balance of interests expressed in FRLTA and ensure that tenants across Florida have access to a needed remedy for unsafe and unhealthy housing.

ARGUMENT

I. The trial court's flawed interpretation of Florida's Impact Rule is contrary to well-established law and, if left undisturbed, will have collateral implications for the enforcement of a landlord's duties set forth within the Florida Residential Landlord and Tenant Act.

The trial court, while correctly identifying and discussing the broad strokes of Florida's Impact Rule, twisted that same rule to insulate a landlord from liability for emotional distress despite evidence of clear and obvious physical impacts upon a tenant. The trial court found the connection between these impacts on Appellant in her rental dwelling, which resulted from a breached duty to maintain the rental dwelling in a reasonably safe manner, and the emotional distress sustained by Appellant to be too attenuated to sustain a viable negligence claim. In granting summary judgment to Appellees, the trial court impermissibly intruded into the jury's role to determine the ultimate questions of fact regarding breach, proximate causation, and damages. Moreover, the trial court's ruling, broad in its conclusion that tenant claims of emotional distress connected to unsafe rental housing conditions should be scarce, threatens collateral harm to Florida's specific statutory balance of repairing and maintaining rental housing within FRLTA.

Florida's Impact Rule, as the trial court rightly summarizes, "requires that before a plaintiff can recover damages for emotional distress caused by the negligence of another, the emotional distress suffered must flow from physical injuries sustained in an impact." R. at 2617 (quoting Rowell v. Holt, 850 So. 2d 474, 477 – 79 (Fla. 2003) (internal quotation omitted)). Concerned with "open[ing] the floodgates for fictitious or speculative claims," Rowell, 850 So. 2d at 478, the Impact Rule applies to limit recovery only where there has been no impact upon a claimant. However, the Impact Rule has nuance and is not a strict dichotomy clothed in absolutes. Id. at 478.

As a threshold matter, the Impact Rule "does not apply and has never applied to torts which involve impact to or contact with the claimant's person." Willis v. Gami Golden Glades, LLC, 967 So. 2d 846, 851 (Fla. 2007) (Lewis, J., concurring). A plaintiff can rather easily meet the "slight requirements" to demonstrate an impact, since all that is required is a showing that "the outside force or substance, *no matter how large or small*, visible or invisible, and no matter that the *effects are not immediately deleterious*, touch[ed] or enter[ed] into the plaintiff's body." Eagle-Picher Indus., Inc. v. Cox, 481 So. 2d 517, 527 (Fla. 3d DCA 1985) (cited with approval in Zell v. Meek, 665 So.

2d 1048, 1050 n.1 (Fla. 1995) (emphasis added). Misapplications, misunderstandings, and "erroneous extensions" of the Impact Rule into cases where there is a clear but small impact can and often do lead to summary denials of meritorious claims, and transform the legal injury analysis of whether a physical impact or contact occurred into an impermissible quantitative assessment into the nature or extent of an injury. See Willis, 967 So. 2d at 854 – 55 (Lewis, J., concurring) (cautioning on how judicial overreach can lead to distortions of the Impact Rule); see also id. at 863 ("[t]his Court has never attempted to determine the application of the [Impact Rule] *based on the nature or extent of* the physical impact.") (Quince, J., concurring) (emphasis added). The inhalation of a substance or an electric shock are classic examples of contact that satisfy the requirement of impact. Eagle-Picher Indus., Inc., 481 So. 2d at 527 – 28.

If there is no impact, only then does the Impact Rule prevent recovery albeit with a notable exception. Even without impact, recovery for emotional distress may still occur where emotional distress is "manifested by physical injury," where the claimant is "involved" in the incident by proximity to the traumatizing event, and

where the claimant suffers the complained-of emotional distress and accompanying physical impairment "within a short time" of the incident. Id. at 526 (quoted with approval in Zell, 665 So. 2d at 1050 n. 1). This exception can be broad in practice, such as recognizing that a bystander to a traumatizing event can state an adequate claim and that there is no requirement that the impact be applied directly by the defendant. See Willis, 967 So. 2d at 848 – 50 (recognizing that a touching by an unknown assailant in a neighboring parking lot to the property owned by the defendant satisfied as an impact); see also T.V. v. Grindr, LLC, No. 3:22-cv-864-MMH-PDB, 2024 WL 4128796 at * 42 – 43 (M.D. Fla. 2024) (recommending rejection of a strict use of the "impact rule" where a minor's download and use of an online app "resulted in [the claimant's] exposure to, and engagement in, sexual relationships and activities with adults"). There are numerous other narrow exceptions to the Impact Rule not germane to this appeal, and the Impact Rule has never extended into the realm of intentional torts. See, e.g. Florida BC Holding, LLC v. Reese, 376 So. 3d 109, 114 – 15 (Fla. 6th DCA 2023) (citing examples).

Regrettably, when trial courts are faced with the interpretation of the Impact Rule, many courts engage in the precise type of

quantitative assessment divorced from the narrow contact or impact question that Justice Lewis forewarned. Many courts conflate the Impact Rule with proximate causation or damages, and especially at the summary judgment phase, impermissibly weigh the evidence as if the ultimate trier of fact on the elements of the negligence claim itself. The trial court fell victim to this error, conflating questions reserved for the jury into the Impact Rule analysis and improperly weighing the evidence of causation and damages in its grant of summary judgment. R. at 2619 – 20, Am. Order Granting Defs.' Mot. for Summ. J. at Pg. 4 – 5. Despite clear and unrebutted evidence of impact from inhaling fumes from faulty wiring in the walls of Appellant's rental dwelling, feeling excessive heat exuding through the walls of the rental dwelling due to the faulty wiring, inhaling fumes from sewage via the pipes in the rental dwelling, and touching sand and other sediment in the water supplied to the rental dwelling through its pipes, the trial court impermissibly weighed the evidence in lieu of assessing solely whether an impact occurred. Id.; compare R. at 1497 – 1534, Pl.'s Opp. To Defs. Mot. for Summ. J. on Impact Rule (summarizing supporting factual positions for impacts on Appellant from actual contact with rental dwelling) with R. at 888 -

920, Defs.' Mot. for Summ. J. on Impact Rule, Pg. 21 (focusing on whether the impact was the sole cause of emotional distress rather than rather an impact occurred). The trial court minimized the critical importance of the contacts Appellant sustained, "doubt[ing]" whether emotional harm from merely feeling or touching sand in water or heat from faulty wiring behind a wall could or "should ever be sufficient" to satisfy the Impact Rule. R. at 2619. The trial court's reluctance to find the contact sufficient appears grounded in prudential concerns regarding whether Appellant's emotional distress sustained was foreseeably connected to Appellees' duty to maintain the rental dwelling and whether the damages sustained were of any material consequence. R. at 2620 – 21. The trial court's analysis diverted from the Impact Rule's focus on an impact, no matter how small, and instead weighed the evidence of causation and harm reserved for the jury. Eagle-Picher Indus., Inc., 481 So. 2d at 527 (quoted with approval in Zell, 665 So. 2d at 1050 n. 1); see also Seybold v. Clapis, 966 F. Supp. 2d 1312, 1315 (M.D. Fla. 2013) (holding that impact by "an invisible force" that shook children inside a car was sufficient for the Impact Rule).

The trial court's Impact Rule error is compounded by its further removal from the jury the critical factual questions of breach, causation, and damages. The Impact Rule, used in this manner as a broad shield from jury trial, will have severe collateral consequences for tenants across Florida. The trial court's ruling significantly diminishes a landlord's legal duties to their tenant to maintain their rental dwelling, and the collateral effects of such a ruling could prevent a future tenant from exercising any material remedy for personal injuries stemming from unsafe and unhealthy rental housing conditions.

Section 83.51, Florida Statutes (2019) provides, in pertinent part, that a landlord of a residential dwelling is required to:

> (a) Comply with the requirements of applicable building, housing, and health codes; or
> (b) Where there are no applicable building, housing, or health codes, maintain the roofs, windows, doors, floors, steps, porches, exterior walls, foundations, and all other structural components in good repair and capable of resisting normal forces and loads and the plumbing in reasonable working condition. The landlord, at commencement of the tenancy, must ensure that screens are installed in a reasonable condition. Thereafter, the landlord must repair damage to screens once annually, when necessary, until termination of the rental agreement.

The duty of the landlord pursuant to FRLTA is two-fold: (1) prior to possession by the tenant, the landlord has a duty to inspect the residential dwelling and to make necessary repairs to transfer possession to the tenant a reasonably safe dwelling,[1] and (2) after possession commences by the tenant, the landlord as a continuing duty to exercise reasonable care in repairing dangerous defective conditions upon notice of their existence by the tenant. Youngblood v. Pasadena at Pembroke Lakes South, Ltd., 882 So. 2d 1097, 1098 (Fla. 4th DCA 2004) (citing Mansur v. Eubanks, 401 So. 2d 1328, 1329 – 30 (Fla. 1981)); see also Perez v. Belmont at Ryals Chase Condo. Ass'n, Inc., 393 So. 3d 859, 862 (Fla. 2d DCA 2024) (making

[1] While not currently before the Court in this appeal, the existence of a waiver of warranty or exculpatory clause in Appellee's rental agreement, R. at 341, Pl.'s Second Am. Compl., Ex. "A" at Pg. 4, is likely insufficient as a matter of law to waive Appellant's claims for obvious or apparent defects or hazardous conditions. See Casasanta v. Sailshare 296, LLC, 274 So. 3d 418, 420 – 21 (Fla. 1st DCA 2019) (Thomas, J., concurring) (discussing that the exculpatory clause was insufficiently clear in separating financial liability for repairs from personal injury claims); see also § 83.47, Fla. Stat. (2019) (forbidding rental agreement clauses "limit[ing] or preclud[ing] any liability of the landlord to the tenant" arising under law). Assuming it remains enforceable on that ground, it is also substantively unconscionable absent evidence Appellant had a meaningful, substantial, and actual opportunity to inspect the rental dwelling utilizing a person sufficiently trained to identify latent defects and hazards invisible to the ordinary person. See § 83.45, Fla. Stat. (2019).

clear that there is no insulation from liability for a landlord just because inherently unsafe or dangerous conditions were readily apparent to the tenant).[2] Any injury resulting from a failure to maintain the rental dwelling is cognizable, both in common law and by FRLTA. § 83.55, Fla. Stat. (1973).

