Report on Involuntary Examinations of Minors

Department of Children and Families
Office of Substance Abuse and Mental Health

November 1, 2019

Chad Poppell
Secretary

Ron DeSantis
Governor

TABLE OF CONTENTS

I. Executive Summary 2

II. Background 3

III. State Trends and Risk Factors for Increases in Mental Health Concerns 5

A. Findings from the National Survey on Drug Use and Health(NSDUH) 5

B. Findings from the National Survey on Children's Health (NSCH) 5

C. Findings from the Youth Risk Behavior Survey(YRBS) 6

IV. Involuntary Examination Process 7

V. Analysis of Data on the Initiation of Involuntary Examination of Minors 9

A. Baker Act Reporting Center 9

B. Clinical Record Review Data 13

VI. Root Causes for Patterns, Trends, or Repeated Examination 14

VII. Recommendations 17

Appendix A 19

Appendix B 25

References 29

I. Executive Summary

The Office of Substance Abuse and Mental Health within the Florida Department of Children and Families (Department) is the state's legislatively designated mental health authority.[i] In that capacity, the office is governed by Chapter 394 of the Florida Statutes and is responsible for the oversight of statewide prevention, treatment, and recovery services for children and adults with behavioral health conditions.

In July 2019, the Department was charged with reviewing the rising number of initiations for involuntary examination of children under the Baker Act. The Baker Act Reporting Center (Reporting Center) at the Louis de la Parte Florida Mental Health Institute at the University of South Florida shows that 36,078 involuntary examinations were initiated under the Baker Act for individuals under the age of 18 between July 1, 2017 and June 30, 2018 (see Table 3 in Appendix B). From fiscal year (FY) 2013-14 to FY 2017-18, statewide involuntary examinations increased 18.85% for children. This age group is seeing a significantly larger increase in examinations as compared to young adults ages 18-24 (14.04%) and adults (12.49%). Additionally, 22.61% of minors had multiple involuntary examinations in FY 2017-18, ranging from 2 to 19.

Using the most recent data available from the Reporting Center, the Department identified 21 minors who had more than ten (10) involuntary examinations in FY 2017-18 with a combined total of 285 initiations. Circumstances for the initiations and medical records were reviewed with the following significant findings:

1. Most initiations were a result of minors harming themselves and were predominantly initiated by law enforcement.
2. Many minors were involved in the child welfare system and most experienced significant family dysfunction.
3. Most had Medicaid health insurance.
4. Most experienced multiple traumas such as abuse (sexual, physical and verbal), bullying, exposure to violence, parental incarceration, and parental substance use and mental health issues.
5. Most had behavioral disorders of childhood, such as Attention Deficit Disorder or Oppositional Defiant Disorder, followed by mood disorders, followed by anxiety disorders.
6. Most involuntary examinations were initiated at home or at a behavioral health provider.
7. Discharge planning and care coordination by the receiving facilities was not adequate to meet the child's needs.
8. Overall, depressive episodes and serious thought of suicide are increasing among Florida's children.

II. BACKGROUND

The Florida Legislature passed Senate Bill 1418 (SB 1418) during the 2019 Session, which was signed into law by Governor Ron DeSantis on June 25, 2019 as Chapter 2019-134, Laws of Florida. This law requires the Department to prepare a report on the initiation of involuntary examination of minors age 17 years and younger. Specifically, the statute requires the Department to:

- Analyze data on the initiation of involuntary examinations of minors;
- Identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child;
- Study root causes for such patterns, trends, or repeated involuntary examinations; and
- Make recommendations for encouraging alternatives to and eliminating inappropriate initiations of such examinations.

The Department is required to submit a report of its findings 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 information in this report builds on the findings of the Task Force Report on Involuntary Examination of Minors[ii] published in November 2017 and The Baker Act Fiscal Year 2017/2018 Annual Report published in June 2019.[iii] For a more comprehensive understanding of what is presented in this report, it is recommended that readers become familiar with the Task Force Report and The Baker Act Fiscal Year 2017/2018 Annual Report. Together, those reports provide important context of how the Baker Act works, the most recent data on involuntary examinations in Florida, and initial findings of contributing factors for the increased number of involuntary examination of minors. The top findings of the Task Force Report included:

1. There were multiple risk factors and stressors that impact child wellbeing such as the impact of child abuse and trauma; the lack of coping skills among children; lack of parental knowledge on how to assist their child and limited family support; poverty/economic insecurity; and social media and cyber bullying.
2. The most common mental disorders diagnosed among children under 18 were conditions amenable to behavior therapy approaches.
3. There was a limited availability of and access to a continuum of services and supports including the need for more services and supports within local communities and challenges in accessing services and supports.
4. The consideration that the increased use of involuntary examinations may be the positive result of years of systemic changes to increase awareness and action when a minor is experiencing a crisis.

The Task Force Report made several key recommendations that have been passed into law since it was published. In 2018, the Florida legislature passed Senate Bill 7026, the Marjory Stoneman Douglas School Safety Act. The Department was appropriated $18.3 million for statewide access to Mobile Response Team (MRT) services and $9.8 million to expand access to Community Action Treatment (CAT) team services. The Department leveraged the existing CAT model to expand from 27 existing teams in 2018 to 41 teams by 2019.

The CAT model is a unique approach to delivering community mental health services and supports by utilizing a team approach to assist children and their families to build upon natural supports in their community. CAT teams serve children ages 11-21 who have a mental health diagnosis or co-occurring mental health and substance use diagnoses and who are at risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care; having two or more hospitalizations; involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement; or poor academic performance or suspensions. Younger children with 2 or more characteristics may also be served. The CAT teams can provide services to eligible children and their families for an extended period with an average length of treatment between 8-12 months. Services are individualized to meet each families' unique needs. The CAT model has demonstrated positive outcomes such as improved family functioning, improved school attendance, and keeping children in their homes.

Mobile Response Team (MRT) services were less developed and required additional policy guidance and planning to ensure effective implementation. Teams began responding to calls at different times between July 2018 and March 2019. By March 2019, there were 40 MRTs serving 67 counties in Florida that target services to individuals under the age of 25. MRTs are required to respond to a mental health crisis in the community within 60 minutes, either face-to-face or through use of telehealth. Although staffing patterns vary across teams, each team has access to a Psychiatrist or an Advance Practice Registered Nurse. The MRT monthly reports for July and August of 2019 demonstrated an 80% statewide average of diverting individuals from involuntary examination.

Statewide access to CAT and MRT services is anticipated to have an impact on the number involuntary examinations that can be explored in future reports. It is important to note that the expansion of CAT and MRT services did not occur during the time that the data analyzed for this report was collected, as Fiscal Year (FY) 2017-2018 is the most recent data available.

III. State Trends and Risk Factors for Increases in Mental Health Concerns

As the increases in involuntary examination are analyzed, it is important to look at the overall prevalence of mental health concerns for children. The three data sources described in this section show significant increases in depressive episodes and thoughts of suicide in Florida's children. They also demonstrate that many children who need treatment services do not receive them.

A. Findings from The National Survey on Drug Use and Health (NSDUH)

The National Survey on Drug Use and Health (NSDUH) provides important estimates of substance use, substance use disorders, and other mental illnesses at the national, state, and sub-state levels. The NSDUH is an annual survey of the civilian, noninstitutionalized population ages 12 and older, using face-to-face, computer-assisted interviews. The NSDUH collects information from residents of households, persons in non-institutional group settings (e.g., shelters, rooming/boarding houses, college dormitories, migratory worker camps, and halfway houses), and civilians living on military bases. Persons excluded from the survey include persons with no fixed household address (e.g., homeless and transient persons not in shelters), active-duty military personnel, and residents of institutional group settings, such as correctional facilities, nursing homes, mental institutions, and long-term hospitals. State and sub-state level estimates are usually based on 2-year or 3-year averages to enhance precision.

