MARJORY STONEMAN DOUGLAS HIGH SCHOOL

PUBLIC SAFETY COMMISSION MEETING

BB&T Center, Chairman's Club

1 Panther Parkway

Sunrise, Florida 33323

July 12, 2018

8:30 a.m. - 5:30 p.m.

COMMISSION MEMBERS/ATTENDEES:

SHERIFF BOB GUALTIERI, Chair

RICHARD SWEARINGEN, Commissioner - Florida Department of Law Enforcement
MAX SCHACHTER, Parent of Victim
LARRY R. ASHLEY, Sheriff - Okaloosa County (via phone)

MELISSA LARKIN SKINNER, CEO - Centerstone of Florida

MICHAEL CARROLL, Secretary - DCF

JAMES HARPRING, Undersheriff/GC - Indian River County
GRADY JUDD, Sheriff - Polk County
LAUREN BOOK, Senator - District 32
RYAN PETTY, Parent of Victim
BERTHA HENRY, County Administrator
SHAWN BACKER, Deputy Chief - Coral Springs Police Department

BRAD MCKEONE, Operations Deputy Chief - Coral Springs Police Department
KATHY LIRIANO
KEVIN LYSTAD, Chief/President - Florida Police Chief Association

DOUG DODD, Commissioner - Citrus County School Board

MIKE MOSNER, Assistant Chief - Coral Springs/Parkland Fire Department
CINDY CAST - Miami-Dade Communications
ROBIN SPARKMAN, Chief of Firearm Eligibility Bureau - Florida Department of Law Enforcement

UTE GAZIOCH - Division of Child and Family Services

JUSTIN SENIOR, Secretary - AHCA
SILVIA QUINTANA, CEO - Broward Behavioral Health
STEVEN LEIFMAN, Judge - Chair of Florida Supreme Court's Task Force on Mental Health and Substance Abuse Issues

Also present:
DAVID COBRA CLEMENTE, Chapter Leader - Parkland Guardian Angels

JEFF OSTROFF

MICHAEL SIRBOLA

I-N-D-E-X

(Thereupon, the following meeting was had:)

CHAIR: All right, we're going to get started. Before we get with Chief Backer we're going to hear from the County Administrator this morning, but before we do that let me just kind of recap. In talking to some people, I just want to make sure that the commission members have an understanding of the importance of yesterday, what we're going to wrap up this morning, and why we're going through this. There's been a lot of discussion, and some criticism about what people did, what people didn't do, why they acted, why they didn't act, and an important aspect of us evaluating that is what people knew, what they didn't know, information that they had access to, information that they didn't have access to, that may have driven some of their actions or inactions.

So, that was a significant reason and backdrop for having to go through all of what we are going through regarding communications. And when you think about it this way, and what we learned yesterday, and what we know, and this is going to lead us into August, and

especially into September for sure, but hopefully in August as well, where we're starting to really look at in a detailed way, you know, with facts, and with evidence, and call logs, and CAD notes, and radio traffic, and everything else putting this whole picture together is, is that what we learned yesterday is, is that if somebody at Marjory Stoneman Douglas High School dials 911, is that we know that that is going into the Coral Springs communications center, and that's where that call is going to be answered. We know that the Coral Springs Police Department is not the primary law enforcement responder at Stoneman Douglas High School, we know that the Broward County Sheriff's Office is.

We know that the way the system is designed is, is that the Coral Springs Police Department when they answer that call, and somebody says there's a law enforcement emergency at Stoneman Douglas, that they would transfer that call to the Broward County Sheriff's Office regional communications center. That call taker would then ask the person certain questions again. That person

would convey the information. They would create an entry into the CAD system, meaning the call taker would create an entry into the CAD system. That entry would then be shipped to the dispatcher. The dispatcher would then send it out over the Broward County Sheriff's Office CAD and/or radio system.

And what we know happened on February 14th is, is a lot of 911 calls went into the Coral Springs Police Department Fire 911 Center. We don't know how many calls, and we're going to find out, and you'll have that in front of you in the near future. We don't know how many calls went to the Broward County Sheriff's Office regional communications center. A few, but not a lot. The exact number we'll find out.

We also know that the Broward Sheriff's Office does not have a CAD system that they share with Coral Springs, so as Coral Springs was getting that information, and they were entering it into their CAD, and their officers were getting it, the Broward County Sheriff's deputies who are being informed of the active shooter situation at Stoneman Douglas didn't

have access to the CAD information that was being entered in the Coral Springs system.

We also know that the Broward Sheriff's Office regional communications center did not have the Coral Springs main dispatch channels, so they couldn't even go up on those channels to even hear what Coral Springs was saying. We also know that the responding deputies didn't have access to the Coral Springs primary channel. Then we heard as well about the responding deputies, and we heard a lot about this thing that has become infamous, in throttle, and you were told that when the radio system's capacity is met, in essence is, is that this throttling thing happens, and that whoever is trying to talk can't talk.

So, the version of it, this is what happens, is that if a deputy gets there, and in this case Captain Jordon got there, and a lot's been made about what she did or didn't do. And she gets on the radio to try and take control of the situation, (radio sounds) what's she going to do, thing becomes a brick, turn it off and throw it away, there's nothing you can do with it. That's what she was getting. That's

throttling. That's the type of tones that you're getting.

So, when people are saying that in Captain Jordan's case, and I don't know Captain Jordan, I met her once for about maybe five seconds, I don't know whether she did a good job, poor job, or somewhere in between. I have no idea. But what I do know, and the evidence here is going to show, and where it's going to show, because the testimony of law enforcement officers and body cam video and audio that shows that she was trying to transmit, and she couldn't transmit, and she could not get on the radio to take control of the scene, and that she was trying to go to their radios, car radios, K-9 deputies' radios, cruiser radios, she was trying to get on there and she couldn't get on there.

All that is extremely relevant to our evaluation of the command and control, which is one of the things specifically we're charged with evaluating here, and whether there was adequate command and control, and whether the scene was handled properly, and whether decisions were made. And so, as there is

criticism of, and it's been in public, public, about whether she allowed EMS in, whether she didn't allow EMS in, whether she set perimeters, whether she did this, which she did, she couldn't communicate. And the evidence that we see, and what you're going to see more of is, is that there is no doubt that the information that was available to Coral Springs exceeded the information that was available to Broward County Sheriff's Office because they didn't have a shared channel, they didn't have a shared CAD, and that people were trying to communicate, and they couldn't communicate because of this throttling issue.

So, in order for us to have a clear understanding of what we are going to see in great detail moving forward I felt that it was, and still feel it is, extremely important that you have a working knowledge, and an understanding of everything leading up to it, and the background, and the framework, so that you can properly evaluate what happened, what people did and what they didn't do, and why they may have acted, and some may have acted and others may not have acted, and it may have

been driven by the knowledge they had and the information available to them because they didn't have the ability and the capability of knowing what others knew because you had stuff that was going out over one system that wasn't on the other system, and you had information that's flowing into one place that wasn't flowing into another. How much we'll find out. Because that's the way the system was set up.

And remember what I suggested to you at the beginning back in April as we go, as we look at all this, there's a difference between human failure, individual failure and people failure, than system failure. If the laws, the policies, the protocols, everything that's set up is right, but people implement it poorly, that's a different issue then whether there's a problem in the structure. And if people acted but they didn't get the right result, but it wasn't because of their incompetence, or their inability, or their lack of something, it's because the system didn't allow them to implement what they wanted to implement, it's two different issues.

And that's one of the things that we got

to try to figure out there as we move forward, is this a people problem, is this a system problem, or is it both. I don't know the answer to that as we sit here, but for sure I can tell you that what is relevant is what people knew, when they knew it, and why they acted or didn't act based upon the information they had. And that's why we got to go through all this, so that you have an understanding as to the systems, the CAD, the radio channels, and the ability to get information and to communicate it.

So, with that, I just wanted to recap that, a kind of where we are as we move into this morning. So, does anybody have any comments, thoughts, questions before we get started? Senator Book.

SEN. BOOK: Thank you, Mr. Chair. And as I was reviewing my notes yesterday, and we'll probably get into this, but the who communicates with who, if Deputy Peterson was on his radio and setting protocol as the first on the scene who got that, who got that, only BSO, or --

CHAIR: Only BSO. He had two radios. One

was the school radio that he was communicating, and that school radio is really like a walkie-talkie, you can go to Walmart and buy it. It's a walkie-talkie, and it's not recorded, it's not on any type of a system, it's really just a school- based walkie-talkie system. And so, he had that radio, but the law enforcement radio, the public safety radio he had was a Broward County Sheriff's Office radio. I believe he was on channel 8A, which is the Parkland channel, the main channel for Parkland, and the people who would have heard his transmissions would only have been Broward County Sheriff's Office dispatch and Broward County Sheriff's Office deputies on 8A.

Now, would other Broward Sheriff's Office personnel have heard that, only, okay only if they changed their radios over to 8A, or they were scanning channels. And to be honest with you, some deputies scan, and some deputies don't. So, remember you heard about all the different zones, and you heard about all the different channels, we you can put the radio on scan, where with what you have in your scan capability you can scan a whole range of

channels and talk groups. But if you are in zone, if you're on 3Alpha as opposed to 8Alpha, and you don't have it on scan, Deputy Peterson can be talking all day long and you're not going to hear it.

So, the ones that would definitely hear it are those that are on 8Alpha, only Broward Sheriff's Office, and those that were scanning. But Coral Springs, or Hollywood, or Fort Lauderdale, unless they went over there they wouldn't, well, they wouldn't have heard it.

SEN. BOOK: But it's recorded?

CHAIR: It's recorded. Sheriff.

SHER. JUDD: Let me reconfirm what our Chairman said, in the sense that when you look at systems and processes, and that's what we do in our business in this world, if you don't have the appropriate system there is always going to be a series of cascading events downward. So, if you don't have the system and the process in place, and I'm not speaking to what training they had or didn't have, when a vast emergency occurs, and this is a vast emergency, there is going to -- when systems fail, and people have to depend on those

systems, then the people are going to fail. And it's -- it is a, the direct causation is not having the appropriate systems and processes in place. So, when -- and I don't want to jump ahead of the testimony, but you can't help but bring decades of experience in here, and when we see this bifurcated system, and then you start to put hundreds of first responders into this vast emergency all at one time, there's going to be a system failure.

Under the best trained best equipped, best trained people, best equipped systems and processes, the first little while is total chaos, because you go from a normal day to having to ramp up for a major emergency. When a Hurricane is coming, and we're darn good at it in the state of Florida, preparing for it, dealing with it, and the aftermath, we have a week or two for this major event, to prepare for this major event, and we have systems and processes that we put in place because of past failures, and it still stresses everything that occurs.

Now imagine if we're sitting here on a sunny afternoon in South Florida and the

Hurricane occurs overhead right now. If we have the right systems it takes a while to get it going, and when we look at this clearly the people on the ground trying to make sense of this were in towers of babble, and, you know, my position is not going to change.

If you want to do what's ultimately best with a system everybody gets on that regional system, and then they figure out the different nuances that's in the best interest of their particular city. And you have to make sure that system, the CAD system, the radio systems have, are robust enough to handle all the, all of those events. Then we can look at the other, the other events.

But I'll end today where I started, it all comes down to local politics, and local control, and are you interested in that or are you interested in what's ultimately the best response for the citizens. I know from a vast amount of experience that your local public safety people desire to get the best resources to people to save lives and to protect them, and you can do it with one united regional system that's sensitive to the different

communities' needs.

CHAIR: And some of the people, to add on to that, some of the people that are tasked with carrying out the processes that are in place today are not the people that made the decisions about the processes, so some of these decisions were made -- this isn't necessarily a Chief Perry, Chief Backer, Sheriff Israel, County Administrator Henry, other -- this has been in place for a long time, and you have some elected officials who probably made these decisions along the way that aren't even here anymore.

So, some of these people that are tasked today with trying to figure this out I would venture to say, and from discussions, are as frustrated with what they have to work with as others are about it. So, the decisions were not necessarily there's, and they may not even agree with those decisions, but they weren't in a position to make those decisions, they didn't make them, but they're stuck with what they got, and they're trying to get it to the best place they possibly can, so you have to keep an open mind to all that as well, is, is that, you

know, don't kill the messenger. Is that the people who are, that we're hearing from today for the most part as far as I know weren't here thirty years ago, when that system was implemented, as far as it relates to the radio system.

Some of the decisions in '13 on the CAD, some of them, some of them were and some of them may not have been, is that the decision makers then may be different people. This is all stuff we're going to figure out, and we just, you know, we keep an open mind to it. But Mr. Schachter, go ahead.

MR. SCHACHTER: We are all here obviously because of this tragedy, but this is a national emergency we have with these school shootings, and this, I thank you so much, Chairman for what you said, and Sheriff Judd, but if we just focus on this issue -- there is a greater problem here, and everybody needs to come at this with the mindset that if we don't stop the attacker, and we don't prevent death in the first couple of minutes it's all over. So, this -- the PROMISE -- this situation is so enormous, and that's why it's even so much more

important that we fix these issues on a systemic level, because it happens so quickly, and you're talking about chaos, and everybody is going to die if you do not get a handle on the situation and put the systems in place so people can do their right job and save lives.

This -- again, I said this yesterday, and I'll say it again, this happened, and everybody was passed way in just over three minutes. You look at Santa Fe, you look at these disasters, it is happening so fast. That's what everybody needs to keep in mind.

CHAIR: Sheriff Ashley.

SHER. ASHLEY: Just to piggy back on that, I can't believe that communications is still an issue after 9-11. We still have these vast array of systems where there is no consolidation, where emergency services can all communicate with each other regardless of what jurisdiction you're in. I think it has to be legislated and mandated if it's every going to change, because I know it won't happen in my county unless they're forced to do it.

I've been dealing with trying to consolidate communications for the last eight

years, and just now getting part of doing that now, so I think if any recommendation, and I'm not a wordsmith, but certainly this, this body should recommend to our legislatures that that be mandated for at least a regional level communications for emergency services.

CHAIR: All right, before we begin with hearing from testimony, presenters this morning, does anybody else have anything they want to -- no, okay. So, you heard a lot yesterday from Broward County Government. I mentioned to you that the Broward County Administrator Bertha Henry couldn't be with us yesterday. You heard a number of people who work for her testify and provide us with information. But the County Administrator is here this morning, and I told her I'd give her an opportunity to address the commission, and I know she's willing to answer any questions that you have, so I'd ask County Administrator Bertha Henry to come up, and welcome, and thank you for joining us this morning.

MS. HENRY: Thank you, Chief Gualtieri, and members of the task force. First, I'd like to again thank you all for allowing our team to

present in my absence. My -- the summary of the session yesterday was that things went very well, in the sense that we all are getting a better understanding of the issue. And, Chief, your recitation of where we are I think is really spot on.

I also believe that this tragedy has brought about a sense of urgency. The members of the public safety community are coming together. We know what we have to do here in this county, and folk are committed to doing that. On behalf of the Broward County Commission I want to again affirm that we are committed to building the best system that is technologically available today for our community. This has never been an issue for Broward County, of resources, number one.

Number two, we recognize that putting this system together is huge. It has a lot of components, and you all heard a lot about how the system is integrated. But again, I'd like to assure you that we're moving as expeditiously as possible. We recognize that we have one or two gaffs that we're working through, but it doesn't mean that we're not

working. There are a lot of things that happen concurrently, that can happen concurrently, and they are happening concurrently.

We also recognize that an incident can happen in the next hour, and this educational process that we've all been going through certainly has heightened at least our awareness of things that we need to be very sensitive to, and we are. Again, I want to thank you all for giving us the opportunity to at least share that whatever cog in this wheel that belongs to the County you can count on us to, to move it forward. We take this very seriously, and I'm hoping by the time this committee completes its work that the piece that we have in this ultimately meets with your, your satisfaction, and that of the rest of our community.

And with that I'll answer any questions that you might have.

CHAIR: Any commission members have questions for the County Administrator? Okay, Mr. Schachter, go ahead.

MR. SCHACHTER: Thank you very much for coming in before us and talking to us. Can you please explain to the commission what is the

hold up in putting the new radio system online? It keeps -- it keeps getting delayed. And I understand it's an enormous project. Can you please elaborate on the problems? For me, testify that my fear is, you know, if there's another mass casualty event the FBI has said that they're worried about contagion, they're worried multiple attacks happening at the same time, and currently if the same thing happens again there's no reason in my mind to think that we're not going to have the same problems all over again. We need that system up as soon as possible.

MS. HENRY: So, the first thing that I would, that I would say, is that the system, there are two components of what we're doing right now. As you all may have heard the new system that we're building will be limited to public safety. Today there are some local government activities on that, on that system. We are moving them to a local government radio system.

The local government radio system is, should be available first quarter 2019. With that we did have somewhat of a delay in that,

and I'm advised that you're aware that the company that we worked with went out of business. As it relates to the main public safety radio system we, first there is an engineering of the system, as you well know. That system has been engineered to accommodate nearly seventeen towers. Those towers are three hundred plus feet, plus, to give maximum coverage for the community. Today we have commitments for all but one, and we expect to hear very shortly from the one community that we would like to use as a host of that last tower. And once that's done we're -- the system is already engineered for that, and when that happens it's done.

What we're doing now, you have to construct these towers in, in many instances, so we're constructing the towers. We are building bunkers around those towers. We recognize that this is public safety, and just as we're concerned about building the technologically advanced system we're also committed to building the safest system, so we want to make sure that the money that our community is investing in those towers and that

system, that we, that we protect it, that we make sure that, as you've indicated, that, that there is a concern that if you were going to have some issue that it could spread throughout the community.

The system has all sorts of redundancies, but one of the things that we feel very strongly about is that, that we know who is on that tower, who is anywhere near that tower at any given time because of its criticality to public safety. So, we're moving forward. Hopefully the community will give us an answer. We met with them a couple of weeks ago. We expect an answer any day. And once we have that answer then we can govern ourselves accordingly.

MR. SCHACHTER: Is that community Tamarac, and is it true that you've been working with Tamarac for a long, long time already, and that is the only holdup, and that needs to be taken care of?

MS. HENRY: That's the only -- well, first yes, the community is Tamarac. And second, that's the only remaining tower that we need to have a resolution to. And as I said we met

with the City as recently as a couple of weeks ago, and they've committed to giving us their answer very shortly. But in the meantime, we are building out the rest of the system.

MR. SCHACHTER: And if you don't get -- if Tamarac doesn't -- that's the only last cog in the wheel, if they don't say that we can put the tower there what then, and you know, it just needs to get done as soon as possible, that's all we're waiting on.

MS. HENRY: So, if once we hear from the City my board will have some decisions to make, and, and I'm sure they're prepared to make them. At this point I don't think there are any other delays, because again, because we're building out bunkers to protect these towers and the systems that operate within those towers. All of the communities that have to host them have agreed to expedite the permitting. It's just been -- this tragedy has really brought about a sensitivity to how fragile things can be, and how as a community we all need to come together and move this issue, and, and they're committed.

I have faith that we'll, that the City

will respond positively to what's going on. Ultimately, they have some concerns about the height of the tower in their community, and, and we do understand that, but ultimately, ultimately, I think we're all committed to public safety. And you can have an unsightly tower, or you can have real communication gaps, and I'm hoping that they come to that conclusion as well.

MR. SCHACHTER: Okay.

MS. HENRY: Any other questions?

MR. SCHACHTER: Thank you very much.

CHAIR: Sheriff Judd, yes.

SHER. JUDD: Thank you for being with us today. Your words are very encouraging. You all are on the game. Please remind Tamarac the grades are six-foot-deep, and we're not really concerned about the height of a tower if it saves lives, that we need a sense of urgency. This commission is here to not only investigate what occurred but to make sure that things occur that need to occur so that we reduce the probabilities as much as possible of this ever occurring again, and it starts with communication. If we can't talk you can't

appropriately react.

And Tamarac needs to understand and respond as if it was one of their children that was shot in that building, and if they act that way you won't have any, any problems working out a quick resolution. But a sense of urgency is important. But I am -- I am really impressed with what I saw of the system yesterday and, and your words about a sense of urgency today. Thank you.

MS. HENRY: And I'm -- again I will share that with the City. And again we, we certainly understand that the City has different issues that they, they're dealing with, but for us it's about the security of the system that we're building, because as important as building that three-hundred-foot tower, and make sure that the coverage is the best that it can be, we also want to make sure that that system is safe, and that we know what's happening with that system twenty four/seven.

CHAIR: I don't think there's anything that prevents us if somebody were to make a motion and it was seconded and passed. I'd be happy on behalf of the commission to send a

letter to Tamarac expressing this commission's support for their cooperation with Broward County. If there was a motion and it passed I'd be happy to do that.

MR. SCHACHTER: I would certainly like to make that motion, Chairman, that, that Tamarac expedites this process as quickly as possible. I think public safety depends on it.

SHER. JUDD: Second.

MR. PETTY: I'll second.

SHER. JUDD: I think it's appropriate for --

CHAIR: Mr. Petty, second the motion. All in favor?

(Aye.)

CHAIR: Any opposed same. Okay, said motion passes, so we'll prepare a letter and get it out as soon as possible to the City of Tamarac expressing this commission's support for them to work with Broward County and expedite the process, and approve that tower's placement.

MS. HENRY: Thank you.

CHAIR: All right, thank you. All right, the next -- and, Ms. Henry, are you going to be

able to stick around for a little bit this morning? Okay, so if anybody has any other questions after the other presentations we'll ask you to come back up then. Okay, thank you.

The next presentation this morning will be on Coral Springs, and Chief Backer is here with us. And it will be Coral Springs' opportunity to present on the radio system from the Coral Springs' perspective. Chief, welcome back. Thank you for being here again.

DEP. CHIEF BACKER: Good morning, sir. Thank you. Before I begin I would respectfully ask for permission from my counterpart at the Coral Springs Police Department, Deputy Chief Brad McKeone who is in charge of operations, the ability, or opportunity to come up and speak for a couple of minutes to address the commission.

CHAIR: Sure. Absolutely.

DEP. CHIEF BACKER: Thank you.

DEP. CHIEF MCKEONE: Good morning. All right, good morning Sheriff Gualtieri and members of the commission. I'm asking that you allow me a few minutes this morning to make a few brief comments on yesterday's

presentations, and some of the follow up questions that came from members of this commission. I was in the audience yesterday, but I wasn't expecting to speak. Based on the agenda and the, and the reference to what was put down, I thought it would be inappropriate or disruptive that I come up from the back of the room and tried to interject into those presentations.

As Deputy Chief mentioned I'm the Operations Deputy Chief for the Coral Springs Police Department, my name is Brad McKeone. What that means for people who many not be familiar with law enforcement, Shawn is the Deputy Chief of the administrative side of the house, which is our dispatch center, which is why he presented yesterday. I have the operations side, which is the patrol, criminal investigations, kind of the, the guys out there on the street for lack of a better term, if that paints a better picture.

I believe my involvement on the day of this tragic event, and the different perspective that I have based on my assignment will be able to provide some clarity to both

the commission and, and other people in the room, and assist you in accomplishing your overall goals. The first point that I wanted to talk about was the regionalization. Sheriff Gualtieri, the way you talk about it, Sheriff Judd, the way you talk about it I love it, I think it's a great idea. The vision that you guys have, the idea of how the system should work is where we need to get I believe, and I believe that is something that this commission can truly help us all with.

But with that being said we didn't join that system back in 2013/2014, whatever it may have been. And again, I wasn't really part of that decision, but that doesn't mean I'm not responsible for making the changes that, that come with, and making any improvements. But I want to make sure again that there is no confusion about our position that we do not disagree with the regionalization, it would offer a number of advantages, but back in 2013 when we did that study ultimately, we did, again we decided not to join, and that was based on coverage and capacity issues.

Again, Sheriff Judd, you mentioned just a

few minutes ago the system, systems need to be in place. County Administrator, Ms. Henry, I think she just mentioned, and kind of summarized all the points that I had, that the system is not in place. That existed in 2013 it exist today, it'll exist next year. We need to get through that. If we can get through that I believe that's one of those, as she used the cog in the wheel, I think that's one of those factors that we need to, so we can move forward and have this conversation to see if we can join the regionalization communicate center.

Not only would this having us join, would have impacted negatively the City of Coral Springs, it would have impacted the City of Parkland, the City of Coconut Creek, the City of Tamarac, because potentially we would have overloaded their system, and they would have also experienced issues, so it wasn't just the citizens of Coral Springs, again, Sheriff Judd, as you were kind of talking about that, that global aspect, or looking at more than just the local community, we had to consider things like that, how would that negatively impact other

cities that we would be joining.

I have a study that I brought with me, I think we mentioned yesterday. I can provide that to the Commission. It kind of goes into more detail. I don't want to take up too much time going through some of that when it's already documented, you'll have a chance to look at it, or we can send it to you electronically if you wish.

The radio, though, is not, and should not be the only factor preventing us from regionalization. The next area of concern is the CAD. And this where again I'm going to kind of go to the members of the commission and Sheriff Gualtieri and ask for your assistance. We've had discussion about switching over to the CAD, but there's limitations that, that are either imposed or expected for us to, to deal with, and that has a negative impact on the level of service that I can provide, that we can provide to the residents of Coral Springs and the residents of Parkland for fire service.

And again, it's not because it has to be that way, that's the way that we want it to be, or people want it to be, or, or the board may

want it to be, so again I'm asking for your assistance. Just like the tower in Tamarac, any influence, any type of ground that we can gather in that way I think would be helpful to all of us in, again, increasing public safety.

The second point that I just want to touch on briefly was, was something that was discussed yesterday about that hometown feel. It -- I know it kind of -- I don't know if it came across accurately, or it was presented in the most, the most effective manner, the way that we kind of envisioned it, but Deputy Chief Backer's example, and I say the duck lady because when I was a patrol officer that's how I knew her, and that's how dispatch knew her, she fed the ducks every morning so she was the duck lady. The dispatchers, again, knew that.

When she went into that canal and she said where she was, and she was there feeding the ducks, nobody had to know the address. We knew where to go. We knew the canal. We saved her life. She may have died if that had not been that knowledge that our dispatchers had, that our officers had, that institutional knowledge. I guess, you know, maybe a better way to say it

is the hometown knowledge of your city, and I believe yesterday representatives from BSO even acknowledged that at one point, that that is a tremendous advantage to have that hometown firsthand knowledge of the city that a dispatcher or communications center operates in, and knowing that if you say it's the upside down building nobody in this room know what that means. If you're a Coral Springs officer, every dispatcher knows where the upside down building is. That's again, those little points, again I just wanted to maybe highlight that briefly.

You know being able to adapt quickly and efficiently has been a proven method by the Coral Springs police and fire departments. The report that I previously mentioned with regards to the regionalization and the CAD restrictions again has, has some impact on that. If there's a negative impact to the citizens of Coral Springs or Parkland with regard to fire service, we must and always will put their safety first.

And the last point I just want to touch on briefly was, was to you, Mr. Schachter.

Yesterday you asked how many calls are transferred to BSO. Based on my evaluation of the law enforcement response, which I may be back in front of this commission at another time to present based on that when we get to that point, but I can tell you that there was a total of four calls that were transferred in some way, shape, or form, to Broward County communications. My understanding is that three calls were transferred, and one call was put out over what we call a mutual aid, channel, or a fourteen-call channel which directly goes to the Broward County Communications Center.

That first call that we received was transferred within twenty-seven seconds. The first call that was transferred regarded information, or had information about an active shooter at Douglas High School, that multiple shots had been heard, and on the tapes you can hear the shots, information about injuries, and the location of the incident being the 1200 building. That information was provided within twenty-seven seconds roughly to BSO.

And one last additional thing I'd like to again to mention to you, Mr. Schachter, I would

like to say thank you, and I appreciate the time that you have taken outside of, of this commission to meet with us to facilitate some of those meetings with the City of Parkland, members of BSO. Because of your efforts we truly had made a difference, and put things in place that have made, allowed us to better serve both Parkland and Coral Springs on the police and fire side, so again thank you.

In closing I just wanted to again thank you for allowing me the time to make these comments. I know that it wasn't on the agenda. I'll be here at the end of Deputy Chief Backer's presentation which, you know, regarding the radios I believe. And if there's any follow up questions I'll be more than happy to come back up and answer them at that time.

CHAIR: When's the last time you all had active discussions with the County, or with BSO and the regional communication center about your differences in the CAD system? When's the last time you all sat down at the table, had a discussion, and tried to reconcile those differences?

DEP. CHIEF MCKEONE: I'm going to speak

based on what I've been told, and correct me if I'm wrong, but that, those conversations had taken place very recently, especially after this incident. And before that there was conversations, but we've even looked into options of, and I think you had mentioned, or touched on it yesterday at some point, that it's not that this has to be an all-in thing, it doesn't have to be one way, there's options out there whether we host servers, whether we have licenses, and again I'm not a technical person, but there are options.

And -- and this is again where I'm going to come back to the commission and ask for your assistance, sometimes -- there's a saying in police work. The only things cops hate more than change is for things to stay the same. And with that, this is where we need to maybe get out of that mindset, we need to be open to, okay, there's a different way to do it, there's a, maybe there's a better way to do it, I can accomplish my goal, but maybe I have to do it, I have to make a left instead of a right. And that's where to your, to your point about the CAD system, there are options, we, we need to

talk about those and figure it out.

CHAIR: So, Coral Springs is willing to collaborate and compromise, and make every effort to reach a consensus to make that happen?

DEP. CHIEF MCKEONE: Absolutely. Look, I think it's something that needs to take place tomorrow.

CHAIR: And so, to that end as well, because, you know, you raised it, so you talk about the hometown feel, you know, I started my law enforcement career working for a small city police department, I get it, thirty-five residents, thirty-five thousand residents in the city. I was a city cop, I get it. We contract with thirteen cities, I get it, but there's also ways to make that happen as well like we talked about yesterday, because the way the system can work is, is you can be part of that regional system for 911 so when somebody calls the person they're talking to can get them help and they don't have to be transferred.

You can reach consensus on a CAD. There's no reason why a CAD system, the data fields,

EMD, EPD, EFD, can't be worked through by everybody, and you can still have that hometown dispatcher employed by the Coral Springs Police Department who is sitting up there in the front of the room on that console that's talking to the Coral Springs cops on the street. That system works in other parts of Florida. It works in other parts of the country. So, you can still maintain that, and still have the synergies and the efficiencies, and the effectiveness, and the great service delivery that all that brings and still maintain what you're talking about.

DEP. CHIEF MCKEONE: And I couldn't agree with you more. And again, that's back to what I said before, the vision, and the way that members of this commission with years and years of experience in law enforcement speak about that, that concept, and how it can work, that's what we need to do. And maybe we, you know, on all sides we need to be a little flexible. We need to, to say, okay, I can live with that because of the benefits that it provides. So, I appreciate that.