Typically, the questions of breach of duty, damages, and most importantly, proximate causation are to be resolved by the trier of fact. Smith v. Grove Apts., LLC, 976 So. 2d 582, 586 – 87 (Fla. 3d DCA 2007). At the summary judgment stage, the trial court was limited in how far it could inquire into whether the breach alleged by Appellant was tied to the Appellees' statutory maintenance duties, whether the injuries Appellant suffered are of a type that FRLTA is intended to prevent, and whether the Appellees' violations were the

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[2] Just as in Perez, Appellees' rental agreement specifically forbids any "painting, installing fixtures, *making alterations*, additions and/or improvements" without prior written consent by Appellees, along with "[n]o financial restitution" for "such items" except where prior written consent is given and where a writing agreed to by the parties exists. Compare R. at 340, Pl.'s Second Am. Compl., Ex. "A" at Pg. 3 (emphasis added) with Perez, 393 So. 3d at 863 n. 2. While the term of the rental agreement likely violates section 83.47, Florida Statutes (2019) in part, it also demonstrates that Appellees had reserved unto themselves the duty of structural alterations, inclusive of plumbing and electrical wiring.

proximate cause of Appellant's injuries. Id.; see, e.g., Cold Storage Café, Inc. v. Barone, 779 So. 2d 371 (Fla. 2d DCA 2000) (reversing summary judgment because whether the condition of the window on the leased premises on the date of the accident was dangerous is an unresolved issue of fact); Grant v. Thornton, 749 So. 2d 529 (Fla. 2d DCA 1999) (reversing summary judgment because tenant was injured while exiting through front window of apartment during fire and alleged that landlord had violated county building and fire codes by maintaining front door with a deadbolt that required key to be used to exit); Bosket v. Broward County Hous. Auth., 676 So. 2d 72 (Fla. 4th DCA 1996) (reversing summary judgment because the issues of whether landlord breached duty to provide tenant with readable stove knobs allegedly requested by tenant, as well as duty to maintain fire extinguisher in safe working condition, were for jury to decide); Bean v. Carey's Rental Agency, Inc., 532 So. 2d 685 (Fla. 3d DCA 1988) (reversing summary judgment because action brought by father of deceased child who died as a result of inhaling noxious fumes from mineral spirits supplied by apartment manager to child's mother who was painting apartment upon the landlord's refusal to do so). A trial court may only decide these issues as a matter of law

where reasonable people could not differ, or where the harm resulting from the tortfeasor's actions or omissions are so bizarre or happen so infrequently that it could not have been reasonably anticipated. Bennett M. Lifter, Inc. v. Varnado, 480 So. 2d 1336, 1339 (Fla. 3d DCA 1985) (discussing that an appropriate jury instruction is vastly preferrable to judicial overreach).

Despite finding that the Appellant had multiple impacts with substances in the rental dwelling from faulty wiring or plumbing, R. at 2619 – 20, the trial court elected to decide the foreseeability of Appellant's emotional distress from those impacts as a matter of law. R. at 2621. The trial court considered that the "foreseeability or gravity of emotional harm from a landlord failing to correct unsafe or unsanitary conditions does not outweigh the need to prevent potential claims which are fictitious, speculative or difficult to prove." R. at 2621. Implicit in its ruling is that touching sediment in water or heat from faulty wiring behind a wall that led to emotional distress was not a foreseeable injury resulting from the landlord's failure to maintain the rental dwelling. See id. However, FRLTA expressly contemplates that such noncompliance by a landlord may be continuous and rise to such a degree that damages flowing from the

failures to make repair are actionable. See § 83.56(1), Fla. Stat. (2019) (rent withholding remedy and diminution in rental value); § 83.63, Fla. Stat. (2019) (tenant casualty damage remedies); cf. McCready v. Booth, 398 So. 2d 1000 (Fla. 5th DCA 1981) (recognizing residential tenant wrongful eviction remedy against landlord). It is eminently foreseeable that a failure to maintain a residential dwelling in safe and sanitary conditions would lead to possibilities like dispossession, diminished value, personal property damage, and emotional distress associated with living in indignity and squalor. In ruling otherwise, the trial court improperly deprived a jury from its proper role of weighing the question of proximate cause.

In deciding that a pattern of similar impacts to Appellant were not sufficient and in depriving Appellant of access to a jury to decide breach, proximate causation and foreseeability, damages, and the credibility of the disputed factual questions in this action, the trial court erred. By engaging in the exact mistake of which Justice Lewis warned, see Willis, 967 So. 2d at 854 – 55 (Lewis, J., concurring), the trial court's view on the Impact Rule effectively shields landlords from most negligence claims in which there is not property damage or immediate bodily injury, undermining Florida's imposed duty on

landlords to maintain safe and habitable housing in compliance with FRLTA. The trial court's error should be corrected in this appeal, and the action remanded for jury trial.

II. The incorrect Impact Rule interpretation will worsen the options available for tenants facing increased exposure to unsafe and unhealthy rental housing, and will exacerbate harms experienced by tenants with disabilities.

Apart from the effects on Appellant, the trial court's incorrect understanding of the Impact Rule operates as a deterrent to other tenants seeking damages as a remedy to landlord noncompliance with FRLTA's duties of maintenance. Much of the existing rental housing supply available in Florida and beyond threatens the health, safety, and wellbeing of those residing within it. Where rental housing affordability remains a myth more than reality, tenants' options to seek needed repairs, maintenance, damages for harms suffered, or alternatives for safer and healthier housing are made scarcer by a narrow view of how unsafe and unhealthy rental housing impacts a tenant. The downstream effects of summary judgment in favor of Appellees on the rental housing rights of other tenants could be pernicious, and this Court should consider those effects as part of its review.

One of the most prevalent concerns for tenants in rental housing is that their rental housing negatively affects their or another occupant's health, safety, or wellbeing. See Abbe Will, New survey finds many renters are concerned about the impact of home on health, Joint Ctr. for Hous. Studies of Harvard Univ. (Mar. 31, 2022), https://www.jchs.harvard.edu/blog/new-survey-finds-many-renters-are-concerned-about-impact-home-health. In the Joint Center for Housing Studies of Harvard University's study, indoor air quality, structural safety, moisture intrusion, and chemical exposure[3] each ranked highly in the chief concerns expressed by tenants regarding their existing rental housing. Id. 37% of tenants surveyed indicated that their concerns for their own health or the other occupants in their household led the tenant to either move or consider moving to another rental dwelling. Id. However, practical considerations, including the broad unaffordability of rental housing across the

[3] These common tenant concerns mirror the impacts that Appellant experienced, including inhaling fumes from arcing wires behind the drywall in Appellant's rental dwelling, feeling excessive heat exuding through the walls of the rental dwelling due to the electrical wiring, inhaling fumes from sewage via the pipes in the rental dwelling, and touching sand and other sediment in the water supplied to the rental dwelling through its pipes. R. at 2532 – 50, Pl.'s Notice of Record Evidence of Impact.

country, limit both the mobility of these tenants to move or to find housing that is in better condition. Id. As the survey respondents noted, many tenants also forego bringing complaints or legal claims against landlords for fear of eviction, rent increases, or other types of retaliation. Id.

Tenants do not have the same level of control over their living conditions given the nature of their possessory interest in their rental dwellings. Tenants are often beholden to their landlord's decisions, from whether to repair certain structures or how the method of living within a dwelling will be regulated. This dynamic places tenants at a comparative disadvantage, as they also have fewer resources and access to representation to challenge unlawful practices. Tenants are also much more likely to be cost-burdened than homeowners, spending a larger proportion of their income on housing acquisition costs alone. Across the nation, almost 50% of all tenant households, compared to around 25% of homeowner households, are cost burdened, spending more than 30% of their income on housing and utility costs. Joint Ctr. for Hous. Studies of Harvard Univ., The State of the Nation's Housing 2024, Harvard College (2024), https://www.jchs.harvard.edu/sites/default/files/interactive-item/

files/Harvard_JCHS_State_Nations_Housing_2024_Figures.pptx at 23, Fig. 22. Duval County, like many large municipalities in Florida, has a large share of low-income tenant households with even greater cost burdens. In 2023, 29% of Duval County tenants had considerably insufficient income to meet their rental housing needs. Shimberg Ctr. For Hous. Studies of the Univ. of Fla., 2023 Annual Report, Univ. of Fla. (2023), http://www.shimberg.ufl.edu/publications/Shimberg_annual_report_Dec_2023.pdf at 13, Table 10.

The impact on tenants is greatest for those with disabilities or for those with disabilities who occupy the rental dwelling alongside tenants. More than five million Floridians live with a disability. Ctrs. for Disease Control and Prevention, U.S. State Profile Data: Adults 18+ years of age, https://www.cdc.gov/dhds/impacts/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/index.html. In particular, respiratory disabilities are common across the United States, with more than 34 million American adults reporting diagnosis with respiratory diseases including chronic obstructive pulmonary disorder, emphysema, chronic bronchitis, and asthma. Ctrs. for Disease Control and Prevention, Interactive

Summary Health Statistics for Adults (2019-2023), https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html. More than one million adult Floridians are diagnosed with chronic obstructive pulmonary disease and more than 1.6 million Floridian children are diagnosed with asthma. American Lung Ass'n, COPD Prevalence Rates and Counts by State and Gender (2021), https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/data-tables/copd-prevalence-rates-by-state-gender; American Lung Ass'n, Current Asthma by State (2022), https://www.lung.org/research/trends-in-lung-disease/asthma-trends-brief/data-tables/asthma-current-state.

Respiratory impairments can be disabling and often result in significant symptoms including labored breathing, fatigue, limited mobility, cardiac function anomalies, and compromised immune response. The contact of noxious odor that the trial court discounts as insufficient, R. at 2619 – 20, may not cause immediate harm to persons without disabilities but for the millions of people with respiratory disabilities, inhalation of smoke, fumes, and vapors can exacerbate their symptoms, cause significant emotional distress associated with exposure, and threaten bodily function or life. See

generally Mayo Clinic, COPD (2025), https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679. People with respiratory disabilities are also more likely to live in poverty, and are more likely to live in the kind of unhealthy and unsafe conditions extant in poorly maintained housing. Nanette Goodman et al., Financial Inequality: Disability, Race and Poverty in America, National Disability Institute (2019-2021), https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf; Paula Braveman, et al., Housing and Health, Robert Wood Johnson Foundation (May 2011), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70451.

In addition to limiting the ability of people with disabilities to recover for harms caused by maintenance failures like those faced by Appellant, the trial court's ruling will also limit options for tenants with disabilities to improve their housing conditions. Tenants with disabilities must often utilize the Fair Housing Act and Florida Fair Housing Act's provisions to force maintenance of their rental property, through requests for reasonable accommodation that identify disability-related reasons why the landlord must remedy

issues like faulty plumbing or dangerous wiring. See 42 U.S.C. § 3604(f)(3) (2018); see also § 760.23(9), Fla. Stat. (2019). The trial court's grant of summary judgment reduces incentives for landlords to accommodate tenants and remedy dangerous conditions by insulating them from the damages such tenants could otherwise claim.

With rental housing scarcity on the rise and the reduced market and economic incentives to maintain rental housing in good, safe, and healthy condition, HUG expects that landlords will only grow more likely to avoid the sizeable expenses of rental housing maintenance and rehabilitation by simply making tenants lump the conditions. The trial court's ruling would make it more difficult for tenants suffering such impacts to seek justice and compensation, and would increase the likelihood of greater harm on those families. HUG respectfully requests that this Court not deviate from the Impact Rule's narrow focus to help ensure those affected may seek relief.

CONCLUSION

The trial court distorted the Impact Rule in a manner that gives Appellees insulation from liability and divests the jury of the factual determinations it should decide. In doing so, the trial court threatens to impair Florida's duty placed upon landlords maintain a safe and healthy rental dwelling for their tenants and will make addressing the effects of unsafe and unhealthy housing on vulnerable tenants much more difficult. Accordingly, HUG respectfully requests that this Court grant the relief sought by Appellant, reverse the trial court's grant of summary judgment to Appellees, and remand this case to the trial court for proceedings consistent with the Court's opinion and mandate.

Respectfully submitted, on January 2, 2025.

