Report on Involuntary Examination of Minors

Prepared by
the University of South Florida

2025

UNIVERSITY of
SOUTH FLORIDA
College of Behavioral &
Community Sciences

Table of Contents

I. General Report Information and Terminology[1]

The terms “child” and “children” are used throughout this report. These terms are defined in this report as people under the age of 18 at the time of their involuntary examination(s). Other terms that are sometimes used by others for part or all this population include “minors,” “juveniles,” and “youth.” The terms “minor” and “juvenile” are typically used in the legal context, with “juvenile” being more commonly used in the context of criminal justice. Youth is a broad term that usually refers to individuals in their teenage years and is used sparingly in this report, such as when a cited report used the word “youth.” The term “children” is used to strike a non-legal tone. Some people use the phrase “children and youth,” which is avoided for brevity’s sake.

Note that in statute and throughout this report, “the Institute” refers to the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida (USF). The Baker Act Reporting Center at USF is affiliated with FMHI and produces this report on FMHI's behalf. The Florida Department of Children and Families (Department) was the entity required to release this report from the inception of this reporting requirement in 2019 until 2024. A statutory change that took effect in 2024 means that “the Institute” is now required to release this report. However, because the Baker Act Reporting Center is funded by a contract with the Department, this report must be approved by the Department prior to release.

Results of analyses of Child Welfare data and Medicaid are not included in this report because data sharing agreements needed to legally provide these data to the Baker Act Reporting Center were not executed in sufficient time to include in this report.

The Department makes available online information about its Children’s Mental Health Program, a list of Children’s Mental Health Resources, and an interactive dashboard of Specialty Treatment Teams. Involuntary (Baker Act) examinations occur at Baker Act receiving facilities designated by the Department and licensed by the Florida Agency for Health Care Administration (AHCA). A list of Baker Act receiving facilities can be generated on the AHCA Florida Health Finder site (look for the box to check on the dashboard to search for receiving facilities). The Department also makes available a map of its Regions and Circuits.

Underlined text throughout this report is an indication that it is hyperlinked to a web page or to another page in the report (such as an Appendix), which you can access by clicking on the underlined text. Some of these links will bring you to journal articles, some of which are publicly available, and others for which only an abstract is publicly available.

References are included as footnotes for ease of reference and also in a reference list that contains all references to peer-reviewed articles cited in this report (see I).

Counts in this report are slightly different than those in the FY 2023-2024 Baker Act Annual Report and different from those on the Department’s Baker Act Dashboard. The reasons for these differences are that a) the Baker Act Reporting Center recently made minor refinements/improvements in the code for LinkKing for SAS that uses probabilistic logic to create a unique person identifier, and b) the Department computes individual identifiers for the Dashboard differently than the Baker Act Reporting Center. More details about the individual identifier can be found in the Baker Act Annual Reports.

[1] For more information, see http://www.usf.edu/cbcs/baker-act/. This document may be reproduced in whole or in part without restriction, provided that the Baker Act Reporting Center, USF, is credited for the work. The following people at the University of South Florida contributed to this report: Annette Christy, Ph.D., Kavitha Gopalakrishnan, M.S., Lillian Deaton, B.A., Jordyn Lord, O.H.M., Danielle Cravero, B.A., Kevin Jenkins, A.A., Anna Abella, Ph.D., and James-Angelo Suarez, MPH.

II. Background

A. Statutory Authority

Section 394, Part I, Florida Statutes (F.S.), commonly referred to as the Florida Mental Health Act or the Baker Act, was originally enacted in 1971 and named after Representative Maxine Baker, who championed mental health reform.[2] The term 'Baker Act examination' is widely used to describe involuntary mental health assessments initiated under statute. The Baker Act was revised in 2019, as specified in Senate Bill 1418 (2019), to require additional reporting in odd-numbered years detailing findings on repeated involuntary examinations of minors. This provision aimed to increase transparency and inform policy decisions regarding children's mental health interventions. This language was revised and expanded in 2024, as specified in House Bill 7021 (2024), as follows to:

- Add additional details about what must be included in the report.
- Require the following to be provided to the Institute for this report: Child Welfare data provided by the Department and Medicaid data provided by the Agency for Health Care Administration
- Change the entity that must submit the final report from the Department of Children and Families (Department) to de la Parte Florida Mental Health Institute (Institute).

Requirements for the Minors Involuntary Examination Report are found in Section 394.463(4), Florida Statutes. The data collected under Section 394.463(2)(a), F.S., is referred to as it relates to data used for this report. This section of the Baker Act refers to documents that Baker Act receiving facilities are required to submit to the Department. Select changes to the Baker Act relevant to children are shown in Appendix A and in a timeline on the Baker Act Reporting Center website.

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[2] See Maxine E. Baker Papers (Archives) at the University of Florida, George A. Smathers Libraries.

III. At a Glance

2025 Report Highlights

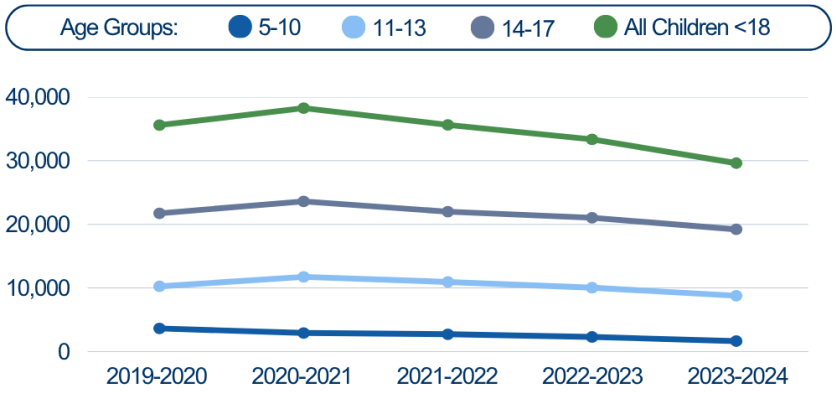
The Involuntary Examinations of Children

30,357 total involuntary examinations in Fiscal Year 2023-2024

19,913 children assessed through involuntary examination

24% of children had two or more involuntary examinations in one year

Count of Involuntary Examinations for Children for Five Fiscal Years

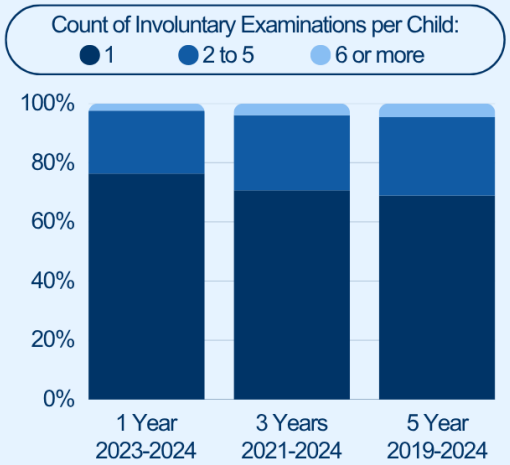


Reasons* for Repeated Involuntary Examinations

- Home or family circumstances
- Service availability gaps
- Social-behavioral health
- System coordination gap
- Professional training resources

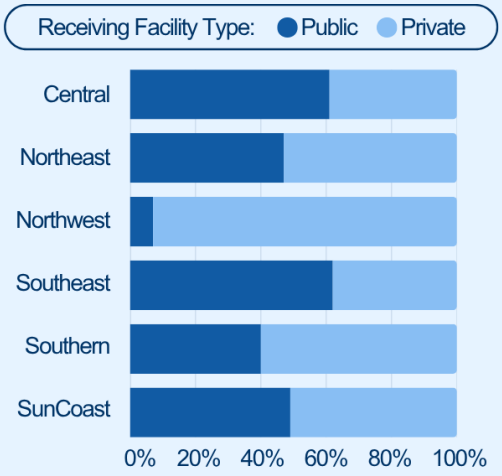
**Key reasons from qualitative interviews with receiving facility staff*

Repeated Involuntary Examinations for Children for 1, 3, and 5 Years*



**Years begin July 1 and end June 30*

Involuntary Examinations for Children at Public and Private Receiving Facilities by Department Region



IV. Involuntary (Baker Act) Examinations of Children

The following text, tables, and figures are based on data from involuntary (Baker Act) examinations during Fiscal Year (FY) 2023-2024, the most complete fiscal year for which data were available at the time of this report. In certain instances, data from previous fiscal years were also incorporated for comparative or contextual purposes. Additionally, receiving facilities are not required to submit documents for individuals who are voluntarily examined, which means that the data used for this report primarily focuses on involuntary examinations. The issue of voluntary examination is addressed in the results from our qualitative interviews (see page 32).

A. Overview of Baker Act Document Submission and Data Entry

This report was developed using data entered from forms listed in Table 1. Forms are available on the Department's website. From the mid-1990s through June 30, 2023, these forms were submitted to the Baker Act Reporting Center at the Louis de la Parte Florida Mental Health Institute, where the associated data was entered. Effective July 2023, Baker Act receiving facilities statewide enter data from these forms into the Baker Act Data Collection System (BADCS), which is created and maintained by the Department. Receiving facilities upload to the BADCS forms CF-MH 3052a, CF-MH 3052b, and CF-MH 3001. Although data elements from form CF-MH 3118 are entered directly into the BADCS, this form is not required to be completed or uploaded. Additionally, while form CF-MH 3100 (Transportation to Receiving Facility) is uploaded by receiving facilities to the BADCS, no data is extracted or entered from this form; consequently, data from this form is not available for analysis or reporting.

Table 1: Documents to Initiate an Involuntary Examination

Form[3]	Form Name
The underlined text below and elsewhere indicates a hyperlink to a web page.	
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	Baker Act Data Collection Form*
CF-MH 3100	Transportation to Receiving Facility**

*This form was called the *Cover Sheet to the Florida Department of Children and Families* until 2023.
**Uploaded to the BADCS, but no data from these forms are entered into the BADCS.

Involuntary examinations are conducted at Baker Act receiving facilities designated by the Department. These facilities include hospitals licensed under Chapter 395, F.S., and Crisis Stabilization Units (CSUs) licensed under Chapter 394, as specified in Section 394.4612, F.S. It is important to emphasize that an involuntary examination does not always result in admission. Additionally, there is no statutory requirement to enter data related to voluntary admissions into the BADCS. Consequently, the results presented in this report pertain exclusively to involuntary examinations and do not include admissions data or counts of voluntary examinations. Note that some percentages do not sum to 100 percent in this report due to rounding.

[3] See the Department's Crisis Service web page: https://www.myflfamilies.com/crisis-services. Links to forms are available at https://www.myflfamilies.com/crisis-services/baker-act/baker-act-forms. Appendix C includes a summary of the Department's initiatives and services related to minors. An Agency for Health Care Administration Dashboard provides information about Baker Act Receiving Facilities. "Hospitals" shown on the dashboard with red dots are for Baker Act receiving facilities licensed by AHCA under 395, F.S. Facilities shown on the dashboard with a blue dot are for Crisis Stabilization Units, which are licensed by the Florida Department of Children and Families under 394, F.S.

B. Statewide and Department Region Level Analyses

1. Counts of Involuntary Examinations by Fiscal Year[4]

Table 2 presents data on involuntary examinations of children under the age of 18 over a five-year period, from FY 2019-2020 through 2023-2024. During this time, there were 93,161 children with 173,842 involuntary examinations. Children aged 14 to 17 accounted for 62 percent of all involuntary examinations for children, followed by those aged 11 to 13 accounting for 30 percent, and children aged five to 10 accounting for eight percent. Over the five-year period, there was a decline in both total number of involuntary examinations across all age groups (Table 2, Part A) and the number of children undergoing involuntary examinations (Table 2, Part B).

Table 2: Counts of Involuntary Examinations and Children Subject to Involuntary Examinations by Age Group and Fiscal Year

Part A: Counts of Involuntary Examinations				
	All Children	**5-10**	**11-13**	**14-17**
Percent Decrease 2019/2020 to 2023/2024	*-15%*	*-34%*	*-14%*	*-12%*
FY 2023-2024	30,357	2,387	8,771	19,199
FY 2022-2023	33,779	2,712	10,022	21,045
FY 2021-2022	35,808	2,902	10,934	21,972
FY 2020-2021	38,311	2,969	11,740	23,602
FY 2019-2020	35,587	3,629	10,234	21,724
All Five Years (FY 2019-2020 to FY 2023-2024)	173,842	14,599	51,701	107,542
Part B: Counts of Children with Involuntary Examinations				
	All Children[5]	**5-10**	**11-13**	**14-17**
Percent Decrease 2019/2020 to 2023/2024	*-17%*	*-36%*	*-16%*	*-14%*
FY 2023-2024	19,913	1,598	5,640	12,951
FY 2022-2023	22,463	1,799	6,481	14,474
FY 2021-2022	23,782	1,935	7,069	15,142
FY 2020-2021	24,923	1,914	7,462	15,908
FY 2019-2020	24,197	2,494	6,730	14,973
All Five Years 2019/2020 to 2023/2024[6]	93,161	8,369	28,912	62,367

Figures are provided on the following pages for counts of involuntary examinations (Figure 1a) and the number of children subject to involuntary examinations (Figure 1b).

[4] A July 2024 amendment (due to House Bill 7021, see p. 29) revised section 394.463(2)(a)2, Florida Statute, changing "shall" to "may" regarding law enforcement's authority to initiate an involuntary examination. This change allows officers the discretion to determine whether to initiate an involuntary examination, rather than requiring them to do so for individuals who appear to meet the criteria. Conceptually, this change could have led to a decrease in the use of involuntary examination. However, the extent to which this one-word change in the Baker Act impacted law enforcement decision-making needs further study.

[5] Note that the sums of the counts of children in the three age groups (adding up horizontally) are slightly higher than the count of all children in this column. This is because some children were in more than one age category during the year. When this occurred, the child was counted in both age categories, but for this total column, children were only counted once. Following are the numbers of children in each fiscal year that were in two age categories during the year: FY 2019-2020 (n=272), FY 2020-2021 (n=361), FY 2021-2022 (n=364), FY 2022-2023 (n=294), and FY 2023-2024 (n=275).

[6] Note that the counts of children for all five years are less than the sum of the counts of children when the five years are summed (vertically) because some children experienced involuntary examinations in more than one year. This means children were counted in each year that had an involuntary examination, but were only counted once in this row of counts for all five years combined.

Figure 1a: Counts of **Involuntary Examinations** for Children under the age of 18: Five-Year Analysis

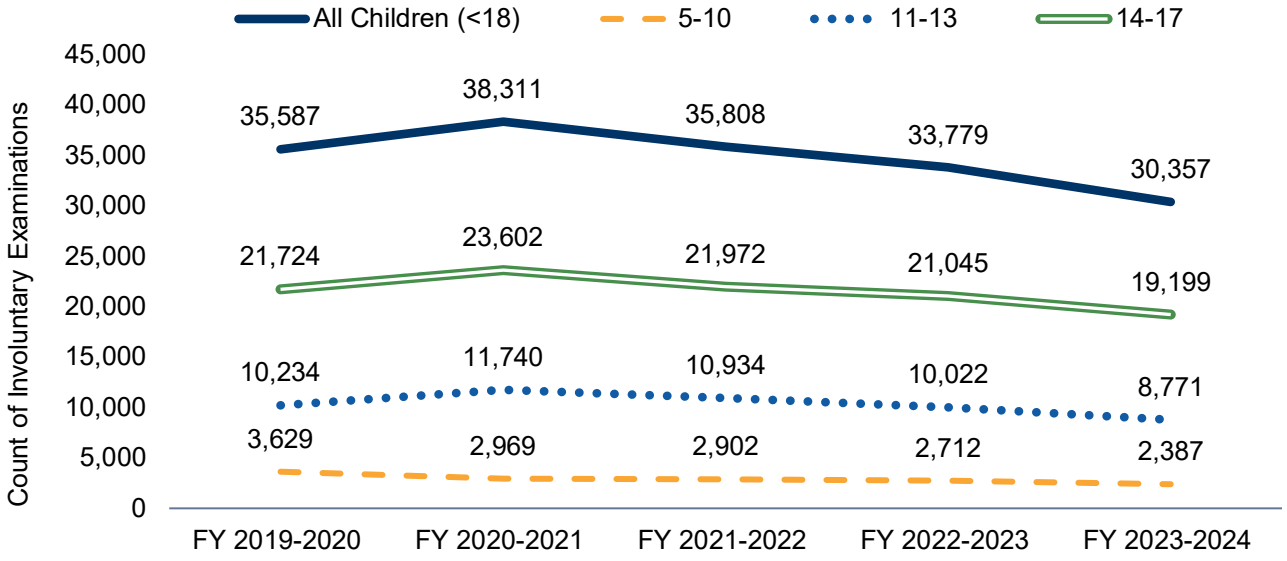
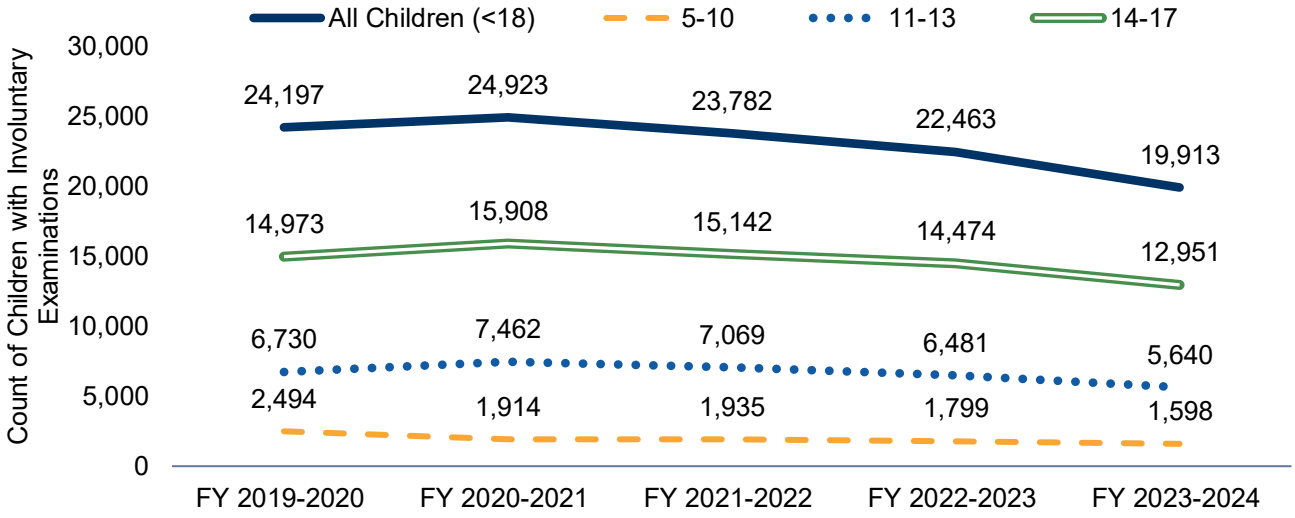


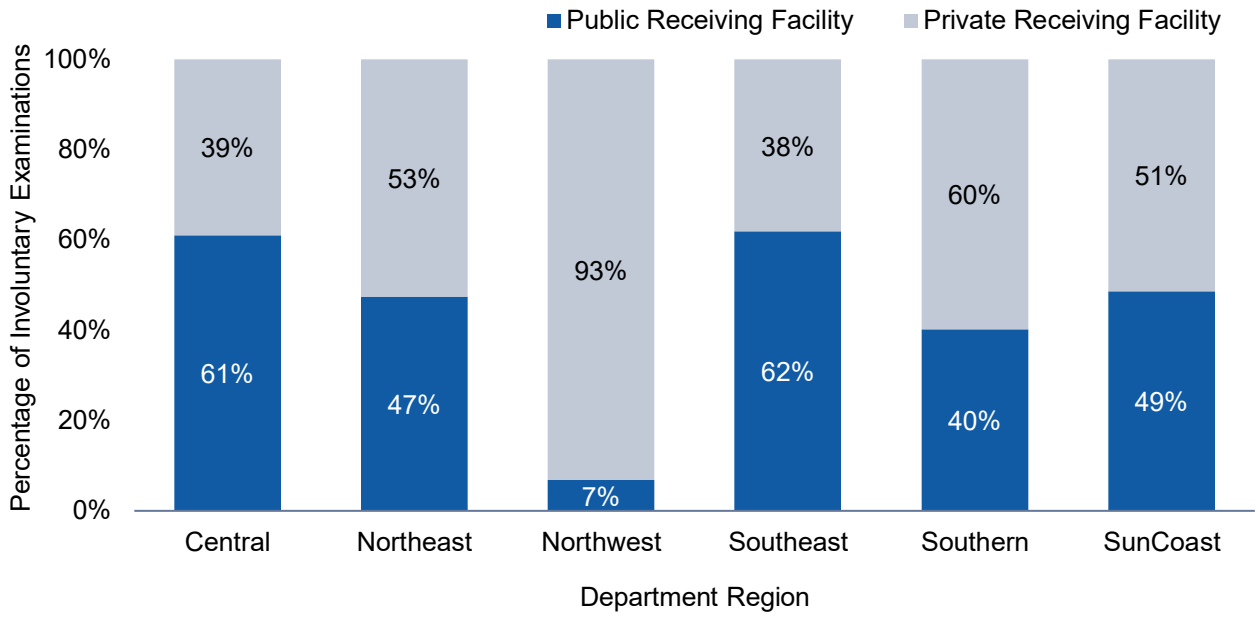
Figure 1b: Counts of **Children** with Involuntary Examinations Under the Age of 18: Five-Year Analysis



Public and Private Baker Act Receiving Facilities: Public receiving facilities are licensed under the Baker Act (s. 394, F.S.) and receive Department funding to provide services related to involuntary examinations. Most are known as Crisis Stabilization Units (CSUs) or Children's Crisis Stabilization Units (CCSUs). In contrast, most private receiving facilities are licensed under the section of statute that addresses hospital licensing and regulation (s. 395, F.S.), and do not typically receive Department funding for involuntary examination-related services. The mix of public and private facilities varies across Department Regions, which contributes to significant differences in where children receive involuntary examinations – whether in publicly funded or privately funded settings[7] (see Figure 2).

[7] Note that children's county of residence (not the county of the receiving facility) was used to categorize involuntary examinations by Department Region. This is an important distinction because approximately half of the counties do not have a receiving facility, such that children in those counties obtain care outside of their county of residence. The Department region for the county of residence and the county of the receiving facility are sometimes different but are usually the same.

