Report on Involuntary Examination of Minors

Prepared by:
The Florida Department of Children and Families
University of South Florida

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Involuntary Examinations of Minors

REPORT HIGHLIGHTS

Factors that Literature Suggests are Related to a Decline in Children's Mental Health

- Poor overall well-being
- Social media use
- Social isolation and loneliness
- Stigma
- Trauma
- Poor access to and coverage of services
- Workforce shortages

Social Media and Children*

- Almost 40% of children ages 8-12 use social media
- Up to 95% of youth ages 13-17 use social media
- More than 33% of youth ages 13-17 use social media "almost constantly"

**Statista.com - Share of Children Owning a Smartphone in the United States in 2015, 2019, and 2021*

Protective Factors for Children's Mental Health

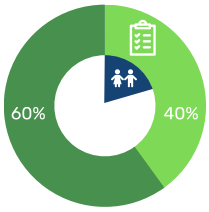
- Connection to school and family
- Access to support services
- Coping and problem-solving skills
- Presence of mentors and support for development of skills and interests
- Emotional self-regulation

Involuntary Examinations for Children, FY 2021-2022

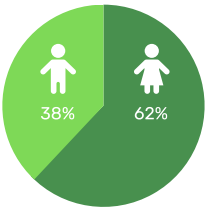
25,387 CHILDREN TOTAL

34,304 INVOLUNTARY EXAMINIATIONS TOTAL

Repeat Exams	Children %	Exams %
1	81.37%	60.22%
2	11.48%	16.99%
3	3.53%	7.84%
4	1.67%	4.93%
5	0.75%	2.77%
6-10	1.08%	5.72%
11+	0.13%	1.54%



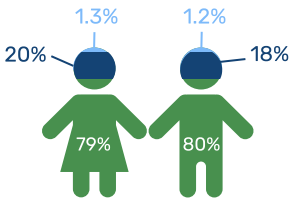
19% of children accounted for **40%** involuntary examinations.



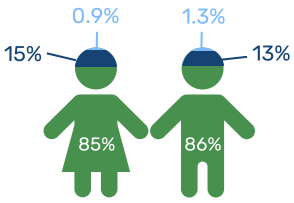
62% of involuntary examinations of children (<18) were females.

Children by Race, Involuntary Examinations, FY 2021-2022

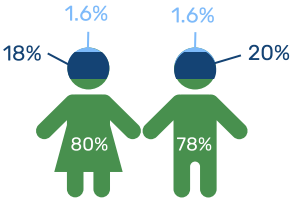
- 6+ Involuntary Examinations
- 2-5 Involuntary Examinations
- 1 Involuntary Examination



White Non-Hispanic



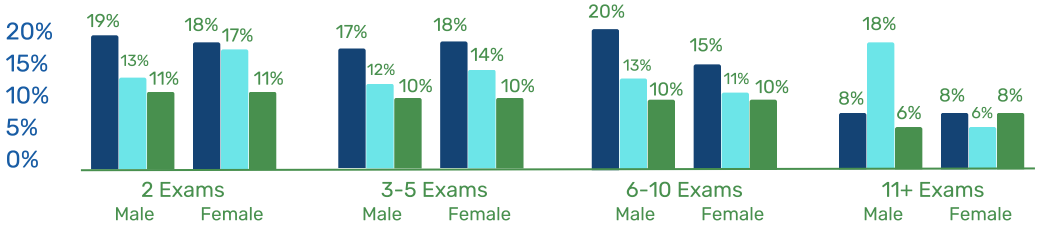
White Hispanic



Black
(Hispanic and Non-Hispanic)

Involuntary Examinations at School

- Ages 5-10
- Ages 11-13
- Ages 14-17



Child Welfare Involved Involuntary Examinations

- Ages 5-10
- Ages 11-13
- Ages 14-17

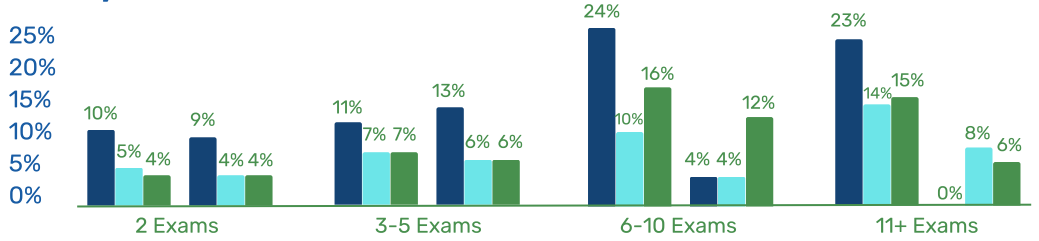


Table of Contents

I. Background

In 2019, section 394, part I, Florida Statutes (F.S.), the Florida Mental Health Act, was revised to require additional reporting in odd-numbered years detailing findings on repeated involuntary examinations of minors (Baker Acts), as follows:

> *394.463(4), F.S. DATA ANALYSIS. — Using data collected under paragraph (2)(a), the department shall, at a minimum, analyze data on both the initiation of involuntary examinations of children and the initiation of involuntary examinations of students who are removed from a school; identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child or student; study root causes for such patterns, trends, or repeated involuntary examinations; and make recommendations to encourage the use of alternatives to eliminate inappropriate initiations of such examinations. The department shall submit a report on its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1 of each odd-numbered year.*

The data collected per section 394.463(2)(a), F.S., refers to documents that Baker Act receiving facilities are required to submit to the Department of Children and Families (Department). Until August of 2023, the Baker Act Reporting Center at the University of South Florida was named in 65E-5 Florida Administrative Code (F.A.C.) as the entity that receives documents on behalf of the Department, enters data from them, and produces reports from data. Effective July 1, 2023, this process was revised to require that designated Baker Act receiving facilities enter involuntary Baker Act examination data into the Department's Baker Act Data Collection Portal (BADCP).

II. Baker Act Examinations of Minors

The following text, tables, and figures were produced using data primarily from involuntary (Baker Act) examinations in Fiscal Year (FY) 2021-2022 which is the most recent FY of data available for current reporting, and some information within focuses on prior years of data. Also of note, receiving facilities were not required to submit documents for individuals voluntarily examined, denoting that the following data captures only involuntary examinations.

A. Overview of Baker Act Document Submission and Data Entry

Section 394.463, F.S., requires the Department to receive and maintain copies of ex-parte court orders, involuntary outpatient services orders, involuntary inpatient placement orders, professional certificates, law enforcement officers' reports, and reports relating to the transportation of individual.

During FY 2021-2022, rule 65E-5.280, F.A.C., specified the process for data submission and required that Baker Act receiving facilities submit Baker Act forms to the Baker Act Reporting Center, which is housed in the Department of Mental Health Law and Policy, de la Parte Florida Mental Health Institute, College of Behavioral and Community Sciences at the University of South Florida. The identified below must be submitted to the Baker Act Reporting Center within five working days after the individual arrives at the receiving facility. The forms received at the Baker

Act Reporting Center are listed in Table 1. The data analyzed for reporting come from data entered from these forms. If a data element is not present on forms, it is not in the Baker Act Reporting Center data.

Table 1: Forms Submitted to the Baker Act Reporting Center

Form[1]	Form Name
The underlined text below and elsewhere indicates a hyperlink to a web page. The links below will bring you to each form on the Department's website.	
CF-MH 3052a	Report of Law Enforcement Officer Initiating Involuntary Examination
CF-MH 3052b	Certificate of Professional Initiating Involuntary Examination
CF-MH 3001	Ex-Parte Court Order for Involuntary Examination
CF- MH 3118	Cover Sheet to the Department

For the defined time period, the Cover Sheet (CF-MH 3118) was used to systematically report demographic and provider information that corresponds to forms CF-MH3052a, CF-MH3052b, and CF-MH3001 listed above.[2] Upon receipt of forms, the Baker Act Reporting Center enters data and produces reports on behalf of the Department. Links to the statute, administrative code, forms, and other materials can be found on the Department's Crisis Services – Baker Act web page.[3] Additional resources readers may want to reference are as follows (with links provided):

- The Baker Act receiving facility list
- Baker Act (section 394, part I, F.S.)
- Rule 65E-5, F.A.C.
- Annual Baker Act Reports

The analyzed Baker Act data is from involuntary examination forms received by the Baker Act Reporting Center. Involuntary examinations occur at Baker Act receiving facilities designated by the Department and include hospitals licensed under Chapter 395, F.S., and Crisis Stabilization Units (CSUs), licensed under Chapter 394, per section 394.4612, F.S. It is an important note that an involuntary examination does not always result in admission. As a result, the data is of involuntary examinations, not admissions data or counts of voluntary examinations. A summary of services relevant to content are in Appendix A.

B. Analysis of Baker Act Examination Form Data Elements

1. Counts of Involuntary Examinations by Fiscal Year

Information regarding involuntary examinations for five years, from FY 2017-2018 through FY 2021-2022, by age group are in Table 2, for all children in Figure 1a, and for children by age groups in Figure 1b. Population counts specific to each age group were used as the denominator to compute the rate per 100,000 of involuntary examinations. Over the previous **five years,** the rate of involuntary examinations per 100,000 population decreased slightly as follows: all children defined as less than 18 years of age: 1,202-1,144, ages 5 to 10: 299-203, age 14 to 17: 2,334-2,251. Over the five years, the rate of involuntary examinations slightly increased for children 11-13 years old from 1,441 to 1,494.

[1] Link to the Department's web page, including links to forms: Florida Department of Children and Families Crisis Services

[2] As per a change that took effect in 07/01/2023, Baker Act receiving facilities are required to enter data from the 3052a, 3052b, and 3001 forms into the new Baker Act Data Collection System (BADCS). Baker Act receiving facilities no longer upload forms to the Baker Act Reporting Center for data entry. These forms and the Transportation Form (3100) are also securely uploaded by Baker Act receiving facility staff to the BADCS. Receiving facilities no longer have to complete the Cover sheet (form 3118), but information from many elements that are contained on form 3118 are entered by Baker Act receiving facility staff into the BADCS. Specifics about this process and the forms are contained in *Florida Administrative Code, Rule Chapter 65E-5.120*.

[3] Additional information about topics such as Baker Act Involuntary Examination Criteria, Processes and timeframes, Discharge Planning, History of the Baker Act, and Patient's rights can be found at the Department's web page titled, Baker Act Additional Resources.

Table 2: Involuntary Examinations, Population, and Rate of Involuntary Examinations Per 100,000 Population by Age Groups

Fiscal Year	Involuntary Examinations Per Fiscal Year				Population by Calendar Year (Denominator to Compute Rate Per 100,000)					Rate of Involuntary Examination Per 100,000 Population				
	<18	5-10	11-13	14-17	Year	<18	5-10	11-13	14-17	Fiscal Year	<18	5-10	11-13	14-17
FY2021-2022	36,188	2,925	10,996	22,267	**2021**	3,164,482	1,439,274	735,895	989,313	**FY 2021-2022**	1,144	203	1,494	2,251
FY2020-2021	38,565	2,964	11,767	23,834	**2020**	3,132,279	1,419,080	729,316	983,883	**FY 2020-2021**	1,231	209	1,613	2,422
FY2019-2020	35,979	3,653	10,300	22,026	**2019**	3,097,580	1,397,269	722,759	977,552	**FY 2019-2020**	1,162	261	1,425	2,253
FY2018-2019	37,982	4,658	11,146	22,178	**2018**	3,056,048	1,386,973	708,286	960,789	**FY2018-2019**	1,243	336	1,574	2,308
FY2017-2018	36,150	4,099	9,957	22,094	**2017**	3,008,195	1,370,867	690,907	946,422	**FY2017-2018**	1,202	299	1,441	2,334

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Figure 1a: Counts of Involuntary Examinations for Children (<18) for 5 Years

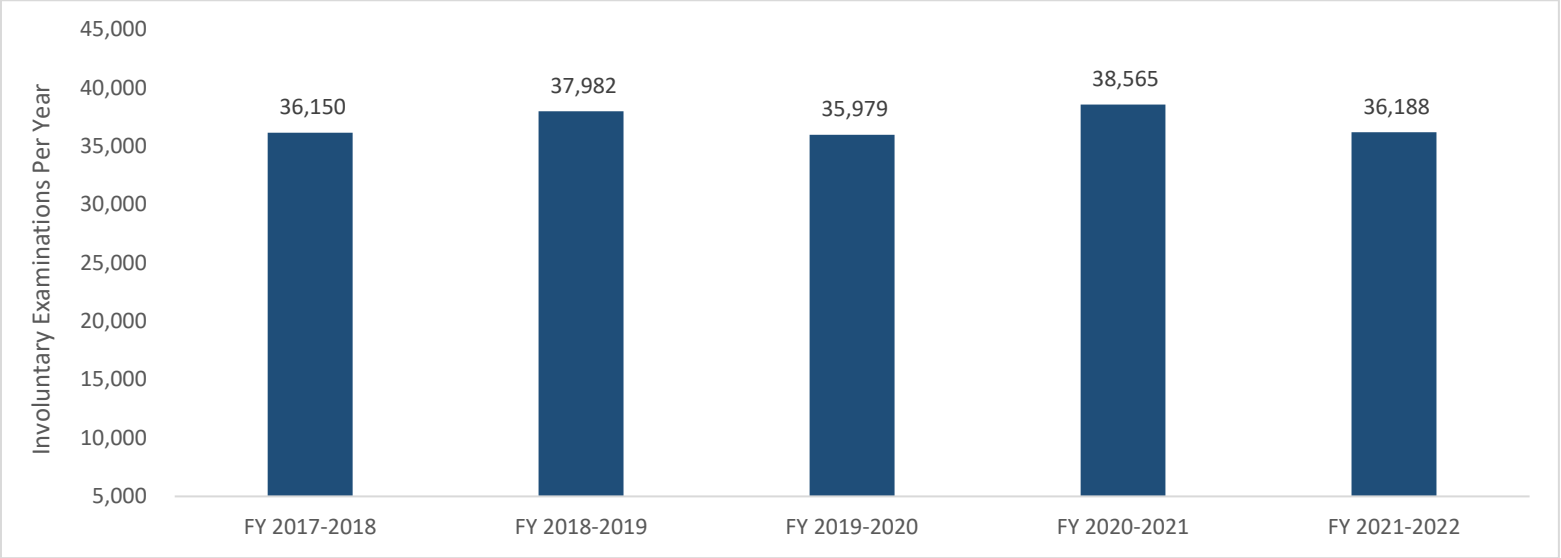
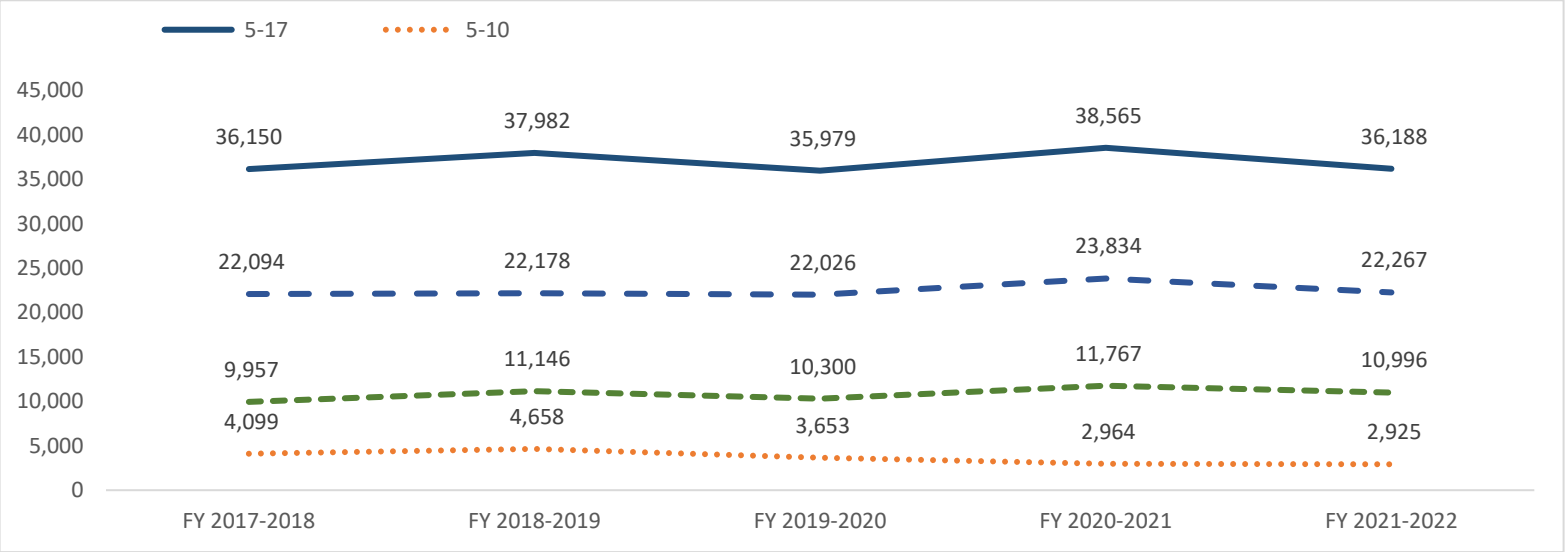


Figure 1b: Counts of Involuntary Examinations by Age Group for 5 Years



2. Repeated Involuntary Examinations – Summary

Repeated involuntary examinations for children (<18) for 1 year (July 2021 through June 2022) and three years (July 2019 through June 2022) are summarized in Table 3.

Table 3: Repeated Involuntary Examinations for Children for 1 Year and 3 Years

1 Year					3 Years				
Involuntary Examinations in FY 2021-2022	Children	%	Exams	%	Involuntary Examinations in FY 2019-2020 through FY 2021-2022	Children	%	Exams	%
All Children									
1	20,657	81.37%	20,657	60.22%	1	46,426	73.56%	46,426	44.23%
2	2,914	11.48%	5,828	16.99%	2	8,740	13.85%	17,480	16.65%
3	896	3.53%	2,688	7.84%	3	3,214	5.09%	9,642	9.19%
4	423	1.67%	1,692	4.93%	4	1,696	2.69%	6,784	6.46%
5	190	0.75%	950	2.77%	5	936	1.48%	4,680	4.46%
6-10	273	1.08%	1,961	5.72%	6-10	1,578	2.50%	11,663	11.11%
11+	34	0.13%	528	1.54%	11-19	426	0.68%	5,759	5.49%
Counts for 20+ are not included in order to redact small cell sizes					20+	94	0.15%	2,526	2.41%
Grand Total	**25,387**	**100%**	**34,304**	**100%**		**63,110**	**100%**	**104,960**	**100%**

1 Year: For FY 2021-2022 (1 Year), there were **25,387** children with **34,304** involuntary examinations. Children with multiple involuntary examinations account for a disproportionate percentage of involuntary examinations. For example, **4,730** children with two or more involuntary examinations during the year accounted for **18.63** percent of children but accounted for **39.78 percent** of all involuntary examinations.

3 Years: For FY 2019-2020 through FY 2021-2022 (3 Years), there were **63,110** children with **104,960** involuntary examinations. Children with multiple involuntary examinations account for a disproportionate percentage of involuntary examinations. For example, **16,684** children with two or more involuntary examinations during the three years accounted for **26.44 percent** of children but accounted for **55.77 percent** of all involuntary examinations.

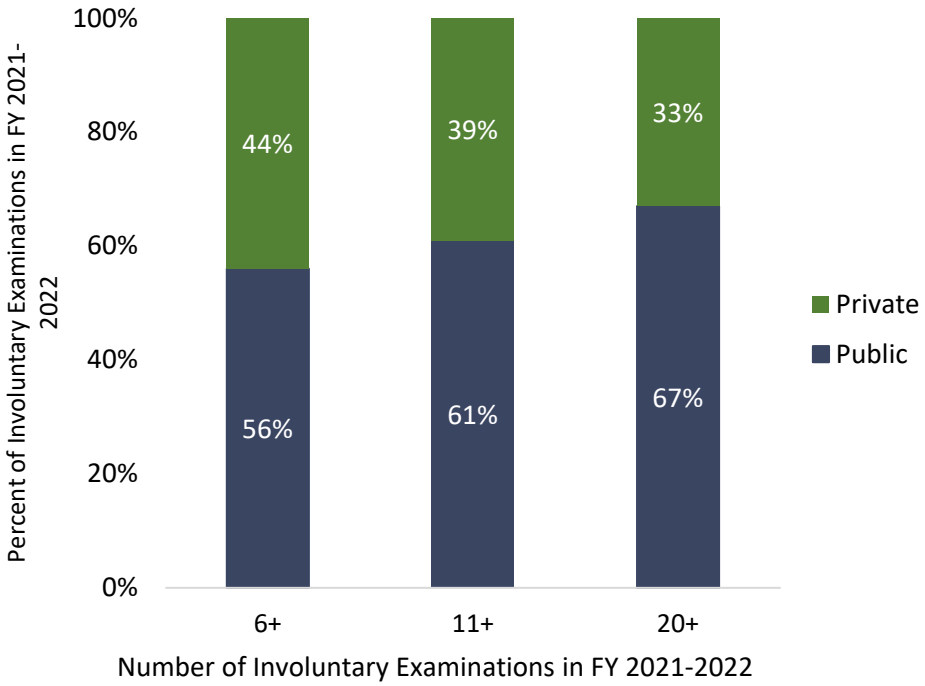
Gender: Nearly 66 percent of involuntary examinations of children (<18) are for females and are true for both 1-year and 3-year periods and varying amounts of involuntary examinations during those time periods (see Table 4).

Table 4: Gender for Children Based on Number of Involuntary Examinations in FY 2021-2022

Involuntary Examinations During Time Period	1 Year FY 2021-2022		Three Years FY 2019-2020 through FY 2021-2022	
	Male	Female	Male	Female
1	38%	62%	44%	56%
2	38%	62%	45%	55%
3	36%	64%	47%	53%
4	42%	59%	47%	53%
5	39%	61%	47%	53%
6-10	38%	62%	44%	56%
11+	31%	69%	56%	43%

Public and Private Receiving Facilities: More involuntary examinations for children with high numbers of involuntary examinations occurred at publicly funded receiving facilities.