According to the most recently published Florida-specific estimates from the 2016-2017 NSDUH, among children ages 12-17 in Florida, approximately 13.0% experienced a major depressive episode in the past year.[iv] This reflects a statistically significant increase over the 2008-2009 estimate of 8.5%.[v] Only about 33% of children experiencing a major depressive episode in the past year receive treatment.[vi] Approximately 4.5% of children ages 12-17 experienced a substance use disorder in the past year.[vii]

In young adults ages 18-25, there was a statistically significant increase in the prevalence of any mental illness from 16.6% to 22.7% between 2008-2009 and 2016-2017.[viii] In young adults ages 18-25, there was a statistically significant increase in the prevalence of Serious Mental Illness (SMI) from 3.3% to 6.4% between 2008-2009 and 2016-2017.[ix] There was also a statistically significant increase in the prevalence of serious thoughts of suicide among young adults in Florida, from 6.1% up to 9.3% during this period.[x]

B. Findings from the National Survey on Children's Health (NSCH)

The National Survey on Children's Health (NSCH) is weighted to represent the population of noninstitutionalized children ages 0-17 living in households in Florida and provides data on their physical and emotional health.[xi] All information about children's behavioral health from the NSCH is based on parent recollection and is not independently verified.

According to the most recently published (2016-2017) NSCH estimates, approximately 10.4% of children in Florida ages 0-17 have any kind of emotional, developmental, or behavioral problem, lasting a year or longer, for which they need treatment or counseling.[xii] This estimate varies according to the number of Adverse Childhood Experiences (ACEs) a child is exposed to. Adverse Childhood Experiences are traumatic events occurring before the age of 18 including all types of abuse and neglect as well as parental mental illness, substance use, divorce, parental incarceration, and domestic violence. A landmark study in the 1990's found a significant relationship between the number of ACEs and a variety of negative outcomes including poor physical and mental health, substance use, and risky behaviors.[xiii] The prevalence of emotional, developmental, or behavioral problems requiring treatment is 5.3% among children in Florida with no ACE, 8.2% among children with one ACE, and 20.5% among children with two or more ACEs.[xiv]

According to a similar measure from the NSCH, approximately 9.0% of children ages 3-17 in Florida received treatment or counseling from a mental health professional in the past year, and an additional 3.0% needed to see a mental health professional but did not.[xv] Among children who received or needed mental health treatment, approximately 35% did not have a problem getting it, 41% had a small problem getting it, and 24% had a big problem getting it.[xvi] Among children in Florida who are currently insured and who used behavioral health care, 44% have insurance that always offers benefits or covers services that meet their behavioral health needs, 28% have insurance that usually offers benefits or coverage that meets those needs, and 28% have insurance that sometimes or never offers benefits or coverage that meets those needs.[xvii]

C. Findings from the Youth Risk Behavior Survey (YRBS)

The Youth Risk Behavior Survey (YRBS) is a statewide, confidential survey of Florida's public high school students. Since 2001, the YRBS has been administered in odd-numbered years.[xviii] In 2017, 31.5% of high school students experienced periods of persistent feelings of sadness or hopelessness within the past year. From 2007 through 2017, the percentage of students who experienced persistent feelings of sadness or hopelessness in the past year significantly increased. A 10-year trend description found a significant increase in the percentage of high school students who experienced persistent feelings of sadness or hopelessness from 2007 (28.5%) through 2017 (31.5%).[xix]

According to the YRBS, in 2017, 17.2% of high school students seriously considered attempting suicide in the past year. Between 2007 (14.5%) and 2017 (17.2%) the percentage of students who had seriously considered attempting suicide in the past year increased significantly.[xx] For additional information on behavioral health trends, including suicide, mental health, and substance abuse, please refer to the Youth Risk Behavior Survey.

IV. Involuntary Examination Process

Section 394.463(1), Florida Statutes (F.S.), establishes the criteria an individual must meet to be taken to a Baker Act receiving facility for involuntary examination. This process includes the three key steps outlined below.

1. **Determine if the Individual Appears to Meet Baker Act Criteria**
   An individual may be taken to a receiving facility for involuntary examination under the Baker Act if there is reason to believe he/she has a mental illness and **because of the mental illness:**
   - The individual has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination, or he/she is unable to determine whether examination is necessary.
   - Without care or treatment, the individual is likely to suffer from neglect or refuse to care for self, such neglect or refusal poses a real and present threat of substantial harm to their wellbeing, and it is not apparent that the harm may be avoided through the help of willing family members, friends, or the provision of other services.
   - There is a substantial likelihood that without treatment the individual will cause serious bodily harm to self or others in the near future, as evidenced by recent behavior.

2. **If the Individual Appears to Meet Criteria, Initiate an Involuntary Examination**

Upon a determination that an individual appears to meet Baker Act criteria, the involuntary examination process may be initiated by the court, law enforcement, or a qualified mental health professional. A circuit or county court may enter an ex parte order specifying the findings on which that conclusion is based.

Law enforcement must take an individual who appears to meet Baker Act criteria into custody and deliver, or have them delivered to an appropriate, or the nearest, facility in accordance with the approved county transportation plan.

A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating they have examined an individual within the preceding 48 hours and find that the individual appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based.

3. **Conduct a Clinical Examination**

The Baker Act defines “involuntary examination” as an examination performed under sections 394.463, 397.6772, 397.679, 397.6798, or 397.6811, F.S. to determine whether an individual qualifies for involuntary services. “Involuntary services” means court-ordered

outpatient services or inpatient placement for mental health treatment pursuant to sections 394.4655 or 394.467, F.S.

Once an involuntary examination has been initiated, the individual must be examined by one of the following mental health professionals to determine if the criteria for involuntary services are met and the appropriate course of action:

- Physician,
- Clinical psychologist, or
- Psychiatric nurse (within the framework of an established protocol with a psychiatrist)[xxi]

The statutorily established examination period is for up to 72 hours. However, for minors, once a Baker Act determination is made, the clinical examination to determine if the criteria for involuntary services are met must be initiated within the first 12 hours of their arrival at the facility. This means the mental health professional must have begun the clinical examination no later than 12 hours after the minor is received. If the examination period ends on a weekend or a holiday, no later than the next working day thereafter, one of the following four actions must be taken:

- The individual must be released, unless charged with a crime, in which case they are returned to the custody of law enforcement;
- The individual must be released, unless charged with a crime, for voluntary outpatient services, subject to the status of pending charges;
- The individual must be released, unless charged with a crime, and asked to give express and informed consent to voluntary admission; or
- A petition for involuntary services must be filed with the clerk of the circuit or county criminal court, as applicable, if inpatient admission is deemed necessary.[xxii]

Involuntary examinations are administered in public and private Baker Act receiving facilities that are designated by the Department and licensed by the Agency for Health Care Administration (AHCA). Receiving facilities may be hospitals, Crisis Stabilization Units (CSUs), or Children's Crisis Stabilization Units (CCSUs) and only those designated by the Department may hold individuals involuntarily. The purpose of receiving facilities is to stabilize and redirect individuals to the most appropriate and least restrictive setting available, consistent with their needs. Receiving facilities initially screen and assess individuals, and if necessary, they may admit individuals for stabilization or observation. All CSUs/CCSUs are public receiving facilities that receive funds from the Department and must provide services, regardless of an individual's ability to pay.

Some receiving facilities are private and do not receive funds from the Department. Whether public or private, all designated receiving facilities are subject to the statutory provisions of the Baker Act and must submit certain information to the Department. To

facilitate receipt of this information the Department developed mandatory forms that are submitted by receiving facilities directly to the Reporting Center and are compiled into a database and analyzed.