Figure 2: Percentage of Involuntary Examinations of Children at Public and Private Receiving Facilities by Department Region[8] for FY 2024-2025

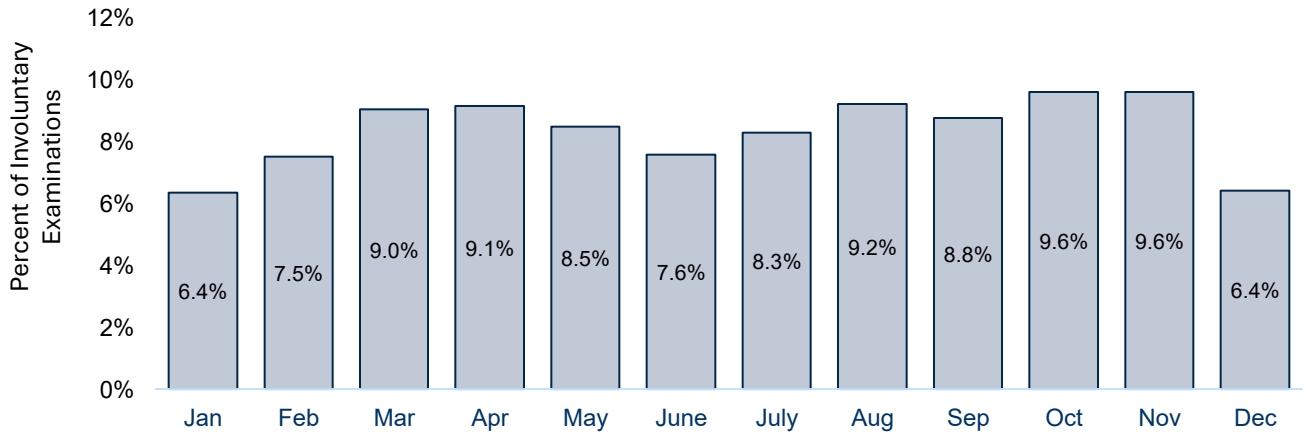


2. Repeated Involuntary Examinations – Summary

There are seasonal trends in the involuntary examination data for children. This is reflected in lower numbers of involuntary examinations during the summer months – when school is typically out of session. So, while there is not a variable of sufficient quality to indicate if an involuntary examination occurred at a school, at a school-sponsored event, or on school transportation, the positive correlation of the volume of involuntary examinations for children with school being in session suggests a relationship between the two.

The percentage of involuntary examinations of children by month for FY 2023-2024 is shown in Figure 3a. The seasonal pattern of these data is shown in Figure 3b.

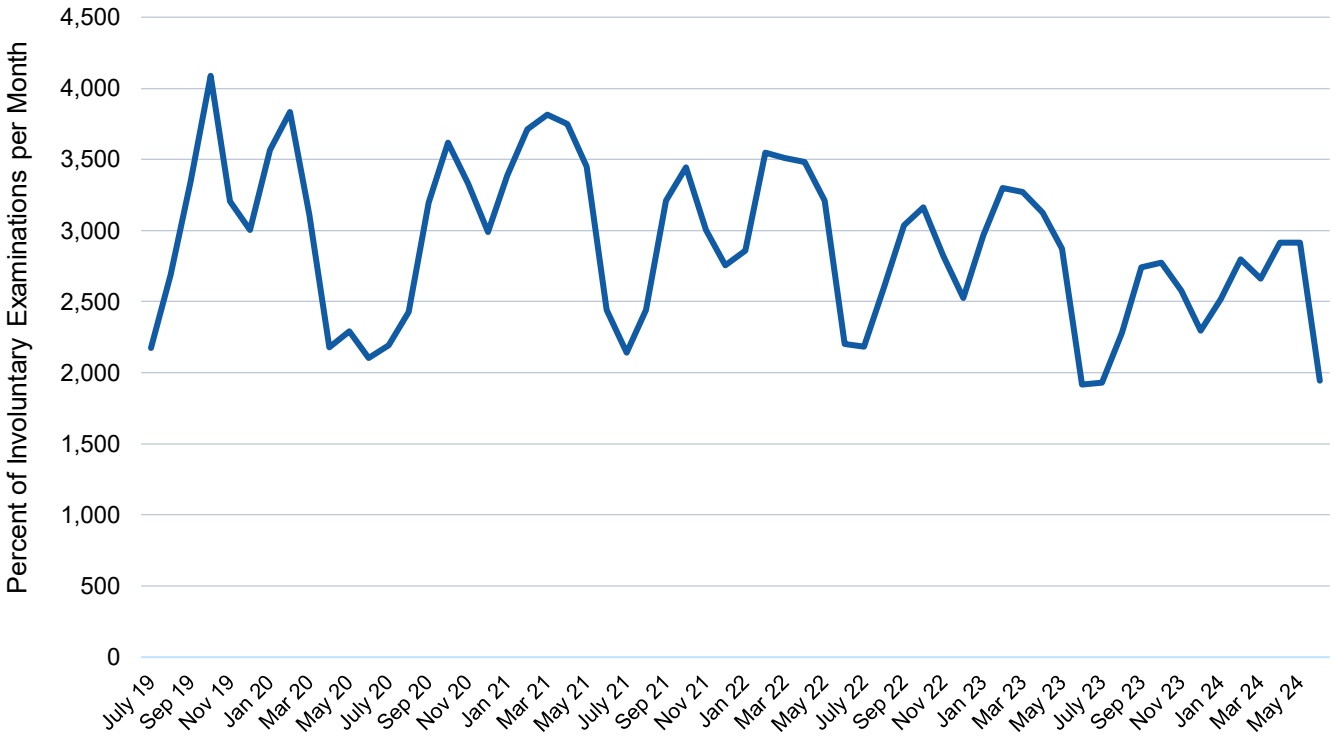
Figure 3a: Percentage of Involuntary Examinations of Children by Month for FY 2024-2025



[8] See https://www.myflfamilies.com/news-events/department-regions-and-circuits

In Figure 3b, the low points for each year are during the summer months.

Figure 3b: Seasonality of Involuntary Examinations for Children for Five Years



3. Repeated Involuntary Examinations – Summary

Tables 3a, 3b, and 3c and Figure 4a, 4b, and 4c, along with Figure 2, present the frequency with which individual children under the age of 18 received an involuntary examination over three timeframes: one year (FY 2023-2024), three years (FY 2021-2024), and five years (FY 2019-2024).

One-Year Analysis: Counts for FY 2023-2024 (1 Year) are shown in Table 3a. There were 19,380 children with 29,612 involuntary examinations during the year. Almost one in four (24 percent) of the 19,380 children with involuntary examinations during the year had more than one involuntary examination.

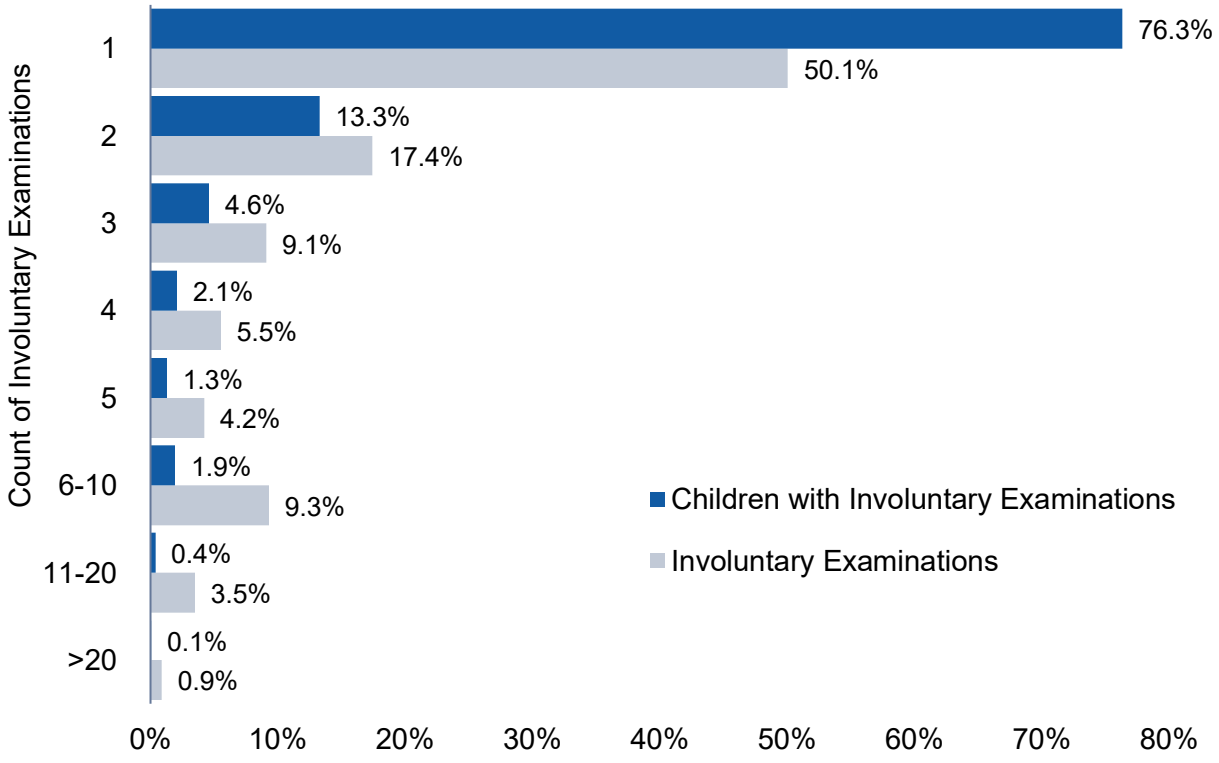
[This space was intentionally left blank so that Table 3a and Figure 4 appear on the same page.]

Table 3a: Repeated Involuntary Examinations of Children Under the Age of 18: **One-Year Analysis**

Number of Involuntary Examinations	One Year: FY 2023-2024			
	Children		Involuntary Examinations	
	Number	Percentage	Number	Percentage
1	15,202	76.34%	15,202	50.08%
2	2,646	13.29%	5,292	17.43%
3	919	4.62%	2,757	9.08%
4	419	2.10%	1,676	5.52%
5	256	1.29%	1,280	4.22%
6-10	385	1.93%	2,824	9.30%
11-20	76	0.38%	1,056	3.48%
>20	10	0.05%	270	0.89%
Grand Total	19,380	100%	29,612	100%

Children who undergo multiple involuntary examinations represent a disproportionately large share of the total examinations conducted. For instance, in FY 2023-2024, 465 children experienced six or more involuntary examinations. Although they represented only 2.40 percent of all children who underwent involuntary examinations that year, these children accounted for 4,113 examinations, or 13.89 percent of the total involuntary examinations conducted among children.

Figure 4a: Percentages of Children and Percentages of Involuntary Examinations for Varying Counts of Involuntary Examinations: **1 Year Analysis**



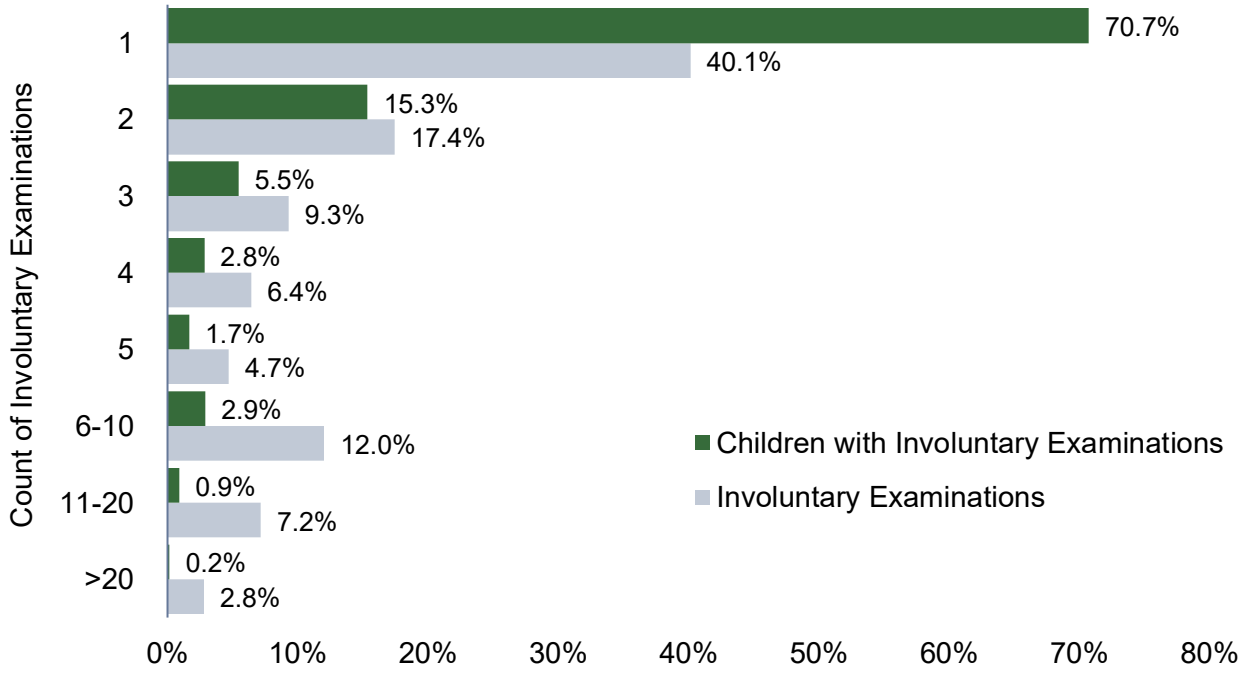
Three-Year Analysis: Counts for FY 2020-2021 through FY 2023-2024 (3 Years) are shown in Table 3b. During this time, 55,840 children underwent a total of 98,617 involuntary examinations. More than one quarter (29 percent) of children who underwent involuntary examinations during the year experienced more than one involuntary examination.

Table 3b: Repeated Involuntary Examinations of Children Under the Age of 18: **Three-Year Analysis**

Number of Involuntary Examinations	Three Years: FY 2021-2022 to FY 2023-2024			
	Children		Involuntary Examinations	
	Number	Percentage	Number	Percentage
1	40,127	70.73%	40,127	40.15%
2	8,706	15.35%	17,412	17.42%
3	3,094	5.45%	9,282	9.29%
4	1,608	2.83%	6,432	6.44%
5	941	1.66%	4,705	4.71%
6-10	1,645	2.90%	12,031	12.04%
11-20	518	0.91%	7,161	7.16%
> 20	91	0.16%	2,795	2.80%
Grand Total	55,840	100%	98,617	100%

Children with multiple involuntary examinations account for a disproportionate percentage of involuntary examinations over the three years (see Figure 4b). The 2,239 children who underwent six or more involuntary examinations in the three years accounted for 49 percent of the children who underwent involuntary examinations, while their 21,987 involuntary examinations represented 22 percent of all involuntary examinations conducted among children during that time frame.

Figure 4b: Percentages of Children and Percentages of Involuntary Examinations for Varying Counts of Involuntary Examinations: **Three-Year Analysis**



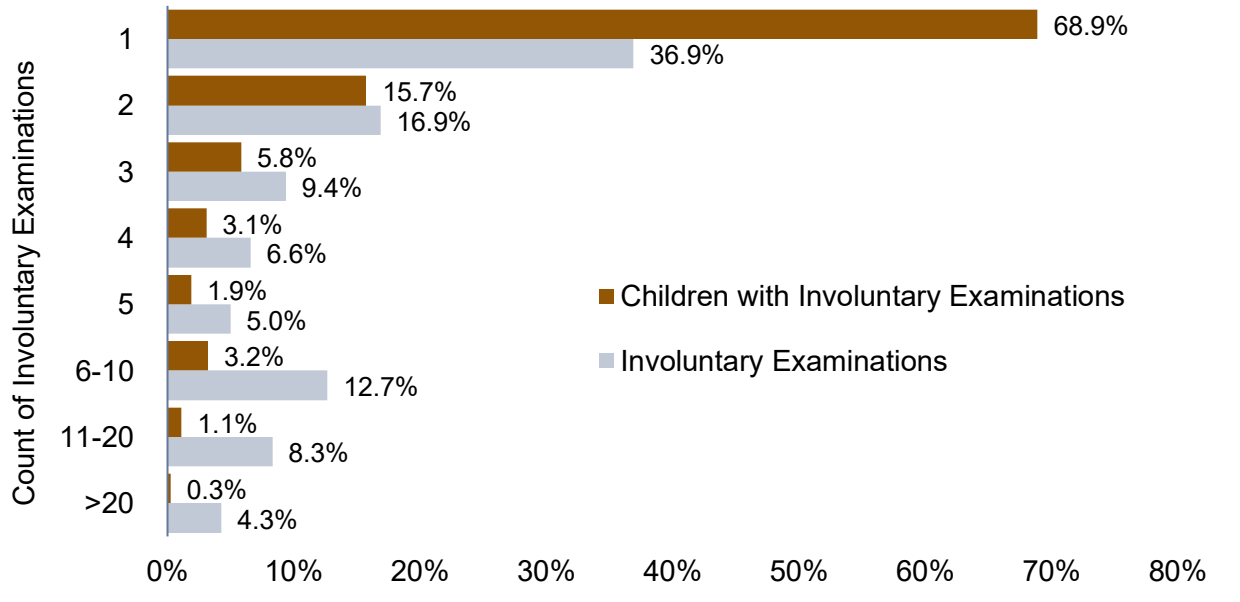
Five-Year Analysis: Table 4c presents data for the five years corresponding to FY 2019-2020 through FY 2023-2024. During this time, 93,161 children underwent a total of 173,843 involuntary examinations. Nearly one-third (31 percent) of children who underwent involuntary examinations during this time frame experienced more than one such examination.

Table 4c: Repeated Involuntary Examinations of Children Under the Age of 18: **Five-Year Analysis**

Number of Involuntary Examinations	Five Years: FY 2019-2020 to FY 2023-2024			
	Children		Involuntary Examinations	
	Number	Percentage	Number	Percentage
1	64,187	68.90%	64,187	36.92%
2	14,661	15.74%	29,322	16.87%
3	5,432	5.83%	16,296	9.37%
4	2,868	3.08%	11,472	6.60%
5	1,735	1.86%	8,675	4.99%
6-10	2,995	3.21%	22,021	12.67%
11-20	1,038	1.11%	14,439	8.31%
21-30	163	0.17%	3,943	2.27%
31-40	47	0.05%	1,611	0.93%
> 40	35	0.04%	1,877	1.08%
Grand Total	93,161	100%	173,843	100%

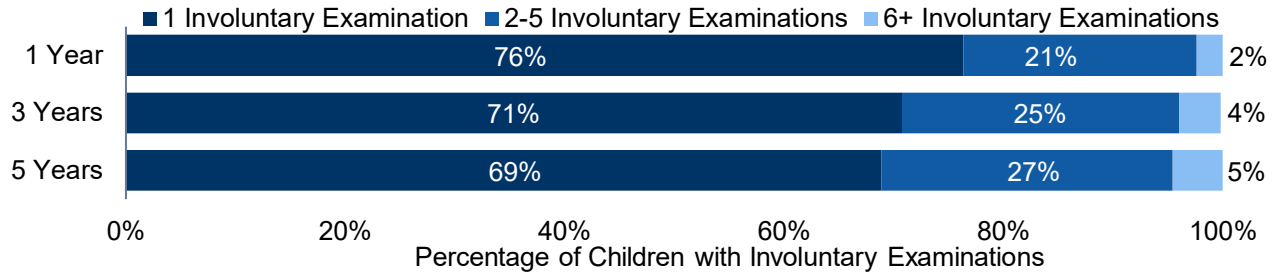
Children with multiple involuntary examinations account for a disproportionate percentage of involuntary examinations over the five years (see Figure 4c). Over the five-year period, 4,278 children underwent six or more involuntary examinations. These children accounted for one percent of the children with involuntary examinations during that time. However, their 43,891 involuntary examinations accounted for one-quarter (25 percent) of all involuntary examinations conducted among children during the same time frame.

Figure 4c: Percentages of Children and Percentages of Involuntary Examinations for Varying Counts of Involuntary Examinations: **5 Year Analysis**



The percentages of children with one, two to five, and six or more involuntary examinations over one-, three-, and five-year periods are shown in Figure 5. The percentage of children with multiple involuntary examinations is higher over time. For example, over the course of one year, 24 percent of children underwent more than one involuntary examination, 30 percent over three years, and 32 percent over five years. **Note that involuntary examinations for adults were not counted in this report**. This means that the actual number of repeated involuntary examinations for some people whose data are included in the results shown in this report could be higher, given that any involuntary examinations that may have occurred at age 18 or older were not counted.

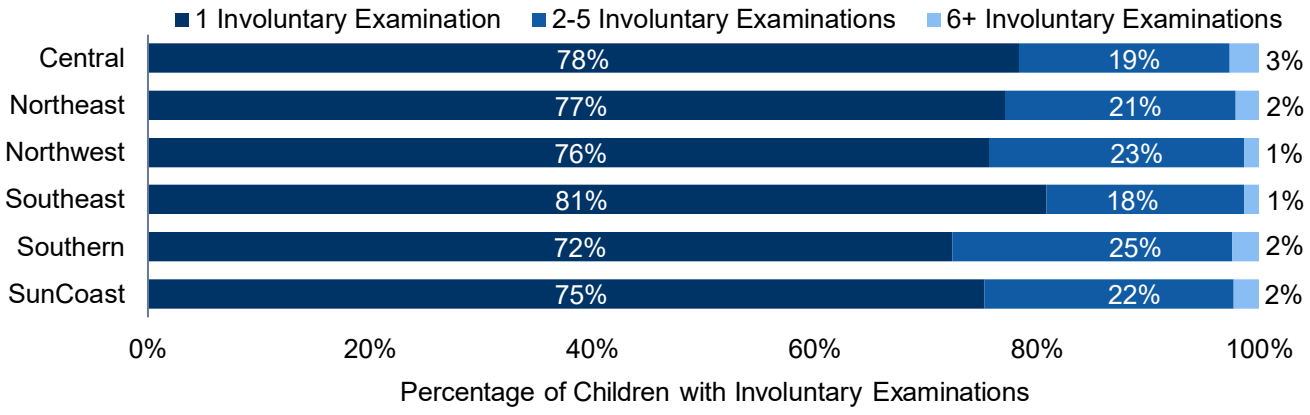
Figure 5: Repeated Involuntary Examinations for Children Under the Age of 18: One, Three and Five-Year Analysis



Pursuant to Section 1006.07(10), F.S., the Florida Department of Education is required to provide counts of involuntary examinations. This data is presented in Appendix B. It is essential to note that data from the Baker Act Data Collection System cannot be used to report on involuntary examinations that occur in schools. Further discussion of this limitation is included in the *Discussion and Recommendation* section of this report (see page 45).

Figure 6[9] presents the percentages of children in each region who underwent one to five, and six or more involuntary examinations in FY 2023-2024. The Southeast Region reported the lowest percentage of children with more than one involuntary examination (19 percent), followed by the Northeast (23 percent), Northwest (24 percent), SunCoast (25 percent), and Southern (28 percent) regions.

Figure 6: Repeated Involuntary Examinations for FY 2023-2024 by Department Region



[9] Note that if a child resided in more than one Department region during the year, they were counted in both regions.

V. Literature Review[10]

The purpose of this section of the report is to share insight into reasons for repeated involuntary (Baker Act) examinations of children from research literature. This is followed by a qualitative analysis based on interviews with the receiving facility staff and an analysis of documents. This literature review and the qualitative components were conducted to 1) understand research findings related to repeated involuntary examinations of children, 2) gain insight from key system stakeholders involved in initiating involuntary examinations and providing crisis stabilization services, and 3) assess existing statewide initiatives related to children's mental health services.