Figure 3: Involuntary Examinations for Children (<18) at Public and Private Receiving Facilities

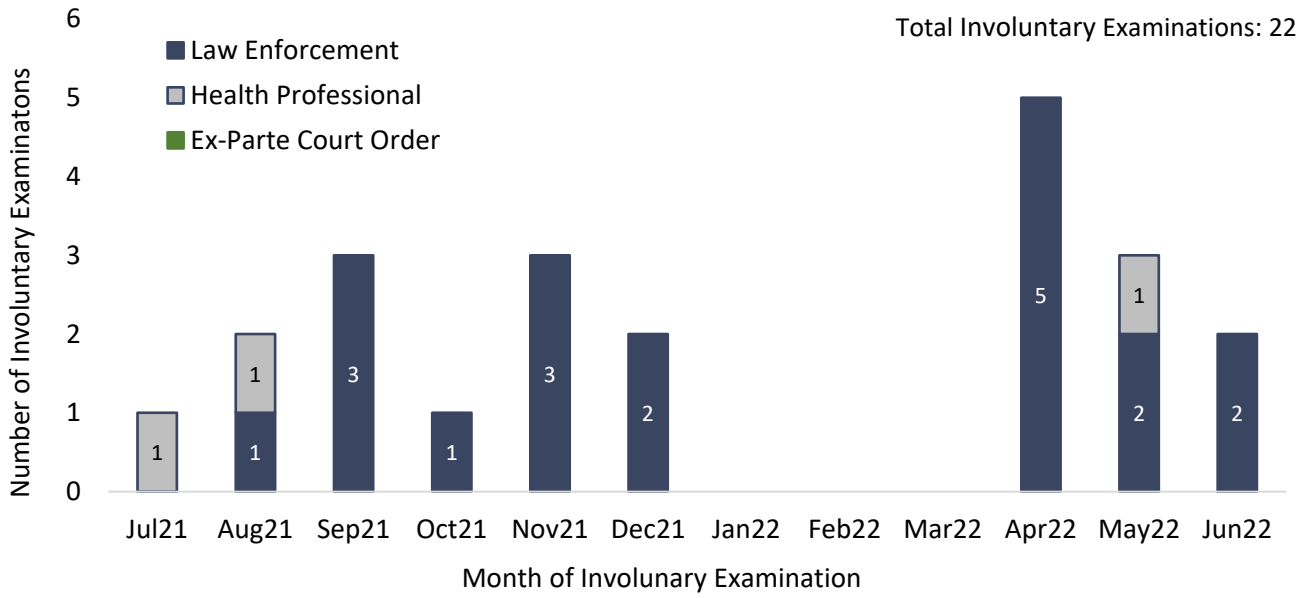


3. Person Level Examples of Repeated Involuntary Examinations for One Year (FY 2021-2022)

A one bar chart was created for each child of the 34 children with 11 or more involuntary examinations in FY 2021-2022. The range of involuntary examinations for the group was 11 to slightly less than 50.[4] In Figures 4a-4d are examples of the types of patterns identified in the bar charts.

Figure 4a is an example of a child with 22 involuntary examinations during the year. The child had between one and three involuntary examinations over a six-month period, then none for three months, then between two and five for the next three months.

Figure 4a: Involuntary Examinations for One Child for One Fiscal Year by Month – **Example 1**



[4] The exact count is not provided to protect identity given that the count that is a number slightly less than 50 is for one child.

Figure 4b is an example of a child with 18 involuntary examinations grouped over six months. Figures can be created going back to January 2018, which shows the longer-term pattern.

Figure 4b: Involuntary Examinations for One Child for One Fiscal Year by Month – **Example 2**

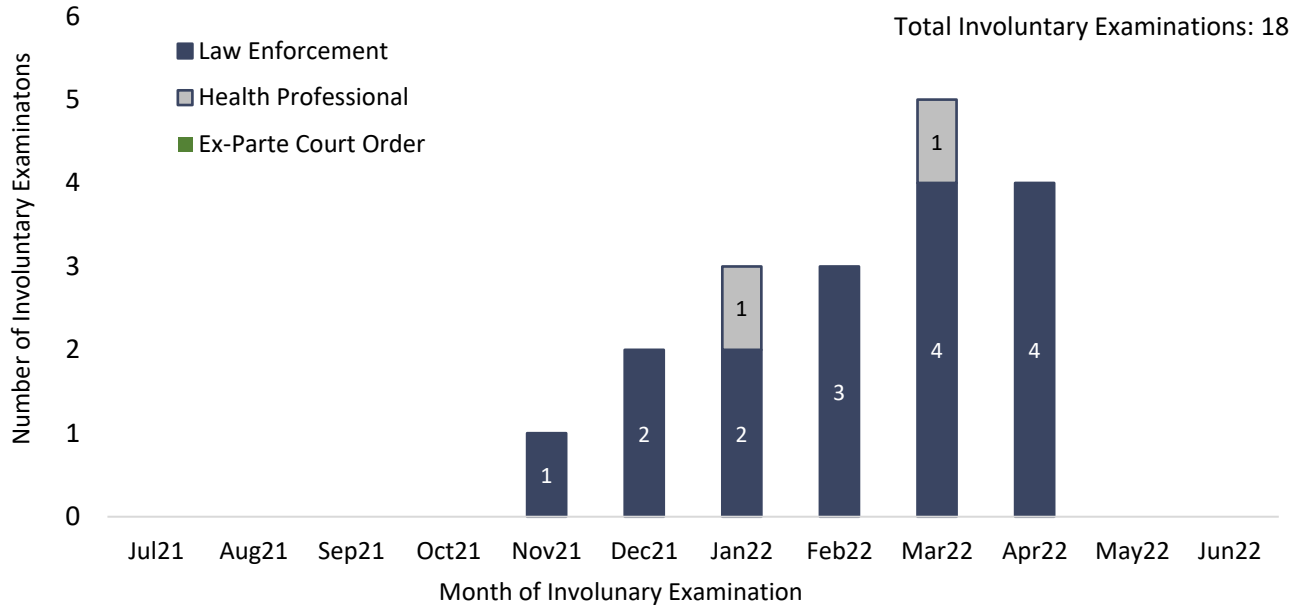


Figure 4c demonstrates a pattern of only law enforcement initiated involuntary examinations with at least one for each month during the year except for January.

Figure 4c: Involuntary Examinations for One Child for One Fiscal Year by Month – **Example 3**

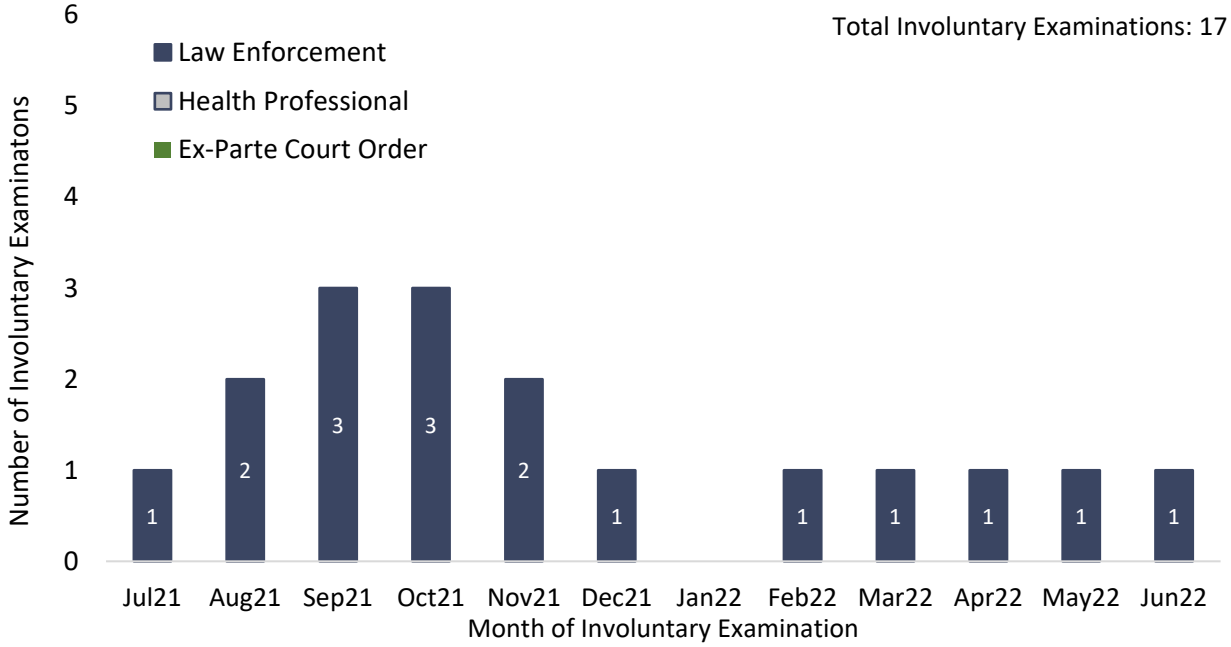
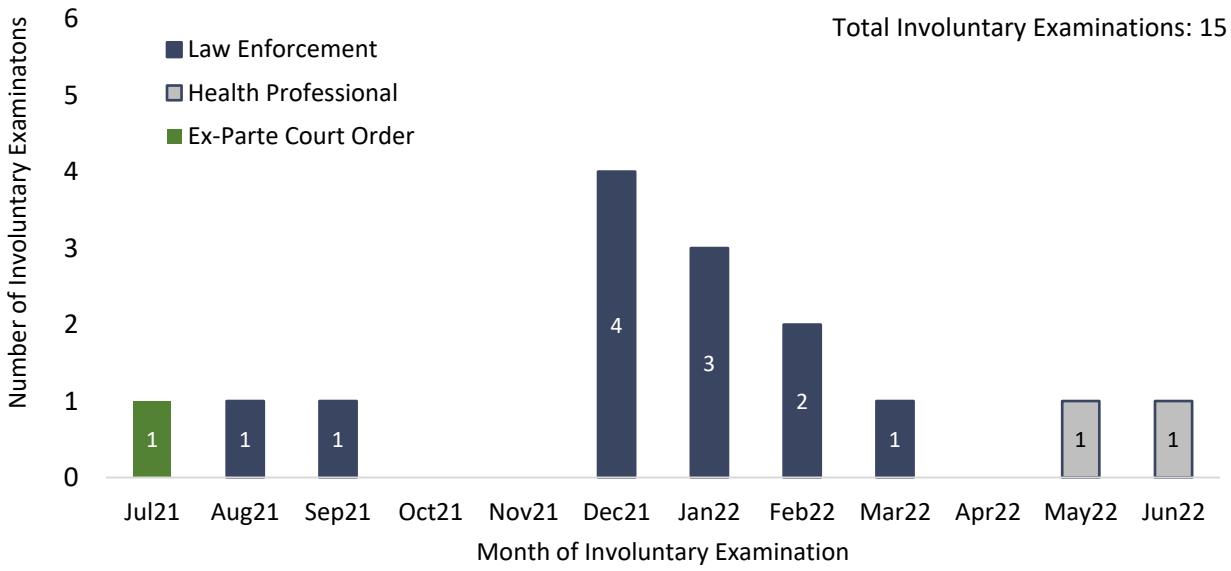


Figure 4d is a child that had involuntary examinations initiated by ex-parte court order, law enforcement and health professionals.

Figure 4d: Involuntary Examinations for One Child for One Fiscal Year by Month – **Example 4**



4. County Level Information

Appendix C contains two tables of information on a variety of metrics at the county level. Readers focusing on a specific county can reference the metrics to provide more context about the county of focus. Section information includes some counties to demonstrate certain issues related to repeated involuntary examinations. Specific counties were chosen to present information as described below.

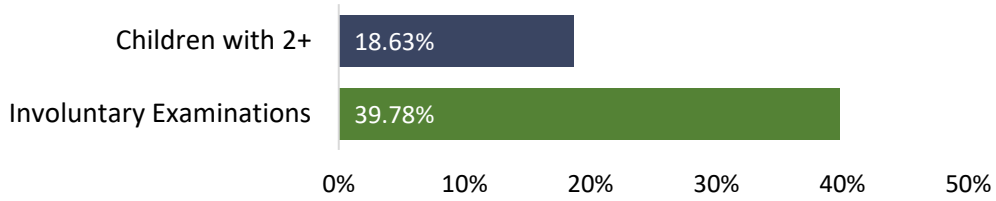
- **Small Numbers Impacting Reporting:** Information for only 42 counties for figures on pages 11 through 14, and for 23 counties for figures on pages 19 through 25 are reported in bar charts due to the small numbers of involuntary examinations for children in relation to the level of reporting.[5]
- Some figures are missing bars due to no children in that category who had an involuntary examination for the year.
- Abbreviations are used for Non-Hispanic (NH) and Hispanic (H) due to space constraints.
- Percentages for African American/Black children are combined for those who were and were not of Hispanic origin because of the small percentage of children reported to be Black Hispanic and the need to redact for small cell sizes.

[5] For example, guidance provided by the Minnesota Department of Health provides an example "[w]when you have cells within tables, are some of the counts less than 5? If so, be cautious in presenting this data. Any calculated percentages will be unstable given the small denominator. A change of one person could make it seem like a 20% difference. In addition, depending on what data you are using, a small cell size could lead to the identification of an individual. In general, a cell size of fifteen or more tends to have more stability in terms of rates or percentages. See Minnesota Department of Health - Data: Quality, Analysis, and Interpretation Also see Washington State Department of Health: Guidelines for Working with Small Numbers and New York State Department of Health: Rates Based on Small Numbers- Statistics Teaching Tools.

5. Proportion of Children to Proportion of Involuntary Examinations

As seen in Table 3, children with multiple involuntary examinations account for a disproportionally sizable percentage of involuntary examinations. The figures on the following pages represent statewide, and 42 counties for children with two or more involuntary examinations in FY 2021-2022. Tables account for a) percentage of all children with Baker Act examination these children account for (blue bar) and b) percentage the involuntary examinations are of the total involuntary examinations for the year. For example, statewide, the 11 children with two or more involuntary examinations account for **18.63 percent** of children with involuntary examinations, but the involuntary examinations accounted for **39.78 percent** of all involuntary examinations for the year.

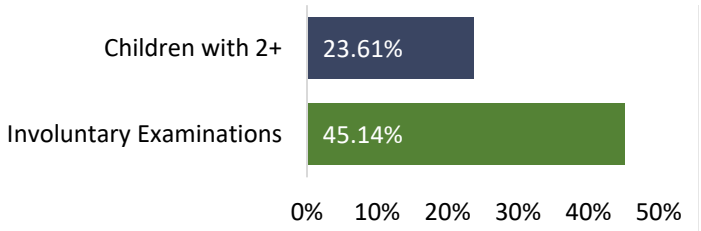
Figure 5: Percentage of Children with Two or More Involuntary Examinations and the Percentage of Involuntary Examinations Out of the Total



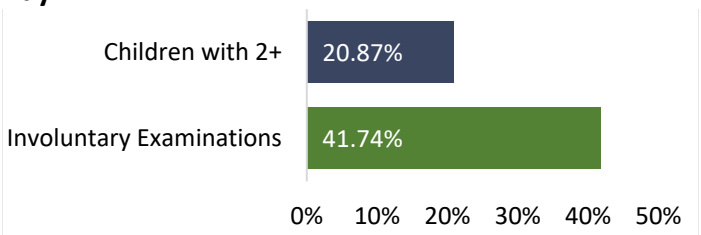
Variability in the metrics is evident in the 42 counties for which bar charts are provided on the following pages. For example, children who were residents of Broward County and had at least two involuntary examinations in FY 2021-2022 account for **13.52 percent** of the children with involuntary examinations, but the involuntary examinations accounted for **29.82 percent** of all involuntary examinations for children for that county for the year. In contrast Pasco County, where **20.16 percent** of children with two or more involuntary examinations accounted for **40.39 percent** of the involuntary examinations. Pasco County had more children with two or more involuntary examinations compared to Broward County, which is one example highlighting variability across counties.

Table 5a. Proportion of Children to Proportion of Involuntary Examinations

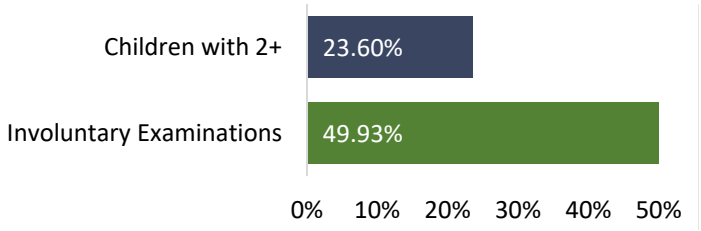
Alachua



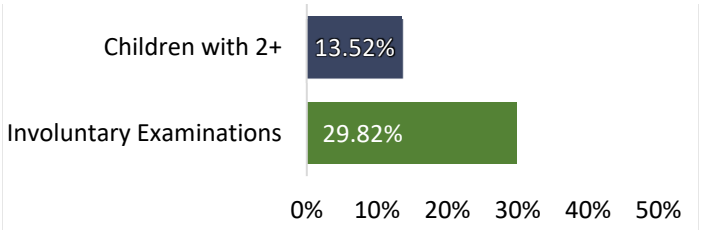
Bay



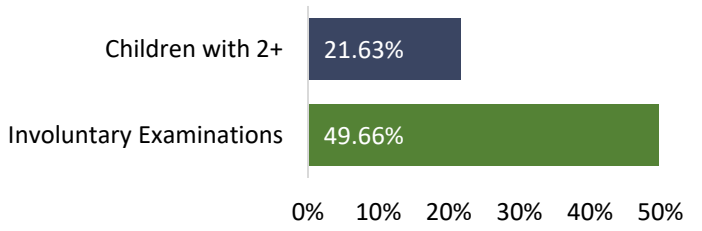
Brevard



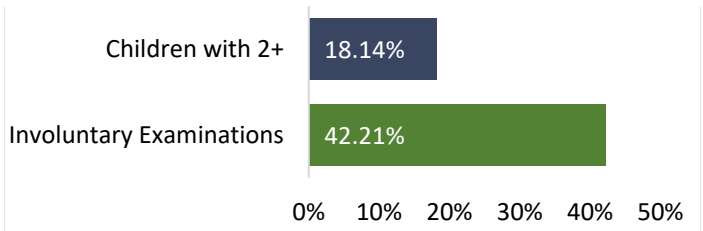
Broward



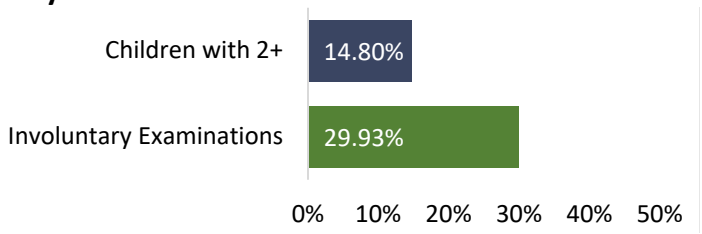
Charlotte



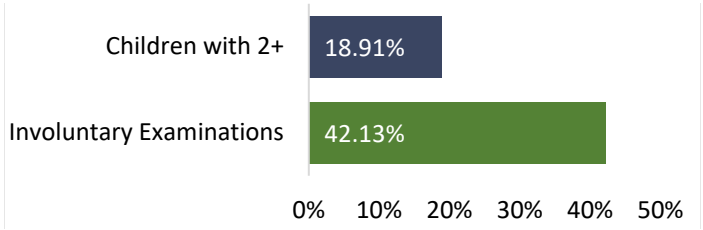
Citrus



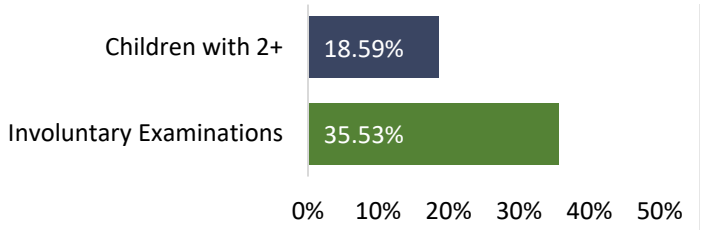
Clay



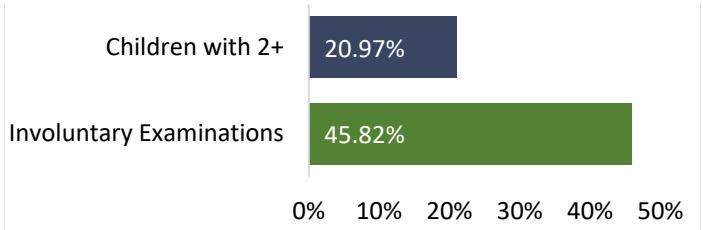
Collier



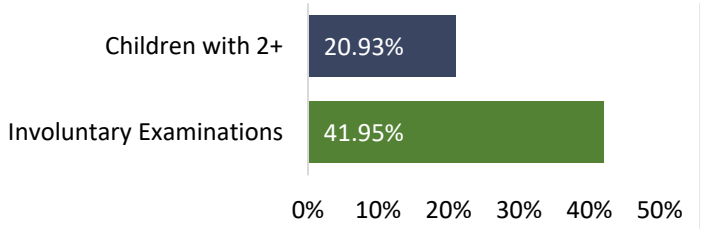
Columbia



Duval



Escambia



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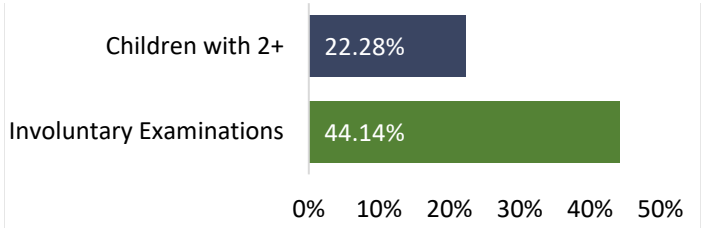

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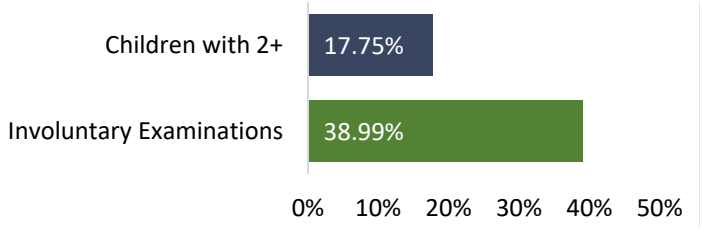