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CERTIFICATE OF SERVICE

I **HEREBY CERTIFY** that, on this 2nd day of January, 2025, a true and correct copy of the foregoing has been furnished through email via the Florida Courts E-Filing Portal to:

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CERTIFICATE OF COMPLIANCE

I **HEREBY CERTIFY** that this Amicus Brief was prepared using the Bookman Old Style 14-point font and contains 4,651 words, excluding exempted sections, in accordance with Florida Rules of Appellate Procedure 9.045, 9.210(a)(2), and 9.370(b).

/s/*Kevin S. Rabin*
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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	$1,805,964
Total	**$1,805,964**

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	2024	$257,986
2. Program income (PAIMI only)			$7,029
3. State			$0
4. Other funding sources [identify each source]			
Total of all PAIMI Program resources.			**$265,015**

Please note in the second form that Question 2. Program Income (PAIMI only) is not the current FY PAIMI allotment. Program income is defined as gross income earned that is directly generated by a federally supported activity or earned as a result of the federal award.

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

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 2025 PAIMI Application. The strategies used for each Objective must be completed. The reason why priority/goal was not achieved or was partially achieved must be completed.

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

Objective: Investigate individual complaints of abuse, neglect, and rights violations of adults with significant mental illness and youth with serious 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:

Target Measures

Target Population:	PAIMI-eligible adults and youth in facilities.
Expected Target:	70
Expected Outcome:	70
Actual Outcome:	182
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, Disability Rights Florida (DRF) received a critical incident report from a Psychiatric Residential Treatment Facility (PRTF) involving KS— a youth female with serious emotional disturbance who was a resident of the US Virgin Islands and receiving treatment at a PRTF in Florida. The report alleged that KS reported that she was in a relationship with a female staff member. DRF obtained consent from KS' guardian to investigate the allegation.

To investigate this allegation, DRF interviewed KS, interviewed clinical staff and administrators, and reviewed medical and other records. After reviewing the records and meeting with administrators, DRF identified that the facility had gaps in its investigation of the incident, did not adequately investigate the incident, and failed to effectively review surveillance videos to determine whether the incident occurred or not. Additionally, the facility could not produce any documentation of their investigative efforts to substantiate the veracity of their investigation. Due to amount of time between the incident and when DRF received the report, DRF did not have access to the video for their investigation.

DRF provided the facility administrators with their investigative findings, including recommendations for additional procedures that they should follow to ensure a more comprehensive investigation of incidents. The facility's administrators acknowledged their shortfall and accepted DRF's recommendations.
As a result of the above steps, DRF closed this case due to the primary issue being favorably resolved. At the time of closing, KS was still housed at the facility, however, the alleged perpetrator had resigned from employment. Additionally, the issues identified in case will be further addressed through a report.

As an example of a neglect investigation, FO is an adult female with significant mental illness who was a civil admission to a State Mental Health Treatment Facility (State Hospital) when they contacted Disability Rights Florida (DRF) to request assistance with an alleged rights violation. Specifically, FO explained that facility staff were locking her and other residents on her unit out of their rooms during class hours in the daytime. DRF agreed to investigate this case, as FO's allegations present both a conditions issue (as this results in patients sleeping on the ground in common areas) and a potential violation of patients' rights to dignity during treatment.

After meeting with FO and obtaining consent to investigate the case, DRF informed the facility's administration that they had received complaints about room access. DRF previously addressed a similar room access issue within this State Hospital in 2023 due to patient complaints in the Civil Transition Unit, but the outcome was limited in scope to a single dorm on that unit. For the current room access complaint, the facility's administration acknowledged that it should not be happening and that patients should be allowed in their rooms.

They also noted that, if a patient is not attending classes, staff should document the absences so that they can be addressed by their recovery team as a treatment issue, not handled punitively through informal restrictions on the unit.

As room access restrictions are a continued problem stretching to other units within the facility, the facility's administration agreed that that resident's room access should not be restricted and that all staff should be instructed that room access restrictions are not permitted. In April 2025, DRF confirmed that the facility's Chief Nursing Officer contacted the Executive Nursing Directors on all units and requested that they instruct all staff about the room access policy. DRF will continue to monitor room access at this facility to ensure that staff adhere to the facility's policy. DRF closed this case as the client's request for service was favorably resolved through negotiation with the facility.

As an example of a rights violation investigation, MH is an adult male with significant mental illness who was residing at a State Mental Health Treatment Facility (State Hospital) when they contacted Disability Rights Florida (DRF) with an allegation of a rights violations due to the fact he is not receiving accommodations for his documented visual disability. Specifically, he alleged that the facility denied him access to a white cane, talking watch, and audiobooks since his admission in July 2024, and only provided him with a staff member to guide him around.

To investigate this case, DRF met with and interviewed MH, who explained that staff repeatedly delay and say that they are working on his requests, but do not ever actually provide a resolution. After accepting the case for investigation, DRF was told by facility staff that MH was forbidden to have a white cane due to a unit policy prohibiting "weapons," but that he had received his talking watch and audiobooks. MH subsequently confirmed that he had received these other accommodations, just not the white cane.

DRF continued to reach out to administrative staff at the facility and MH's treatment team to get to the root of this issue, as staff repeatedly told DRF that there was no policy against canes, but at the same time were refusing to evaluate MH for one. After speaking with his treatment team, particularly his treating physician, multiple times, DRF reached an impasse regarding either their unwillingness to assist MH or their ignorance about their legal obligations to do so. After escalating the issue to the state hospital's administration and formally explaining how MH was being denied accommodations, the facility evaluated MH. The evaluation determined that MH was eligible to receive a white cane, and MH received a white cane along with his freedom of movement privileges.

At this point, his individual issues were resolved. DRF then wrote to the state hospital's administrator explaining these systemic issues. In response, they acknowledged their error and expressly apologized for the way MH's treatment team handled this issue and communicated with DRF. They implemented a new form to be used within 5 days of admission of any client requesting accommodations for disabilities. They also confirmed that they will be re-training all nursing staff about their obligations to use this form and the provision of accommodations.

DRF closed this case as all issues were resolved in the clients favor through negotiation. Additionally, State Hospital agreed to reasonable systemic responses to avoid these issues in the future. DRF will continue to closely monitor allegations regarding accommodations for disabilities, particularly for visually/auditorily impaired patients, at this facility. The outcomes of this case have a broad impact that enhance the rights and safety and all current and future patients at this facility.

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

Strategies Used:

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:	18
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 one example, JK is a 5-year-old with serious emotional disturbance (Attention Deficit Disorder w/Hyperactivity (ADHD) and Other Emotional/ Behavioral). JK's parent contacted Disability Rights Florida (DRF) to request assistance with accessing appropriate academic and behavioral supports. DRF agreed to investigate and assist the parent regarding the following primary objectives: 1.) review records provided by the parent and request additional records as needed; 2.) assist with the completion and development of the Functional Behavioral Assessment (FBA) and Behavior Intervention Plan (BIP); 3.) ensure that the services and supports on the Individual Education Plan (IEP) are adequate and being followed by the team.

To advocate for JK, DRF staff reviewed JK's educational and behavioral records and participated in several IEP meetings to ensure that the school established proper supports for JK. They found that, while JK was enrolled in school, there were several issues involving behavior where JK was not properly supervised and was allowed to run all over campus and escaped from staff. Furthermore, the school staff continued to contact law enforcement instead of working within JK's behavior plan.

DRF worked with JK's parent and the school district to ensure a change of schools so that the client was better supported by staff with training in the area behavior. They also assisted with ensuring that JK would get specialized transportation since their needs could not be met at the previous school. DRF worked with school district staff to ensure the team was prepared for JK and that their supports were immediately in place.

JK is currently in their new school. DRF participated in an IEP and BIP meeting with the support team at JK's new school. All parties agree that JK is doing well and staff have had very few issues with JK at school. The parent feels that JK is learning and has no issues with this current team.

In a second example, GM is a youth female with serious emotional disturbance (disruptive mood dysregulation (DMDD), severe recurrent major depression, generalized anxiety, and post-traumatic stress (PTSD)) whose parent contacted Disability Rights Florida (DRF) about multiple incidents of disability-related discipline that resulted in suspensions, as well as unanswered requests for an evaluation to determine eligibility for an Individualized Education Program (IEP).

To investigate this request, DRF staff reviewed educational records, contacted the district's representative, and successfully advocated for the development of a 504 plan to provide accommodations that support GM's needs arising from the challenges associated with DMDD, depression, anxiety, and PTSD. As a result of DRF advocacy, GM's school district agreed to discontinue the use of school removals as a form of discipline while waiting for evaluations to be completed. Upon completing the evaluations, DRF also advocated for GM's eligibility for Other Health Impairment and the creation of an initial IEP. GM's team developed goals to address gaps in math computation, independent functioning, and social-emotional skills. They also included weekly counseling services. Additionally, DRF provided the parent with support for self-advocacy and guidance on scheduling an IEP meeting to review or amend the plan with the new IEP team should the parent decide to transition GM to a new school.

As a result of the above outcomes, DRF closed this case as issues favorably resolved in the client's favor. They mailed a case closing letter with DRF Client Satisfaction Survey, DRF Client Grievance Procedure, and self-addressed stamped envelope to GM's parent at their current address.

In a third example, BW is a youth male student with Serious Emotional Disturbance, an intellectual disability, and a language impairment. BW's parent contacted Disability Rights Florida (DRF) regarding the school refusing to re-evaluate the youth and provide appropriate supports and services for them. BW's parent indicated that BW was not making appropriate progress and was having behavior problems. The behavior problems were so significant that BW was committed under the Baker Act and held for 72 hours.

To investigate this request, DRF requested educational records from the school. They also contacted the school district regarding the need for a comprehensive re-evaluation of BW along with the development of a Positive Behavior Intervention Plan (PBIP) and the addition of language therapy. DRF participated in several Individualized Education Plan (IEP) meetings for BW and advocated for the evaluations to be completed and a PBIP to be developed.

In response, BW's team completed the evaluations, revised his IEP to include more measurable goals and objectives, added language therapy as a related service, and developed a PBIP that was implemented and resulted in improved behavior for BW. Since these changes, BW's behavior and academic achievement have improved as a result of updated evaluation information and an IEP that is able to be implemented. DRF closed this case as issues resolved in the client's favor as a result of Administrative Remedies.

Objective: Monitor facilities that provide residential care and treatment to adults with significant mental illness and youth with serious 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:

Target Measures

Target Population:	PAIMI-eligible adults and youth in facilities.
Expected Target:	10
Expected Outcome:	10
Actual Outcome:	20
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 2024 - 2025, Disability Rights Florida (DRF) continued efforts to monitor facilities that provide residential care and treatment to adults with significant mental illness and youth with serious emotional disturbance. DRF worked on monitoring projects at a total of 20 facilities in the current fiscal year. The facilities monitored include: 1 Assisted Living Facility, 5 Psychiatric Residential Treatment Facilities/Residential Treatment Facilities, 4 County Jails, 6 Crisis Stabilization Units (Baker Act Receiving Facilities), 1 State Mental Health Treatment Facility (State Hospital), and 3 APD facilities that serve residents that are dually diagnosed with Developmental Disabilities and Significant Mental Illness. Narratives for a sample of DRF's monitoring efforts by facility type are listed below.