V. Data on the Initiation of Involuntary Examination of Minors

The Department examined data from the Reporting Center, the Florida Safe Families Network (FSFN), and the Substance Abuse and Mental Health Information System (SAMHIS). Data from these sources can provide useful information in terms of numbers of and reasons for initiations, child welfare involvement, and service usage; however, it cannot determine the root causes for the repeated use of the involuntary examination. Therefore, the Department determined that reviews of clinical records is needed to understand more about what circumstances exist in children's lives that may lead to the need for repeated involuntary examinations. For the purposes of this report, the Department focused on children with more than ten involuntary examinations in the course of FY 2017-18.

A. Baker Act Reporting Center

The Department contracts with the Reporting Center to obtain Baker Act forms from receiving facilities, analyze the data and prepare the Annual Baker Act Report. The Baker Act requires the Department to receive and maintain copies of:

1. Documents to initiate involuntary examinations that are submitted by receiving facilities:
    - Law enforcement officers' reports
    - Professional certificates
    - Ex parte orders for involuntary examination
2. Documents related to involuntary outpatient services and involuntary inpatient placement submitted by the Clerk of the Court:
    - Involuntary outpatient services petitions and orders
    - Involuntary inpatient placement petitions and orders

Certain limitations to the data should be noted. As described above, the data analyzed by the Reporting Center for the Annual Baker Act Report are from involuntary examination initiation forms submitted by Baker Act receiving facilities. These forms are handwritten or typed and typically mailed to the Reporting Center, read and manually entered into their data system. At times, elements of the forms are missing or illegible, such as social security numbers. Social security numbers are necessary to count individuals and the number of forms missing social security numbers impacts the count of minors with repeated involuntary examinations. As a result, the reported number of involuntary examinations initiated is potentially an undercount.

Some involuntary examinations do not result in an admission to a Baker Act receiving facility because the clinical examination performed prior to admission determined they

did not meet the criteria. The data do not include information on what occurred after the initial examination. For example, the data do not reveal how long individuals stayed at the facility, whether they remained on an involuntary or voluntary basis, or whether the involuntary examination was converted to a Marchman Act assessment.

According to The Baker Act Fiscal Year 2017/2018 Annual Report, the most recent data available, there were 205,781 total involuntary examinations during this period (this includes all ages). Minors under the age of 18 accounted for 17.5% of those examinations (see Table 3 in Appendix B). Involuntary examinations of minors have more than doubled from FY 2002-03 through FY 2017-18 (105.78% change). By contrast, the population of children increased 8.66% from calendar year 2002 to 2017. Involuntary examinations of minors have increased more rapidly than the population as shown in Table 1.

Table 1: Increase in Involuntary Examinations of Minors in Population Context

	Age Groups of Minors			All Minors (< 18)
	10 and Under	11-13	14-17	
Involuntary (Baker Act) Examination Increases				
FY 17/18	4,099	9,956	22,094	36,149
FY 02/03	2,106	4,262	11,199	17,567
# Increase	1,993	5,694	10,895	18,582
% Increase	94.63%	133.60%	97.29%	105.78%
Population Changes*				
2017	1,370,867	690,907	946,422	3,008,196
2002	1,250,375	652,237	865,735	2,768,347
# Increase	120,492	38,670	80,687	239,849
% Increase	9.64%	5.93%	9.32%	8.66%

*Population statistics are not available by fiscal year, so calendar year counts were used to compute population change.

To analyze patterns of repeated involuntary examination, the Department requested the information presented in Table 2 from the Reporting Center. This table demonstrates the number of repeated involuntary examinations for one year and five year, respectively.

Table 2: Repeated Involuntary Examination Initiations for Minors for 1 Year and 5 Years

One Year – FY17/18					Five Years – FY13/14 through FY17/18				
# of Involuntary Examinations	Minors		Involuntary Examination		# of Involuntary Examinations	Minors		Involuntary Examination	
	#	%	#	%		#	%	#	%
1	9,297	77.39%	9,297	53.93%	1	34,290	70.46%	34,290	40.54%
2	1,646	13.70%	3,292	19.10%	2	7,494	15.40%	14,988	17.72%
3	516	4.30%	1,548	8.98%	3	2,852	5.86%	8,556	10.12%
4	232	1.93%	928	5.38%	4	1,367	2.81%	5,468	6.47%
5	131	1.09%	655	3.80%	5	865	1.78%	4,325	5.11%
6	70	0.58%	420	2.44%	6	520	1.07%	3,120	3.69%
7	35	0.29%	245	1.42%	7	342	0.70%	2,394	2.83%
8	35	0.29%	280	1.62%	8	206	0.42%	1,648	1.95%
9	*	>1%	108	0.63%	9	165	0.34%	1,485	1.76%
10	*	>1%	180	1.04%	10	106	0.22%	1,060	1.25%
11-19	*	>1%			11-15	273	0.56%	3,363	3.98%
					16-20	112	0.23%	1,982	2.34%
					21-25	41	0.08%	920	1.09%
					26-43	36	0.07%	974	1.15%
Totals	12,013	100.00%	17,238	100.00%		48,669	100.00%	84,573	100.00%

*Redaction: Cell sizes smaller than 25 were redacted from this report to prevent identification of people.

The Department then focused further analysis on minors with more than 10 initiations for involuntary examination in FY 2017-18. This included 21 minors for whom a total of 285 involuntary examinations were initiated in that one-year period. There was almost an equal number of boys (n = 11, 52.38%) and girls (n = 10, 47.62%). More than half were white (n = 12, 57.14%), one third (n = 7, 33.33%) were black. Race was other or unknown for almost 10% (n = 2) of the minors.

Figure A: Race

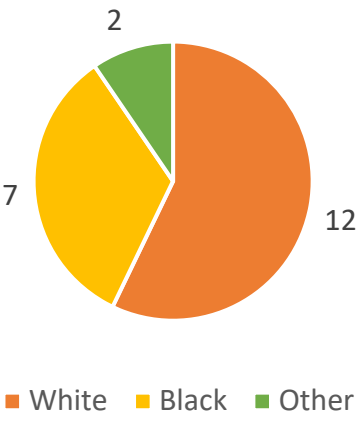


Figure B shows that law enforcment initiated the majority of involuntary examinations of these minors.

Figure B: Initiator Type for Involuntary Examination of Minors with > 10 Involuntary Examinations in FY 17/18