The 2023 Report on Involuntary Examination of Minors,[11] showed that females made up the majority of repeated involuntary examinations, and that children ages 14-17 had the greatest number of involuntary examinations, compared to other grade level-based age groups (5-10 and 11-13). Coding of initiation forms for involuntary examinations revealed that mood disorders were the most prevalent diagnoses for children with repeated involuntary examinations, with 22 percent of their involuntary examinations indicating a mood disorder diagnosis. This was followed by Oppositional Defiant Disorder (9 percent), Attention Deficit Hyperactivity Disorder (9 percent), Bipolar Disorder (8 percent), and Anxiety Disorders (6 percent); all other diagnoses represented 5 percent or less of repeated involuntary examinations.[1]

These data provide valuable preliminary insights into patterns of repeated involuntary examinations of children. However, understanding the reasons behind repeated involuntary examinations is limited. This information is crucial to better addressing the needs of children with ongoing mental health issues and to have them receive appropriate treatment.

As shown in the results earlier in this report, almost one quarter (24 percent) of children over one year, 29 percent over three years, and almost one third (31 percent) over five years experienced more than one involuntary examination. Lee and Cohen (2021) found that, of the states with relevant data, Florida had the highest rate of "emergency psychiatric detentions" (e.g., involuntary examinations) of children.[12,13] Given the poor long-term outcomes these children are likely to suffer and the strain this high utilization places on the behavioral health system, there is an urgent need to address the problem of repeated involuntary examinations of children.

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[10] The Law Atlas is a source for information about a variety of laws. Every state has statutory language that allows for a short-term involuntary mental health assessment. While this is called involuntary examination in Florida, nationally this can be referred to as short-term emergency commitment. The updated version of the Law Atlas does not currently contain a summary of laws for short-term emergency commitment for each state. However, its legacy site (The Policy Surveillance Program) contains such a summary by state. Although the information on this site is dated, it offers insights into laws across states and provides statutory references for further learning. It is important to note that some of the literature cited in this section of the report uses data from other states or countries. As such, the laws may differ somewhat from Florida's. However, in general, the concepts addressed in these articles are relevant to acute mental health care of children, if not specifically looking at the Baker Act. We use the term "involuntary examination" throughout this literature review for consistency. However, it is important to understand that the legal mechanisms present in the locations of studies cited in this section may have different names. In some instances, it was difficult to determine whether studies were discussing voluntary admission or only involuntary admission.

[11] See https://www.usf.edu/cbcs/baker-act/documents/ba_minors_report_nov2023.pdf

[12] Lee, S., & Cohen, D. (2021). Incidences of involuntary psychiatric detentions in 25 U.S. states. *Psychiatric Services*, *72*(1), 61-70. https://doi.org/10.1176/appi.ps.201900477

[13] It is important to note that only half of U.S. States (n = 25) had "usable counts" for "emergency or longer-term [psychiatric] detention" (Lee & Cohen, 2021, p. 61). Furthermore, Lee and Cohen (2021) included only five states in a figure comparing rates of "emergency psychiatric detention" from 2011-2018 (p. 66). And the data used for this study are dated.

Findings were synthesized from research studies on factors associated with involuntary examinations (or their equivalents and see footnote 10 on the prior page of this report) of children, focusing on repeated admissions and related risk factors when possible. Research specifically evaluating repeat involuntary examinations among children is sparse. Many studies focus on overall prevalence and counts, adult populations, or psychiatric hospitalizations, which may be voluntary. Furthermore, while many studies address frequency of admissions, length of stay, and demographic factors related to involuntary examinations, less is known about the reasons for repeat examinations. Findings from research that focus on this phenomenon suggest a complex interplay of clinical, systemic, and social considerations at play.

A. Clinical and Behavioral Risk Factors for Involuntary Examinations

Several key clinical and behavioral factors emerged as predictors of involuntary examinations. Self-harm and suicidal behavior stand out as primary triggers for involuntary examinations, with multiple studies identifying these as leading causes for initial involuntary examination.[14, 15, 16, 17] Similarly, aggressive behavior and violence towards others represent another major risk category, often associated with law enforcement involvement and extended holds in healthcare facilities.[14, 18, 19] Conduct or impulse control disorders were risk factors for repeated involuntary examinations.[20]

Developmental and learning disorders represent another risk category, with research indicating that intellectual disabilities and neurodevelopmental disorders are associated with increased risk for repeat involuntary examination[18]. Additionally, traumatic experience is a risk factor, with one study finding that children with a history of victimization, peer problems, and a history of violence are more than twice as likely to have repeated intakes for emergency psychiatric hospitalization.[21]

B. Mental Health System Factors

Several studies identified systemic issues that contributed to involuntary examinations. A primary concern was the widespread lack of psychiatric inpatient beds, which often resulted in extended lengths of stay at emergency or crisis facilities.[17, 22] Mental health service availability

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[14] Chen, Y. L., Kraus, S. W., Freeman, M. J., & Freeman, A. J. (2023). A machine-learning approach to assess factors associated with hospitalization of children and youths in psychiatric crisis. *Psychiatric Services*, *74*(9), 943-949.
[15] Peterson, B. S., Zhang, H., Santa Lucia, R., King, R. A., & Lewis, M. (1996). Risk factors for presenting problems in child psychiatric emergencies. *Journal of the American Academy of Child & Adolescent Psychiatry*, *35*(9), 1162-1173.
[16] Santillanes, G., Kearl, Y. L., Lam, C. N., & Claudius, I. A. (2017). Involuntary psychiatric holds in preadolescent children. *Western Journal of Emergency Medicine*, *18*(6), 1159.
[17] Schölin, L., Tucker, Z., Chopra, A., Borschmann, R., & McKay, C. (2024). Detention of children and adolescents under mental health legislation: a scoping review of prevalence, risk factors, and legal frameworks. *BMC pediatrics*, *24*(1), 12.
[18] Farquharson, W., Schwartz, J. E., Klein, D. N., & Carlson, G. A. (2023). Factors associated with police bringing children to a psychiatric emergency room. Psychiatric Services, 74(5), 488-496.
[19] Hoffmann, J. A., Stack, A. M., Monuteaux, M. C., Levin, R., & Lee, L. K. (2019). Factors associated with boarding and length of stay for pediatric mental health emergency visits. *The American journal of emergency medicine*, *37*(10), 1829-1835.
[20] Cushing, A. M., Liberman, D. B., Pham, P. K., Michelson, K. A., Festekjian, A., Chang, T. P., & Chaudhari, P. P. (2023). Mental health revisits at US pediatric emergency departments. *JAMA pediatrics*, *177*(2), 168-176.
[21] Tossone, K., Jefferis, E., Bhatta, M. P., Bilge-Johnson, S., & Seifert, P. (2014). Risk factors for rehospitalization and inpatient care among pediatric psychiatric intake response center patients. *Child and adolescent psychiatry and mental health*, *8*(1), 27.
[22] Wood, D. B., Donofrio, J. J., Santillanes, G., Lam, C. N., & Claudius, I. (2014). Treating psychiatric emergencies in incarcerated minors in the emergency department: what is the cost and what is their disposition?. *Pediatric emergency care*, *30*(6), 403-408.

varied substantially across regions of the country, which led to gaps in care.[19] Poor communication and collaboration between related systems–mental health services, child welfare systems, and juvenile justice agencies resulted in fragmented care and contributed to repeated involuntary examinations.[23]

Poor access to mental health services is a systemic issue, with studies documenting barriers to identifying community-based care options (e.g., outpatient therapy) and attending appointments, long wait times for services, scheduling and transportation barriers, and inconsistent referral practices.[24, 25, 26, 27] These access issues can lead to increased reliance on emergency and crisis services when less intensive options might be more appropriate.

C. Social and Environmental Considerations

Family factors play a crucial role in involuntary examination patterns. Family disruption, parental mental health issues, substance abuse, and lack of stable caregivers are risk factors for the use of involuntary examination.[28, 22] These family-related challenges often intersect with broader socioeconomic factors.

Socioeconomic status emerges as a determinant, with low income, lack of insurance coverage, and unemployment associated with a higher risk of involuntary examinations of children.[18, 29] Community resource availability and context also play a role, with higher risks for youth in congregate care, rural areas, or regions with limited service availability.[30]

Treatment compliance and engagement present ongoing challenges, with some studies noting that treatment refusal and lack of compliance by children and families contributed to repeated examinations.[31, 32] Appropriate follow-up care and post-discharge support are important factors to prevent repeated involuntary examinations.

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[23] Yampolskaya, S., & Mowery, D. (2017). Profiles of youth in therapeutic group care: Associations with involuntary psychiatric examinations and readmissions. *American Journal of Orthopsychiatry*, *87*(1), 76.
[24] Gould, S. R., Beals-Erickson, S. E., & Roberts, M. C. (2012). Gaps and barriers in services for children in state mental health plans. *Journal of Child and Family Studies*, *21*(5), 767-774.
[25] Graaf, G., Hooley, C., Baiden, P., & Keyes, L. (2023). Parent reported barriers to children's mental health services in the United States. *Social Work in Mental Health*, *21*(4), 360-382.
[26] Kerns, S. E., Pullmann, M. D., Putnam, B., Buher, A., Holland, S., Berliner, L., ... & Trupin, E. W. (2014). Child welfare and mental health: Facilitators of and barriers to connecting children and youths in out-of-home care with effective mental health treatment. *Children and Youth Services Review*, *46*, 315-324.
[27] Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(6), 731-738.
[28] Rice, J. L., & Tan, T. X. (2017). Youth psychiatrically hospitalized for suicidality: Changes in familial structure, exposure to familial trauma, family conflict, and parental instability as precipitating factors. *Children and youth services review*, *73*, 79-87.
[29] Lindsey, M. A., Joe, S., Muroff, J., & Ford, B. E. (2010). Social and clinical factors associated with psychiatric emergency service use and civil commitment among African-American youth. *General hospital psychiatry*, *32*(3), 300-309.
[30] Romansky, J. B., Lyons, J. S., Lehner, R. K., & West, C. M. (2003). Factors related to psychiatric hospital readmission among children and adolescents in state custody. *Psychiatric Services*, *54*(3), 356-362.
[31] Doupnik, S. K., Passarella, M., Terwiesch, C., & Marcus, S. C. (2021). Mental health service use before and after a suicidal crisis among children and adolescents in a United States national Medicaid sample. *Academic pediatrics*, *21*(7), 1171-1178.
[32] Hoffmann, J. A., Krass, P., Rodean, J., Bardach, N. S., Cafferty, R., Coker, T. R., ... & Zima, B. T. (2023). Follow-up after pediatric mental health emergency visits. *Pediatrics*, *151*(3), e2022057383.

D. Demographic Patterns

Demographic differences in involuntary examination patterns are evident from the research literature. Multiple studies document higher risks for repeated emergency mental health visits among racial minority youth, and another showed a higher risk for law enforcement involvement in mental health crisis response for Black and Latino youth.[17, 33] These differences may be related to cultural or socioeconomic patterns in seeking help for mental health crises.

Gender-specific patterns are also evident, with studies reporting that males were at higher risk for aggression-related examinations, while females were more likely to be examined for self-harm behaviors.[15] Age-related differences appeared in examination outcomes, with older youth experiencing higher rates of examination and greater lengths of stay.[18]

Insurance status and socioeconomic factors are shown to predict involuntary examination risk, with public insurance (e.g., Medicaid) and lower socioeconomic status associated with higher examination rates.[19, 28] These patterns likely reflect broader systemic challenges in access to preventive and community-based mental health services.

E. Implications and System Needs

The findings presented here point to several critical needs in the mental health system for children. First, there is a clear need for improved coordination between mental health systems, child welfare, and juvenile justice systems, as many children with repeated involuntary examinations are involved in these systems.[21]

Preventing repeated involuntary examinations requires a comprehensive approach that addresses children's immediate clinical needs and underlying social factors such as family stress and economic status. This includes expanding community-based services, improving family support systems, and addressing systemic barriers to care access at multiple levels.[27]

There is also a need for targeted interventions for high-risk groups, including youth with histories of trauma, those with developmental disorders, and those with involvement in child welfare and juvenile justice systems.

F. Limitations and Research Needs

While this review provides important insights into factors associated with involuntary examinations of children, it also reveals gaps in current knowledge. The research base is largely retrospective, and there is a lack of standardized reporting on examination frequencies and outcomes. Additionally, most studies focus on immediate clinical factors, with less attention to long-term outcomes and the effectiveness of different intervention approaches.

These findings underscore the need for more prospective studies examining the trajectories of children following involuntary examination, as well as research evaluating the effectiveness of various prevention and intervention strategies. There is also a need for more detailed examination of how different system-level factors interact to influence involuntary examination patterns and outcomes. Qualitative studies may be instructive in further understanding the complex array of factors at play in trying to address the needs of youth experiencing mental health crises.

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[33] Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016). Racial and ethnic disparities in mental health care for children and young adults: A national study. *International Journal of Health Services*, *46*(4), 810-824.

VI. Baker Act Receiving Facility Staff Interviews

A. Method

1. Recruitment

The Baker Act Reporting Center conducted a qualitative assessment to examine factors contributing to repeated involuntary (Baker Act) examinations in Florida. Recruitment for interviews focused on staff and administrators at Baker Act receiving facilities with direct involvement in processes or policies related to children. Receiving facilities were contacted using a standardized email template. Emails outlined the evaluation's purpose and expectations for the interviews and included an informational flyer and a scheduling link. Facilities were asked to identify two to three knowledgeable staff members for virtual interviews. Follow-up email messages were sent to non-respondents, and additional staff were contacted as needed. All participants were informed that responses would be de-identified to ensure confidentiality.

2. Procedures

Interviews were conducted via Microsoft Teams and lasted approximately 45-60 minutes. A verbal informed consent process was used at the start of each session, emphasizing the voluntary nature of participation, the minimal risk involved, and the strict confidentiality that would be maintained. Interviews were recorded with participant permission; otherwise, detailed notes were taken.

In advance of the interviews, participants received a summary of aggregate counts of involuntary examinations from their receiving facility. Interviews followed a structured interview guide covering the following topics (see Appendix F for complete interview protocol):

- Participants' roles and involvement in involuntary examination procedures for children.
- Perceptions of repeated involuntary examinations, including alignment with Baker Act Reporting Center facility data and patterns by age or referral source.
- Internal or external strategies addressing repeated admissions.
- Perceived causes of repeated involuntary examinations (e.g., family dynamics, behavioral health needs, service gaps, training, trauma, coordination).
- Service coordination efforts, early intervention adequacy, and mental health system barriers.
- Observed outcomes for children with multiple involuntary examinations and recommendations for improvement.
- Facility practices for voluntary examinations and the effects of the 2023 statutory change that no longer requires a hearing at the receiving facility to assess voluntariness for children.
- Additional comments and insights beyond guided questions.

Qualitative Analysis

Interview data were analyzed using thematic coding guided by a structured codebook. All responses were de-identified, ensuring that no names or facility identifiers were included in the interview text being coded. The codebook organized data into key themes, including staff roles, voluntary examination practices, awareness of repeated admissions, rapid readmissions, observed patterns, perceived causes, system functioning, and general reflections. Codes captured issues such as service availability, coordination gaps, age-related trends, and barriers to care. Thematic analysis identified recurring insights, challenges, and recommendations across facilities. These findings may support policy and service delivery improvements statewide.

Interviewees raised the issue of a lack of service availability, including for substance abuse treatment. Information on the location of certain services is listed in Appendix H to provide context for this issue.

Please note that the information contained in the following sections is based solely on Baker Act Reporting Center interviews of receiving facility staff. Future reporting can complement these findings by focusing on analyzing claims data from the Agency for Healthcare Administration or AHCA, data from the Department, as well as interviewing staff from AHCA, the Department, the Managing Entities, and other key stakeholders. For example, analysis of Medicaid claims data from AHCA, Child Welfare data and Financial and Services Accountability Management System or FASAMS data from the Department can enhance our understanding of repeated involuntary examinations of children and add further context to these qualitative findings. Relevant services are licensed and/or funded by AHCA or the Department. For example, the Department licenses substance abuse providers, while AHCA licenses other healthcare providers, including Baker Act receiving facilities. AHCA, via Medicaid, and the Department fund services relevant to children with involuntary examinations. In the future we can delve into the impact of the type, location, volume, and quality of services, as well as how they are funded to give context to the finding below.

B. Results

1. Participants

Staff at eleven receiving facilities were interviewed from all six Department regions. It is important to note that there are over 120 receiving facilities in Florida; the findings of this qualitative assessment represent fewer than 10 percent of receiving facilities. Twenty-five individuals with various roles participated in the interviews. The counts of facilities and interviews by Department region are shown in Table 4. Receiving facilities were selected for interviews based on involuntary examination data from FY 2023-2024, with facilities having higher numbers of repeated involuntary examinations for children being prioritized for interviews. The goal was to interview staff at Baker Act receiving facilities in all six Department regions. Two receiving facilities were selected in each Department region with the highest frequency of involuntary examinations to conduct staff interviews. When staff at a receiving facility were not responsive to being interviewed, the next receiving facility in that Department region on the list was contacted.

Table 4: Interview participant count by facility and region

Region	Receiving Facilities	Participants
Northwest	1	2
Northeast	2	4
Central	1	4
SunCoast	3	7
Southeast	2	5
Southern	2	3
Total	11	25

Interview participant roles ranged from managerial to direct care. Most of the participants held management roles such as Director or Program Supervisor. Their positions oversaw the running of the facilities and compliance with legal requirements. There were also some Therapists and Social Workers interviewed who provided the perspective from working directly with children, either in a long-term or crisis unit setting. Lastly, there were direct care workers, such as case managers, who handled day-to-day tasks for children, like creating care plans or setting follow-up appointments. Interviewed individuals had varying backgrounds and levels of seniority in their roles. Some participants were new to their role, having only a few months in the position, while others had more than twenty years of experience in their respective roles.

2. Prevalence and Characterization of Repeated Involuntary Examinations

Interview participants described a persistent pattern of repeated involuntary examinations for children. While the number of involuntary examinations varied between regions and facilities, providers overwhelmingly reported that a significant subset of children experienced multiple behavioral health incidents that resulted in repeated admissions. When the aggregate counts of repeated involuntary examinations of children at their receiving facility were shared, one respondent stated that they “thought it’d be higher.”

Although repeated involuntary examinations made up a small percentage of overall admissions, staff know these children well due to their frequent presence.

Rapid readmissions, which typically occur within 30 days or even “within a couple days,” were viewed as concerning. Interview participants indicated that the experience of these children often reflected inadequate follow-up care or broader system strain. "Several providers thought the data we provided on children's repeat involuntary examinations at their facility underestimated the problem, with one provider suggesting the counts "should be higher" based on their firsthand experience. "Participants noted a difference in resource availability to the community across different Department regions, with some areas having less access to mental health services. Due to the geography, some regions provided services to children coming from multiple counties.

3. Processes for Handling Repeated Involuntary Examinations

Participating Baker Act receiving facility staff followed their facility’s standardized clinical and administrative procedures, which applied to all children admitted under the Baker Act. However, repeated admissions often demanded more intensive coordination and individualized care. Children were triaged at intake, assessed for safety and mental health needs, and assigned to the appropriate stabilization unit. Staff reported that children with a history of repeated involuntary examinations often followed a predictable cycle: they were admitted during a behavioral health incident, stabilized

temporarily, discharged, and then returned within a short period (i.e., a few days or weeks) due to limited follow-up care and inadequate system support.

Some receiving facilities developed internal protocols that flagged high-utilizing children for focused attention. These included multidisciplinary meetings or case conferences involving clinical staff, case managers, and administrators. One provider emphasized the importance of identifying children with repeated involuntary examinations: "It's one of the first things that we want to identify when we have the whole group together so that we can all be aware that there's something potentially chronic going on or that we need to take a different approach." During these meetings, staff reviewed previous discharge plans, assessed the services attempted, and identified where breakdowns occurred. If a prior approach failed, the team aimed to revise the treatment plan and refer the child to additional community resources when available.

Facilities also differentiated between general readmissions and rapid readmissions, which may indicate distinct service gaps. Rapid readmissions were defined as occurring within 30 days of a previous involuntary examination, although some readmissions occurred in as little as 12 to 24 hours after discharge. As one receiving facility staff explained, "Rapid readmission would be they're back to the facility within a couple days…if they were here [months ago] and now they're here again, that's still a readmission because that is two Baker acts in one year, but it doesn't fall into that rapid readmit category which is handled completely differently for both adults and kids." Rapid readmissions were often treated as red flags, prompting internal reviews and outreach efforts to prevent a recurrence.

Discharge planning began at the point of admission and remained a central focus throughout the child's stay. Staff aimed to coordinate outpatient follow-up care and community-based services but acknowledged that these efforts often fell short once the child left the facility. One clinician said, "We have to give them the appointment within seven days… and a medication management appointment within 30 days, and parents don't always follow through." In many rural or underserved areas, accessing psychiatric services remained a challenge, with people facing long wait times or transportation issues that hinder continuity of care (see content in this report about health care workforce shortages).

4. Efforts to Address Repeated Involuntary Examinations

Efforts to address the issue of repeated involuntary examinations of children involved both internal facility-based strategies and coordinated external partnerships. Internally, receiving facilities implemented a range of practices aimed at improving continuity of care and reducing readmissions. Facilities conducted daily treatment team meetings to discuss children at high-risk and possible new interventions, particularly for children who experienced frequent or rapid readmissions. One provider emphasized the importance of adapting their approach, explaining the goal was "to do something different that we hadn't done before to try to find success." These discussions frequently involved a retrospective review of the discharge plan, including the services recommended, what may have failed, and the supports needed moving forward.

Some receiving facilities invested in evidence-based treatment approaches to further enhance in-facility care. A few units implemented Dialectical Behavior Therapy (DBT)[34] with considerable staff training over extended periods. One facility described becoming a "DBT comprehensive unit," noting that although internal treatment can help stabilize children during their short-term stay, long-term success also depended on external psychosocial supports. Other internal efforts included embedding licensed clinicians into schools with high involuntary examination referral rates, hosting family engagement

[34] See https://www.health.harvard.edu/blog/dialectical-behavior-therapy-what-is-it-and-who-can-it-help-202401223009 for a summary of DBT.

workshops, and increasing the use of mobile crisis response teams. These interventions aimed to provide earlier support before a child reached the point of requiring involuntary examination. As one provider stated, “We’ve embedded therapists in schools where we saw the highest rates of Baker Acts. It’s helped a lot.”

Receiving facilities pursued strategies in collaboration with community stakeholders. First, some Baker Act receiving facilities participated in cross-agency collaborations to better manage the needs of children with frequent admissions. Local Review Teams (LRTs) were a key example, bringing together representatives from schools, the Department, behavioral health agencies, law enforcement, and other service providers. One staff member referred to their LRT as “treatment planning on steroids,” describing it as a highly coordinated effort that even included a local ambulance worker who had transported the same child multiple times. These collaborative spaces enabled service mapping, barrier identification, and problem-solving across various systems.