CHAIR: And we'll -- we look forward to

doing everything we can to help you, and to help Coral Springs, and to help everybody in this community come together, and bring it together so that the best safety services are delivered to the citizens. And anything we can do to help, let's all take that like Sheriff Judd said, we're not here just to figure out what happened, you know, we're spending a lot of time and effort because we want to, and we believe that there's an opportunity to make it better, and to help you all get it to where everybody wants it to be.

So, we certainly appreciate your comments, and your time, and thank you for coming forth. Do any other commission members have questions for the Chief before we turn to over to Chief Backer? Sheriff.

SHER. JUDD: I just want to congratulate you and say that's professionalism.

DEP. CHIEF MCKEONE: Thank you.

SHER. JUDD: And there's nothing that I would want more than for Broward County to be the example as to how we should do it all across the state, and all across the nation, because the reality is if we can't create the

energy to create the best professional cohesive system at ground zero in Broward County then we'll never get it done any place else. And to me when I hear you speak about, yes, we all need to give a little, it needs to happen tomorrow, and you all work toward that end while this commission is working, that's professionalism.

CHAIR: Go ahead, Mr. Schachter.

MR. SCHACHTER: I just wanted to say thank you. Thank you for being transparent, thank you for coming up here and talking to us, and your commitment to fixing this. And I want to tell you from my family thank you, and all the Coral Springs residents.

DEP. CHIEF MCKEONE: Thank you.

CHAIR: Thank you. All right, Chief Backer.

DEP. CHIEF MCKEONE: Sir, again, thank you for the latitude with the schedule, and the flexibility.

CHAIR: Absolutely.

DEP. CHIEF BACKER: I understand that I'm here to talk about radio systems today, specifically what Coral Springs has in place at

this time. And obviously we'll be addressing the patching issue that is on the foremost of everybody's mind that occurred on that day.

The first slide that I have here is just providing a little bit of background. It goes back to 2005, in which it dictates that P25 became and adapted technology, a pathway by the Public Safety Institute. P25, for those that don't understand, is basically a set of standards for the design and manufacturer of interoperability two-way radio systems. So, that became the standard back in 2005. Concurrently at that time in 2005 Coral Springs radio system had already begun to reach end of life. The City moved forward with trying to procure digital P25 compliant radios in anticipation of moving to a new radio platform.

In 2013, as Deputy Chief McKeone maintained, I believe we spoke about yesterday, the City had consulted with RCC Consultants to evaluate not only our current environment and our technology, but also all available options to us. And I'm going to spend a little bit of time on this slide because it goes back to everything we've been discussing today about in

a perfect world if all the systems are in place properly than a regional system could work, and we'd really have no justification for not being a part of that.

So, when RCC issued their recommendation to us they had concerns over radio capacity and coverage not being adequate back in 2013. Those concerns still exist today in 2018, and until the new system is up, 2019, 2020, that concern is still in effect, and that does affect the level of service, not only to Coral Springs but some of the contiguous cities around us, with the documented throttling issues that have taken place.

RCC in their recommendation was also concerned over the governance of the CAD. I know we just addressed that again. And again, this is where maybe some recommendations and some influence from the commission will have a beneficial impact going forward, for not only us but the County, in that there has got be a I guess a little bit of give and take, right? Maybe we've got our heels dug in, and they've got their heels dug in, and everybody has got to sit back down and be a little bit for

flexible and accommodating to each other. And we're hopeful that maybe with some of your guys' influence that will take place.

Another byproduct of the report that was issued by RCC was that our local government radio users would not be able to transition over to the regional system. That is a concern for the City of Coral Springs. Our utilities, I believe Parkland's utility department, our parks and rec, they all inter-operate on that local government system on our system now.

I want to take a moment and just, I know I kind of just talked about it, but I want to read from the actual slide that was presented to our commission back when these decisions were being made. And again, I want to reiterate that a lot of these conditions are still in effect today, which impacted our decision to buy a new radio system.

Migration of the Broward County system not recommended by RCC. It doesn't not provide satisfactory in-building radio coverage within the City of Coral Springs. At or nearing full capacity, does not offer the same dedicated channel capacity as provided by the City's

existing system. The County does not have the capacity to support local government users. The County's system coverage and channel capacity can't be expanded until upgrade in 2018, which as we know is not going to happen in 2018. Loss of direct control of talk groups standards and maintenance. That's referring back to the CAD and the governance.

So, all of those things were things that were taken into account by the City when they chose to not join the system. And again, going back to a Utopian society, a perfect radio system, perfect CAD, all that works great, and everybody can join the regional system. But the system has not performed satisfactory to, to our best of our knowledge. In fact, if you were to do just a basic Google search you would come up with a litany of articles talking about some of the performance issues that the system as a whole has experienced. Those are a great concern to the leaders of Coral Springs, and the level of service that we're able to provide to our constituents.

In fact, when you look at those articles, I've personally, we've talked with Chiefs of

Police that are actually exploring the possibility of getting out of the regional system. I think that's the point that it's at right now, from a level of frustration from some of the end users. So, again, circling back around, I just think it's going to be of critical importance for this commission to have some solid recommendations about how to avoid those kind of circumstances, and how to actually move this system forward to being truly regional to provide the best service to the County.

Okay, I'm going to get back on track to the actual assessment and radio. Our old system was a Motorola Legacy 800 trunked radio system. I believe we heard a lot of testimony yesterday about what that means and how that operates. Key bullet let me see if the pointer is working here, no. Key bullet, in 2005 critical components had reached end of life and were no longer supported. I'm going to say this, and it's going sound almost comical, and when I heard it I couldn't believe it. We were actually buying parts off of E-bay to keep the radio system running, Motorola could not

provide parts, end of life, done, we had to replace. So, again, when you look at the totality of that, and the capacity issues, I think the City almost felt obligated to move forward with procuring their own radio system.

It's kind of what I just talked, touched on there on that side. A key point here, again the radio system that we brought is a hosted master site radio system digital P25. It provides complete interoperability through patching with every radio system in the County that exists today. In 2005 the City of Coral Springs implemented their new radio system. Sometime in May of that year we cut over to the new radio system. In addition to the new radio system all of the radio consoles in the communications center were upgraded to the P25 standard as well. And one of key components, and one of the things that was of extreme importance to the City leadership, and is still very important today, and, Senator Book, I think you saw it when you came to do the tour, by switching to the new radio, and then ultimately to the CAD system that we procured, our radios are GPS enables.

We have a screen right over our main channel console that shows the City of Coral Springs and where every police and fire unit is at that moment. It's color coded to tell you whether they're in route to a call, at a call, available, so it provides us an ability to provide closest unit dispatching and know where everybody is in real time. If you were an officer and you get in a foot chase through, you know, a community, they can zoom into that grid, or area where you are, and they're going to know right where your radio is to be able to provide support and get, you know, assistance to you. So, that was a huge benefit for us, and again part of the reason that some of the decisions were made for the community of Coral Springs.

A couple other technological pieces. When the radio was upgraded there were six repeaters that were installed for the fire department to boost in building radio coverage. I'm not sure if you've got any Walmarts -- or any -- some of the labyrinth schools that exist that are these concrete monoliths, even the best system you can have some dead spots inside of something

like that. So, we did a study to look at that, and we procured some repeaters to insure that in coverage, building in coverage was sufficient.

And yesterday we also heard, or during the demonstration you heard about a microwave loop. That is what our system has today. We have three tower sites, one being in the confines of the Coral Springs Police Department Public Safety Complex in Coral Springs. We lease some tower space in Margate on a cellular mobility tower. And then the third place that we have a tower with equipment is in Coconut Creek. That tower is owned by the County. It is by their good graces that we are allowed to have our equipment co-located up there.

Okay, moving on to kind of the nuts and bolts of what our radio system looks like on an everyday, you know, every day activity, a normal day. We have eighty-three talk groups, and I think you guys heard some testimony yesterday as to what a talk group is, any of which can inter-operate with the regional radio. Currently our radio system has one thousand one hundred and thirty-four users on

it. That does include not only all of our public safety but also all of our local government users. And as noted before we would have still had to maintain some level of a radio system for the local government.

The system also includes the fire station alerting system, which as I'm not a fireman I'm not really proficient in what that, how that operates or what that does. If you need to hear more testimony on that I do have somebody from fire here. Key point here, daily average capacity usage of our radio system is between eighteen and nineteen percent, okay, so basically what that's telling you is that our system is not overtaxed or doesn't have enough capacity to handle. In fact, on February 14th I don't believe we ever rose about forty-eight, above forty eight percent capacity for our radio usage, so we have plenty of capacity.

Our radio system has eleven channels and since it's trunked, you heard how that works, the controllers select which channel you're going to get to transmit over. Of our eleven hundred thirty-four users from a police department standpoint what you're looking at is

two hundred twelve officers, is our allocated strength right now, and we have about a hundred civilian support staff. Not all of them are on radio, some of them are clerical in the building.

And the reason I bring up the manpower and the staffing is to show you what our talk groups look like. So, we have one main channel. I know we call it a channel, it's a talk group. We have our main channel. We have a law teletype, which is where the officers would switch to to run driver's license inquiries, criminal histories, background checks, get general information. We have two tactical talk groups that can be used for operations. And then we have sixteen additional talk groups for special operations, the SWAT team, the VIN unit, our VICE and Narcotics unit, excuse me for the acronym. They would have, you know, their own dedicated and encrypted channel for usage.

Generally, on a day to day basis if you were talking about patrol on, or excuse me, if you were talking about BRAVO shift, which is the daytime hours, our minimum staffing is

fifteen officers. You're going to have probably two sergeants and a lieutenant. You're going to have a litany of detectives, traffic units, specialty units, special operations officers, or excuse me, detectives that are going to be out there on a day to day basis, so a fair average number.

You're looking at about sixty users just on the police side at any one given day during the week. Those numbers are a little bit less on the weekend, as some guys are off during the weekend. ALPHA shift again is probably going to be about half those users when you look at the patrol minimums, and not all of the specialty units working at night.

Our fire department that services Coral Springs and Parkland has a main channel talk group. They have five tactical talk groups and six additional talk groups for special operations or training. Their radio coverage includes eight fire stations, the fire administration and inspections division, and equates to roughly fifty users a day again on that same radio system.

The last component to the users that are

on our radio system would be the local government users, and that adds roughly about another ninety, so doing rough math, you know, we're closing in on about two hundred users during the week during the day that are on the system at any one time.

This is a quick chart to just show you the basic push to talk usage that our radio experiences. This chart is from February 14th. It does show you the spike during the time frame in which we were responding to Marjory Stoneman Douglas. And this is an important map in my opinion. This map, what's outlined in the dark black shows Coral Springs, but the green shaded area is the coverage map that our radio provides. So, in the event that somebody else is on a different radio system, and they're within a lot of miles of us, geographically we have the ability to patch and provide a redundant level of service that might be lost otherwise.

All right, patching. I know this came up yesterday. I'm sure there's some questions that everybody has. I'm going to talk through the slide, and then I'd like to talk about a

few operational components to that if I could. A patch group, I think you guys all understand, is a link to talk groups that allow radio users to communicate with each other while on separate radio systems. I like to describe a patch as basically kind of a three-way call.

When radios are patched theoretically everybody that's on both systems can hear everything that's taking place and transmit across both systems. On February 14th there were a lot of patching, or patching situations that occurred. Within our own communications center our fire department patched three channels together for them to support their operations. Typically, the host agency does the patch.

And why do we patch? Let me, before we get into the mechanics of what took place that day. I've explained this before in other areas, and I want to explain it again. I think the Sheriff started demonstrating when you take a radio out. When this call goes out you have officers from all these agencies driving what we call code three, lights and sirens, very fast through rush hour traffic thinking about

do they have their vest on, getting their rifle out, where do we park, what's going on. The stress is incredible.

When stress takes over the first thing that goes is fine motor skills, okay? It is not a practical exercise, in my opinion, to ask an officer to pull their radio out and start manipulating some of these small buttons, if they even know where the other agency's channel is on the fleet map within the radio. That's why patching for as far back as I can remember has been basically the practice down here in South Florida, because it is a more effective efficient way.

The other thing about patching versus switching radio channels, take the 14th for example, we had a hundred and thirty, or a hundred and thirty-two officers that went. I have to be able to ensure that all hundred thirty-two officers heard where to go, know where it is, and then somehow some way you'd like to be able to confirm that they're over there so that we know we have everybody on board and accounted for. That's not practical, doing it, that's why patching has been the

industry standard. And I'm trying to explain that in lay terms, you know, that's why patching has been kind of the industry standard.

So, on the 14th, typically what happens, the agency that's responsible for the response is typically what's called the host agency for the patch, meaning they effect the patch, okay? What I can tell you in reviewing the information is that we were calling the Sheriff's Office at the same time they were calling us to discuss the patch, and ultimately what was communicated to our dispatch center was that BSO did not have our main channel on their console, and they were asking us to patch the radios. And they specifically asked for us to patch 13JOINTOPS2.

I don't know why that decision was made versus 8ALPHA. I don't know. I can't answer that. But what I can tell you is that after that request was made our dispatchers were able to effect the patch, and according to the analytics that we've received from Motorola that patch stayed up for six hours and nineteen minutes, okay? Now I'm going to talk about

that for a second, because we're not a hundred percent convinced that is entirely accurate. The patch was up. We're not sure everybody could hear.

We do have a couple moments on the radio where it appears that possibly certain officers couldn't hear what was transpiring. I don't know if that's user error, or a failure of the patch. That's something that has to be analyzed. It's something that the County is aware of. We were told after this event at a meeting that the County was aware. I think BSO and us had brought this concern forward, and the response that we got from the County was that this was something that the police foundation who is conducting their after action would be looking into.

We were concerned what that delay would be and having the information or answers to that would be way too long, so we did author an e-mail to the County asking for that investigation to be expedited. So, we're hoping to get some answers as to -- I'm sorry? No, I never received a response back. So, in regards to Broward Sheriff's Office not having

our main channel on their console, when I heard that, somewhere around April 3rd that was brought to my attention. I was kind of stunned to be honest with you. I've heard their deputies come up over our radio, so I know their deputies have us in their radios. I had no idea that we were not programmed into their main channel console.

I immediately told Kathy Liriano that we would authorize that. We received a communication from them asking for the authorization. The next day Chief Perry signed a letter authorizing them to program our main channel, or multiple frequencies, let me see, it looks like four, definitely two, our PD main and our patrol tactical channel were provided to them. April 4th we gave them authorization to program those channels into their consoles. And again, we had no idea that we weren't in their console.

Depending on the population right now Coral Springs is somewhere between the fourth and fifth largest city in Broward County, so the fact that we wouldn't be on their system wouldn't even seem obvious to us. It would

seem obvious that we would be. But I'm glad to say that I think that's been rectified now moving forward.

I have a couple other slides pertaining to patching, but they're more illustrative in nature. Yesterday you saw some very similar slides during some of the other presentations, and this is what our dispatchers see in regards to patching, their console for patching. And as I've described, and as we demonstrated for Senator Book, it's roughly three to four clicks of a mouse to be able to link a couple channels together. So, this is one of the two screens that shows all of the consoles that are available for our dispatchers to select. And then this is some of the nomenclature that is, if you look back to the previous screen, the top right, that's the area where the patches are effected.

I can't speak to the technical terms, I'll talk in layman. That's the box where all the patches get dumped into and executed, and then these are just blow ups of what those patches look like, and you can see that we are able to effect more than one patch. And this shows

you, the box on the right shows you that once the patches, or once the talk groups are in there and the execute button is hit, it shows you that the channels are patched. In layman's terms, for the best I can do to explain that.

All right, with that I will make myself or Deputy Chief McKeone available for any questions.

CHAIR: While you're right there go back for a second to what you just said about April 3rd.

DEP. CHIEF BACKER: I'm sorry?

CHAIR: Go back to what you just said about April 3rd. You said April 3rd, correct, I want to make sure I get this date right.

DEP. CHIEF BACKER: Yes, April 3rd.

CHAIR: You said on April 3rd of 2018 you became aware that Broward County Sheriff's Office did not have your main channel in their console, right?

DEP. CHIEF BACKER: Yes, sir, we received an e-mail from Broward County requesting those.

CHAIR: So -- and then you mentioned previously that on February 14th that -- and Broward County testified yesterday that they

could not affect the patch on February 14th because they did not have the Coral Springs main channel, correct, that they didn't have it in their console to patch. They're the host agency, so they're responsible for doing the patch. They -- they theoretically could have, should have, best case scenario, patched 8A with the Coral Springs main talk group, right?

DEP. CHIEF BACKER: In an ideal situation that's what would have taken place.

CHAIR: Right.

DEP. CHIEF BACKER: I didn't hear the testimony yesterday, but I have reviewed the call in which their duty officer called us and indicated that they didn't have us in the console.

CHAIR: Right. So, Ms. Mize testified yesterday that they couldn't effect the patch because on February 14th they didn't have your channel to patch. You can't patch what you don't have, in essence, okay. So, then you just testified that there was a request though for -- so my question -- on the February 14th did Coral Springs in its console have 8A in its console?

DEP. CHIEF BACKER: I believe so, but I'd like to check without communications administrator.

CHAIR: She's saying yes. Okay, so --

DEP. CHIEF BACKER: That's a yes.

CHAIR: Right. So -- so you said though that somebody for some reason requested that the patch be a 14JOINTOPS2 as opposed to the patch -- so in other words as opposed to -- Broward County Sheriff's Office under the protocol here in Broward County is the host agency, was responsible for the patch under the established protocol, correct?

DEP. CHIEF BACKER: Yes, sir.

CHAIR: Okay. But they couldn't effect the patch because you can't patch what you don't have. So, somewhere, if I understand this is, is that what would have been a better course was for somebody to say, okay, we can't do this, but Coral Springs, you have obviously your main channel, and you have 8A, so Coral Springs, you guys go ahead and effect the patch of 8A with the Coral Springs main, and you effect the patch, but as opposed to doing that somebody said patch 14JOINTOP2 that nobody was

on.

DEP. CHIEF BACKER: I don't know who from the County would have --

CHAIR: But is that what you're saying? I want to make sure I understand what you're laying out for us.

DEP. CHIEF BACKER: Right. The phone call that we received in our communications center from their duty officer --

CHAIR: I think Kathy knows.

MS. LIRIANO: Good morning commission. Chair, so on the 14th, on February 14th we were, we received a call from a duty officer from the Broward Sheriff's Office. On that call they advised that they did not have Coral Springs Police main channel on their consoles, and they requested for Coral Springs to patch to 14OPS2. We did on that day. And prior to this incident since the upgrade of the radio system have all of Broward County's main channels for every district on our consoles, including the mutual aid channels.

CHAIR: And -- and is there any reason -- so you did patch 14JOINTOPS2, you did patch it.

MS. LIRIANO: Yes, sir.

CHAIR: Okay. So is there any reason, you know, why somebody didn't say to the Broward duty officer, look, we can patch it, but you guys can't, we need to stay on the primary, as like the Chief laid out for tactical reasons and operational reasons, is that why don't we just go ahead and patch 8A as opposed to doing what they said, or what they asked, and doing what would have been more effective operationally? Did anybody -- is it because nobody just thought about it, or why, why didn't you guys just do despite of what they asked, is my question, if you know.

MS. LIRIANO: No, when the -- in a normal -- in a perfect world, host agencies do the patch.

CHAIR: Right. Right.

MS. LIRIANO: And at that point they didn't have our --

CHAIR: Right, but what I'm saying is, and I know they didn't have it, right, I know they didn't have it, but why didn't -- knowing that they didn't have it why didn't you guys just do it because you had both?

DEP. CHIEF BACKER: I'm going to give you

my opinion, or my assumption. If I were receiving that call and that was the request that was made of me I would assume that they had already moved their operations to that channel, and that's why they were patching us together with that channel.

CHAIR: No, fair enough. I'm just trying to figure it out so that we understand. And there may not be an answer to it.

DEP. CHIEF BACKER: I think -- quite frankly I think the Broward Sheriff's will have to speak to why that request was made for that particular channel.

CHAIR: And -- and we can ask them. It may have just been some person who just --

DEP. CHIEF BACKER: Thinking in the heat of the moment.

CHAIR: Right. I get it. I get it. But -- but if, and again in that perfect world we don't live in, if, because they didn't have it, if you all had, again this is not a casting of anything, but in that, again in that perfect world that doesn't exist, if somebody said, hey, patch 14JOINTOPS2, and somebody on your end had said, you know, you sure, because

nobody is on that, why don't we just go ahead and patch 8A with us, then hypothetically that would have been a -- not even hypothetical, that would have been a better course. But again, that's the perfect world that doesn't exist.

DEP. CHIEF BACKER: I think knowing what we know now I hundred percent agree with that.

CHAIR: Yeah. Right. Okay. Okay, I just want to make sure we understand, and we know the landscape. All right, commissioners, questions? Sheriff Ashley.

SHER. ASHLEY: Thank you, Chief. Yes, sir. If I'm a Coral Springs police officer and I need to speak to Broward Sheriff's Office from my portable am I capable of doing that?

DEP. CHIEF BACKER: Yes, sir, we have their channels in here. You just have to know where in the fleet map to switch to what zone and what channel.

SHER. ASHLEY: So, would a Coral Springs officer that day in Parkland be able to turn his radio on and speak to Broward SO?

DEP. CHIEF BACKER: If they knew where to manipulate the channel and the selector

switches to on the fleet map, yes.

SHER. ASHLEY: Would they normally know how to do that?

DEP. CHIEF BACKER: I don't know how to do it. I mean I know it's on there, but I'd have to search.

SHER. ASHLEY: I guess that would apply to if they needed to speak to a trooper they would have to change the channel on their portable. And do you know if they know how to do that?

DEP. CHIEF BACKER: They all know how to do it, it's a question of knowing where everything is in that fleet map.

SHER. ASHLEY: Okay. You said that your radio system only had a forty eight percent capacity on the day of the tragedy, is that correct?

DEP. CHIEF BACKER: On the day of the tragedy we never eclipsed forty eight percent capacity of usage of the radio.

SHER. ASHLEY: Because nobody could talk to you, wouldn't that be a fair assumption, other than you're officers?

DEP. CHIEF BACKER: No, when the radios were patched we were still at only forty eight

percent.

SHER. ASHLEY: How long does the patch take? How long did it take to effect the patch?

DEP. CHIEF BACKER: Once the request is made, I believe it was up in under a minute.

SHER. ASHLEY: How long before the request was made?

DEP. CHIEF BACKER: I'd have to go back and look at the timeline of all that.

SHER. ASHLEY: I'm just trying to determine was, was the tragedy done, was it over when the patch was made? I mean we're talking about six minutes here.

DEP. CHIEF BACKER: I would believe so, because we were already on scene asking for that patch, and the shooting was already over.

SHER. ASHLEY: Okay, thank you.

CHAIR: Kathy, is there anything you want to add to clarify on that?

MS. LIRIANO: Just a couple of things. When the radio capacity, when you're asking about the forty eight percent, for those that don't understand the radio system when, for example, because it also included the fire

department, so with their three patches for all the mutual aid that was coming in we had, you know, every city in the County coming in assisting us, their radios go onto your radio system once you have that patch. The same thing with law enforcement with that patch, so when it reached the forty eight percent, day to day eighteen to nineteen percent, having these other agencies with these patches on our radio system, it would load your system, and that's why we reached forty eight percent.

SHER. ASHLEY: Thank you. And I guess -- and this is not directed at anybody. I guess what I'm trying to identify for the commission is we're talking about host incident communications. I'm trying -- this commission is trying to figure out how do we communicate prior to and during this, and not after everything has occurred, so patches are, are not a fix here, it's over. And so, if the Coral Springs can't communicate with Broward Sheriff's Office when they're both responding to the same scene then, then a patch doesn't really help in trying to mitigate --

MS. LIRIANO: And just -- and I

understand, Commissioner. And one of the things to under, to understand about talk groups, let's say we were on the County system. If we were on the County system and Coral Springs had to respond, we would be on different radio channels, or different talk groups, so those talk groups would still need to be patched for us to be able to communicate. When the patch is initiated, obviously that would be I guess a concern that you have, but even in Broward County they have different districts, different main channels that they have to patch if they want their people to hear unless they switch over.

SHER. ASHLEY: If I may just give an example of our county. If one of our deputies is at a scene, or at an incident, or responding to, as back up to one of the municipalities in our, in our county, they just turn to the channel of the county, or the municipality they're responding to. All those municipalities are programmed in the deputy's radio. He just turns a channel and he's talking with their primary station at that point. So, I just -- I'm just trying to figure

out that immediate communications, what's necessary, and the patch doesn't fix the problem that we're dealing with here.

DEP. CHIEF BACKER: Sheriff, on a day to day basis here in Broward, with the geography being what it is, we generally back up our own officers, so the geography I think is a little bit different, and not applicable here in this environment, and I think that needs to be considered as well. But I understand your point.

SHER. ASHLEY: But you're backing up other officers as well.

DEP. CHIEF BACKER: In Coral Springs.

SHER. ASHLEY: I mean Broward County Sheriff's Office operates in your jurisdiction sometimes. FHP operates in your jurisdiction sometimes. I mean all these other law enforcement agencies operate within your jurisdiction, and might call for help, or try to call for help, and being able to communicate I think is certainly necessary.

MS. LIRIANO: And just so you are aware, just like the Chief said earlier during his presentation the officers, we have talked to

them on our main channel before, for Broward Sheriff's Office, and also other jurisdictions, neighboring jurisdictions that have our channels that are under the regional system, and they come over. If they're on a traffic stop, or anything like that, they come over our main channel. And a lot of the officers in our city that work the north end, which is, you know, adjacent to Parkland, they know how to get over to their system, and where to locate it.

SHER. ASHLEY: Was there any attempt by Broward deputies on the scene to go to your system, to your primary?

MS. LIRIANO: When -- when I was -- we don't -- for when it comes to what their officers did on that day we would have to analyze -- and I have a report, I just have to, you know, I'm not going to give you misinformation of the radio activity, of who was affiliated to our radio system. I know that we had affiliations with Margate units, but I know that as well we had a lot of fire response, so I would have to compartmentalize it between fire and police to be able to give

you the statement.

SHER. ASHLEY: Did any Coral Springs police officers go to Broward channel that you're aware of?

MS. LIRIANO: I can't answer that because I don't have, I don't have a report to be able to access their system.

DEP. CHIEF BACKER: I think that's something that Deputy Chief McKeone when we get into the response phase will be able to speak on in that regard. I can tell us as someone that responded myself I had no thought about trying to get on my radio and switching channels. To me in my mind it was always about patching to them, and also being in contact, and in communication with them upon arrival.

SHER. ASHLEY: Thank you.

CHAIR: I can tell you, Sheriff Ashley, just in discussions we've had with BSO, and with others is, is that most of the street level personnel, while they've technically somewhere in the fleet map had the capacity most of them didn't know how to do it, and don't know where those channels are, which then raises a question about training. You know we

train in a lot of things, and we train in tactical response, et cetera, but it raises a question that has been brought up, is, is that how often have agencies trained in radio interoperability, and being able to move so that you know, and do they have easy access.

One of the things that was -- and again, because we know there's no perfection in this, but one of the things that was -- I don't -- you probably didn't hear it yesterday, but one of the things that was raised yesterday, and Ms. Mize talked about it is, is that how the zones are set up, right, A, B, C, D, et cetera, and then you've got your talk groups within the zones. In each zone, A, B, C and D, you can have unique talk groups in positions, you know, whatever, 1, 2, 3, 4, but some of the bottom end ones are consistent across all the zones.

So, if it was set up where in every zone the very last thing, and, Chief, your point it well taken tactically speaking, but it is also very easy. If you're in whatever position you're in and all you got to do is turn it all the way to the end and then everybody is on the same page, that is a viable solution. But then

you come back to the issue tactically is, is that if everybody was on one and you're switching everybody over to the other, then you'd have to do some sort of a board check and make sure that everybody has moved to the end.

So, there -- there is no hundred percent in, in any of this, it's a community, and it's a law enforcement community working together collaboratively trying to figure out how you are going to effect the best interoperability you can in these unique situations. And that's probably where there's room, there's room in our county, I can tell you that, and there's room across the board. And hopefully this is a, a learning point for everybody, is that we need to do a better job with tactical interoperability for these major events.

SHER. ASHLEY: One last -- separate channels aside, certainly if everybody is looking at the same CAD screen that would, that information would be helpful as well. Thank you.

DEP. CHIEF BACKER: I agree that seeing that information at the same time would be appropriate. Not everybody that's operating in

the city is running a CAD. For example, I have no computer in my car. I would not expect an officer who is driving well above the speed limit negotiating intersections and dangerous traffic to be looking at their CAD. I don't think that that -- in fact our policy prohibits that. It's not what we would want them to do.

But to your point, Sheriff, if I could go back for a second, and I believe Sheriff Judd said it earlier, those first few minutes, you know, they're chaos. We're trying to get all those things, you know, situation and under control, and coordinated. Even if this had just been solely a Coral Springs response, or just solely a Broward Sheriff's response, I think when you look at it those first few minutes are just, they're a mess. There's no other way to put it. You have so many resources coming at one time, you know, and everybody wants to, to help.

CHAIR: Sheriff Judd, and then Chief Lystad.

SHER. JUDD: I think -- just so I have it clear, the system and the process failed in, in the sense that when you went to a new system

nobody went through a checklist to make sure that regional had all, had your main, and had all of your systems, right, I mean is that the bottom line to it? Somebody -- someone some place, either from your, from your radio group to your systems administrator should have had a checklist and said, okay, BSO has all of these mains, or all of these systems in place, and in fact as on go day they didn't have it.

DEP. CHIEF BACKER: Yes, sir, that's fair to say. I believe the responsibility is within each agency to inquire and get the authorization to put whoever they want on their console. I believe we've had them --

SHER. JUDD: But -- but the reality is you're the one that changed the system. I mean the administrator at regional, and I'm not trying to defend regional, they wouldn't know necessarily that you changed, or you changed systems, or maybe they would, but it seems like to me that the agency going to the new radio system has the obligation to coordinate with regional and go, hey, we got a new system here, we need to get all this stuff programmed so that we can all talk, and that just didn't

happen.

DEP. CHIEF BACKER: It did to come extent, sir, because they have, the deputies all have our radios programmed with the new radio channels, so the frequencies were provided when we upgraded. What they chose to program to what of their equipment --

SHER. JUDD: So, they had your main, they just didn't have it in the system.

DEP. CHIEF BACKER: That's my understanding.

MS. LIRIANO: They didn't have it in their console. So, customarily when we upgrade, for any agency that upgrades the radio system there is a letter that goes out to the counties, and also, we also have an agreement with Palm Beach and Miami-Dade, for letting them know, informing them we are upgrading to this radio system, and that's when the requests come in, because, you know, there's a -- Plantation has ours, they requested it. When they upgraded to the P25 they also said, hey, we're upgrading, you know, sent out the request to get our radios onto your channel, onto your consoles, and that's what we did.