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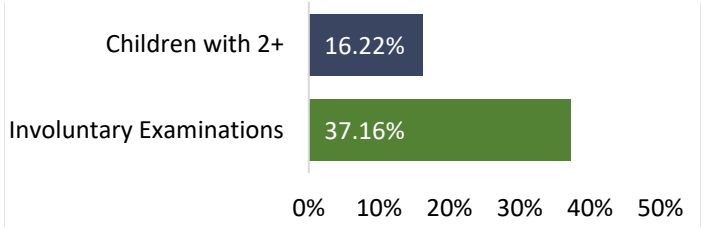
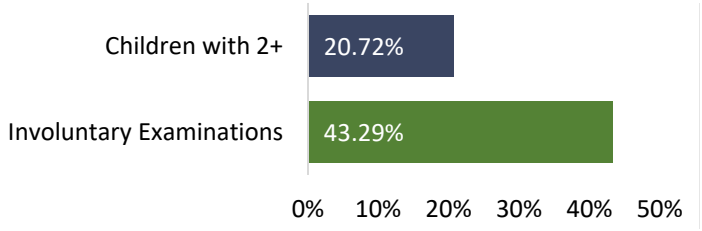
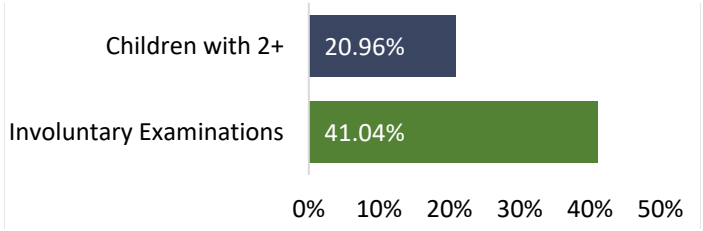


Hillsborough



Indian River



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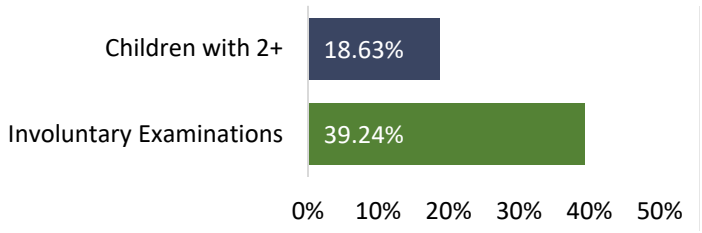

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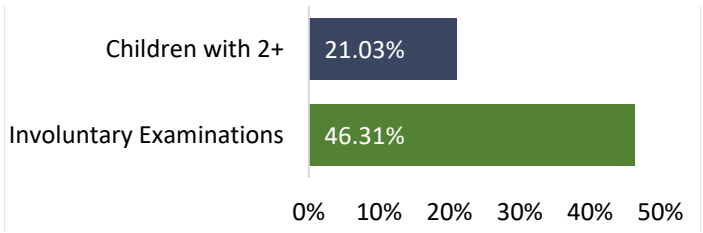

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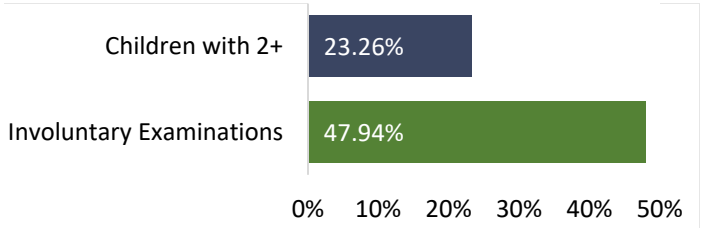

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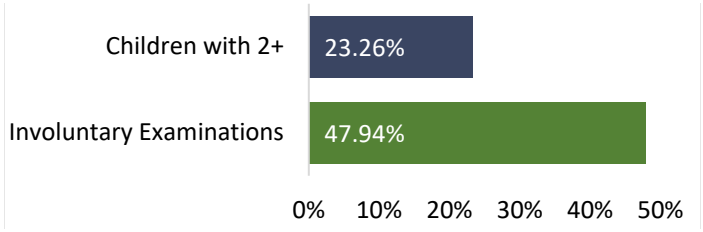

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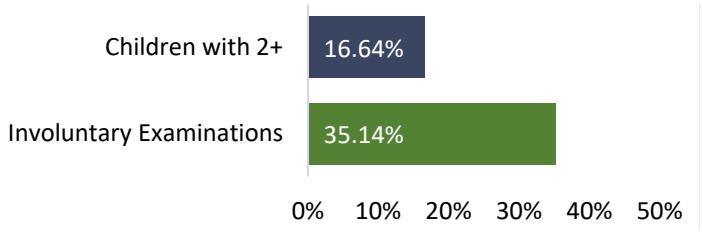

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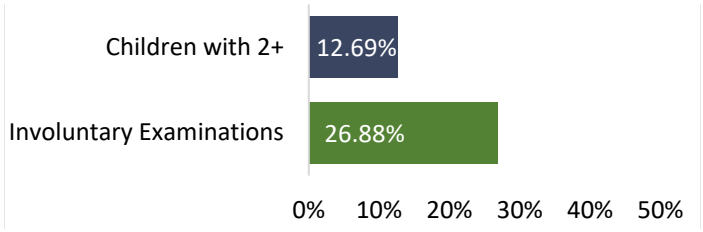

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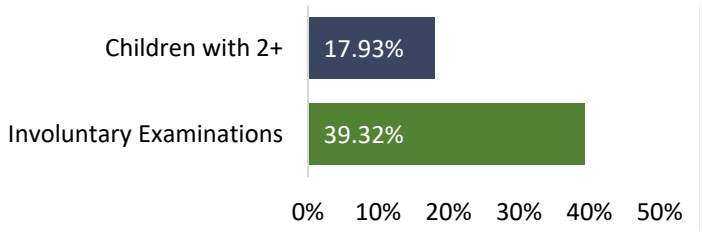

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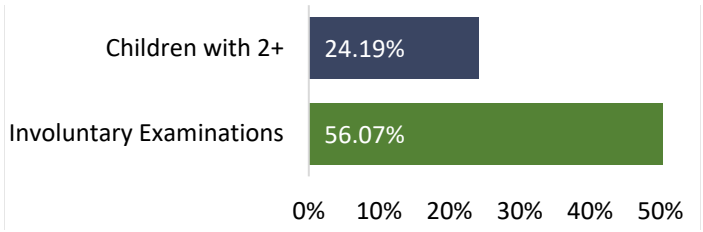

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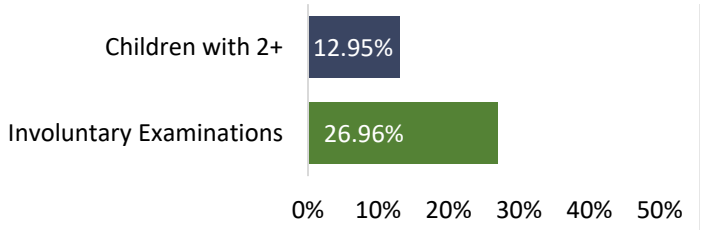

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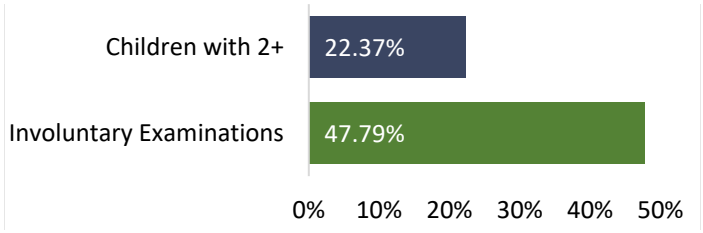
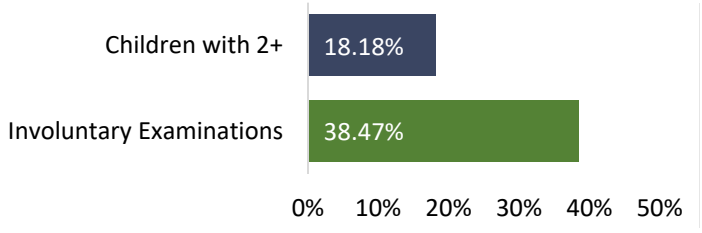


Orange



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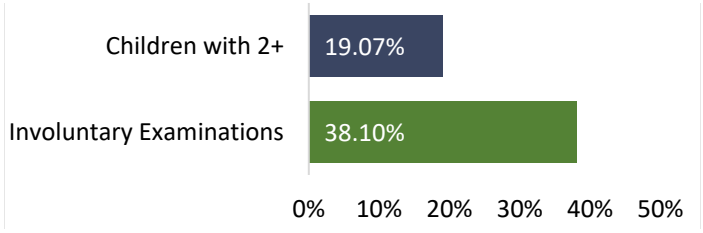

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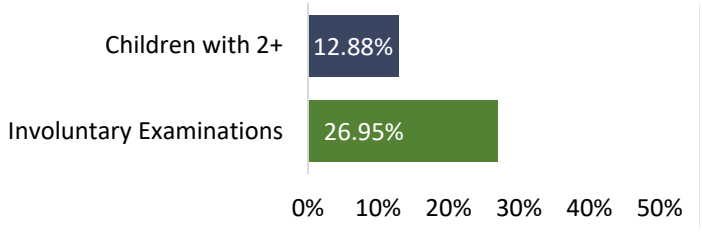

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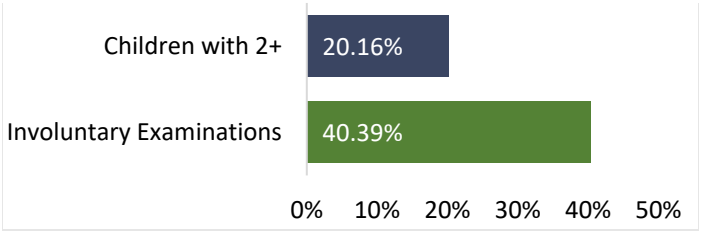
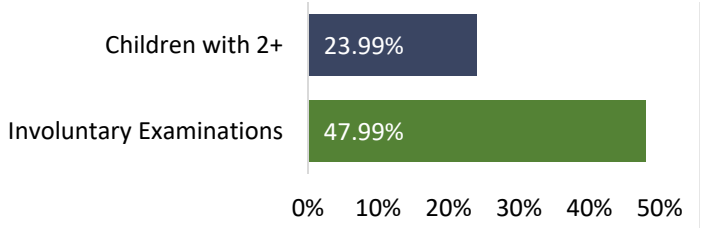


Pinellas



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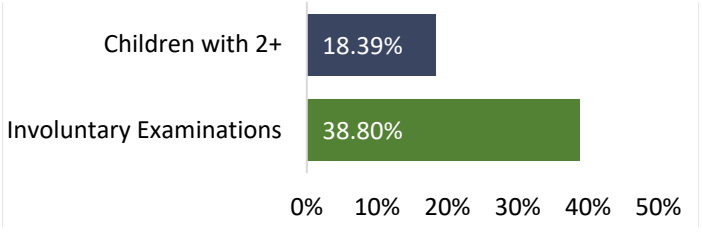

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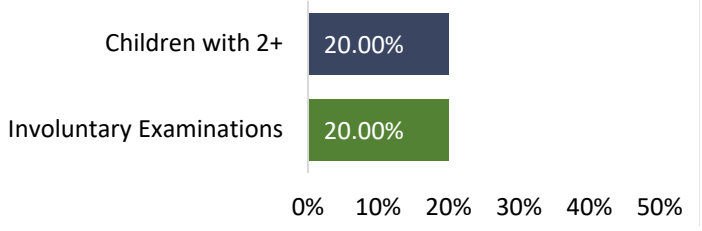

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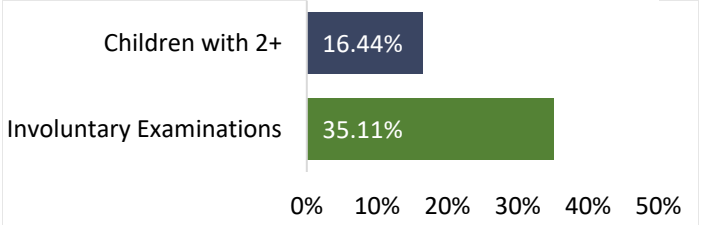

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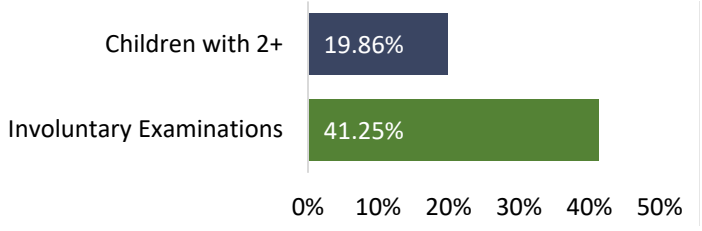
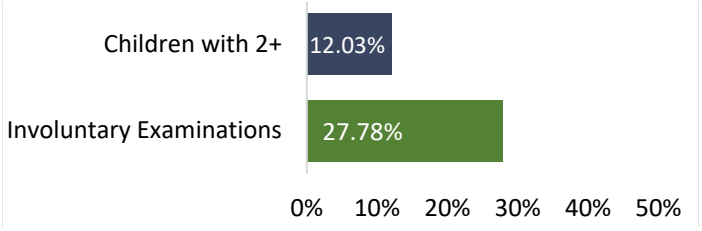
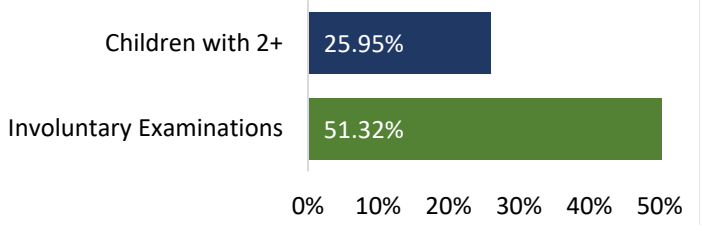


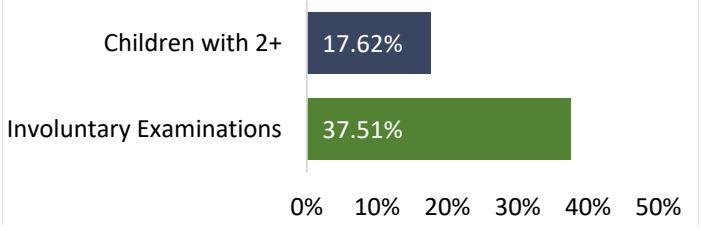
Santa Rosa



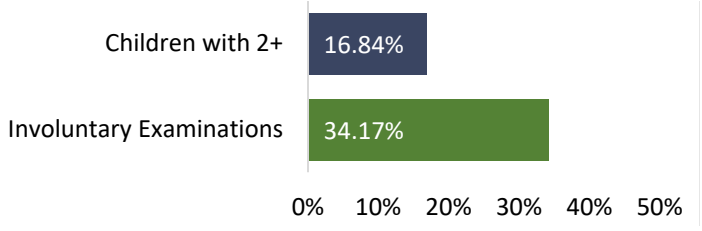
Sarasota



Seminole



Suwanee



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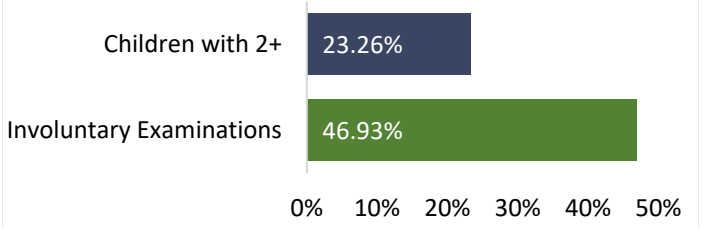


6. Location at Time of Involuntary Examination Initiation

Baker Act receiving facility staff indicate on the Cover Sheet (CF-MH3118) if the child was at school, child welfare involved, or juvenile justice involved. The elements were used to summarize the percentage of children based on number of involuntary examinations within specified age groups identified on the Cover Sheet.

Juvenile Justice Involved: Date regarding justice involved children at the time of involuntary examination are presented in a table, rather than a bar chart. Percentages of children who had involuntary examination initiated while at a juvenile justice facility are low.

Table 6: Location at Time of Involuntary Examinations – **Juvenile Justice Involved**

# of Involuntary Examinations in FY 2021-2022	Males				Females			
	Ages <18	Age 5-10	Age 11-13	Age 14-17	Age <18	Age 5-10	Age 11-13	Age 14-17
2	1.45%	0.00%	0.52%	2.17%	0.36%	0.00%	0.16%	0.50%
3-5	1.40%	0.00%	0.48%	2.27%	0.72%	0.52%	0.22%	1.06%
6-10	1.56%	2.83%	0.83%	1.65%	0.68%	0.00%	0.00%	1.20%
11+	1.13%	0.00%	0.90%	1.50%	0.75%	0.00%	0.56%	0.88%

School (Figures 6a and 6b): The overall percentages and patterns for children with involuntary examinations initiated at school are similar for male and female children with 10 or less involuntary examinations. The percentages for children with 11 or more involuntary examinations differ by gender, with male 11- to 13-year-old children having a higher percentage (18 percent) of involuntary examinations compared to males of other ages and all age groups for females. For example, for males with 11 or more involuntary examinations, 8 percent of children ages 5 to 10, 18 percent of children ages 11 to 13, and 6 percent of children ages 14 to 17 had involuntary examinations initiated while at school. Females with 11 or more involuntary examinations had relatively low and similar percentages of involuntary examinations while at school (age 5-10 = 8 percent, age 11-13 = 6 percent, age 14-17 = 8 percent). Both male and female children, those with 10 or less involuntary examinations, were more likely to have the involuntary examination initiated while at school, the younger their age. Male children with 11 or more involuntary examinations, who were aged 11 to 13, were more likely to have the involuntary examination initiated at school than for other age groups.

Child Welfare Involved (Figures 7a and 7b): Male children with six to 10 and 11 or more involuntary examinations were more likely to be child welfare system involved. This was especially the case for 5- to 10-year-old males (six to 10 involuntary examinations 24 percent, 11 or more involuntary examinations 23 percent). For females, the pattern is similar for those with two and three to five involuntary examinations compared to males.

Figure 6a: Location at Time of Involuntary Examinations – **School** – Males

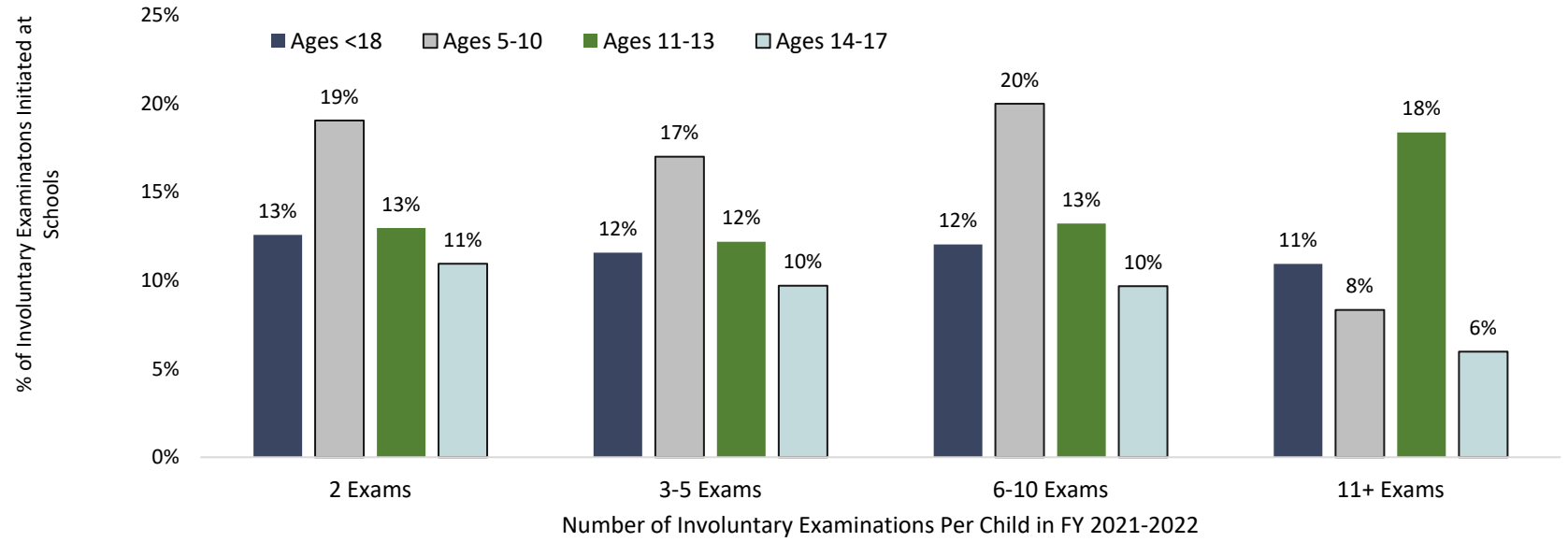


Figure 6b: Location at Time of Involuntary Examinations – **School** – **Females**

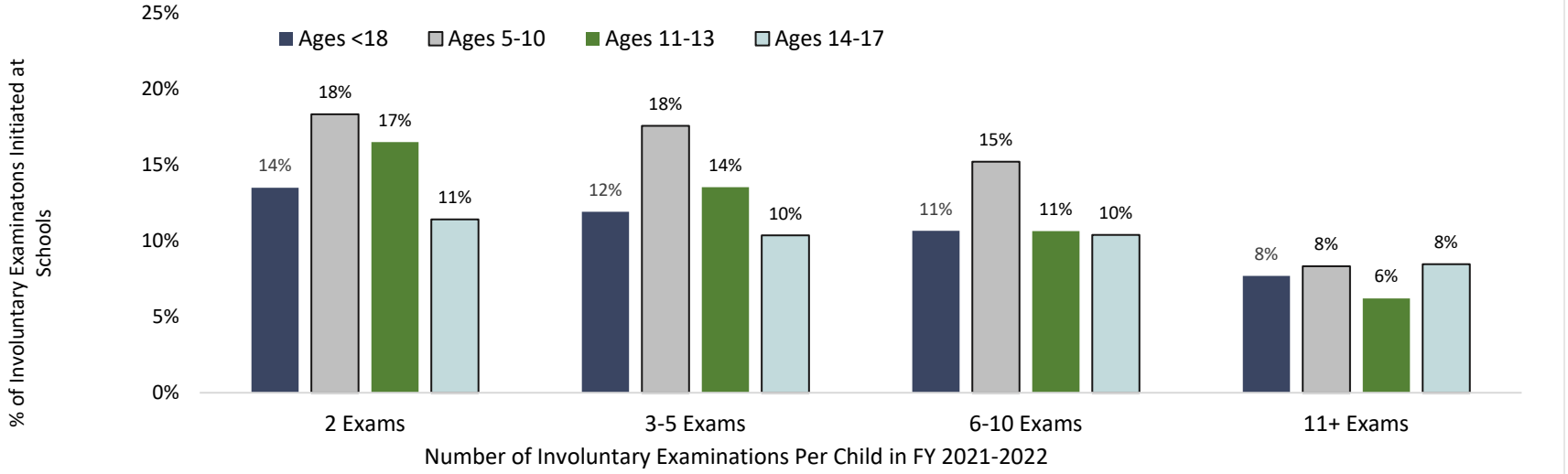


Table 7a: Location at Time of Involuntary Examinations – **Child Welfare Involved** – Males