Second, educational outreach was another community-based strategy, particularly for school and law enforcement personnel. Staff from Baker Act receiving facilities trained school-based staff—including guidance counselors and behavioral specialists—on involuntary (Baker Act) examination criteria as specified in statute, trauma-informed practices, and de-escalation techniques. In some areas, receiving facilities partnered with law enforcement to pilot co-responder models, pairing clinicians with officers during crisis calls.[35] One provider observed, “When it’s just a deputy, they may feel like they have to Baker Act. But with a clinician there, we can often resolve it without a trip to the CSU.” Additionally, some facilities partnered with law enforcement agencies to provide Crisis Intervention Training (CIT), during which they review the appropriate use of the Baker Act. Despite these efforts, many providers emphasized that long-term success depended on broader investments in outpatient care, residential treatment, and school-based mental health infrastructure. As one clinician explained, “We can do all the coordination in the world, but if there’s nowhere to send them after discharge, they’re just going to come back.” This underscores the need for a more robust and accessible behavioral health continuum to address underlying issues before they escalate to repeated crises.

5. Patterns of Repeated Involuntary Examination

a. Age

There were several consistent patterns of children who experienced repeated involuntary examination. These patterns were closely tied to the child’s age, the context, or the setting from which the crisis originated, and the outcomes that followed repeated contact with the system. Age was one of the most striking patterns participants mentioned as it relates to repeated involuntary examinations. Adolescents, particularly those between the ages of 13 and 17, were the most likely to experience repeated involuntary examinations. Participants reported that many of these children were involved with behavioral health services for years and often lacked consistent support systems. One provider shared, “Our readmissions are mostly kids between 14 and 17. They’ve been in the system a long time and don’t have consistent support.” These older children were sometimes described as seeking involuntary examination intentionally, either to escape stressful environments or because they perceived inpatient facilities as safe and predictable spaces. Staff noted that some children “know what to say to get back on the unit,” especially if they viewed hospitalization as a means to avoid school, family conflict, or other obligations.

[35] See https://bja.ojp.gov/program/pmhc/learning for details, including a brief video and the *Police-Mental Health Collaboration (PMHC) Toolkit.* Also see https://csgjusticecenter.org/publications/developing-and-implementing-your-co-responder-program/

Children in 5th through 10th grades were also identified as a high-risk group. One staff member explained that in some peer groups, involuntary examinations had become “normalized,” even describing it as “almost like a status symbol.” By contrast, children under the age of 10 were less commonly readmitted, although notable exceptions existed, particularly for those with significant developmental or behavioral diagnoses. For example, receiving facilities frequently encountered repeated admissions among younger children on the autism spectrum or those exposed to trauma, including domestic violence. “We don’t see a whole lot of four-year-olds, but we have seen a few,” one clinician noted. “We do see seven- to eight-year-olds, and many times they’ll be repeat admissions.” Providers also raised concerns about transition-age youth nearing 18, who were at risk of aging out of services without proper support, often leading to instability or a shift into the adult mental health system.

b. Setting

Participants of the receiving facility interviews indicated that the setting played a key role in shaping involuntary examination patterns. Children in foster care, group homes, or other residential placements were repeatedly identified as the most frequent utilizers. According to interview participants, these settings often struggled with limited staff capacity, a lack of trauma-informed training, and low tolerance for disruptive behaviors. One provider stated, “A big majority [of our repeat kids] come from a foster home setting or a group home.” Staff at another receiving facility participating in the survey reported a child readmission rate of 13.2 percent for a recent month and noted that the majority of these were from a group home. Another receiving facility participating in the survey described children from a boys’ camp-like facility run by the Department who were frequently admitted because “they don’t want to be there… they don’t like the people, they don’t like the places.” Group home staff may lack alternatives to calling law enforcement when behavioral issues arise, resulting in involuntary examinations becoming a default response.

Home settings were another common origin of repeated involuntary examinations, especially when law enforcement was called to intervene in family crises. As one provider explained, “Law enforcement’s usually from the home. It’s not like just out in the community or that they see them on the side of the road hanging out or something… It’s usually that the family has called them due to aggressive behavior or something.” In many cases, participants indicated that the perceived parents or caregivers felt overwhelmed or lacked access to crisis services, leading them to seek law enforcement involvement even for non-life-threatening behavioral concerns.

School-based referrals were also frequent, particularly for younger children with complex behavioral or developmental needs. Some staff reported that students “get bored at school” or act out in ways that are misunderstood. Others expressed concern that school personnel were not always equipped with appropriate training in de-escalation or trauma-informed care, which increases the likelihood of initiating an involuntary examination in response to challenging behaviors. In response, several receiving facilities embedded mental health clinicians in high-need schools and partnered with school resource officers (SROs) to support early intervention and avoid unnecessary hospitalizations. Mobile response teams were also used to provide on-site de-escalation and evaluation at schools.

Notably, some staff observed that involuntary examinations declined during school breaks and summer vacation, suggesting that for some youth, school-related stressors were a significant trigger. For others, the CSU itself becomes a perceived “safe place,” offering predictability, food, and shelter that may be lacking at home. This dynamic may reinforce repeated admissions, particularly among children who are otherwise unstably housed or disconnected from support systems.

6. Reasons for Repeated Involuntary Examinations of Children

Eleven reasons for repeated involuntary examinations of children are listed below.

a. Family and Home Environment.

Some of the most frequently reported reasons for repeated involuntary examinations of children were related to home and family circumstances. There was a range of challenges, from noncompliance with follow-up care, lack of motivation, refusal to engage in services, and dysfunctional home environments.

b. Challenges to Following Treatment Recommendations.

Participants widely reported that parents and caregivers faced numerous challenges to follow recommended treatment plans, which often involved multiple components, including medication management, psychiatric evaluation appointments, therapy appointments, or other referrals to community services. These components require considerable time, oversight, and coordination by parents and caregivers, who are often not prepared to engage in these activities and are frequently "burned out" from trying to cope with their child's behaviors. Participants reported logistical challenges that parents and guardians faced, such as a lack of flexibility or time to take children to appointments while trying to maintain their jobs and/or care for other children in the household. Some also faced transportation barriers and inadequate insurance coverage, particularly in lower income communities. In some cases, parents and guardians did not agree that the recommended services were necessary or may have believed the services were not worth the burden it caused to manage them. Participants also suggested that parents or guardians simply prefer to use involuntary or voluntary examination as a mental health service. One participant said:

> "I've had kiddos who, the parents would have them do voluntary so they could have a mental health examination. Rather than go through the [outpatient services] process because it takes a long time to get appointments. So they said, OK, I'll just go ahead and Baker Act my child voluntarily and then they can get the mental health help they need."

Participants indicated that some parents or guardians felt that if their child had repeated involuntary examinations, it would either "send a message" to their child or increase their likelihood of being admitted to residential services through the Statewide Inpatient Psychiatric Program (SIPP).[36] One participant said:

> "I think sometimes parents and guardians are under the impression that the more Baker Acts a child has, sometimes they feel that, that's going to increase the, that's gonna kind of light a fire under the end goal of potential residential placement… Sometimes those repeated crisis admissions are a setback…those SIPP placements, they don't accept as quick because these children haven't been able to even have the opportunity to try therapy."

Several participants explained that children needed to demonstrate that they had engaged in and "failed" lower-level services (e.g., outpatient) to be eligible for certain inpatient services.

[36] Note that SIPP is a Medicaid reimbursement term for services reimbursed by Medicaid as allowed in a Section 1115 Waiver from the Centers for Medicare and Medicaid Services for people less than 21 years old. See Appendix H for more information about SIPP.

c. *Refusal to Engage*

Another commonly mentioned reason for multiple involuntary examinations was a lack of motivation or refusal to engage in services, either by parents/guardians or older children/teens. Participants frequently emphasized that families had to want to get help to successfully address their needs and prevent crises from recurring, and many did not. In many cases, participants asserted that appropriate services were available, but they were not being accessed. Refusal among teens was also mentioned as an important factor, with parents and guardians feeling they had no control over this problem or, at least, were so exasperated by the teen's refusal of treatment that parents and guardians gave up trying to follow treatment recommendations.

d. *Poor Home Environment*

Participants' responses also indicated that, in many cases, children's needs were not being met at home. Home environments for this population were often described as dysfunctional due to a variety of issues, including untreated parent/guardian mental health or substance use conditions, poor parent/child communication or relationships, numerous stressors in the home, and sometimes abuse or neglect. In some regions, it was noted that many grandparents were serving as guardians for children and were ill-equipped to understand behavioral or mental health conditions, community resources, and had poor financial capacity to address the children's needs.

e. *Difficulties Understanding Needs*

Many participants mentioned parents' and guardians' inability to understand and address children's challenging or extreme behaviors. This was especially true for certain conditions, such as Oppositional Defiance Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD), and Autism Spectrum Disorder (ASD). It was commonly reported that parents or guardians misunderstood symptoms of these conditions as misbehavior or defiance and downplayed the severity and chronic nature of their conditions. Many parents and guardians were said to hold beliefs that contradicted notions of psychiatric conditions, for instance, "old school" or "bootstrap" mentalities that place responsibility on children to improve their behavior on their own. In some communities, parents reported that seeking certain services for their child "went against their beliefs." Interview participants also indicated parents and guardians often lacked awareness of typical child development and how to respond to transitional periods (e.g., adolescence). They perceived resistance among parents/guardians to engage in parent education because they did not want to be told they were "doing it wrong." Other feedback suggested parents and guardians may become overwhelmed and feel they have few options for addressing their child's risky or challenging behaviors:

> They're coming back because the parents just don't know what else to do. They just can't manage [their child's] impairment. And they're just at a loss. And so, before the right help is able to show up and, you know, get a hold of the problem, they are just like "I guess we have to just call the cops again. I can't have my 9-year-old jump out of a moving vehicle…"

f. *Lack of Structure and Safety.*

Lack of structure, discipline, and security at home featured heavily in participants' stated reasons for repeated involuntary examinations. Parents or guardians may lack knowledge of authoritative parenting practices, including effective communication skills and setting clear rules and responsibilities (e.g., chores).[37] Participants expressed concern about the lack of emotional availability and neglect sometimes observed in parents. Additionally, family dynamics may be fraught with frequent conflict and argument and may feel emotionally unsafe for children. Participants also mentioned that this is the case

[37] The American Psychological Association provides a helpful summary of Parenting Styles.

for children in out-of-home care, especially those in group homes. One participant perceived group homes as generally being unable to provide a warm environment where children could form needed attachments. It was also acknowledged that children transitioning to foster care faced increased risk for crisis or were at risk for running away. In many of these instances, parents and guardians or group home staff were described as unaware of appropriate resources or interventions and of repeatedly turning to law enforcement (via 911) to address conflicts. Generally, interview participants stressed that if nothing changed after children returned home, there was no reason to expect the same behaviors or crises would not recur:

> They want, like the magic pill, and that's just not, you know, your child's 15 years old. It's taken 15 years to get to today. You're not gonna solve that in 15 minutes. It's gonna take time. And they just don't wanna—a lot of them don't wanna commit to the amount of effort that it's gonna take to really, you know, mend that relationship.

This problem of unstable home environments complicated efforts to address the root causes of crises. One participant described a continuous cycle of short-term stabilization followed by re-entry into an unstable home environment, and then back to crisis stabilization:

> It is not unheard of for us to have discharge ready and in place, and the minor will be ready for discharge. We've done all this work for their three or four days here, or however long they're staying here, only to discharge them to have an argument with parents in the parking lot, to have law enforcement—law enforcement will be called to our parking lot only to have that exact same minor re-Baker Acted in the parking lot, less than an hour after discharge.

While these “rapid” readmissions make up only a portion of all readmissions, several participants shared similar scenarios to highlight the challenges of treatment and recovery when home environments remained unstable.

g. “Intentional” Involuntary Examinations

Participants frequently reported that children ran away to escape their home life: “My top four people that I see on my list, they don't like their home life and so they come in here to escape it.” Similarly, staff from all facilities consistently reported observing children deliberately triggering involuntary examinations as a means of obtaining security and stability.

> ...we have clients who prefer our setting [to] their home life, and they will prefer to be Baker Acted, and they know what to say to get back on the unit because it's more...it's a more comfortable environment for them, which is sad.

Participants suggested many children preferred Baker Act receiving facilities to their homes because they provided a clear routine, structure, regular meals, and individual attention that children may not receive at home. One staff who was interviewed commented,

> We have one juvenile who was Baker Acted multiple times, and it's because she just doesn't want to be at home…she doesn't go to school, her family keeps her out of school. She doesn't have a social life. She does nothing, and she always fights with her family, and so she comes in here because we treat her nice.

A participant said nearly half of the children in their region who had repeated involuntary examinations were already involved with higher-level services, such as a Community Action

Treatment (CAT) team, or they had already completed residential treatment. However, they continued to be admitted for crises due to significant challenges with home life. Another participant noted that among those with the most re-admissions, the vast majority were making conscious decisions to seek out involuntary examination. In some instances, children may seek an involuntary examination to avoid involvement in the criminal justice system (i.e., to "get out of" charges).

h. Co-Occurring Conditions

Co-occurrence of mental health and substance use conditions was a major concern of several participants, some of whom mentioned that there were no juvenile addiction receiving facilities in their region, even though at least half of the children admitted under the Baker Act had substance use problems. Co-occurring disorders were mentioned by participants as a common source of exasperation for parents and guardians, given not only the lack of resources to address substance use, but also the triggering effect each condition has on the other.

i. Social and Behavioral Reasons

Social Connection and Status. Several interview participants shared that many older children sought involuntary examination for social reasons; for instance, they made friends at the receiving facility and may have planned to get re-admitted at the same time as their friend, or siblings may try to get admitted together, or they may have found a sense of community lacking from their home or school environment. One participant elaborated on this pattern:

> Another trend that we see with the youth unfortunately is, they make friends with different kids on the unit. They—you know, it's crazy, you can say–but they like make plans to get Baker Acted at the same time and come back and we do see that a lot as well...I don't know if they just don't have, you know, a good support at school or friends at school, so I think they look for friends here.

Behavioral vs. Mental Health. Many interview participants distinguished between actual mental health conditions and behavioral challenges, emphasizing that many of the repeated admissions were related to behavioral challenges and not actual mental health diagnoses. People interviewed stated that many children with repeated involuntary examinations had conduct disorders. These behavioral problems were said to be accentuated by developmental phases, and parents and guardians often lacked understanding of how to respond to the behavioral issues when they emerged. There was a concern that the behavior problems became learned and more difficult to address over time. It was also suggested that aggression or "acting out" was sometimes rooted in trauma, and many children with involuntary examinations experienced abuse, neglect, or trafficking, which requires intensive and consistent professional treatment they often did not receive.

Children's Social Worlds. Participants noted that the generational gap between parents and children contributed to this lack of understanding of children's experiences. One participant said parents were "...just not understanding their child. We live in a time right now that is very, very different and it's very stressful. So, you know, kids are kind of left to their own devices." As part of this "tough world" children are navigating, several participants saw social media as a contributing factor to crises, and many suggested parents and guardians were unaware of the extent of their children's social media use or its negative consequences. Some participants also shared that bullying was common among children with repeated admissions, and it was often more intense because of social media.

j. Professional Training.

Interview participants were asked about the extent to which professional training may be related to repeated involuntary examinations. This question referred primarily to professionals authorized to initiate involuntary examinations (e.g., law enforcement or certain licensed health professionals). The question was also relevant to personnel such as group home staff or educators who may refer a child to an authorized professional (e.g., send them to a school psychologist or call 911).

Law Enforcement. While interview participants were careful to demonstrate respect for other professionals' roles and the restrictions they worked within, they frequently described instances of perceived "inappropriate" or "unnecessary" initiation of involuntary examinations by law enforcement and school-based licensed clinicians allowed by statute to initiate involuntary examinations.[38] For law

enforcement, participants described their limited training to adequately assess mental health indicators or to safety plan with children in crises. The Department provides free self-paced on-line Baker Act training courses for law enforcement officers and mental health or school based professionals. The training is not required however, Baker Act courses are among the most well attended.

While some participants saw frequent use of involuntary examinations among law enforcement as problematic, others accepted or even encouraged it, as facility staff would then be able to make proper determination about whether the child met Baker Act criteria:

> We always tell [officers], you know, "I would much rather you write a Baker Act and then ask professionals who are assessing the person to determine their appropriateness or not." Like, that's not their lens. That's not their area of expertise. So you know, when in doubt, please do a Baker Act and we want to make sure that person is safe to, you know, not be inpatient.

However, in other cases, law enforcement officers were said to initiate involuntary examinations based on seeing a history of mental health problems and previous involuntary examinations. And this history was sometimes conveyed by parents and guardians to law enforcement, for example. Several participants stated that they perceived that law enforcement officers sometimes misunderstood signs of Autism Spectrum Disorders as a rational for initiating an involuntary examination. Participants said that children used "buzz words" that officers took at face value:

> A lot of kids, you know, [use] that buzz word or that buzz phrase, "I'm going to kill myself." You know, they'll say that, but that's not truly what they mean. But there's not any like, digging into it to really see, you know, because they're not a mental health counselor, they're not a social worker, you know, they're just a police officer who may or may not have an understanding of that or may not have time to dig into that understanding. So you know once that phrase is said, you're under a Baker Act.

Several participants acknowledged that law enforcement officers had few options for addressing children in crisis. Law enforcement officers are not mental health professionals who can create safety plans or provide further assessment or support. Therefore, they may see involuntary examinations as the best or only solution to resolving the problem.

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[38] Note that school psychologists are not one of the professional types listed in the Baker Act allowed to initiate involuntary examination. A recommendation in the Department of Children and Families *Task Force Report on Involuntary Examination of Minors* was to "include school psychologists licensed under Chapter 490 to the list of mental health professionals who are qualified to initiate a Baker Act" (see p. 27).

Licensed Clinicians. There was regional variation in interview responses about whether training for clinicians played a role in frequent or what were perceived to be unnecessary involuntary examination initiations. A participant from one region said their schools regularly trained personnel and they saw the least number of involuntary examinations from schools compared to involuntary examinations from other locations. Among those who saw clinician training as a contributor to repeated involuntary examinations, participant's suggested clinicians' assessments were often limited or their cases included exclusionary criteria that were not appropriate for admission. This was, in part, attributed to poor understanding of the Baker Act and its eligibility criteria as well as misusing the Baker Act for behaviors clinicians may not otherwise know how to address:

> Usually, it's like the LCSWs or LMHCs, LMFTs[39] that are able to write the Baker Act that really don't have a good understanding of what it really encompasses...Because sometimes they tell the patients or their families that you know this is what's gonna happen, and that's not necessarily the process or what is able to be happening. Sometimes they'll write them for a child that has, you know primary autism and their behaviors are associated with that diagnosis, not necessarily, you know, something going on that would make them criteria for meeting that inpatient need.

Interview participants said they saw many cases from school settings where they felt children were "manipulating" the Baker Act process and putting clinicians in a position to have little choice but to initiate an involuntary examination:

> The child will tell me to my face," I forced her hand. She didn't have a choice. I said, 'If you don't send me the back to [the facility], I'm gonna go home and kill myself.'" And then as soon as the child arrives to us, they're just like, "you know me. Like, you know me better than that. I'm not going to do that, but she can't not send me here if I say that she has to."

However, unlike law enforcement officers, many participants felt that licensed clinicians should be better equipped to assess the nature of these statements and determine when family involvement or other interventions were needed. It was suggested that school personnel may make decisions to initiate involuntary examinations due to the stressful environment in which they work and concerns about liability if they do not initiate such examinations. The Department provides free opportunities for professional development and continuing education for licensed clinicians, nearly 7,900 CEUs were issued for Baker Act and Marchman Act courses in FY 2024-2025. The Department also publishes the Baker Act Handbook, a best practice resource guide and frequently asked questions to assist practitioners facing these situations.

k. Service Infrastructure

Interview participants were asked about the extent to which children's mental health service infrastructure was adequate for preventing repeated involuntary examinations. While responses varied across regions, overall, participants identified numerous gaps in services or barriers to using existing services.

Intensive Care. A consistent theme across interviews was that more intensive treatment options were lacking. Many participants spoke about gaps in access to residential treatment facilities for children, with several pointing out that they had no substance abuse treatment options in their area. For example, in one area, multiple interviewees noted that the closest facility with substance abuse treatment for

[39] LCSW = Licensed Clinical Social Worker, LMHC = Licensed Mental Health Counselors, and LMFT = Licensed Marriage and Family Therapists.

children was three hours away. One participant remarked that most of these services were located in central and south Florida, and they typically only accepted private insurance or private pay, making them out of reach for low-income or uninsured/underinsured families. Several participants reported a lack of availability of Statewide Inpatient Psychiatric Program Services (SIPP). Furthermore, interviewees indicated that SIPP did not offer locked facilities, so it would not accept children with a history of running away. One area was described as having some intensive outpatient programs. However, from interviewees' experience coordinating care, these were found to be inaccessible to families on Medicaid and had long wait times. Another participant identified a need for completely closed in-patient care that addressed substance abuse, particularly for older males (ages 14-17), for whom outpatient services were "not enough," contributing to Baker Act re-admissions.

Intermediate Care. Some participants suggested the need for more intermediate or acute short-term care services for children who required more than one hour of outpatient services per week but did not meet the criteria for residential or inpatient services. When discharging children, many staff felt they had "nowhere to put them" during the sensitive period following their temporary stability, either because of a lack of appropriate services or a lack of availability of services even if they did exist. Therefore, relapses and/or re-admission were common during this time. This window was seen as crucial for starting treatment, especially for children who have been treated with psychotropic medication that needs to be taken consistently. Yet, they may only be discharged with enough to last a matter of days. This presented a significant challenge for parents and guardians in setting up and attending appointments in a short timeframe. One participant noted that without continuing medication, mental health conditions are likely to "deteriorate," and children may need more intensive services, which means it may take longer to reach stability.

Transportation. Transportation was identified as a significant barrier to children attending appointments. Many participants expressed a need for transportation to be provided in situations where parents or guardians lacked stable means of transportation or had limited ability to get children to appointments during the day due to work schedules. One participant mentioned that other regions in the state offered clients transportation, which was considered essential to staying connected to services, but this was not an option in their area.

Limited Outpatient Services. Several participants discussed a lack of outpatient services, though the type of outpatient services that were lacking varied by region. In some instances, there were very few child psychiatrists, or they were difficult to access, while in other areas, psychotherapists were lacking or had limited availability. One participant pointed out that there was more availability for virtual psychotherapy, but this was not seen as the best option for children with significant mental health or behavioral needs, and in-person therapists often had long wait times. One participant suggested that a reason for the limited availability was lower caseloads for therapists, which had decreased significantly in recent years, thereby limiting capacity.