ASSISTED LIVING FACILITIES

Disability Rights Florida (DRF) opened a monitoring project for a Limited Mental Health Assisted Living Facility with 126 beds serving adults with significant mental illness in the Northeast Region in Q2 of FY 2024-2025. DRF selected this facility to ensure compliance with rights protections requirements of adults with disabilities, including significant mental illness, per statute and rule. DRF's monitoring team completed the virtual pre-monitoring interview with facility administrators along with the on-site monitoring of the facility in Q3 of FY 2024-2025.

During the monitoring process, DRF did not identify any substantial issues during require follow-up, with no significant complaints from residents nor any significant safety issues identified during the site visit. As a result, DRF sent the facility a monitoring closing letter in Q4 of FY 2024-2025.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES/RESIDENTIAL TREATMENT FACILITIES

In one example, Disability Rights Florida (DRF) opened a monitoring project for a Statewide Inpatient Psychiatric Program with 38 beds serving youth with serious emotional disturbance in the Southeast Region in Q1 of FY 2024-2025. DRF selected this facility to ensure compliance with rights protections requirements of youth with disabilities, including serious emotional disturbance, per statute and rule. DRF's monitoring team completed the virtual pre-monitoring interview with facility administrators along with the on-site monitoring of the facility in Q2 of FY 2024-2025.

During Q2 of FY 2024-2025, DRF's monitoring team communicated the following post-monitoring recommendations for improvement to the facility administrators:

1. Change all door hinges so that they are ligature free.
2. Remove shoestrings from sneakers that are stored in the cabinets in the dayrooms to prevent potential ligature.
3. Cease the practice of allowing residents to sleep in the seclusion room.
4. Identify staff who are sleeping on duty, particularly overnight staff, and stop this from occurring.
5. Educate residents on the complaint/grievance process, as several residents that DRF interviewed did not know of the process.
6. Remove the Statewide Advocacy Council's number from all the Emergency Contact lists/posters, as it no longer exists.

In Q3 of FY 2024-2025, DRF confirmed that the facility resolved each of the above post-monitoring recommendations for improvement. The outcomes for this monitoring project include:

1. Accelerated the facility's replacement plan and installed 10 new continuous hinges, replacing the remaining standard hinges in the older section of the facility. Additionally, the continuous hinges that did not have angled tops, have been modified to now have angled tops that are securely covered to eliminate any exposed sharp edges.
2. For sneakers with shoelaces, enhanced suicide prevention by providing youth with known histories of suicidal ideation, self-injurious behavior, or recent attempts with "slides" (a form of flip flop like shoe) on site for use should their status require an added level of safety. Second, as an enhancement to the facility's existing contraband and safety protocols, when a child is preparing to leave the facility or needs their shoes on, staff will ensure that their shoes are properly laced and tied, and upon return, those same shoes will be checked to confirm that the laces remain intact and are not missing.
3. Amended its Seclusion and Restraint policy to require Shift Supervisors and Floor Managers to immediately change room assignments during roommate conflicts to avoid use of the safe room for conflict resolution. Additionally, roommate placements will be regularly reassessed through input from a multidisciplinary team to ensure resident safety and well-being.
4. For reports of staff sleeping on shift, implemented new quality assurance steps including randomized supervised check-ins during overnight and weekend shifts (3 of which have already occurred), real-time surveillance camera monitoring and scheduled breaks.
5. Improved the accessibility of their complaint process by implementing a formal education component about the complaint process during each resident's orientation, administration of group sessions focusing on the steps of the complaint process for staff and residents, and re-training of staff.
6. Removed the contact information for the no-longer-practicing Statewide Advocacy Council from all emergency lists and posters throughout the facility.

DRF provided the facility with a formal letter notifying them of the closure of the monitoring project.

In a second example, Disability Rights Florida (DRF) opened a monitoring project for a Psychiatric Residential Treatment Facility with 149 beds serving youth with serious emotional disturbance in the Southeast Region in Q1 of FY 2024-2025. DRF selected this facility to ensure compliance with rights protections requirements of youth with disabilities, including serious emotional disturbance, per statute and rule. DRF's monitoring team completed the virtual pre-monitoring interview with facility administrators along with the on-site monitoring of the facility in Q3 of FY 2024-2025.

During Q3 of FY 2024-2025, DRF's monitoring team requested that the facility address the following issues that they identified during the monitoring process:

1. Reduce the safety risk posed by non-ligature-free door closers and door hinges by utilizing a method that would prevent the closers from being a ligature risk and/or replacing them with a device that would eliminate the risk.
2. Implement methods to better monitor staff to ensure they are not sleeping on duty, through randomized quality assurance checks, to ensure that this behavior is not occurring.
3. Amend the facility's process for reviewing seclusion and restraint events.

4. Amend the facility seclusion and restraint policy to include clear and specific definitions and procedures distinguishing seclusion from time-out.
5. Amend the facility's restraint policies to ensure that restraints are utilized in accordance with federal and Florida law and not pre-authorized prior to any inciting event occurring. Also, update the policy to state that ETO should not be administered if the child was able to deescalate between the time the order was received and by the time the medication was retrieved.
6. Amend the patient handbooks to include more client-friendly language.

Throughout the remainder of FY 2024-2025, DRF continued to wait for the facility's response to their post-monitoring summary letter. This project will remain open into the next FY as DRF works with the facility to resolve each of the above items.

COUNTY JAILS

For the first example, Disability Rights Florida (DRF) opened a monitoring project for a County Jail in the Northeast Region in Q2 of FY 2024-2025. DRF selected this facility to ensure compliance related to the care and treatment of detainees. DRF's monitoring team completed the virtual pre-monitoring interview with facility administrators along with the on-site monitoring of the facility in Q2 of FY 2024-2025.

During Q2 of FY 2024-2025, DRF's monitoring team communicated the following post-monitoring recommendations for improvement to the facility administrators:

1. Develop and implement a clear protocol for managing non-suicide-related mental health crises, including an assessment and stabilization procedure for detainees who may require immediate intervention.
2. Since the jail does not have designated special housing for detainees with special needs, establish shift meetings between nursing staff and jail staff to review any inmates with medical needs. Also, jail staff should maintain a list of inmates with special needs
3. Amend the Use of Restraints policy to: 1.) prohibit the use of prone containment, i.e. the practice of restraining detainees with disabilities to a bunk past the time of immediate struggle or danger; 2.)include language outlining timeframes for repositioning of detainees with disabilities in prone restraints to reduce the risk of positional asphyxiation; and 3.)develop a section to the policy outlining the duties of medical staff, which include observing the respiratory function of detainees while they are in prone restraints.
4. Amend the Use of Restraints policy to include guidelines for the use of the restraint chair and provide data for restraint incidents requiring the restraint chair over the last 12 months.
5. Provide responses to a list of additional questions related to DRF's review of the jails handbooks, policies, and procedures.

During the monitoring, the facility also agreed to upload the DRF brochure to the jail's tablets and kiosks for detainees. DRF provided electronic copies of the DRF brochure. At this time, DRF confirmed that the jail appropriately resolved items 1, 2, and 3 in the above list. However, this project remains open as DRF continues communications with the jail to resolve items 4 and 5. This project will remain open into the next FY until all post-monitoring recommendations for improvement are resolved.

In a second example, in Q1 of FY 2023-2024, Disability Rights Florida (DRF) opened a monitoring project for a County Jail with 2,024 beds serving adults with significant mental illness in the Southeast Region of Florida. DRF selected this facility for monitoring due to complaints of rights violations, including possible abuse or neglect, occurring at this facility that have been received via DRF's Institutional Intake Mail.

DRF's monitoring team completed their pre-monitoring interview and on-site monitoring in Q2 of FY 2023-2024. During the monitoring, DRF did not find problems that required formal recommendations for improvement. Instead, DRF did identify areas requiring more information and collaboration—most notably staffing shortages and overcrowding on the Mental Health Unit, DRF's need for self-advocacy information for future clients from the jail, and the jail's interest in utilizing DRF's posters and brochures. In Q2 of FY 2023-2024, DRF sent their Post-monitoring Summary Letter to the jail with the following requests:

1. provide details about any efforts to secure additional mental health staff and/or make improvements to mitigate overcrowding on the Mental Health Unit;
2. provide updates on these efforts twice over the succeeding twelve months;
3. provide self-advocacy information that DRF could provide in cases where individuals present disability-related issues at the jail;

4. confirm that the jail's Division Manager received DRF posters and brochures and make these resources available on the Mental Health Unit and Medically Necessary Assistive Devices Unit.

In FY 2024-2025, DRF completed two progress assessments of the jail's efforts to improve mental health staffing/services and mitigate overcrowding on the Mental Health Unit—the first in Q1 and the second in Q2. The jail demonstrated improvements by hiring additional mental health professionals, expanding coverage of mental health services to include evening and weekend hours, restructuring the Mental Health Unit to increase the number of beds, and implementing daily multidisciplinary assessment meetings that succeeded in bringing the number of detainees housed on the unit under capacity. As a result, in Q3 of FY 2024-2025, DRF's monitoring team approved closure of the monitoring project and mailed a monitoring closing letter to the facility along with a summary of DRF's monitoring process and final resolutions.

The outcomes for this monitoring project include:

1. Confirmed that the jail took the following steps towards improving mental health staffing and mitigate overcrowding on their mental health unit:

a. completed a mental health housing review with Command staff, the Contract Compliance Division Manager, and the Health Services Administrator at Wellpath that resulted in an increase in bed space on the four MHUs (increasing bed space to 108);
b. reviewed mental health staffing matrices to better schedule available staff;
c. implemented a daily interdisciplinary meeting to review all inmates housed within the four MHUs;
d. added additional mental health staff, including transitioning a per diem Mental Health Professional (MHP) to full-time and hiring a per diem MHP to specifically cover afternoon and evening shifts, a full-time psychologist that provides extended weekday coverage, a full-time MHP, two additional per-diem MHPs, utilization of Wellpath's Travelling MHP, and use of MHPs from other Wellpath facilities on an on-call basis;
e. confirmed that staffing additions now allows the jail to provide on-site mental health coverage seven days a week, ensuring continuous availability of MHPs;
f. implemented a proactive approach to mitigate overcrowding on the Step Units through daily multidisciplinary assessment meetings;
g. continued to provide evening and weekend mental health coverage by staggering staffing schedules;
h. maintained 108 beds on the Mental Health Unit while bringing the unit under capacity with 107 total detainees housed;

2. provided DRF with self-advocacy Information for detainees requiring disability-related accommodations at the jails;

3. distributed updated DRF posters and brochures to be placed on the Mental Health Unit and Medically Necessary Assistive Devices Unit, including a general DRF brochure, a pamphlet on the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program, a digital version of the general DRF brochure to be placed on the detainee kiosks.

CRISIS STABILIZATION UNITS (BAKER ACT RECEIVING FACILITIES)

In one example, Disability Rights Florida (DRF) opened a monitoring project for a Baker Act Receiving Facility with 98 beds serving adults with significant mental illness and youth with serious emotional disturbance in the Suncoast Region in Q1 of FY 2024-2025. DRF selected this facility to ensure compliance with rights protections requirements of adults and youth with disabilities, including significant mental illness and serious emotional disturbance, per statute and rule. DRF's monitoring team completed the virtual pre-monitoring interview with facility administrators along with the on-site monitoring of the facility in Q2 of FY 2024-2025.