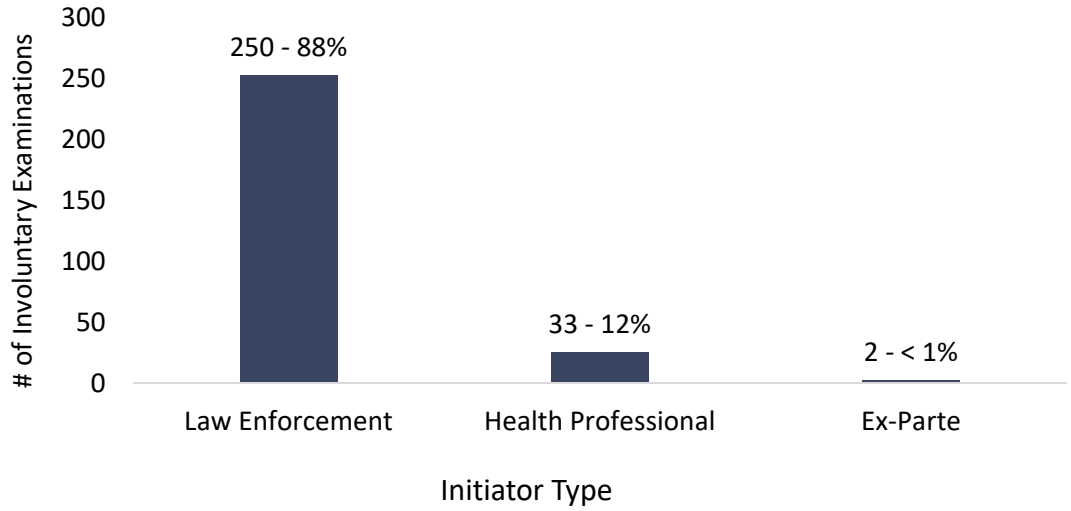
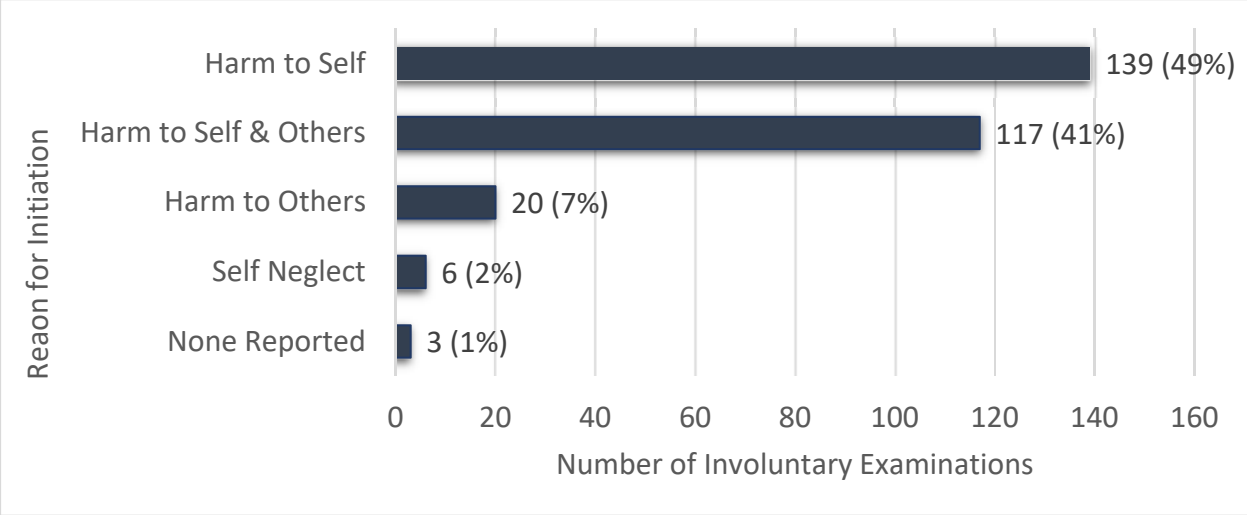


Figure C demonstrates that almost half (n = 139, 48.77%) of the 285 involuntary examinations for minors with over 10 involuntary examinations were based on “harm to self only.” Less than half (n = 117, 41.05%) were based on “harm to self and others” while 7% were based on “harm

to others" only. Harm type was not reported for 3 (1.05%) involuntary examinations. There is no harm type for 6 involuntary examinations based on evidence of "self-neglect only."

Figure C: Harm Type for Involuntary Examination of Minors with > 10 Involuntary Examinations in FY 17/18



B. Clinical Record Review Data

To conduct clinical record reviews, the Department's Office of Substance Abuse and Mental Health (SAMH) headquarters office worked with the SAMH Regional offices who have established relationships with designated Baker Act receiving facilities. The SAMH Regional staff contacted the receiving facilities that assessed the minors with more than ten initiations to review applicable records using a clinical record review tool developed for this analysis (available in Appendix A). Receiving facilities were provided with an explanation for the purpose of the clinical record reviews and a copy of the tool. When the record review was complete, SAMH headquarters staff analyzed and aggregated the clinical review tools to identify trends and patterns. Certain limitations to the clinical record review data should be noted.

- The data gathered by SAMH Regional offices was obtained by reviewing clinical records at Baker Act receiving facilities. Navigating each clinical record posed challenges to reviewers as each facility organizes the clinical record in a different way. Some facilities use electronic records while others use paper records.
- The information collected during the clinical record review are protected health information pursuant to the Health Insurance Portability and Accountability Act, 45 CFR Part 160, 162, and 164. Information that could identify a minor cannot be included in this report. To ensure confidentiality, some facilities limited reviewers' access to certain clinical information.
- This is a new legislative requirement and facilities are not required to document the information related to some elements listed in the clinical tool.

- There were time constraints caused by Hurricane Dorian office closures.
- Using a new and untested tool by various staff members across the state can negatively affect inter-rater reliability.

Of the 285 involuntary examinations, 189 (66%) were included in the clinical record review. This does not mean that the remaining 96 involuntary examinations did not occur, but that records of those examinations could not be obtained for this review. The clinical record reviews revealed the following in repeated involuntary examinations:

- 78% were initiated in a community setting. A community setting means the minor was at home or with a behavioral health provider at the time of initiation.
- 22% were initiated in a school setting.
- 91% resulted in an admission to the receiving facility.
- 86% were diagnosed with a behavioral disorder of childhood (e.g., Attention Deficit Disorder or Oppositional Defiant Disorder).
- 81% were diagnosed with a mood disorder.
- 43% were diagnosed with an anxiety disorder.
- 14% were diagnosed with a schizophrenia spectrum disorder.
- 1% were diagnosed with an adult personality disorder.
- 29% used substances, but less than one percent were diagnosed with a substance use disorder.
- 24% were diagnosed with developmental disorder (including Autism) and had a co-occurring behavioral health disorder.
- 52% were diagnosed with a medical issue.
- 81% of the minors had Medicaid health insurance
- 38% were involved in the child welfare system or an out-of-home placement setting.
- 76% were exposed to some type of abuse or neglect during their lifetime.
- 52% experienced bullying.

It was also noted that several of the involuntary examinations reported in the Reporting Center data were found to be duplicates resulting from a minor being received at one facility and transferred to another facility. Each facility then filed the required forms with the Reporting Center resulting in a duplication. The implication is that there are fewer actual involuntary examinations than those submitted to the Reporting Center.

VI. Root Causes for Patterns, Trends, or Repeated Involuntary Examinations

The root causes of these trends and repeated involuntary examinations are complex and no "one size fits all" solution is available. As outlined in the previous section, there are certainly patterns in terms of history of abuse, history of trauma, co-occurring substance use and

developmental disabilities, as well as experiences of bullying. Further analysis is necessary to determine how services are provided between the admissions to better ascertain needs and barriers in the community service array. That said, the medical record reviews yielded practice concerns on the part of receiving facilities that can and should be addressed to better serve these children and families.

Reviewers found that many Baker Act receiving facilities treated each admission as a single episode rather than a continuation of care. In many of the clinical records, there was little connecting one admission to another, even those only a few weeks or a month apart, aside from using previous records to fill in historical data in the assessments. There was little evidence of the treatment team attempting to identify a long-term solution to increasingly serious clinical presentation. There seemed to be a standard approach: evaluate, stabilize, and discharge with an appointment.

The reviewers found that most of the time discharge planning was completed and that appointments to traditional behavioral health services were made prior to discharge. However, when there is a pattern of repeated admissions in a short period of time, there should be an approach to investigate the situation more closely and think about alternative approaches that might prevent the need for further admissions.

It was not evident that Medicaid health plans provided care coordination even though most of the minors had Medicaid. This may be because documentation of utilization management is not typically part of a clinical record. Regardless, Medicaid health plans are poised to be able to identify minors who are frequently admitted and assist providers with information about services and non-traditional supports that are covered by Medicaid and available upon discharge. Health plans can assist with care coordination by offering alternatives to inpatient services, making appointment reminder calls, and assisting with rescheduling appointments that are missed. Health plans can also ensure that the minor has access to primary health care and dental care.