Many participants also shared that resources for children with autism (e.g., evaluation and diagnosis, therapy, and education) were lacking or had long wait times. These resources were described as a significant need because many children with Baker Act admissions are diagnosed with Autism Spectrum Disorders (ASD). It was widely agreed among survey participants that both families and professionals lacked understanding of ASD and did not know how else to address these children's needs. Many behaviors related to ASD were said by survey participants to be misperceived as mental health crises, defiance, or potential threats to self or others, or in some cases they understood that behaviors were related to ASD but felt they had no other options for addressing their needs or parents sometimes "need a break." Therefore, involuntary examination was often used as a means of providing some alleviation. One survey participant shared,

> Officers have shared with me firsthand, that sometimes due to a lack of better choice even though they know autistic children rarely, not never, but rarely meet Baker Act criteria, they will still Baker act the child to bring them here.

Some participants mentioned having school-based services that helped address outpatient therapeutic needs, whether this involved having a position such as a behavioral health coordinator to connect children to services or therapists occasionally visiting schools to provide services. Participants spoke of few formal opportunities for children to receive therapy in school, and some said school-based mental health services that previously existed were no longer available. For instance, in one region, a behavioral health provider that reportedly provided services to over 1,600 students was "pulled out." Other participants noted that positions such as system navigators or care coordinators were beneficial in helping to bridge the gap in support for families when children transitioned out of crisis care; however, these supports were often sparse and lacked stable funding.

7. Voluntary Admissions – 2022 Statutory Change

A change in the Baker Act that took effect in 2022 means a hearing is no longer required to assess the voluntariness of a child's voluntary admission.[40] Instead, a child's voluntariness must undergo a "clinical review." This change in language means that parents and guardians may pursue a voluntary admission of a child to a Baker Act receiving facility. Conceptually, this change could have increased the number of voluntary admissions and decreased the number of involuntary admissions of children to receiving facilities. During our interviews, we asked about this voluntariness issue to learn more about the impact of this statutory change.

When staff were asked about how their facilities handle voluntary Baker Act examinations, they discussed the processes behind admitting children for examination, how often their facility received children for voluntary examinations, and how voluntary examinations were impacted by the statutory change that led to voluntariness hearings no longer being required.

Processes for Voluntary Admission of Children. The process for voluntary examination differed from facility to facility. Some facilities did not admit any children voluntarily, while others only accepted children 14 years old or older voluntarily, and still others did not specify an age minimum. Of the facilities that accepted children voluntarily, all ten mentioned that most often, the parent or guardian brought them in for care. All ten facilities specified that the parent or guardian must provide informed consent for the child to be admitted voluntarily. Staff at five receiving facilities specified that children must also assent to voluntary admission.

Staff at all eleven receiving facilities specified that the child had to be assessed first to determine if they met criteria for voluntary or involuntary admission. Before being discharged, children were re-evaluated. Depending on the child's needs at the time of the assessment, the doctor recommended either outpatient services or an extension of voluntary admission if an additional day or two in care would be beneficial.

Frequency of Voluntary Admission of Children. When asked about the frequency of voluntary examinations, staff at five receiving facilities reported the proportion of voluntary to involuntary examinations. Four of these five facilities reported receiving fewer voluntary examinations than involuntary ones, with a range of 13 to 40 percent consisting of voluntary examinations. One facility reported that the split is roughly half and half.

[40] See House Bill 1179 (2022) and Senate Bill 1844 (2022).

Staff at four receiving facilities provided a monthly count of children who came in for a voluntary examination. Three of these four facilities reported receiving only one to two children per month voluntarily. One facility reported that the number varies by month, with a range of one to 10 children admitted voluntarily each month.

At one of the remaining two facilities that receive children for voluntary admission, one staff member reported seeing voluntary admissions every week, while another staff member indicated that there were more voluntary admissions during the day and more involuntary admissions at night.

Perceptions of Change Where Voluntariness Hearing Was No Longer Required. More than half of the 10 facilities that receive children for voluntary admission reported an increase in voluntary admissions after the statutory change. Specifically, staff at five out of 10 facilities reported no change in the use of voluntary admission, while four reported an increase in its use. For the remaining facility, one staff member reported an increase, but another reported no change.

Of the facilities that reported an increase in the use of voluntary admission, three facility staff members noted that it was now easier for children to receive voluntary treatment, which avoided the use of involuntary examination. One staff member explained that it became easier to initiate voluntary examinations because voluntariness hearings were not required. In the past, they lacked the capacity to conduct voluntariness hearings.

VII. Organizational Overview

The evaluation team conducted a content analysis to assess statewide efforts to address children's mental health and crisis service needs, as they relate to involuntary examinations. The analysis included 85 source documents spanning November 2017 to July 2024 from multiple Florida agencies and stakeholder groups, including 1) 38 sets of meeting minutes from subcommittees of the State of Florida Commission on Mental Health & Substance Use Disorder, 2) 20 reports from the Department of Children and Families' Office of Substance Abuse and Mental Health Services, 3) three reports and one meeting agenda from the Marjory Stoneman Douglas High School Public Safety Commission, 4) 19 documents from the Florida Statewide Office for Suicide Prevention, and 5) five legislative summaries related to the Baker Act (see details in Appendix G). The Baker Act Reporting Center used *NotebookLM*[41], an AI-powered tool, to help organize content, summarize key findings from each source, and synthesize cross-cutting themes across sources. Multiple evaluation team members participated in downloading and reviewing the source documents, defining several levels of prompts for the analysis, and reviewing output for accuracy. This process enabled efficient cross-referencing of materials, identification of recurring challenges, and development of concise, policy-relevant summaries that reflect a wide range of stakeholder perspectives.

Note that documents from the Florida State Health Improvement Plan (SHIP) were excluded from our analysis using *NotebookLM* due to the lack of sufficient details online for this analysis.[42] However, it is worth pointing out that Mental Well-being and Substance Abuse Prevention is one of six Priority Area Workgroups (PAWs) for the 2022-2026 SHIP. The Mental Well-being and Substance Abuse Prevention PAW has four goals as follows: 1) reduce the impact of adult mental, emotional, and behavioral health disorders, 2) reduce the impact of pediatric mental, emotional, and behavioral health disorders, 3) reduce substance use disorders and drug overdose deaths, and 4) reduce suicide behavior deaths.[43]

[41] Google. (2023). *NotebookLM* [Large language model]. https://notebooklm.google/
[42] Also see https://floridaship.org/meetings-and-reports/ for links to
[43] See https://floridaship.org/wp-content/uploads/2022/03/2022-2026-State-Health-Improvement-Plan-Executive-Summary.pdf page 8.

Those interested in learning more about the goals of the six SHIP PAWS can explore the Florida SHIP Indicator and Performance Data Dashboard. In September 2025, the Baker Act Reporting Center will provide a count for FY 2024-2025 of involuntary examinations for children and children subject to involuntary examinations that can be used to demonstrate progress with SHIP metrics.

State Commission on Mental Health and Substance Use Disorder

Pursuant to section 394.9086, Florida Statutes, the Commission on Mental Health and Substance Use Disorder (Commission) is responsible for examining the current implementation of mental health and substance use disorder services in the state and determining how to improve the effectiveness of existing practices, procedures, programs, and initiatives; identifying any gaps or barriers in the delivery of services; assessing the adequacy of the current infrastructure of the 988 Florida Lifeline system and other components of the state's crisis care continuum; and recommending changes to existing laws, rules, and policies necessary to implement the Commission's recommendations.

The Florida Commission on Mental Health and Substance Use Disorder has prioritized strengthening the children's behavioral health system, with a focus on reducing unnecessary involuntary examinations under the Baker Act. Commission-led subcommittees have issued targeted recommendations to enhance access, coordination, and crisis response.

1. Improving School and Community Collaboration

The Children and Youth and System of Care Subcommittees called for formalized partnerships between school districts and behavioral health providers. A statewide memorandum of understanding (MOU) is being developed to define referral protocols, provider roles, and shared performance goals. Additional efforts include expanding the use of graduate-level behavioral health interns in schools and boosting district enrollment in the Medicaid in Schools Program to sustain funding.

2. Expanding Access and Family Navigation

The Family Access and Entry Workgroup recommended embedding behavioral health in pediatric primary care, broadening school-based telehealth infrastructure, and creating centralized, family-centered navigation hubs that integrate services across agencies to improve early identification and engagement.

3. Crisis Response Enhancements and Service Gaps

Florida's "No Wrong Door" crisis care model incorporates Mobile Response Teams (MRTs), Baker Act receiving facilities, and the 9-8-8 Suicide and Crisis Lifeline. Persistent gaps remain, especially in rural MRT coverage (addressed in 2024 with an $11 million funding allocation to expand), receiving facility bed availability, and transportation. Standardized Mental Health First Aid (MHFA) training is recommended for first responders to manage better and de-escalate crises involving children.

4. Involuntary Examinations and Utilization Trends

The Commission observed promising reductions of involuntary examination use in select counties, linked to better coordination between Medicaid plans and Managing Entities. The Department continues to analyze high-utilizer data and explore alternatives to law enforcement transport for less restrictive crisis stabilization options.

5. Legislative Recommendations

Proposed revisions to Section 394.467, Florida Statutes, would limit continuances for involuntary placement hearings to seven days and allow for remote hearings, enhancing both efficiency and safety in the judicial process for children in crisis.

A. Florida Department of Children and Families - Office of Substance Abuse and Mental Health Services

The Department, through its Office of Substance Abuse and Mental Health (SAMH), continues to lead efforts to strengthen the behavioral health system for children, especially those repeatedly subjected to involuntary examinations. Recent legislation and Department reports emphasize early intervention, coordinated care, and improved crisis response.

1. Legislative Measures Enhancing Crisis Services and Coordination

Key laws, such as House Bill 945 (2020), Senate Bill 7026 (2018), and Senate Bill 7012 (2020), target system gaps and support community-based care. House Bill 945 mandates quarterly reporting on children frequently admitted to crisis stabilization units and requires Managing Entities to coordinate with Mobile Response Teams (MRTs) to provide school-based early intervention (sunset). Senate Bill 7026 and Senate Bill 7012 expanded access to Mobile Response Teams and Community Action Treatment (CAT) teams, while strengthening discharge planning protocols for receiving facilities.

2. Data-Informed Oversight and Systemic Challenges

Despite a 15% decline in involuntary examination of children since 2019, as shown in Table 2, some children continue to cycle through crisis services without consistent follow-up, and families often face difficulty accessing and navigating behavioral health resources, reinforcing the need for continued proactive, systemic reforms.

4. Rule Development and Future Direction

Ongoing rulemaking under Chapter 65E-5, F.A.C., the Mental Health Act Regulation, aims to standardize terms like “high utilizer,” improve discharge planning, and support closed-loop referrals. These initiatives reflect Florida’s sustained commitment to reducing the use of involuntary examinations through integrated, child-focused behavioral health systems.

B. Marjory Stoneman Douglas Public Safety Commission

In 2018, the Marjory Stoneman Douglas High School Public Safety Commission, established within the Florida Department of Law Enforcement under Senate Bill 7026, emphasized the urgent need to strengthen Florida’s school safety and behavioral health systems in the context of involuntary examinations of children. Lessons drawn from the Parkland tragedy reveal systemic failures in crisis response, data sharing, and care coordination.

1. Behavioral Health System Challenges

Florida’s behavioral health system is widely regarded as underfunded and fragmented. The absence of an integrated case management system prevents effective tracking and coordination of care for children with recurring crises. Children with multiple repeated involuntary examinations without a sustained intervention plan—highlight a limitation in current practice.

2. *Trends in Involuntary Examinations*

The Marjory Stoneman Douglas Public Safety Commission reviewed data from 2002 to 2018, showing that involuntary examinations of children increased by 140 percent, from 15,000 to 36,000 cases annually. While greater awareness may explain part of this trend, law enforcement remains the primary initiator. The Commission identified confusion regarding criteria for initiation, legal implications (such as those related to firearms), and insufficient post-examination follow-up protocols. These findings led to the statewide implementation of Mobile Response Teams, which have demonstrated effectiveness in diverting and are contributing to a downward trend of involuntary examinations. There has been a 15% decline in involuntary examination of children since 2019, as shown in Table 2.

3. *Legislative Progress and Ongoing Gaps*

Legislation, such as the Marjory Stoneman Douglas High School Public Safety Act of 2018, expanded funding for school-based behavioral health services, mandated school mental health plans, and established behavioral threat assessment teams. However, implementation remains inconsistent across districts, and key tools—such as statewide data systems—require further development to support decision-making and care coordination.

C. Florida's Statewide Office for Suicide Prevention

Florida's Statewide Office for Suicide Prevention (SOSP), established in 2007 under Florida Statutes § 14.2019 and housed within the Department's Office of Substance Abuse and Mental Health, is tasked with leading statewide suicide prevention efforts. While the Baker Act is not a direct focus of its statutory mission, the SOSP plays a critical role in advancing awareness and prevention strategies for children through initiatives that align with statewide goals to reduce unnecessary involuntary examinations. By promoting early intervention, crisis de-escalation, and coordinated community-based care, the SOSP contributes to a broader system of support aimed at preventing crises before they require more intensive responses.

A key component of this alignment is the SOSP's support for Mobile Response Teams (MRTs), which deliver 24/7 in-person crisis intervention services. These teams have proven highly effective in providing rapid assessment and de-escalation of individuals in crisis, achieving a 78 percent diversion rate from involuntary examinations in FY 2024–2025. The SOSP also advances coordination between MRTs and the 988 Florida Lifeline, an essential access point for behavioral health support that served over 144,980 Floridians in FY 2024-2025 and diverted 96 percent of calls from requiring an in-person response. By strengthening these integrated systems, the SOSP helps reduce reliance on involuntary examination procedures and supports more proactive, community-based crisis care for children.

In schools, the SOSP has contributed to policies requiring the use of standardized suicide risk screening tools, such as the Columbia–Suicide Severity Rating Scale (C-SSRS), in partnership with MRTs. Additionally, the office expands access to evidence-based suicide prevention trainings for educators, child welfare advocates, and professionals serving children, such as Youth Mental Health First Aid and Question, Persuade, Refer (QPR). These programs enhance the capacity of schools and community partners to identify risks early and respond with appropriate care.

Through initiatives like the School Mental Health Assessment, Response, and Training for Suicide Prevention (SMARTS) program, which adapts the Zero Suicide framework to school settings, the SOSP fosters systems-level approaches to prevention. While not directly targeting involuntary examination usage, these efforts strengthen the state's infrastructure to reduce crises among children and support voluntary, family-centered behavioral health care.

D. Legislative Initiatives Impacting Involuntary Examinations of Children

Florida has enacted a series of legislative measures aimed at strengthening the behavioral health system for children and reducing the frequency of involuntary examinations. These efforts focus on enhancing crisis response, improving care coordination, and increasing accountability across agencies.

1. Coordinated Care and High Utilizer Intervention

Under House Bill 945 (2020), the Department and the Agency for Health Care Administration (AHCA) must jointly identify children and young adults (up to age 25) who frequently use crisis stabilization services and develop cross-system strategies to address their needs. Regional Managing Entities (MEs) are required to implement “no-wrong-door” models to improve access and service delivery.

2. System Oversight and Local Collaboration

In 2024, House Bill 7021 created the Office of Children’s Behavioral Health Ombudsman within the Department to investigate complaints and systemic service issues. The legislation also mandates regional behavioral health collaboratives, bringing together schools, law enforcement, providers, and other stakeholders to address service gaps and improve coordination.

3. Crisis Services and Discharge Planning

Recent laws enhance Mobile Response Teams (MRTs) and Crisis Stabilization Units (CSUs), removing the 30-bed cap on CSUs and strengthening discharge planning for high utilizers. Discharge plans must now include follow-up care, crisis prevention strategies, and coordination with families or support networks.

4. Baker Act Revisions for Children

Policy changes allow clinical reviews to replace judicial hearings for voluntary admissions and give law enforcement discretion in initiating involuntary examinations. New protocols also require officers to use the least restrictive transport methods and notify parents of the receiving facility whenever possible.

5. Monitoring Repeat Examinations

In FY 2024-2025, more than 31,600 involuntary examinations were conducted on children; 33 percent had multiple episodes. House Bill 7021 (2024) mandated reporting and analysis of repeated examinations and the development of recommendations to reduce use.

E. Summary Across Reports: Remaining Challenges and Barriers

Across state reports, legislative analyses, and commission findings, several systemic challenges have been identified in Florida’s efforts to improve children’s behavioral health services, including those relating to crisis care and the use of the involuntary examination. A primary concern was the longstanding underfunding and fragmentation of the behavioral health system, which lacks a centralized case management infrastructure to support children with recurring needs. This fragmentation contributes to inconsistent care coordination, limited monitoring of repeat crises, and gaps in service continuity.

Despite the implementation of the “No Wrong Door” approach, access to crisis services remains uneven, especially in rural areas. Baker Act receiving facility locations and crisis transport logistics continue to limit timely access to care. Although recent legislative reforms promote less restrictive methods and better parental communication during law enforcement transports, police remain the primary responders in many cases. A substantial portion of these examinations are initiated by law

enforcement, and many stakeholders continue to express confusion regarding the legal thresholds, firearm-related implications, and follow-up responsibilities.

Finally, barriers to cross-agency collaboration persist, including limited data sharing, insufficient real-time information systems, and inconsistent application of privacy laws. Although House Bill 7021 established the Office of Children's Behavioral Health Ombudsman, further reforms are necessary to enhance transparency, data accessibility, and integrated oversight across Florida's behavioral health landscape.

F. Cross-Cutting Initiatives

This section of the report summarizes findings that span the various sources through an AI-based analysis. These cross-sector efforts represent a unified approach to advancing behavioral health outcomes for children and reducing the need for involuntary crisis intervention. Five key themes emerge across state legislative reviews, agency data, and system assessments:

1. Expansion and Enhancement of Crisis Services

Florida's "No Wrong Door" approach is supported by Mobile Response Teams (MRTs), Baker Act receiving facilities, and the 9-8-8 Florida Lifeline. Recent legislation (e.g., House Bill 945, House Bill 7021, Senate Bill 7026) has expanded Mobile Response Teams, removed CSU bed caps, and enhanced school-based services. MRTs maintained a 78 percent diversion rate from involuntary examination in FY 2024–2025, while the 9-8-8 Lifeline diverted 96 percent of contacts from needing an in-person response.

2. Gaps in Crisis Infrastructure

Despite improvements, challenges persist in accessing care, particularly in rural areas, alongside limited CSU bed capacity and transportation issues. Coordinated partnerships between 9-8-8 centers and MRTs are underway, and standardized training (e.g., Mental Health First Aid) is recommended for first responders, educators, and other professionals serving children.

3. Legislative and Policy Reforms to Reduce Involuntary Examinations

The number of involuntary examinations of children has decreased since 2018. Legislative changes now permit greater law enforcement discretion, promote the least restrictive transport methods, and streamline voluntary admissions. Legislative changes in 2024 aimed to expedite hearings and expand remote access. The Department has increased efforts to inform receiving facilities and other system stakeholders of recent changes. The Department updates the Baker Act Manual and Frequently Asked Questions annually, most recently in October 2025. The Department has also updated its Baker Act training courses, which are now available as self-paced, free courses. These trainings are available through the Florida Alcohol and Drug Abuse Associations' Learning Management system.

4. Addressing High Utilization and Repeat Examinations

Roughly 20 percent of children undergoing involuntary examinations account for nearly 45 percent of all such involuntary examinations among children. Gaps in follow-up care and a lack of a centralized case management system hinder consistent support. Some children experience multiple repeated involuntary examinations without a formal intervention, underscoring systemic limitations.

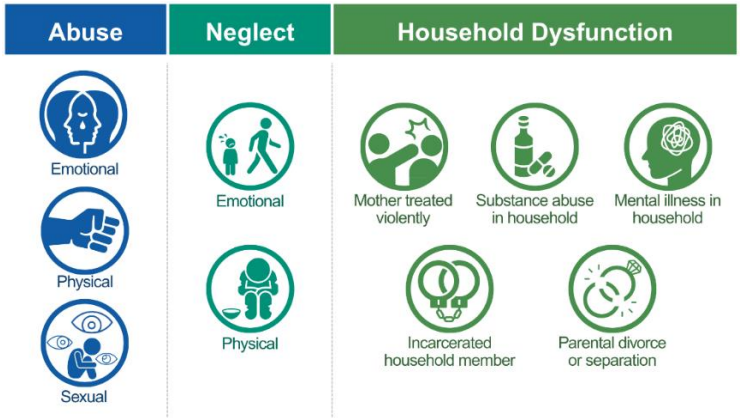
VIII. Relevant Related Topics

Following are brief summaries of several issues that can impact behavioral health or that are affected by it. The Baker Act Reporting Center does not have data on these topics that can be linked to involuntary examination data, which would allow us to empirically explore the relationship between these issues and the use of involuntary examination. Since coverage of extensive content on each of these topics is beyond the scope of this report, the focus is to provide basic information about each topic, along with links to additional resources. Readers of this report are encouraged to consider how these topics may impact and be influenced by the involuntary examination of children. This includes future research and policy considerations that can be undertaken to address the relationship of these issues to the use of involuntary examination.

A. Trauma

A deeper understanding of trauma is essential for addressing behavioral health-related concerns, including factors that may place children at risk for involuntary examination. The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study, conducted from 1995 to 1997, demonstrates the correlation between early adverse childhood experiences and negative health outcomes such as chronic illness, poor mental health, and substance abuse. The study examined various domains of adversity, related to abuse, neglect, and household challenges (depicted in Figure 7), from childhood into adulthood.

Figure 7: Ten Items Collected from the Original Adverse Childhood Experience Study



The ACE Study demonstrated that each adverse childhood experience occurring before the age of 18 was associated with an increased risk of developing serious health conditions later in life. Findings from the original study found that over half of participants reported experiencing at least one ACE, and one-quarter reported two or more. Adults with four or more ACEs were found to have a four-to-twelve-fold increase in health risks compared to those who reported no adverse childhood experiences.[44] Additional information about ACEs is available on the Centers for Disease Control and Prevention (CDC) website.[45] The National Child Traumatic Stress Network (NCTSN) serve as a valuable resource for learning about childhood trauma. Its mission is "to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States." The NCTSN provides guidance on trauma-informed practices, interventions, and systems-level supports.

[44] Felitti, V. J., Anda, R. F., Nordenberg, D., Edwards, V., Koss, M. P., Marks, J., S., et. Al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study, *American Journal of Preventive Medicine, 14*(4), 245-258.
[45]The Centers for Disease Control and Prevention have web pages that provides details of *Risk and Protective Factors* and a how to *Help Youth at Risk for ACES*, which may also be of interest to readers of this report.

B. Workforce Shortages

According to Mental Health America's 2024 report, *The State of Mental Health in America*, the national ratio of mental health providers to the population was one provider for every 340 individuals (340:1). Florida ranked 43rd in mental health workforce availability, with a ratio of 510:1. In contrast, the highest-ranked geographic included Massachusetts (140:1), Alaska (150:1), and the District of Columbia (160:1). The states with the lowest provider availability were West Virginia (620:1), Texas (690:1), and Alabama (800:1).