CHAIR: But, Kathy, on the 14th if they had, if the BSO deputies in their portables had your channel, and your officers had your channel in their radios, and the BSO deputies had switched over to Coral Springs, and assuming they knew, most of them didn't so they couldn't get there, but assuming that they knew and they could have got onto the Coral Springs main channel, then they wouldn't have been able to communicate with their dispatch because their dispatch didn't have it in their consoles.

So, by suggesting that the deputies navigate away from their 8A and onto the Coral Springs channel, then they would have no communicate with their life link, which is their dispatcher. So, it's -- that's a mess.

MS. LIRIANO: Yes.

DEP. CHIEF BACKER: Under operational circumstances like that -- under operational circumstances like that I think the prudent and most effective way is to effect the patch.

CHAIR: Right, I get it. I get it.

SHER. JUDD: But at the end of the day when you change that system you have an

ethical, not legally, an ethical obligation not only to send a letter to them, but you should have a check and balance system, so you go, huh, I sent that letter a week ago and nobody has contacted me back to make sure that this stuff is on their main, or that they have rejected the need for it being on their main. So, had this data gone out, whether it's Palm Beach, Miami, regional in Broward, wherever, had this letter gone out, and if you said it did I have no reason to doubt that, but if you floated that letter out without any follow up system and process in place then you're gambling that in whatever is going on in their world that that letter got to wherever it needed to go to make sure that data was in their computer.

So, there should have been a check and balance. There should have been a follow up. There should have been a tickler file on that process to go, hey, we changed to a new system, I floated this letter out, I hadn't heard a word back. That's -- that's my point.

DEP. CHIEF BACKER: I see your point, Sheriff, and I think that's something we can

most certainly look to implement going forward as a process improvement, but I do know that the fact that we were changing, and what those new frequency were, frequencies were going to be, was communicated. But to your point, yeah, probably a better idea that we get together during one of the, you know, monthly, you know, regional communication meetings and have a discussion about, okay, what was the impact, what did you do, you know are we good to go, you know, a hundred percent.

SHER. JUDD: Did you get us in your system, did, okay, yes, I did, well, good, let's have a check, what time are we going to get together and check to make sure the system works, because we know in our worlds, and, and I suggest in everybody's worlds, but we just know about ours, we're all very busy, and sometimes paper and e- mails, and notes get either discarded, not seen, shuffled off until I get some time, and then they get stacked up, and the next thing you know you end up with this, this end result. You notified them, for whatever reason it wasn't in the system apparently.

CHAIR: Chief Lystad, you're next.

CHIEF LYSTAD: Thank you, Mr. Chair. Some of the questions you already asked I was going to ask, but I have a couple of other questions. I want to start first with, with Coral Springs' radio system, the current system, and its capabilities. Have you seen the Broward system that's supposed to come in place and online, do you know the technical specs of that?

DEP. CHIEF BACKER: I do not.

CHIEF LYSTAD: You're nodding.

DEP. CHIEF BACKER: Kathy does.

CHIEF LYSTAD: Okay, so my question is, is this. With the new system, one, is your radio, or are your radios compatible, and able to integrate into that system? That's my first question. My second question is, is by doing that would you lose any of the features and benefits that you currently have with your system?

DEP. CHIEF BACKER: So, you have two-part questions. I can definitely answer the first. In regards to the loss of features I think I would have to turn that over to Kathy. My understanding of the new system that they're

getting will be interoperable with us, but it will require what's known as an ISSI link. So, it is capable. I guess they're moving away from a hosted master site system, they're going to something different, and it's going to require a link, but they will be interoperable.

In regards to loss of features, I'm assuming you're asking about like the GPS thing that I was talking about.

CHIEF LYSTAD: That's correct.

DEP. CHIEF BACKER: If we were to migrate to their system I don't know what the GPS capabilities are. I think --

MS. LIRIANO: So, basically, when the new system that the County has procured, it is a P25 compatible system. Currently with their system Coral Springs and Plantation, we're all under the Motorola hosted master site, so the interoperability is, is effective. And ISSI link that the Chief was explaining is that when the County migrates to the new radio system they're going to be maintaining their own master site, but they still have a link through the main hosted master site of Motorola so that any other P25 compatible radio, or any radio

system through Motorola is able to still communicate and have interoperability.

The feature of the GPS, it is a per agency, from the meetings that I've attended for the regional system it's per agency, if they want to incur the costs of adding that feature they can onto their radios, just like we did, we incurred the cost of adding the GPS feature when we established that policy.

CHIEF LYSTAD: Okay, so then the root of the question becomes if you all consolidate, if you all are integrated, so you foresee the same difficulties that occurred during the Marjory Stoneman Douglas response still being able to occur and happen under the current, or under the planned two systems coming together?

DEP. CHIEF BACKER: If all of the components of the systems are working as designed, and as they're supposed to, I believe the response would be more effective, yes.

CHIEF LYSTAD: More effective, or it would still have issues?

DEP. CHIEF BACKER: Well, when you have two jurisdictions that are responding to one event, again going back to those first couple

minutes, I think you're still going to have that level of chaos, and until we get, you know, face to face, and the radio channels patched to be establish that command and control, and start taking control of the scene and giving out assignments, those first couple minutes I still think are going to be rough.

CHIEF LYSTAD: Okay. The fleet map that you have, is that designed by Coral Springs, you design your own fleet map?

MS. LIRIANO: We did -- for police we did design our own fleet map, and right now for, I can give you a couple examples, for fire they have a county fleet map, and right now we've been in communication, I've been attending the regional meetings, and law enforcement after this incident, and also after the Fort Lauderdale shooting, has said, look, they're, they have something in place, fire does, we need to adapt to the same. So, we are involved in these meetings to try to do something as similar as possible with them, the same layout.

One of the ideas that the Sheriff brought up as the last channel, that Angela Mize had brought up yesterday, so we are actively in

these meetings to work alongside the regional system, because when they go to the P25 and they're able, or have the capacity to add us onto their consoles at the dispatch center, which would be the, the best option, they can, you know, just, all it is the volume to hear what is going across. So, even if you're on separate, different radio systems to have the redundancy in case something were to happen to the other, we are still, as long as you have that talk group, the talk group is the key, set up in your console, you're able to still communicate with the other agencies, it's just having the talk group set up onto that console.

CHIEF LYSTAD: Okay, thank you.

CHAIR: Commissioner Dodd.

MR. DODD: You made reference to an investigation, or something with the Police Foundation, and I'm not really sure what that is. Can you explain that a little bit?

DEP. CHIEF BACKER: My understanding is that Broward County has hired the Police Foundation to conduct an after action into the response for lessons learned and best practices going forward. That would be an independent

investigation separate from what FDLE has been doing, separate from what this commission has been doing.

CHAIR: And you weren't here on Tuesday. I represented in my opening remarks that they have been, and I've been in communication with them, and we're communicating with the, and coordinating with them, so we're aware of what they're doing.

MR. DODD: And that's including everything with the incident, I mean --

CHAIR: No. It's a narrower review than what we're doing. The FDLE executive investigation is extremely narrow. I'd say the Police Foundation is a little bit broader, but nothing is as broad as what we're doing.

MR. DODD: Okay.

DEP. CHIEF BACKER: And they've already been on site with us, and we've already met with them, and spoken with them several times.

MR. DODD: And then my second question deals with, it was kind of mentioned just now about the regional meetings, but the input that Coral Springs has had into the radio system upgrade that Broward County is looking into.

Obviously, there's been some more information here this morning to look at, you know, cooperating together, so are those meetings, those regional meetings, a lot of information sharing between agencies, and not just Coral Springs but, but I was just curious about your input into those meetings.

DEP. CHIEF BACKER: I'm going to turn that over to Kathy to answer because she attends the meetings. I do not.

MS. LIRIANO: So, with the regional meetings, they are actually very informative, and it's good because we get to learn a little bit of their processes, and they get to learn about our processes, and at the end of the day we can just kind of bounce ideas off each other. At the end of the day we're all in the same industry, public safety, and providing the best service in the communications field. So, there's a lot of lessons learned with actually, because a lot of these meetings include operations, a lot of chiefs, sergeants, lieutenants from different agencies that are part of the regional system.

So, we have, are involved from CAD

portions to, to the radio, so we go in there and be, we're being informed. Last month I attended a meeting at Motorola where they went more in depth about their radio system, what they procured, and explained different processes, you know, had presenters just go into more detail so we were just as informed as the rest of the county, you know, users that'll be, you know, procuring that radio system.

MR. DODD: So, I think that's a great thing for this commission. If we're going to recommend more consolidated regional communications systems, that we, part of that would be the groups coming together, the task force, whatever that would be entitled of that communication sharing. So, thank you.

CHAIR: Secretary Carroll.

SEC. CARROLL: Just a point of clarification, not so much a question, because based on what Sheriff Judd was asking I do agree that both parties had a responsibility to make sure what was on the console, but I thought yesterday based on testimony from Broward that they had the information and made a conscious decision because of the hundred

channel limit of what they could put on the console that they elected to do with one set of data and not the other set of data.

So, I'm not sure who or how that decision was made, but I still agree with Sheriff Judd that at some point both parties should have understood what the decision was, and what the ramifications of that decision were. So, I'd just like some clarification around that, in terms of -- and I don't need it today, but we'll get it later on, because I, it was just my impression that the information was given, and there was a decision that was based on capacity and that hundred channels.

But there was no discussion after that decision was made I take it, because your testimony today is you had no idea that it wasn't on there. So, the breakdown was after that decision was made there was no communication during that process or after that process that it was not going to be included on the console, correct?

DEP. CHIEF BACKER: Correct. And I believe, you know, we're all in agreement that that would be a process improvement going

forward to make sure that something like that doesn't happen again.

SEC. CARROLL: And just -- and this is my ignorance to radios, but when you said you only reached forty eight percent capacity, if in fact they had done a patch onto the main channel does, does your capacity, would that increase the capacity the folks in the Broward radio system to communicate, or would it simply add to your capacity? Does it add to the capacity of both sides equally?

DEP. CHIEF BACKER: So, I understand there might be some ambivalent information about that. My understanding in lay terms is that when we patch we absorb that load. I understand there might have been some testimony here yesterday indicating that that's not the case. I think that's a better question for Motorola and their engineers.

CHAIR: Well, and Cindy will be back here when we get finished, from yesterday, and that might be a good question for Cindy, see if she knows. And there is somebody here from Motorola still, and we can bring them back up.

DEP. CHIEF BACKER: Yeah, I think that's a

great question. I'd love to know the answer, you know, to that as well. My understanding is that's the way it is, but that may not be the case, so I think that's a great point to clarify.

CHAIR: Mr. Schachter, you're next.

MR. SCHACTHER: I want to -- Chairman Dodd brought up a good point, is that, you know, by having each of these agencies come up here it's helpful, but to actually effect solutions you need to have everybody working together in the same room. And the Broward League of Cities, School, and Community Public Safety Task Force is the task force that I am on, and also the newly formed School and Safety Director April Schentrup is on that, and the gentleman that heads that is the Mayor of Sunrise Mike Ryan, who has the support of, of every public safety person that I know, and is doing a tremendous job.

That's the ones that actually already issued their first report, and Mayor Ryan has, has a breadth of knowledge, and because it takes coordination between all of these different entities everybody needs to be in the

same rook working together at the same time, and so I think that that is a great idea.

Because just to have each one of these entities coming up here, it's wonderful, it gives us information, but everybody needs to be in the room working together, because obviously it's what, what they're saying, you know, has an effect on someone else, and it needs to be obviously back and forth. So, if we could effect that and, and, you know, have them working together to, to fix all this, I think that would be extremely helpful.

Go ahead, I'm sorry, were you going to say something?

CHAIR: No. Were you finished, or no?

MR. SCHACHTER: I just wanted to ask, Commissioner Lystad, or Chief Lystad brought up some questions, and I was just a little confused. So, do you think that this is going to work, you know, like if they're able to get on the new system? I was just a little confused by, you know, the testimony. I'm not as educated in that area as you.

CHIEF LYSTAD: So, in response, I think it can. It can work. My concern is over system

integration. Any system can be integrated together, and as long as Coral Springs is talking to Broward Sheriff's, and Broward Government about how the systems integrate, and how we'll talk to each other, that's my concern, is to make sure that they're, they're both going to be able to integrate and work together seamlessly.

And the other concern I have is, is that, you know, cities are formed, and cities have police departments, and some cities have more revenue, and money to add features and, and benefits, and there's, there's always, there's always that next gadget that everybody wants, and I want to make sure that Coral Springs, you know, they're, they're going to be looking out for their residents as well, they don't want to lose features. But as I understood the testimony today the systems will work together, the systems will be integrated together, and the cities actually will have the option if they want to pay the extra money to add the features that Coral Springs has, such as GPS for the officers, which I think it phenomenal. It's very easy to lose track of where an

officer is at in the heat of the moment, in the heat of foot chases, and the fact that they have that I think is phenomenal.

MR. SCHACTHER: And then my last question is, Chief, you've stated that you would like out assistance to help push this issue and make sure this gets done. In your opinion how can we, because I understand there's been conflict between the City and the County, how do you, you know, and obviously this doesn't happen unless everybody is transparent and honest here, how, in your view how can we help make sure that happens, and do you think that, you know, having the League of Cities Task Force that I'm talking about coordinate, and Mayor Ryan, is a good suggestion?

DEP. CHIEF BACKER: I'll answer the second part first. Any influence and help that we can get, I know Mike Ryan is, like you said, a wealth of knowledge when it comes to radios and, and all these things, and I think certainly having support from multiple entities would be, would be helpful. I'll speak from the fifty-thousand-foot overview, and at the end of the day what we need is, and what we're

telling you we're willing to do, is be flexible to a certain extent as it relates to the governance and the programming, and accessibility to CAD.

Right now, I don't feel that there's -- I don't think either party is being flexible enough to really be committed to making that work, and --

MR. SCHACTHER: What party are you talking about?

DEP. CHIEF BACKER: The County and us. We have a way of doing business that we feel best serves our community, and the inability to have a modicum of program and control over that CAD impacts that. I understand from a technology standpoint why you want less hands meddling to insure system continuity, I get that, but we'd be talking about one administrator, not all thirty- eight people in our system, you know, having that level of access.

So, again, but those discussions are ongoing. We have met. I do believe in a perfect world if we can agree on how that works best for everybody, with a little bit of give and take, us going on the CAD and remaining

with our radio system would be the best solution right now going forward.

MR. SCHACHTER: It's been five months since this tragedy. I don't want to wait another five months. What do we need to do to fix this?

DEP. CHIEF BACKER: Everybody has got to be a little bit more flexible. There has to be a directive that what's best for maybe just the County, if it's not best for the end users, and you're not taking their feedback, it's not incorporated quickly, or it's not considered, or you don't give them the level of control that they're looking for to program, that's not necessarily the most efficient.

MR. SCHACTHER: I would, you know, appreciate your insight.

CHAIR: Commissioner Swearingen, you're next.

COMM. SWEARINGEN: Thank you, Mr. Chair. Chief, first I want to say thank you to you and Chief McKeone for your transparency today, as well as your willingness to be open minded about moving towards the regional system, which I think we all agree is in the long term the

best interest of the citizens here in Broward County. And I'm not a radio expert, so I apologize. I just want to clarify.

Yesterday we heard testimony that one of the concerns about Broward's system was that there were other entities other than public safety on their system, local government. And we heard testimony, while we haven't heard any definitive, the impact that had on the system, we did hear testimony from Motorola that it's logical to conclude that having those additional entities on there in a time of crisis could have led to the throttling issue because you've got additional entities other than a public safety entity turning on their radio, or changing channels, or whatever.

In your testimony today I believe you indicated on Page 4 that you have local government entities on your system as well, so my question is are you concerned that if the, the incident was in Coral Springs, and you're adding all of these public safety entities onto your system, I realize that day you only hit forty eight percent, but that's because I think most of the traffic was being pushed to

Broward, or -- are you concerned that if the incident were to happen in Coral Springs and you're adding law enforcement, that these other entities on your system, you'd be making basically the same mistake that Broward made by having entities other than public safety on your system?

DEP. CHIEF BACKER: I am not. As I gave you was the total number of uses, they're not all working at the same time. I believe we have more than enough capacity to handle any event in Coral Springs.

COMM. SWEARINGEN: Thank you, Chief.

CHAIR: Senator Book, go ahead.

SEN. BOOK: Thank you, Mr. Chair. And this is a question for, I guess for all of the sheriffs in the room on the commission. I was -- on Page 7 we're talking about Coral Springs fire, and they had three patches that worked. Perhaps I, I don't know enough about the intricacies of fire versus law enforcement. Why are we not talking about an issue that the fire had? Did -- was there issues that we're just not talking about? Why is that?

CHAIR: No, I think -- because Coral

Springs in their communication center dispatches fire and police, 911 for all of it. Coral Springs contracts with Parkland, so Coral Springs fire was the host agency for fire, so they were able to effect the patch with other channels, and they had all of the other channels in their console, they were able to click the button, and they were able to effect it without a problem, and it was their responsibility.

As you heard under the protocol here in Broward County is, is that the Broward County Sheriff's Office was the host agency because they are the police, excuse me, the police provider in Parkland, but for whatever reason, because of whatever reason they didn't have the Coral Springs primary police channel to click the button on to patch with 8A. They didn't have it, so when they didn't have it, and they couldn't effect it, somebody from, a duty officer according to the testimony from the Broward Sheriff's Office, picks up the phone and calls Coral Springs and says patch 14JOINTOPS2, which is a mutual aid channel, but nobody was on that channel.

And that would -- that gets back to some of the questions I had earlier, is, is that again in the perfect world that doesn't exist is, is that could Coral Springs have said, hey, guys, wait a minute, we understand that you don't have it, and you can't effect the patch, and the patch won't work, but why don't we patch 8A onto our system. But then the problem you would have had was, is that if they had taken it then, all of the deputies on the street wouldn't have been able to necessarily communicate with their dispatch.

So, there's -- there's all kinds of -- does that answer your question?

SEN. BOOK: I guess part of where I'm trying to, to tie up, is the seamlessness, the continuity, that it seems to perhaps exist for whatever, I mean --

CHAIR: I don't think it's a fire issue. I think that the fire, the fire patch, and you can speak to this, the fire patch worked because everybody had what they needed to have, and they were able to effect it. It's not a -- the patching system works.

SEN. BOOK: I think it's the procedures

perhaps.

CHAIR: It's the procedures, yeah, go ahead if you want to speak to --

DEP. CHIEF BACKER: Well, I have Assistant Chief Mike Moser from the Coral Springs/Parkland Fire. He can speak to any fire related issues.

CHAIR: And it's the patch that's in question, the patch --

ASST. CHIEF MOSER: Right. The only thing I wanted to elaborate on, and you had brought up a good point. The patch that occurred between the Coral Springs Fire talk groups and the County mutual aid talk groups that the fire department used is the same exact patch that would have been attempted between Coral Springs main and the 14OPS channel. It's exactly the same. They were successful when our fire dispatchers did them from our console, so I just want to make sure that you understand it's the same thing.

It's not that we were trying to patch channels, and then another agency was trying to patch different systems together. They're -- they're two systems that were done on the fire

side correctly and, and I don't want to say correctly, they were successfully done, and they worked, and the other patch, we're unaware of what the issue was.

CHAIR: Sheriff Judd.

SHER. JUDD: Yes. Chief, my closing word on this is that you have to look out for the best interests of your community, and we understand that. And we talked about the regionalization, and you don't want to lose anything, but I strongly encourage regional BSO and you to sit down and work out these issues, so you get to a win/win, because the last thing you want is something forced on both of you that neither of you like or is in your best interest. And this train is up on the track, and it's rolling, and if you don't see it, or hear it, or feel it, it's going to run over you, and then you're going to be stuck with the results.

So, at the end of the day I hear the ideal world, but in the real world, the real world is BSO has got to understand they've got to be as sensitive to your needs as, as they possibly can be, because, yes, they're regional, but all

service is local, and it's individualized to the people that need help, and everybody is entitled to the absolute best service. So, what I suggest, I would operate with a sense of urgency. I'd get everybody in a room and start huddling and say let's fix this thing before they give us a fix that we may not like.

DEP. CHIEF BACKER: Yes, sir, I think we're committed to doing that. We will make sure that those meetings, you know, we re-engage in those meetings. We've already had some. I do want to clarify. It's not BSO, it's the County where we've got to really get together. I don't think there's been an issue between us and BSO as it relates to communications.

SHER. JUDD: Okay, I understand. But whoever, whoever the players are in this thing.

DEP. CHIEF BACKER: Understood.

SHER. JUDD: And -- and at the end of the day it needs -- it has to be, and it can be a win for everyone. But the last thing you want -- because we all grew up in local government, the last thing we want is somebody from the outside coming in and saying, well, since you

all can't fix it we're going to fix it for you, and then you're going to have to get used to it. That's not ideal.

DEP. CHIEF BACKER: Agreed, sir.

CHAIR: Thank you, Chief, we appreciate your testimony. So, we're going to have to do some --

DEP. CHIEF BACKER: Thank you all.

CHAIR: Thank you very much. We're going to have to do some schedule adjustments, which we'll do, but for right now we've been at it for two hours. We still have Cindy Cast to come back up and answer any questions you have. Then I know at least one commission member has asked for Ms. Henry to come back up and respond to a question, so let's go ahead and take a fifteen-minute break. Well come back and then we'll wrap up with communications, and then move on to the next topic.

(Thereupon, a recess was had and the meeting continued as follows:)

CHAIR: We're going to resume here. Cindy, if you would come back up please. So, Cindy Cast from Miami-Dade Communications is back to answer any questions you have. Perhaps, you

know Secretary Carroll, if you want to I think there was that one question that you had. It was a technical question, if you want to ask that of Cindy maybe -- did you hear the question before?

MS. CAST: Yes, I did.

CHAIR: Can you -- can you respond to that?

MS. CAST: Yes, I can.

CHAIR: Okay, go ahead.

MS. CAST: Okay, so technically the question was asked how does patching work between two separate systems, does the capacity, or the loading of the patch carry it on from one system to the next. So, in a scenario, and I'm not talking specifically about their systems but just in general, technical radio systems, two separate ones, when you patch a talk group you're using a resource, and I'll go back to the example I used yesterday, a five-channel truck system. One channel is a working, I mean a control channel, four channels are working channels.

With another system, we'll say this one just cause of my fingers, is a four-channel

system, one channel is a control channel, so it has three channels that are working channels. If one talk group gets patched between then any time anybody talks on either one of the systems on that talk group it uses one channel, which is the transmit and frequency pair, on each system at the same time.

So, that means for the five-channel system over here, one control channel, four working channels, every time someone talks on that talk group that is patched one channel gets used, only three left available frequency pairs to be utilized. On this channel there were three working channels, every time it gets used only two channels are left. So, it doesn't share the capacity of the frequencies to the other system, they both tie up a frequency pair on each of the individual infrastructures. And that's the way it works across the board unless the control channels have some kind of shared control channel between both systems, which is not the case here.

So, that means that, for your question, the capacity cannot carry over from Coral Springs to help BSO, and BSO's capacity cannot

carry over from BSO's system to help Coral Springs infrastructure wise.

CHAIR: Actually, it doesn't help anything.

MS. CAST: Not the infrastructure to help capacity. Each system independent has to support the capacity.

CHAIR: Right. You would -- you would still have -- if you had throttling on one the patch isn't going to fix the throttling issue.

MS. CAST: If you have throttling on one system, and the system is working without throttling on their own independent talk groups, on the patched group it will have experienced the throttling, because they won't be able to converse and access the channel of the other system, because it doesn't have any working channels to give it access to.

CHAIR: Secretary Carroll, does that --

SEC. CARROLL: Yes, thank you.

CHAIR: Okay. Go ahead, Commissioner.

MS. LARKIN SKINNER: Yesterday we learned a little bit about queuing, which then might lead to throttling later, or whatever happens. But what I'm interested in is what is the

experience like for officers and deputies in the field, and, and the experience like for dispatch, let's say, when queuing happens?

MS. CAST: So, every radio is very complex, and it could be programmed differently, so it could be programmed, the radio itself, so when a queue takes place that means you have four working channels, all four working channels are being talked on on different talk groups. Someone goes to key up their radio, but these are already currently being utilized so there is no available working channel for the talk group to talk on.

The radio, one way of programming it, it gives a high-pitched squelch tone, so that high pitched squelch tone is different than any other tone the radio normally hears, so the radio user knows I'm on queue. Now if they have training they know in some configurations the way it could be programmed is they continue to press to the push to talk button on the radio, the radio will eventually give it the regular access tone saying, okay, now you have a free working channel, you are now open microphone for you to communicate. And that's

from a user side.

Sometimes, depending on the way the radio is programmed it might not have a high-pitched tone. It could have a long deep tone. Again, there's different tones that could be utilized depending on the programming. And sometimes if you hold the PTT it will not automatically give you the next working channel, you might have to let go and hold it again.

The problem is when you let go and hold it again, if you don't utilize the feature of continuing to hold it you lose your line. It's sort of like you're back in the bank, you got out of line, and you went all the way to the back of the line if you let go, whereas if you continue to hold you are the next person, because the system sees you, you got logged in that your unique radio wanted to actually communicate, so you're the next in line, and that's when you get the next available working channel.

MS. LARKIN SKINNER: So, in theory if queuing happens someone may we waiting, their turn comes up, they transmit their message, but whoever needs to answer them then is also going

to be queuing, so there will be a delay --

MS. CAST: So, the infrastructure could be set up so that there is different priority levels. Every radio has a unique identification number. That unique identification number could have a different priority level, so if you queue, if you press your push to talk and you're a higher priority than someone else that's pushed it, you still go ahead of them.

The console usually, not always, but generally the console has the highest level of priority, so a console could always, if it is configured in this manner, be able to communicate and go over any other radio in the field that's talking. That's a general best practices, but sometimes the consoles might not be set in this priority level, it depends on the configuration. Which is one of the things I started yesterday, is radios are very complex, there is a lot of different features, so you have to really see the details of how it's programmed and the configuration of the infrastructure to know.

MS. LARKIN SKINNER: So, do you know is

that best practice in the public safety industry, that the console would have the priority?

MS. CAST: Yes.

MS. LARKIN SKINNER: Okay, thank you.

CHAIR: Commissioner Dodd.

MR. DODD: Does the GPS mapping feature that a lot of these new systems utilize, does it require additional capacity, or is that like data, metadata or whatever, that doesn't use the frequency? How does that work?

MS. CAST: So, it depends. It's a very, a complex answer. So, you could have an infrastructure that utilize the capacity of the radio frequencies to do GPS tracking, and that's a data message that goes back and forth to the infrastructure. Some systems are set up that they have a separate core of frequencies utilized for those data messages that go back and forth, so it depends on where they're using it, how they're sending the data packets, and what's the back-end infrastructure to support the mapping. So, there's -- both mechanisms are available out there from vendors.

CHAIR: Anyone else? Chief Lystad.

CHIEF LYSTAD: I just want to have, if you could, just explain a little bit about what they call route fleet mapping, we call profiles, and so there's always a different perspective on that. As I understand Broward profiles each individual agency controls that. Can you either talk about profiles, and how they should be created, or how they are, their best practices so that they become more effective for users?

MS. CAST: So, there's many different forms of creating templates, fleet maps, profiles, and that is basically the programming that goes behind the scenes into the radio itself. Some counties, some cities, choose to take on the responsibility, so every user on that radio system has to come to one specific place, and they have to get it authorized by that system administrator, and they can only have the configuration that that system administrator approves. So, across the board any user, any discipline, they know exactly what is the protocol of which talk group, which zone, which system they have to move to, because the system administrator which manages

the infrastructure has all of the data.

However, that could become very costly because you have to have the staff to be able to support all the different agencies that might write off of your infrastructure, so other agencies, what they do if they don't have that level of staffing, is they might take on the responsibility, is all of the internal departments for that county or city come to the system administrator for their county or city, and any outside agencies that have a different hierarchy go to an outside vendor, contractor, that work for the same infrastructure, or manufacturer, that does the work for them.

But again, in that case there is some difficulty from a system manager perspective because they don't know how does that radio program, they don't know does that agency have that talk group or not. And having too many talk groups on a radio doesn't become helpful because the officer or deputy will never be able to find it on his radio. So, it's not just the radio programming itself, but having the training, or the knowledge by the different officers or deputies on how to move around in

their radio, and how to access the different talk groups.

So, best practice would be making sure that the system administrator knows the information, whether they do it or a vendor does it outside, and also having training put in place so that the people who actually have the device are able to utilize all the functionality and features.

CHAIR: Anybody else? So, is there -- as you sat here listening to the presentations after your presentation yesterday is there anything that you feel that you need to share with us to provide clarification from what we've heard that in your expertise is something that we need to know about, that needs clarification?

MS. CAST: I think each of the individuals that spoke on the separate infrastructure systems, and they answered the questions provided, all of the information that was being requested by this commission, if there is something that someone did not understand I'm here to clarify it, but I think each individual agency provided details.

CHAIR: And everything in your understanding, I just want to make sure that there's nothing that from your perspective, and hearing it, it's kind of, you know, that catch all, is there anything that you saw, heard, that needs clarification, so we have an accurate understanding. Is there anything that, that sticks out in your mind, or do you feel that from what you've heard is, is that everything was accurately conveyed?

And I'm not saying that anybody intentionally provided any inaccurate information, I'm not saying that, but there was a lot talked about, and you are here as our subject matter expert, so that's why I'm asking you, and the question is, is there anything that sticks out in your mind that you've heard in the last day and a half that this commission would benefit from your knowledge and expertise to clarify?

MS. CAST: So, each of the different system presentations provided detail on the way the systems work. They talked about the key components, such as fleet mapping, the type of talk groups that might be on the radio, which

ones might not have been on the radio. They talked about the console having the capability, or not having the capability because they had the limitations of the talk groups that the console was able to utilize.

They talked about the new system, and the capacity of the new system. So, they shared all of the key components on talk groups, consoles, the agencies and users that were using it, and the amount of utilization that each system had, and what was available and what was not available, so I believe that they covered all of the basis. There weren't any catch you's, or things that, that might not have been relevant based on what they said.

CHAIR: Great. Senator Book, go ahead, then Mr. Schachter.

SEN. BOOK: Thank you, Mr. Chair. And thank you so much for providing us with a lot of information. But in, for example, in Miami-Dade are you doing something different than what we're doing in Broward, something better, something that could be improved that we could glean that could enhance what we're doing, looking at and hearing what you've

heard, that maybe if that were in Miami you would change?