While family members were contacted to obtain collateral information, little support was offered to families during a crisis. In some cases, family therapy was suggested, but not pursued. At times, it appeared that family members were coordinating referrals to other placements such as residential treatment or special need schools independently, rather than a discharge coordinator or case manager.

There was also very limited evidence that outpatient therapists and school mental health personnel were contacted for their perspective on what might be occurring with the minor, although the minor was attending therapy on a regular basis or a school was repeatedly calling law enforcement regarding a particular child. Coordination between professionals working with a minor should be the expectation. Better information about suicide prevention resources, social supports, and self-help groups, such as NAMI should be included with discharge instructions.

Reviewers did find documentation of referrals to CAT teams and residential services for longer term treatment. It is important to note that the majority of these admissions occurred prior to the CAT expansion from 28-41 teams. It is also worth stating that even now there is a waiting list for many CAT teams and interim services need to be arranged while they are waiting to enter the program.

In terms of eliminating "inappropriate initiations", it is important to understand that s. 394.463, F.S. allows law enforcement officers, who are not mental health professionals, to initiate an involuntary examination based on the reason to believe the person has a mental illness and is a danger to themselves or others. Data presented in this report demonstrates that law enforcement officers initiate most involuntary examinations.

The majority of the involuntary initiations reviewed met the criteria, in context of how the law is written. The purpose of the law is to ensure rapid access to a clinician for a more thorough examination and determination of need (for admission). Of the involuntary examinations included in the clinical record review, nine percent did not result in an admission to a Baker Act receiving facility. In these instances, the minor was examined and then released. When an admission was required, the length of stay was generally short.

Documentation in clinical records did not support the idea of inappropriate involuntary initiations, generally. It should be noted, that there is no equivalent law for individuals with intellectual and developmental disability (including Autism), traumatic brain injuries, and other conditions that may contribute to aggressive behavior or mimic psychiatric symptoms to receive crisis-based services. Law enforcement officers that are called to the scene may not know that the person does not have a mental illness or there may be no alternative available to the officer to address the situation.

Minors with intellectual and development disabilities, without a co-occurring behavioral health disorder are unlikely to benefit from crisis stabilization services as provided in receiving facilities. Treatment methodologies for these disabilities are not the same as behavioral health disorders and may require different types of therapies and medications. The Agency for Persons with Disabilities (APD) is tasked with providing services to Floridians with developmental and intellectual disorders. The process to become eligible for services through the APD can take many months. In the meantime, many families have limited options to cope with adverse behaviors. Behavioral health providers and school personnel need training to ensure that minors with intellectual and developmental disabilities are rapidly referred to APD and to support parents in applying behavior plans.

Listed below are the contributing factors identified through the data and clinical record reviews of these high utilizers of acute care:

- Lack of support for parents during the admission, including information on community support resources and crisis planning for future episodes.

- Inadequate solutions for individuals whose primary behavior challenges are not mental illness, but who are experiencing an emergency.
- Challenges with community mental health services and coordination of care. Although aftercare appointments are provided, there are no warm hand-offs and minimal coordination with providers already treating the child.
- Repeat admissions appear to be treated with the same intensity and discharge planning as one-time admission. Individualized care was not evident in the clinical records.

VII. Recommendations

1. Increase care coordination for minors with multiple involuntary examinations.
    a. Collaborate with the Reporting Center to determine if a notification process can be developed to identify minors with repeated involuntary examinations.
    b. Utilize the Wraparound care coordination approach for children with complex behavioral health needs and multi-system involvement to ensure one point of accountability and individualized care planning.
    c. Utilize existing local review teams. Florida has an interagency agreement between several child serving agencies to collaborate and coordinate services through a staffing process that occurs at the local and state level. Local Review Teams consist of representatives from the Department, the Department of Juvenile Justice (DJJ), the Agency for Persons with Disabilities (APD), the Department of Education (DOE), the Multiagency Network for Students with Emotional/Behavioral Difficulties, community providers, Managing Entities, Community Based Care Organizations, and the Guardian ad Litem. The teams staff cases that are complex and often multi-system involved and attempt to develop a plan for resources focused on keeping the child/adolescent in the community. The State Review Team meets monthly to review data from the previous month, discuss system issues, and develop recommendations to state agencies and the Children and Youth Cabinet.

2. Begin Rule Development to Amend the Administrative Rule 65E-5 to:
    - Revise the Cover Sheet (CF-MH 3118) and related forms incorporated in rule to require facilities to provide information about actions taken after the initiation of an involuntary examination, including whether an individual was transferred, released, or admitted for treatment. The additional 1 day to 5 change for submission to BA forms should assist facilities with timely form submission.
    - Require electronic submission of Baker Act forms to the Reporting Center. The Reporting Center already supports the receipt of electronic submission using a secure upload. This method of transmission reduces staff time and resources spent while allowing or a more efficient delivery method.

- Propose language to address the duplication issue resulting from transfers. The change needs to identify which facility should submit the forms in the event of a transfer.
- Improve care coordination and discharge planning by requiring providers to develop specific policies and procedures to address individuals who utilize crisis services frequently.

3. Support Baker Act technical assistance by funding a position in the Office of Substance Abuse and Mental Health within the Department. Implementation of the Baker Act occurs within the framework of a complex, coordinated system of care, which includes the full array of behavioral health and related services. The Department currently has one FTE to oversee Baker Act and Marchman Act policy at the headquarters office. This position is primarily responsible for conducting the analysis for and writing legislative reports such as this, drafting any changes to the administrative rules that govern Baker Act services, and updating important tools to help the public understand and effectively implement this complex policy such as the Baker User Reference Guide, Frequently Asked Questions, and related training courses.

   These important tools that improve the of understanding of laws, rules, policies and procedures relating to the Baker Act have not been updated in many years. Technical assistance is critical to be more responsive to the needs of those implementing the provisions of the Baker Act. However, due to limited staff resources it is difficult to meet the research demands required to complete analyses and legislative reports. These efforts are not keeping pace with ongoing need for technical assistance.

4. Ensure that parents and guardians receive information about the local MRT upon discharge. MRTs can respond in person and provide short term crisis intervention to reduce the need for repeated involuntary examinations. In addition, information about suicide prevention resources, social supports, and self-help groups, such as NAMI should be included with discharge instructions.

Appendix A

Clinical Records Review

Minor's Name: _____ SSN: _____

Facility Name: _____ Date of Review: _____

Desk Review ☐ Onsite Visit ☐ Facility Address: _____

SAMH Staff Name/Region: _____

Total # of Admissions: _____ Involuntary Examination Type: Threat to Self ☐ Threat to Others ☐ Both ☐

Was the minor referred by a school? Yes ☐ No ☐ If yes, Name of School: _____

Insurance Plan: _____ Unknown ☐

Authority: Section 394.463(4), F.S.:
(4) DATA ANALYSIS.—Using data collected under paragraph (2)(a), the department shall, at a minimum, analyze data on the initiation of involuntary examinations of children, identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child, study root causes for such patterns, trends, or repeated involuntary examinations, and make recommendations for encouraging alternatives to and eliminating 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.