Florida has taken several proactive measures to address behavioral health workforce challenges. One such initiative is the establishment of the Florida Center for Behavioral Health Workforce (FCBHW) at the Louis de la Parte Florida Mental Health Institute, University of South Florida. The Center, was created pursuant to Chapter 2024-12 as outlined in Senate Bill 330 (2024) and contained in 395.902(2)d, F.S. and "stands in service to Florida and its constituents to **grow, retain, and innovate** the behavioral health workforce" through a) research and dissemination, b) education and professional development, and c) policy analysis and implementation.[46] The FCBHW is required to:

- Analyze the current behavioral health workforce supply and project future demand
- Develop strategies for addressing identified workforce gaps
- Expand pathways to behavioral health professions through enhanced educational opportunities and improved faculty development and retention
- Promote behavioral health professions
- Collaborate with behavioral health teaching hospitals to establish best practices for integrated workforce development programs

Details about the progress of the FCBHW can be read about in its 2024-2025 Annual Report and a March 2025 Interim Report. The Interim Report includes information about training and licensed workforce resource mapping, including information on demographics of professionals across multiple license types, as well as changes in the volume of licensed individuals over time. Current priorities discussed include infrastructure development, research, education and professional development, and policy analysis. Several policy and implementation recommendations are made, concerning specific bill language.

The statute also introduced the designation of behavioral health teaching hospitals, outlined in Senate Bill 330 (2024), "to advance Florida's behavioral health systems of care by creating a new integrated care and education model." Four hospitals were designated as behavioral health teaching hospitals.

- Tampa General Hospital, in affiliation with the University of South Florida.
- UF Health Shands Hospital, in affiliation with the University of Florida.
- UF Health Jacksonville, in affiliation with the University of Florida.
- Jackson Memorial Hospital, in affiliation with the University of Miami.

C. Social Media

Research examining the impact of social media on children continues to expand, including the effect of bans and restrictions on social media use (such as via changes in state laws). McAlister and colleagues (2024) emphasized the importance of focusing on emotional regulation of adolescents as a way to help

[46] See FCBHW Annual Report at https://www.usf.edu/cbcs/documents/research/fcbhw/2024-2025-annual-report.pdf

understand how “adolescents navigate the digital social environment .”[47] Other recent publications have focused on digital detox (Setia et al.)[48] and digital mental health interventions.[49]

As of 2024, at least 40 states and Puerto Rico had introduced legislation concerning adolescent use of social media, with at least 50 related bills enacted.[50] Florida addressed this issue with a statutory amendment that took effect on January 1, 2025. Chapter 2024-54 (2024), enacted as section 501.1736, F.S. (Social Media Use of Minors), under Chapter 501 (Consumer Protection), establishes age-based restrictions on social media platform usage. The statute includes age-based restrictions for social media platforms, accompanied by civil penalties. There are separate restrictions for youth under 14 years old and those aged 14 to 15 years old.

D. Social Isolation and Loneliness

The US Surgeon General, Centers for Disease Control and Prevention, American Medical Association, and World Health Organization (WHO) have addressed the challenges of social isolation and loneliness across the lifespan. Research by Thompson and colleagues (2022) concluded that “isolated children follow distinct patterns of change over childhood, and isolation seems most detrimental to health at the time it is experienced. Social isolation can be a valuable indicator of co-occurring problems and provide targets for mental health intervention in young people.”[51] According to the WHO, five to 15 percent of adolescents experience loneliness.[52] A global study conducted by Gallup and Meta on perceived of social connectedness among youth aged 15 to 18 found that, five percent reported feeling “not connected at all,” 21 percent were “a little connected,” 37 percent were “fairly connected,” and 37 percent were “very connected.”[53] The health risks associated with chronic social isolation include increased likelihood of a person’s risk for heart disease, stroke, Type 2 diabetes, depression, anxiety, suicidality and self-harm, dementia, and early death.[54]

Community-wide efforts and interventions are being developed in response to growing concerns about the impacts of loneliness. For example, in May 2025, leaders in three Tampa Bay cities partnered to support Tampa Bay Connections. The program led by Tampa Bay Thrives “seeks to combat loneliness, improve community unity, and enhance the overall health and vitality of the region.”[55] The Frome Model[56] from the UK inspired this Tampa Bay initiative, which focuses on a) convening stakeholders

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[47] McAlister, K. L., Beatty, C. C., Smith-Caswell, J. E., Yourell, J. L., & Huberty, J. L. (2024). Social media use in adolescents: Bans, benefits, and emotion regulation behaviors. *JMIR Mental Health*, *11*, e64626.
[48] Setia, S., Gilbert, F., Tichy, M. L., Redpath, J., Shahzad, N., & Marraccini, M. E. (2025). Digital detox strategies and mental health: A comprehensive scoping review of why, where, and how. *Cureus*, *17*(1), e78250.
[49] McAlister, K., Lawrence-Sidebottom, D., McCutchen, D., Roots, M., & Huberty, J. (2025). The role of technology and screen media use in treatment outcomes of children participating in a digital mental health intervention: A retrospective analysis of Bend Health. *Frontiers in Digital Health*, *7*, 1556468.
[50]See https://www.ncsl.org/technology-and-communication/social-media-and-children-2024-legislation
[51] Thompson, K. N., Odgers, C. L., Bryan, B. T., Danese, A., Milne, B. J., Strange, L., Matthews, T., & Arseneault, L. (2022). Trajectories of childhood social isolation in a nationally representative cohort: Associations with antecedents and early adulthood outcomes. *Journal of Child Psychology and Psychiatry*, *63*(12), 1471-1481. https://doi.org/10.1002/jcv2.1207
[52] World Health Organization. (n.d.). *Social isolation and loneliness*. WHO Retrieved May 23, 2025, from https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/social-isolation-and-loneliness
[53] Meta & Gallup. (2023). *The Global State of Social Connection* [Report]. Meta & Gallup.
[54] Centers for Disease Control and Prevention. (n.d.). *Health effects of social isolation and loneliness*. U.S. Department of Health and Human Services. Retrieved May 22, 2025, from https://www.cdc.gov/social-connectedness/risk-factors/index.html
[55] Zeisse, C. (n.d.). Mayors unite to launch 'Tampa Bay Connections'. *Tampa Bay Thrives*. https://tampabaythrives.org/blog/mayors-unite-to-launch-tampa-bay-connections/
[56] Abel, J. (2021, November 28). The Frome model. *Compassionate Communities UK*. https://compassionate-communitiesuk.com/2021/11/28/the-frome-model/

across sectors, b) mapping existing resources, c) launching an awareness campaign, d) advocating for increases in targeted funding, and e) developing measurement indices to track collective progress.

E. Suicide Prevention

In 2007, the Florida Statewide Office for Suicide Prevention (Section 14.2019, Florida Statutes) and the Florida Suicide Prevention Coordinating Council (Section 14.20195, Florida Statutes) were established. The Department of Children and Families publishes the Florida Suicide Interagency Action Plan, highlighting the importance of increasing safety through lethal means reduction. Additional resources are provided through the 2024 Suicide Prevention Coordinating Council Annual Report. Readers are encouraged to review this report to gain a broader understanding of Florida's ongoing efforts.

F. Protective Factors

There is substantial literature on protective factors for the mental health of children, and specifically for children of parents with behavioral health disorders, including substance use disorders.[57, 58, 59, 60] Resiliency is a concept related to protective factors. The American Psychological Association defines resiliency as "[t]he process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands. Several factors contribute to how well people adapt to adversities, predominant among them (a) how individuals view and engage with the world, (b) the availability and quality of social resources, and (c) specific coping strategies." The authors of a systematic review of resilience and mental health research concluded from their review of 25 relevant studies that:

> "Resilience is strongly associated with mental health in children and adolescents and deserves a more prominent role in research, prevention programs and routine clinical care. Including social, cultural and family context in the evaluation of resilience is of great value, as this can identify targets for early and preventive interventions." (Mesman, Vreeker, & Hillegers, 2021, p. 586)[61]

The authors of a scoping review that included 24 studies of resilience of transition-aged youth (16-29 years old) stated that:

> "The study of resilience provides a unique framework for understanding the complex personal factors and systems that contribute to youth mental health. Particularly, adopting a resilience perspective may re-frame and de-pathologize conceptions of youth with [serious mental illness], turning our attention towards one's strengths, values, and resources, in contrast to a sole focus on individual risks or impairment" (Nesbitt and colleagues, 2023).[62]

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[57] Samji, H., Long, D., Herring, J., Correia, R., & Maloney, J. (2024). Positive childhood experiences serve as protective factors for mental health in pandemic-era youth with adverse childhood experiences. *Child Abuse & Neglect*, Article 106640. https://doi.org/10.1016/j.chiabu.2024.106640

[58] Van Schoors, M., Van Lierde, E., Steeman, K., Verhofstadt, L. L., & Lemmens, G. M. D. (2023). Protective factors enhancing resilience in children of parents with a mental illness: a systematic review. *Frontiers in psychology*, *14*, 1243784. https://doi.org/10.3389/fpsyg.2023.1243784

[59] Wlodarczyk, O., Schwarze, M., Rumpf, H.-J., Metzner, F., & Pawils, S. (2017). Protective mental health factors in children of parents with alcohol and drug use disorders: A systematic review. *PloS One*, *12*(6), e0179140. https://doi.org/10.1371/journal.pone.0179140

[60] Mesman, Vreeker, and Hillegers (2021) stress the importance of "the application of longitudinal studies and innovative measurement techniques will improve our understanding on the cascade effects of stressors on resilience and mental health outcomes" p. 586.

[61] Mesman, E., Vreeker, A., & Hillegers, M. (2021). Resilience and mental health in children and adolescents: an update of the recent literature and future directions. *Current Opinion in Psychiatry*, *34*(6), 586–592.

[62] Nesbitt, A. E., Sabiston, C. M., deJonge, M. L., Barbic, S. P., Kozloff, N., & Nalder, E. J. (2023). A scoping review of resilience among transition-age youth with serious mental illness: tensions, knowledge gaps, and future directions. *BMC Psychiatry*, *23*, Article 66.

Florida continues to emphasize resiliency through several statewide initiatives. The Florida Department of Education's Resiliency Florida provides resiliency-focused reading lists for pre-kindergarten through grade 12, information about resiliency and mental health resources, and coordinates the volunteering of resiliency coaches. Additionally, the Florida Department of Children and Families supports resiliency through its Hope Florida initiative, which connects individuals and families to services through the assistance of Hope Navigators. Hope Navigators support Floridians with their own identified needs to create an individualized path to prosperity, economic self-sufficiency, and hope. This approach focuses on community collaboration among the private sector, faith-based community, nonprofits, and government entities, breaking down traditional community silos to maximize resources and uncover opportunities.

It is essential to recognize that the role of resilience in mental health remains an ongoing topic of discussion. While fostering resilience is a valuable component of support, it represents only one aspect of support children may need to navigate the complex challenges they face. Therefore, funding of resiliency-based initiatives must be complemented by adequate funding for a full spectrum of services that support both children and their families.

In Spring 2023, the first Florida-specific Youth Survey, focusing on health education, including resiliency, was completed.[63] This survey has two main sections to understand the health of students in Florida. There were 3,609 students from the 2022-2023 school year who completed the Youth Survey. Scores were based on a Likert scale with answers ranked as 1 being never and 5 being almost always. The means of the responses were categorized as low (1-2.49), medium (2.5-3.49), and high (3.5-5), with "high" being the more positive outcome in this case. The mean general resilience score was high at 3.74. Of the qualities included in resiliency, gratitude was the highest at 4.23, and citizenship was the lowest at 3.01. This survey will be administered again in Spring 2025.

G. Florida Metrics

Mental Health America and the Annie E. Casey Foundation provide valuable comparative metrics that highlight Florida's performance relative to other states and the nation overall on issues related to the behavioral health of children. The factors related to these rankings can be further explored to identify areas that could be focused upon to improve the lives of Florida's children. While these metrics address broader societal issues, many of the underlying factors directly impact behavioral health and, therefore, the use of involuntary examination of children.

Mental Health America's The State of Mental Health in America (2024, p. 12) includes a state-by-state ranking of youth mental health based on seven distinct measures.[64] Florida ranked 22nd nationally. The highest-ranking jurisdictions were the District of Columbia (1st), Connecticut (2nd), and Massachusetts (3rd), while Oregon (49th), Arizona (50th), and Nevada (51st) were ranked lowest.

The Annie E. Casey Foundation's 2025 Kids Count Data Book provides an annual ranking of states based on overall child well-being, as well as performance across four specific topics, shown in Table 4. Each topical metric is comprised of measures of four constructs, detailed in the Interactive 2025 Kids Count Data Book.

[63] See https://www.fldoe.org/schools/k-12-public-schools/sss/fl-youth-survey.stml

[64] The seven metrics for this youth index and how Florida ranks on each are as follows: 1) youth with at least one major depressive episode (MDE) in the past year (35th), 2) youth with substance use disorder in the past year (13th), 3) youth with serious thoughts of suicide (27th), 4) youth (ages 6-17) flourishing (16th), 5) youth with MDE who did not receive mental health services (15th), 6) youth with private insurance that did not cover mental or emotional problems (27TH), and 7) students (k+) identified with emotional disturbance for an individualized (40th).

Table 5: Kids Count Metrics for Five Years

Metrics	2021	2022	2023	2024	2025
Overall Well-Being	35	35	31	30	35
Economic Well-Being	42	42	37	42	43
Education	12	13	5	5	19
Health	31	35	33	31	32
Family and Community	32	32	32	30	30

Many of these metrics can be associated with behavioral health challenges, either as a cause or an effect of mental illness and co-occurring mental health and substance use issues. The 16 individual measures that comprise the four overarching metrics reflect complex, multifaceted problems. They are related to broad societal issues, such as variability in wealth and access to resources, as well as policy decisions and investments. While these factors are beyond the scope of this report, they represent important contextual considerations in understanding the factors that influence the use of involuntary examination involving children.

IX. Discussion and Recommendations

In general, the Baker Act Reporting Center recommends considering services and initiatives that can address the "relevant related topics" described in this report. The Baker Act Reporting Center recommends that the Florida Center for Behavioral Health Workforce consider how the Center can address workforce shortages in children's mental health, particularly in acute care settings.

Legislative Initiatives: Meeting the needs of children with repeated involuntary examinations can be furthered by continued monitoring and reporting on system improvement strategies that include:

- Establishing and funding a statewide case management system for high utilizers.
- Implementing a real-time alert mechanism for timely intervention.
- Expanding cross-agency data sharing and care coordination.
- Enhancing family engagement in voluntary care.
- Increasing training on FERPA and HIPAA for appropriate information sharing.

Recommendations from Baker Act Receiving Facility Staff Interviews: Based on a review of participant responses, recommendations to address family needs and improve system collaboration are as follows:

- Consider funding for family navigator positions to assist families in follow-up care and support them in learning about strategies and resources to address children's needs.
- Increase awareness of Mobile Response Teams and expand police co-response models to provide better clinical evaluation and support for children experiencing mental health crises during police calls for service.
- Embed therapists and care coordinators in schools with high numbers of Baker Acts to provide dedicated mental health evaluation and support to children and connect them with needed services.
- Continue existing training and provide continuing education for police, school personnel, and other clinicians around appropriate inclusionary and exclusionary criteria for the Baker Act.
- Disseminate data/recommendations to county and statewide mental health collaboratives or interagency groups.
- Consider developing parenting classes with a focus on children with ADHD, ODD, and Autism, or if these resources exist, recommend them to relevant parents and caregivers.

Document Review: Review of documents led to the following recommendations:

Data Use and Form Content: The following recommendations pertain to the formatting of required involuntary examination initiation forms and data use.

1. *Proactive Use of the BADCS Data*

The Department's Baker Act Data Collection System (BADCS) presents a unique opportunity to identify children who have undergone repeated involuntary examinations, allowing for targeted and coordinated efforts to address their needs. The involuntary examination data used for this report are unique in that they include data on involuntary examinations of both uninsured and insured children, including children with Medicaid. While the data includes children regardless of their funding source, the funding source is not identified in the data and requires a manual matching process.

Managing Entities do not have access to data of children who are insured or have Medicaid, and only Department staff have access to the BADCS data. To remediate this, the Baker Act Reporting Center could integrate the secure transfer of spreadsheets showing information about children who meet a certain threshold of repeated involuntary examinations into its contractually required quarterly reporting to the Department. Implementing efforts to sustain service delivery or coordination would require funding to provide the necessary staffing resources.

2. *Additional Data and Collaboration with the Florida Behavioral Health Care Data Repository*

Incorporating additional data sets for future analyses would enhance understanding of the factors associated with involuntary examinations of children. As of 2024, both child welfare data and Medicaid data are required to be included in this report. Data must be provided to the Baker Act Reporting Center well in advance of reporting deadlines to ensure sufficient time for analysis.

Access to Child Welfare and Medicaid data, provided in advance of the reporting deadlines, would significantly strengthen analyses. Even a few variables can be highly informative – for example, whether a child was in out-of-home placement at the time of an involuntary examination or had prior involvement with Florida's child welfare system. For Medicaid, useful indicators include whether the child was enrolled at the time of examination and whether they had ever been enrolled. Following a longitudinal analysis of cohorts, such as children who experienced an involuntary examination five years ago, linked with Florida Department of Health death records, could provide critical insights. Understanding the timing and nature of the deaths within this population, while rare, would help address an important area of concern.

Having information about the day of their involuntary examination or even if their children received various services (such as those listed in Appendix C) can help us to learn about the impact of these programs on children's lives. Furthermore, more nuanced analyses can be conducted to examine various services provided by Managing Entities and services funded by Medicaid (some of which may include different services being provided during the same time period). The institute is committed to pursuing these data acquisition and analysis efforts, contingent upon the availability of funding and resources. Funding for these tasks constitutes a modest increase in the current budget of the Baker Act Reporting Center. Collaborating with the Florida Behavioral Health Care Data Repository, which is being created as specified in House Bill 1207 (2025) and is an outcome of the Commission on Mental Health and Substance Use Disorders, can facilitate data access and enhance the nature of data analyses that can be applied to the issue of repeated involuntary examination of children.

3. Forms

Forms used to initiate involuntary examinations are part of Section 65E-5, Florida Administrative Code (see 65E-5.280, F.A.C.). These forms may only be revised through a formal rulemaking process. The Department of Children and Families follows the process established in Chapter 120, F.S. and noticed the public of workshop and rule development activities through the Florida Administrative Register. The Department made several updates to these forms in recent and is currently revising several more to reflect statutory changes enacted in 2024 and 2025. In accordance with Chapter 120, F.S. the Department holds public workshops to review all proposed changes to administrative rules and incorporated forms. The public is notified of workshops and hearings through the Florida Administrative Register. Anyone from the public and interested stakeholders can participate and provide feedback for the Department's consideration prior to adopting changes.

4. BADCS (Involuntary Examination) Data

The Baker Act Reporting Center is currently working with Department staff to enhance the Baker Act Data Collection System (BADCS).[65] The focus is on revising the structure and options for certain variables (such as the "prior location" variable), considering the utility of including optional variables given their low percentage of completion, entry of data from the Transportation to Receiving Facility form (CF-MH 3100), and updates due to changes in forms, such as the inclusion of an option on the law enforcement (CF-MH 3052a) and health professional (CF-MH 3052b) forms to indicate that the involuntary examination was initiated at school, a school sponsored event, or on school transportation.

5. Report Due Dates

Modifying statutory and contractual due dates would allow for more complete reporting, including:

- **Florida Department of Education data:** Adjusting the statutory due date from July 1 to a date further out in time, such as August 1, for involuntary examination occurring in school settings, such as on school transportation, or at a school-sponsored activity would allow for full inclusion of cases through the fiscal year ending June 30 as specified in Section 1006.07(10), Florida Statutes. The current due date of July 1 makes it difficult to produce complete data.
- **Institute Report:** Aligning statutory due dates with contractual report deadlines would improve the completeness of the reports when submitted to the Department of Children and Families within a more reasonable timeframe.
    - Including complete data through the end of the fiscal year (June 30) means that enough time needs to pass for receiving facilities to enter data into the BADCS for the data for the fiscal year to be complete. Although the statute requires receiving facilities to enter data within five days of an individual's arrival, this is not always the case. BADCS remains open for editing by receiving facility staff. Records may be incomplete pending the receiving facility staff tracking down specific information. The proposed changes in Table 6 would increase the likelihood of complete data, enable the inclusion of data for the most recent fiscal year in the Report of Repeated Involuntary Examinations of Minors, and distribute the workload more evenly in relation to the Baker Act Reporting Center's funding and staffing.

[65] See Appendix E for graphics of the BADCS data entry screens.

Table 6: Current and Proposed Report Due Dates

Report	Current		Proposed	
	Contractual Due Date to the Department	Institute's Statutory Due Date	Contractual Due Date to the Department	Institute's Statutory Due Date
Repeated Involuntary Examinations of Minors	July 1 (odd years)	November 1 (odd years)	November 1 (odd years)	December 15 (odd years)
Baker Act Annual Report	November 1	November 15	January 15 (even years)	March 1 (even years)
Marchman Act Annual Report	November 15	December 31	February 1 (even years)	March 1 (even years)

Structure of Baker Act Reporting and Center Funding: Direct funding of the Baker Act Reporting Center is a suggestion, with no approval from the Department of Children and Families required for the release of reports. This would remove the requirement for the Department to approve Baker Act Reporting Center reports prior to their release. While this is not currently required by statute, the University of South Florida's (Baker Act Reporting Center) contract with the Department specifies that such approval must be obtained prior to publication of the report.

Report Due Dates: The due dates for the Baker Act Annual Report and the Marchman Act Annual Report are too close in time. This is an even more acute issue in odd-numbered years, when we are typically required to edit the Report of Repeated Baker Act Examinations of Minors close to its due date after the Department provides its feedback. Moreover, this is also during the time we are completing the annual reports. This means the finalization of reports is done in several weeks during the Fall. Requiring the Baker Act Annual Report and the Marchman Act Annual Report to be submitted several months later, beyond June 30, will lead to more complete data. Changing these reports from annual to bi-annual will provide more time for additional qualitative and quantitative analyses. The due dates of March 15th for the two annual reports to be posted online mean they would be available before the beginning of legislative sessions in even-numbered years. The proposed change in the due date for the report on Repeated Involuntary Examinations of Minors means that this report would be available before the beginning of legislative sessions in odd-numbered years.