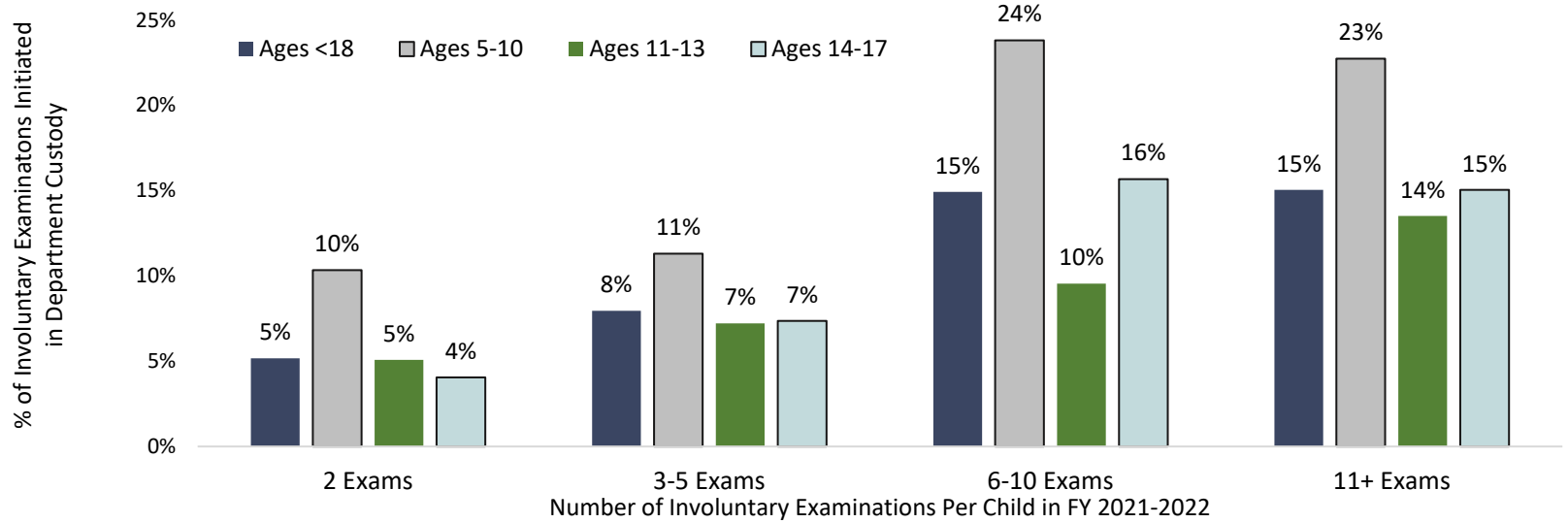
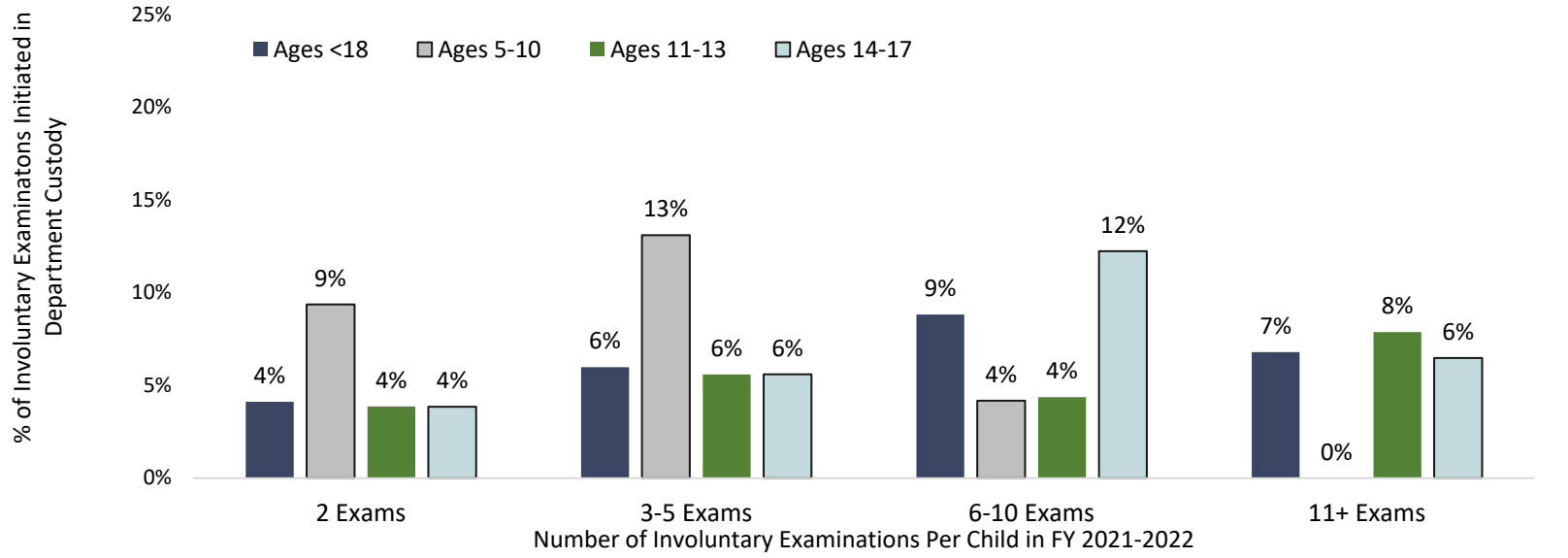


Table 7b: Location at Time of Involuntary Examinations – **Child Welfare Involved** – Females



7. Percentage of Children in Age, Gender, and Race/Ethnicity Groups

Statewide, and for specified counties with at least 300 involuntary examinations for children in FY 2021-2022, data is detailed on the following pages. The percentages of children with one, two to five, and six or more (6+) involuntary examinations according to categories of age, gender, race, and ethnicity (Hispanic Origin) are depicted in the bar charts. Abbreviations were used for Hispanic (H) and Non-Hispanic (NH) for bar charts due to space constraints. African American/Black children who were of Hispanic and Non-Hispanic origin were grouped into one category because the counts of African American/Black Hispanic children were so small that a) they would require redaction and b) the percentages of children with one, two-five, and six or more involuntary examinations are unstable with such small numbers.

Guidance on How to Read Bar Charts

The bars in the figures on the following pages use color to exhibit the percentage of children with one (blue), two to five (grey), and six or more (green) involuntary examinations during the year. Six groups (bars) for each age group.

Gender, Race, Hispanic Origin Combinations

- Male White Non-Hispanic (NH)
- Male White Hispanic (H)
- Male Black Non-Hispanic or Hispanic (NH, H)
- Female White Non-Hispanic (NH)
- Female White Hispanic (H)
- Female Black Non-Hispanic or Hispanic (NH, H)

Age Groups

- All Children (<18)
- 5-10
- 11-13
- 14-17

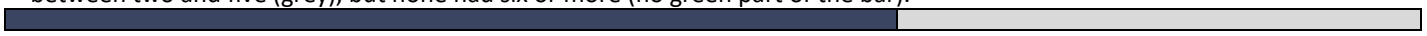
Each bar sums to 100% horizontally. The bars represent each grouping of children and the percentage out of the total for children in that group who had one, two to five, and six or more involuntary examinations during the year.

Meaning of Length of Colors in Bars

Example 1a: The bar below shows that during the year the group had a high percentage of children with 1 involuntary examination (blue), while a lower percentage of children constituted two to five (grey) and six plus (green) involuntary examinations.

Example 1b: The bar below shows that during the year the group had a lower percentage of children with one involuntary examination (blue), with higher percentages of children with two to five (grey), and six or more (green) involuntary examinations.

Example 1c: The bar below shows that during the year the group of children had one (blue) involuntary examination or between two and five (grey), but none had six or more (no green part of the bar).



Statewide

During FY 2021-2022 there were **34,304** involuntary examinations for **25,387** children. *NH = Non-Hispanic, H = Hispanic*

Statewide data can be used to compare counties to the overall percentages for the state.

Figure 8a: Involuntary Examinations FY 2021-2022 – All Ages Statewide

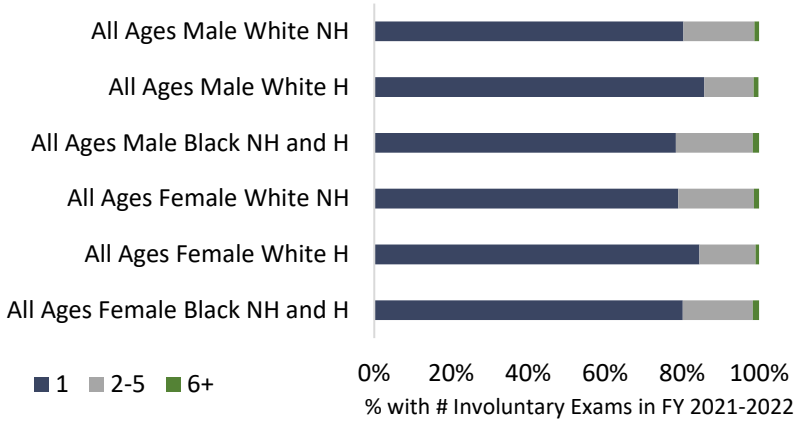


Figure 8b : Involuntary Examinations FY 2021-2022 – Ages 5-10 Statewide

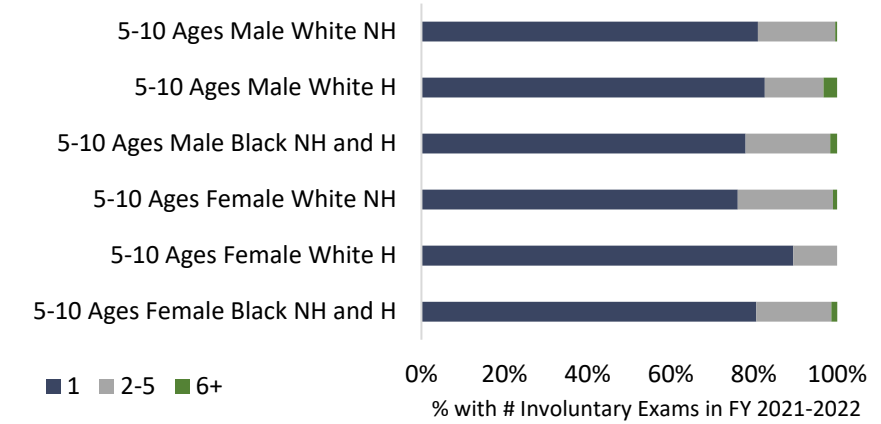


Figure 8c: Involuntary Examinations FY 2021-2022 – Ages 11-13 Statewide

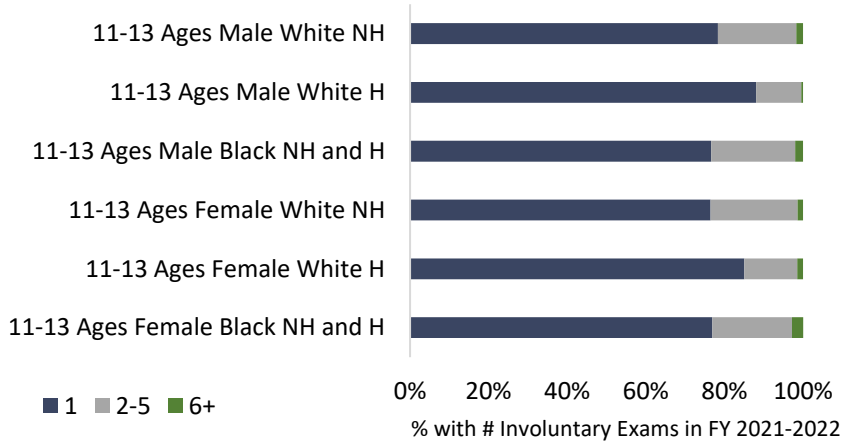
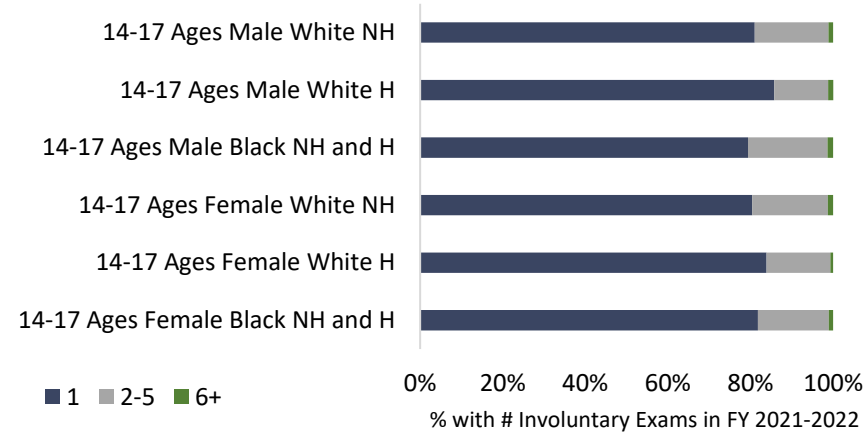
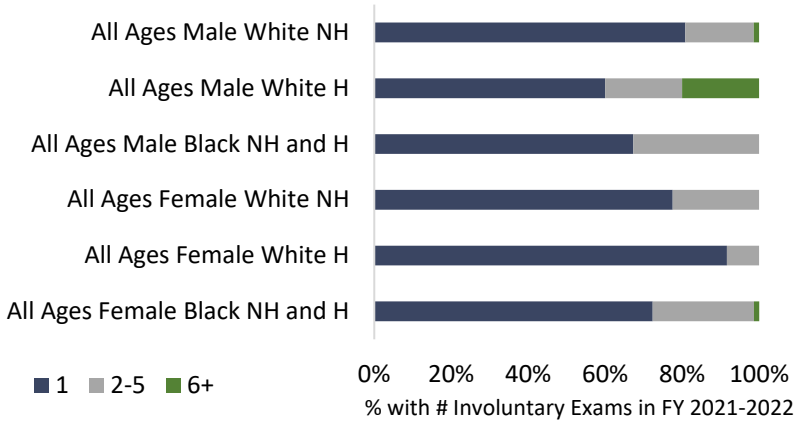


Figure 8d: Involuntary Examinations FY 2021-2022 – Ages 14-17 Statewide



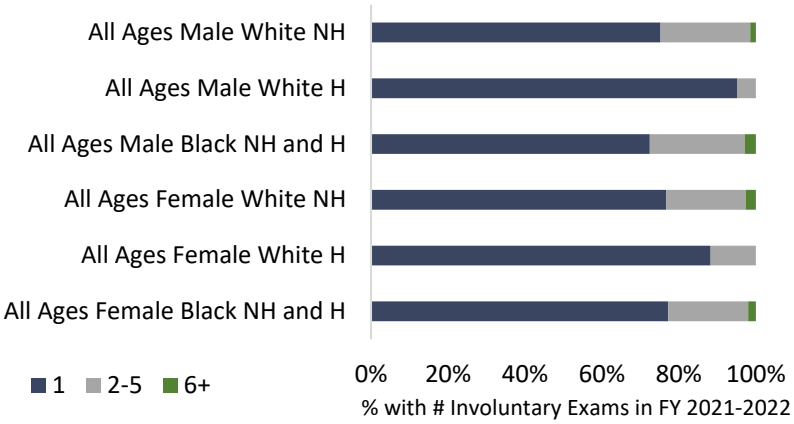
Alachua

During FY 2021-2022 there were **377** children residents with **525** involuntary examinations.



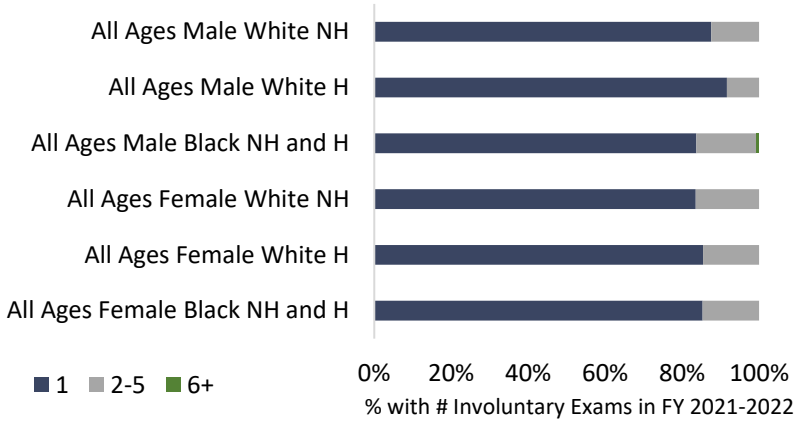
Brevard

During FY 2021-2022 there were **928** children residents with **1,416** involuntary examinations.



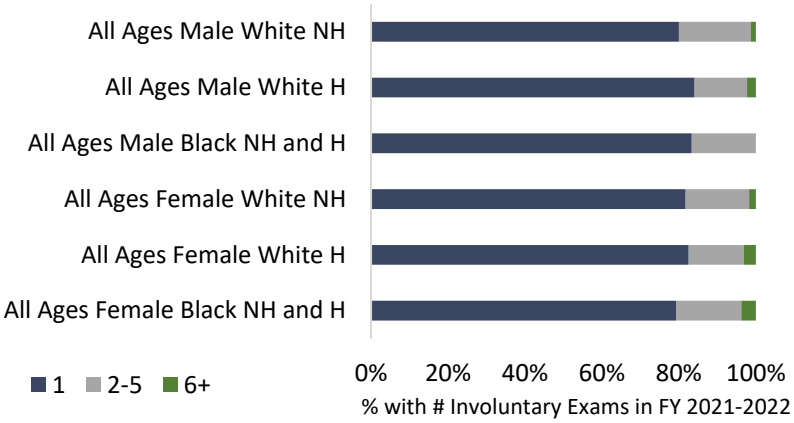
Broward

During FY 2021-2022 there were **1,524** children residents with **1,878** involuntary examinations.



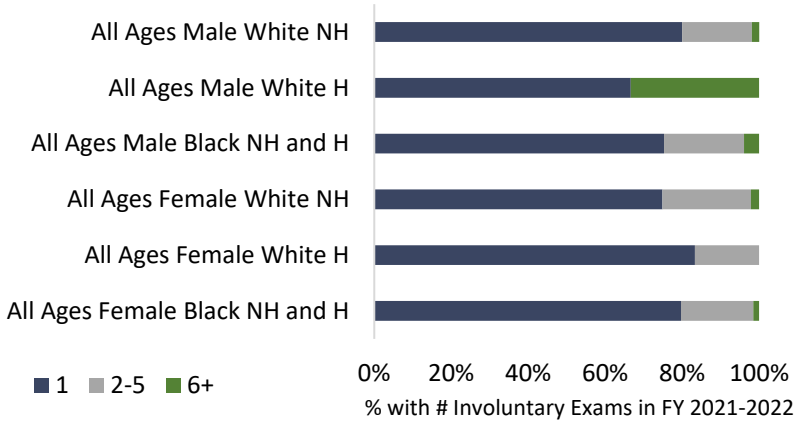
Collier

During FY 2021-2022 there were **571** children residents with **800** involuntary examinations.



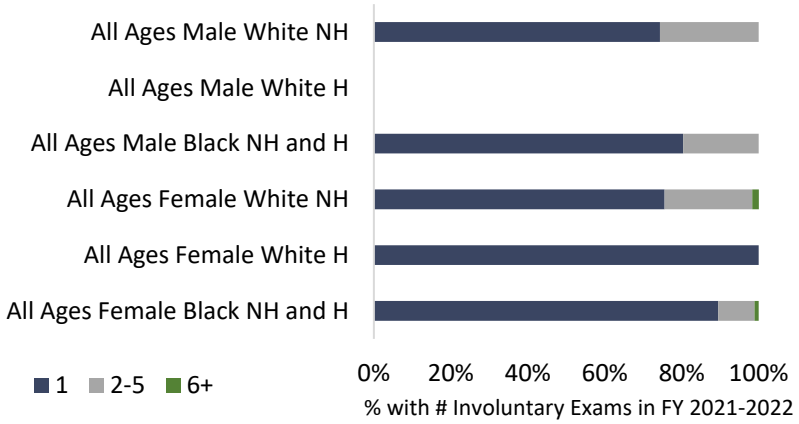
Duval

During FY 2021-2022 there were **1,116** children residents with **1,628** involuntary examinations.



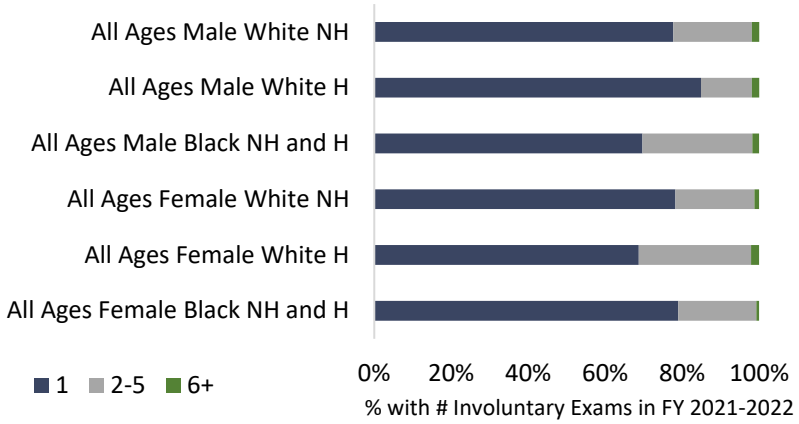
Escambia

During FY 2021-2022 there were **497** children residents with **677** involuntary examinations.