MS. CAST: So, the infrastructure in Miami-Dade is very different than the infrastructure utilized here. Our system was twenty years old, and we did replace it, which is a really long process. It took years to replace and move everybody over. So, I guess to give you a background of the Miami-Dade system, we have countywide simulcast trunk systems. There are a little over thirty thousand radios on the system, between mobiles, portables, and desktops and consoles, but we have two separate systems that are countywide simulcast.

One system has only law enforcement, which is police, state, federal, local, cities, tribal, and corrections. That's one system. A separate system has everybody else, which would be fire, EM, local government, any of the departments, our seaport, our airport, they all utilize the same system. So, out of the thirty thousand, again two separate systems, they sort of have the same coverage to some extent, the majority of them have the same exact coverage,

so if one system has a failure the protocol is to move to the other system as their backup.

So, it's a completely different configuration, it's been in place for a long time. We also are self-maintained. We have a little over fifty individuals who run and operate the radio system full time, twenty-four/seven every day of the year. We have people on call. We support over thirty-four city police departments that work on the system. They don't have separate individual systems from those thirty-four.

There are in the county six different separate systems that are outside of the counties, and we do exactly what they do in the example that they gave. We have on our consoles a talk group for that city that has a separate system, and we patch to it. And that's what we do every day for any quick incident that takes place, so it's the same protocol, or procedures that they do. Our configuration, or the way we're designed, is different, but it might just be different because, again, we're self- maintained. The agencies, we have over a hundred twenty-five

agencies on our system. So, it might be different just because of that.

When I explained radio infrastructure systems, each one is very unique, and those key questions sort of are fundamental on how they're designed.

SEN. BOOK: Thank you. Mr. Chair, can I -- thank you. The other question that I have is have you experienced, I mean I know that in Miami-Dade there have been catastrophic events throughout the history, have you experienced some of the challenges that, that presented itself here on February 14th, the throttling, the queuing, whatever?

MS. CAST: Okay, so our infrastructure, because they're two separate ones they have two separate groups of everything, so it's twenty channels on one, so I don't have enough hands for that, there's twenty channels, one control channel, so you have nineteen working channels on one, twenty channels, one control channel, nineteen working channels. Two separate control channels, two separate infrastructures, so throttling, or the control channel being inundated with data, has not taken place in the

eighteen years I've been there.

Could it, I don't know; I've never seen it there because of the way that we handle and manage the, or the protocols, the procedures we have in place, the training that's done to the individuals that use the system; so, so far, I've never seen it.

Queuing, which is in our case nineteen working channels get utilized, and the twentieth person comes up, they get the high pitch beep, yes, we've had queuing, and they hold the button and they get in line, they go out. So, it's hundredths of a second that they might experience, it doesn't happen often, but in big storms, or big incidences, queuing could happen, but it doesn't impact the operation, or the response to the operation. It has never gotten to that level.

CHAIR: Okay, the last question, Mr. Schachter.

MR. SCHACHTER: I mean obviously this is something that I'm very curious about, and that is why did we not do two separate systems like Miami did, and if we would have had that would that have, would we, that have fixed all of our

problems, and Jan Jordan would have been able to command the BSO on, on campus? That's something that, you know, I don't know if you can answer, or somebody can answer. I'm curious about that.

And also, should we be switching to two separate systems? It sounds like it makes more sense to me, but, you know, I'm not an expert.

CHAIR: Okay, so first they already said they are switching to two separate systems. The new system will be a law enforcement only system, a public safety system, and then everybody else will be on something else. So, they already said that. And you can answer if you want, but I don't think that you can answer as to why Broward County made decisions about one or two systems --

MS. CAST: Right. So, every city, or county, or state, when they go into developing a radio system they go through a huge process of answering questions about how best to deliver the services, and what is the, the funding that they have available to do that. And I'm sure those decisions, or discussions, took place, and I'll let someone from Broward

come up and, and answer more specifically.

CHAIR: Okay, Cindy, we very much appreciate -- yeah, go ahead.

MR. SCHACHTER: I'm not -- I'm not sure, you know, of that. It was my understanding that it was just the buses that are going to be offloaded, and --

CHAIR: Okay, we're going to bring somebody. You asked for the County Administrator to come back up. She's going to come back up in a second, you can ask that question. Cindy, we very much appreciate you being here. Thank you. You are a wealth of knowledge, you did a great job, and we appreciate it. Thank you very much.

MS. CAST: Thank you, sir. Thank you.

CHAIR: One question, Chief Backer, would you come up for a second? And I tried to find you at the break, I couldn't, so I'm going to put you on the spot and ask this question now that I'm competent of what your answer will be. Will you please by next Friday, a week from tomorrow, provide me and the commission, I'll share it with everybody, a list of what Coral Springs concerns are, and what you find to be

impediments to joining the County CAD system?

You have a list of the things, and we didn't get into that, but you alluded to that there are issues, and there are things that you feel like that Coral Springs has probably dug in on, there's things that the County has dug in on. The County Administrator is going to come up in a second and I'm going to ask her for the same thing. So, will you by a week from tomorrow provide us with a list of what Coral Springs feels needs resolution before you would be willing to migrate over to the County's CAD system?

DEP. CHIEF BACKER: Two things. One, absolutely we will hundred percent provide that. I can't see Kathy behind me but I'm sure she's writing it down, and she will have a comprehensive document probably before the timeline that you're asking. Secondly, I would like to note that after we concluded we did have a side meeting with Bertha Henry and a lot of her staff, and we've all exchanged information again, and we're talking about getting together sooner than later to work on this issue.

I think we have a commitment from Ms. Henry to collaborate and work towards resolving this. I'm confident that if each entity is reasonable and practical that we'll get that done.

CHAIR: And anything we can do to facilitate it, so I appreciate your willingness to provide that list by a week from tomorrow. Thank you. Appreciate it. Thank you.

DEP. CHIEF BACKER: Yes, sir, you will have it.

CHAIR: Thank you. Ms. Henry, would you come back up? I'm sorry, Senator, I'm sorry, go ahead.

SEN. BOOK: Thank you. And as the County Administrator comes up I just would ask the Chair if, because plantation is also one of those that is not part of the regional system could we ask of them, I know they are not here, but send them something, because I think what we're trying to do is get everybody on the same page, and have them a part of those discussions so that we can work for that unified?

CHAIR: I'll send a letter to them, and reach them, and ask them, yes, to do that. So,

I'll just ask you a couple of questions, and then open it up to questions from everybody else.

MS. HENRY: Yes, sir.

CHAIR: Is, is that do we have your commitment to work collaboratively, and to seek a compromise with Coral Springs, and potentially, we don't know the issue with Planation, but to work collaboratively and compromise where you can to get to a place where Coral Springs feels comfortable, and the County feels comfortable in getting at least Coral Springs and the County on the same CAD system?

MS. HENRY: Absolutely.

CHAIR: Okay. And will you -- the same question, will you by a week from a tomorrow provide me with a list of what the County sees as issues that need resolution, that require compromise between the County and Coral Springs?

MS. HENRY: The answer is yes. And as you've indicated we had a short session a few minutes ago, and admittedly I was not aware that, and I guess the term was used, there was

a conflict. I -- I -- at my level I'm interacting with the, with the City Manager, and City Manager Goodrum and I don't have any communication challenges, so if there's some issues at the staff level they will certainly get those ironed out so that we can identify where there are some, some differences, and we'll work them out.

We have -- we have a community that reached out to us and said, hey, look, we'd like to be able to dispatch for ourselves, do our own call taking and dispatch, and we said as long as you're on, you're willing to stay on the County's CAD, because we certainly want to not go backwards in terms of having call transfers, we're happy to accommodate that, and they were working towards that aim.

So, we are open to whatever works best for the system in its totality, so you have my commitment that we'll do that, and we'll get you that list.

CHAIR: Great. Thank you, I look forward to receiving that by next week. Mr. Schachter, you had a question for the County Administrator.

MR. SCHACHTER: I just wanted to clarify. On March, you said the first quarter of 2019 you'll have a new system for, for the buses, is that correct? And then with the new, and then what about fire and EMS, and -- I'm just trying to see if Miami's system and how they have everything separated, will that, is that the way we're going to have it, or not?

MS. HENRY: So, let me start with their -- we will have two systems, a local government radio channels, I mean for non-public safety. What will be up and running 2019 would be all of the County agencies that are currently on the system that are not law enforcement, so they will be on the local government radio system. The City of Fort Lauderdale, the City of West Park, there are a couple of cities that have reached out to us and asked if they could come on our local government radio system, and we said yes, and we would work with you to program you in. Now, whether they will be on at 2019, at when we're up, I can't say that at this point because I don't know what their requirements are, other than maybe the smaller city West Park.

As the school board is also working with us to come off, their, the buses if you will, to come off of the radio system. I cannot today tell you what their, what that timeline is cause we're going through the requirements with them as well.

But the remaining system that we're looking to have available last quarter of 2019 will be just that one system, but it has been configured with quite a bit of redundancy, so we're a little different than Miami-Dade, and what we were able to accomplish is, is based on what is available to us today. A lot of, and maybe she can speak to that, a lot of this is about frequency availability by the FCC, and as some of you may have heard they're trying to move away from certain systems, and so with the, with the frequencies that we are allowed to have we believe we have the best system, we have the redundancy that we need, and if we find out that that's not the case we'll keep pursuing it until we do.

MR. SCHACHTER: Are you saying that you went to the FCC and they would not give you more frequencies --

MS. HENRY: They were not available. They were not available.

MR. SCHACTHER: And is -- is that a problem, is that something that we should be addressing, or --

MS. HENRY: I'd -- it's -- I don't know -- I don't believe that you as this committee would have the ability to do that, because if they're not available that means other entities have them, and unless we're going to take them from them, we wouldn't do that. And we didn't believe that that was a big problem for us because of the way the new system for us is being reconfigured with the redundancy.

MR. SCHACHTER: Are there any delays, or any other impediments like what we're having with Tamarac on the, you know, the other system, the separate system that's supposed to be up and running March '19, any impediments, anything we should be aware of?

MS. HENRY: No, not at this time.

CHAIR: All right, well, thank you Ms. Henry, we appreciate you being here. Yes, Sheriff Ashley, go ahead.

SHER. ASHLEY: I'll just ask one question.

Her previous testimony that there may be some cities that are looking to go away from the regional communications, have you heard anything of that from any of those cities?

MS. HENRY: Well, what -- what has come to my attention, the City of Coconut Creek had asked if they could have the ability to have their own call taking and dispatch, but they would stay on the regional system, and wanted to make sure that they could use those assets if they had their own dispatchers and call takers, and the answer was yes.

If there are other communities that are looking to leave they've not brought that to my attention. I've -- but I can't say that that's true or not, they've just not brought it to my, to my attention.

CHAIR: So -- so does Coconut Creek understand that if they were to do that, and a 911 call comes in, that they are creating a situation where their citizens who are calling in are not talking to the person that can get a cop to them?

MS. HENRY: Well, for that city they've indicated that they will stay on the CAD and

use the same protocols.

CHAIR: But the -- the 911 call would go into the regional center.

MS. HENRY: It would go into the common CAD, and yes, and they can, they can send the call to wherever it needs to go, so they -- that was a commitment that they made in order to continue to use the infrastructure.

CHAIR: Any other questions, last --

MR. SCHACHTER: Yes, Chairman, how can the commission, because, because of the failures I think there's -- maybe she's not aware of them, but there are other cities that don't trust the County system. How can we, you know, encourage other cities, and, you know, make sure that we don't have --

CHAIR: We can make recommendations, and then we can put it in the report that we submit on January 1st.

MS. HENRY: So, what I will do is reach out to see if there are such cities, because I'm not aware of them. So, I'll find out if there, if there are, and I'll report back.

CHAIR: Okay, thank you, Ms. Henry, we appreciate you being here. Thank you for your

staff, their cooperation and participation. We appreciate it. Thank you very much.

MS. HENRY: Thank you.

CHAIR: All right, so we're going to move on now, so just for housekeeping we've got -- it's about 11:30. Of course we're, you know, behind schedule, but we'll figure this out. The next presentation, which will take about an hour, will be on the law of gun purchase and possession, disqualification. We have Robin Sparkman from the Florida Department of Law Enforcement that's here. And after Ms. Sparkman's presentation it will be 12:30. We'll break for lunch at 12:30, and then we'll take a look at the schedule for this afternoon. So, Ms. Sparkman, welcome.

MS. SPARKMAN: Thank you. Thank you for having me. I appreciate the opportunity to come and share this information with you guys. I am the Chief of the Firearm Eligibility Bureau, which is a division of the Florida Department of Law Enforcement. We process the background checks for firearms that are purchased from federally licensed firearm dealers in the State of Florida to non-licensed

individuals as is required by Florida Statute 790.065.

Our mission is twofold. The first is to go ahead and quickly process those background checks so that law abiding citizens who are eligible to receive those firearms can do so in an expeditious manner. And then the second part of that mission is to prevent those transfers to individuals who are prohibited by state or federal law.

The legislation that, that we are based upon is, there's not a lot. It's actually very minimal. The National Firearm Act of 1934 was the first law. It's a federal law to regulate firearms in the United States, and it came about in the days of the gangland violence, and really regulates automatic, automatic machine guns, automatic firearms, short barreled rifles, short barreled shotguns, and that type of firearm. And its authority is limited to those.

The firearm legislation that really made the biggest impact and carries forward in today is the Gun Control Act of 1968, and that Act created categories of prohibited individuals,

and that's what we really base our background checks on today. That Act was passed in the wake of several high-profile assassinations, John F. Kennedy, Robert Kennedy, and Martin Luther King, Jr. Florida Statute 790.065 came about after that in the late '80's, and in 1991 the Firearms Purchase Program stood up and actually began doing automated background checks.

So, the Gun Control Act basically said if you are, if your record reflects that you are this type of prohibited category, if you fit in this type of prohibited category you aren't allowed to purchase or possess a firearm, however it was kind of the honor system. The form was handed to the customer, the customer filled out the form, and if they said they weren't a convicted felon and signed on the bottom of it then the firearm transfer proceeded. It wasn't until the actual background checks began in the late '80's here, in the early '90's here in Florida, that we actually began checking those answers against the databases that we have access to.

And in 1993, the Brady Handgun Violence

Prevention Act was passed, and that became a mandate state, or national, a national mandate which was enacted in November of 1998. So, Florida was well ahead of the curve on that one.

There is a different between the laws that oversee purchase and the laws about possession of firearms. In federal code it's a little bit easier to follow United States Code 922(g)1-9, both, ban both purchase and possession of the firearms if you fall, if you're a type of category or person that falls under those laws. 922(n) as it's called bans purchase but not possession of previously owned firearms.

In Florida we're a little bit more disparate and across the board. 790.065 is sale and transfer of firearms and tells us what we can and cannot do while we're conducting the background check and gives us the authority to do our work there. And then there are individual statutes, some of which were created by the Marjory Stoneman Douglas Public Safety Act, that address possession of firearms. So, it's a little bit, a little bit more disjointed in Florida law.

We also have some other laws that guide our activities, which is 790.335 which prevents the government from creating or maintaining a list of legal firearm owners, and there is a federal mandate for that also, the Firearm Owner's Protection Act.

This list is the list of federal prohibitors. These are the categories of people who are prohibited from purchasing or possessing a firearm according to federal law. Most of the public will be glad to tell you they know the first one, which is the felony conviction one, but the other ones are a little bit less well known, but when a transaction comes into our center for a firearm background check we look at all of these, and not just the felony conviction, fugitive from justice, unlawful user of controlled substance, of course the mental health disability is a high profile topic, illegal alien, dishonorable discharge, renounced United States citizenship, respondents to protection orders, convicted of misdemeanor crimes of domestic violence, and under indictment or active information for a felony.

Our state disqualifiers are expanded on the federal disqualifiers, so state law gives us the ability to also screen background checks against some juvenile crimes that were committed, an adjudication of delinquency on a crime that would be a felony if committed by an adult will prohibit an individual until they reach age twenty-four, or until that crime is expunged from their criminal record.

We expand on the number of protection orders we can deny on. Federal law covers domestic violence protection orders only. State law expends the definition of what domestic violence is to the state definition and adds into that other types of protection orders. If an individual in Florida receives adjudication withheld on a felony or a misdemeanor crime of domestic violence they are prohibited from purchasing a firearm until three years has passed since the completion of their sentencing provisions. So, if they were assigned to do two years of probation following their adjudication withheld they must complete that two years of probation and then an additional three years before they become

eligible to purchase a firearm in Florida. And then there are a list in the statutes spelled out of enumerated offenses, that while those enumerated offenses have not been yet disposed in court the arrest alone is sufficient to prohibit the transfer of a firearm.

I'll talk just a minute about the mental health prohibition. It is, it applies to those individuals who have been to court and have been adjudicated by a court as mentally incompetent or ordered to treatment by the court. This also applies to individuals who are deemed mentally incompetent to proceed in a criminal process, or who have been deemed not guilty by reason of insanity.

It does not apply to persons who recognize that they are suffering from a mental illness and voluntarily seek treatment, and remain voluntary through the treatment process, no court order mandating them, they voluntarily go through the process. It is also not prohibiting for people who are Baker Acted, held for observation, and then released at the end of that observation period without a court order. And a physician diagnosis alone, a

physician saying I believe this person is, is mentally ill, and suffers from a mental illness, without going that extra step and getting that court order then the physician's diagnosis alone is also not prohibiting.

When the determination is made by the court, and recorded by the Clerk of Court, the Clerk of Court submits that order to use electronically through a web application called MECOM, or the Mental Competency Database. They have thirty days within the adjudication to report that order to FDLE. The person record is created in MECOM, and then it is, MECOM interfaces with the NICS index, and the NICS index is that system that's available nationally, should that person travel outside the state of Florida to purchase a firearm in another state that information is then made available through the NICS index to all other states.

The only time remove someone from MECOM, it takes a court order to get them in, it also takes a court order to get them out. So, individuals who are suffering through a mental health crisis can recover, get better, their

doctor could say they're better, they could petition the court to have their rights restored, and if the court deems that they are no longer a threat to public safety then the court can restore their rights, and they would be removed from MECOM, and removed from the NICS index.

New to us in the Marjory Stoneman Douglas Public Safety Act is the risk protection order, so that was -- as I understand it the spirit of the law was such that there are these individuals who are Baker Acted, during their time of observation they are released without a court order, without being held, and yet they still in the minds and judgment of the law enforcement officials who took them to the Baker Act facility remain a danger to public safety. And this risk protection order is the mechanism that the legislature has given those law enforcement agencies to petition the court to take the firearms away from this person and make them ineligible to receive another firearm during the length of the risk protection order.

A law enforcement agency is the petition in this type of order. It is, can be issued

ex- parte, without a hearing, so that's a temporary order, and then upon a hearing a final order can be issued for a period of up to twelve months. Before the twelve months is up, the law enforcement agency can petition for an extension for another twelve months, and the respondent can petition to have the order removed.

If an individual with a risk protection order attempts to purchase a firearm, and we process that background check, we call that law enforcement agency that is the petitioning agency and make them very much aware of what has happened. That has only happened once since this law is enacted, and it's in your county, Sheriff Judd.

It prohibits possession in addition to prohibiting purchase of a new one, so this is one law that applies to both purchase and possession. It requires the surrender of any firearm that that individual has on them at the time, and they may also voluntarily surrender any other firearms they may have at their home or in their vehicle. Law enforcement may seek a warrant to seize additional firearms if they

do not voluntarily surrender them, and at the end of the order, time of the risk protection order, then the firearms are returned to that person pending, only after a background check has been done and that background check indicates that that person is eligible to receive them.

When we do background checks we get, you get one of two decisions out of FPP, and that is either an approval, there is no record that indicates that person is un-eligible to receive, therefore the purchase or the transfer may go forward, or they get a non-approval, which means that they, that there is a match to a record which contains a prohibiting event or arrest, and that individual is ineligible to receive a firearm, and therefore they are not approved.

There is a status that's somewhere in between, and that is what we call a decision pending. Sometimes we'll pull up a criminal record, or we'll look at a criminal justice information system and there is a piece of information that may be missing. For instance, perhaps they were arrested, and they went to

court, but the court disposition was not reported back to the system, it may be a very old record. We put a decision pending on that, the transfer is kind of held in abeyance until the research is completed, we find that piece of missing information, and we can either make an approval or a non-approval decision.

Some other changes that SB7026 had on our operations is it changed the age limit from eighteen to twenty-one for the purchase of a firearm, for any firearm, including long guns, with certain exceptions. It extended the state- wide waiting period for all firearms to three days. Previously that was only on handguns, and now it also applies to long guns. And it created the risk protection order as a mechanism for law enforcement.

I want to talk just briefly about this term that gets thrown a lot called the gun show loophole and explain exactly what that is so that we're all talking about it on the same level playing field. A federal firearms licensee, an FFL which is licensed by the ATF to conduct business as a firearms dealer is required to do a background check regardless of

where he or she is standing when that firearm is transferred. So, if they're in their bricks or mortar store, or if they're at their home, or if they're at a flea market, or a community center, or an arena, or a gun show in any location they are required to do the background check before they transfer that firearm to an unlicensed individual.

No background check is required when an individual who is not an FFL transfers a firearm, so a private collector for example. Say it's an individual who owns fifteen or twenty firearms, and they're a collector, they're an enthusiast, there are three or four that they want to get rid of because they now have their eye on three or four more they'd like to buy, so they go to one of these exhibitions, or arenas, or county fairgrounds that's hosting a gun show, they rent a table from the gun show coordinator, and they sell their private collection at that gun show. Those firearms are not required by law to have a federal background check, or a background check like a federal licensee has to do.

So, the question becomes then is that

person a private collector or is, or are they a firearm dealer, and there is a book written by the AFT that tells you whether they are or not. And I would not be the authority on that, so we would, we don't make that call at FDLE, that is an ATF question.

The Florida Constitution, however, provides that counties may enact an ordinance that requires a background check when the sale occurs on property to which the public has the right of access. And that is -- the intention of that, the spirit of that is to close that loophole, if you will, where private sellers are side by side, table next to table with FLLs, and they're selling their firearms, and that individual who knows he or she is disqualified walks into that gun show where they know there will be private sellers and looks and says, oh, that's an FFL, I can't buy gun there, here's a private seller, I'll go to this private seller and I'll buy my gun there.

So, the county ordinances are meant to close that loophole, and say even if you're a private seller at one of those events you must do a background check before transferring a

firearm, and those background checks have to be facilitated by a federal firearms licensee, or an FFL. That same constitutional amendment allows for counties to also extend that three day waiting period up to five days.

This is a map. I had to modify it a little bit from what I provided earlier because Alachua County passed an ordinance just recently. There are ten counties that have ordinances that either require the background checks on the property which the public has the right of access or extend the waiting period. The counties in blue have a three-day waiting period with a county ordinance, and the counties in gold have a five- day waiting period with their county ordinance. These ordinances are enforced by the counties by code enforcement, by the deputies. They are not enforced by ATF or by FDLE.

And I'll be glad to answer any questions.

CHAIR: Commissioners, anybody have questions? Okay, I do. Would you go back for a second to Slide 4, I'm sorry Page 4. I just want a clarification --

MS. SPARKMAN: Which is which one, I'm

sorry?

CHAIR: It's the juvenile one, so Page 4. It's Page 4 in my book, I'm sorry. It's the one on state qualifications, disqualifications, and you talked about juvenile prohibitions, where they're disqualified. It says with juvenile prohibitions until age twenty-four or until expunged. So, does that mean that if you take a juvenile, and there's a petition for delinquency, and they are determined delinquent because it's a, let's say, a robbery let's say, and they were sentenced through the juvenile system and the judge found that they were delinquent, for that fourteen year old, so does that mean that that person is then prohibited, because it's a felony, prohibited from purchasing a firearm until age twenty four, but at age twenty five they can go purchase a firearm?

MS. SPARKMAN: That's correct.

CHAIR: Okay. And if the record for some reason is expunged earlier than that then that eliminates the firearm disability.

MS. SPARKMAN: Correct.

CHAIR: Okay. And so, but it only applies

to those offenses that are disqualifying, so let's say at age thirteen is that the kid is arrested for vandalism, is that at age nineteen, or make it easier, at age twenty-two they wouldn't be disqualified for purchasing a gun.

MS. SPARKMAN: That's correct.

CHAIR: So, it still has to be the felony, and the only different is, is that if you are adjudicated of a felony as an adult is, is that that prohibition stays in place unless something removes that disability.

MS. SPARKMAN: That's correct.

CHAIR: But it's an automatic removal of disability at age twenty-four or expungement for juveniles.

MS. SPARKMAN: That's correct.

CHAIR: And I just want to make sure that we're all on the same page with this. There are -- as it relates to the Baker Act, and we're going to hear from Judge Leifman this afternoon about the Baker Act and its requirements. There are roughly about a hundred ninety-two thousand Baker Acts on an annual basis in the state of Florida. The

absolute majority of them are somebody taken into custody for an involuntary examination, period, and anybody that is taken into custody for an involuntary examination, whether it's by law enforcement, whether it's by a mental health professional, or anybody that is Baker Acted and taken to a receiving facility for an examination, under no circumstances does that Baker Act, and that taking into custody affect their ability to buy or possess or own a firearm.

MS. SPARKMAN: Not alone.

CHAIR: Right, alone, that's what I'm talking -- well, and prior to February 14th, or put it this way, prior to March 9th when the Governor signed SB7026 is, is that there was no risk protection order mechanism in place, right?

MS. SPARKMAN: That's correct.

CHAIR: Right. So, on February 1st of this year if somebody was Baker Acted because they're a danger to themselves or others, they were taken to a receiving facility, they were kept for eight hours and released, there was no mechanism available to law enforcement to then

prohibit that person from purchasing a firearm.

MS. SPARKMAN: That's correct.

CHAIR: But today because of 7026, and because of the risk protection order process, the Baker Act itself still is not a disqualifier, but law enforcement can petition the court for a temporary, and then a final, and for up to a year, with a year extension, that person can be disqualified from purchasing or possessing a firearm.

MS. SPARKMAN: That's right. The behavior that initiate, that caused the law enforcement officer to initiate the Baker Act could be the foundation for the risk protection order.

CHAIR: Right. Exactly. So, and that's the landscape today, but prior to 7026 a Baker Act, and still today, a Baker Act in and of itself does not disqualify somebody from purchasing or possessing a firearm.

MS. SPARKMAN: That is correct.

CHAIR: And so, in the, in the mental health arena in order to be disqualified from purchasing or possessing a firearm it requires an actual adjudication, you have a few other examples in there, but an adjudication by a

judge.

MS. SPARKMAN: Right, the individual is afforded due process.

CHAIR: So, I just want to make sure, because there's a lot of misconception I know in the public on that is, is that if you ask the majority of the people in the community is the absolute majority of the people believe that somebody who is Baker Acted, that that effects their ability to buy or possess firearms, and that is absolutely not the case. And -- and it's been stated, you know, in this situation, that if Cruz had been Baker Acted he wouldn't have been able to buy that AR and that's erroneous.

MS. SPARKMAN: Right, it is a huge misconception.

CHAIR: All right, anybody -- Senator Book.

SEN. BOOK: Thank you, Mr. Chair. And -- and perhaps this is something that Judge Leifman can expound upon, but do you know how difficult it is to be adjudicated mentally incompetent by a court? Is it a difficult standard?

MS. SPARKMAN: I think Judge Leifman would be the right person to comment on that.

SEN. BOOK: Okay, I'll save my questions for Judge Leifman. Thank you.

CHAIR: Anybody else, any other questions for Ms. Sparkman? Okay.

MS. SPARKMAN: Thank you.

CHAIR: Thank you very much. All right, the next presentation is going to take some time. We have it scheduled for an hour and a half, and it's an overview of the mental health system by Ute Gazioch from DCF, and that's the presentation, that's one that we had to move from last time to this time. And it is now, I said we were going to break at 12:30. I thought that this presentation and questions might take a little longer. I don't want to start the next one because it will take us well into 1:00 or 1:30 before we're finished with that.

Lunch will be ready in about ten minutes, so why don't we -- I got about ten minutes to 12:00 now. Lunch will be ready at noon, about ten minutes from now, so why don't we try, why don't we be back here, I'll give you what we

did yesterday, I think it worked, forty-five minutes, so why don't we be back here, we'll start again at 12:45 with Ute's presentation, and then when we come back at 12:45 we'll discuss the schedule for the rest of the day. I think we're going to have to drop off some things at the end of the day because otherwise we won't get out of here until 7:00, and I know people have travel and everything else.

So, let me look at the schedule, we'll come back and talk about the schedule we begin with her presentation. But we'll break now. Lunch will be ready in a couple minutes. And we'll start again at 12:45.

(Thereupon, a recess was had, and the meeting continued as follows:)

CHAIR: Okay, we'll go ahead and get started with this afternoon's presentations. So, as we've done with the other topics we're going to start with a broad perspective of Florida's mental health system, and then kind of gradually bring it down to Broward County level, and then eventually into the specifics of what happened here, is Cruz's involvement with the mental health system. So, we're going

to begin with the presentation from DCF, and Ute Gazioch is here from the Department of Children and Families to give us an overview of Florida's mental and behavioral health system. Welcome.

MS. GAZIOCH: Thank you.

CHAIR: Thank you for being here.

MS. GAZIOCH: Thank you, Chairman Gualtieri, and members of the commission for having me. Today I will be speaking with you from a very high level about Florida's behavioral, community behavioral health system. And what that means in our terms is it includes the services that are available to our community members who have either a mental illness or a substance use disorder. So, I will not be addressing any of our state hospitals which cannot just be accessed by community members, those require court proceedings.

To give you kind of a very, very high foot overview of mental illness is that it is a medical condition. It can disrupt a person's thinking, the way people feel, a person's moods, their ability to relate to others, as

well as their ability to function on a daily basis. There are hundreds and hundreds of diagnoses that make up mental illnesses within our community mental health system, especially our publicly funded community mental health system. We usually encounter individuals who have what we call a serious mental illness, and those are usually grouped into categories such as major depression, schizophrenia, bi-polar disorder, basically those illnesses that affect a person's ability to function in the community.

Mental illness strikes men and women at about the equal rate, and it does not discriminate in terms of socioeconomic background, gender, ethnicity. Basically, anybody can have a mental illness. There are many things that affect the way our brain works. There's genetics. There's environmental causes, such as stress and trauma. And again, environmental factors such as stress and trauma, lifestyle, as well as biochemical issues in the brain. I think it's important to also distinguish that there are many different brain conditions that are not

necessarily all mental illnesses. And I think we have a tendency to lump those things together, but just to be clear there are other things that affect brain functioning, like a traumatic brain injury, which would not be considered a mental illness.