#	Topic – Include what is noted in the Medical Record and any Reviewer Comments
1	**Minor's Record Number:**
2	**Date/Time of Minor's Admission:** **Date of Discharge:** **Indicate if not admitted** ☐
3	**Are they in custody of a biological parent, foster care, other relative, non-relative?** **Who do they live with most of the time?**
4	**When was the parent or guardian contacted?** **Were they invited to participate in the treatment? Yes** ☐ **No** ☐

5	**History of sexual, physical, verbal, emotional abuse or trauma** **Any Reports to the Florida Abuse Hotline? Any involvement with child welfare, foster care services or out of home placement (ex: SIPP, group home)?**
6	**Medical History (including any co-occurring intellectual disabilities):**
7	**Psychiatric History:**
8	**Substance Use:**
9	**Examination and mental status examination;**
10	**Working diagnosis, ruling out non-psychiatric causes of presenting symptoms of abnormal thought, mood or behavi**
11	**Course of psychiatric interventions including medication history, trials and results;**
12	**Course of other non-psychiatric medical problems and interventions;**

13	**Identification of prominent risk factors including suicidal ideation, threatening/ harming others, physical health, psychiatric and co-occurring substance abuse;**
14	**Other system involvement(i.e. School, DJJ, APD…):** **Has the minor been diverted from arrest?** **Legal history?**
15	**Describe information documented in the progress notes that may contribute to repeated admissions? Evidence of family dysfunction, problem in school, bullying/cyber-bullying, disciplinary, poor grades, arrests or legal issues, unstable housing, lack of access to food, clothing, medical care etc.**
16	**Discharge or transfer diagnosis details:**
17	**Does it appear coordination of care occurred with the release of information to schools, family, other providers, etc.?**
18	**Cover Sheet(form 3118) completed? Yes ☐ No ☐**
19	**Does the involuntary examination include:** (a) A determination of whether the minor is medically stable: Yes ☐ No ☐ (b) A determination that abnormalities of thought, mood, or behavior due to non-psychiatric causes have been ruled out: Yes ☐ No ☐ (c) A thorough review of any observations of the minor's recent behavior Yes ☐ No ☐ (d) A review of forms CF-MH 3100 (Transportation to Receiving Facility) and CF-MH 3001 (Ex Parte Order) or MH 3052a (Report of Law Enforcement Officer) or form CF-MH 3052b (Certificate of Professional): Yes ☐ No ☐ (e) A brief psychiatric history: Yes ☐ No ☐ (f) A face-to-face examination of the minor occurs within 12 hours to determine if the patient meets criteria for release Yes ☐ No ☐

20	**Nursing Assessment Findings**
21	**Review the treatment plan and identify the individual's strengths and challenges. Are there issues with:** **Living arrangements** **Social supports** **Financial supports** **Health** **Mental health** **What are the goals, preferences, and natural social supports such as family, friends, and peer support group meetings and social activities?** **Are they utilized?**
22	**Did it appear that the minor had an opportunity to assist in preparing and reviewing the treatment plan prior to its implementation? Yes ☐ No ☐** **Was it signed by the minor and included space for minor's comment? Yes ☐ No ☐**
23	**The minor received the opportunity to participate in discharge planning? Yes ☐ No ☐** **Was discharge planning coordinated with the guardian/parent? Yes ☐ No ☐** **Was discharge planning coordinated with any treatment providers serving the child at the time of admission?** **Yes ☐ No ☐**
24	**Are transportation resources addressed? Yes ☐ No ☐**
25	**Is access to stable living arrangements addressed? Yes ☐ No ☐**
26	**Did the minor receive assistance (as needed) with securing needed living arrangements or shelter to individuals who are at risk of re-admission within the next 3 weeks due to homelessness or transient status and prior to discharge?**

27	**Did the minor receive assistance with obtaining aftercare appointments for needed services, including medically appropriate continuation of prescribed psychotropic medications, requested to occur within 7 days of discharge? What were the aftercare service providers, date and time of appointment and any other the aftercare planning efforts? Are high risk minors referred to a CAT team or First Episode Psychosis team (where available)?**
28	**Medications or prescriptions for medications, psychotropics or others, were provided to a discharged minor to cover the intervening days until the first scheduled medication aftercare appointment, or for a period of up to 21 calendar days, whichever occurs first**. Yes ☐ No ☐
29	**Did the minor receive education and written information about their illness and medication? Yes ☐ No ☐**
30	**Did the minor receive contact and program information about and referral to any community-based peer support services in the community? In subsequent readmissions is there any indication that the discharge plans from previous admission were followed? If not, what reason or barriers are identified?**
31	**Did the minor receive contact and program information about and referral to any needed community resources? In subsequent readmissions is there any indication that the discharge plans from previous admission were followed? If not, what reason or barriers are identified?**
32	**Was the minor referred to any substance abuse treatment programs, trauma or abuse recovery focused programs, or other self-help groups, if indicated by assessments? If so any indication of follow up?**
33	**Personal safety plan details:**
34	**Were there any Psychiatric Emergency Treatment Orders? Yes ☐ No ☐ If yes, what was the situation?**

35	**Was Seclusion or Restraint utilized? Yes ☐ No ☐ If yes, what was the situation?**
36	**Did the receiving facility follow-up with the referrals provided at discharge to determine if the minor was effectively linked? Yes ☐ No ☐**
37	**Identify the top findings or concerns from the review that may have contributed to repeated involuntary examinations:**

Appendix B

Involuntary Examinations – FY17/18 Overview

There were **205,781** involuntary examinations in FY 17/18. Three-quarters of involuntary examinations were for adults aged 18 through 64 (n = 151,345, 73.55%), with 17.53% (n = 36,078) for those less than 18, and 7.41% (n = 15,253) for people 65 and older. Young adults (age 18-24) accounted for 12.79% of involuntary examinations statewide. There were 3,105 (1.51%) forms where age was unknown because a valid date of birth was not included on the Cover Sheet.

Table 1: Involuntary Examinations: FY 01/02 to 17/18 – All Ages, Minors, and Young Adults[1]

Fiscal Year	All Ages			Minors (< 18)			Young Adults 18-24		
	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000
2017-2018	205,781	N/A	1,005	36,078	N/A	1,186	26,328	N/A	1,445
2016-2017	199,944	2.92%	992	32,763	10.12%	1,092	26,243	0.32%	1,446
2015-2016	194,354	5.88%	981	32,475	11.09%	1,097	25,861	1.81%	1,431
2014-2015	187,999	9.46%	964	32,650	10.50%	1,102	24,467	7.61%	1,365
2013-2014	177,006	16.26%	919	30,355	18.85%	1,030	23,087	14.04%	1,301
2012-2013	163,850	25.59%	859	26,808	34.58%	914	21,763	20.98%	1,237
2011-2012	154,655	33.06%	818	24,836	45.26%	848	20,594	27.84%	1,179
2010-2011	145,290	41.63%	773	21,752	65.86%	743	19,616	34.22%	1,128
2009-2010	141,284	45.65%	754	21,128	70.76%	702	19,072	38.05%	1,135
2008-2009	133,644	53.98%	711	20,258	78.09%	664	17,601	49.58%	1,042
2007-2008	127,983	60.79%	685	19,705	83.09%	643	16,622	58.39%	987
2006-2007	120,082	71.37%	661	19,238	87.54%	652	16,384	60.69%	975
2005-2006	118,722	73.33%	668	19,019	89.69%	651	16,244	62.08%	986
2004-2005	114,700	79.41%	660	19,065	89.24%	664	15,664	68.08%	991
2003-2004	107,705	91.06%	634	18,286	97.30%	648	14,123	86.42%	933
2002-2003	103,079	99.63%	620	16,845	114.18%	606	13,175	99.83%	908
2001-2002	95,574	115.31%	586	14,997	140.57%	547	11,959	120.15%	860

[1] The population statistics used to compute involuntary examinations rates per 100,000 are age specific. For example, the denominators used to compute the rates per 100,000 for children were for children 5 through 17, for young adults for the population 18 through 24, and for older adults for the population 65 and older. The age range 5 through 17 was used for children because including the population of children from birth through age 4 (who are not typically subject to involuntary examination) would incorrectly lower the rate per 100,000 for children.