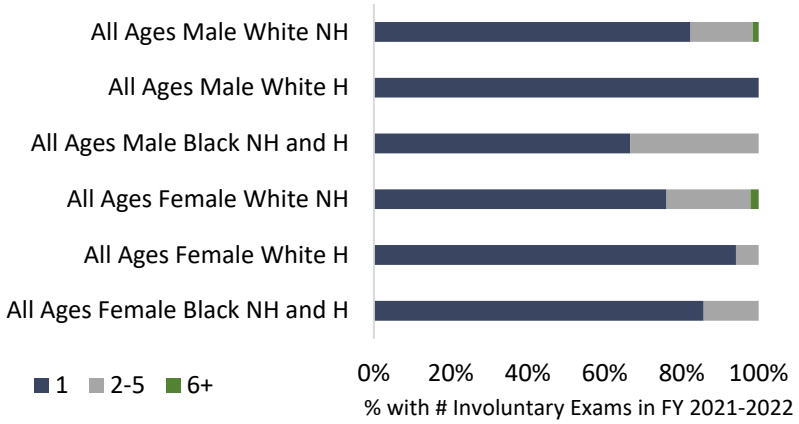
Hillsborough

During FY 2021-2022 there were **1,733** children residents with **2,423** involuntary examinations.



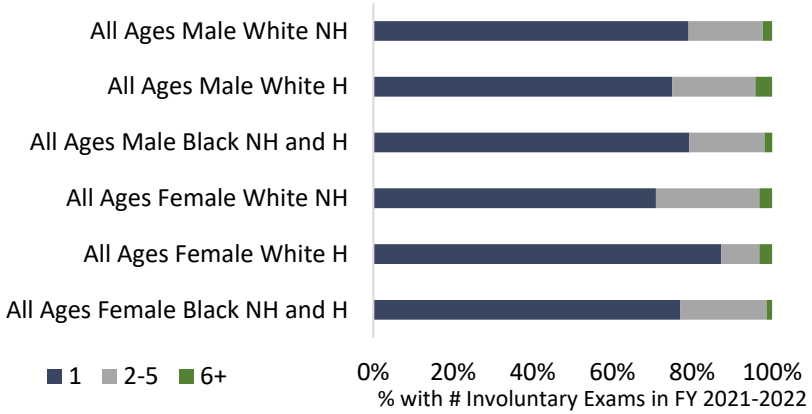
Lake

During FY 2021-2022 there were **510** children residents with **683** involuntary examinations.



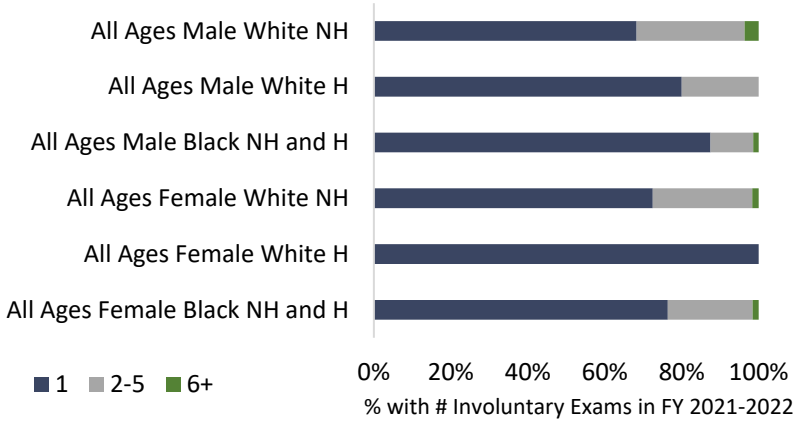
Lee

During FY 2021-2022 there were **856** children residents with **1,259** involuntary examinations.



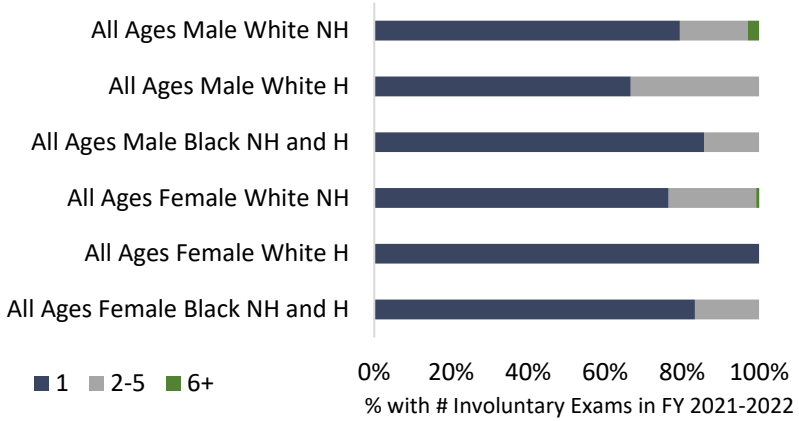
Leon

During FY 2021-2022 there were **460** children residents with **678** involuntary examinations.



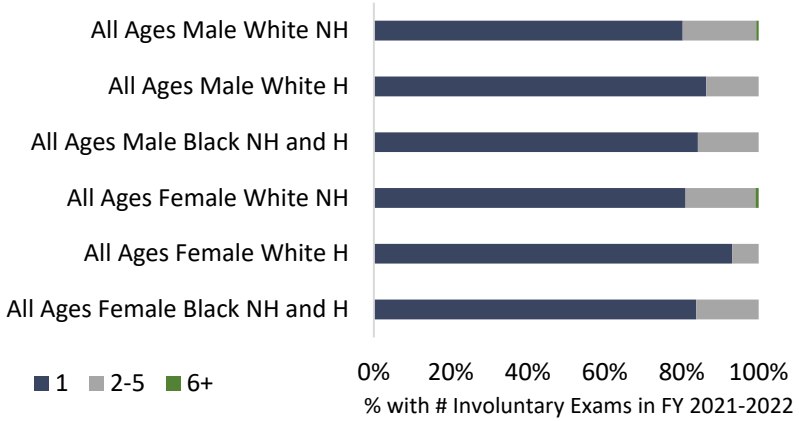
Manatee

During FY 2021-2022 there were **304** children residents with **398** involuntary examinations.



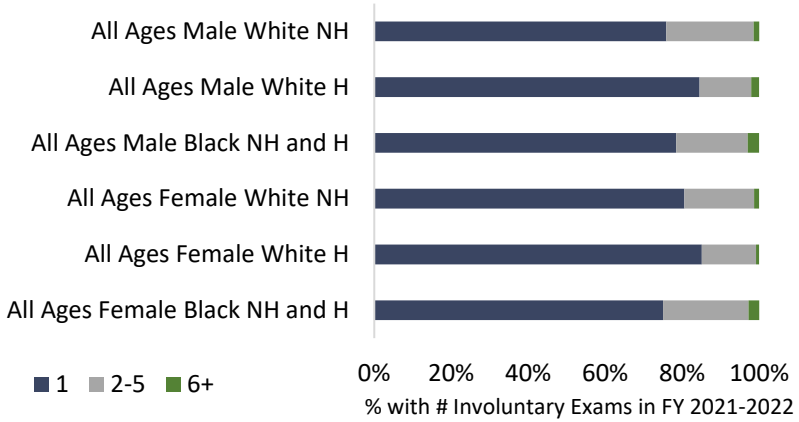
Marion

During FY 2021-2022 there were **691** children residents with **888** involuntary examinations.



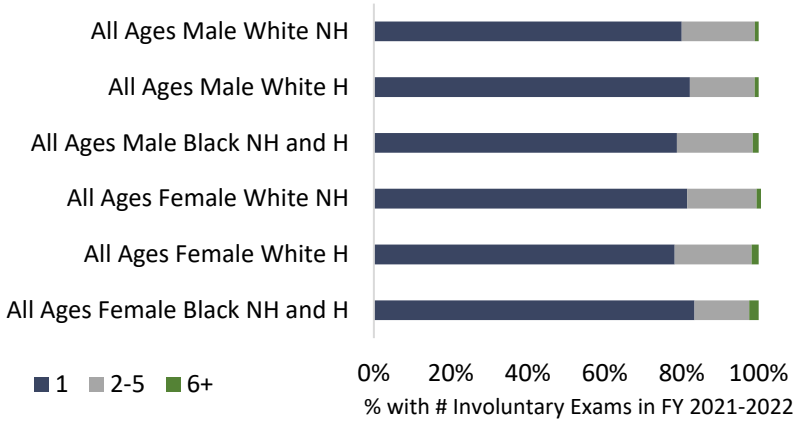
Miami-Dade

During FY 2021-2022 there were **1,963** children residents with **2,655** involuntary examinations.



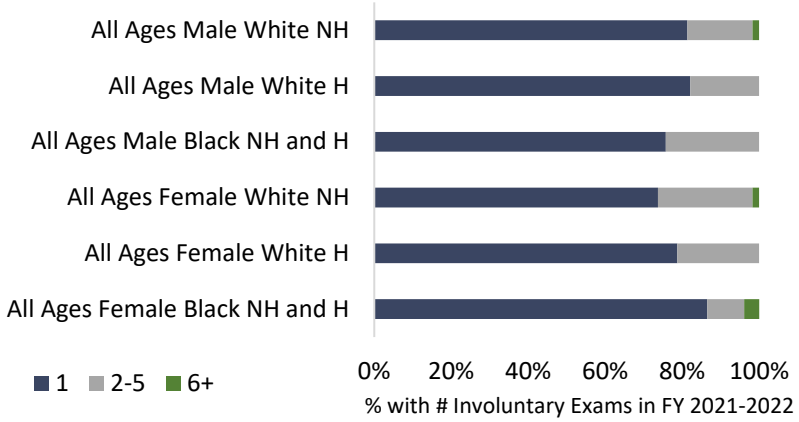
Orange

During FY 2021-2022 there were **1,722** children residents with **2,290** involuntary examinations.



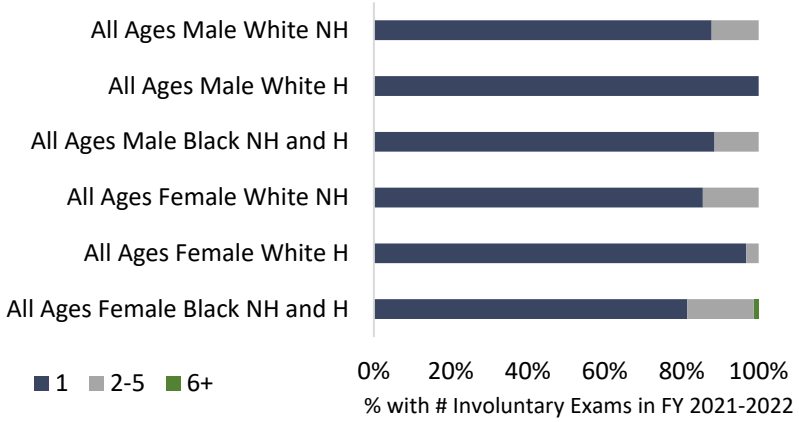
Osceola

During FY 2021-2022 there were **540** children residents with **706** involuntary examinations.



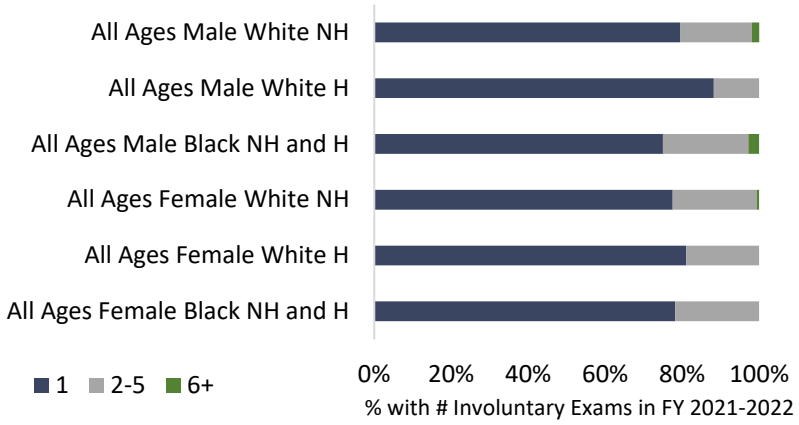
Palm Beach

During FY 2021-2022 there were **815** children residents with **972** involuntary examinations.



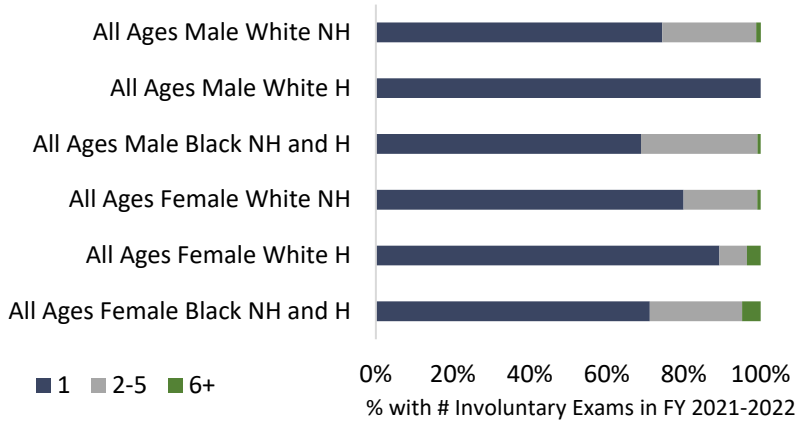
Pasco

During FY 2021-2022 there were **878** children residents with **1,176** involuntary examinations.



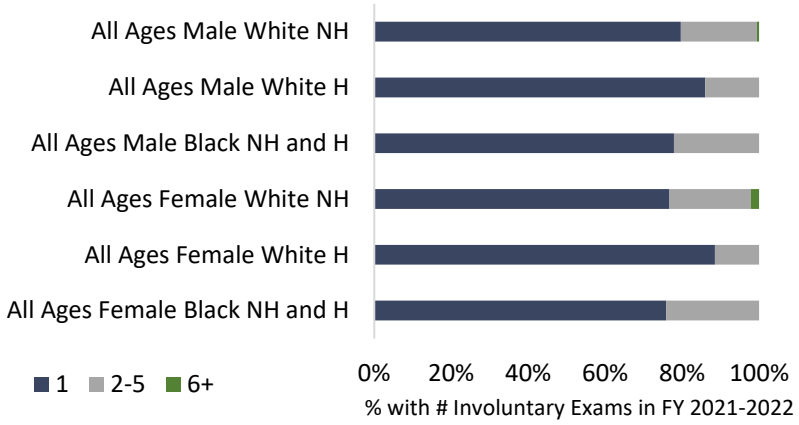
Pinellas

During FY 2021-2022 there were **1,159** children residents with **1,694** involuntary examinations.



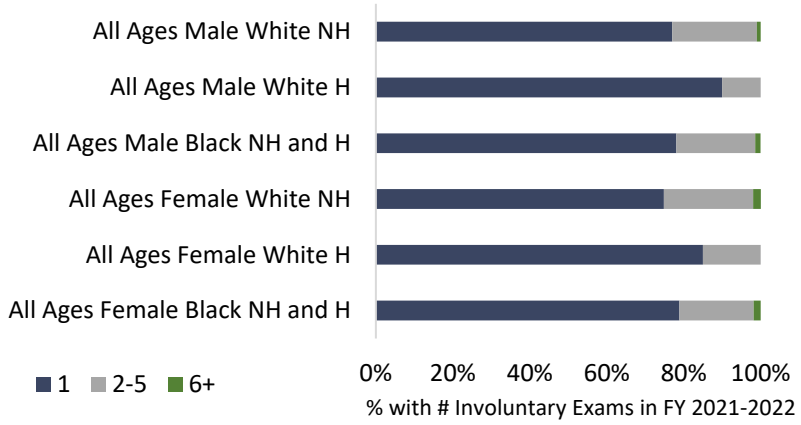
Polk

During FY 2021-2022 there were **1,229** children residents with **1,639** involuntary examinations.



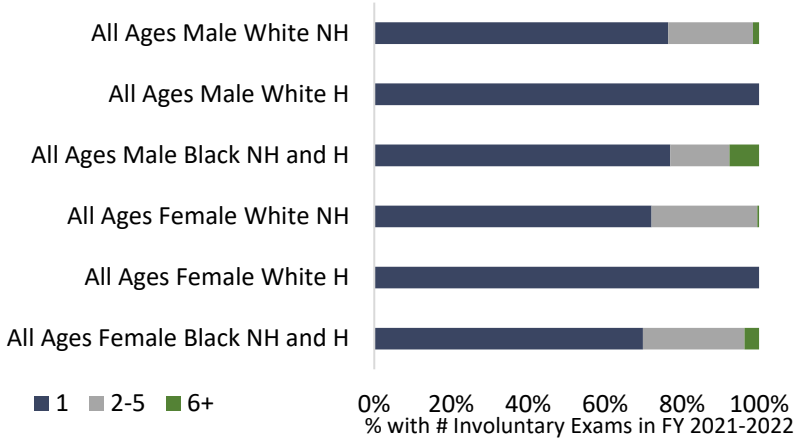
Saint Lucie

During FY 2021-2022 there were **574** children residents with **783** involuntary examinations.



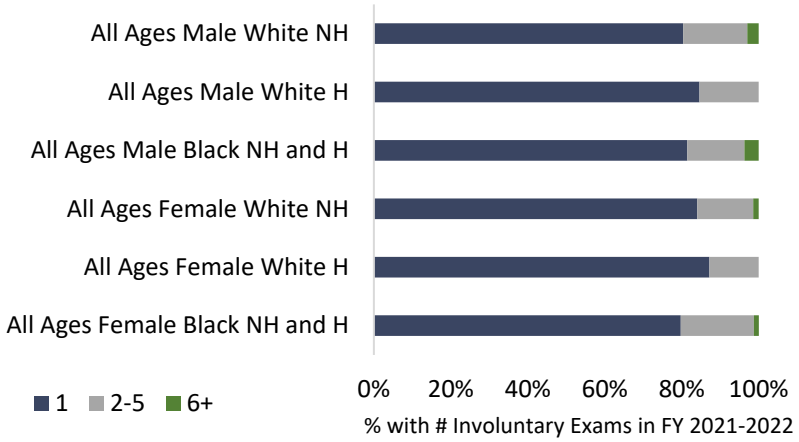
Sarasota

During FY 2021-2022 there were **524** children residents with **797** involuntary examinations.



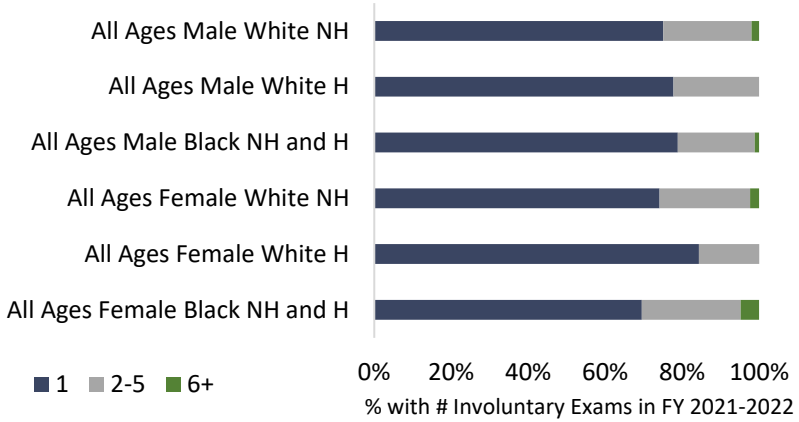
Seminole

During FY 2021-2022 there were **647** children residents with **853** involuntary examinations.



Volusia

During FY 2021-2022 there were **778** children residents with **1,125** involuntary examinations.



C. Coding of Involuntary Examination Form Text

1. Concepts of Coding

To understand the root causes of involuntary examinations of minors, the Baker Act Reporting Center coded text from initiation forms utilized by law enforcement and health professionals as qualitative evidence and justification for initiation. The entry screen for coding is displayed in Appendix D. Coding the content of the forms utilized the text to measure certain constructs. Text from the forms is not a quality measure of what was occurring with the individual subject to the involuntary examination, or the circumstances related to the initiation, due to the information used is based on the initiator's account of happenings or recounts told by the individual, family, or third party. However, forms used to initiate involuntary examinations are legal forms to document the removal of individual liberty as allowed in the Florida Mental Health Act. The criteria are a) evidence of mental illness and b) evidence of imminent harm to self, harm to others, and/or self-neglect.

2. Process of Coding

Baker Act Reporting Center staff developed a customized Microsoft Access database to code qualitative content from involuntary examination documents used to produce data. Staff participated in interrater coding in which all staff coded the same 15 involuntary examination documents. The interrater coding was divided into three rounds consisting of five documents each, followed by discussions and database refinement. Baker Act Reporting Center staff developed supplemental training, staff were provided with additional technical support to pose questions, and issues were clarified. A sampling scheme was used to code content from documents for children with involuntary examinations in FY 2021-2022. A 5 percent sample of forms was taken for children with one or two involuntary examinations, a 15 percent sample for children with three to four involuntary examinations, and a 25 percent for children with six to 11 involuntary examinations. Content from all initiation forms for children with 12 or more involuntary examinations were coded. The logic the sampling method was to be able to produce data that could be generalized to the population of minors who experience an initiation while being limited by the availability of staff time and resources for coding. The total number of involuntary examination forms and the count of children for which forms were coded is in Table 6. The sampling strategy resulted in the coding of content from 2,476 forms for 554 children. The Baker Act Reporting Center continues to refine and code text from the remaining forms as part of an ongoing future data analysis efforts.

Table 6: Count of Coding: Involuntary Examinations and Children

Involuntary Examinations in FY 2021-2022	Sample of Involuntary Examination Forms	Coded	
		Involuntary Examinations	Children
2-3	5%	666	290
4-5	15%	562	135
6-11	25%	581	86
12 or More	100%	667	43
Total		**2,476**	**554**

Two thirds of the coding (n = 1,695, 68%) were for involuntary examinations initiated by law enforcement, while one third (n = 781, 32%) were for those initiated by a health professional. Twelve of the involuntary examinations in the sample were initiated via an ex-parte court order. The ex-parte court orders were excluded from coding, representing a minor (<1%) proportion of involuntary examinations sampled and the ex-parte court orders are continuously missing the detail contained in the law enforcement and health professional forms.