There are also developmental disorders that often get grouped into mental illnesses, such as autism spectrum disorders. They would not, also not necessarily be considered a mental illness. And it's important to make that distinction because the way that we want to treat those conditions are all very different, and they respond to different interventions, medications, and so forth.

To give you an idea of the prevalence of behavioral health conditions approximately eighteen percent of the general population has a diagnosable mental illness. Again, that can be any mental illness, so when you hear that one in five that's what they're talking about, about one in five individuals has a mental illness. Again, that's not necessarily a serious mental illness. When you start talking about a serious mental illness those numbers go

down pretty drastically, and we talk about one in seventeen, which comes out to just a little less than six percent of the population.

About twenty million Americans had a diagnosable substance use disorder last year, and about eight million had both a mental illness and a substance use disorder, so you often encounter individuals who have both mental health as well as substance use conditions.

In terms of children, children have, there are some diagnosis that can be used for both adults and children, then there are some diagnosis that are specific to children. They are called, you know, conditions of childhood. And then there's some diagnosis that we typically don't use until after the age of eighteen. But it's estimated that about thirteen to twenty percent of all children have a mental disorder, and we know that most mental illness starts by age fourteen.

So, I know in the pervious presentations, one of the themes that I heard over and over, which I'd like to also stress, is that it is very important that we, we screen for

behavioral health conditions early, because like most other illnesses, and chronic illnesses, the earlier we can detect something, intervene, and treat, the better the trajectory is for that person over a lifetime.

I want to also talk about stigma of mental illness just a little bit, because I think it has a huge impact on how people seek treatment, and how they often try to hide their conditions. People think that if they have a mental illness that they are crazy, and that people will label them as crazy. You know, there's two thoughts of school, there's a school of thought that thinks mental illness is not a real thing, people are faking it, they're making it up, and if they just wanted to, they could fix their behaviors. And then there's another group that thinks once you have a mental illness you can never recover, that's it, we should just lock folks up and throw away the key. And really none of those are accurate.

A lot of folks also think that children don't suffer from mental illnesses, but they do. And for the most part, you know, I think

it's a human condition that we often lack inside, so most of think that it would not be something that would happen to us. And I think that's important to consider because I think that stigma has a huge impact on persons readily seeking treatment. It's something that they hide. It's something that families hide. You know, there was discussion the other day about parents' responsibility in this. Again, a lot of parents feel isolated if, if they think their child has a mental illness, so because of that stigma, and that shame, it really leads to people not finding treatment, and working with treatment providers.

To give you an overview of our legislative authority I'm going to be specific to mental health on this. We are governed by Chapter 394 of the Florida Statutes. The first part of that is probably the part that you are all most familiar with, which is the Florida Mental Health Act, also known as the Baker Act. This is the main legislation that authorizes the Department to designate our local community providers to receive people who have been, who are brought in involuntarily for an

examination. And we often call that being Baker Acted.

There's also sections that specifically address guidelines for children's services, as well as community adult services, and then also involuntary commitment of sexually violent predators. But we won't get into that today, we'll kind of stay in parts 1, 3 and 4. Those statutes outline the functions of DCF. We are the designated State mental health substance us and methadone authorities, which gives us the responsibility of writing administrative code, as well policy in regards to systems.

We also designate any facility that would be able to receive a person on an involuntary status. That includes addiction receiving facilities, crisis stabilization units, and also private hospitals who have psychiatric units. We allocate our state and federal funds to seven contracted behavioral health managing entities. These are the agencies that are responsible in their geographic area to contract with private providers who actually provide any of our prevention, treatment, and recover services.

And I want to -- one of the things that I want to really bring across today, that this is only part of the behavioral health system. The managing entities are the folks who contract with agencies with our state dollars, and those are general revenue dollars, those are federal block grant dollars, but there are multiple ways that behavioral health services are paid for that are not all necessarily within this structure.

So, for people, for example, who have Medicaid, you know, they would not be funded through the managing entities. Individuals who have private insurances would not necessarily go through the managing entities unless they needed a service that those plans would not pay for, then the managing entity could fill those gaps. So, basically, what we provide is the safety net. We provide services for those individuals who are indigent, or who are under insured, or not insured at all. And to, to ensure that, you know, folks that can afford care we work on a sliding scale system.

So, as I said earlier the Department, we also promulgate rule, as well as policy, and we

are also the licensing entity for all substance abuse services. The managing entities were established in statute in 394.908(2). We were fully implemented around 2012, so depending on how you look at it, I look at it as it still being fairly new, but some people might say they've been around for a while. I think, you know, we're still in that, in that process of all, you know, from the Department having had hundreds of contracts to moving to managing entities it's been a, it's definitely been a process. But I think we're finally in a place where our managing entities, you know, really have a grasp of their system of care, and are starting to ensure that, that those gaps are being filled.

They are nonprofit corporations, and they are the ones that manage the day to day operations of that behavioral health care system. And just this gives you an idea where the seven managing entities are. And Broward is actually the only place where a managing entity does not facilitate services in one of our working regions. Broward actually has their own managing entity, Broward Behavioral

Health Coalition. And I know that you'll meet that CEO, I think later, Ms. Sylvia Quintana.

In terms of again the populations we serve there is that factor of, of not being able to pay for your care, or your care not being covered by one of those insurance plans. We do concentrate primarily on those individuals who have a serious mental illness. Those priority populations are outlined in statute. In terms of children it's a lot more broad. We can serve children who are at risk. We can serve children who have an emotional disturbance, and those who have a serious emotional disturbance. And then obviously individuals who have substance use disorders or are at risk.

We do have priority populations within that. Obviously when you work within limited resources you do have to at times prioritize, and for that, for those purposes our priority populations are pregnant women and parents with substance use disorders, obviously because of the risk that substance use conditions pose on small children. And we also very much focus on intravenous drug users, obviously also because of the potential of, of death and overdose, and

so forth, to give you an idea of how many people we serve, last fiscal year almost three hundred ten thousand people were served through our managing entities, and then below that you'll see a breakdown in terms of mental health substance abuse adults and children. Don't try to add those up, they will not add up to three hundred nine because folks can move between areas. So, if a child turns eighteen and moves in to the adult system they were counted in the adult system and in the children's system. But the actual distinct number of people served is that three hundred nine thousand four hundred fifty- one. So, again, this is not all the people in Florida that receive behavioral health services, this is only the number that the managing entity has served.

In terms of budget you'll see that our community behavioral health budget for last year was just over $720 million. A little over five percent of that goes to operations, and that includes DCF's operations as well as the managing entity operations. That also includes things that we don't consider services, such as

training, the Baker Act reporting center, which is where the Chair got his numbers earlier in terms of the number of Baker Acts, which last year were actually, went up a little bit, and were about around a hundred and ninety-nine thousand, the examinations that were initiated. And then you can see what our funding is across the state, and you'll see that Broward received just a little over $57 million for their services.

Again, there are multiple funders which the behavioral health system, which makes it a very complex system, especially because people don't necessarily fall into the funding stream that they are. So, if you have a child with a serious emotional disturbance and they need very intensive in-home care, parenting support, and you have private insurance, it is very unlikely that your private insurance is going to pay for that level of care. So, it becomes very complicated at the provider to keep all this straight, because most of the providers within our network are, they have some of their funding through us, through DCF. A majority of them are Medicaid providers, so they accept

Medicaid. You know, some may take all of the plans, some may take some, and then there's also private insurance considerations.

Some counties have county funding that they fund programs with. Some counties have children services councils. Some people get grants from private organizations. So, in terms of funding perspective it's, it's all these fund sources, and the providers piece together all these buckets of money, and then try to provide whatever is needed in that community.

In terms of access, especially for children a lot of referrals come through pediatric settings. If those pediatricians do thorough screenings and have referral relationships with providers. Also, many people with behavioral condition get all their care through their primary care physician. So, we talked a little bit earlier about twenty percent of the population having a mental illness, and then we looked at the three hundred and ten thousand that were served, and clearly there's a lot of people who have a mental health diagnosis who are getting their

treatment in a pediatric setting. There are also many who never ever get treatment for their behavioral health conditions.

But pretty much our goal is to have an open- door referral process where it does not matter where the referral comes from, that wherever folks are calling, that that place will actively connect people to where they need to go. I think that's an area that we can definitely do a lot better in, but that is the goal, that if folks need help that they have a place to go, and they're not being told, oh, sorry, we don't take that insurance, and then it's just a click. That -- that we care, coordinate, and get folks to the places that they need to go.

In terms of the community service array, it looks very similar between the adult system and the children system, and if I had a pointer I would put a little imaginary line between the CSU and the State treatment facilities, because really what we consider the community system kind of stops at the CSU level. So, we start with prevention services. For substance use, there's actually evidence-based programs that

our managing entities fund in the school systems, or with our anti-drug coalitions to provide prevention services for substance use.

On the mental health side, we talk more about behavioral health promotion, and wellness promotion, and talking to families when their kids are very young about how they can help their children have social and emotional, what we call social and emotional health, meaning they're able to socialize with others, they're able to manage their emotions, their anger, their disappointment, and so forth.

In terms of if a child does need treatment the lowest level of care is outpatient, and that's typically bringing your child to a therapist in a, in a therapist's office, whether that's a private therapist or within one of our community behavioral health providers. That can also include medication therapy, seeing a doctor. If a child requires more intervention than that we start going to the community support model where we're doing in home visits, and really our goal is to ensure that we are meeting the family where they're at, so you'll see -- and Henderson has

always done this, where there are in-home programs, literally they'll go to people's homes at 6:00 at night, they'll go to homes at weekends. They'll -- they'll do basically whatever it takes to make it as easy for that family to be able to receive those services, because, you know, families have lives. They have to go to work, and those hours don't always match with, with outpatient type hours.

For children specifically, we've also implemented community action teams throughout the state, which are very intensive in-home services. And one of your commissioners is actually the creator of that model. That started, when did it start, about five years ago with a few teams, and with the funding this year we'll be able to scale that up to forty teams across the state. So -- and basically those are self-contained teams that included a psychiatrist, therapist, case manager, flexible funding, to wrap that family as tight as possible to provide whatever they need when they need it, twenty four/seven access, coming to the home to hopefully provide that family the support to learn how to work with their

child within that setting. Because residential setting, you know, are important, and that's the next highest level, but unfortunately what happens is children get better, and then they return to the same exact environment that they came from, and nobody has really worked with that family.

And you'll see the adult system works very similarly for adults. We don't have CAT teams, but we have assertive community treatment teams, those are our fact teams for, for folks that probably wouldn't make criteria to be in a locked state mental health treatment facility but we're trying to keep them in the community. Again, that twenty-four/seven access, somebody is on call at all times, and can respond to the home at all times.

And then we have our, in the community setting our highest level of care, which are in- patient beds and crisis stabilization units for individuals who are in a mental health crisis and need to be somewhere safe for a few days, sometimes longer, and then hopefully will be brought back to the community.

As I'm speaking about this I just, I just

want to make sure that we understand the purpose of a crisis stabilization unit, because it didn't just come with this tragedy, but for a long-time people say, well, why weren't, weren't they Baker Acted, they need treatment. A crisis stabilization unit is not really long-term treatment. It is literally what the name says. It is a crisis stabilization. So, if you have a person who is either an imminent threat to another person or themselves you want some place where they can be safe, they can be evaluated, given medication, short term counseling, so forth, but it's not a long-term solution.

So, you know, I just don't -- I just don't want anybody to think that people recover on a CSU. Again, this is, these are chronic illnesses that take long term treatment, long term supports, and that is not what a CSU can do. On the reverse, if folks are put on crisis stabilization units that really don't need that level of care you can do a lot more harm than good. You can actually harm that person, because as you can imagine they can be, most of the time they're not, people think they're

scary places, but it is very unusual to see people with a serious mental illness when you don't have that serious mental illness, and you are locked up with them for the next three or four days.

CHAIR: While you're there will you just explain the interplay between the receiving facility and the CSU so that everybody has an understanding of that?

MS. GAZIOCH: Sure. So, CSUs are usually designated as a receiving facility, so in order to receive somebody, or accept somebody for an evaluation, you must be designated that, on an involuntary basis, you must be a designated receiving facility. So, when a law enforcement officer, for example, and close to fifty percent of all involuntary examinations are initiated by law enforcement. The other half usually is by the mental health professionals who are licensed to do so, and just a little less than two percent are initiated by the courts.

So, the designated receiving facility literally, I also think that's another misconception, that people think that if

somebody has been, a Baker Act has been initiated, that they're going to be admitted, and actually the initial initiation is just for the examination. So, that means you will take them to a designated receiving facility and they will be screened by a mental health professional, looked at to see if they actually meet that criteria.

If they do not meet the Baker Act criteria, they will likely be released. In a perfect world, in good practice they wouldn't just be released to the street, there would be care coordination, there would be services followed up in the community, because logic would dictate that even if you don't meet criteria if you were taken there there's probably some, you probably need some help.

There are always those outliers. I've seen people brought in in custody cases where, you know, one of the persons called the cops on their wife because they wanted the kids, and they wanted a Baker Act on the record. I've had a kid dropped off because the parents were going on vacation. I ruined their vacation when I called them and said you need to come

back, he doesn't meet criteria. So, there's always those strange outliers, but for the most part if people are brought there it's for a reason, and even if they're not admitted they really should have some kind of follow up plan that happens at the receiving facility.

So, the first thing that happens is that, you know, initial assessment to see if that person really meets criteria. Does that answer your question, or did you want me to -- okay.

Okay, so in terms of Broward Behavioral, again they are the managing entity in Broward County that is funded to administer the safety net of behavioral health services here. They contract with a variety of behavioral health providers, and they partner with many of the community stakeholders. The fifteen-network provider there is, is mostly mental health providers. They actually contract with over thirty, because they do, you know, there's also substance abuse providers, peer coalitions, other places that they, other providers that they contract with that provide services.

Broward County actually is one of the more robust counties in Florida in terms of funding

sources, and in terms of service array. I actually grew up here, so this is the county that I was used to, and the provider system that I was used to, and when I moved up north I was shocked to see how much we actually, you know, we always complained in Broward that there's not enough until I went somewhere else and said I would never complain again.

So, Broward County has a number of providers. Obviously, there's a lot of folks who have commercial insurance here, folks that are covered by Medicaid, Medicare. Broward Behavioral Health Coalition is very ambitious in terms of applying for additional grants to bring other resources into the community. The County has designated behavioral health funding. Broward has a children's services council that pays for, for things. And then obviously there's always the other state agencies. DJJ provides a number of behavioral health programs to the juveniles that they serve. The educational system, schools have a certain level of therapists. And that's all a good thing, but that can also create challenges.

And again, one of the themes that I picked upon in previous speakers is connecting those dots. When you have so many entities providing services you can start having silos, and then the communication doesn't get shared. So, you may have a therapist at the community behavioral health center, and they're working on things, you may have a school therapist that you're seeing, they may not even know about each other, or talk to each other, so that is definitely one of the challenges that we have in our behavioral health system, is silos within systems that don't often, or, you know, sometimes they do, sometimes they don't, but the sharing of information and being able to connect those dots becomes very different.

One of the other challenges I think that we experience is that there are these arbitrary lines between the children's system and the adult system. We have the age of maturity, which is eighteen, which makes somebody a legal adult. It doesn't necessarily mean that they're mature, or that they actually are an adult, but the way that our systems look at it, diagnosis differ, level of acuity differ. So,

you can have a seventeen- year-old who is in services, has met medical criteria, definitely needs to be there, and suddenly at eighteen that diagnosis no longer makes them eligible for adult services. So, we definitely have issues around transitions.

Their service models differ. In the children's world you have a lot of emphasis on family-based programs, where in the adult world we suddenly, we don't engage the family as much as we do in the children's world. And there's obviously developmental considerations. When you talk about teenagers, eighteen-year olds, you know, turn eighteen, you know everything, you can fire your therapist, you don't have to go to your program anymore, and they were wrong anyway, you know, then that stigma comes in, I'm not crazy, I don't have a mental health issue, and we lose them.

And I think as a system it's our responsibility to figure out how to better engage this, this group of individuals, because at the end of the day that's what we should expect based on their developmental milestones, and, you know, I think that's part of our

responsibility, and our job, is to engage, and to build that trust and rapport, and make them want to come back, and make them want to be part of our, our programs.

And again, I think that brings us to some of the keys of effectiveness. One of the most important things that I think we need to think about when we treat, whether it's children or adults, is that we match the intervention to what the need is. And that's difficult, and it takes a lot of assessment, and it takes a lot of thoughtful assessment, because I can show you four people with the exact same diagnosis and they'll all be on different medications, and what worked for the first person absolutely didn't work for the second, maybe worked for the third a little bit, but you really have to spend a lot of time looking at the function of someone's behavior.

Behaviors will always have a function. There's always a need. There's something that's met with the behavior, and regardless of diagnosis that's different for every kid. So, I think we always talk in terms of programs, and I heard a lot over the last few days that

magic wand, unfortunately there isn't a magic wand, you really have to do the work, and you have to assess well, and then you have to figure out the motivation, how to engage that individual, and then match that individual to the right intervention at the right level.

Also, in terms of losing that communication, and being able to connect that dots, we really, one of the keys to effectiveness is, is effective care coordination, and having that one person that has accountability for making sure that all those other systems are talking to each other. So, care coordination, case management, those things are absolutely integral, because when you start looking at kids who have serious emotional disturbances, or adults with serious mental illness, they never have just this one issue, right.

They come in contact with the criminal justice system, now they'll have either probation or parole officers. They come in contact, you know, they usually have issues at school. Usually there are a lot of family issues, so you may have child welfare engaged.

And again, if all those silos work separately, you know, your chances of success are very low. But if you have very good care coordination, and you have people who connect those dots and make sure that everybody on that team is at the right, on the right page, and you're engaging that child and their family in your decision making to get their buy in, and their engagement, your outcomes will likely be much better.

And again, to not think that we cure people, people get better, people definitely recover. I'm willing to bet that everyone in this room either works with somebody or knows somebody that has a serious mental illness, and you don't know, that they have that serious mental illness, they function well, but, but there needs to be ongoing support, and there needs to be places that people can go to get that support.

Again, those challenges, multiple issues that overlap, it's never one thing, which also means there's never just one answer. The silo systems, communication, again different funding types and different rules. What Medicaid

requires may not be what the state requires, which is totally different than what insurance requires, and, you know, if you're a parent with a child that has special needs, or if you're a person with a mental illness whose frustration tolerance is probably not as high anyway, these are very different systems to manage, and again a care coordinator or case manager can really help navigate that system.

An effective engagement, again it's different, whether it's with, whether it's stigma. When you start getting into more of the adult diagnosis like thought disorders, schizophrenia, and those things where people do have paranoia, or they do have hallucinations that tell them that you're the devil and you really shouldn't talk to them, those are very real for that person, and again that, that, you know, we have to figure out how to engage those people and make coming into treatment worth their while.

I won't spend too much time on the Baker Act because I know Judge Leifman will be here. But again, the number one purpose of the Baker Act when it was first conceived in the 1970's

was actually to protect individual's civil rights. It provides for a place for persons to have an assessment and stabilize, again, the crisis. It's not long-term care. It should really stabilize that crisis, and then help navigate the community behavioral health system for that person, so that they can go into the community and have services in place almost immediately, because the crisis is usually not a hundred percent over once somebody leaves the CSU, but they no longer meet that, you know, that threshold that, that of an, of an immediate danger.

It does say that we have to use the least restrictive form of intervention, and it does provide for voluntary and involuntary examination and stabilization in in-patient and out-patient settings. So, the law does allow for out-patient orders as well, but they are not widely used throughout the state. And again, it is a constant balancing act between somebody's rights and liberties, because it is the only time that we allow somebody to be locked up against their will when they have not committed a crime. So, there is that balance

between their civil liberties and the safety of the community, and the safety of that individual.

Again, that criteria, it was discussed the first day we were here, that number one, the person does have to have a mental illness, so that is kind of what everything else flows on, you know, follows. So, it kind of makes sense, for example if somebody is a threat to somebody else, who has harmed somebody else, and they don't have a mental illness, they should really, they've committed a crime and they should go to jail. So, that mental illness is kind of that first threshold. Obviously for police officers, there's no expectation that a police officer would have to do a full diagnosis and know, so it's basically a reasonable suspicion that that person has a mental illness.

Also, police officers, it's a little bit different. They have a little bit more, they're the only ones that can make the determination based on witness statements, whereas a mental health professional actually has to hear and see the behavior that would

lead to their decision that the person meets this criteria.

Again, the first step is always trying to get that person into service voluntarily, or see if willing family members, community members can help, but if that person refuses, or they're unable for themselves to judge, then the Baker Act can be initiated.

There has to be a decision that without that treatment that person is likely to suffer from neglect, or refuse to care for themselves, and usually you'll see that for person with schizophrenia, or another psychotic disorder, where they may not be harming themselves or others but they haven't left their apartment in two weeks, they haven't showered, they're not eating, they may think their water is poisoned, they may think their food is poisoned, so clearly there is a serious threat to their well-being because of their mental illness.

Or that there is a substantial likelihood that without that treatment the person will cause in the very near future serious bodily harm to themselves or others. And again, there should be recent behavior, and again law

enforcement can actually take statements from family members and use that as evidence, whereas a clinician really has to make that determination themselves.

The involuntary examination period is up to seventy-two hours. That's an important thing to note, it's up to. If the person at any point during that seventy-two hours no longer meets criteria they have to be discharged. So, that could happen after fifteen hours, sixteen hours, or hour seventy-one. If the person continues to meet criteria, the first thing a receiving facility would do is ask that person to sign in voluntarily. If that person does not, when they refuse, and they still meet criteria that receiving facility will initiate a petition for involuntary treatment with the courts.

Once they are filed, once that is filed they can hold the person beyond the seventy-two hours, and then there will be a court hearing, at which point a judge will determine whether criteria has been met. There has to be a second opinion by either a psychologist, a licensed psychologist, or another medical

doctor. So, again if, if they no longer meet criteria they must be released. If -- if the involuntary examination was initiated while the person was in the process of committing a crime they need to then be returned to law enforcement, and again if not, they just need to be released, or a petition has to be filed with the court to keep folks longer.

Any questions about that, because I know the Baker Act has been a hot topic?

CHAIR: You know, we'll have Judge Leifman here in a little bit, and I'm sure he'll go into it in great detail on the Baker Act, so.

MS. GAZIOCH: Okay. Okay, great. So, what we'd like to see in the children's system of care is that it's a coordinated network between community providers, schools, juvenile justice, primary care, that families, like I said, are engaged, and that they drive their treatment. They really need to be a part, and an active member. They have a responsibility in this, just like the provider does. That it's culturally and linguistically competent. That's another reason why we see drop out, or a lack of engagement. If you don't speak the

person's language, it's difficult to engage or do anything. And that we have an array of services that really meets the need of, of the people that we serve.

I think what we, what we do see a lot is that we create programs, and then we try to fit the people into the programs rather than figuring out what that person really needs and finding the services that, that they need. And -- and I think that's where you see a lot of drop out, because the person is not actually getting what it is that they need.

So, again, that services are individualized and least restrictive. Again, you can do harm if you put people into a service level that they're really not meant to be in. That we meet the needs of young children. I think also that is an area we can do better in, again, that early screening, and those early interventions, and facilitating that transition to adulthood.

Again, the CAT programs I think have shown great promise in working with kids, specifically kids that have multiple issues and, and serious emotional disturbances,

because they are team based, they are completely family focused, so they're not just working with the child and then returning that child into a family that may not be very functional. They work with the entire family. They can work with siblings and uncles, the more the merrier.

They have several professionals on the team, but they also have paraprofessionals, so they have peer mentors, and people that the kids can talk to that's not therapy. And again, the goal is to keep kids out of residential treatment and keep them within their family unit, and help that family unit deal with that, that child, because that's challenging, right, and your traditional parenting may not work with a child that has a serious emotional disturbance.

Other programs that we're introducing are coordinated specialty care for early serious mental illness, again trying to, especially for individuals with schizophrenia trying to identify young people. Usually schizophrenia that first break is in the early twenties, and we went to make sure that we catch those people

during that first break and intervene immediately with the right medication, the right peer supports, the right therapeutic supports so that we can change that trajectory. So, hopefully if we can keep that first psychotic episode as short as possible, intervene, those people are much more likely to be successful and become a productive member of our society.

And basically, Broward County has both of those. As a matter of fact, the coordinated specialty care team here in Broward County was actually one of the first that was in the original RAIS study, which is the study that went on for multiple years to look at these interventions and see how successful they are for persons with their first psychotic episode.

Again, you know, I think our providers do a lot of things well, you know, I think they're constantly looking to engage folks better. They're working with multiple funders, all with different rules. I remember when I was a provider my notebook was this thick of every Medicaid plan, and all their different Medicaid criteria, because one will accept this, the

other won't, people switch. I mean it's -- it's very complicated, so, and their working with limited resources. But we certainly always have to look at our opportunities for improvement.

Again, timely access to care, meaning a no wrong door, especially for people coming out of CSUs, because if somebody is coming out of a CSU and their first appointment isn't for six weeks there's a pretty good likelihood that they're never going to show up to that appointment, so having something there to bridge that time.

Integration with primary care, we know that people with mental illness, substance use disorders, have a much higher mortality rate then, than others. Their medications have, have pretty substantial side effects. They tend to smoke more, so their life expectancy is on average twenty years less. So, it's really important that we integrate the primary care with the behavioral health care.

And again, that accurate assessment and service linkage, you know, we watch shows, and go, well he needs therapy, he needs this, and,

and we kind of come up with these terms that we think will fix everybody, but that's not true. Some kids do not do well in therapy. As a matter of fact, therapy is the exact wrong thing for them. So, making sure that we really look at every individual as an individual and fit the treatment to meet their needs, and that is challenging when you work within limited resources.

Again, the right service at the right amount at the right time, engaging folks and keeping them in care, because what we do know is when we do have kids that stay, and we do have adults that stay within our system of care, we have good outcomes. But one of our issues is that we lose a lot of people, where they just quit treatment, or they do their first session and they never come back.

Coordinating that care, again having that one single point of accountability that knows what everybody else is doing and can bring those people to the table. And again, lots of opportunities for improvement in the transition from the child system to the adult system.

In terms of SB7026, what it did for the

Department of Children and Families, it codified the CAT teams, those community action teams. It appropriated an additional $9.8 million so that we could establish thirteen more teams, which brings us to a total of forty. Also appropriated $18.3 million for additional mobile crisis teams. And mobile crisis teams are available twenty- four/seven. They are pretty much on demand crisis interventions that can either assist in facilitating and involuntary examination, or if that's not what that person necessarily needs helps, a crisis team can follow a person for a little while to make sure that they're linked to the, to the right services.

Executive Order 1881 asked the Department of Children and Families to convene meetings with law enforcement, managing entities, school systems, juvenile justice, and service providers to improve communication, and to foster collaboration, to also look at blended funding models. Again, when you have silos you may be funding the same thing somebody else is funding and you don't even know it. And then you, you know, people say, well, we're getting

any people, there must not be a need, well that need might, need might be there, and you can be using these resources for something completely different. So, it's really important that people get to the table and talk to one another and coordinate.

It also allows the Department to provide criminal justice mental health and substance abuse grants to law enforcement agencies and sheriff's offices, and mandates that all the managing entities have law enforcement representation on their boards.

At this point the first Executive Steering Committee convened already, and basically the regional offices, the Department's regional offices are holding their circuit meetings, pretty much as we speak. Most of the regions already had their initial round of meetings. Broward's first meeting is actually on Monday. So, the expectation is, is that the circuits will put together recommendations that we will put into a report in terms of improving, meeting the behavioral health needs of the community while we're meeting the public safety needs of the community. And those

recommendations are due to the Governor on January 1st of 2019.

And that's it. So, I will now open it up for questions.

CHAIR: Questions, Chief.

CHIEF LYSTAD: I just have a question as it relates to the silos and the informations. So, if I have a child that maybe comes into law enforcement contact and gets baker Acted in Fort Lauderdale, the child lives in Hollywood. And so, the Fort Lauderdale Baker Acts him. In Hollywood he's being seen by his primary care for a mental illness. And he goes to school in, let's make it Miramar, and the school psychologist there is also seeing issues. Do all of them see each other's information, or no?

MS. GAZIOCH: No, not necessarily.

CHIEF LYSTAD: And is that a HIPAA issue?

MS. GAZIOCH: It is HIPAA. It is a HIPAA issue. But I will tell you this, you know, one of the things that I think, and this is my personal opinion, one of the things that we can definitely do better with is making sure when any kids or adults come into our system get

releases of information. That is your -- it's the easiest way, I mean that is really what HIPAA is about, that person is giving you permission to share that information. I spent sixteen years in direct care, and I can tell you the only blank forms that I carry to every home visit, that I had in every folder, were releases of information, blank ones.

And, you know, when you, when you do that, that's part of a really good assessment process. So, when you first see that child -- so if that child comes into the CSU, right, that CSU best practice would dictate that they ask the family questions. Now, again it does require that the family, you know, provides that information, but they should be asking are they seeing a therapist somewhere. And then there should be a release of, you know, the next thing should be do you mind if we share information, and you talk about the importance of coordinating those services.

In my experience, again that's just my personal experience, I would say in all the years I've practiced I think I had two people refuse to sign releases, and one person take

their, you know, release back because they didn't want their mom to know something, they got mad at her. But for the most part really that's a practice that we need to talk about more, because if you have a signed release HIPAA no longer is an issue.

CHIEF LYSTAD: Okay, but even with a signed release there still would be no central clearing house.

MS. GAZIOCH: No, there's no central clearing house. It would require those two providers to speak to one another. One would have to reach out and, and yes, there's no on central place where there's records or anything like that. No, it would require communication.

CHIEF LYSTAD: All right, thank you.

CHAIR: Commissioner Petty.

MR. PETTY: Thank you, Mr. Chair. My question, I think there's just one, it may be a two part, we'll see, but it goes to this transition from adolescence to adult care. Does DCF -- the first part of my question I guess then is does DCF have a set of recommendations that you could share with the commission about best practices, or things that

need to change, or regulations that need to be modified, or laws that could be created that would improve this transition period?

MS. GAZIOCH: Sure. I don't have anything readily available, but we can certainly work on that and, and get that to you.

MR. PETTY: Mr. Chair, is that something we could entertain? Okay. I guess the -- the second part of the question would be are there, outside of DCF's recommendations are there industry, state, national best practices that, that you're aware of that we are not doing currently in Florida that we could or should be doing specifically around this transition?

MS. GAZIOCH: There are -- there are some best practices around independent living programs. SAMHSA currently has a grant, and actually Florida operates one Hillsborough County that addresses specifically the needs of transitional youth. It's called the Healthy Transitions Grant. That particular area has seen very good outcomes. They're using a lot of social media, texting type of interventions, and peer interventions.