X. Appendices

Appendix A: Selected, Relevant Statutory Changes[66]

The content of this figure does not comprehensively cover all changes in the Baker Act relevant to minors. A summary of changes is provided. There is a hyperlink to each bill listed below. For example, click on "SB 1518" to go to a page that provides the bill text and history for Senate Bill 1518 from 2013, as well as analyses of this bill. Text in bills that is underlined is new text. Text stricken out is to be deleted. This content is also available in a timeline on the Baker Act Reporting Center website. HB = House Bill and SB = Senate Bill

1971: HB 665	• Created the Florida Mental Health Act (Baker Act) that addressed voluntary and involuntary examinations and treatment services for adults and minors.
1996: HB 903	• Required all Baker Act receiving facilities to submit involuntary examination initiation forms to the Florida Agency for Health Care Administration (AHCA). The Baker Act Reporting Center at USF was created to receive and enter data from documents on behalf of AHCA.
2013: SB 1518	• After a pilot program in 2008, Managing Entities (MEs) were established across Florida to create more accountability and ensure quality mental health services were available. MEs took over several functions from the Department of Children and Families, including contracting with publicly funded Baker Act receiving facilities for their provision of service.
2016: SB 12	• Created a "no wrong door" model, expanded Managing Entities' responsibilities, and changed the recipient of involuntary examination initiation documents from AHCA to the Florida Department of Children and Families. Rule 65E-5 F.A.C. named the Baker Act Reporting Center to continue receiving these documents to enter data from and report on.
2017: HB 1121	• Required facilities to initiate an involuntary examination of a minor within 12 hours after arrival and created a task force to address the involuntary examination of children.
2018: SB 7026	• The Marjory Stoneman Douglas School Safety Act created the Office of Safe Schools, expanded Mobile Response Teams (MRTs) and Community Action Teams (CAT), and required a Centralized Integrated Data Repository, the Florida Safe Schools Portal.
2019: SB 7030	• Implemented recommendations from the Marjory Stoneman Douglas Public Safety Commission and required school districts to develop a multi-tiered system of support to deliver mental health care.
2020: HB 945	• Required highest utilizers of care who were 25 years of age and younger to be identified and provided services through Mobile Response Teams.
2022: SB 1844	• Allowed minors to assent to voluntary admission after a clinical review, rather than requiring a hearing about the minor's consent. Required law enforcement to use the least restrictive restraints when transporting.
2024: HB 7021	• Created the Office of Children's Behavioral Health Ombudsman, added requirements for a comprehensive and personalized discharge process, and changed language to state that law enforcement "may," instead of "shall," initiate involuntary examinations, giving law enforcement more discretion to decide whether to initiate an involuntary examination.
2025: HB 969	• Required the evaluation of school mental health services and supports.

[66] The text of House Bill 665 is available in the *1971 Summary of General Legislation*, published by the Florida Legislative Bureau. This content starts on p. 76 of the report, which is p. 84 of the document. The text of House Bill 665 is available in a summary of legislation from 1996 published by the Joint Legislative Management Committee. This content begins on page 243 of the report, which is p. 259 of the document. Additional relevant information about statutory changes is available on the Florida Department of Education's Safe Schools website, specifically regarding the Marjory Stoneman Douglas High School Public Safety Act and Related School Safety Legislation.

Appendix B: Florida Department of Education Counts of Involuntary Examinations

The Florida Department of Education is required to provide counts of involuntary examinations as specified in 1006.07(10), F.S.

> 1006.07(10) REPORTING OF INVOLUNTARY EXAMINATIONS.—Each district school board shall adopt a policy to require the district superintendent to annually report to the department the number of involuntary examinations, as defined in s. 394.455, which are initiated at a school, on school transportation, or at a school-sponsored activity. By July 1 of each year, the department shall share such data received from school districts during the previous year with the Department of Children and Families.

The Florida Department of Education's Public Schools/Districts webpage provides links to a list of schools in each district and to each district's homepage.

Counts lower than ten were redacted to protect people from being identified.

Districts		Fiscal Year 2023-2024				Fiscal Year 2024-2025			
		Counts of Involuntary Examinations				Counts of Involuntary Examinations			
District Number	District Name	School Grounds	School Transportation	School Sponsored Events	Counts of Students	School Grounds	School Transportation	School Sponsored Events	Counts of Students
1	Alachua	15	0	0	12	<10	0	0	<10
2	Baker	<10	0	0	<10	0	0	0	0
3	Bay	41	0	0	36	38	0	0	35
4	Bradford	12	0	0	12	18	0	0	15
5	Brevard	85	0	0	72	72	0	0	66
6	Broward	205	<10	<10	183	313	0	<10	263
7	Calhoun	<10	0	0	<10	<10	0	0	<10
8	Charlotte	59	0	0	43	40	0	0	34
9	Citrus	37	<10	0	34	21	<10	0	22
10	Clay	24	0	0	22	31	0	<10	21
11	Collier	128	0	0	114	136	0	0	121
12	Columbia	27	<10	0	25	38	0	0	34
13	Dade	198	<10	<10	170	172	0	<10	157
14	DeSoto	21	0	0	20	14	<10	0	14

Districts		Fiscal Year 2023-2024				Fiscal Year 2024-2025			
District Number	District Name	Counts of Involuntary Examinations			Counts of Students	Counts of Involuntary Examinations			Counts of Students
		School Grounds	School Transportation	School Sponsored Events		School Grounds	School Transportation	School Sponsored Events	
15	Dixie	<10	0	0	<10	10	0	0	<10
16	Duval	126	<10	0	105	109	<10	0	91
17	Escambia	38	0	0	33	38	0	0	36
18	Flagler	64	0	0	55	61	0	0	54
19	Franklin	<10	0	0	<10	0	0	0	0
20	Gadsden	<10	0	0	<10	0	0	0	0
21	Gilchrist	<10	0	0	<10	<10	0	0	<10
22	Glades	<10	0	0	<10	<10	0	0	<10
23	Gulf	<10	0	0	<10	<10	0	0	<10
24	Hamilton	0	0	0	0	<10	0	0	<10
25	Hardee	<10	0	0	<10	<10	0	0	<10
26	Hendry	11	0	0	10	13	0	0	11
27	Hernando	50	0	0	41	38	0	0	36
28	Highlands	27	0	0	26	24	0	0	22
29	Hillsborough	133	<10	0	119	167	0	0	146
30	Holmes	12	0	0	12	15	0	0	15
31	Indian River	21	0	0	21	52	0	0	47
32	Jackson	32	0	0	29	45	0	0	32
33	Jefferson	<10	0	0	<10	<10	0	0	<10
34	Lafayette	<10	0	0	<10	<10	0	0	<10
35	Lake	76	<10	0	63	74	0	0	69
36	Lee	167	<10	<10	150	160	0	0	141
37	Leon	89	<10	<10	86	75	0	0	61
38	Levy	15	0	0	13	10	0	0	<10
39	Liberty	<10	0	0	<10	<10	0	0	<10

Districts		Fiscal Year 2023-2024				Fiscal Year 2024-2025			
District Number	District Name	Counts of Involuntary Examinations			Counts of Students	Counts of Involuntary Examinations			Counts of Students
		School Grounds	School Transportation	School Sponsored Events		School Grounds	School Transportation	School Sponsored Events	
40	Madison	16	0	0	14	<10	0	0	<10
41	Manatee	<10	0	0	<10	21	0	0	20
42	Marion	186	0	0	163	197	0	<10	167
43	Martin	27	0	0	24	19	0	0	17
44	Monroe	<10	0	0	<10	<10	0	0	<10
45	Nassau	30	0	0	24	<10	0	0	<10
46	Okaloosa	26	0	0	21	20	0	0	20
47	Okeechobee	26	0	0	22	39	0	0	39
48	Orange	178	0	0	162	137	0	<10	118
49	Osceola	19	0	0	16	24	<10	0	21
50	Palm Beach	129	<10	0	113	147	0	0	124
51	Pasco	62	0	0	59	45	0	0	43
52	Pinellas	198	0	0	163	201	0	<10	173
53	Polk	118	0	0	103	45	0	0	44
54	Putnam	16	0	0	16	16	0	0	16
55	St. Johns	26	0	0	22	31	0	0	28
56	St. Lucie	46	<10	<10	41	48	0	0	45
57	Santa Rosa	114	0	0	106	83	0	0	76
58	Sarasota	74	<10	0	63	94	0	0	75
59	Seminole	31	0	0	29	54	0	0	46
60	Sumter	18	0	<10	15	<10	0	0	<10
61	Suwannee	30	0	0	24	28	<10	0	27
62	Taylor	17	0	0	15	12	0	0	<10
63	Union	<10	0	0	<10	<10	<10	0	<10
64	Volusia	121	<10	0	100	70	<10	0	66

Districts		Fiscal Year 2023-2024				Fiscal Year 2024-2025			
District Number	District Name	Counts of Involuntary Examinations			Counts of Students	Counts of Involuntary Examinations			Counts of Students
		School Grounds	School Transportation	School Sponsored Events		School Grounds	School Transportation	School Sponsored Events	
65	Wakulla	<10	0	0	<10	10	0	0	10
66	Walton	24	0	0	21	16	0	0	13
67	Washington	12	<10	0	11	15	0	0	13
68	Florida School for the Deaf & the Blind	0	0	0	0	<10	0	0	<10
71	FLVS	0	0	0	0	<10	0	0	<10
72	FAU Lab School	0	0	0	0	0	0	0	0
73	FSU Lab School	<10	0	0	<10	<10	0	0	<10
74	FAMU Lab School	0	0	0	0	0	0	0	0
75	UF Lab School	<10	0	0	<10	0	0	0	0
76	Department of Corrections	*Not included in FY 2023-2024 Reporting*				0	0	0	0
80	IDEA Public Schools					0	0	0	0
81	TSC					0	0	0	0
82	FSU Bay					0	0	0	0
N/A	**Florida**	**3,345**	**18**	**<10**	**2,933**	**3,226**	**10**	**<9**	**2,837**

Appendix C: Brief Summary of Initiatives and Services

Note that underlined text indicates a hyperlink to a relevant page on the Department's website.

Hope Florida: A Pathway to Prosperity

Hope Florida utilizes Hope Navigators to guide Floridians on an individualized path to prosperity, economic self-sufficiency, and hope. This approach focuses on community collaboration among the private sector, faith-based community, nonprofits, and government entities, breaking down traditional community silos to maximize resources and uncover opportunities. These 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 federally 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) is a Florida KidCare program developed in partnership with the Department of Health and the Department of Children and Families. BNet is a statewide network of 14 behavioral health service providers serving children 5 to 18 years 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.[67]

Dashboard: Note that the Department provides an interactive dashboard that shows the locations of services relevant to children, such as Community Action Teams (CAT), Florida Assertive Community Treatment Teams (FACT), Family Intensive Treatment Teams (FIT), and Mobile Response Teams (MRT).

Community Action Treatment (CAT)

Community Action Treatment (CAT) Teams provide comprehensive, intensive community-based treatment to families with youth 11-21 years, 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/have not been adequate. CAT teams employ a multidisciplinary clinical team approach, providing round-the-clock on-call care availability outside of regular business hours, 365 days a year.[68]

Coordinated Specialty Care (CSC) Early Psychosis

Coordinated Specialty Care (CSC) is a recovery-oriented treatment program for people with first-episode psychosis (FEP). CSC promotes shared decision-making and utilizes a team of specialists who work with the participant to create a personalized treatment plan.

Family Intensive Treatment (FIT)

[67] https://www.sunshinehealth.com/members/cms/benefits-services/florida-behavioral-health-network.html
[68] https://centerstone.org/programs/childrens-community-action-treatment-cat-team/

Family Intensive Treatment (FIT) provides intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental, substance abuse. The program serves families that have been determined to be unsafe with children under the age of ten. Child welfare professionals, including child protective investigators, child welfare case managers, or community-based care lead agencies can make referrals for services.

Florida Assertive Community Treatment (FACT)

FACT teams in Florida promote independent, integrated living for adults serious mental illness who have not responded well to traditional treatment. FACT teams offer a 24/7, multidisciplinary approach to deliver comprehensive, community-based care to people where they live, work, attend school, and spend their leisure time. The programmatic goals of this program include enhancing participants' quality of life and community involvement, as well as preventing recurrent hospitalizations and incarceration.

Lifeline and 988

In July 2022, a new three-digit code, 988, was implemented nationwide for landlines and cell phones for people in emotional distress or suicidal crisis. The 988 Florida Lifeline is a network of local crisis centers with staff who are trained to provide free and confidential emotional support and crisis counseling to people experiencing a suicidal crisis or emotional distress and connect them to resources. People may also contact the Lifeline via text and chat using 988. Additionally, the Department provides free and readily available resource information and a marketing toolkit online at 988floridalifeline.com.

Mobile Response Teams

There are now over 50 Mobile Response Teams (MRTs) that provide crisis intervention services to individuals of all ages 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 and other relevant skills. Services offered include evaluation and assessment, development of safety or crisis plans, provision of or facilitation of stabilization services, supportive crisis counseling, education, development of coping skills, linkage to appropriate resources, and connection of individuals who require more intensive mental health and substance use services to the necessary level of care.[69]

[69] 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 D: Finding Services, Education/Training, and Other Support

The following resources are available to help you learn about topics relevant to this report and locate relevant services. Clicking on the underlined text will bring you to the relevant web page for that topic.

988 Florida Lifeline

The 988 Florida Lifeline (formerly known as the National Suicide Prevention Hotline) "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 more information can be found at 988floridalifeline.com

For Deaf and Hard of Hearing: For TTY, use your preferred relay service or dial 711 then 988.

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 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

US Department of Health and Human Services FindTreatment.gov

US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Relief Information

National Institute of Mental Health "Help for Mental Illness" Web Page:
Provides information about and links to resources for getting immediate help in a crisis, finding a healthcare provider or treatment, determining if a provider is right for you, participating in research, and learning more about mental disorders. Contact information is provided, including for live online chat.

American Foundation for Suicide Prevention: Suicide Prevention Resources

National Alliance on Mental Illness (NAMI)

Mental health support, training, education, and advocacy. Find Your Local NAMI

Peer Support Coalition of Florida

Loneliness/Social Connection:

Centers for Disease, Control and Prevention resources: Loneliness and Improving Social Connections, Coalition to End Social Isolation and loneliness: Resources and Research

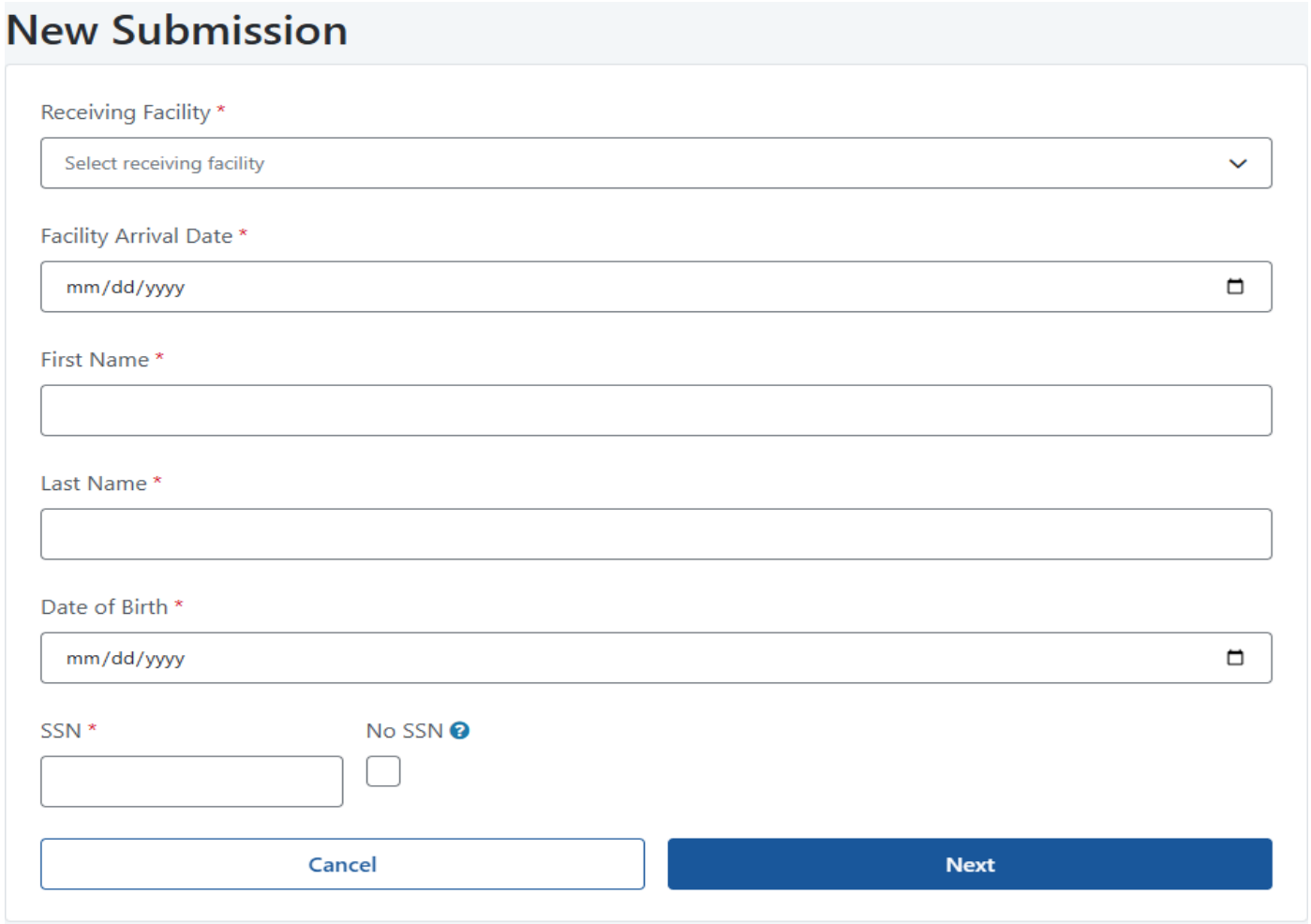
Social Media:

The U.S. Surgeon General's Social Media and Youth Mental Health Advisory provides guidance to take action, such as for children (p. 18) and their parent or caregivers (p. 17)

Appendix E: Graphics of BADCS Entry Screens

Data must be entered into this data entry screen to create a record (see Figure D1). The information entered here is compared to existing data in the database to determine if a record for this involuntary examination already exists.

Figure D1: Initial Entry Screen



The following three figures make up the main entry screen of the BADCS. They are shown here as three separate figures for ease of presentation.