3. Overview of Sections of Forms Coded

Law Enforcement Forms (CF-MH3052a)

Figure 8a and 8b indicate sections of the one-page law enforcement initiation form used to document that an individual meets the criteria for involuntary examination. Text in Figure 8a is used to demonstrate that the individual meets statutory criteria while text contained in Figure 8b are used as evidence to support the belief that criteria are being met. A percentage (2 percent, 40 forms) of involuntary examinations coded that were initiated by law enforcement officers contained an additional narrative page. The continuation page provides area to extend the information beyond what fits in the box as shown in Figure 8b. Content from the continuation pages was also coded.

Figure 8a: Documentation of Evidence Type – Check Boxes – Law Enforcement Form

1. I have reason to believe said individual has a mental illness as defined by s. 394.455(28), Florida Statutes:

   "Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in Chapter 393, F.S., intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

   AND because of the mental illness (check all that apply):

   ☐ a. Individual has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **OR**

   ☐ b. Individual is unable to determine for himself/herself whether examination is necessary; **AND**

2. Either (check all that apply):

   ☐ a. Without care or treatment said individual is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **OR,**

   ☐ b. There is substantial likelihood that without care or treatment the individual will cause serious bodily harm to (check one or both) ☐ **self** ☐ **others** in the near future, as evidenced by recent behavior.

Figure 8b: Documenting of Evidence – Law Enforcement – Text

Circumstances supporting the belief the criteria are met, including specific information about the individual's behavioral health issues, threats and actions, and information offered by others. If school personnel are involved, please describe the nature of their involvement.

Health Professional Form (CF-MH3052b)

Figures 9a, 9b, and 9c indicate sections of the health professional initiation form used to document an individual meeting the criteria for involuntary examination. Unlike the law enforcement form, the health professional form requires a *diagnosis of mental illness*. The difference between the forms is based on the premise that health professionals have required training to diagnose behavioral health disorders, while law enforcement do not have the same training. Content from the box in Figure 9c was lacking in 9 percent (n = 73 out of 781) of health professional forms, suppressing data available for coding.

Figure 9a: Documentation of Evidence Type – Check Boxes and Diagnosis Text – Health Professional Form

Section I: CRITERIA

1. There is reason to believe said individual has a mental illness as defined in section 394.455(28), Florida Statutes:

"Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, F.S., intoxication, or conditions manifested only by antisocial behavior or substance use impairment.

Diagnosis of Mental Illness: List all mental health diagnoses applicable to this individual and the DSM/ICD codes:

AND because of the mental illness (check all that apply):

- ☐ a. Individual has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **OR**
- ☐ b. Individual is unable to determine for himself/herself whether examination is necessary; **AND**

2. Either (check all that apply):

- ☐ a. Without care or treatment said individual is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **OR,**
- ☐ b. There is substantial likelihood that without care or treatment the individual will cause serious bodily harm to (check one or both) ☐ **self** ☐ **others** in the near future, as evidenced by recent behavior.

Figure 9b: Health Professional Forms – Supporting Evidence

Section II: SUPPORTING EVIDENCE

Document observations supporting the criteria in Section I (including evidence of recent behaviors related to criteria). Include the individual's behaviors and statements, including those specific to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury. If school personnel are involved, please describe the nature of their involvement.

Figure 9c: Health Professional Form – Other Information (On Second Page)

Section III: OTHER INFORMATION

Identify other sources relied upon to reach this conclusion. If information is obtained from other persons, describe these sources (e.g., reports of family, friends, other mental health professionals or law enforcement officers, as well as medical or mental health records, etc.).

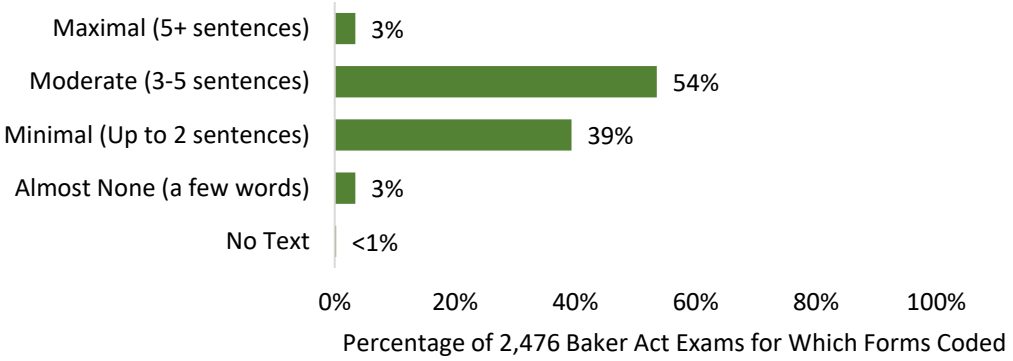
Transportation Form (CF-MH3100)
Content obtained from the Transportation to Receiving Facility Form, available in 30 percent (n = 753) of forms, was coded. Submission of forms to the Baker Act Reporting Center was not a requirement during the time coding was completed.

4. Coding Results – Form Quality and Length

Form Text Legibility: Information was typed for 43 percent (n = 975) of all coded forms. While 45% of law enforcement forms were typed, 27 percent of health professional forms were typed. The text on majority of forms was legible, with only 1 percent (n = 20) of forms having barely legible text, and less than 1% (n = 2) of forms with text that was non legible.

Volume of Text: Baker Act Reporting Center staff coded the volume of text in the sections of the forms as shown in Figure 9. Categories were used due to the prohibitive amount of time counting the number of words on each form would take.

Figure 9: Coding – Text Volume

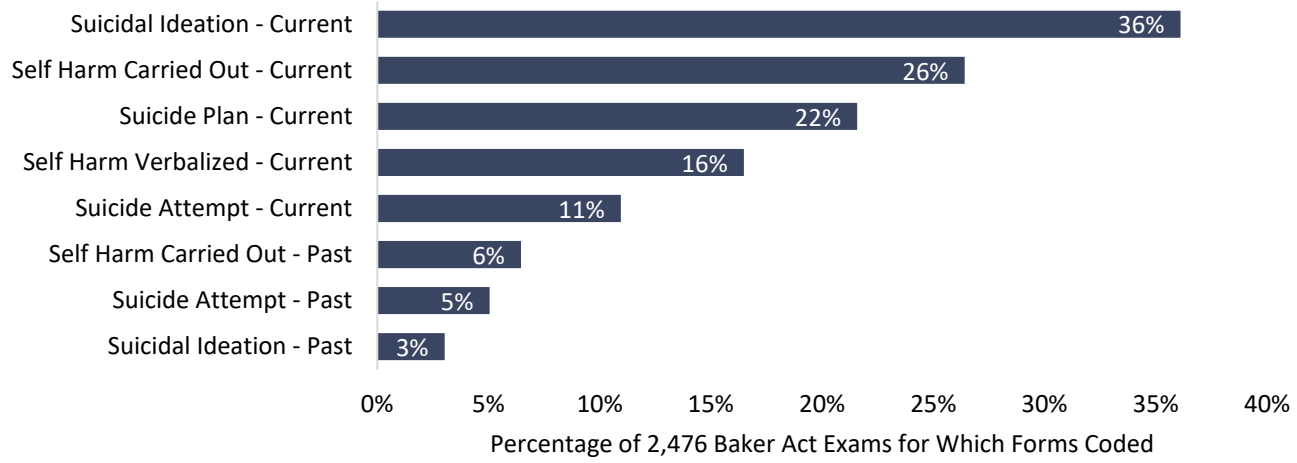


5. Coding Results

- **Suicide Related Cognitions and Behaviors**

Thirty-six percent of involuntary examinations for which forms were coded indicated current sucidal ideation, with twenty-six percent indicating current self harm that had been carried out (this refers to self harm without an intent to die). Twenty-two percent currently had a plan to complete suicide. Eleven percent had a current suicide attempt, with smaller percentages indicting the following behavior had been carried out in the past: self harm (6 percent), suicide attempt (5 percent), and suicidal ideation (3 percent).

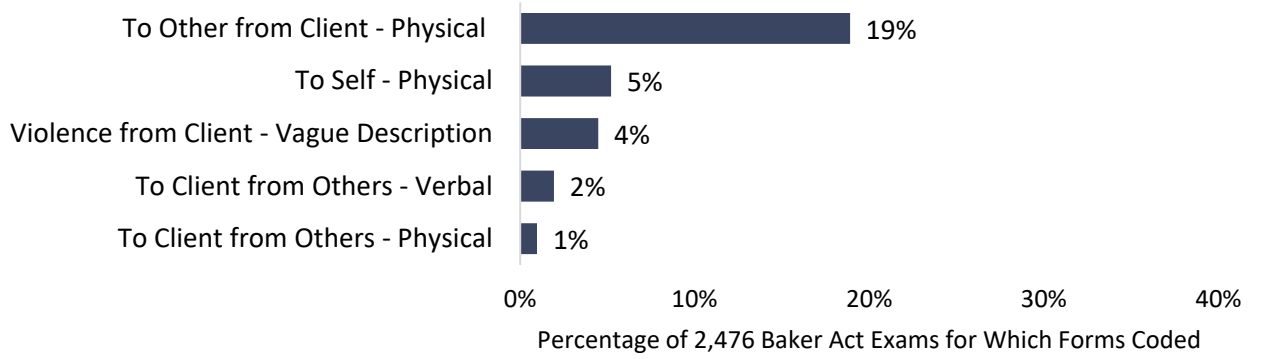
Figure 10: Coding Content: Suicide Related Cognitions and Behaviors



- **Aggressive/Agitated Behavior**

Text on the forms included a variety of behaviors that, for coding purposes, were categorized as either being agitated or aggressive. The summation is that the behavior type could be an indication of harm to self or others. Note that some variables in Figure 12 could have been traumatic and categorized as one of the ten experiences conceptualized in the Adverse Childhood Experinces (ACES) study (see page 43). The most common type of agitated oraggressive behavior was to others from the individual that was physical in nature (19 percent), followed by to self of a physical nature (5 percent), and violence from the individual that could not be further categorized because of vague descriptions (4 percent). Agitated or aggressive behavior that would not contstitute evidence of harm to self or others, but that provides context to the situation was present in cases as verbal to the individual from others (2 percent) and physical to the individual from others (1 percent).[6]

Figure 11: Coding Content: Agitated/Aggressive Behavior



- **Weapons**

Less than 1 percent of involuntary examination forms coded mentioned firearms as a weapon. Examples of other weapons documented on the forms included razors, tools, office supplies, fire related implements, kitchen items, jewelry, glass, household items (curtain rod, bed sheets, broom, brush), chemicals (bleach, Lysol, oil put on floor), and other miscellaneous items. Sample items referenced on forms included pieces of broken windowsill, wooden board, rope like object, banjo, shoe, skateboard, charging cord, metal spatula for spreading tar, car crusher and pole, stick, rock, coconut, a deputy's weapon, and unnamed blunt objects.

- **Property Damage**

Property damage documented on forms included slamming (doors, phone to ground, door into wall), hitting or punching (walls), breaking (a picture, a window, household items, lock to tv, flower pot, business card holder), damaging (curtains, door, school property, family member's car), throwing (a vacuum, a phone, knife/machete at door, glass salt shaker, vases, books, bleach, plate, pictures, pieces of furniture, rocks at garage, metal chair at windows, products around the grocery store, things), destroying (a window, living room, house, furniture, items inside residence, by flipping objects), shattering (windows with a rock), smashing (glass door), pushing (shopping carts into vehicles), kicking (police care divider, police car window, window of car, radio console, water foundation, vehicle), fire related (attempted arson), and vague statements such as destructive in home, or a history of violence against property.

- **Behaviors and Symptoms**

A distinction was made between text indicating diagnoses and text indicating symptoms or behaviors related to disorders. Types of symptoms and behaviors that were present in at least 1 percent of forms coded included: cutting (11 percent), hallucinations (6 percent), depression (6 percent), psychosis (1

[6]Note that only 14 involuntary examination cases coded indicted only past self harm, a past suicide attempt, or a past of suicidal ideation in the text without also having text indicting current suicide related behavior and/or aggressive/aggitated behavior that could mean harm to self or others.

percent), and anxiety (1 percent). Behaviors and symptoms contained on less than one percent of forms included paranoia, starving/restrictive eating, and throwing up on purpose.

- **Diagnosis**

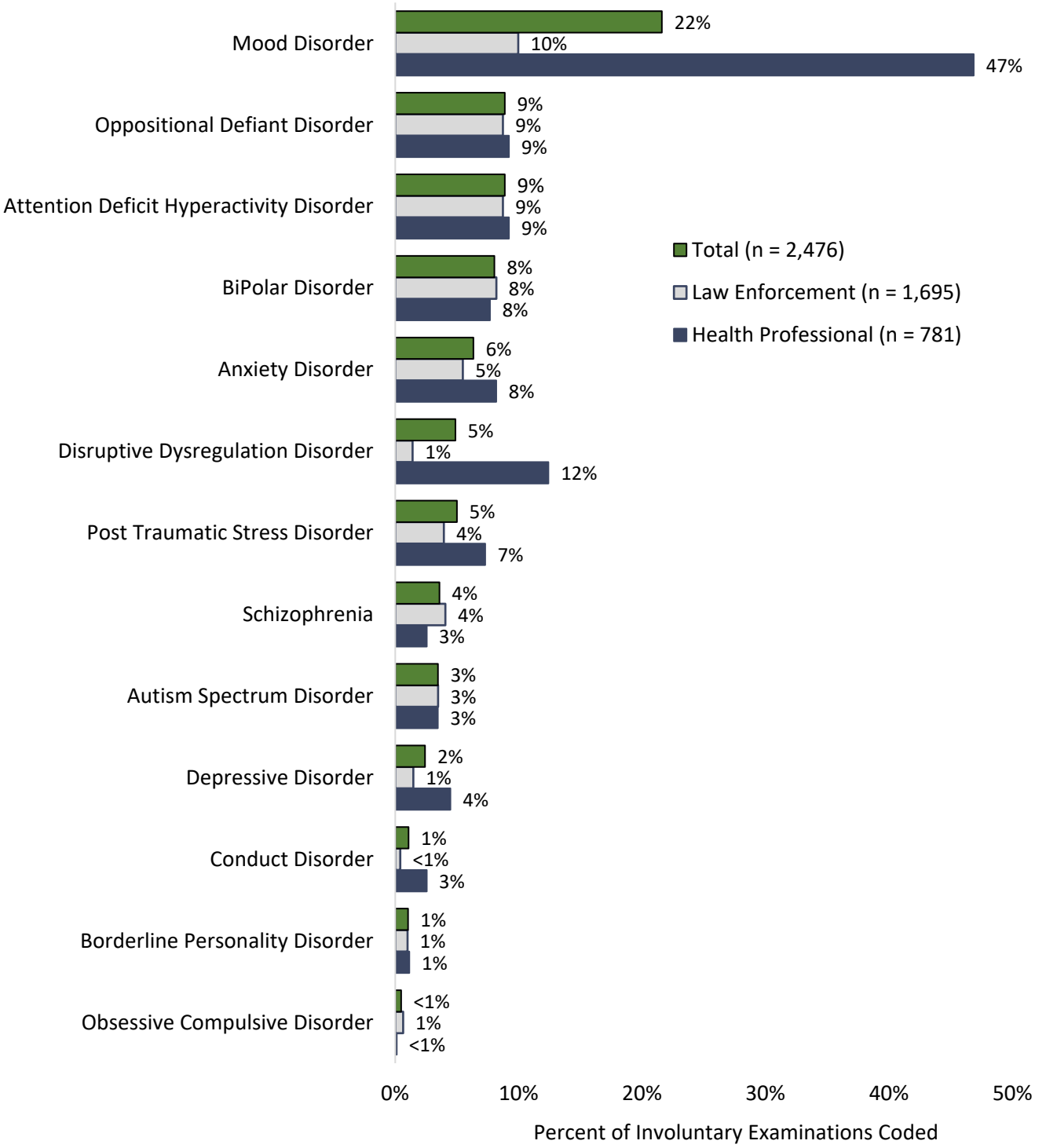
Information was coded related to diagnoses on the health professional, law enforcement, and transportation forms. Coding related to diagnosis was not completed only using text from the diagnosis text field of the health professional form. The approach was taken due to the primary objective of coding was to report content from the forms relevant to documenting that an individual met the criteria for an involuntary examination. A secondary objective was to extract what was occurring with the individual at the time of the involuntary examination and characteristics.

Majority of forms for a health professional initiated involuntary examination (715 out of 781, 92 percent) contained text in the diagnosis field, with 86% containing diagnoses, 6% containing descriptive text but no diagnoses, and 8 percent with no text in the diagnosis field. [Note: Many forms containing both diagnosis and descriptive text about behavioral and cognitive processes that were not diagnoses. Those forms were counted as part of the 86 percent of forms with a diagnosis.] There were 20 forms (3 percent of health professional forms) with no diagnosis but indicated suicidal related behaviors in the diagnosis field, such as ideation, attempts, or gestures. There were 17 forms (2 percent of health professional forms) with no diagnosis but indicated psychosis or an acute psychotic episode. Limited forms (<1 percent) contained text in the diagnosis field such as homicidal ideation, intentional overdose, or acute agitation and belligerence that were not diagnoses. Only 10 percent of forms for involuntary examinations initiated by health professionals contained a DSM or ICD code.[7] Only 18 percent of involuntary examinations from law enforcement coded contained diagnostic information on the initiation form (3052a) or the transportation form (3100) if it was submitted. The lesser percentage of forms with diagnoses, compared to health professional forms (3052b) is logical, given that law enforcement are not trained clinicians and as such there is not a specific field on the 3052a form for a diagnosis. Many instances, law enforcement forms had writing on them to mark that the individual or a family member indicated they had a specific diagnosis.

The diagnoses in Figure 12 are ordered from the most frequent occurrence to the least for all forms coded, present on at least 1 percent of forms. Mood disorder was the most common diagnosis, with almost twenty-two (22 percent) of all forms coded indicating the diagnosis present on the forms. The diagnosis was more common for health professionals (47 percent) than for law enforcement (10 percent).

[7]A basic description of ICD and DSM Codes can be found at this web page: *American Psychiatric Association: Coding and Recording Procedures.* A more detailed discussion of these codes can be found by *reading A Comparison of DSM and ICD Classifications of Mental Disorder* form January 2018 on the Cambridge University Press website or by downloading a pdf of the article at this site.

Figure 12: Coding Content – Diagnoses



- **School Involvement, Mobile Response Teams or 988, and Social Media**

Forms for 11 involuntary examinations mentioned a Mobile Response Team (MRT) and included the individual completing the form having indicated in text that information was obtained regarding MRT involvement.

Forms for five involuntary examinations mentioned 988. The 988 Suicide & Crisis Lifeline was effective nationwide in July of 2022. Data coded was for involuntary examinations from July of 2021 through June of 2022, before 988 was fully implemented. Data indicated individuals either called or texted 988 but were not definitive if the call or text led to a response or initiation of an involuntary examination.

Forms for 10 involuntary examinations referenced social media. Platforms recorded included Facebook Live, Snapchat, and Instagram. Documentation on forms included the individual had watched a video on social media about body positivity and online posts of a sexual nature. Several forms mentioned the individual messaged a friend or otherwise posted on social media about harming themselves, such as by taking pills, or killing themselves. At least 1% of forms also contained text in the categories in Figure 14.

- **Additional Variables**

The variables on Figure 14 had not been reported in the coding results and were present for at least 1% of forms coded. Some of the variables in Figure 14 could be related to trauma and categorized as one of the 10 experiences conceptualized in the Adverse Childhood Experiences (ACEs) study (see page 43). The variables coded that suggested trauma include child abuse – physical, bullying, death of someone, family instability, family conflict, or sexual assault.

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III. Issues Related to the Root Causes of Involuntary Examinations

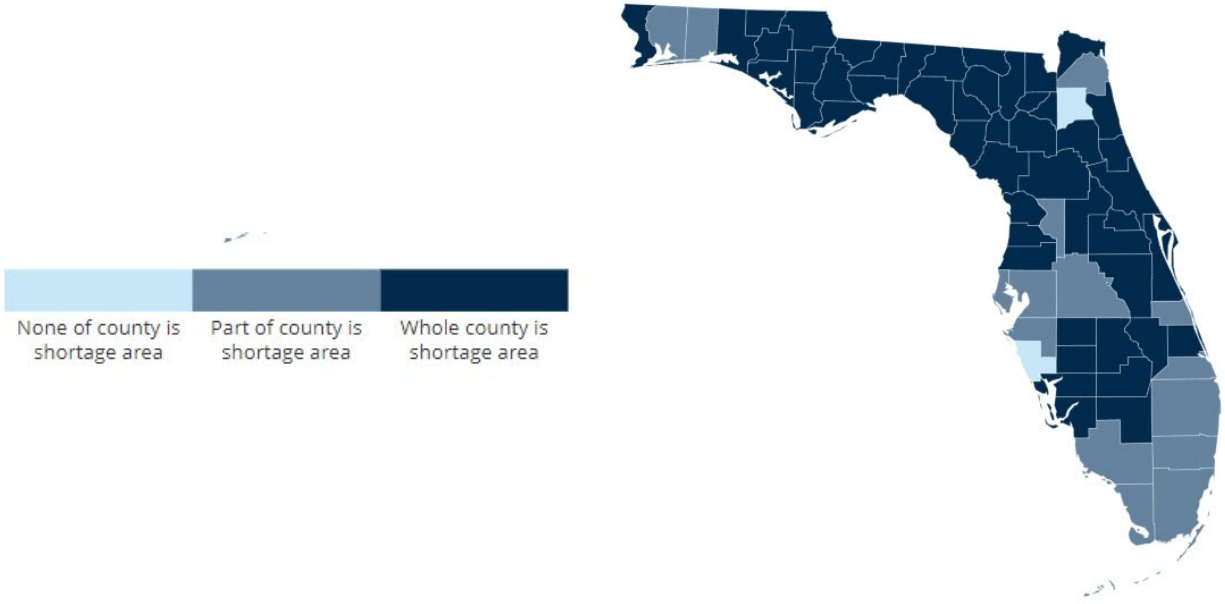
Section three summarizes issues that could contribute to the root causes of repeated involuntary examinations of minors. The scope of this report does not allow for analyzing of these issues/topics. Links to additional resources have been provided in the text and footnotes for reference.