I didn't talk much about peer services,

but peer supports is something, it's basically a person who has lived experience, they're in recovery, and then they go through training and certification to become certified peer recover specialists, and, and we're really hoping to increase the utilization of those in our systems of care, because in this program, the Healthy Transitions Program, for example, they have youth peers, and they do a great job of engaging kids that have literally been living on the streets that have either run away from home or left the child welfare system at eighteen not wanting to have any contact with adults or, you know, basically like I'm done with everything, I'm leaving.

And they've been very successful more through media and, and peer services, not necessarily formalized therapy, but to engage those youth, provide them with care coordination, and really work with them on getting jobs, finding stable housing, and, and those type of things. So, yes, I can definitely get you some information on those practices.

MR. PETTY: I guess then my, my request,

Mr. Chair, would be to get a set of recommendations from DCF, and including sort of industry best practices around this transition period from adolescents to adult, adulthood, and what we should do there. I have one more question, if that's okay.

CHAIR: Yes, absolutely.

MR. PETTY: When -- when a child enters the, the system of care, and the family is less than cooperative, or doesn't want to cooperate, or refuses service, or is an impediment to care, what, what can be done, what's the procedure, what happens?

MS. GAZIOCH: There's not a formal procedure. You know, if they're -- like it depends to what level. So, for example, if a kid was prescribed medication and they're refusing to give it you may make a call to the abuse hotline for, for medical neglect, but that's pretty far- fetched. Again, I think -- I think providers, and there are some that do this really, really well, it's about not giving up.

Figuring out, you know, continue to work with that family, you really have to have kind

of a never give up attitude, and you really have to meet with those parents and figure out what it is that you can do for that family that will again engage them, you know. And I think there ways to do that. There are strategies to do that. It's a lot of times not maybe starting with what you can there for and helping them resolve whatever it is that they're going through.

Again, families have multiple needs, so if you're coming in and saying, hey, you know, we're here to do family therapy, and that parent may have a mental health issue of their own, that parents might have serious financial issues, that person might be going through major marital issues. Again, looking at why is it that this person doesn't want me here, and figuring out how to address that.

MR. PETTY: So, I thought I had one question, I actually have more. In this case we've heard that, and again we're still hearing more testimony, but that there were recommendations against Cruz having access to weapons, and it, and it sounds like, at least from what we know so far, right, that, that

Cruz's mother allowed access, or sort of against the recommendation of mental health professionals.

What is the best practice or procedure for a mental health professional that becomes aware of either the patient or a family member contraindicating what, what the recommended treatment should be, or the recommended plan, or program, or whatever? And I'm trying to be very specific because this is a, this is an issue obviously of life and death, potentially imminent harm to that person themselves or to other people, in the case of weapons and things like that, so what should happen?

MS. GAZIOCH: Well, if there is imminent harm, so if, and again you do have to follow the statute because of the issues of civil liberties. But if there is imminent harm the Baker Act would be the avenue to use. So, if that person -- but again, you know, you have to meet that standards that's in the statute. So, for example if, if there's a fight in the home and a child threatens their parents, you know, the mobile crisis team goes out. At that point they're able to deescalate the crisis, and at

this point the child says, no, no, no, no, I'm not going to hurt them, I was just angry, he no longer meets that criteria.

So, you know, at that point however there should be linkages to services but be perfectly honest I am not aware of any actual procedure that a provider, or any kind of anything that the provider can do legally to force a parent into services.

MR. PETTY: So, the crisis team comes out, there's an evaluation made. Is law enforcement part of that crisis team?

MS. GAZIOCH: Different models -- different areas have different models. Some crisis teams go out by themselves. Some crisis teams have partnerships with law enforcement where they say, you know, they'll go out by themselves sometimes, and other times depending on how volatile the situation is they may ask law enforcement to accompany them for safety reasons, but there's not one set rule around that.

MR. PETTY: But law enforcement is the only one, I think you testified that law enforcement is the only one that can make an

independent recommendation based on witness statements, and things like that. So, if law enforcement is not there there's really not much the mental health professional or crisis team can do?

MS. GAZIOCH: It's a clinical decision, so if there's a licensed practitioner on the crisis team, you know, they, if they're observing the person is still agitated, and they might be saying one thing, but their clinical opinion is this person is still a danger, they, they still can. But they have to see that. They have to see the actual behaviors, they have to witness it.

MR. PETTY: But -- but who do they go then if they believe there's imminent harm?

MS. GAZIOCH: They could initiate involuntary examination, and then they would call law enforcement to do the transport, to --

MR. PETTY: And in the case of -- the case of the child if the family refuses, can they refuse?

MS. GAZIOCH: Baker Act, no.

MR. PETTY: Okay. All right.

MS. LARKIN SKINNER: Mr. Chairman, may I

answer from a provider point of view what my center's policy is?

CHAIR: Yes, go ahead.

MS. LARKIN SKINNER: So, I've Baker Acted a number of people involuntarily in my career, and in situations where maybe I didn't do a Baker Act, or I did do a Baker Act and then somebody ended up in my hospital, and one of the things that they were talking about is that they were going to harm someone else, in the past we would notify law enforcement, and if we knew they had guns, or if we heard they did from family, or from them, we would notify law enforcement.

But my understanding before the law, the recent law change, law enforcement's hands were tied unless the person voluntarily surrendered those weapons. Not that the law has changed our procedure would be the same, but law enforcement has been given the power to remove those weapons.

CHAIR: Senator Book, go ahead.

SEN. BOOK: Thank you very much, Mr. Chair. I have a question, because you brought up something interesting about when does a

parent, when can a parents' issue, how, how do we trigger the next level. And I think in Commissioner Petty's example about if you know there's weapons, maybe they're not an imminent risk, would you suggest, perhaps if you didn't have certain policies or procedures in place, a call to the abuse hotline, because that would trigger an investigation from the Department.

MS. GAZIOCH: I'm not sure that I would recommend, I think that the policy that was talked about here now, that there is, that police have the authority to remove weapons, if that's the case I think our providers, if parents are not willing to remove weapons, I think if they think even, even if there's not an imminent harm right now, and they don't meet Baker Act criteria, I think it would be good practice for that provider to go ahead and call law enforcement to verbalize their concerns about weapons in the home, to see if those can be removed based on the protective --

SEN. BOOK: In this case --

MS. GAZIOCH: -- the new -- the new language.

SEN. BOOK: In this case though I think

that one of the things, this issue was this individual wanted to pursue weapons and the parent did not, they were not stopping that action. So, I think they're not necessarily there, but facilitating, or enabling in my, in my humble opinion constitutes neglect, abuse really, because, you know, you're allowing that individual to have access to dangerous weapons. So, that -- that was one of the one issues.

I have a question about the mobile crisis unit. I've been out with the mobile crisis unit here with Henderson to different school settings, and first for that mobile crisis stabilization unit individual to speak to a child who has expressed, in one of the cases that I witnessed, suicidal ideations, that was alerted, you know, the counselor from other students, that counselor needed to get permission from a parent.

If a parent, if that parent said I don't want you talking to my child, boom, done, correct or incorrect?

MS. GAZIOCH: You do have to have parental consent, yes.

SEN. BOOK: So, if that parent blocked

access, and that they would be sent away, and that's kind of that --

MS. GAZIOCH: Actually, in a crisis situation, a child can consent in a, in a crisis situation. And I don't have the exact language with me today in terms of when and when not a child can consent. I don't know if you can help me out, but I can definitely get that to you. But children actually do have the right to seek crisis counseling without their parental consent.

SEN. BOOK: For -- and then if you could do that, but also, and perhaps, Commissioner, you can help from a provider's perspective, to what length of time, because I also know that children can go to a school counselor, for example, one or two times I believe it is, maybe up to three, but then they need parental consent.

MS. LARKIN SKINNER: So, it's been a while since I've looked at the specific laws, and there's some confusion in it, because if a child wants treatment for substance use disorders they can get it no matter what age they are without parental consent. On the

mental health side however, which is kind of strange, they do, they can ask for it in a crisis, so then if it's no longer a crisis it can't really continue without parental consent. I mean that -- the last time I personally looked at it that's what it said.

SEN. BOOK: Thank you.

CHAIR: Just to clarify something there just -- is in this situation when Cruz got the firearm, and you said that you would think that it would be neglect, I just want to clarify something, that at that point, is that was already eighteen so it wouldn't be, it wouldn't be child neglect because he was eighteen, and what is mother facilitated was his obtaining a state ID card so that he could then go purchase the firearm, so it wouldn't be.

Prior to him being eighteen, we'll hear a little bit more about this, prior to him being eighteen what was also recommended against was he wanted a pellet gun because he couldn't have a firearm, and she got him the pellet gun. But as far as the firearm goes it was after eighteen, and he went on his own, but what she got was the state ID card, so he could do it.

Just to make sure we're, we're clear.

Secretary Senior, you had a question?

SEC. SENIOR: I just wanted to -- and thank you very much for your presentation. It's really important that people understand, and going to Page 5 of the presentation, that this system is really for people that are uninsured or under insured, and it's important that people understand what that means, and why. And I'll tell you, our agency runs the Medicaid program, and we serve in any given month more than two million children, and we cover substance abuse and mental health services for those children, and so they do have health care coverage.

Un-insurance for children is, the rate is fairly low around the country. It's a fairly low un-insurance rate in the state of Florida as well, and so the kids that are ending up in this program, we're going to learn about Nicholas Cruz obviously, he was in a program that was here to fill in a gap in the system to make sure he did not fall through the cracks.

It is possible if someone had private insurance, or if they had a Medicare health,

Medicaid health plan, that, that the scenario that the police chief gave would, the providers would be able to exchange electronic medical records with one another, and in fact the health plan might know instantaneously, the hospital would ping a system, and they would know that an enrollee had been sent to the hospital, and they can communicate with each other.

I think we need to -- in this particular system we do need to think about the handoffs, because people could be eligible for Medicaid one day and not eligible for Medicaid the next day. They are going to, in our program, Medicaid was created in the 1960's so you become an adult at twenty-one, and you can lose all of these services at twenty-one. And it's not just a matter of a hand off, you go off what's referred to as a cliff, right? You had -- our service package for kids is we cover everything that's medically necessary in unlimited amount, duration, and scope.

You know, eligibility for an adult, there are limited ways to be eligible in the, in the first place, as an adult, but even if you had

adult eligibility our service, our service package is very defined, in terms of you get X number of in-patient hospital days per year, you get this amount of physician visits per month, you get this amount, I mean it's a prescribed thing, and the, managing entities then can offer services --

MS. GAZIOCH: Beyond that.

SEC. SENIOR: Beyond that, because you are underinsured at that point. So, thinking about how these handoffs happen is, is kind of imperative, but we are, we are actually talking about kind of a different, a strange and unique situation for a child in this instance with Nicholas Cruz. It's not that common that you'd have an uninsured, or underinsured child that is above the Medicaid eligibility thresholds but doesn't have any other insurance going through this system.

CHAIR: Sheriff Judd.

SHER. JUDD: If a child seeks mental health counseling, or the parents send them for mental health counseling, can the mental health counselor communicate back with the parent about the status, and how counseling is going,

and how they are responding to it, and so forth?

MS. GAZIOCH: So, in terms of HIPAA the parent is the guardian of that child. There are things that are confidential. They may not go -- a therapist doesn't have to go into every detail of a session, but they certainly can provide a parent with updates, in terms of it's going well, he's participating, and so forth, but the actual therapy notes have a protection.

SHER. JUDD: Okay, see, that's one issue. So, you refer your child for mental health counseling and then the therapist cannot legally share with you the details of the counseling, so if the, if the child is not cooperating with the, with the counseling, you can say the child is not cooperating?

MS. GAZIOCH: Yes.

SHER. JUDD: If the child says, you know, I have these ideations about stabbing mom in the middle of the night, I don't really want to carry it out, but I think about it, can you share that information?

MS. GAZIOCH: If the -- if the clinician feels that that's a true threat then yes.

SHER. JUDD: But if they in their subjective opinion think it's not a true thing then they can't.

MS. GAZIOCH: Right.

SHER. JUDD: So, you have an environment currently where there's the amount of information that can be shared with a parent is restricted by HIPAA, and is determined with a subjective, based on their experience and, you know, their training, so they get, they have to make a subjective statement about what they can say and how much they can say, but they can't talk about the details of what's occurring.

How much of that can be shared with law enforcement, and, and I say law enforcement, that always raises everybody's flags in the mental health world, but you're having this ongoing dialogue with this child that you're helping, but this child continues to talk about, well, you know, I think about killing people, I don't think about killing people, I'm angry that my mom does this, I'm angry that my dad does this, I'm angry because, and so we've got this, this environment here, and maybe, and this particular scenario we're fortunate enough

that somebody is there. How much of that can be shared?

MS. GAZIOCH: Well, if there is a threat that can be shared. And again it's, you're right, there is clinical discretion. I mean the entire, you know, behavioral health field, there's a lot of research, there's -- but still clinicians have to make clinical decisions all the time, that is what they're trained to do.

In terms of, you know, and one of the things that they are trained to do is they should as a clinician be able to determine what, what rises to the level of, of a true threat that needs to be shared. But again, a lot of these things can be addressed in the beginning. I mean there are reasons that we have that the therapeutic sessions are confidential, right, because a lot of times, you know, we have abusive parents, a lot of times things like sexual abuse, physical abuse, are disclosed in therapy sessions, and there's an argument to be made that much of that would not be disclosed if a child thought that everything they said in therapy would definitely be said to their parents.

So, it works both ways, so again you, you're constantly striking that balance. You want that child to be honest with you, and up front with you, but one of the things that every clinician, every, every person in the behavioral health field should be doing at time of intake, be very clear about what is confidential, what is not confidential. Abuse, neglect is actually not confidential, but it doesn't necessarily be told to the parent, it has to be, you know reported to the abuse hotline.

And in that, when a clinician works with a child, and builds that therapeutic rapport, one of the things that they're usually working on is building trust between that child and the parent if it's not an abusive situation, and, and you talk to that child, and you can get a scent from that child to, to tell the parent about what's going on, and if there are truly those issues with a family then a clinician also have the duty to make a good clinical decision to say we really need to have family therapy here so that both the child and the, the parent are in the session together.

So, again, therapy comes in many different forms, shapes, sizes. It's not always just a therapist meeting with a child. Really, you know, when we do look at best practices for family, you know, which is one of the reasons our CAT teams are successful, is because it's in the family approach. Really individual therapy, especially when there are a lot of those family issues, may not be the right service for that child. You, you know, you really should be engaging in family therapy.

SHER. JUDD: Here's what we're involved in on the ground, from our perspective. The child tells us, and we're taking, we're saying a child, but it can be an adult. We get there and the child, and the child or the adult looks the officer in the eye and goes, you know, I feel like killing myself, or, you know, I'm going to shoot my neighbor, you know, if he comes back outside. And we made some of those value judgments in the past, but as of this horrible event in Broward County we take everybody at face value on their words, and we don't let them change their mind.

So, we put them into the system, whereby

now the information is not shared backwards, it may, whether it's a child -- obviously an adult is a different circumstance, but it's not shared with a parent, and we're accepting for the purpose of this argument the parents are rational reasonable people, and they're concerned, and what's wrong with my child, and then -- and we had an event on one of these RPOs recently where the guy shows up to the judge and says, oh, I was just kidding, I didn't mean I was going to shoot myself, and the judge gave him his guns back.

While we're accepting people who are not rational at face value, and I don't know if there's an alternative to that in the mental health world, and many times in the court world, and we're on, in the ground, on the ground trying to make sure the next massacre at a school doesn't occur, and somebody say, well, daggummit, you know, you Baker Acted him because they had these ideations, and mental health goes, well, we can't talk about it, and the guy shows up with a gun and starts shooting.

I think that's the frustration that we're

all at right now. And one of the -- and we'll get into it later on with Cruz, but these kinds of events apparently occur over and over, and over, and over, and over, and the copes are going well, and the neighbors are going well, and the teachers are going well we could have predicted that because we've been dealing with this person and that conduct.

So, I guess I said all that for mental therapy for me.

MS. GAZIOCH: I'm glad you could get that off your chest.

SHER. JUDD: How the -- how do we -- how do we create a process, or a system where we can get all of this, all of this individual data put together, and break down these silos, and make sure they get services, and that we are able to follow their ebbs and flows in the process?

MS. GAZIOCH: Yes, I mean the communication pieces, and the silos, like I said, I mean those are issues. Again, if you would ask my preference it would be I, I would love to see that the first contact for, for behavioral health care is not a Baker Act.

Unfortunately, currently that is one of our main ways to get into the system, but again I think if we put more emphasis on our community system, because that's where people get well. People don't get well, people get stabilized on a crisis unit, and they are absolutely, I mean they must be there, you must have that place to take somebody for safety, but I think the more we can do early on working with families and children, the quicker that we can intervene, I would hope that we wouldn't have that many contacts with, with Baker Act.

SHER. JUDD: Well, that's part of it, but how, how do we share that data, or, or track that data so that, you know, we truly don't want to know the intimacies that need to be confidential, but we need some kind of a barometer that this person is, is meandering through this system over and over, or is not responding, or continues, not to be a threat, I mean they haven't reached that, wherever that line is in the subjective world, but what's your idea about a system or a process so that we can monitor that individual without it being any kind of public record, or we can be part

of, part of the super confidential system, but those of us trying to prevent these shootings all know about these people?

MS. GAZIOCH: It's an interesting concept. Again, I think as Commissioner Senior pointed out, you know, there's, there's a data system around Medicaid that captures people who have Medicaid. Then that person loses Medicaid and now they're in our system. And at this point I, I don't have a good answer for you in terms of, of that. But you're absolutely right, the best predictor of future behavior is past behavior, so this constant, well, this one knew, and this one knew, you know, I think we have to, even if it's not data points, because we're not there yet, there yet in terms of the technology, but at least starting with better coordination between all the people that touch that person, and that would include the school, the provider, so that again whether that's a care coordinator or a case manager, but where all those pieces of information land in the same place until we have better technology to do that.

SHER. JUDD: And -- and that's the whole

-- to me that's the cornerstone of what we're trying to do here, because after the fact everybody knew he was going to do it sometime, but none of the dots ever got connected in advance, and truly the possibility is there to connect the dots, but we got to have some systems' changes, and some paradigm shifts I think.

CHAIR: Sheriff Ashley, and then Secretary Carroll.

SHER. ASHLEY: Thank you. Great presentation. I, Sheriff, Commission, I think we already have that available, and the subjectivity is what's killing us, for lack of a better word. Florida Statute 456.059 for psychiatrists, 491.47 for psychologists, 491.147 for social workers, all protects those individuals from civil liability for divulging privileged communication in suicidal and homicidal patients that, that express a threat, that I want to kill my neighbor, I want to kill my mom, I want to kill. They're all protected from divulging the information. They can call us and tell us that.

The subjectivity comes in, are they

serious or not when they make these threats to us, when they make these statements to us as service providers, and there is no mandate that says you have to call law enforcement and say that this subject is suicidal, or homicidal, and is threatening to kill this person or that person. And I think we as a commission could certainly make that recommendation that that should be a mandatory report if you're suicidal or homicidal, that law enforcement should know that in order -- you know, we put intel flags on people all the time when we respond to residences that they've got this issue, from universal precautions to violence, to the like, so I don't know why we wouldn't do that when an individual actually expresses that threat, and take them at their word. So, just that point.

CHAIR: Secretary Carroll.

SEC. CARROLL: Just from a little bit different standpoint, the slide that Ute originally showed around the stigma, half of the issue we have, or a big challenge we have in getting folks to engage in mental health treatment, particularly with parents of children who may have a mental illness, is

they're reluctant to have their child stigmatized, so they, rather than seek treatment they hide it. And so, we want to find a way to get these folks to bring kids voluntarily to get treatment, because we believe the earlier the better.

Most practices would tell you that if you have a mentally ill child you better have some family therapy attached to that counseling for the child, because the parent needs to develop the skills to parent a child with a mental illness or behavioral disorders. What we see a lot with kids early on, before they're diagnosed with a serious mental illness, is you have behavioral health issues, conduct disorder, that type of stuff that you see start displaying itself.

The only way that we can address that, we can bring a kid into counseling, but you have to have the parent there at the table because they have to have the skill to begin parenting in a way that sets consequences, and helps that child, kind of like behavioral analyst approach to, to raising a child, so -- and I think we try and do that more and more. We don't have

enough services on the street to do that quite frankly.

We have -- we talked about these CAT teams. Five years ago, we had none. Commissioner was the first to have one. We now have forty-two. I would tell you we don't have enough, because they provide, the beauty of those teams is they not only provide individual counseling and therapy to the child, they provide intensive parental support to folks in that home to understand what they're dealing with, and what they should be doing from a coping mechanism, and when an alarm should go off to them. So, I think a lot of that has helped.

I do agree we have to find a better way to -- in terms of the data piece, sharing if information with parents to me is a no brainer, the parent should get this. Now I don't that they should get everything that somebody says in a therapeutic session, because they might as well be there if that's the case, and if they're going to be there you're not going to get everything from the child, but they do need to get what they need to get to keep their

child safe and progressing.

From a data perspective, we worked with AHCA because AHCA has a wealth of information on kids who receive, and adults quite frankly, receive behavioral health services through Medicaid. We have the community mental health system, which is what we call the system of last resort. You have to exhaust all other resources before you come into our system. We could never see into the Medicaid system. A lot of folks go between our system and Medicaid. Not all. I think if you added up the folks that go through our system and the folks that go through the Medicaid system it accounts for about two thirds of the folk who receive mental health services in the state.

But we do a much better job now of providing that information to the managed entities who manage this on the ground in every community, where at least now for the first time, and this was just in the past year, where they can see from a, from a data perspective where the folks they're serving are hitting, you know, because it used to be we successful with this person or did this person just go

into jail for six months and the reason they haven't been receiving services is because they've been incarcerated. We never knew.

Now we tend to pick more of that because of the data sharing, but we still don't have private pay insurance on there. I think the biggest thing if you're talking about the Baker Act specifically, and Ute referred to this, and I think this is one of Sheriff Gualtieri's pet peeves, is when somebody comes out of the Baker Act if they're eighteen, any age, we can't force them to engage in services. So, if they absolutely are adamant that they don't want services we can't force the services on them, however we can do a lot better job at aggressively and proactively engaging them and helping them understand it's in their best interest to engage in services rather than just release them with no one hand off, and no connection to a service.

And that is something that we have to work, when Ute was talking about coordination of care, that's a gap that exists in every community. It's something that we have prioritized within the Department. It's a gap

that has to be closed, and each one of the managed entities, it's something we are actually developing measures around to see if they close it. And quite frankly it was onus behind the executive order that the Governor issued, was to try and find out for those folks that are either released from jail or released from a crisis unit who are dealing with these issues, who is doing that proactive follow up, and trying to engage these folks in services.

If they adamantly refuse there's not anything we can do, it's their right, but most wouldn't adamantly refuse the services. Most refuse the services because they go out, they go about their life, they don't think they need the service, they don't have the wherewithal to get to the services. Some of them don't have stabilized housing. There's a whole complex reason why they don't, but we've got to get better at that. And it's a huge hole in our system, because it creates a revolving door with the law enforcement, and also within our crisis unit. So, to me there's different issues here.

And with respect to Cruz, and this is an

important distinction, was even when the folks locally who went out to do the Baker Act assessment, he had already turned eighteen, and so he had the right at that point to refuse to go further. They at that point assessed him as not meeting criteria, but he was eighteen, he had the right engage in the adult protective investigation that took place or disengage. He had the right to engage in services or disengage.

And unless he was doing something criminal at that point there wasn't a lot that the social workers could do because he turned eighteen. It changes when -- when there's a child and they're refusing treatment if we find that that child absolutely has to be in treatment you can call, and abuse investigation and we'll look at it, and if in fact that child has a serious mental health diagnosis, and the fact that you're not seeking services is putting that child or others at risk, that's absolutely something we can then intervene in.

It's not different than if your child had cancer, they just had an organ removed because of cancer and all of the doctors say you have

to have ongoing radiation, or chemotherapy, and the parent says, well, no, and the docs are telling us there's a ninety percent likelihood that the cancer will return, is that abuse and neglect. Well, it depends, if you go out and the parent say we understand that but we're using alternative medicine, and we think this gives our child as good a chance as the chemo, that's one thing. But if you're doing nothing, well that's, probably most folks would say that's kind of negligent and, and reckless to the livelihood of that child, so it would have to be independently looked at.

So, for a child we have a little bit of room to intercede when they refuse, although in the end if there's not a diagnosis, and there's not evidence that the parent is abusing and neglecting the child, there's nothing we can do to force them into treatment. But I do think the Sheriff, and I've heard the Sheriff talk about this over and over, for those folks who are released from these, and we talked about it, on Baker Acts you can be released not in eight hours, or ten hours, you can be released in two hours if they deem you not to meet

criteria.

That does not mean you don't have an issue, and the fact that we release you out onto the street with no one hand off, no services in place, is creating an issue where the next time something more serious may come of it, and so that's the piece I think we need to get our arms around.

CHAIR: Secretary Carroll, you're right, and you know you heard me say it a thousand times, it is a pet peeve of mine, and I've been very vocal about it, is, is the greatest void in the system right now is case management navigation, wrap around services, whatever you want to call it, and discharge planning for many of receiving facilities is not existent, and you have people that are going in under the Baker Act, and in some cases they're there for an hour, two hours. Sometimes they might be there for seventy-two, but that's rare in my experience, and most of the time are released, and there's a huge gap.

And the reason why there's a huge gap is, without beating a dead horse with it, is, is because these people, if they, for blanket

statement, but if they could make it work on their own they would. They can't. They need hand holding, they need services, and you have a much better outcome with intensive services and follow up than you do leaving it to their own volition to try and get help. It doesn't work. And the greatest void in the entire system in this state, and probably other places, is whatever name you want to put on it, is somebody holding their hand and getting them to the best possible place that you can get them, and we don't have that.

And, you know, and in this case, like with Cruz as an example, he fell off the grid. And if we get to it this afternoon you'll see as we go through the Henderson records, is there was intensive, intensive contact that he had with Henderson, and then when he turned eighteen and he refused services, and then soon after that he move, he moved to Lantana, and when he was living up in Palm Beach County he's living with somebody else, and then he comes back down here and he's living with the family he lived with, so he, he fell off the grid, he fell off radar. There was nobody that was looking at him, and

the intensive services abruptly stopped for a bunch of reasons. One is turning eighteen, and he left Broward County, went to Palm Beach County, he was floating around, and nobody knew where he was staying.

So, you know, you end up with, and Commissioner Petty, getting back to what you said a little while ago in this, is that there's a, and Sheriff Judd, there's a gap, there a delta, and that gap and that delta is somewhere between okay and somebody that meets the criteria for a Baker Act. And there's a whole lot of people that fall in this gap, in this delta area. And Ute, like you said is, is that these people, and a lot of it, a lot of it is a determination about whether you get Baker Acted or not. It is subjective, and a lot of it turns on whether you say the right thing or the wrong this, right?

MS. GAZIOCH: It is, yes.

CHAIR: And if you say the magic words you're going, and if you say something short of the magic words, or you have learned to say things that are short of the magic words, then you're not going to get Baker Acted. Then once

you get into the receiving facility -- the definition of stabilization from a crisis stabilization unit standpoint is also subjective, and a clinician's determination that somebody is stable, have met the definition of releases from the CSU after a Baker Act, may be different, very different than mine or yours.

We may not want that person on the street, but their job is, is to get them from here, not to here, is to get them from here to here, and then they discharge them, but again they're discharging them with no discharge planning, no follow up services, and the next time that anybody has contact with them is when they get back up to here again.

So, and if you disagree with any of that you're welcome to --

MS. GAZIOCH: No, and I think that's our practice, I mean they have to do discharge planning, that's part of rules, but if they don't it needs to be reported, and we need to look into that.

CHAIR: And the most concerning people are the people that are in this gap, and this is

where a whole bunch of them are, is in the gap, so the question comes, is, is that is there something we could recommend, is there something the legislature can structure, is there something there. But you have to balance it against civil rights because you're depriving people of their freedom. Is there something that you can do that's short of the Baker Act but will identify and do something to deal with this conduct that isn't an imminent danger to themselves or others.

And that's -- and that's the dilemma. This is a -- this truly is a dilemma situation. And that's where we are -- and -- and here, you know, in Broward, I don't think Broward is any different. Well hear from the managing entity here in a second, but I don't think they're any different as far as the level of case management is concerned.

MS. GAZIOCH: Well, actually I think you'll be surprised at some of the things that Broward is implementing.

CHAIR: Good.

MS. GAZIOCH: And you're absolutely right, I mean we started our care coordination efforts

about three years ago when we were looking at data for something completely different and we saw that, you know, out of these seventy thousand people who were Baker Acted only about thirty thousand were receiving case management, and we said how is that possible if you're supposed to, you know, you're supposed to be discharged with a discharge plan. It's supposed to include medical needs, it's supposed to include an appointment for a physician. If you've been placed on medication, you need to consider that.

So, those -- the rules are in place, and I, so I think it's a practice issue. I know that in the areas where we've really concentrated on the care coordination efforts, and we started it without funding, and we really challenged our MEs and providers to put it in because we didn't have any extra funding, we've gotten some since then, but for example in Miami they had five people who were literally never, over years and years engaged in services, and were in and out of, I mean talk about a revolving door, they were the five highest utilizers, and it was all crisis

stabilizations, and they implemented warm hand offs with really intensive care coordination. In a year in care coordination those people were not re-hospitalized.

So, I think, you know, I think there are ways of doing it. I know Centerstone had implemented even before we started our care coordination high utilizer care coordination programs. It is a matter, you know, part of the issue is, is that you, you know, you need to bring that up to scale, and at this point there's not necessarily all the resources there need to be to do that unfortunately, because you can't, you know, when you already have a system that's very, you know, you're already investing in your doctors, and you have to have your CSUs, you can't just take money from that and put it into something else because you'll just create another gap.

So, but I -- but I do think the care coordination piece, and the warm hands off certainly have huge promise.

MR. SCHACHTER: In Los Angeles they have a program where they have, you know, their top fifty high risk individuals, and they are

constantly check up on them. I can't remember the name of it, but even in mass casualty events like in Parkland, I'm sure that they touched all those top fifty individuals, and I think it's, this is part of something that we need to recommend, it needs to be that, you know, constant touching, and making sure, and, you know, even more so. But thank you for your testimony, it's wonderful.

I just wanted to follow up on Chief Lystad's remark. You know, he asked you one specific question, and to see if there were these silos and sharing information. I wanted to ask you a more broader question. You have visibility to all these different programs, are you, can you identify for this commission any other silos that are not sharing that you think would be beneficial once we make recommendations?