Table 2: Involuntary Examinations by Age Groups for FY17/18

Age Groups	Involuntary Examinations FY17/18	% of Involuntary Examinations	
		Total	Within Each Age Grouping
Children (<18)	**36,078**	**17.53%**	
10 and younger	4,090	2.02%	11.34%
11-13	9,942	4.91%	27.56%
14-17	22,046	10.88%	61.11%
Adults	**151,345**	**73.55%**	
18-24	26,328	12.99%	17.40%
25-34	39,740	19.61%	26.26%
35-44	31,540	15.56%	20.84%
45-54	29,871	14.74%	19.74%
55-64	23,866	11.78%	15.77%
Older Adults	**15,253**	**7.41%**	
65-74	9,542	4.71%	62.56%
75-84	4,154	2.05%	27.23%
85+	1,557	<1.00%	10.21%

Initiation type, evidence type, and harm type for involuntary examinations in FY17/18 are summarized in Figure A. 51.67% of the involuntary examinations in FY17/18 were initiated by law enforcement, with almost half initiated by professional certificate (46.31%). The remaining 2.02% were initiated via ex parte order.

Figure A: Initiation Type for FY17/18

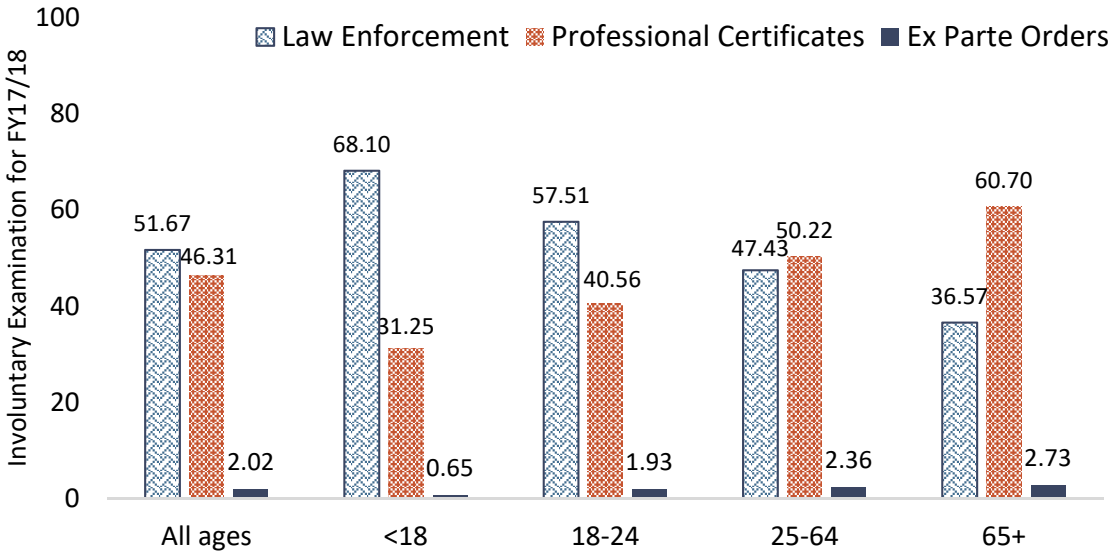
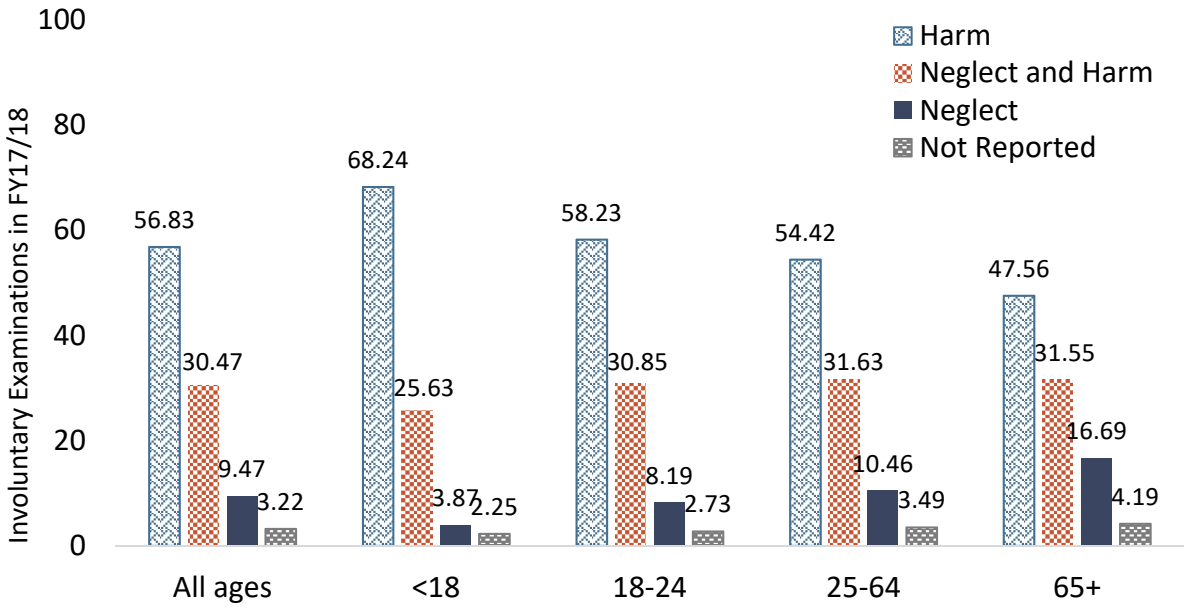


Table 3: Involuntary Examination Initiations by Professional Certificate Type

Professional Certificate Type	All Ages	Minors (<18)
Percentages Computed on Total # of Involuntary Examinations by Professional Certificate Type		
Physician (not a Psychiatrist)	68.04%	52.96%
Physician (Psychiatrist)	9.28%	9.07%
Licensed Mental Health Counselor	9.29%	19.36%
Licensed Clinical Social Worker	5.33%	12.33%
Psychiatric Nurse	2.02%	1.30%
Clinical Psychologist	1.27%	1.03%
Physician Assistant	0.92%	0.59%
Licensed Marriage and Family Therapist	0.24%	0.77%
Multiple Professional Types Reported	0.68%	0.54%
Not Reported	2.93%	2.03%