During Q2 of FY 2024-2025, DRF's monitoring team communicated the following post-monitoring recommendations for improvement to the facility administrators:

1. Provide an update on patients' current access to fresh air breaks. Specifically, (1) a timeframe or estimate on when any architectural fixes to the patio areas will be completed and (2) how NTBH is accommodating patients' access to fresh air and outdoor breaks while this is happening.
2. Interviewees expressed concerns about a lack of access to water and hygiene items while in treatment. DRF requested that the facility provide an update on how they intend to respond to these continued reasonable request complaints.
3. Review and revise policies related to discharge to bring with into compliance with Florida laws and regulations regarding minimum requirements for discharge planning.
4. Review and revise the Seclusion and Restraint policy to ensure compliance with Florida laws and regulations, particularly regarding (1) defining prohibited restraint practices and other relevant general standards, (2) ensuring that current policy reflects all procedural requirements for post-restraint debriefings, and (3) including information about the requirement to develop personal safety plans and ensuring that staff conducting restraints have access to these plans.
5. Consider rescinding policies purporting to allow for blanket restrictions or modification of patients' rights when necessary to achieve treatment goals, as blanket restrictions on patients' rights are not compliant with Florida laws and regulations.
6. Include additional information in the Patient Handbook informing patients about when restraints are used, why they are used, and when they may not be used.

Throughout Q3 and Q4 of FY 2024-2025 DRF attempted to communicate with the facility and their Chief Executive Officer regarding the above issues but were unsuccessful. In response, DRF will escalate their efforts by writing a complaint letter outlining the above issues to the

Managing Entity that contracts the facility and, if the Managing Entity fails to respond, they will file a formal complaint with the Agency for Healthcare Administration (AHCA). This project will remain open into the next FY as DRF drafts the letter and awaits responses from the Managing Entity and, potentially, AHCA.

In a second example, Disability Rights Florida (DRF) opened a monitoring project for a Baker Act Receiving Facility with 84 beds serving adults with significant mental illness in the Northeast Region in Q2 of FY 2024-2025. DRF selected this facility to ensure compliance with the rights and safety of residents at the facility. DRF's monitoring team completed the virtual pre-monitoring interview with facility administrators along with the on-site monitoring of the facility in Q2 of FY 2024-2025.

During Q2 of FY 2024-2025, DRF's monitoring team communicated the following post-monitoring recommendations for improvement to the facility administrators:

1. Provide the following information related to the facility's practice of locking patients out of their rooms: a.) Provide any policies related to RPBH's practice of locking patients out of their rooms; b.) Confirm the hours at which patients are locked out of their rooms; c.) Provide the process for patients to access the bathroom during room lockout hours.
2. Confirm if the facility requires patients to attend classes and, if they do not, amend the patient handbooks to reflect the current attendance policy.
3. Update the patient handbooks to include DRF's correct contact information.
4. Review and revise the grievance policy to bring it into compliance with Florida Administrative Code by:

a. adding explanations to the formal grievance and grievances appeals sections of the patient handbooks that a patient will be given or mailed a written response within 24 hours of a decision;
b. changing the timeline for providing written response to formal grievances in the Patient Advocacy Program policy from "within 7 days" to "within 24 hours of disposition" (or other similar language);
c. adding a timeline for resolving grievance appeal in the Patient Advocacy Program policy that includes a final decision within 5 working days of receipt of an appeal and a written response to an appeal provided to the patient within 24 hours of disposition;
d. posting the full grievance process along with the phone numbers for the above-named entities in the dayrooms and next to the patient telephones on each unit.

5. Provide the Seclusion and Restraint rates, along with a breakdown of rates by unit, for the first quarter of 2025 (January 1, 2025 – March 31, 2025), once the first quarter data is available.
6. Revise the facility's seclusion and restraint reporting practices to ensure that they report all seclusion and restraint incidents to DCF on a monthly basis, as required by State regulations and provide DRF with confirmation of this change by May 1, 2025.
7. Bring the policy on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion into compliance with Florida law by amending their definition of LIP, specifically replacing "APRN" with "psychiatric APRN" or "APRN with a psychiatric certification".
8. Bring the Physical/Chemical Restraint and Seclusion policy up-to-date by removing all mentions of the Geri-Chair, if that device is no longer in use.
9. Provide an expected timeframe for when the repairs to the outdoor gate (an elopement risk) will be completed.

During the monitoring, the facility also requested DRF brochures and posters to make available on the units while also expressing interest in scheduling DRF to provide on-site rights training sessions to patients and facility staff. DRF mailed a package with DRF brochures, PAIMI brochures, and updated DRF posters to the facility's Director of Performance Improvement, as well as, initiated communication for the rights training.

Throughout Q3 and Q4 of FY 2024-2025, DRF continued to work with the facility to resolve the above items. By the end of Q4, DRF had confirmed that the facility had appropriately address the above items and requested policy updates demonstrating the policy amendments. This project will remain open into the next FY as DRF waits for the facility to provide the updated policies.

STATE HOSPITAL

In FY 2022 – 2023, Disability Rights Florida (DRF) opened a monitoring project for a State Hospital with 959 beds serving adults with significant mental illness, along with adults with significant mental illness who have been entered in the Forensic Client Services Program, in the Northwest Region of Florida. The purpose of this project is to investigate complaints by residents at the facility about receiving inadequate nutrition. In Q2 of FY 2022 - 2023, DRF requested and reviewed the facility's current policies and procedures about food service and nutrition followed by a one-day on-site monitoring—which targeted food service issues. DRF staff spoke to a sample of residents across all units at the facility, conducting 15 formal, sit-down interviews about food service and nutrition issues, along with numerous informal discussions with other patients.

After the monitoring, DRF drafted a letter and shared their findings with the facility's hospital administrator and senior staff, drawing attention to resident complaints about a lack of food, a lack of healthy snacks, small portions, and food that arrives cold and/or late. In Q3 of FY 2022-2023, DRF met with the facility's administrator and senior staff about these issues, where they agreed to make numerous changes to their nutrition program, including adding a higher-calorie and better nightly snack, working to improve their food delivery infrastructure to make sure the food arrives hot and on-time, and other policy changes about related topics.

Subsequently, the facility obtained budgetary approval to begin implementing these changes and began a trial run of some changes in one individual unit. Throughout FY 2023 – 2024, DRF tracked the hospital-wide implementation of these changes. They also conducted additional monitoring to confirm changes to nutrition plan. During that monitoring, however, DRF identified some irregularities, resulting in continued monitoring to address them.

Throughout FY 2024 - 2025, DRF continued to track the progress of these changes. They conducted monitoring in Q1 about unrelated issues and used the opportunity to discuss the food service with many residents, only to find that some previous positive changes (such as sandwiches at night) had now expired due to lack of budget, while other issues, such as breakfast arriving extremely late and causing patients to miss classes, were still prevalent. DRF addressed these issues in a letter to the facility's administrator and met with senior staff from the facility in Q2 of FY 2024 - 2025. Notably, in this meeting, the facility's dietician acknowledged that the entire facility had previously been working off a default caloric requirements for women aged 50-70 –meaning that many people, especially younger people and men, were receiving only around 1800 calories until approximately February 2024, when it was corrected to instead use the default caloric requirements of an average 40 year old male, which is 2188 calories/day. This confirmed that the original complaints about inadequate portions and calories were accurate. They also described several other positive changes, such as improved infrastructure, better insulation for hot food, and a breakfast program intended to stop patients from missing classes. While they informed DRF that told this program would be implemented in the Spring of 2025, the facility repeatedly delayed and ultimately reneged on this promise, claiming that patients didn't want the new program.

This project will remain open into FY 2025- 2026 while DRF continues to work with the facility to resolve the core issues. DRF intends to analyze facility data about timeliness of the food service and also to follow up with individual patients and clients about their experiences, in order to determine whether the most significant issue (late food interfering with classes and programming) remains a problem and continue to take all necessary steps to advocate for a solution.

APD FACILITIES

In one example, in Q1 of FY 2024-2025, Disability Rights Florida (DRF) opened a monitoring project for 34-bed secure forensic facility in the Northwest Region that serves adults dually diagnosed with significant mental illness and developmental disabilities that have been adjudicated not guilty under Chapter 393 of Florida State Statutes. DRF opened this monitoring project due to larger systemic concerns about rights violations—including long-term punitive use of seclusion and aggressive and dangerous security practices—at forensic APD facilities. The primary goal for the monitoring was to use it as an opportunity to speak to patients and attempt to identify any additional clients who may have been abused by security staff or had any other issues of potential abuse or neglect at the facility.

During Q2 of FY 2024 – 2025, DRF conducted a meeting with all senior staff at the facility along with an on-site visit, where DRF staff toured the facility, photographed areas accessible to residents, and conducted confidential interviews with a number of current residents. The only significant issue immediately raised by residents was regarding several recent fights, which DRF communicated to the facility administrator. DRF did not identify any significant health or safety issues as part of this monitoring, but did develop multiple additional cases for review as part of the larger systemic project, consistent with DRF's initial goals.

As a result, DRF closed this monitoring project in Q4 of FY 2024-2025 with any further work on the primary concerns regarding the rights violations at forensic APD facilities being addressed under systemic projects.

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

Strategies Used:

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:	6
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 2024-2025, Disability Rights Florida (DRF) engaged in tracking and analyzing several bills related to abuse, neglect, and/or rights protections of individuals with significant mental illness or serious emotional disturbance during Florida's 2025 legislative session. Five bills, in

particular, exemplify DRF's work in this area.

Reporting of Student Mental Health Outcomes

In the Third Quarter of the 2024-2025 Fiscal Year, Disability Rights Florida (DRF) monitored the development and consideration of House Bill 969. In recent Fiscal Years, DRF has worked extensively with partners to not only challenge district-level practices resulting in the inappropriate or excessive involuntary removal and mental health examination of students alleged by school administrators to be in a mental health crisis and therefore potentially in need of services and evaluation, but to also commence policy education efforts that resulted in the introduction of legislation (during both the 2022 and 2024 state legislative sessions) proposing to address these same issues. As originally filed, House Bill 969 required the state to facilitate an annual evaluation of the mental health services provided to students by school districts, including through an evaluation of student outcomes. To assist in this evaluation, House Bill 969 as filed would have required each school district to provide the state with the district's school board approved mental health assistance program plan and outcomes data as well as deidentified survey results and aggregate data related to mental health service referrals stemming from schools' threat assessment and management processes.

As ultimately passed by the 2025 Florida Legislature, House Bill 969 directs the state's nonpartisan legislative research and analysis office to evaluate mental health services provided to students by school districts and to provide an initial and final evaluation to the Governor and Legislature while requiring specified entities to coordinate the provision of data and information needed for evaluation and inclusion in the report (including data related to outcomes and performance of integrated and coordinated behavioral health systems of care and aggregate data related to mental health service referrals stemming from the school districts' behavioral threat assessment and management processes. In the upcoming Fiscal Year and beyond, DRF will continue to review this and all related reporting to gauge the state's evolving framework for ensuring the health, safety, and well-being of students in the state, including students with serious emotional disturbance, as well as the protection of all educational and civil rights of students in the state accordingly.