MS. GAZIOCH: Well, again I think all, you know, we talked about different state agencies provide services. At this point none of those data systems are connected, so if a young person was receiving clinical or therapy services through DJJ because the had been

arrested, or had contact, and then if they showed up at the community mental health center for something else unless they reported it there is no connection, there's no, no, there's not one data system that has all of this, and that, those -- exactly.

MR. SCHACTHER: What else? Perfect. This is exactly what we need to know. What else -- and, you know, we --

MS. GAZIOCH: Education. Education has their own system. Juvenile Justice has their own system. We have our -- it's all different data systems.

MR. SCHACTHER: And when you're putting together Commissioner Petty's, you know, best practices, if you could list those for us that would help us.

MS. GAZIOCH: Okay.

MR. SCHACHTER: Thank you so much.

MS. GAZIOCH: Secretary Carroll, go ahead.

SEC. CARROLL: Real quick to add to that too. One of the big holes specifically related to the schools is connecting the community, mental health community directly with the schools, because even as we beef up schools'

ability to provide this type of counseling to kids, kids don't live at school, they live at home, and in the community, and anything that's going on in the school has to be continued when they go home, and in the community, and if they're receiving community services it really has, there has to be a stronger link.

I'm hoping that the creation of these threat assessment teams, that brings all of those people together, and quite frankly I believe the law allows them to share information openly. I hope that corrects that information sharing at some level with some kids, but I think it's critically important as schools begin to plan how they're going to implement and utilize the additional mental health resources that are being provided to them through the law, they need to be able to connect that to community mental health services, because these families are often involved in multiple different places, and if that link isn't made these silos are going to continue.

CHAIR: Without too -- and then Secretary Senior, one second. But one of -- one of the

things that I wish we had, and I'm an advocate for, I don't know if we'll ever see it, is actual case management entities, because I believe that there has to be ownership, and somebody has to own these people, and be responsible, and there has to be a top of the funnel, that somebody is ultimately accountable.

And you have some entities that engage in case management to some degree, and some that are trying. But as they're bouncing around between school counselors and private therapists, and the whole system back and forth, it is related to these people that are of most concern, and have the most need, there isn't one person who objectively is overseeing them, and it's my characterization, owns, them, and when I say ownership I mean responsibility and accountability for them.

And I think that the providers do a great job in providing, but case managing is, case managing is different than providing, and that to make objective decisions it would be best suited by a person in an entity that isn't in the business of providing services, it is in

the best position of navigating those services, sending them there, bringing them back, sending them here, bringing them back, to get into the best possible place. Some people, you will only get them to this place, you'll never them all the way, but at least you can get them to the best possible place they can and then continue to monitor them.

But until we have more effective, and is this still a true number, is, is that Florida is the third largest state in the country and depend upon whose numbers you use per capita funding we rank around forty ninth or fiftieth. Is that still an accurate number, or is that --

SEC. CARROLL: Well, there would be -- there would be some debate on what the actual number is, but in general yes.

CHAIR: General, generally. So, when we have that, and the investment where we are the third largest state and somewhere around the forty ninth or fiftieth in per capita funding in mental health, that's why there is not enough resources in the case management world, because you've got to provide services, and there's a huge gap, but you can't fix that gap

unless there's funding for case management. And it's just simply you have to make choices, and if you're choosing between actually providing services or providing intensive case management -- and that's why you see a lot of local entities that are implementing their own case management programs. And it's happening. It's happening in our county, it's happening other places.

Secretary Senior, go ahead.

SEC. SENIOR: I just wanted to say and this -- at a state level I think there's a great opportunity. Our agency is procuring right now a new enterprise system that is going to, is intended to create a platform that will allow this type of information sharing across state agencies, whether it be DCF and the Agency for Healthcare Administration, the Department of Juvenile Justice, but any, giving, giving these entities access to our information, and giving them the opportunity to input their information into our system so, so we would have a location, a location.

That's going to be I think very important for children. Obviously when you get to the

adult realm most, most adults aren't going to be enrolled in Medicaid anywhere in the country, and so you've got all of these private insurance companies, or uninsured folks, and it becomes a little bit more difficult to break down potential silos, and it almost has to happen at the provider level, with the providers being capable of exchanging electronic medical records, and people really owning their own medical history.

UNDER SHER. HARPRING: Mr. Chair.

CHAIR: Go ahead.

UNDER SHER. HARPRING: You know, regarding the follow up and the case management, there's already a template that exists for that for those jurisdictions that have mental health court, veterans' court, as we do in the Nineteenth Circuit, as well as drug court. And I think that the template exists, but as with many of these things the issue comes down to either local legislative bodies, or state legislative bodies, it's the willingness to provide the funding for it, because you have to have the people that are dedicated to do it.

But I've seen that in the Nineteenth

Circuit where I reside, that, that our personnel, and it a community approach because we have personnel that work for the Sheriff's Office where, where I am, as well as people in the mental health community, that track these individuals. Now of course keep in mind they've some into our purview because we've arrested them, and they meet certain criteria, but they are assigned a case manager, and that case manager assists with, and a lot of times you have these, you know, coexisting issues with substance abuse and mental health, much of the time, and they have a case manager.

The case manager ensures for a period of time that once they are released from incarceration that they're getting to their counseling sessions, they're getting their medication, they're getting stabilized in residences, and I think that that template exists. But as with almost everything that we've talked about a lot of that comes down to, you know, comes down to willingness.

And I just would like to say one thing about the, the database issue. We've talked about that in a lot of other areas, and this

might be a little counterintuitive, but I on some level caution the commission on, on having large databases accessible to a lot of people, or a lot of different entities relative to people's mental health, because we know many times people that are Baker Acted, sometimes they are one and done, and sometimes we're trying to resolve, from the law enforcement side we're trying to resolve something in the field, it meets the criteria and we do that, and then that person doesn't come back.

And then of course there is that follow up with a lot of people that we know who they are, we have the flags in our system, we're heading to the residence for a call for service and we kind of already know what, what the result is going to be. But let me cycle back real quick on that, on that same topic, in that we have seen a great reduction in recidivism relative to the people that have come into our particular purview on the law enforcement side, that have gone into either veterans' court, mental health court, or drug court, and I think that that template could potentially be something that should be looked at by those

that are going to move forward in this particular area.

CHAIR: Commissioner Petty, as we wrap this up.

MR. PETTY: Yeah, just a quick comment I think. So, if there are models for case management that we could look at and replicate in this area, I think that's interesting. It goes to a comment that Commissioner Carroll made a moment ago, is, you know, I think you mentioned, you know, school districts start to think about bringing these services in, we may want to make some recommendations about, to your point, on case management, where that should happen. Should that be the responsibility of the school district, or should that happen in the community? I don't know where, but should that happen in some other entity that doesn't, that can ensure that when that student goes home that there's continued follow up and, and proper case management.

So, I don't have an answer, but it's something --

CHAIR: You know, and maybe -- maybe we

could have a, you know, follow up discussion on this and, we were having an informed discussion, but, you know, an enhanced informed discussion after you have an opportunity to see and have it all laid out as to what Cruz did receive, and give you an idea as to the intensity of it. And it may help round out the discussion on this, so why don't we, you know, we'll continue that discussion once you've had an opportunity to see what happened here and compare it to what we've now heard. Yes, go ahead.

MS. LARKIN SKINNER: As the, the way the system works right now to identify a high need, we call them high needs, high utilizer, so identifying someone with high needs, typically they are a high utilizers of systems, of the system, and all the services in the system. With regards to what this commission is tasked with in looking at the Parkland massacre, and the perpetrator of that massacre, I haven't heard anything yet that would have tagged him as that, and therefore would have made anyone go, hmm, you know, perhaps he should be in case management.

And I'm only saying that because I just haven't heard anything yet. I mean if he wasn't in and out of a crisis stabilization unit I don't know that he ever would have been tagged as somebody that we would then go out, try to engage, and wrap services around. Because there are models for that, even beyond mental health court, drug court, and veterans' court.

So, that's something I think that as we listen to his life being built out in front of us, that we consider that, because it may even be that we need a different mechanism for how we tag that, of how we flag those people. Law enforcement has a mechanism, and I know that because after Parkland in our county we had five or six kids in their infinite wisdom talking about how they were going to do something at school, they were going to kill somebody, do this, do that, and two of them happened to be in services with Centerstone, my company, and so I contacted the Sheriff's Office and we talked about what our process would be to, to notify, and one of the things they told me is that they had at least two of

like four of the kids on a watch list already.

So, I know in law enforcement they had a watch list for these folks that were high risk, not because necessarily of their mental health issues but because of the threats that they were making and their past behaviors. Just food for thought.

CHAIR: Okay. All right, why don't we hear from the managing entity? Ute, thank you very much, it was a great presentation.

MS. GAZIOCH: Thank you.

CHAIR: We appreciate you being here. So, I don't think this next presentation is going to take very long. It will be kind of a follow, segue way into, from where we were into the Broward County mental health system, and the presentation from Silvia Quintana, who is the CEO of Broward Behavioral Health. Welcome, and thank you for being here.

MS. QUINTANA: Thank you so much for inviting me and having me. How do I get this going? Okay, so I'm here to present on the managing entity for Broward County, which is Broward Behavioral Health Coalition. We were asked to present on the services that we

purchase from our network, and also the gaps that we see in the system, so this is what this presentation is about.

So, Broward County was funded this past fiscal year '17/'18 with $57.8 million. We purchased -- we purchased about $34.2 million in mental health services, that's fifty nine percent of our budget, $20.9 million in substance abuse services, and about four-point four three percent. $2.5 million is our operational oversight. Of the substance abuse and mental health funds $2.4 million is used for prevention services, to do prevention substance abuse and mental health promotion.

The role of the managing entity, and I think Ute presented this before, is to really oversee, is to then provide the administration management support oversight of the DCF funded behavioral health system of case in Broward County. Our mission basically is to be, have a responsive compassionate behavioral health care experience for people in our community, and, and our mission and values are spelled out there.

Okay, this is the $2.4 for prevention that

I wanted to point out. We served in fiscal year '16/'17 approximately twenty-seven thousand individuals, adults and children. You see the spread there. The reason why we have such little numbers in youth, this is eighteen and under, is because a lot of them have Medicaid, and so therefore we are only serving either the, either gaps, or kids that are uninsured in our system. The majority of the money goes towards the adults, that's eighteen and over.

During this fiscal year, '17/'18, our fiscal year ends June 30th, through May, not including June, we've served about twenty-eight thousand individuals, without counting June, of which this year we did a lot more outreach services, and those are peer support services to connect people between systems, and we are tracking individual connections with that, so we have an additional twenty two thousand outreach engagement types of units that we have.

Services types funded, you see it there. We have addiction receiving facility ARF and JARF that was funded through June 30th, and now

it's privately funded. We have aftercare assessment case management. We recently got, received funding from DCF on a new CAT team that was funded last fiscal year and procured, and so that team started towards the end of the fiscal year last year.

Care coordination teams, we have specialty CCT teams that are made up of a licensed clinician that oversees case manager and a peer specialist together. They practice in evidence- based practice called CTI, Critical Time Intervention, and they focus on individuals that are high risk high utilizers that are transitioning from one high level of care to another. And this is an initiative that started about a year and a half ago, two years, with funding that we received from DCF, and previously we had started a pilot with a smaller amount of money. We have three of those teams in Broward County focusing on substance abuse, on mental health, and care coordinating services.

We have a central receiving center, or system, funded at Henderson, that we received a year and a half ago. This was going to be our,

going into our second year, full year, and this is where people are dropped off by the police, or hospitals, where people do not meet criteria. This is focusing on adults only at this point. And pretty much individuals are referred there to be triaged, and to be assessed for levels of care, and connected to the community mental health centers in the community.

We have clubhouses, drop in centers, crisis stabilization units, crisis support. We have a mobile crisis team in Broward County. We have day/night treatment programs, detoxification units. We have a FAIT team, Family Intensive Treatment team that focuses on the individuals that are in the child welfare system that need mental health or substance abuse services.

First episode team, this is for individuals sixteen to thirty-five that need, they have their first psychotic episode. It's really a prevention program for people that are beginning their process of becoming psychotic, and so we try to get them into, they provide services through this team to divert them from

the chronicity of the illness and try to get them mainstream with their families into their process of recover. We also purchase from the providers flexible funds. We give them flexible funds to be able to individually provide whatever needs their treatment plan identifies, which could be transportation, it could be things that they need in order to fulfill their recovery plan.

Information and referral, in-home services, we provide out-patient therapy in the office, but we also do in-home services, so providers basically have teams that go into the home and provide treatment in the home. Intervention medical service, psychiatric services, medication assisted treatment, that's very opiate, opiate focused. Out-patient outreach prevention, recovery, and peer support, residential, supported employment, and supported education for people that are in need of assistance to get jobs or be successful in school.

Supported housing and living, and transition to independent process, which is a life coach that we, we received, and it's an

evidence-based practice that we have, the focus is on kids that are transitional age youth, somebody was asking about that, ages fourteen to twenty one is through a SAMHSA grant that we receive through the Broward County, and we practice and evidence based practice called transition to independent process. And the case managers can have lived experience, or they could be professional case managers, and they are trained on a specific practice.

And they're really a life coach, so kids that usually do not want to engage in our traditional mental health services really like this, because they really have a life coach that, that can go along with them. We have had a great successful program with that, and I think Ute was mentioning that, that that was also a program that was offered in Hillsborough County, that they're using that practice.

So, these are the different arrays of services and who provides them, so we have, these have the types of the emergency services that we purchase from the system. Pretty much we have children and adult mobile crisis team through Henderson. Juvenile addiction

receiving facility through Fort Lauderdale Behavioral Health Center. Crisis stabilization through Henderson. Crisis Baker Act receiving facility through Memorial University Pavilion Fort Lauderdale Behavioral Health. Residential detox, in-patient detox, in-patient mental health services at Memorial.

We have an in-patient detoxification for pregnant women with their children, where we take all of the family into residential services, not the father but definitely the mother and the children. We have an out-patient detoxification program at Memorial for adults. Medical assisted treatment programs at Memorial, Banyan, and BARC.

Children's Residential Services, we purchase statewide in-patient services, which is SIP placements for individuals that need that level of care. This is a secured facility for youth up to the age of eighteen or twenty-one, depending on who pays for it, whether it is Medicaid or us. And we purchase that service for kids that have no insurance in order to meet their needs.

We have -- we purchase residential level

two services from Covenant House, Here's Help, and Concept House depending on the need. Juvenile incompetent to proceed residential services are usually offered through the statewide contract in Twin Oaks, so we have that available through the State.

Adult residential services, again we have a short term, we purchase a few beds of short-term residential treatment services for forensic and few civil clients at the STAR program at Citrus. Residential level one forensic, level one is provided through Henderson Behavioral Health. We also have not secure residential level one provided through Henderson Behavioral Health and Gulf Coast. Level two is provided by Henderson and House of Hope for co-occurring substance abuse, Archways and Banyan. Residential level two for women and their children at Susan B. Anthony, and residential level two at BARC only for substance abuse not co-occurring, and residential levels three and four at Gulf Coast, House of Hope and Archway.

So, there's different levels of residential care, and people get in there based

on a tool that we use called, a level assessment tool called the LOCUS, people have to score the need for that level of care in order to get in, and we basically are ensuring that their progress and treatment is appropriate on a monthly basis to make sure that they're being discharged a appropriately and there's a bed available for the next person coming down the pike.

Children/youth nonresidential program, these are all the providers that offer those services in the network. We have a total of thirty-one providers in our network. Adult residential services, again this is -- I'm not going to mention all of them, there's just the list of services that are being offered. Adult, children, and family support services, this is very important. We talked about peer specialists before. We believe in peer specialists, because I think they've done an awesome job in really enhancing our system of care and integrating with our traditional community mental health centers and service array.

Peer support services, training, advocacy

for adult and children all right provided by South Florida Wellness Network. It's a peer run organization where everyone there is a peer, and is trained and certified, and they continue to provide training and capacity building of our network. They train providers, and they train peers to become peer specialists.

We also have drop in centers where people can come in and pretty much do whatever they want to do, whether it's art, music, et cetera, and develop other alternative ways of expressing themselves. And we have 9 Muses, the Rebel Center, and also Foot Print for Success. Supported employment at various facilities, and this is an evidenced base practice using IPS, supported housing using Housing First at Henderson.

These are all the evidenced based practices that are being provided through our network of providers, and we have trained people on all kinds of things because we knew that we needed, for example, trauma clinicians for adults and children were, three years ago we started the training process for all the

clinicians available, so we have motivational interviewing, wellness recover action planning, which is really focused on peer, it's a peer, peer to peer approach, mental health first aid, trauma focused CBT, which is for children eighteen and younger, trauma incident reduction, which is for youth, adolescents and adults.

And all these are treatment, treatment services to deal with trauma, resolving trauma. Transition to independent process, which I mentioned before. We also discovered another evidence-based practice called moral reconation therapy that works very well with a criminal justice involved individual, and we have now a program with youth that works very well with that.

Crisis intervention team, we are, we do train police officers in becoming, law enforcement officers in becoming trained on CIT, supportive housing, IPS, FACT team evidence-based practice, the critical time intervention, of course the Locus and (unintelligible) a level of care assessment.

In 2015/'16 we did a survey to find out

how many clinicians were practicing evidence-based practices and delivering services under an evidence-based practice, and our network had eighty-seven, eighty seven percent of our clinicians and supervisors who are using one evidence-based practice or another in their, in their service delivery.

New initiatives, of course we just started this year with SDR grants in Medication Assisted Treatment. We have a Community Action Team; the CAT team is a new program for us last year. We expanded our care coordination teams. We started with care coordination being done by peers supervised by a licensed clinician, connecting people from state hospital discharges to the community, and they were in, reaching in to the state hospitals, and then that worked out so well, and were doing so well that that was expanded to now have peers attached to detoxification centers and receiving facilities that we contract with.

The Short-Term Residential Treatment Program, which is a civil forensic, very small, eight beds. The, let me see which one, what else do we have here. We have a few -- we have

a primary behavioral health care integration pilot that was funded through the health foundation to try to connect primary health with behavioral health. And we were talking a little bit about, we got stuck in the data connection when we were doing this pilot and funding the data connection between primary health and behavioral health.

Family Connection through Peer Recovery is a federal grant that we receive to enhance the quality of the care and the knowledge of the child welfare case managers to understand family dynamics so that they can help families and divert people from the foster care system. And that's part of our initiative with Child Welfare Integration.

We do have a Maternal Addiction Program that detoxifies pregnant mothers on opiates on any trimester and is in collaboration with our residential program for moms and babies. And we have had a success of, I think it's seventy-nine newborns drug free, born drug free, whose moms were addicted to opiates, when we started two years ago.

The Family Engagement Program is also

based with peers at BSO, Broward Sheriff's Office. We co-locate there through Henderson. Licensed clinicians, certified addiction professionals and peer specialists, people that have, these are women that have gone through the process of either having their child removed and being substance abusers that are now doing well in recover, and we use them to engage parents that are coming into the system so that they can accept treatment and be supported that way.

We have a Family Intensive Treatment Team, which is a FIT team for parents that are addicted to drugs that are going into the child welfare system. The Power of Peers is a program that I mentioned before, with peers being discharged from the hospitals and now being attached to receiving facilities and detoxification.

Post-Arrest Diversion Program, we have one of those in conjunction with the jail, where we identify individuals that are being arrested, and are identified with having mental health problems. And we have a collaboration between the state attorney, the public defenders, and

the provider, which is Broward Regional, and if all is accepted these consumers are sent to this program, they receive the supported housing, supported employment, they receive mental health treatment, and they also receive moral resonation therapy in case management. And the idea is to get their lives turned around, and they pretty much, the state attorney agrees to drop their charges. The target is third degree felonies, and some second degrees that are non-violent, for that program, and we're doing pretty well with that.

And then the One Community Partnership is the one that talks about the transition to an independent, this is the program that funds the transition to independent process. We through that program also have the CLAS Standards initiative, where we are, we have plans for CLAS Standards, making sure that everybody meets the cultural linguistic federal level of requirements. We do trainings. And there's a whole involvement of consumers in developing the training, and we even have videos that we have developed to educate the public on what that is.

And then recently with the MSD shooting the trauma trained clinicians have been available to the community, the first responders, the teachers, the students, to offer services for treatment resolution. And we also have funded a program through SHINE that offers alternative therapies to survivors, families, and first responders, and this include trauma train, music therapists, art therapists, drama therapists, and all of these are working with the kids in the summer, and the parents, to offer other ways of resolving and processing their trauma.

Priority needs and gaps, what we have identified through our network is that housing and care coordination at the ME level and the provider level are essential. We need more of those services, and this housing and care coordination is what helps people that are coming out of those receiving facilities and so forth, glue them with good discharge planning, because then they can, they can, they can really access the services that they need so that they don't come back into the system again.

We also need to sustain and increase the managing entity operational integrity capacity. We have a line item for our operations that has stayed the same, and we need to make sure that as our programs grow we also grow to be able to provide technical assistance and oversight of the network. FACT Team enhancement would be beneficial. Short term residential peer support services are important, to continue to fund those. Supported housing project and flex funds to fund the rents, and subsidy rents for individuals is important. We don't have enough affordable housing in Broward County, and so we need more of that.

We are working on partnerships with the medical, the Medicaid managed care plans to develop better rates for the providers, telemedicine. Anyway, I think you can read the rest of our needs, they're a long list. If you have any questions?

CHAIR: Okay, you got it. Okay, any questions for Ms. Quintana? Yeah, Sheriff Ashley.

SHER. ASHLEY: Thank you for your presentation. I'm just trying to figure out,

in treating mental health patients is there a predominant method, is it more medication, pharmaceuticals, is it more counseling and therapy, a combination of both, or something other?

MS. QUINTANA: It's a combination of many things that works. So, individuals need to be assessed, and of course tried and tested for the right medication. I think Ute talked before about the fact that different medications work different on different people. But once the medication is secure, many times even before you get to the medication you need to really engage them, because people may think that they don't have a problem, and so the SPER, the peer supported initiatives with trained peers are crucial in engaging folks because what they do is they offer hope to people that are really living very miserable lives, right?

And those people basically come out and say, hey, I was there three years ago, and three years ago I as in jail, I was in the state hospital, or I was turning in and out of the detox units, or the, you know, the

receiving facilities, and look at me now, I'm working, and I'm trained, and I'm able to help you out. That light of hope that is instilled through peers to people that are really difficult to engage is a very important piece. That's a first step, engagement. Then you need to have an assessment, make sure that they're on the right medications, that they have an advocate, which could be the peer, to talk to the doctor about this is not working well, their signs and symptoms, and so forth, so it's kind of like a navigator that helps a person from their perspective to engage into treatment.

And then finding out from that person what is it that you would want in life, because it's not necessarily what the case manager thinks, or what the doctor thinks, it's what they want. People will work for what they want, and so -- and that's part of all this evidence based practice, it's like what do you want to, well, I want to work, okay, so if you want to work but you're really sick, we'll find, let's see whether we can find you a job, and so in the process of finding that person a job you, the

person realizes that, oh, my God, I just got the best job of my life but I can't hold it together, I can't think straight, I can't focus straight.

And that's where you say, well, maybe we need to adjust your medication, or maybe we need to get some therapy for your, people have trauma, and trauma gets triggered, right, so maybe we need to go to a trauma therapist and get you -- so it's through the goals of people, what they want to do, and usually with a peer advocating because the speak the same language is how you can get people with all the supports that they need.

So, it's about engagement, it's about having an advocate and a peer. It's about medication, and it's about reaching the goals that you want to reach as soon as possible and providing the supports in order for you to be successful in your goals.

SHER. ASHLEY: Thank you. I just want to bring to the attention of the commission the Citizens Commission on Human Rights of Florida, are you familiar with that organization?

MS. QUINTANA: No.

SHER. AHSLEY: Well, they got out -- they've published a number of reports recently addressing medications, and specifically psychotropics, and the dangers associated with psychotropics, and side effects, and that's why my question in what is the predominant method of treating mental, mental health issues, is it more medication, or more therapy, or counseling. Do you see any dangers with prescriptions being abused, or overused, or over prescribed, or --

MS. QUINTANA: Sometimes individuals are over medicated, and an advocate can come and say, oh, this person is sleeping all the time, they can't function enough. And, you know, the doctors see the patient fifteen minutes and they do the prescription. Unless someone that is a reliable reporter can come back to the next doctor's visit and say, you know, doctor, this person is sleeping most of the time, this persons' medication is not working well, this person -- you know, you need to -- you need to be -- and sometimes the person who is receiving the medication, they can't tell, or they can't report to the doctor what's going on, so it's

really a combination of the relationship with the doctor. And of course, doctors will adjust medication down, or they, so it's a combination of those things. So, it's -- I think that part of it has to do with how, how do we communicate with the doctor. For some -- for a lot of the mental illnesses people do need some medication. Not everybody needs medication for everything. Some people go to therapy and work it through other behavioral, you know, other behavioral health, or behavioral interventions. So, it's a combination depending on what, what your diagnosis is.

SHER. ASHLEY: And thank you for, for the benefit of this commission. If you've not seen or read these reports I would highly recommend them. Their claim is pretty outrageous, that the vast majority of our mass shooters have been under the influence of psychotropics before, during, or after, not after, but before or during. And some pretty eye-opening claims with a lot of reference, medical references and doctor's claims, and the like, so it may be worth our while to examine is, are we over prescribing medications for mental, mental

health issues.

MS. QUINTANA: Okay.

CHAIR: Any other questions for Ms. Quintana? Okay, well, we thank you very much. We appreciate you being here. I believe Judge Leifman is here. Why don't we take a quick ten- minute break, and I've got 3:06, we'll come back at 3:16, ten minutes. Thank you.

MS. QUINTANA: Thank you.

(Thereupon, a recess was had and the meeting continued as follows:)

CHAIR: All right, we're going to go ahead and get started here with a presentation on the Baker Act from Judge Steve Leifman. Judge Leifman is from Miami-Dade County, and as you'll hear and know he's a brilliant expert in this area, and somebody that we get a lot of information from on the Baker Act, and mental health in general. Judge Leifman, welcome, and thank you for being here.

JUDGE LEIFMAN: Thank you very much, Mr. Chairman. Members of the commission, good afternoon. My name is Steve Leifman, and I Chair the Florida Supreme Court's Task Force on Mental Health and Substance Abuse issues, and I

want to thank you very much for the opportunity to be here, but more importantly I want to thank all of you for this very important work, though I know all of us wish it really wasn't necessary.

Florida has a very interesting and somewhat tortured history when it comes to providing treatment and services to people with serious mental illnesses. Many of the current problems and weaknesses of our community mental health system can actually be traced back to historical events that have shaped public policy and attitudes towards people with mental illnesses in the state.

During the early part of the nineteenth century Florida actually exported people out of the state who had mental illnesses. We sent them to Georgia and South Carolina and paid those states $250 per person to house them for us. We were one of the last states in the United States to open up a state hospital, and that was, the first hospital actually was opened in Chattahoochee, which previously had been a civil war armory.

With little effective treatments at that

time, we're talking now 1876, people were warehoused in very difficult and inhumane conditions. And this went on for almost a hundred years. It wasn't until 1971 when the legislature passed into law the Florida Mental Health Act, which went into effect the following year in 1972. This Act brought a dramatic and comprehensive revision of Florida's ninety-seven- year-old mental health laws, and substantially strengthened the due process and civil rights of persons in mental health facilities, and those that were of the aid of emergency evaluations and treatment.

The Act, usually referred to as the Baker Act, was named after Maxine Baker, a former state representative from Miami who had sponsored the legislation. The intent of the legislation at the time was to encourage voluntary commitments, as opposed to involuntary commitments. Before the Baker Act was enacted a person could be placed in a state hospital with the signatures of the three people and a county court judge indefinitely. There was no process. People were locked away. In fact, you could be as young as twelve years

old and put in a state hospital with adults indefinitely until for whatever reason they decided to release you.

And so, what the Baker Act really did was prohibit the indiscriminate admission of persons to state institutions, or the retention of people without just cause. Its mandated court appointed attorneys, it established patients' bill of rights, it prohibited the placement of people with mental illnesses in jails unless the committed a criminal act. And at the time it really was considered around the country as one of the most important landmark pieces of legislation.

It also established the criteria for involuntary examination, and involuntary placement at a state psychiatric hospital. Now, I want to be really clear, because I think there's a lot of confusion of what people think a Baker Act is. And so, when someone is, quote/unquote, Baker Acted, what that really means is that they are getting admitted for an examination only. They are not getting admitted for an involuntary commitment, it's only the first step. And before you can even

be taken to a Baker Act facility, or a crisis stabilization unit, you have to meet criteria to even get in the door. And this is what causes a lot of confusion among law enforcement, and other people that are doing it.

So, in order for a person to be taken, just taken to the receiving facility for an examination, they must meet three criteria. One, there has to be a reason to believe that the person actually has a diagnosable mental illness, meaning they have to be diagnosed, or thought to be diagnosed with something like schizophrenia, bi-polar, or major depression. If they are under the influence of drugs or alcohol that does not count. If they are developmentally disabled that does not count. And so, if someone is developmentally disabled and acting out, or under the influence, and are taken to a Baker Act facility for an examination, they're going to be out in five minutes. That's the first criteria.

The second criteria just to get in for an exam is that because of their particular mental illness they have refused voluntary

examination, or they unable to determine whether an examination is necessary, so they can't be voluntary. And number three, without care the person is likely to suffer from neglect resulting in real and present threat of substantial harm that can't be avoided through the help of others, or there is a substantial likelihood that without care or treatment the person will cause bodily harm to self or others in the near future, as evidenced by their recent behavior.

And this is just what's required to get him in the door for an examination, and so what often happens is a police officer may take them in because they're acting out in a way that may be dangerous to the community, but they don't, or can't understand, they're not trained doctors, and so when the person gets to the facility they'll often see the person leave by the time they're walking out to their car.

It also raises a lot of frustration from the providers because they end up bringing a lot of people that are not meeting criteria in a system that's already under resourced and over-burdened, and so they're trying to deal

with people that they don't even have legal authority to examine. And so, if the police officer hasn't been adequately trained, or properly trained a program like CIT, which I don't know if you've had much discussion about, that stands for Crisis Intervention Team Training. It's a forty-hour training program that is really doing a wonderful job around the state, and I'm going to talk a little bit more about it later, but it trains law enforcement officers how to understand this criteria, how to deescalate a situation, how not to arrest someone, and where to take them if they meet that criteria.

Now, an involuntary examination can be initiated by one of three ways. And so, this is important too because not everybody can send someone in involuntarily. A circuit court judge, not a county court judge but a circuit court judge, can enter what we call an ex-parte order that it based upon sworn testimony that directs a police officer to then pick up the individual and take him to a Baker Act facility.