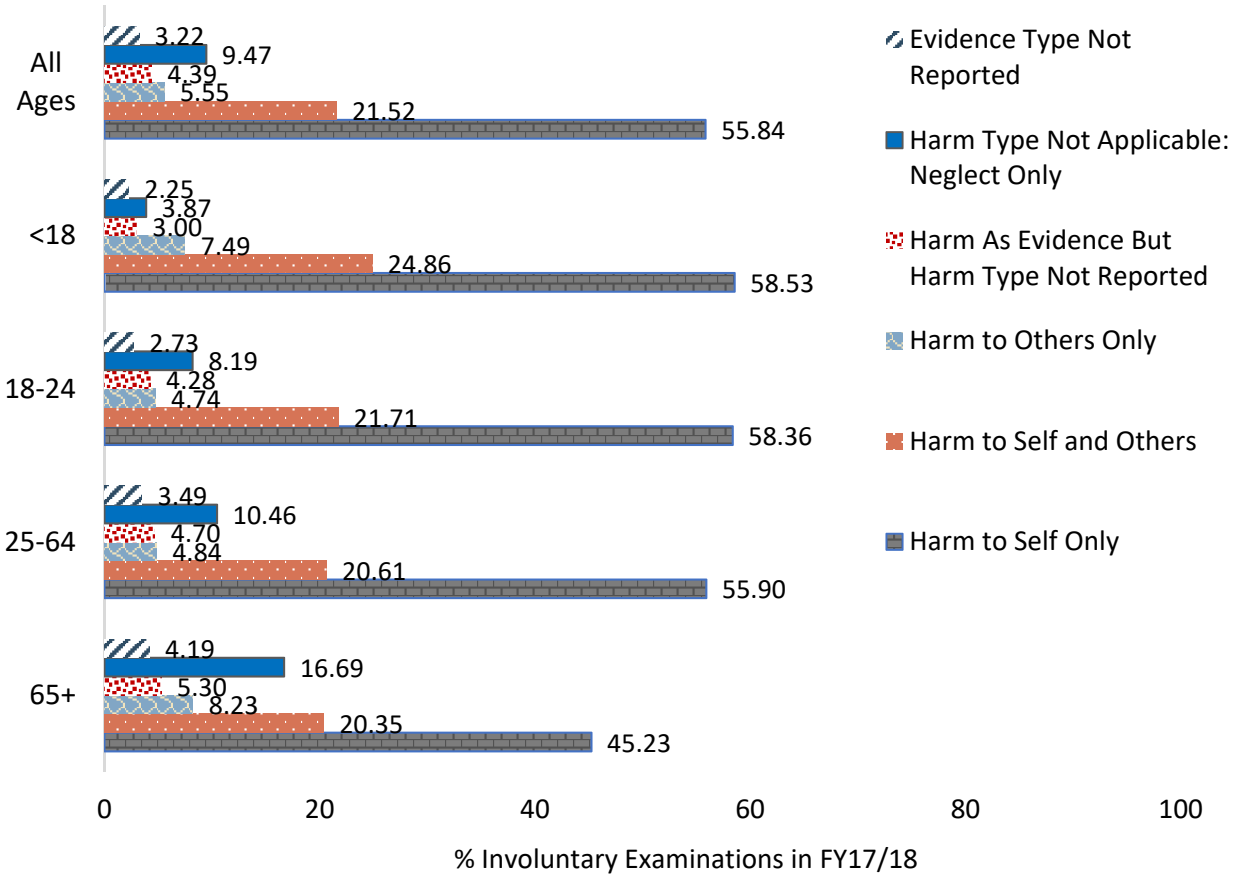
Over half (56.83%) of involuntary examinations were based on evidence of *harm only*. Almost one-third (30.47%) were based on *harm and self-neglect*. Less than ten percent (9.47%) of involuntary examinations were based on evidence of *self-neglect only*. Evidence type was not reported on forms for 3.22% of involuntary examinations.

Figure B: Evidence Type for FY17/18



Harm can be further broken down into harm to self and/or harm to others. More than half (55.84%) of all involuntary examinations were based on evidence of *harm to self only.* One in five (21.52%) of all involuntary examinations were based on *both harm to self and harm to others. Harm to others only* was the evidence upon which 5.55% of all involuntary examinations were initiated. The most striking aspect of Figure C is how similar the proportions are across age groups of harm and evidence type combinations. Neglect only (no harm type) was more common as age increases.

Figure C: Harm Type for FY17/18



References

[i] Section 394.457(1), F.S.

[ii] Florida Department of Children and Families. (2017). *Task Force Report on Involuntary Examination of Minors*. Retrieved from https://www.myflfamilies.com/service-programs/samh/publications/docs/S17-005766-TASK%20FORCE%20ON%20INVOLUNTARY%20EXAMINATION%20OF%20MINORS.pdf

[iii] Baker Act Reporting Center, Louis de la Parte Florida Mental Health Institute. *The Baker Act Reporting Center FY 17/18 Annual Report*. Retrieved from https://www.myflfamilies.com/service-programs/samh/publications/docs/BA%20FY%2017-18%20Report.DCFFeedbackMay6_USFRevisionsJune4_V9a.pdf

[iv] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2016 and 2017). *Table 30 – Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in Florida, by Age Group: Percentages, Annual Averages Based on 2016-2017 NSDUHs*. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeSpecificStates2017B/NSDUHsaeFlorida2017.pdf.

[v] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2018). *National Survey on Drug Use and Health: Comparison of 2008-2009 and 2016-2017 Population Percentages (50 States and the District of Columbia)*. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTrendTabs2017/NSDUHsaeLongTermCHG2017.pdf.

[vi] Substance Abuse and Mental Health Services Administration. (2015). *Behavioral Health Barometer: Florida, 2015*. Retrieved from www.samhsa.gov/data/sites/default/files/2015_Florida_BHBarometer.pdf.

[vii] *Health Measures in Florida, by Age Group: Percentages, Annual Averages Based on 2016-2017 NSDUHs*. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeSpecificStates2017B/NSDUHsaeFlorida2017.pdf.

[viii] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2018). *National Survey on Drug Use and Health: Comparison of 2008-2009 and 2016-2017 Population Percentages (50 States and the District of Columbia)*. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTrendTabs2017/NSDUHsaeLongTermCHG2017.pdf

[ix] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2018). *National Survey on Drug Use and Health: Comparison of 2008-2009 and 2016-2017 Population Percentages (50 States and the District of Columbia)*. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTrendTabs2017/NSDUHsaeLongTermCHG2017.pdf.

[x] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2018). *National Survey on Drug Use and Health: Comparison of 2008-2009 and 2016-2017 Population Percentages (50 States and the District of Columbia)*. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTrendTabs2017/NSDUHsaeLongTermCHG2017.pdf.

[xi] Data Resource Center for Child & Adolescent Health. *The 2016-2017 National Survey on Children's Health (NSCH) Combined Data Set – Fast Facts*. Retrieved from www.childhealthdata.org/learn-about-the-nsch/FAQ.

[xii] Child and Adolescent Health Measurement Initiative. *2016-2017 National Survey of Children's Health (NSCH) Interactive Data Query - Florida* (Question/Variable Name: Children Qualifying on the CSHCN Screener Ongoing Emotional, Developmental, or Behavioral Conditions Criteria). Topic: Child and Family Health Measures – Physical, Oral Health and Functional Status – Indicator 1.11: Children with Special Health Care Needs. Retrieved from www.ChildHealthData.org.

[xiii] Child Welfare Information Gateway. *Adverse Childhood Experiences (ACES)*. Retrieved from https://www.childwelfare.gov/topics/preventing/preventionmonth/resources/ace/

[xiv] Child and Adolescent Health Measurement Initiative. *2016-2017 National Survey of Children's Health (NSCH) Interactive Data Query - Florida* (Question/Variable Name: Children Qualifying on the CSHCN Screener Ongoing Emotional, Developmental, or Behavioral Conditions Criteria). Topic: Child and Family Health Measures – Physical, Oral Health and Functional Status – Indicator 1.11: Children with Special Health Care Needs – Sub Group: Adverse Childhood Experiences. Retrieved from www.ChildHealthData.org.

[xv] Child and Adolescent Health Measurement Initiative. *2016-2017 National Survey of Children's Health (NSCH) Interactive Data Query - Florida* (Indicator 4.4). Retrieved from www.ChildHealthData.org.

[xvi] Child and Adolescent Health Measurement Initiative. *2016-2017 National Survey of Children's Health (NSCH) Interactive Data Query - Florida* (Indicator 4.4a). Retrieved from www.ChildHealthData.org.
[xvii] Child and Adolescent Health Measurement Initiative. *2016-2017 National Survey of Children's Health (NSCH) Interactive Data Query - Florida* (Indicator 3.5). Retrieved from www.ChildHealthData.org.
[xviii] http://www.floridahealth.gov/statistics-and-data/survey-data/youth-risk-behavior-survey/
[xix] Centers for Disease Control and Prevention. *Youth Risk Behavior Survey Data Summary & Trends Report 2007-2017*. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf
[xx] Centers for Disease Control and Prevention. *Youth Risk Behavior Survey Data Summary & Trends Report 2007-2017*. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf
[xxi] § 394.463(2)(f), F.S.
[xxii] § 394.463(2)(g), F.S.