Other Bills being Analyzed by DRF

CS/CS/HB 1091 / Substance Abuse and Mental Health Care: This bill recognizes Florida's 988 Suicide and Crisis Lifeline as a component of the state's coordinated system of care, and authorizes the Florida Department of Children and Families to oversee and set standards for call centers; allows discharge of a guardian advocate when a patient is released from involuntary outpatient services; requires clinical psychologists involved in involuntary placement determinations to have at least 3 years of clinical experience; permits a designated receiving facility to retain a patient for the 72-hour examination period, even if transfer timelines are not met, if involuntary examination criteria still apply; aligns involuntary outpatient placement criteria and procedures with those used for involuntary inpatient placement, including a required services plan; authorizes administrative law judges to conduct hearings, waive a patient's attendance under specified conditions, and issue final orders for continued involuntary services with judicial review available; removes certain requirements for establishing medication-assisted treatment providers for opiate addiction; revises training requirements for forensic evaluators and clarifies that experts must consider and document less restrictive treatment alternatives available and appropriate within the community.

CS/CS/SB 1620 / Mental Health and Substance Use Disorders: This bill codifies recommendations made by the state's Commission on Mental Health and Substance Use Disorders; defines person-first language to mean language used in a professional medical setting must emphasize the patient as a person rather than his or her disability or illness and requires use and promotion of person-first language as the standard in professional behavioral health settings; requires the continued promotion of best practices in crisis intervention and trauma-informed care; requires that individualized treatment plans for adults and juveniles be reevaluated at least every 60 days; requires the use and statewide integration of a functional assessment tool; requires the Florida Department of Children and Families (DCF) to conduct biennial reviews and the Florida Agency for Health Care Administration (AHCA) to prioritize licensing for short-term residential treatment facilities in underserved counties and high-need areas.

CS/CS/SB 168 / Mental Health: The "Tristan Murphy Act" aims to add alternative pathways to prosecuting defendants with mental illnesses; amends Ch. 916, F.S., to provide legislative intent that a defendant who is charged with certain felonies, any misdemeanor, or any ordinance violation and who has a mental illness, intellectual disability, or autism be evaluated and provided services in a community setting when this is a feasible alternative to incarceration; provides legislative intent to require crisis intervention team training for law enforcement officers.

CS/CS/CS/SB 954 / Certified Recovery Residences: This bill requires local government to adopt an ordinance, subject to certain restrictions, to formalize and streamline the process for applicants seeking reasonable accommodations from land use regulations in order to open a certified recovery residence; stipulates specific timelines and requirements for the ordinance, such as written application processes, final determinations within 60 days, and consistency with federal fair housing and disability laws; for certain Level IV certified recovery residences, eliminates staffing requirements when residents are not present, and increases the number of residents that a recovery residence administrator can oversee from 150 to 300 if the administrator maintains a minimum 1:6 personnel-to-resident ratio when residents are present.

Objective: Continue to evaluate restraint and seclusion data from the time period prior to changes in Florida laws restricting the use of restraints and prohibiting the use of seclusion in Florida schools. Disability Rights Florida will Investigate individual complaints of restraint and seclusion to analyze and determine 1) whether school districts are properly implementing the current Florida laws pertaining to restraint and seclusion and 2) whether the legislative changes regarding restraint and seclusion have decreased the use of these tactics on students with serious emotional disturbance/significant mental illness. This investigation and analysis will continue for more than one fiscal year. Information gathered through this process will be used to inform Disability Rights

Florida's advocacy efforts aimed at ensuring proper implementation of the legislative changes that limit the use of restraint and prohibit the use of seclusion in schools.

Strategies Used:

Target Measures

Target Population:	PAIMI-eligible students in public schools, alternative schools, segregated settings.
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 seclusion and restraint of students, including restraint used for the stated purpose of crisis prevention and intervention procedures, during the FY 2018-2019 and FY 2019-2020 school years. The purpose of this request 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 mental illness.

In previous FYs, DRF's investigation of these issues included analyzing and compiling statewide data related to the use of seclusion and restraint in Florida's school districts and 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.) This litigation concluded successfully in FY 2022-2023.

In response to the successful conclusion of this litigation, DRF opened this project in Q1 of FY 2024-2025 to determine whether: 1.) school districts are properly implementing current Florida law regarding restraint and seclusion and 2.) whether the legislative changes regarding restraint and seclusion have decreased the use of these tactics on students with disabilities. The result of this analysis will be used to inform DRF's advocacy efforts aimed at ensuring proper implementation of the legislative changes that limit the use of restraint and seclusion in school.

Throughout FY 2024-2025, DRF continued to analyze the data related to restraint and seclusion incidents involving K-12-aged students. They also continued finalizing an internal report about the use of restraint and seclusion for previous school years and used individual case work to identify students with disabilities that have behavioral challenges, including those with serious emotional disturbance (SED) and significant mental illness (SMI), were subject to excessive and inappropriate use of restraint and seclusion.

In Q3 of FY 2024-2025, DRF completed its internal report and closed the project. Due to capacity constraints, however, DRF is currently unable to gather and evaluate data following the legislative changes to identify and analyze trends in the inappropriate use of restraint and seclusion as behavioral intervention tools across all school districts in Florida. Through their individualized casework and the ongoing analysis of existing data, DRF will continue to identify specific districts that maintain high numbers of restraint and seclusion incidents. This analysis will guide their advocacy efforts to ensure that school districts properly implement the legislative changes limiting the use of restraint and seclusion. DRF will look to create a new discipline project once those specific districts have been identified.

Objective: Investigate individual complaints regarding housing discrimination occurring against youth with serious 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:

Target Measures

Target Population:	PAIMI-eligible individuals residing in community-based facilities or their own homes.
Expected Target:	2
Expected Outcome:	2
Actual Outcome:	3

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 one example, KG is an adult female and disabled veteran with significant mental illness (anxiety, PTSD) who contacted Disability Rights Florida (DRF) for assistance determining the status of their tenancy and whether they needed assistance with a request for reasonable accommodation. DRF's investigation identified that KG was receiving assistance from a housing advocacy agency and maintained a tenancy at a privately owned apartment building. Also, KG has mental health issues which appear to have affected her tenancy. KG made several claims concerning alleged domestic violence occurring in apartments that management determined were vacant. During the course of the investigation, an incident occurred at the property resulting in a police response. The housing advocacy agency assisting KG also responded and moved KG from the apartment where she was living and arranged for temporary housing at a hotel while other living arrangements are explored.

Since KG no longer resides at the property where they sought assistance concerning the status of their tenancy or assistance with reasonable accommodation, DRF moved forward with closing her case due to services no longer being needed because of relocation. DRF sent a case closing letter with DRF Client Satisfaction Survey and DRF Client Grievance Procedure to KG at her current address.

In a second example, LG is an adult female with significant mental illness who was renting a public housing unit at the time of their request for service with Disability Rights Florida (DRF). LG was evicted after multiple lease violations including dumping trash in neighbors' yards, putting dead animals on neighbors' cars, shouting outside in the middle of night, destroying property, etc. Legal Services of Greater Miami rejected LG's application for representation. DRF agreed to investigate to determine if LG had been a victim of discrimination by the housing authority such that the eviction could be "undone" as requested by LG.

To investigate this case, DRF reviewed records from the housing authority and advised LG that there was no legal basis to allege that the eviction was discriminatory and no legal basis to move to set the final eviction judgment aside. DRF offered to assist LG with securing a spot in subsidized housing through a request for reasonable accommodation, but LG declined. Instead, LG asked that DRF determine if she was on a waiting list for a voucher at the Miami Housing Authority. DRF agreed, investigated the matter, and reported to LG that they were not on the waiting list. DRF advised LG that there are other housing programs in Miami and asked that, if LG wished for DRF to investigate whether LG was on a waiting list for any of these other programs, that they return necessary releases. LG did not return the releases and did not respond to multiple contact attempts.

Throughout the pendency of this file, DRF made significant efforts to maintain contact with LG in light of their intermittent homelessness and mental illness but, at the conclusion of this file, LG alleged that DRF had stolen their money and failed to return multiple attempts at contact. As a result, DRF closed this case as client's objective was partially met due to DRF providing LG with information about whether her eviction qualified as discrimination. DRF mailed a case closing letter with DRF Client Satisfaction Survey and Client Grievance Procedure to LG at her current address.

Objective: Investigate reports of serious incidents involving children and youth who reside in Residential Treatment Facilities (RTFs) and Psychiatric Residential Treatment Facilities (PRTFs). Advocate for appropriate remedies as indicated.

Strategies Used:

Target Measures

Target Population: PAIMI-eligible youth residing in Residential Treatment Facilities (RTFs) and Psychiatric Residential Treatment Facilities (PRTFs)

Expected Target: 12

Expected Outcome: 12

Actual Outcome: 22

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:

While this priority reflects Residential Treatment Facilities and Psychiatric Residential Treatment Facilities cases that Disability Rights Florida

(DRF) closed within FY 2024-2025, it is relevant to note that DRF attempted to investigate 15 additional cases but were unable to proceed due to lack of guardian consent or inability to contact the guardian to obtain consent. For these 15 additional cases, DRF provided I&R resources to the client in place of a full investigation.

In one example, AM was a youth with serious emotional disturbance who resided in a private Residential Treatment Facility (RTF) for children and adolescents Disability Rights Florida (DRF) received an incident report alleging physical abuse against AM while at the RTF. Specifically, the report alleges that a staff member punched AM in the face during a restraint incident, where AM was resisting restraint by kicking and biting facility staff.

To investigate this report, DRF conducted a full investigation by reviewing clinical can video records but could not substantiate physical abuse. However, DRF was able to verify from video evidence that AM was subjected to dangerous, unsafe, and unapproved restraint techniques that could have harmed him. In response, DRF discussed the findings with facility, who agreed that the practice was unsafe and unapproved. The facility confirmed that they would ensure that staff discontinue the identified practices.

At the time of case closure, AM was still a patient at the RTF. DRF notified AM of the case closure and AM gave DRF permission to discuss the investigation with his guardian. This case also has been linked to an ongoing open project that will address systemic abuse of children in this RTF.

In a second example, IL was a youth with serious emotional disturbance with a history of suicide attempts and seeking means to commit suicide. At the time of intake, IL was a patient at a private Psychiatric Residential Treatment Facility (PRTF) for children and adolescents. Disability Rights Florida (DRF) received an incident report alleging neglect against IL. Specifically, the report outlined that, shortly after IL requested to be placed on 1:1 after an altercation with a peer, staff permitted IL to enter her room unattended. Shortly after, staff found IL hanging by her bed sheet from the door hinge.

Upon receipt of the guardian's consent, DRF staff visited the facility, met with the Program Manager and Clinical Manager, and carried out an environmental check of the door hinge—which had since been changed to a ligature-free hinge. DRF also interviewed IL and implicated facility staff. During the interviews with staff, DRF observed that some staff were aware that IL's histories of trauma, suicide attempts, and seeking means to commit suicide. While DRF determined that the staff's neglect was not intentionally malicious, they verified that the staff's failure to carry out supervision and monitoring protocols as outlined in IL's care plan placed IL at significant risk, as she had the time and opportunity to attempt suicide as a result of staff neglect. DRF staff discussed their investigative findings with the facility.