Second, any sworn law enforcement officer

in Florida also has the authority to involuntarily Baker Act someone for an examination only based upon what they see, and in their discretion. And third, a physician or a clinical psychologist, a psychiatric nurse or a clinical social worker as defined by statute may execute what we call a professional certificate stating that they have examined an individual in the previous forty- eight hours, and they believe this individual meets the criteria for an examination.

Now, interestingly enough over half, about sixty percent of the involuntary examinations were based on evidence of harm only. And I'm going to break that down in a minute. So, harm can either be to self or to others, and so about sixty percent of the involuntary examinations come in fall under that category. About one quarter of the cases that come in for an involuntary examination were based on both harm and self-neglect, and less than ten percent were based on self-neglect alone, meaning that, and I'll talk about the standard in a minute, but that you were self-neglecting yourself so badly that you were putting

basically your life at risk.

Now, they break down the harm type, which is very interesting as well. More than half, about fifty six percent of all the involuntary examinations that were based on harm were harm to self, so mostly people that were at some type of suicidal risk were coming in for an involuntary examination. About twenty one percent of all the involuntary examinations were based on both harm to self and others, and only about five and a half percent of all involuntary examinations were based on only harm to others.

So, assuming an individual in fact meets the initial criteria to be examined they have to be examined almost immediately without delay by a clinical psychologist or a physician, and as you know they can be held no longer than seventy-two hours. Within the seventy-two-hour period one of the following must happen. Number one, the person must be released unless they're charged with a crime. The person must be released for out-patient treatment. The person must be asked to give expressed and informed consent to take voluntary treatment,

or a petition for involuntary placement must be filed with the circuit court by the administrator of that facility.

If the petition is in fact filed by the receiving facility there must be clear and convincing evidence that the person has a mental illness, like I described earlier, so it can't be because they have a sociopathology issue, under the influence, or some kind of substance use disorder, it has to be an actual serous mental illness, and they have refused voluntary placement, or they're, they're unable to determine whether placement is necessary, that he or she is incapable of surviving alone or with the help of others, and without treatment they are likely suffer from neglect which poses a real and present threat of substantial harm to his or her well-being, or there is substantial likelihood that in the near future he or she will inflict serious bodily harm to the self or others, as evidenced by recent behavior causing, attempting, or threatening such harm, and all available less restrictive treatment alternatives which would offer an opportunity for improvement to his or

her condition have been judged to be inappropriate.

Now, having said that, the vast majority, and remember we had about two hundred thousand involuntary examinations last year in Florida. More than half of them, just over a hundred thousand of them were initiated by police officers. I want to put that into some context as well. It's more than the total number of arrests that police made last year for burglary, grand theft auto, and assault combined, are the number of law enforcement involuntary examinations in this state, which shows you how much the police are involved in this aspect of the issue.

The vast majority of these individuals are either released, or they agree to voluntary treatment. Last year only one thousand seven hundred eighty-seven people were in the state civil psychiatric hospital. We had two hundred thousand involuntary exams last year, all right, a mere fraction, less than one percent of the people that went in for an involuntary examination in Florida were adjudicated, meaning there was a court hearing and a judge

determined they should be involuntarily committed to a state hospital. It's a fraction. And it also, I'm going to talk about how that affects some of the gun laws that were passed, because it's left a gaping hole because of that.

Now, while there may be more people than the seventeen hundred that were actually committed what happens is if you are committed by the court and there is a not a bed available the individual languishes at the crisis stabilization unit until a bed opens up, which often can be months. The crisis stabilization unit does not get paid while the person is waiting for that bed to open up, so guess what happens in the vast majority of those cases? The person gets tired at staying at a CSU, which is a small facility inappropriate for long term care, they switch to voluntary status, they finally agree to take the pill, the shot, the medication, and then they get released back to the street without very few services.

Like the sheriff mentioned earlier that is one of the vexing problems of this, of this

situation. Florida does a pretty decent job of getting people examined for an involuntary hospitalization, but a very poor job of any follow up. I mean this is a sad commentary on our situation, but two weeks ago I took my dog to the vet. He had a minor little fungus that was easily treated. It was on a Saturday. Monday morning the veterinarian's office called my house to see how my dog was doing, wanted to know if he needed any extra assistance, or anything else they could do.

Do you want to take a guess how many people who left a crisis stabilization unit that had been deemed imminently dangerous to self or others got a call when they left the facility? We're treating our dogs better than we're treating our fellow citizens in our state. And while the science, research, and treatment for mental illnesses has significantly changed since the Baker Act was passed almost fifty years ago the criteria for involuntary hospitalization in Florida has stayed the same.

And unfortunately funding for mental health services in Florida has remained near or

at the bottom in the United States. It was discussed, discussed earlier, we are between forty ninth and fifty first per capita in mental health funding, which makes it very difficult to serve this population. In fact, only about twenty something percent of Floridians who need mental health services are able to get it. We should think about it this way. Could you imagine if you had cancer, and we told eighty percent of the people that had cancer that they couldn't get access to services because we only have enough money to serve twenty percent? That's what's happened here.

We have forgotten that these are real organ illnesses, they are illnesses of the brain. It is an organ. It's no different than heart disease, diabetes, cancer. In fact, what's more significant is that the recovery rates for people with serious mental illnesses is actually better than for people with heart disease and diabetes. The key is getting early treatment, access, and services to they can get into recovery and stay in recovery.

Generally, people with serious mental

illnesses are no more dangerous than the general population, and on medication they are actually much less dangerous than the general population without a mental illness. That doesn't mean that we should ignore the people that are exhibiting signs and symptoms, and we need to do a better job to make sure that we get them the services they need, and make sure that they do not get easy access to firearms.

Florida is also what we call a minority state. We are one of I believe four states that has the criteria for involuntary examination and involuntary commitment in the United States. And I don't believe we do that because we are this great civil libertarian state. I believe we do it because we're cheap. And if we have to acknowledge that more people need services we're going to have to acknowledge more money to pay for those services.

And so we have been incredibly restrictive in allowing people to get access to baker Act services, and I think really it's time that we start to look at some of the other states that are doing a better job in this arena, broaden

our criteria, but I will tell you we could have the most liberal criteria in the country and it will be useless if we don't improve that continuity and continuum of care when people leave those services, so if you're going to broaden the Baker Act, which I think you need to do, we also have to make sure there is a corresponding improvement on what we do with the individuals when they leave that system.

I'd also like to briefly address some of the loopholes that remain in both the Baker Act and for individuals that have been adjudicated incapacitated in guardianship proceedings, which I'm sure you have not even discussed. There's a whole other section in the law for people that have become what we call incapacitated, family members that may have dementia that are incapable of caring for themselves. So, under Florida law, for instance, if you have been incapacitated by the court, meaning that a guardian is going to be appointed to look out for your best interests, you can no longer get married. However, you can still go out and buy a gun, and keep a gun.

I think that something needs to be

adjusted. In fact, two days ago in USA Today on the front page there was a fascinating article. About nine percent of the households in the United States have family members sixty-five years or older that have dementia. Forty five percent of households with individuals forty-five years or older also possess firearms, and so there is real concern, and that's what the article was about, people with dementia accidentally shooting, killing spouses, neighbors, postal workers, because they get scared, they don't know what's going on, and they still have access to their firearms.

In 2018 the legislature enacted some really wonderful laws that were designed to bar people with mental illnesses from accessing or possessing guns, but what they did is they kind of left a big hole, and it goes back to what were just talking about a moment ago. So, what the law says, if you're adjudicated mentally defective, quote/unquote, or committed to a mental institution, you can no longer possess or own a firearm or get a concealed firearm permit. Only one percent of people out the two

hundred thousand that are going into our system are adjudicated. The vast majority are voluntary, and so it's left a hole.

So, if you come into a Baker Act facility, you meet the first criteria to be examined. You then go through the process where a doctor has found that you meet the criteria under dangerousness, but you decide to voluntarily take medication, that law does not apply to you, and you still have access to purchase and maintain a firearm.

Now, we fixed part of that on the purchasing of the firearm, but they didn't extend the same law that was passed three years ago that closed the loophole for people that moved to a voluntary status, and so one of the recommendations that you may want to consider is extending what we did on the purchase of a firearm for people that are switching to voluntary status.

Now, having said that there's still a problem with the implementation of that law. There was an article a few weeks ago that said about seventeen percent of people who should be on that list have not gotten on the list

because of delays between the providers sending the information to the Clerk of Court and the Clerk of Court in the circuits not appropriately getting those names on the list. In fact, in the article they said that about fifty-seven hundred people who should have been on the list and stopped from purchasing probably bought firearms during that period because they didn't get on there quickly enough. So, there needs to be some oversight in that system, there needs to be some accountability that needs to be added to make sure that wonderful law is actually being implemented appropriately.

Now, on a positive note there have been some very promising practices going on around the state with our law enforcement, particularly with the rapid expansion of crisis intervention team policing. And I'll give you a classic example from my own community. In Miami-Dade County we now have the largest trained squad of police officers in CIT in the United States. We have over six thousand officers at all thirty-six police departments in Miami-Dade County.

But it's not enough just to train the law enforcement officers, we also have trained all of our 911 call takers so when a call comes in the call taker knows to start to ask questions if the case involves someone with mental illness. If it does the dispatcher makes sure a trained officer gets dispatched to the scene, that is walking into a situation they understand, and they're more equipped to handle the situation. We also set up a four-hour training program for every police chief in Miami-Dade, and their majors, so that we can even train them on how to run a CIT program and coordinate it.

We have a liaison officer appointed at every single police department in Miami-Dade, and every station of Miami-Dade police department in the City of Miami that meet on a quarterly basis with our CIT coordinator, our providers, and our managing entity. It is the most amazing thing to watch because the level of collaboration and coordination in the largest county, in Miami-Dade County, stuns me in a wonderful way every single day, and it empowers the police officers to do their work.

And so, if they have a case where they've gone out two or three times and they don't feel it's being addressed adequately they report it to the liaison officer. The liaison officer then take that information to the quarterly meeting, or picks up the phone and calls my coordinator, who may call me, who I may have to call who I have to call, and immediately we intervene, immediately we make sure the system is working.

Between 2010 through 2017 we keep data on every single call the City of Miami and Miami-Dade Police Department makes, CIT call, because they handle about sixty percent of our mental health calls. They handled eighty-three thousand four hundred twenty-seven mental health calls, and out of the eighty-three thousand four hundred twenty-seven calls they only made a hundred forty nine arrests. Our police shootings almost stopped. Our police injuries almost stopped.

And they're making sure people are getting taken to a Baker Act facility if they meet criteria, and if not, they try to hook them up with other services. And if there's other

problems they work with us on a regular basis, and we coordinate all of that activity. Most of this is about communication. We've had a couple very serious situations in our community that could have turned into really horrible, horrible situations, but because of the level of collaboration and cooperation, and empowering our police officers to know who to call twenty-four hours seven days a week, we've been able to intervene in some situations that fortunately have never made the news. And the outcomes have been surprisingly positive with the two individuals I'm thinking about who are now in recovery back home, and under intensive treatment. So, it can be done.

So, in summary what I'd like to say is, number one, Baker Acting someone only means they are being taken in for an examination, and they can only get there if they meet criteria. It doesn't mean they're being committed to a hospital. Our criteria for examination and involuntary placement is almost fifty years old and does not reflect modern science, research, or medicine, and should be broadened, like most states have done, so long as we improve our

continuity and continuum of care.

Florida needs more civil state psychiatric hospitals so when people do meet criteria they don't languish at a crisis stabilization unit and figure out a way to get out quickly by taking a pill, but get into the hospitals that they need so that we can make sure that they get the services they need.

We need to close the remaining loopholes in the Baker Act, and then to guardian, excuse me, the guardian cases for individuals that are incapacitated. We need greater enforcement for the mental health providers and the clerk of courts to make sure that they're reporting the information once they have it, and so it doesn't get delayed, and people can't purchase firearms that should not be able to.

We also need to work with our insurance industry. One of the biggest problems in our mental health system in Florida is we do not have insurance parody, and so what happens is people who have insurance can't get mental health case with their insurance providers, and they get pushed into the public mental health system that's already overburdened and under

resourced, making it more difficult for more people to get access to care.

And we also need to do a lot more in the arena of trauma. Trauma is physiological. It's not an emotional response. We all have this little thing in our bodies called the pituitary gland, and the pituitary gland -- and you're like why is a judge talking to me about a pituitary gland. This is really important. The pituitary gland is part of your warning systems, so if you're a police officer and you go out to an accident where people have been killed in a car accident the pituitary is going to send a message to the adrenaline, and the adrenaline is going to release a chemical called cortisol, and it's your flight or fight mechanism, and it's going to tell you to leave.

But if you're a law enforcement officer, or if you're a soldier in active duty, you can't leave, and so what happens is the cortisol continues to fire, and it overdoses the brain, and it permanently alters the brain activity, and it causes PTSD. It explains why last year more police officers died in the line of duty, excuse me, died by suicide than in the

line of duty. It explains why law enforcement officers have some of the highest divorce rates, suicide rates, substance abuse rates, and domestic violence rates, because they suffer from very serious trauma issues.

My CIT coordinator gets a hundred fifty calls a month from police officers that we have trained for their own personal mental health issues. They will not, and do not want to go to their departments for help, and so we've actually had to set up a system for them to get help outside the department with the department's permission to make sure that they get treated, and it's helped.

But you have to understand ninety two percent of all the women in jail and prisons in the United States with a serious mental illness were sexually abused as children. A young brain that is overdosed with cortisol is damaged even more than an adult brain. Seventy five percent of men who are in the jail and prison with serious mental illnesses also have very serious trauma issues. So, one of the recommendations that I hope you are able to look at and make is that every pediatrician in

Florida should be screening for trauma, and our schools should be training out teachers how to identify kids that are showing signs and symptoms of serious mental illness.

The American Psychiatric Association Foundation, whose Board I serve on, has a program called typical or troubled, question mark, and it teaches teachers how to identify kids that are showing signs and symptoms. We wait too long, and the longer these illnesses go untreated the more damage there is to the brain, the more expensive it is, and the more dangerous situations become. And so, if we start to screen earlier we will get much better outcomes, and we will avoid some really horrific situations.

Thank you, I'll be happy to answer any questions that you may have.

CHAIR: Judge, do you know of any, you mentioned some other states, Florida is behind, fifty years old in the Baker Act, off the top of your head are there any state laws existing that you would recommend we look at for models for where, where we should go?

JUDGE LEIFMAN: Our supreme court has

looked at about four that we like. One of them in particular is Wisconsin. And all these laws have been upheld by their supreme courts, so they've passed constitutional muster. You know, I think what you want to look at when you're looking at the Baker Act, you want to look at where the science is. And so, we know that when someone is in a psychotic episode the longer it goes to get them out of that episode the more likelihood there's going to be permanent brain damage. So, if you have someone that's psychotic but may not be what we consider imminently dangerous to self or others we want to take a look at that individual and make sure they get treated so that they are not maintaining the illnesses, so they don't get permanent brain damage.

You know, we know that when kids are doing bad things with animals that can be an indication of something serious, so maybe harming or killing animals could be an added criteria. And the third one that we find our magistrates get frustrated with is you may have somebody at home that has destroyed the house, but they haven't made a direct threat against

any individual in the house so they're not meeting criteria. So, maybe the destruction of property can be an added piece to the Baker Act that would significantly strengthen the magistrate or judge's hand to be able to involuntarily commit.

Commissioners, any questions for Judge Leifman? No, okay.

JUDGE LEIFMAN: Can I just touch upon one question that was asked earlier about medication? There are -- there is study out of Harvard a year or two ago that said that most people that were getting arrested that had serious mental illnesses were not on medication, so I think the data really suggests that the medication actually reduces people's arrest rates, and it's not necessarily that they were on medication when they did something bad.

Now, having said that, the medications can have some very serious side effects. They can cause diabetes, weight gain, shaking, and so one of the problems that we have in Florida is the formularies that are used often are the older less expensive medications with more side

effects, and so it's harder to get people to take medication if they know they're going to get these really bad side effect. So, we want to make sure the best medications are available to people, but we also know that using too much medication for too long, there's a recent study that shows that it may actually shrink brain tissue, and so it's really important that when someone is in psychosis you get them out of it as quickly as you can, and have a really good doctor who understands these issues back down on the medication so they make sure that its done appropriately. All right.

CHAIR: Senator Book, go ahead.

SHER. ASHLEY: Can you reference that study?

JUDGE LEIFMAN: Pardon?

SHER. ASHLEY: You referenced that study as what?

JUDGE LEIFMAN: I'll send it to you.

SEN. BOOK: Thank you, Mr. Chair. And thank you, Your Honor, for being here and sharing all of your wealth of knowledge with us today. One of the things that the Chair and the commission has talked a lot about today is

the delta of the gap in services of individuals who may be leaving these CSUs and need more help. I had the privilege of visiting with you and some of the jail gap diversion programs that you have started in Miami-Dade, that while we have a great amount of resources in Broward County aren't necessarily being utilized, so could you just speak to some of those to enlighten the commission?

JUDGE LEIFMAN: Sure. We have a very sophisticated pre and post arrest diversion program. The pre-arrest is CIT, which I already mentioned, and we have three post arrest diversion programs. So, if anybody in Dade County is arrested they are immediately screened. The jail uses an updated screening tool, and we don't have corrections staff do it, we actually have a medical staff do the screening at the jail.

If there's an indication that the person has a serious mental illness they see a psychiatrist that day. The psychiatrist does a full assessment, and if they feel they meet criteria under the Baker Act they do a professional certificate that I mentioned

earlier, and within three days of the arrest of the misdemeanor they're blood tested, we make sure they have no communicable illnesses, they are then transported to a crisis stabilization unit. And because as I read the criteria under the Baker Act they have a criminal charge pending the seventy-two hours does not apply, so we reset the case in about two weeks, which is really what most of these individuals need for stabilization.

They don't necessarily need long term hospitalization, and they don't need an hour at a crisis unit, a couple weeks really seems to make all the difference in the world. They begin to stabilize. We send a member of our team to go visit with them. If they agree to go into our program, which about eighty percent of them do, they are not re-booked, they are picked up by our Department of Corrections and they are taken directly to the courtroom.

When they get to the courtroom there is a peer specialist waiting for them. I have eight peers that work for the court, four of them graduated from our program. The county has provided us a car. We have their actual

medication in court waiting for them. We have clothes. We have food. We have begun the Medicaid benefit process so that we can get them on federal benefits, and we can get them housing and treatment. We have housing available for them. And then the peer drives then where they're going to be sleeping that night.

They will get picked up, and they will be brought back to court when they need to come back in court, but during the period they're out of custody they have to go to a day activity program, they have to go to treatment, and they have to stay on their medication. And then they start to come in front of the court, and as they begin to recover we set them on a Friday late afternoon calendar where we monitor their progress and depending on the charge and priors in most cases the state attorney will drop the charge like any pretrial diversion program.

Our recidivism rate among our misdemeanor population went from seventy two percent to twenty. It worked so well that the state attorney allowed us to expand it to felony

cases, where we do a similar program for them on non- violent felony cases. That program has saved the county sixty-eight years of jail bed days. When we started our mental health diversion program in 2000 Miami-Dade County had a hundred eighteen thousand arrests per year. This year we're down to fifty-six thousand arrests. We're less than most counties in Florida.

Our jail audit has been cut almost in half. We closed one of our main jails, at a real savings of $12 million a year. And thankfully to the good people of Dade County, and my County commission and mayor, they're reinvesting about $42 million of the dollars we've already saved them, and we're now constructing, hopefully we'll begin in a week or two, the first of its kind in the country, a mental health diversion facility for the most acutely ill that keep recycling the deep ended system.

Florida Mental Health Institute at the University of South Florida has the ability to tell a community who the highest utilizers of criminal justice and mental health services are

in their community, so we send the names of thousands of people that had been arrested in Dade County over a five-year period who we knew had serious mental illness. And we thought, okay, we have huge prevalence in Dade, they'll narrow it maybe to a thousand, fifteen hundred people, but that will be a good start. They actually have, just so you understand, live data of all the FDLE records, all the Baker Act records, all the Medicaid and Medicare records.

They narrowed down these thousands of people to ninety-seven in Miami-Dade County, primarily men, primarily diagnosed with schizophrenia, primarily co-occurring and homeless, who over a five year period these ninety seven people were arrested twenty two hundred times, they spent twenty seven thousand days in the Dade County jail, thirteen thousand days at a Baker Act facility, or a crisis stabilization unit, or a hospital, cost tax payers $13.7 million, and we got nothing for it.

And so, this facility that we're constructing will be for this most acutely ill, because part of the problem, is you have to

think about these as mental illnesses, it's plural, and there's different levels of acuity of these illnesses. There is no capacity anywhere, it's not just Florida, for that really high utilizer population that's very sick. The system is painfully fragmented, painfully under resourced, and very difficult to access, because remember most crisis stabilization units, most community mental health providers, they were developed when most people in Florida and elsewhere were still in hospitals. They were never really designed for the most acutely ill, and we're not asking them to do more than they can do without the resources to do it.

And so, the building will really be a mid-level intensive level of treatment that will be a one stop shop that will have what we consider the fourteen essential elements that people that are that sick need to recover in one place. And it will be a medical home model, so we'll have primary health and psychiatric services, crisis unit, short term residential facility, a day activity program run by people with mental illnesses to teach

self-sufficiency. It has a magnificent kitchen for a culinary supportive employment program. We'll have a courtroom in there so that we can administer their cases, or Baker Act, or Marchman Act cases. We'll have trauma related services.

And instead of just kicking people to the curb once we have adjudicated their case we will slowly, gently, reintegrate them back into society with all the supports and services and long-term management to manage their illness. We don't have to fix the whole system. You can target the system and make it work for the people that need the different level of illnesses. Thank you.

CHAIR: Okay, thank you, Judge Leifman. We certainly appreciate you being here, and your expertise. So, that concludes the presentations in the open session for today. We made up a lot of time here this afternoon. I know I've had some discussions with some of you about, you know, potential, what we're going to do with the schedule the rest of the day, but I think it's best that we just power through this and, and continue with the closed

session, because we're not that far. We're only probably about fifteen, twenty minutes off schedule right now.

So, what we're going to do is hear the public comment, and then we'll announce the closed session, and then we'll begin with the agenda items in the closed session. So, for public comment, and again we will ask all those who are speaking during the public comment session section to limit your comments to three minutes. And the first person that we'll hear from is David Clemente.

PUBLIC COMMENTS

MR. CLEMENTE: Good afternoon, Chair and commissioners. My name is David Cobra Clemente. I am the Chapter Leader of Parkland Guardian Angels. I came into Parkland on the first day of the shooting. I been there ever since. The beginning of this school year when they started, start back up after this shooting, I brought in a team of Guardian Angels, which we've been at Douglas High School ten to twelve hours per day five days a week. We started our day off at 3:00 in the morning, and we didn't leave until the end of that last

bell at 3:00 in the afternoon.

We have the okay of the City. We had the okay of the commission, the okay of the mayor. We set up a tent outside of Douglas High School. We had hundreds and hundreds of parents that came by, stopped by, and either call or text the Guardian Angels and thank for our support. We had students that would stop by the tent to speak to the Guardian Angles. Most of the students who had been affect with the shootings stopped by and they talked to us and told how us how their feelings was of the, of the shootings. We had a whole lot of students, while they was in school they would call the Guardian Angles while we were sitting outside in the tent and told us the situation of what was going on inside the school.

We had hundreds of parents that would call us and let us know, that the kids feel safe when they see the Guardian Angels outside of that school every single day of that school year. Now, when the school year had ended we figure we can't do this for another year, because when we came in to Parkland, I am, I'm from Florida, I live in Tamarac, so when we

came into Parkland the guys that I brought there, my team that I brought there, we donated all our time, so the team that I brought into Parkland, they took four months out of work to make sure they're at that school every single day, and make sure those kids were safe, the teachers were safe, that community was safe.

Now we've decided that we would pull out of, pull out of the school so they get back to form, fortunately we received while we was away from Parkland hundreds and hundreds of calls that went into our national headquarters, and plus hundreds of calls that came into me, and text messages to me, through Facebook, and begging the Guardian Angels please do not leave Parkland, and do not leave this Douglas High School.

So, what the Guardian Angels decided to do, we're going to put together an Angel Watch Program for all five schools that's in Parkland, not inside the schools but the perimeter of the schools, on the outside of the schools. We are only the eyes and the ears of the police department, we only the eyes and ears of the community. What we see we say. We

see something, you say something. That's what we there to do.

We have -- we have the love, like I said, of Parkland, and plus the City of Parkland. We received awards from the commission, we received the highest award from Douglas, Douglas Stoneman High School, sorry, and we received awards from the mayor department, we received hundreds of letters that came in from the city. We received gift cards, and we received cards, you know, regular cards from the students. This is all from Parkland, but I what I would like, what I would like to do, and hope to see, is that's just Parkland, I would love for some of the commissioners that's here also to give the support to the Guardian Angels why we there. So, this is what I wanted to say.

CHAIR: Okay, thank you, sir, we appreciate your comments.

MR. CLEMENTE: Thank you, sir. Thank you, guys. Thank you.

CHAIR: Next citizen comment is Jeff Ostroff.

MR. OSTROFF: Hi, good afternoon,

commissioners. I just wanted to touch base on the topic I brought up yesterday about the, you know, the repeaters. You know, it's great that we're moving on this new system, the new radio system, and that I think eliminates one of the big weak links in our system here. But then when you remove the big links now you want to start looking at some of the smaller ones, and one of the ones that I had figured causes a problem for us is what if all of the sudden you got this new system, and now you're racing to the scene of active shooting, and you run into the building and now you have no signal. That just kind of undoes everything you worked for so hard.

So, what I had suggested yesterday, and what I wanted to expand on a little bit, was putting, you know, repeaters inside the schools for your public services frequencies. And to do that you don't just put a, you know, a repeater up on the wall, you have to, and call it day, and say it's beer thirty, let's go home. You'd really need to go around and characterize the entire campus, and you need to find out where you have voids in the signal.

You got to check all your classrooms, the hallways, the staircases. You've got to check the cafeteria, the administration offices, and you got to make sure that there aren't any voids in coverage anywhere. You don't want to run into a building anywhere and find out that your radio didn't work, because if you thought public outcry was bad on this case just wait until it happens again, and the public is really mad. You don't want to be on the end of that barrel for sure.

And then one of the other logistical ideas I was thinking about is, you know, now with the new Senate bill, the 7026, and there's more security in the schools now, you know, you might find a lot of schools have single point entry now, and all the doors are going to be locked, but if you have a hundred fifty cops racing to the scene of an active shooting system how are you going to get in the door, who has the key? Has that all been worked out, you know, is there like a lock box on the outside of the building with master keys that you can hand out real quickly, because you won't have time to run to the office to find

the security guys, or whoever might have the key. They might hide in the, in the custodial closet, as we saw at MSD.

So, those are some things that I think you should all consider and work out. Thanks.

CHAIR: All right, thank you. Michael Sirbola.

MR. SIRBOLA: Hello. As we said earlier, trauma is biological. This is really important. Culture is biology. We are humans, not animals. We are tool users. Humans do not literally gnaw on themselves, as will an animal stressed beyond its ability to cope. No, what we do is we use tools, not teeth, we cut. Our children are literally gnawing on themselves. What are we going to do about it?

Your punitive versus empathy-based system prevents people from calling the place, DCF, or school counselors. They're afraid. They wait until they're almost dying before they make the call, in the case of the hospitals. We aren't trustable to deliver help instead of condemnation and judgment, and we tend to make things worse in many occasions, at least in the eye of the public. This needs to change.

Right now, you know, speaking of making things worse, we're about to put in a person with a gun in every one of our schools. There's a shortage of those so we're going to have eighty guardians. We just heard some truly terrifying statistics on police and military mental health. I'm going to ask that you as a committee, following just as the FDA does when it's investigating drugs, if it finds great efficacy it steps in and changes the course of that, and puts it out and makes it available to everyone. I'm going to ask that you as a committee perhaps meet in private and come to the conclusion that those eight officers, or two hundred fifty, get trauma aware training so that they can calm themselves, and so they can know how to deal with these children.

It's very specific training. Dr. Ablon with Think:Kids.org trained all five thousand plus officers up in New York and saw more than a fifty percent reduction in antagonistic interdictions. And then there's also Dr. Gordon with the Mind Body Medicine Institute that will help them to learn how to calm

themselves in, in difficult situations, and deal with their own trauma. I'm talking about the officers. Please, this is an emergency request. As a commission it's something that isn't on your current agenda, but I ask that you consider to do because we need to get this training done before they come in here.

Under funding is child abuse. This isn't happening by accident. Our kids aren't the issue, we are. We implemented zero tolerance, and disrespected our own children, and created an us and them situation, and we're dealing with their response to our actions. How many of you I wonder are aware of the billion-dollar complex PTSD lawsuit in Compton, California? It was filed by a number of teachers, actually six. There were six teachers and students who got together, they sued the school district in a billion-dollar lawsuit.

If you're not familiar with what complex PTSD is it's what we do to our children every day in our society in schools where they're basically pinpricked just a little bit, and they have no control over that, and over time that affects who they are, how they behave. In

other words, this doesn't, this changes how we react to things. We think more in terms of black and white, we're more reactive --

CHAIR: Okay, thank you, Mr. Sirbola.

MR. SIRBOLA: -- and then it affects our organizations, all of them, all of them, because --

CHAIR: Your time -- your time is up. Thank you.

MR. SIRBOLA: -- it's behaviorally transmitted. Thank you.

CHAIR: As we transition now into the closed session, in order to do that I've got to read the following. This meeting requires us to here and discuss active criminal investigative information, active criminal intelligence information, and/or other information that is confidential and exempt under Florida law. Because of this under the authority of Florida Statute 943.687(8) the meeting is closed to the public and is exempt from Florida's Sunshine Law found at Florida Statute 286.011 and Section 24(b) Article I of the State Constitution.

The required written declamation of the

commission chair will be entered into the commission minutes. Only authorized commission members, commission support staff, and persons otherwise specifically authorized by the Chair may attend this meeting. We will not reconvene today in a public meeting. We will take a brief break and begin the closed portion of the meeting in about five minutes. Thank you for your consideration.

So, we'll take a five-minute break, and we'll come back in closed session.

(Thereupon, the above meeting concluded for the day.)

C E R T I F I C A T E

(STATE OF FLORIDA)

(COUNTY OF BROWARD)

I, NIDELIS GONZALEZ, Reporter, certify that I was authorized to and did report the foregoing proceedings and that the transcript is a true and correct transcription of my notes of the proceedings.

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NIDELIS GONZALEZ, Reporter

Commission Number: FF188630

Expires: 01/11/2019

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