1. Workforce Shortages

Workforce shortages[8] impact social determinants of health in general and health outcomes more specifically, to include the use of involuntary examinations for children.[9] Impact is based on the premise that shortages of professionals to address behavioral health needs, make it more likely that a child experiences a crisis that leads to an involuntary examination. Health workforce shortage is a worldwide problem and can be "defined as not having the right number of people with the right skills in the right place at the right time, to provide the right services to the right people."[10] The County Health Rankings website makes the point that that access to care requires not only financial coverage, but also access to providers. Nearly 30 percent of the United States population lives in a county designated as a Mental Health Professional Shortage Area (HPSA).[11]

The Rural Health Information (RHI) Hub dashboard provides information about HPSAs by state and every county can be visualized on a map. The map of Florida from the RHI Hub is below in Figure 13. Only two counties, Clay and Sarasota, indicate no shortage of mental health professionals. Parts of each of 15 counties have at least one HPSA as follows: Broward, Collier, Duval, Hillsborough, Indian River, Manatee, Martin, Miami-Dade, Monroe, Okaloosa, Palm Beach, Pinellas, Polk, Santa Rosa, and Sumter Counties. The entire area of each of the remaining 50 counites indicates shortages.

Figure 13: Mental Health Professional Shortage Areas in Florida



[8]The Commonwealth Fund provides a brief summary of *Understanding the U.S. Behavioral Health Workforce Shortage* that focuses on understanding "who makes up the behavioral health workforce," and "how we can bolster the behavioral health workforce." Those wanting a concise summary of this issue may want to read the content on this web page.

[9]Healthychildren.org provides a helpful summary of different professional types: See *Mental Health Care Providers for Kids: Who's Who*.

[10]Quotes from page 107 of Džakula, A., Relić, D., & Michelutti, P. (2022). Health workforce shortage: Doing the right things or doing things right? *Croatian Medical Journal, 63*(2), 107-109), citing Lopes, M. A., Almeida, A. S., Almada-Lobo, B. (2015). Handling healthcare workforce planning with are: Where do we stand? *Human Resources for Health, 13*(38).

[11]For more information about HPSAs, see the web page Health Resources & Services Administration, Health Workforce Shortage Areas. *HPSA Find* site with a dashboard to generate HPSA information, such as at the state and county level.

There is a shortage in the healthcare workforce in general for primary care specialists, emergency room physicians, and physicians in many other sub-specialties.[12]

The ratio of population size to the number of mental health providers is in Table 8. For instance, should a county present with population totaling 50,000 and have only 20 mental health providers, the ratio would be: 2,500:1.[13]

Approaches to increase the number of psychiatrists include increasing psychiatry residency slots in existing programs and creating new psychiatry residency programs but requires funding.

Table 8: Mental Health Providers in 2022 – Rates *MHPs = Mental Health Professionals*

County	# of MHPs	Ratio	County	# of MHPs	Ratio	County	# of MHPs	Ratio
Florida	42,380	510:1	Gulf	18	800:1	Okaloosa	411	520:1
Alachua	1,854	150:1	Hamilton	1	13,990:1	Okeechobee	27	1,490:1
Baker	41	700:1	Hardee	7	3,630:1	Orange	3,865	370:1
Bay	486	370:1	Hendry	15	2,690:1	Osceola	697	580:1
Bradford	34	840:1	Hernando	185	1,080:1	Palm Beach	3,839	390:1
Brevard	1,112	550:1	Highlands	86	1,200:1	Pasco	574	1,020:1
Broward	4,374	440:1	Hillsborough	3,109	480:1	Pinellas	2,390	400:1
Calhoun	10	1,360:1	Holmes	13	1,520:1	Polk	861	880:1
Charlotte	232	840:1	Indian River	257	640:1	Putnam	53	1,400:1
Citrus	142	1,110:1	Jackson	69	690:1	St. Johns	379	770:1
Clay	287	770:1	Jefferson	10	1,460:1	St. Lucie	598	570:1
Collier	438	880:1	Lafayette	2	4,190:1	Santa Rosa	185	1,050:1
Columbia	191	370:1	Lake	426	930:1	Sarasota	896	500:1
Miami-Dade	5,343	500:1	Lee	1,047	750:1	Seminole	904	520:1
DeSoto	72	480:1	Leon	791	370:1	Sumter	70	1,940:1
Dixie	3	5,700:1	Levy	20	2,210:1	Suwannee	37	1,200:1
Duval	2,350	430:1	Liberty	35	230:1	Taylor	7	3,120:1
Escambia	712	450:1	Madison	13	1,410:1	Union	9	1,820:1
Flagler	93	1,300:1	Manatee	506	820:1	Volusia	893	630:1
Franklin	11	1,140:1	Marion	417	930:1	Wakulla	24	1,450:1
Gadsden	66	660:1	Martin	363	440:1	Walton	65	1,230:1
Gilchrist	26	710:1	Monroe	193	430:1	Washington	6	4,240:1
Glades*	3	1:350	Nassau	121	780:1			

*Data for Glades County are from 2021 because 2022 data were not available.

While much of the workforce focus is on psychiatry, there are shortages of other professional types, including psychologist, social work, and rehabilitation counselors, for example. The behavioral health workforce is also in need of increased peer support workers.[14]

[12]Florida Medical Association, *Florida's physician shortage: It's not just primary care and rural areas* (2022, April 21).

[13]County Health Rankings, Mental Health Providers. The data for this table came from the National Provider Identification (NPI) data file[13] from the Health Resources Services Administration (HRSA) that are made available at countyhealthrankings.org, (see Table X. According to the Centers of Medicare and Medicaid Services (CMS), "[c]overed health providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA – see Centers for Medicare and Medicaid Services, National Provider Identifier Standard (NPI) For general information about HIPAA see the Centers for Medicare and Medicaid Services, Medicare Learning Network, *MLN Fact Sheet: HIPAA Basics for Providers: Privacy, Security, & Breach Notification Rules*.

[14]The Peer Support Coalition of Florida provides Florida specific information on peer support. This includes news, training, resources. This includes news,

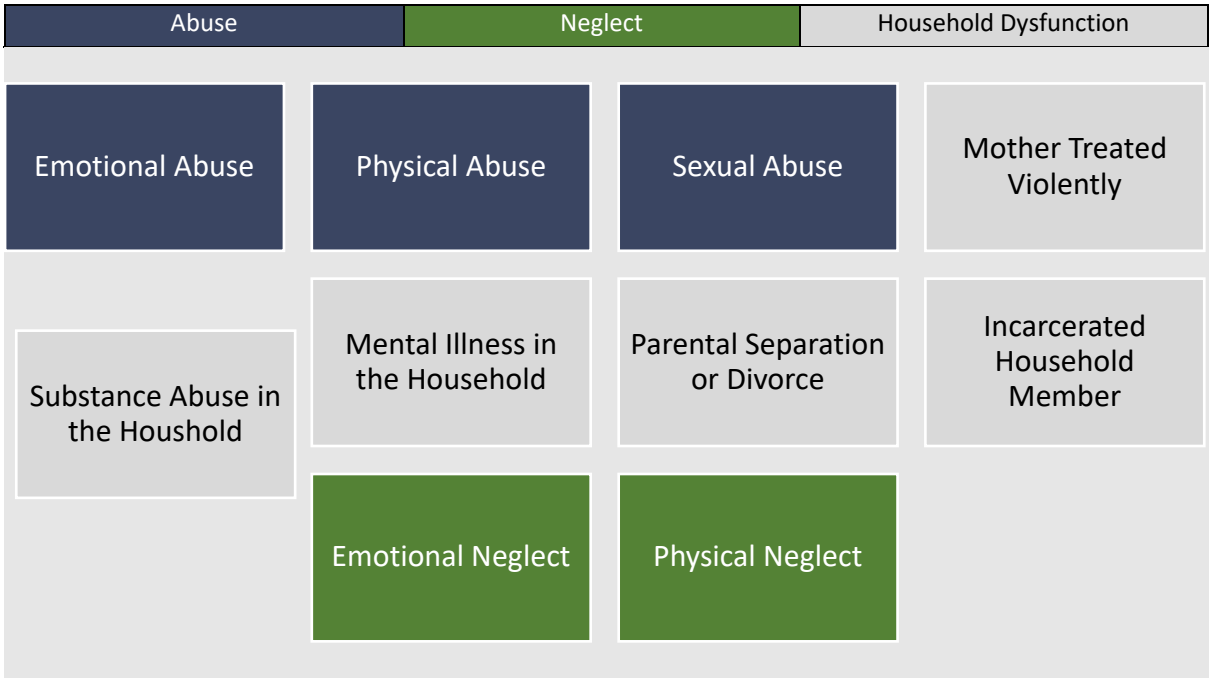
2. Stigma

A consistent and interfering aspect with help-seeking and recovery continues to be the stigma, prejudice, and discrimination attached to mental illness. Common stereotypes of mental illness can include dangerousness, incompetence, and permanence, which can often result in discriminatory behaviors against individuals.[15] There are several types of stigmas. Impacts of self-stigma include self-sabotage, ruminating (such as on negative thoughts), and suicidal ideation.[16] The complexity of and understanding of stigma is central to reducing negative impacts on care seeking and treatment engaging individuals.[17] Connecting individuals with lived experience "has a deeper and broader impact on public stigma than education."[18]

3. Trauma

Understanding the effects of trauma support addressing behavioral health related concerns, including being at risk for and/or subject to involuntary examination. As such, concepts were used as part of the coding strategy. The study on Adverse Childhood Experiences (ACEs) conducted in the latter half of the 20th century illustrated the correlation between early ACEs and negative health outcomes such as chronic illness, poor mental health, and substance abuse later in life. Researchers examined aspects related to abuse, neglect, and household challenges (Figure 14) which may have profound impacts on adolescents into adulthood.

Figure 14: Ten Items Collected from Original Adverse Childhood Experience Study



The research demonstrated that each ACE before the age of 18 increased the risk for developing health related conditions later in life. The initial ACEs study found that more than half of the study participants

[15] Sheehan, L., Nieweglowski, K., Corrigan, P.W. (2017). Structures and Types of Stigma. In: Gaebel, W., Rössler, W., Sartorius, N. (eds) The Stigma of Mental Illness - End of the Story? Springer, Cham. https://doi.org/10.1007/978-3-319-27839-1_3

[16] Ponte, K. (2021, February 8). *The Many Impacts of Self Stigma*, NAMI Blog.

[17] Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014, October). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care, *Psychological Science in the Public Interest, 15*(2), 37-70.

[18] Corrigan, P. W. (2022). Coming Out and Proud to Erase Stigma of Mental Illness, *World Psychiatry, 21*(3), 388-389.

experienced at least one ACE and one-quarter experienced at least two ACEs. Adults who reported four or more ACEs had a four-to-12-fold increase in health risks compared to adults who reported no ACEs

4. Suicide and Suicide Prevention

In 2007, the Florida Statewide Office for Suicide Prevention (section 14.2019, F.S.) and the Florida Suicide Prevention Coordinating Council were created (section 14.20195, F.S.). Florida is currently implementing six federal grants to assist with suicide prevention efforts.[19] The Department also makes available online the Florida Suicide Interagency Acton Plan and information about lethal means reduction. For additional information and to learn more about statewide suicide efforts, reference the Florida Suicide Prevention Coordinating Council 2022 Annual Report.

Zero Suicide began in early 2010 with the mission to "seek to transform the way health systems care for people with suicidal thoughts and urges." [20] In Florida, individual agencies (e.g., community behavioral health agencies, state departments) or communities (e.g., local coalitions, task forces) engage in Zero Suicide by assessing suicide care practices and implementation of evidence-based tools and strategies in the pathway of care for individuals at risk. This assessment is often accomplished with the support of Managing Entity oversight and/or federal suicide prevention grant training and consultation. Zero Suicide system enhancements address screening, assessment, safety planning, lethal means access, treatment, care transitions, and quality improvement practices.

Information from the Florida Department of Health's Community Health Assessment Resource Tool Set (FLHealthCHARTS) of rates for youth aged five through 17 years are in Table 10.[21]

Table 10: Deaths by Suicide for Youth 5-17

Year	Rate Per 100,000	Deaths by Suicide
2021	15.1	3,325
2020	14.4	3,113
2019	16.1	3,427
2018	16.9	3,552
2017	15.5	3,187
2016	15.4	3,122
2015	15.8	3,152
2014	15.1	2,961
2013	15.0	2,892
2012	15.3	2,922
2011	14.6	2,765
2010	14.6	2,753
2009	15.3	2,854

[19] Florida Department of Children and Families, Suicide Prevention Focused Grants web page.
[20] Zero Suicide web page, which contains information about research, the Zero Suicide movement to "call for safer suicide care in health and behavioral health powered by a network of implementors and innovators.," as well as their toolkit and other resources.
[21] Florida Health Charts, Deaths from Suicide, Data Dashboard

Table 11: 2021 Statewide Counts and Rates Per 100,000 for Suicide and Intentional Self Harm by Age Groups *** Redacted due to small cell size.*

Deaths by Suicide by Age														
Age Group	Firearm		Drug Poisoning		Suffocation		Cut/Pierce		Non-Drug Poisoning		Other Mechanisms		Total	
	Children	Rate	Children	Rate	Children	Rate	Children	Rate	Children	Rate	Children	Rate	Children	Rate
10-14	11	0.9	<10	**	16	1.3	0	0	0	0	0	0	29	2.36
15-19	47	3.86	8	0.66	33	2.71	<10	**	<10	**	6	0.49	99	8.13
20-24	129	10.07	17	1.33	42	3.28	<10	**	<10	**	12	0.94	215	16.78
25-34	261	9.13	29	1.01	147	5.14	6	0.21	11	0.38	23	0.8	484	16.93
35-44	246	9.16	42	1.56	129	4.8	10	0.37	<10	**	28	1.04	467	17.39
45-54	245	8.98	54	1.98	133	4.87	15	0.55	10	0.37	37	1.36	491	17.99
55-64	327	10.98	76	2.55	123	4.13	21	0.71	24	0.81	38	1.28	600	20.15
65-74	297	11.57	62	2.42	66	2.57	16	0.62	12	0.47	30	1.17	475	18.51
75+	360	16.99	39	1.84	33	1.56	<10	**	11	0.52	14	0.66	464	21.89
Total	**1,924**	**9.79**	**329**	**1.67**	**722**	**3.67**	**78**	**0.40**	**88**	**0.45**	**188**	**0.96**	**3,325**	**16.91**
Non-Fatal Hospitalizations by Age														
Age Group	Firearm		Drug Poisoning		Suffocation		Cut/Pierce		Non-Drug Poisoning		Other Mechanisms		Total	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
<18	<10	**	1,281	29.69	11	0.25	26	0.6	13	0.3	41	0.95	1,374	31.85
18-21	19	1.93	562	56.95	<10	**	28	2.84	<10	**	40	4.05	662	67.08
22-24	19	2.47	271	35.24	6	0.78	24	3.12	<10	**	18	2.34	342	44.48
25-44	44	0.79	1,821	32.85	39	0.7	252	4.55	52	0.94	211	3.81	2,419	43.64
45-64	37	0.65	1,597	27.99	18	0.32	114	2	57	1.00	103	1.81	1,926	33.76
65-74	16	0.62	463	18.04	<10	**	23	0.9	22	0.86	19	0.74	546	21.27
75+	11	0.52	300	14.15	<10	**	26	1.23	11	0.52	17	0.8	367	17.32
Total	**148**	**0.67**	**6,295**	**28.61**	**83**	**0.38**	**493**	**2.24**	**168**	**0.76**	**450**	**2.04**	**7,637**	**34.7**
Non-Fatal Emergency Department (ED) Visits by Age														
Age Group	Firearm		Drug Poisoning		Suffocation		Cut/Pierce		Non-Drug Poisoning		Other Mechanisms		Total	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
<18	<10	**	2,910	67.44	26	0.6	1,318	30.55	97	2.25	792	18.36	5,144	119.22
18-21	<10	**	749	75.89	10	1.01	347	35.16	19	1.93	270	27.36	1,398	141.65
22-24	<10	**	351	45.65	<10	**	203	26.4	13	1.69	147	19.12	720	93.64
25-44	15	0.27	1,811	32.67	33	0.6	905	16.33	78	1.41	725	13.08	3,567	64.35
45-64	10	0.18	1,017	17.82	13	0.23	347	6.08	38	0.67	320	5.61	1,745	30.58
65-74	<10	**	212	8.26	0	0	40	1.56	5	0.19	48	1.87	308	12
75+	<10	**	87	4.1	<10	**	34	1.6	<5	**	38	1.79	163	7.69
Total	**36**	**0.16**	**7,138**	**32.44**	**87**	**0.4**	**3,195**	**14.52**	**252**	**1.15**	**2340**	**10.63**	**13,048**	**59.29**

5. Social Media

Dr. Marcia Morris, associate professor in the Department of Psychiatry and associate program director for University of Florida's Student Health Psychiatry, highlighted both the positive and negative aspects of social media in a May of 2023 web posting for the *University of Florida News* as follows:

"Undoubtedly, social media can be a powerful tool for fostering connections, accessing resources, promoting creativity, and facilitating self-expression. However, it is important to address the potential negative effects of prolonged usage, such as feelings of isolation or the development of negative emotions."[22]

Time spent on social media has been shown to reduce the quality of sleep and the amount of daily physical activity, which are important for mental and physical health. In the new digital age, how youth spend time is vastly different from previous generations. Risk factors for health issues are becoming more internalized, rather than external. Additional efforts are needed to identify and address risk factors before they become a crisis, as well as to examine how the effects of the factors carry into adulthood.

With the signing of Chapter 2023-36, F.S., House Bill 379 (2023) by Governor DeSantis, Chapter 1003, F.S., was amended to include language prohibiting the use of certain platforms on district-owned devices and through internet access provided by the school district, authorizing teachers and other instructional personnel to designate an area for wireless communications during instructional time, and requiring public schools to provide instructions on the social, emotional, and physical effects of social media.[23]

Note that internet safety is a separate, but related issue to the impacts of social media. Some aspects of Chapter 2023-36, F.S., address internet safety.[24]

6. Social Isolation and Loneliness

Mental Health America documented that nearly half of Americans reported "feeling alone" (46 percent) or "left out" (47 percent). This included over two-thirds of 11- to 17-year-olds that "felt stressed out about loneliness."[25]

In addition to loneliness and isolation increasing the risk of certain types of illness (heart disease and stroke, for example), the afflictions contributed substantially to mental health challenges. Social connectedness to combat loneliness can be based on six fundamental pillars.

- Strengthen Social Infrastructure
- Enact Pro-Connection Public Policies
- Mobilize the Health Sector
- Reform Digital Environments
- Deepen Our Knowledge
- Cultivate a Culture of Connectedness

The 2019 article, "Conceptual Framework for Social Connectedness in Mental Disorders: Systemic Review and Narrative Synthesis" is available online for information on social connectedness and mental health.[26]

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[22] Social Media and Mental Health: Considerations from experts this Mental Health Awareness Month (2023, May 17). University of Florida News. This web posting focuses, in part, on college students.

[23] Florida House of Representatives Web page for House Bill 379 (2023).

[24] The Florida Department of Education provides links to resources about Internet Safety on its website.

[25] Mental Health America: *Is Your Child Lonely*

[26] Hare-Duke, L., Dening, T., de Oliveira, D., Milner, K., & Slade, M. (2019). Conceptual Framework for Social Connectedness in Mental Disorders: Systemic Review and Narrative Synthesis, *Journal of Affective Disorders, 245*, 188-199.

7. Resiliency

The Department is committed to supporting resiliency in Floridians has expanded the behavioral health training program with the Florida Alcohol and Drug Abuse Association (FADAA) to promote and support resiliency in children and youth by offering webinars, workshops, and online courses related to coping skills, wellness, strengths-based care, and communications. The Department continues to offer training for behavioral health professionals, health care practitioners, child welfare professionals, caregivers, and other stakeholders for continuing education credits.

A priority of the Department of Education, is First Lady Casey DeSantis' strengthening resiliency initiative. The initiative was put into action with new standards that were developed and added to the Florida Administrative Code (6A-1.094124) and took effect in November of 2022 for "Required Instruction Planning and Reporting" in order to implement steps to address resiliency of children. School districts are required to annually provide a minimum of five hours of data-driven instruction to students in grades six to 12 to cover at a minimum:

1. Strategies specific to demonstrating resiliency through adversity, including the benefits of service to the community through volunteerism.
2. Strategies to develop healthy characteristics that reinforce positive core values and foster resiliency such as:
    a) Empathy, perseverance, grit, gratitude, and responsibility.
    b) Critical thinking, problem solving, and responsible decision-making.
    c) Self-awareness and self-management.
    d) Mentorship and citizenship.
    e) Honesty.
3. Recognition of signs and symptoms of mental health concerns.
4. Promotion of resiliency to empower youth to persevere and reverse the harmful stigma of mental health by reframing the approach from mental health education to resiliency education.
    a) Strategies to support a peer, friend, or family member through adversity.
    b) Prevention of suicide.
    c) Prevention of the abuse of and addiction to alcohol, nicotine, and drugs.
    d) Awareness of local school and community resources and the process for accessing assistance.

8. Justice System Involvement

Youth involved in the juvenile justice system are likely to have similar traumatic experiences and other challenges that impact social determinants of health.

Some projects funded by the Department's Criminal Justice, Mental Health, and Substance Abuse (CJMHSA) Reinvestment Grant Program focus on youth. Although the CJMHSA Program focuses on criminal justice, many of the concepts and projects apply to youth who experienced involuntary examinations not criminal justice system involvement. The CJMHSA was created in 2007 per section 394.658, F.S.[27] The program is administered by the Department and funds one year planning grants and three-year implementation or expansion grants. The implementation and expansion grants must demonstrate a "well-established collaboration plan that includes

[27] See *Chapter 2007-200, Council Substitute for Council Substitute for House Bill No. 1477* (2007).

public-private partnership models and the application of evidence-based practices." The purpose of CJMHSA Reinvestment Grants is:[28]

- Diverting individuals with mental health and/or substance use disorders from the criminal and juvenile justice systems,
- Improving the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance use disorder, or co-occurring disorder and who are in or at risk of entering the criminal or juvenile justice systems, and
- Providing funds to plan, implement, or expand initiatives that increase public safety and avert increased spending on criminal and juvenile justice systems.