During the investigation, DRF received a second, similar incident report again alleging neglect against IL. The report stated that, similar to the initial incident, staff permitted IL to retreat to her room unattended after a verbal altercation with staff. Shortly after, two staff members found IL using a sweater to choke/strangle herself. At Dr's order she was restrained, and clothes and sheets were removed from her room, following which IL banged her head on the wall, sustained injury to the head, and used her hands to attempt to strangle herself. The supervisor on staff during this incident as the supervisor on staff during the initial incident in this case.

In response, DRF investigated the second incident as part of the IL's initial case related to ongoing staff neglect at the PRTF. DRF concluded that the facility failed to develop adequate safety planning to account for IL's histories of trauma, suicide attempts, and seeking means to commit suicide. Furthermore, they determined that the facility took no proactive measures to reconcile potential triggers associated with IL's past traumas, that staff failed to follow the facility's monitoring protocols that had been developed to keep patient safe, and that the facility failed to control environmental factors and proactively maintain a safe environment such as eliminating ligature points, particularly for patients with histories of suicide attempts/suicidal ideation such as IL. As a result, DRF filed a report with the State investigating agency and linked this case to an ongoing open project that will address systemic abuse of children in this PRTF.

In a third example, Disability Rights Florida (DRF) received a critical incident report from a Statewide Inpatient Psychiatric Program (SIPP) involving TB, a youth male with serious emotional disturbance. The report detailed that TB eloped from the facility while being supervised by staff. He was missing for about 15 minutes before staff realized that he was not with the group. The facility notified law enforcement, who later located TB outside of the facility grounds and returned him to the facility.

To investigate this case, DRF reviewed the incident report, TB's medical records, and video footage of the incident. They also interviewed TB at the facility. Based on the evidence received, DRF, determined that staff grossly misrepresented the length of time that TB was missing before staff realized he was not on the unit—approximately 1 hour instead of the report of 15 minutes. Additionally, the facility informed DRF that, after DRF requested records, the facility conducted its own investigation and found that three staff members were negligent in their duty to provide safety to the children in its care. The facility cited three employees for negligence which included one staff actively playing basketball with the youths while using his cell phone, another staff wearing ear pods in the gym while supervising the youths, and the third staff who was responsible for transitioning the youths failing to conduct a head count of the children he was transitioning from the gym to the unit.

Apart from violating facility policy, DRF concluded that these staff members were negligent, placing TB at risk and causing him to leave their supervision and elope from the facility. During the investigation DRF was informed that the facility had destroyed the supervision log every 30 days and it was therefore not available for DRF review. As a result of this investigation, the facility has agreed to change its supervision log destruction policy and will include supervision logs in the patients' electronic health records to ensure proper preservation.

As a result of the above steps, DRF closed this case due to the objective of the case being fully met. DRF reviewed the case outcomes with TB

and his guardian, who approved of the case closure. DRF mailed a case closing letter with DRF Client Satisfaction Survey and DRF Client Grievance procedure to TB at his home address.

Objective: Continue the monitoring of three State Mental Health Treatment Facilities (SMHTFs) ("state hospitals") that treat civil commitment patients to enact meaningful improvements to treatment planning and discharge processes. Disability Rights Florida will engage key stakeholders and collaborate on the development and implementation of effective discharge planning measures for long-term residents of the three SMHTFs, which will be tailored to the unique strengths and needed areas of improvement in each facility.

Strategies Used:

Target Measures

Target Population:	PAIMI-eligible individuals residing in State Mental Health Treatment Facilities.
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:

Disability Rights Florida (DRF) established this objective to advocate for meaningful improvements to treatment planning and discharge processes in State Mental Health Treatment Facilities ("state hospitals"). This objective stems from previous monitoring activities during FY 2022-2023 that presented significant PAIMI-related challenges, causing Disability Rights Florida (DRF) to transition the monitoring project to an independent systemic advocacy objective on their PAIMI program. To achieve the goals of this objective, DRF will be developing and implementing strategies to investigate barriers to discharge at Florida's three (3) state hospitals, including conducting interviews with facility residents who have experienced significant barriers to discharge, reviewing statistical trends in discharge timeframes, and researching solutions to address barriers to discharge for individuals who have remained housed at the state hospitals for 2+ years while achieving little to no progress towards discharge.

In Q1 of FY 2024-2025, DRF completed on-site monitorings at each of the three SMHTFs associated with this objective, with a total licensed bed capacity of 2,455. The goal of the monitoring was to identify and speak with patients that have been at the facilities for over one year with little to no progress towards discharge, experienced delays in placement of one year or more after being placed on discharge status or been readmitted shortly after being discharged. During interviews, DRF discussed treatment/discharge planning with the patients and obtained patient consent to review their treatment/discharge planning with the goal of identifying systemic problems that could be contributing to the most vulnerable patients experiencing delays in their treatment progress and ultimate discharge from the SMHTFs. After completing the on-site monitorings, DRF requested clinical records for residents who have over one year with little to no progress towards discharge, experienced delays in placement of one year or more after being placed on discharge status or been readmitted shortly after being discharged.

In Q2 of this FY, DRF started organizing and reviewing the records received in response to the aforementioned records request. In Q3 and Q4, DRF completed reviewing these clinical records and identified barriers and/or facility shortcomings that have led to delays in treatment progress or discharge for extended periods of time. Furthermore, DRF started requesting and reviewing detailed updates from clients to identify shortcomings of treatment planning and discharge processing by the state hospitals. This project will remain open into the next FY while DRF continues to discuss discharge barriers and identified shortcomings with the administrators at each state hospital and to request and review potential rule changes to the requirements to discharge from the state hospitals.

Objective: Litigation to address the Florida Department of Corrections' failure to provide students with serious emotional disturbance or significant mental illness a Free and Appropriate Public Education. DRF is litigating against the Department to address its failure to, among other things, ensure that students have access to (1) mental-health services on their Individualized Education Programs (IEPs) and (2) an appropriate educational curriculum.

Strategies Used:

Target Measures

Target Population:	PAIMI-eligible students in 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:

During 2022-2023, Disability Rights Florida (DRF) litigated a due process hearing on behalf of a student with disabilities who is in custody of the Florida Department of Corrections (FDC) to enforce his rights under the Individuals with Disabilities Education Act (IDEA). Specifically, Disability Rights Florida (DRF) alleged that the FDC rewrote the student's pre-existing Individualized Education Plan to only include GED prep, denied him access to secondary school education, and denied him appropriate behavioral and mental-health supports-moves that DRF determined were made for the administrative convenience of the FDC and not the student's unique needs. Ultimately, DRF determined that the FDC's handling of the student's educational needs is a systemic issue that impacts all incarcerated students eligible for services under the IDEA. As a result, DRF transitioned the individual case to a systemic advocacy project to continue litigation to address the FDC's failure to provide PAIMI-eligible students with Free and Appropriate Education in FY 2023-2024.

At the close of FY 2023-2024, DRF and the FDC had completed their appellate briefings and argument of the case before the presiding Judge at the Northern District of Florida, Tallahassee Division. The court ruled in favor of DRF's client and the FDC appealed the order from the Norther District of Florida to the 11th Circuit Court of Appeals. As a result, DRF was waiting for the 11th Circuit Court's decision on the appeal which, therefore, meant that the enforcement action was on hold pending that decision.

In Q1 of FY 2024-2025, DRF drafted a motion for legal fees and successfully negotiated a settlement agreement with the FDC, which included the requested legal fees and the dismissal of the appeal with prejudice. In Q2, DRF drafted and finalized the compensatory education request and submitted it to the district's attorney for review. The attorney responded with a stronger offer for DRF's client. Throughout Q3, DRF reviewed and amended the final settlement agreement and sent it to the attorney for final review. In Q4, DRF received the final signatures on the settlement agreement and accepted the offer for their client. As a result, DRF closed this project in Q4 of FY 2024-2025.

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

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

Strategies Used:

Target Measures

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

Expected Target: 1000

Expected Outcome: 1000

Actual Outcome: 1437

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 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 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 (e.g. county jails and state prisons), 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 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 serious emotional disturbance who are members of underserved populations, as well as their families and supporters.

Strategies Used:

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:	20
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 2024-2025, Disability Rights Florida (DRF) provided 20 separate outreach events to special populations, including older adults, individuals who reside in rural areas, individuals who are economically disadvantaged, and individuals with mental illness who are part of the blind community. DRF provided outreach in a variety of ways, including live and virtual presentations, 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:

Target Measures

Target Population:	PAIMI-eligible individuals, their families, and supporters.
Expected Target:	60
Expected Outcome:	60
Actual Outcome:	203
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 203 public awareness activities that include 40 public awareness events with the distribution of DRF brochures, 29 E-Newsletters, 10 Disability Deep Dive Podcast episodes, 18 Disability Rights Florida blogposts, social media posts on 6 social media platforms, information distribution through 1 DRF website, 2 phases of the Disability Rights Florida Public Planning Survey distribution, and 97 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/serious 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 serious emotional disturbance. This objective is particularly important for PAIMI-eligible youth transitioning from secondary school into adulthood.

Strategies Used:

Target Measures

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

Expected Target: 1

Expected Outcome: 1

Actual Outcome: 6

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:

After Supported Decision Making (SDM) was codified into law in Q2 of the previous fiscal year, Disability Rights Florida (DRF) has shifted its efforts from advocating for the passage of the bill on SDM to educating state policy makers, school districts, the judiciary, and attorneys about the application of SDM and SDM agreements. In FY 2024 - 2025 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 staff provided 6 training and education events to individuals with significant mental illness/serious emotional disturbance, family members, lawyers, and judges on the appropriate use of SDM as an alternative to guardianship. The training and education events served a total of 261 individuals.

In one example, DRF staff provided an SDM training at the 2025 Family Café exposition—the largest single gathering of individuals with disabilities, self-advocates, and family members in the state. DRF held an education and training event on the legal options for individuals once they turn 18, with a focus on SDM. DRF staff also answered a variety of questions about these options from audience members. The presentation served 50 attendees.

In a second example, DRF received an invitation to be a guest speaker in the SOW 5034: Social Work Professions course at Florida State University (FSU)—a course that is part of the Master of Arts in Social Work at FSU and consists of students who will be seeking employment as social workers after completion of the program. In Q1 of FY 2024-2025, DRF staff gave a presentation on the Protection & Advocacy system, with a significant emphasis on SDM. DRF informed attendees about how people with disabilities can seek out and use SDM in their daily lives. The presentation served 19 attendees.

In a third example, DRF was invited to participate in a presentation hosted by a Center for Independent Living (CIL). DRF's presentation covered a variety of legal options for adults with disabilities, including guardianship, guardian advocacy, designation of healthcare surrogate, Power of Attorney, and Supported Decision Making (SDM). DRF also answered audience members' questions about SDM as part of the panel along with a guardianship attorney, two staff members from the CIL and a Waiver Support Coordinator. The presentation served 17 attendees.

Overall, this objective will remain open into the next fiscal year as DRF continues its efforts to educate state policy makers, school districts, the judiciary, and attorneys about the application of SDM and SDM agreements.

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

Strategies Used:

Target Measures

Target Population: PAIMI-eligible individuals and their supporters.

Expected Target: 4

Expected Outcome: 4

Actual Outcome: 20

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 2024-2025, Disability Rights Florida (DRF) conducted a total of 20 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 Facilities, Drop-in Centers, and Clubhouses. Over the course of the fiscal year, 1,207 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 also distributed informational materials, including DRF's "Supporting Individuals with Significant Mental Health Conditions" and our PAIMI Mental Health Resources Guide.

FACILITY-BASED EXAMPLES:

As an example of rights and self-advocacy trainings to PAIMI-eligible individuals in an inpatient treatment setting, Disability Rights Florida (DRF) conducted resident rights trainings at a forensic State Mental Health Treatment Facility with a total of 260 beds in Northeast Florida—with a total of 83 residents attending the training sessions. During the rights training sessions, DRF presented to residents from 3-4 living areas at a time in the multi-purpose room—covering all 10 living areas over the course of the day. They also answered resident-rights related questions from residents and spoke privately with residents who requested to submit an intake, which were opened as individual prescreens/I&Rs.

DRF provided residents with PAIMI brochures (83 in total) and provided the facility's Assistant Institutional Superintendent and Rehab Director with updated DRF posters to hang above the resident phones in each living area (25 posters in each language in total). Additionally, DRF left the remaining PAIMI brochures with the Rehab Director, who will add the brochures to the resident information booth in the primary social area (282 brochures in total). After the rights training sessions, the facility's Rehab Director and Art Director gave DRF a guided tour of the facility grounds.

In a second example, DRF staff conducted 14 inpatient rights training sessions at a State Mental Health Treatment Facility with a total of 613 beds in Northeast Florida—with a total of 286 residents attending the training sessions. During the rights trainings, DRF staff presented to residents from two buildings at a time in the facility's chapel and visited the remaining living areas to speak with residents directly in the day rooms—covering all 18 living areas over the course of the two days. DRF staff provided information on the history and description of DRF, the PAIMI grant, DRF advocacy work, mental health rights training, and DRF's institutional intake line. DRF provided residents with "Supporting Individuals with Significant Mental Health Conditions" brochures during each rights trainings session. The trainings were interactive between DRF staff and facility residents, with residents engaging and asking questions and participating regarding their rights while inpatient as well services once discharged. DRF staff also answered resident-rights related questions from residents and spoke privately with residents who requested to submit an intake.

DRF provided residents with PAIMI brochures and provided the facility's Customer Relations Department with updated DRF posters to hang above the resident phones in each living area (36 posters in each language in total). Additionally, DRF left the remaining PAIMI brochures with the facility's Customer Relations Department, who will add the brochures to the resident information booth in the resident cafe. During the rights training, the facility's Customer Relations Department inquired about coordinating annual resident/staff rights trainings with DRF.

COMMUNITY-BASED EXAMPLES:

As an example of rights and self-advocacy training to PAIMI-eligible individuals in a community-based setting, DRF conducted an interactive rights training and outreach presentation at a Clubhouse in Pinellas Park, Florida. 40 individuals (consumers/peer staff) received information during the presentation. DRF provided information about DRF (including P&A history and authority, grants, access authority, DRF history and makeup of DRF's current teams), DRF services (including how to receive DRF services via FIRST and MH Intake Line), information about the PAIMI grant and the PAC, rights training of persons with disabilities for individuals in inpatient settings and in the community. DRF played the "What Do P&As Do?" video from DRF's website. DRF staff also answered questions from participants regarding rights and services. DRF also provided information to individuals in attendance (consumers/peer specialist staff), which included DRF bags with DRF materials (DRF brochure, PAIMI brochure, 10 Steps to Effective Self-Advocacy brochure, Are You Prepared for an Emergency brochure, Voting brochure, MH Resource Guide, DRF hand sanitizer, DRF pen, DRF magnet).

During the training, attendees expressed concerns/questions about following mental health-related issues:
• DVR: getting services (can contact DRF if they want our assistance)
• SSA: qualifying (I/R: NOSSCR)
• Family law: child custody (I/R: FBLRS, legal aid, family law attorney)

After the training, Clubhouse staff provided DRF with a tour of the facility. Additionally, several Clubhouse members requested PAC applications, which they completed and submitted to DRF.

In a second example, DRF conducted an interactive rights training and outreach presentation at Center for Independent Living (CIL) in Broward County. The presentation included the "Who We Are" DRF and the "Voting Accessibility" PowerPoint presentations. Approximately 30 individuals who attend the CIL's youth summer program attended/participated (ages 14-21 years of age). DRF provided information about DRF (including P&A history and authority, grants, access authority, DRF history and makeup of DRF's current teams), DRF services (including how to receive DRF services via FIRST and MH Intake Line), information about the PAIMI grant and the PAC, and voting accessibility. Attendees

participated in an engaging discussion w/DRF staff. DRF played the "What Do P&As Do?" video from DRF's website. DRF staff also answered questions from participants regarding rights and services.

DRF also provided information to individuals (consumers/peer specialist staff), which included DRF bags with DRF materials (DRF brochure, PAIMI brochure, 10 Steps to Effective Self-Advocacy brochure, Are You Prepared for an Emergency brochure, Voting brochure, MH Resource Guide, DRF hand sanitizer, DRF pen, and DRF magnet). The location was provided with additional DRF brochures.

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

Footnotes:

Advisory Council Report

Advisory Council Report (Required)

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	2024-2025

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 Officer

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

Public reporting burden for the ACR section of the annual PAIMI PPR is estimated to average 10 hours per response. This includes the time needed to review the instructions, to search existing data sources, to gather the data needed, and to complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project; CBHSQ, Room 15E21B; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is (0930-0169).

The ACR Section of the ANNUAL PAIMI PPR

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The ACR Section of the Annual PAIMI PPR	
SECTION A. GENERAL INFORMATION	
Fiscal Year:	2024-2025
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:	Lindsey Nichole Betterman 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.	Lindsey Nichole Betterman
Telephone Number:	[redacted]
E- Mail Address:	[redacted]
Date Submitted:	December 16, 2025
By signing this document, the Chair certifies that this report reflects the consensus of the PAC members.	Lindsey Betterman

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.	1
B.1.c. Family members of individuals who are recipients/former recipients (R/FR) of mental health services.	2
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.	3
B.1.f. Mental health professionals:	2

B.1.f.1. Social Workers	1
B.1.f.2. Psychologists	
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.	1
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].	0
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).	8
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.]	73%

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, 1 Special Meeting, and 1 Check-in Meeting)
B.3. e. Number (%Average) of PAC members present at Meeting.	61%

SECTION C. PAC DATA ON ETHNICITY & RACE

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	2
C. A. 2. Not of Hispanic Origin	9

(Add C.A.1 & C.A.2., the total should be the same as the one listed in B.1.k. (members serving as of 9/30).	**Total: 11**
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	**6**
C. B. 6. Two or More Races	**1**
C. B. 7. = C.B.1 through C.B.6.	**Total: 11**
Members may select as many racial identifications as they want.	
C. C.1. Total Number of PAC member vacancies on September 30.	**Total PAC Vacancies**
	0

SECTION D. Sex of PAC Members	
D.1 FEMALE : 8	D.2 MALE : 3
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? ____	Yes	No X

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 Team**
- **PAIMI Program Coordinator**
- **Executive Director**
- **Director of Finance**
- **System Administrator**

Invited as needed:

- **Litigation Director**
- **Director of Public Policy**
- **Staff Attorneys on Public Policy Team**
- **Staff Attorneys on Investigations Team**
- **Advocate/Investigators on Investigations Team**
- **Rights Training and Outreach Coordinator**
- **Quality Assurance Coordinator**

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.

- **Attorney - Director of Investigations Team: Planning, information sharing**
- **PAIMI Program Coordinator: Planning, information sharing, meeting coordination, minutes, and travel assistance**
- **Executive Director: Information sharing and PAIMI grievances**
- **Director of Finance: PAIMI financials and information sharing**
- **Litigation Director: Information sharing**
- **Quality Assurance Coordinator: Information sharing**
- **Rights Training and Outreach Coordinator: 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 PACc and the Board to attend each other's meetings. During FY 2024-2025, the following Board members attended PAC meetings:

- **Beth Boone, information sharing**

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 FY 2024-2025 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.	Yes	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. **Activity 1 - DRF's Tour of a Clubhouse in Kendall, FL on January 30, 2025. 1 PAC member toured the newly opened facility, spoke to Clubhouse members about the PAIMI program, and distributed PAIMI and DRF brochures.** **Activity 2 - DRF's Rights Training at a Clubhouse in Pinellas Park, FL on May 29, 2025. 1 PAC member attended and participated by speaking to Clubhouse members about the PAIMI program, PAC membership, and the PAC application process. They also assisted in distributing PAIMI and DRF brochures.** **Activity 3 - The Family Café from June 13 – June 15, 2025, in Orlando, Florida.** o **2 PAC members attended Family Café Conference** o **2 PAC members assisted with the DRF's Public Forum (DRF Project #18903)**	X	

F.5.b. Out-of-State Trainings/Educational Activities.	Yes	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.		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
In-state activity #1	1 PAC Member		1	
In-state activity #2	1 PAC Member		1	
In-state activity #3	2 PAC Members	2		

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 2025 Family CAFÉ event and led small group discussions to solicit input from the public at DRF's Public Forum at the 2025 Family CAFÉ event.

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).

F.10.e. Briefly describe any other activities, e.g., fund raising, public relations, etc.

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.

The advocacy work done on behalf of PAIMI eligible individuals to receive a Free and Appropriate Pubic 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. This advocacy included legal intervention for children facing discriminatory practices as well as rights education for families and professionals.

Regarding the PAC's concern regarding the inappropriate use of Power of Attorney's for adults, DRF has been supportive of legislation promoting Supported Decision Making as an alternative to guardianship as well as provides ongoing education regarding self-determination in the transition to independence process.

The PAC is dedicated to improving access to community based supports and services. To that end DRF provides legal assistance whenever necessary to intervene on behalf of individuals with disabilities to ensure their access to medically necessary healthcare as well as advocate and educate policy makers and service providers on alternatives to institutionalization and available community supports.

The Council is working, on an ongoing basis, to improve access to public programs and services. DRF provides ongoing intervention for public accommodations, government services, disaster planning/recovery, voting, and transportation inadequacies.

DRF is on target with the protections and/or outcomes related to abuse, neglect and/or rights protections of individuals with significant mental illness. Cases regarding PAIMI eligible individuals are being investigated and ongoing updates are provided, keeping the council informed of how the Goals are actively held in high importance by staff in the work that they do.

The Council would like to increase the awareness of rights amongst those with disabilities and to educate policy makers. DRF regularly participates in community-based events bringing awareness of all of their available supports and services to include accessibility and to enhance their self-advocacy skills.

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 which will remain consistent with the above for fiscal year 2025 - 2026. The outreach of the underserved populations that DRF is prioritizing falls in line with the goals of the council as well.

SECTION G. PAC ASSESSMENT OF PAIMI PROGRAM OPERATIONS

G.2. OTHER COMMENTS CONCERNING PAIMI SYSTEM OPERATIONS:

Briefly describe any special initiatives, problem solving techniques, or innovative practices that may help other State P&A systems.

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.

Dr. Beth Boone, Chair, Board of Directors Grievance Committee

Cherie Hall, Executive Director, Disability Rights Florida

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. 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.