Examples of grants funded efforts:

- Mental health courts.
- Diversion programs.
- Crisis intervention teams.
- Treatment accountability services.
- Coordinated specialty care programs.
- Alternative prosecution and sentencing.
- Specialized training for criminal justice, juvenile justice, and treatment services professionals.
- Service delivery of collateral services such as housing, transitional housing, and supported employment.
- Reentry services to create or expand mental health and substance abuse services and supports for affected individuals.

The CJMHSA Technical Assistance Center (CJMHSA-TAC) at the de la Parte Florida Mental Health Institute at the University of South Florida supports counties applying for and carrying out reinvestment grant projects per section 394.659 , F.S., and includes guiding communities through a Sequential Intercept Mapping (SIM).[29] The SIM Model was developed by Munetz and Griffin in 2006.[30] The SIM Model focuses on the criminal justice system and integrates concepts of the Risk, Need, Responsivity (RNR) Model. Criminal justice system recidivism, such as re-arrest, is the outcome of focus for the RNR.

Six intercepts in the SIM Model:

- Intercept 0: Community Services
- Intercept 1: Law Enforcement
- Intercept 2: Initial Detention and Initial Court Hearings
- Intercept 3: Jails and Courts
- Intercept 4: Reentry
- Intercept 5: Community Corrections

A portion of SIMs focus on a narrower population, such as children or veterans. Juvenile SIM reports produced by the CJMHSA-TAC were in the following counties: Dixie (2021), Duval (2022), Glades (2021), Hillsborough (2022), Palm Beach (2023), Pinellas (2022), and Volusia (2021).[31] Intercept 0 was added to the model in 2016 due to the early intervention points of Intercept 0 that can be seen as separate from the law enforcement involvement part of Intercept 1. Implementation and access to community services that are part of Intercept 0 could prevent progression to contact with law enforcement.

9. Access to and Coverage of Services

Access to healthcare in general, and behavioral health services specifically, is a topic of focus for many agencies, professional associations, foundations, and other entities.

[28] Source of text for the bulleted text below is from the "About Us: Center History" page of the CJMHSA TA Center at USF.
[29] A 2021 CJMSA TAC titled "Sequential Intercept Model Lunch & Learn is available as a PowerPoint and a recorded webinar.
[30] Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57*, 544-549.
[31] All CJMHSA-TAC SIM reports are linked to on this web page.

Individuals need knowledge of a service to access. Recent efforts to publicize the 988 Florida Suicide & Crisis Lifeline is an example of efforts to educate and build awareness to the public about resources. Education is needed for individuals to understand cost issues to accessing certain services, including how insurance works. Access to healthcare services could be impacted by insurance coverage (including Medicaid), availability of services (may not exist or long wait list), language, transportation, or additional challenges.[32] Technology, such as telehealth, increases access to certain services. Telehealth access expanded in recent years, including changes to state policies.

IV. Recommendations

1. **Continued Data Efforts Focusing on Children Who Are High Utilizers:** Utilize additional data sets to examine high utilization of crisis services to gain a comprehensive understanding of challenges and opportunities. Analysis may include examination of the 11 factors related to repeated involuntary examinations of minors discussed in this report.

2. **Mobile Response Team Data:** Conduct an analysis of data collected from MRT encounters. Update data collection to include the process for recommendation #2.

3. **Focus Efforts to Address Metrics in the SHIP:** Focus data collection, analysis, and policy development efforts in collaboration with Florida's State Health Improvement Plan (SHIP) elements. Mental well-being and substance abuse prevention is a priority area in the 2022-2026 SHIP.[33] As stated in the SHIP, "mental and emotional well-being enables individuals to realize their own abilities, cope with the normal stresses of life, work productively and contribute to his or her community."

The focus for the 2022-2026 SHIP Priority Area Workgroup (PAW) for Mental Well-being and Substance Abuse Prevention[34] are as follows:

- Reduce the impact of adult mental, emotional and behavioral health disorders.
- Reduce the impact of pediatric mental, emotional and behavioral health disorders.
- Reduce substance use disorders and drug overdose deaths.
- Reduce suicide behaviors and death.

[32]Social Determinants of Health Series: Transportation and the Role of Hospitals, American Hospital Association website. Also see Health Research & Educational Trust. (2017, November). Social
Determinants of Health Series: Transportation and the Role of Hospitals. Chicago, IL: Health Research & Educational Trust. Accessed at www.aha.org/transportation.

[33]Florida SHIP (State Health Improvement Plan) website. The seven priority goals are 1) Alzheimer's Disease and Related Dementias, 2) Chronic Diseases and Conditions, 3) Injury, Safety, and Violence, 4) Maternal and Child Health, 5) Mental Well-Being and Substance abuse Prevention, 6) Social and Economic Conditions Impacting Health, and 7) Transmissible and Emerging Diseases.

[34]*2022-2026 State Health Improvement Plan Priority Area Workgroup Charter – Mental Well-being and Substance Abuse Prevention* web page. Information about the purpose and primary functions of the Priority Area Workgroups (PAWS) is contained on the floridaship.org web pages for each of the seven SHIP priority areas.

V. Appendices

Appendix A: Brief Summary of Initiatives and Services

Hope Florida: A Pathway to Prosperity

Hope Florida uses Hope Navigators to guide Floridians on an individualized path to prosperity, economic self-sufficiency, and hope by focusing on community collaboration between the private sector, faith-based community, nonprofits and government entities to break down traditional community silos, in an effort to maximize resources and uncover opportunities. Hope Navigators are essential in helping individuals identify their unique and immediate barriers to prosperity, develop long term-goals, map out a strategic plan, and work to ensure all sectors of the community have a 'seat at the table' and are part of the solution.

Several Federal and state funded programs listed below are available to support children and families facing mental health concerns and complications.

Behavioral Health Network (BNet)

The Behavioral Health Network (BNet) program developed in partnership with the Department of Health and the Department. BNet is a statewide network of behavioral health service providers serving children five to 18 years of age with a serious emotional disturbance, mental health, or substance use disorder, offering services that include, but are not limited to, in-home and outpatient individual and family counseling, targeted case management, psychiatry services, pharmaceuticals for behavioral health or substance use conditions, up to 30 days of residential care and 10 days of inpatient care, individualized wrap-around services, parent assistance and respite. BNet is available to children enrolled in the Children's Medical Services Health Plan or subsidized Florida Healthy Kids members.[35]

Community Action Treatment (CAT)

During FY 22/23 the Department increased access to Community Action Treatment (CAT) Teams that provide comprehensive, intensive community-based treatment to families with youth 11 to 21 years of age, who are at risk of out-of-home placement due to a mental health or co-occurring disorder and related complex issues for whom traditional services are not or have not been adequate. As part of this effort the Department developed three new CAT models, an in-home family treatment approach, a family crisis care coordination model, and a model adapted for younger children, to expand the capacity of CAT team services. CAT teams use a multi-disciplinary clinical team approach with families with round the clock on-call care availability outside of normal business hours, 365 days a year.[36] Teams throughout the state can be found on the Department's website.

Coordinated Specialty Care (CSC) Early Psychosis

Coordinated Specialty Care (CSC) is a recovery-oriented treatment program for individuals with first episode psychosis (FEP). CSC promotes shared decision making and uses a team of specialists working with the individual to create a personal treatment plan. There are currently 16 CSC providers in Florida.

Family Intensive Treatment (FIT)

There are 28 Family Intensive Treatment (FIT) teams providing intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. Families are eligible to receive FIT services when a child is determined to be "unsafe" by a child welfare professional, with priority given to families with children zero to 10 year of age. Referrals for FIT team services are made by child

[35] https://www.sunshinehealth.com/members/cms/benefits-services/florida-behavioral-health-network.html

[36] https://centerstone.org/programs/childrens-community-action-treatment-cat-team/

welfare professionals, including child protective investigators, child welfare case managers, or community-based care lead agencies. Teams throughout the state can be found on the Department's website.

Multidisciplinary Child Welfare Teams

There are four Multidisciplinary Child Welfare teams that serve families with child welfare involvement who may not meet FIT team eligibility. Families may be referred to Multidisciplinary Child Welfare teams if a child welfare professional has concerns that a parent has an unmanaged or undiagnosed mental health, substance use, or co-occurring disorder. Multidisciplinary Child Welfare teams provide timely access to intensive behavioral health services and address concerns related to abuse or neglect, as well food insecurity and housing instability.

Florida Assertive Community Treatment (FACT)

There are 39 FACT teams in Florida that promote independent, integrated living for adults with serious mental illness who have not responded well to traditional treatment. FACT teams offer a 24-hour-a-day, seven-days-a week, multidisciplinary approach to deliver comprehensive community-based care to individuals where they live, work, or other preferred setting. Goals of the program include improved participant quality of life and community involvement, in addition to prevention of recurrent hospitalization and incarceration.[37] Teams throughout the state can be found on the Department's website, www.myflfamilies.com.

Additional Team-Based Programs that Serve Adults with Serious Mental Illness

There are four additional team-based programs that serve adults with serious mental illness who may not meet FACT team eligibility. The goal of the team-based programs is to decrease crisis episodes, promote independent living, and improve community involvement. The team delivers mental health rehabilitation interventions and clinical case management to promote continuity of care and ease of service access until a full transition to community-based care is optimal.

988 Florida Suicide & Crisis Lifeline

In July of 2022, a new three-digit code, 988, was implemented nationwide for landlines and cell phones for individuals in emotional distress or suicidal crisis. The previous number (1-800-273-8255) remains available to individuals in distress/crisis, as well. Administered by the Department, the 988 Suicide & Crisis Lifeline is a nationwide network of over two hundred local crisis centers with staff trained to provide free and confidential emotional support and crisis counseling to individuals experiencing a suicidal crisis or emotional distress and connect them to resources. Individuals may also text and chat using 988.

Mobile Response Teams

The Department's 51 MRTs provide crisis intervention services in any setting where a behavioral health crisis is occurring. Available 24 hours a day, MRTs are staffed by a team of professionals and paraprofessionals trained in crisis intervention skills. Services offered include, evaluation and assessment, development of safety or crisis plans, providing or facilitating stabilization services, supportive crisis counseling, education, development of coping skills, linkage to appropriate resources, and connecting individuals who need more intensive mental health and substance use services to the needed level of care.[38] Teams throughout the state can be found on the Department's website.

[37] Source: Life Management Center, Florida Assertive Community Treatment web page

[38] More information about best practices and reporting requirements can be found on the Department's Program Guide for Managing Entity Contracts, Mobile Response Team pdf.

Appendix B: Finding Services, Education/Training, and Other Support

The following are resources for topics relevant to the Involuntary Examination of Minors report and locating services. Clicking on underlined text will connect to correlating websites.

988 Suicide & Crisis Lifeline "The 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline) offers 24/7 call, text and chat access to trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support." For Deaf and Hard of Hearing: For TTY Users: Use your preferred relay service or dial 711 then 988. **Talk**: Call 988 on a landline or cell phone. **Chat with 988 Online.** **Text** 988 to start a text conversation.
211 Call 211 24/7 to speak to someone who can help with a variety of issues, such as disaster recovery, food programs and benefits, housing, uses, healthcare expenses, mental health, and substance use.
Florida Warm Line (Peer Experience Line)* The Florida Warm Line is for individuals with a mental illness who want to talk with someone who shares personal experience coping with mental health issues. *Note this is not a crisis line and it is not 24/7.
Florida Department of Children and Families: Get Help – Find Local Services
Hope Florida Connect with a Hope Navigator by calling 850-300-HOPE or choose the "I Need Help" or "I want to HELP" options on the HOPE Florida web page.
Florida Department of Health: Mental Health Links
American Foundation for Suicide Prevention: Suicide Prevention Resources
National Alliance on Mental Illness (NAMI) (support, training, education, and advocacy) Find Your Local NAMI
Peer Support Coalition of Florida
Loneliness/Social Connection Prevention resources: Loneliness and Ways to Improve Social Connectedness. Coalition to End Social Isolation and loneliness: Resources and Research.

Appendix C: Statewide and County Metrics for Context

Data below obtained from FLHealthCHARTS contains metrics related to self-harm, emotional\behavioral disability reported in educational settings, abuse/violence, foster care placement, and questions related to ACEs, which are taken from the Florida Youth Substance Abuse Survey (FYSAS). The FYSAS tracks indicators related to substance abuse, mental health, and ACEs. More information and complete FYSAS survey results can be found on the Department's website.

Table B1: Characteristics of Children Statewide and by County * Indicates data missing\not reported)

County	Rate Per 100,000					
	Age 12-18	Kindergarten to 12th Grade	Age 5-11		Age 5-11	Age 12-17
	Hospitalizations for Non-Fatal Self-Harm Rate	Students with Emotional/Behavioral Disability	Children Experiencing Child Abuse	Children Experiencing Sexual Violence	Children in Foster Care	
Florida	86	400	540	47	485	418
Alachua	197	300	503	41	711	393
Baker	39	400	0	0	591	313
Bay	161	900	990	119	1,004	794
Bradford	96	500	371	93	602	606
Brevard	112	400	622	59	633	481
Broward	47	400	323	15	266	282
Calhoun	252	**	524	87	961	472
Charlotte	138	1,400	1,220	67	571	603
Citrus	44	600	572	103	881	798
Clay	108	1,300	739	59	563	379
Collier	119	300	424	47	303	270
Columbia	67	200	822	115	1,234	836
DeSoto	171	300	752	75	790	954
Dixie	0	**	920	335	1,004	944
Duval	92	600	749	50	470	445
Escambia	111	300	1,370	169	779	531
Flagler	51	300	394	39	538	517
Franklin	0	900	1,544	140	1,684	632
Gadsden	78	600	575	79	288	429
Gilchrist	183	**	740	67	404	218
Glades	0	**	1,123	374	998	269
Gulf	0	600	1,690	356	356	964
Hamilton	90	**	282	0	470	413
Hardee	0	200	638	35	850	602
Hendry	47	300	756	138	779	745
Hernando	83	500	270	57	638	547
Highlands	14	400	1,017	100	974	384
Hillsborough	80	400	662	16	643	485
Holmes	63	400	1,485	65	517	507

County	Rate Per 100,000					
	Age 12-18	Kindergarten to 12th Grade	Age 5-11		Age 5-11	Age 12-17
	Hospitalizations for Non-Fatal Self-Harm Rate	Students with Emotional/Behavioral Disability	Children Experiencing Child Abuse	Children Experiencing Sexual Violence	Children in Foster Care	
Indian River	49	400	680	52	460	361
Jackson	28	1,000	600	60	660	258
Jefferson	103	**	410	205	512	833
Lafayette	0	**	606	0	303	305
Lake	126	900	321	46	357	346
Lee	142	400	623	70	662	631
Leon	49	500	621	37	516	362
Levy	71	**	581	183	520	595
Liberty	0	**	907	0	0	557
Madison	74	**	428	0	428	424
Manatee	72	200	1,103	70	875	750
Marion	86	600	788	95	891	737
Martin	28	200	588	39	245	279
Miami-Dade	69	400	147	20	182	222
Monroe	68	800	637	21	595	518
Nassau	182	500	207	14	496	330
Okaloosa	96	400	835	77	675	394
Okeechobee	150	600	895	29	808	729
Orange	102	200	410	50	308	299
Osceola	61	400	248	50	230	270
Palm Beach	49	300	321	44	286	317
Pasco	78	500	859	36	833	630
Pinellas	86	400	1,132	26	889	656
Polk	129	200	595	44	612	554
Putnam	84	900	1,415	228	1,366	1,558
Santa Rosa	139	300	898	115	516	341
Sarasota	121	300	631	78	483	370
Seminole	94	400	494	38	477	469
St. Johns	143	500	466	47	254	240
St. Lucie	100	500	450	39	412	376
Sumter	95	500	279	93	186	272
Suwannee	132	200	478	133	717	636
Taylor	0	400	452	113	960	964
Union	82	**	164	82	821	1,236
Volusia	87	700	577	57	686	441
Wakulla	0	900	537	36	322	357
Walton	34	300	1,077	125	1,358	787
Washington	250	800	853	301	351	624

Table B2: Characteristics of Children Statewide and by County – Trauma Related Variables

County	Percent of High School Students Who Experienced…								
	Emotional Abuse	Emotional Neglect	Mental Illness in Household	Physical Abuse	Physical Abuse in Household	Sexual Abuse	Substance Abuse in Household	Four or More Adverse Childhood Experiences (ACEs)	Living with an Incarcerated Household Member
Florida	17%	31%	33%	11%	9%	7%	25%	21%	23%
Alachua	15%	31%	42%	14%	9%	11%	32%	25%	27%
Baker	15%	27%	35%	11%	9%	6%	28%	26%	31%
Bay	17%	33%	38%	11%	11%	6%	29%	25%	25%
Bradford	15%	26%	26%	7%	7%	7%	26%	18%	29%
Brevard	19%	33%	37%	11%	9%	10%	26%	22%	24%
Broward	16%	26%	18%	10%	10%	5%	13%	14%	10%
Calhoun	16%	36%	40%	7%	9%	9%	31%	28%	37%
Charlotte	17%	33%	43%	6%	10%	7%	36%	26%	28%
Citrus	19%	40%	46%	14%	15%	10%	45%	35%	39%
Clay	20%	37%	46%	12%	12%	5%	33%	26%	29%
Collier	18%	31%	32%	13%	9%	8%	23%	21%	18%
Columbia	15%	36%	34%	12%	11%	6%	32%	24%	29%
Miami-Dade	15%	30%	28%	12%	7%	6%	22%	18%	20%
DeSoto	16%	37%	30%	6%	7%	3%	32%	23%	29%
Dixie	13%	29%	32%	10%	9%	6%	27%	22%	27%
Duval	18%	29%	27%	12%	7%	7%	21%	19%	22%
Escambia	14%	25%	33%	8%	7%	4%	26%	21%	27%
Flagler	22%	40%	46%	13%	11%	10%	39%	29%	30%
Franklin	29%	49%	35%	12%	10%	19%	31%	39%	40%
Gadsden	18%	27%	23%	14%	15%	4%	19%	22%	30%
Gilchrist	11%	31%	36%	11%	8%	6%	28%	25%	29%
Glades	12%	31%	26%	4%	3%	10%	23%	18%	19%
Gulf	16%	34%	47%	13%	12%	11%	40%	36%	41%
Hamilton	10%	20%	19%	9%	7%	6%	21%	18%	29%
Hardee	**	**	**	**	**	**	**	**	**
Hendry	14%	30%	21%	9%	9%	7%	21%	20%	26%
Hernando	19%	39%	42%	11%	12%	9%	34%	31%	36%
Highlands	18%	34%	31%	11%	9%	8%	28%	24%	26%
Hillsborough	15%	31%	29%	9%	7%	5%	20%	15%	21%
Holmes	17%	35%	41%	12%	15%	13%	33%	35%	39%
Indian River	15%	29%	36%	9%	11%	5%	34%	26%	28%
Jackson	20%	32%	34%	12%	11%	7%	27%	27%	33%
Jefferson	**	**	**	**	**	**	**	**	**
Lafayette	**	**	**	**	**	**	**	**	**
Lake	20%	35%	33%	10%	7%	7%	27%	21%	19%
Lee	23%	35%	38%	13%	11%	6%	28%	26%	27%
Leon	15%	38%	37%	12%	9%	5%	31%	24%	28%
Levy	9%	24%	29%	6%	8%	6%	23%	16%	22%
Liberty	6%	23%	38%	4%	10%	1%	38%	28%	24%
Madison	14%	26%	19%	5%	5%	1%	17%	13%	23%

County	Percent of High School Students Who Experienced…								
	Emotional Abuse	Emotional Neglect	Mental Illness in Household	Physical Abuse	Physical Abuse in Household	Sexual Abuse	Substance Abuse in Household	Four or More Adverse Childhood Experiences (ACEs)	Living with an Incarcerated Household Member
Manatee	20%	33%	27%	11%	7%	8%	27%	22%	21%
Marion	18%	33%	40%	11%	10%	10%	35%	28%	32%
Martin	13%	26%	27%	7%	5%	5%	23%	15%	15%
Monroe	15%	28%	29%	12%	6%	6%	26%	21%	25%
Nassau	17%	33%	42%	8%	9%	10%	31%	24%	29%
Okaloosa	16%	30%	39%	11%	9%	8%	29%	22%	27%
Okeechobee	14%	31%	32%	10%	11%	6%	26%	24%	34%
Orange	15%	28%	26%	10%	9%	4%	19%	17%	13%
Osceola	18%	33%	36%	10%	8%	8%	26%	21%	23%
Palm Beach	17%	29%	27%	9%	3%	5%	17%	15%	16%
Pasco	19%	33%	39%	11%	10%	8%	29%	24%	21%
Pinellas	18%	31%	33%	10%	8%	6%	28%	22%	21%
Polk	17%	35%	42%	14%	12%	8%	32%	29%	33%
Putnam	11%	30%	28%	8%	10%	6%	29%	23%	34%
St. Johns	19%	28%	37%	12%	8%	8%	27%	20%	17%
St. Lucie	18%	34%	28%	15%	7%	4%	13%	22%	26%
Santa Rosa	17%	34%	41%	9%	12%	7%	33%	27%	26%
Sarasota	19%	34%	39%	12%	10%	8%	28%	26%	27%
Seminole	16%	28%	34%	7%	8%	6%	20%	20%	19%
Sumter	16%	28%	29%	11%	7%	6%	27%	21%	25%
Suwannee	15%	35%	32%	11%	12%	7%	29%	19%	22%
Taylor	23%	39%	31%	5%	4%	4%	32%	27%	31%
Union	17%	32%	38%	12%	14%	9%	24%	30%	34%
Volusia	19%	33%	43%	12%	11%	7%	31%	28%	33%
Wakulla	20%	34%	44%	10%	11%	8%	36%	30%	37%
Walton	20%	34%	40%	14%	8%	7%	36%	28%	30%
Washington	13%	35%	33%	8%	9%	8%	36%	27%	35%

Appendix D: Coding Variables (Data Entry Screen)

This graphic of the data entry form for coding is presented on the final page due to larger size and ensuring the variables are visible. The page is sized to 11 X 17 (ledger).