Figure D2a: Main Entry Screen – Part I

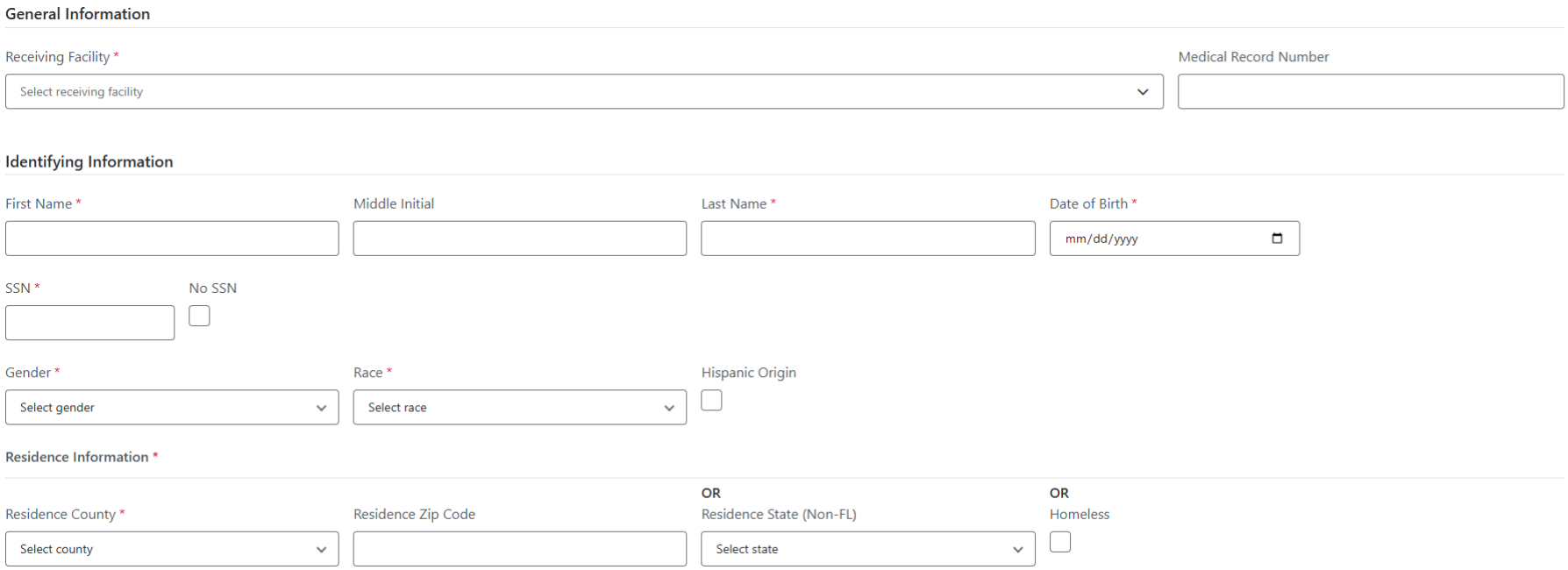


Figure D2b: Main Entry Screen – Part II

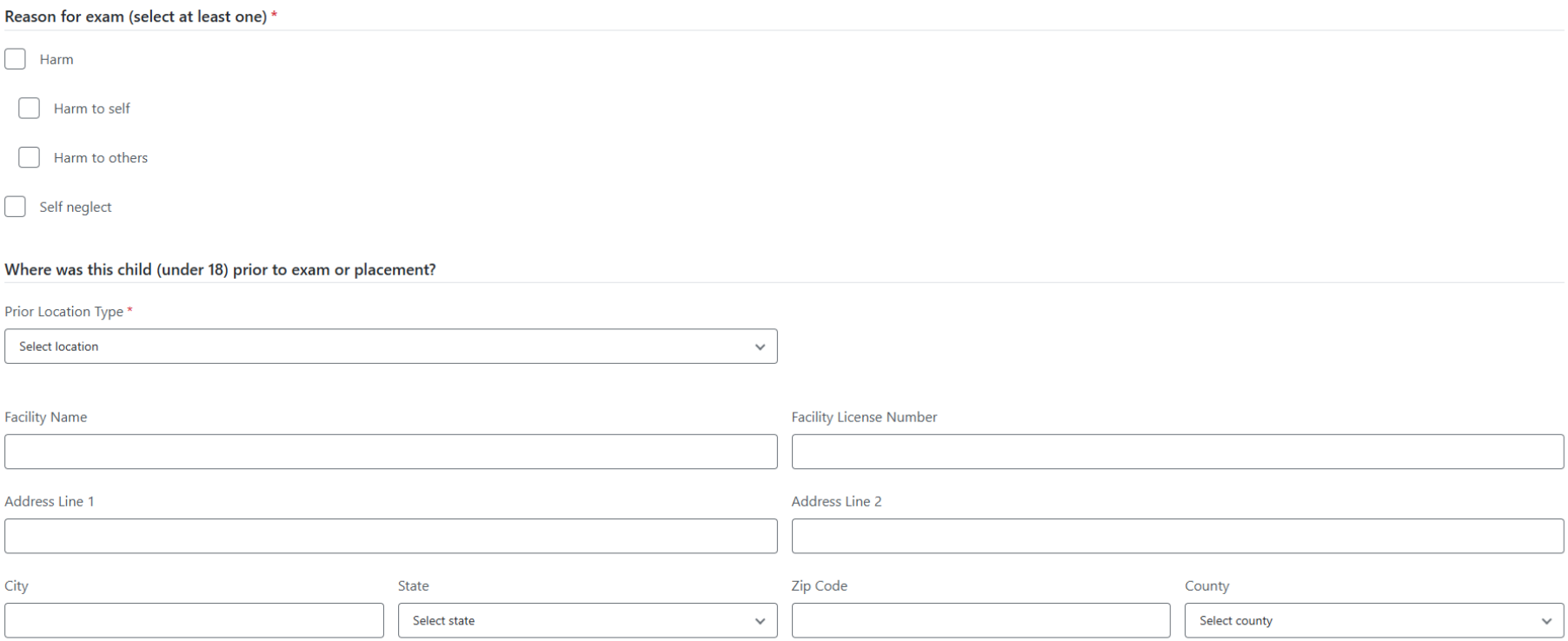
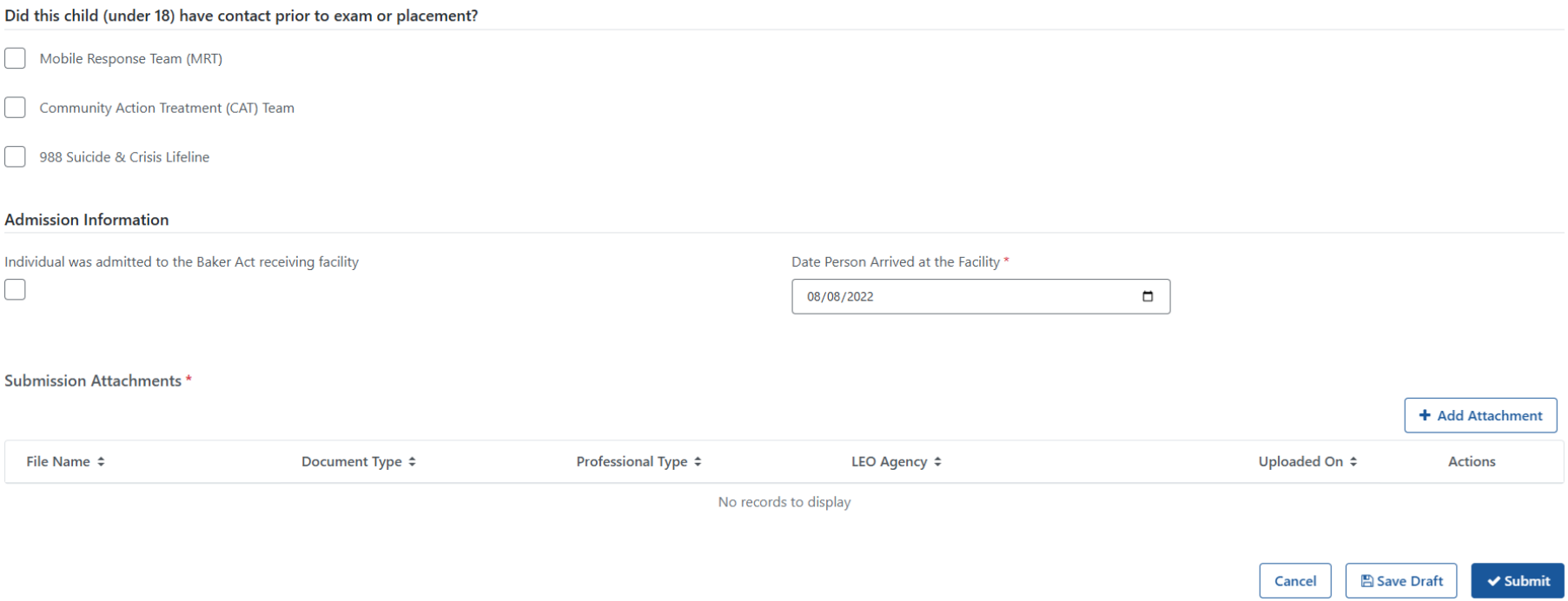
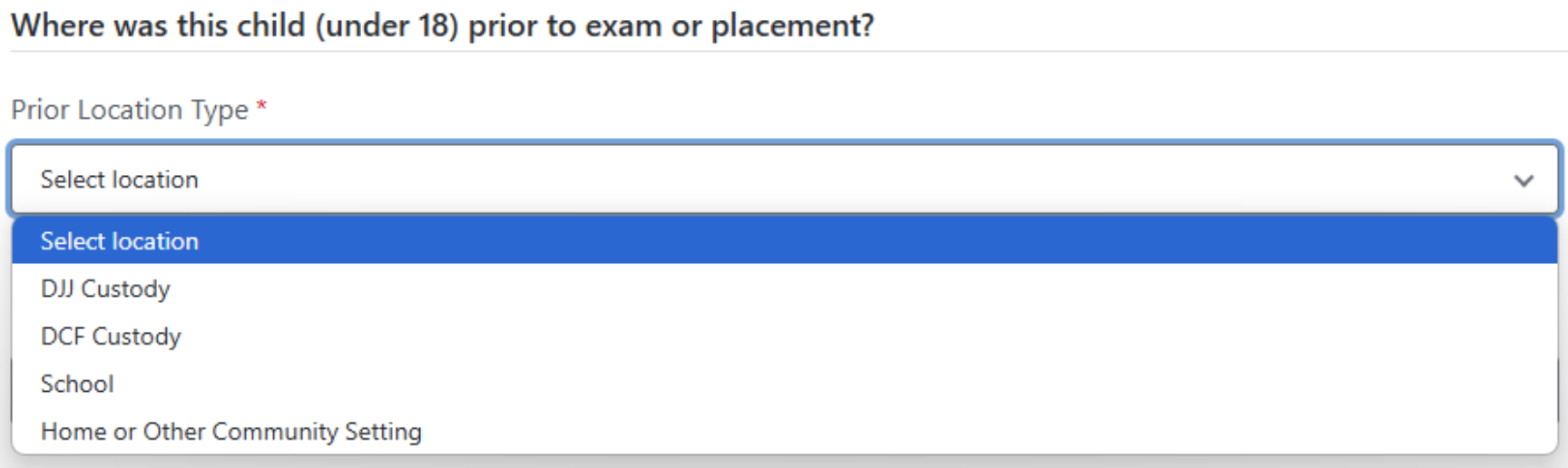


Figure D2c: Main Entry Screen – Part III



The options for the variable about the location of the child prior to the involuntary examination are shown in Figure D3. Note that the BADCS is not used to enter data for involuntary inpatient placements. The inclusion of the word “placement” here is in error.

Figure D3: Values for Location Variable



Appendix F: Qualitative Interview Protocol

Involuntary (Baker Act) Examinations of Minors: Receiving Facility Staff Interview Guide

Interviewee/s:	Interviewer/s:
Facility:	Region:
Date:	Time:

Script for Informed Consent

Thank you for taking the time to participate in this interview today. My name is _____, and on the call with me is _____. We are with the Baker Act Reporting Center at USF, which is operated on behalf of the Florida Department of Children and Families (DCF). The Center collaborates with DCF to create three statutorily required reports – Baker Act Annual Report, Marchman Act Annual Report, and Repeated Baker Act Examinations of Minors Biennial Report. As part of this collaboration, we are conducting virtual interviews to explore the community and system-level factors that impact repeated involuntary examinations among minors. We're conducting interviews with staff from Baker Act receiving facilities throughout Florida to learn more about patterns related to repeated involuntary examinations among minors.

You are being asked to take part in this evaluation because you have been identified as a staff member who is directly involved in processes or policies related to involuntary examinations among children or youth at your facility.

Before we begin, let me ask: Have you had a chance to review the informed consent document that was sent to you recently by email? (*If the participant has not reviewed the informed consent form, offer to review the informed consent form with them on the call or to reschedule the interview*).

As part of this interview, we'll ask questions about what kinds of challenges may be associated with readmissions, what kinds of individual, family, and community factors may be involved, the extent to which an adequate service array is in place, any gaps in services that need to be addressed, and opportunities for improvement in children's mental health and crisis services. We expect this interview to last between 30 to 45 minutes. I want to emphasize that your name will not be used in any reports about the interviews and no quotes will be attributed to you. These same questions will be asked of other interview participants who are in similar roles and we will summarize themes across responses.

Do you have any questions about your participation in this interview?

Are you willing to continue?
Yes (Proceed to next question)
No (Thank the individual and end the call)

[IF YES]: Great, are you willing to have the interview recorded to ensure that we have an accurate record of the interview?

[IF NO]: Thanks for your consideration. I understand. We will keep track by taking notes.

Yes (Begin recording, proceed with the interview)
No (Proceed with the interview supported by note taker)

[START INTERVIEW]
Okay, let's get started.

Interview

1. To begin, could you please describe your role(s)?
2. In what ways are you involved in overseeing Baker Act processes or policies for minors?
3. Can you explain how voluntary examinations are handled at your facility?
    a. About how many voluntary examinations would you say you have on a weekly or monthly basis?
    b. Have there been any changes in the use of voluntary examinations with the statutory change in 2023 that led to voluntariness hearings no longer being required?
4. Is the issue of *repeated* Baker Act exams among children something that comes up in your role? If so, how?

Facility Data Review

We would like to review the data summary we sent related to children's involuntary examinations at your facility.

[SHARE SCREEN WITH DATA SUMMARY AND READ KEY INFORMATION]

5. To what extent does this data align with what you already know about repeated Baker Act exams among minors at your facility?
    a. Does anything stand out to you as noteworthy?

6. To what extent is there discussion at your facility around repeated Baker Act exams among minors?
    a. *(if it is discussed)* What kinds of efforts have there been to address this issue?
        i. (*Probe:* For example, through training, system coordination, work groups or task forces, etc.)

7. To what extent do you see differences in repeated Baker Act exams with regard to age?
    a. *Prompt:* For instance, do you see this as a bigger problem for a particular age group among children and youth?

8. To what extent do you see differences in repeated Baker Act exams with regard to setting?
    a. *Prompt*: For instance, do you see more repeat Baker Act exams coming from schools, foster care, the community, or another setting?

9. When you think of children or youth who have multiple Baker Act exams, what do you think are some of the top reasons for this?

    [PROBE IN THE FOLLOWING AREAS IF RESPONSE IS LIMITED]

    a. Home or family circumstances?
    b. Untreated behavioral health conditions?
    c. Professional training?
    d. Service availability or gaps?
    e. System coordination?
    f. Other reasons?

10. To what extent do you feel there is adequate service coordination to prevent repeat Baker Acts?
11. What kinds of prevention and early intervention services are in place to identify mental health needs for children?
    a. To what extent are these sufficient for families' needs?
12. What gaps or barriers are there in children's mental health services that might make it difficult for families to get comprehensive care?
13. To your knowledge, what ultimately happens with children or youth who have multiple Baker Act exams?
14. What recommendations do you have for how to address problems related to repeat Baker Act exams among minors?
15. Is there anything else you'd like to share or that we should ask regarding repeat Baker Act exams for children?

Thank you for your time. Please feel free to reach out if you have any additional thoughts or questions.

POST-INTERVIEW STEPS FOR INTERVIEWER:

- ❑ Update Interview Tracking Spreadsheet columns N through R
- ❑ Upload audio recording from Teams (detach audio using ClipChamp) to Audio Recordings folder
- ❑ Upload Teams transcript to Transcripts folder

Appendix G: Summary of Documents Used in Organizational Review

Document Set	Document Name
State of Florida Commission on Mental Health & Substance Use Disorder	
Access to Care Subcommittee Meeting Minutes	ATC Meeting Minutes_240227.pdf
	ATC Meeting Minutes_240326.pdf
	ATC Meeting Minutes_240423.pdf
	ATC Meeting Minutes_240528.pdf
Child and Youth Subcommittee Meeting Minutes	CAY Meeting Minutes_230517.pdf
	CAY Meeting Minutes_230531.pdf
	CAY Meeting Minutes_230628.pdf
	CAY Meeting Minutes_230712.pdf
	CAY Meeting Minutes_230726.pdf
	CAY Meeting Minutes_230809.pdf
	CAY Meeting Minutes_230906.pdf
	CAY Meeting Minutes_240202.pdf
	CAY Meeting Minutes_240315.pdf
	CAY Meeting Minutes_240410.pdf
	CAY Meeting Minutes_240508.pdf
	CAY Meeting Minutes_240603.pdf
	CAY Meeting Minutes_240710.pdf
	CAY Meeting Minutes-AP_230802.pdf
Data Analysis Subcommittee Meeting Minutes	Data Analysis Meeting Minutes_230517.pdf
	Data Analysis Meeting Minutes_230614.pdf
	Data Analysis Meeting Minutes_230913.pdf
	Data Analysis Meeting Minutes_240214.pdf
	Data Analysis Meeting Minutes_240410.pdf
Finance and Workforce Subcommittee Meeting Minutes	FAW Meeting Minutes_230524.pdf
	FAW Meeting Minutes_240208.pdf
	FAW Meeting Minutes_240314.pdf
	FAW Meeting Minutes_240411.pdf
	FAW Meeting Minutes_240606.pdf
	FAW Meeting Minutes_240711.pdf
System of Care Subcommittee Meeting Minutes	SOC Meeting Minutes_230525.pdf
	SOC Meeting Minutes_230627.pdf
	SOC Meeting Minutes_230720.pdf
	SOC Meeting Minutes_230809.pdf

Document Set	Document Name
System of Care Subcommittee Meeting Minutes *(continued)*	SOC Meeting Minutes_230922.pdf
	SOC Meeting Minutes_231018.pdf
	SOC Meeting Minutes_240131.pdf
	SOC Meeting Minutes_240327.pdf
Florida DCF Office of Substance Abuse and Mental Health Services	
Office of Substance Abuse and Mental Health Publications	2019 Florida Behavioral Health Workforce Survey-Final.pdf
	Behavioral Health ME's - Multiyear Review Final
	Community Action Team Guidance.pdf
	CSSUReport 2016.pdf
	DCF Substance Abuse and Mental Health FY 23-24 Catalog of Care.xlsx
	FINAL - Report on Executive Order 18-81 - Response to the Marjory Stoneman Douglas High School Tragedy.pdf
	FIT Report 2015 Final _013015.pdf
	FY 23-24 Catalog Caveats.pdf
	HB945.14 Standards of Care in Crisis Stabilization Services_2020.pdf
	High Utilization of Crisis Stabilization Services Children and Adolescents First Quarter Report July - September 2020.pdf
	High Utilization of Crisis Stabilization Services Children and Adolescents First Quarter Report July - September 2021.pdf
	High Utilization of Crisis Stabilization Services Children and Adolescents Fourth Quarter Report April - June 2021.pdf
	High Utilization of Crisis Stabilization Services Children and Adolescents Fourth Quarter Report April - June 2022.pdf
	High Utilization of Crisis Stabilization Services Children and Adolescents Second Quarter Report October - December 2021.pdf
	High Utilization of Crisis Stabilization Services Children and Adolescents Second Quarter Report October – December 2020.pdf
	High Utilization of Crisis Stabilization Services Children and Adolescents Third Quarter Report January - March 2021.pdf
	High Utilization of Crisis Stabilization Services Children and Adolescents Third Quarter Report January - March 2022.pdf
	Mobile Response Framework 2018.pdf
	Multi-Year Review Report SFY 19-20 and 20-21 - FINAL.pdf
	S17-005766-Task Force on Involuntary Examination of Minors.pdf
State of Florida Marjory Stoneman Douglas High School Public Safety Commission	
Marjory Stoneman Douglas High School Public Safety Commission Report and Agenda	MSD Safety Commission Report 1_2019.pdf
	MSD-Report-2-Public-Version.pdf
	MSDPSC-Agenda-July-30-31,-2024-Public.pdf

Document Set	Document Name
Florida Statewide Office of Suicide Prevention	
Statewide Office of Suicide Prevention Reports and Resources	2018 Annual Report of the Suicide Prevention Coordinating Council.pdf
	2019 Annual Report Suicide Prevention Coordinating Council FINAL.pdf
	2020 2023 Florida Suicide Prevention Interagency Action Plan.pdf
	2020 Suicide Prevention Coordinating Council Annual Report - Final.pdf
	2021 Suicide Prevention Coordinating Council Annual Report - Final.pdf
	2023 Suicide Prevention Coordinating Council Annual Report.pdf
	Availability of Covered Services by County as Reported by Managing Entities.xls
	national-strategy-suicide-prevention.pdf
	preventionresource.pdf
	Suicide Prevention Awareness Month Proclamation.pdf
	Suicide Prevention Coordinating Council 2022 Annual Report.pdf
Florida Legislature	
Bill Analyses	h1179b.HHS_Voluntariness Bill Analysis
	h1179z1.CFS_Voluntariness Bill Analysis
	HB 7021 CFS Analysis
Managing Entities	
Central Florida Behavioral Health Network	HB 945 ME Report - Hillsborough 2025 Update
Southeast Florida Behavioral Health Network	House-bill-945-mrt-overview

Appendix H: Department Licensed Substance Abuse Treatment Providers

While the Agency for Health Care Administration licenses most health care providers in Florida, including Baker Act receiving facilities, substance abuse treatment providers are licensed by the Department of Children and Families (the Department). The Agency for Health Care Administration is also responsible for Medicaid in Florida. It is essential to recognize that all healthcare providers, including those specializing in mental health and substance use, are funded by multiple entities, regardless of which agency licenses them. This includes Medicaid, Florida KidCare, or Commercial Insurance. The Department pays for services to children who are not otherwise insured, or in the event their insurance policy does not cover the necessary treatment. In accordance with 65E-14.021, F.A.C., the Department reimburses for a range of Substance Abuse Prevention, Assessment, Outpatient Individual and Group Treatment, Residential levels I-IV, Inpatient Detoxification, Outpatient (ambulatory) Detoxification, Aftercare, and Information and Referral services.

SIPP: Several people the Baker Act Reporting Center interviewed mentioned the Statewide Inpatient Placement Program (SIPP). SIPP is a Medicaid funding category made possible via a Section 1115 Waiver[70] from the Center for Medicare and Medicaid Services.[71] Residential treatment centers that accept individuals for treatment reimbursed via the Florida Medicaid SIPP waiver are discharge options for some Baker Act-receiving facilities for individuals under 21 years of age.

Given that several Baker Act receiving facility staff members mentioned service availability as a challenge, a focus of our future reporting will be on analyzing service availability, including funding. Funding is needed to access services. Even with funding there can be a lack of availability for other reasons.[72] For this report, we have included information about substance abuse treatment services for children.

Substance Abuse Treatment Services: The Baker Act Reporting Center interviewed staff from Baker Act receiving facilities who mentioned difficulty accessing substance abuse services for children. Information about substance abuse treatment services for children and adolescents is summarized in Table H, using data provided by the Department in early November 2025 from their Provider Licensure and Designation System (PLADS). For these Department licensed substance abuse services, children are defined as those under 10 years of age, while adolescents are defined as those between the ages of 11 through 17.

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[70] For more information about Section 115 Waivers, see the following: KFF. (n.d.). *Medicaid waiver tracker: Approved and pending section 1115 waivers by state*. Retrieved November 7, 2025, from https://www.kff.org/medicaid/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

[71] Florida Agency for Health Care Administration. (2025, March). *Section 1115 waiver for Medicaid coverage of services in institutions for mental disease: Florida implementation plan* (Report to the Florida Legislature).

[72] See this resource for information about service availability: Association of American Medical Colleges. (n.d.). *Exploring barriers to mental health care in the U.S.* https://www.aamc.org/about-us/mission-areas/health-care/exploring-barriers-mental-health-care-us

Eight counties have no substance abuse treatment services for children or adolescents (Glades, Hardy, Hendry, Lafayette, Manatee, Sumter, Suwannee, and Washington). Statewide, there is a bed capacity of 96 for inpatient substance abuse services for children or adolescents. The majority of these beds are located in Palm Beach County (65), followed by Bay County (15), Leon County (12), and Miami-Dade County (4). These four counties also have outpatient substance abuse services for children and adolescents. The remaining 55 counties have no inpatient substance abuse treatment services, but they have at least one outpatient substance abuse program for children or adolescents. It is important to note that children and adolescents may receive substance abuse services in a county different from their county of residence or the county of the Baker Act receiving facility at which they are being examined. However, the geographic distribution of these inpatient substance abuse services for children and youth is in keeping with the what the Baker Act receiving facility staff interviewed reported regarding the difficulty accessing services. Additional data collection and analysis are needed to determine the availability of services at the licensed providers listed in Table H. That is, having licensed treatment programs is only the first step toward accessing services. A more nuanced assessment of the capacity of these programs will be the focus of reporting efforts in the future.

Table H: Summary of Department Licensed Substance Abuse Treatment Providers Serving Children and Adolescents

Legend	Counties with only outpatient services	Counties with inpatient services, in addition to outpatient services	Counties with no services
	Children = individuals 10 years and younger	Adolescents = individuals 11-17	*Interim License **Probationary License

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Alachua						
Outpatient Treatment	Adolescents Only	Alachua County Board of County Commissioners	Gainesville	32641	PROV-000467	SITE-00006445
Outpatient Treatment	Children and Adolescents	Chrysalis Center, LLC	Gainesville	32609	PROV-000959	SITE-00005567
Outpatient Treatment	Adolescents Only	Wayne Halfway House, Inc.	Gainesville	32609	PROV-002537	SITE-00006100
Baker						
Outpatient Treatment	Children and Adolescents	Meridian Behavioral Health Care, Inc.	Macclenny	32063	PROV-000183	SITE-00005440
Bay (One inpatient program with a total bed capacity of 15)						
Inpatient Detoxification (15)	Adolescents Only	Chemical Addictions Recovery Effort, Inc	Panama City	32404	PROV-000108	SITE-00001508
Intensive Outpatient Treatment	Adolescents Only	Chemical Addictions Recovery Effort, Inc	Panama City	32401	PROV-000108	SITE-00005890
Outpatient Treatment	Adolescents Only	Chemical Addictions Recovery Effort, Inc	Panama City	32405	PROV-000108	SITE-00005194
Outpatient Treatment	Adolescents Only	Chemical Addictions Recovery Effort, Inc	Panama City	32401	PROV-000108	SITE-00005890
Outpatient Treatment	Children and Adolescents	Life Management Center of N.W. Florida	Panama City	32405	PROV-000142	SITE-00001589

[73] Note that some Providers have more than one row in this table with identical information. This means that there is more than one services offered at that site.

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Bradford						
Outpatient Treatment	Children and Adolescents	Meridian Behavioral Health Care, Inc.	Starke	32091	PROV-000183	SITE-00003340
Brevard						
Intensive Outpatient Treatment	Adolescents Only	Peace Club	Melbourne	32904	PROV-001705	SITE-00006033
Outpatient Treatment	Adolescents Only	AMIkids Behavioral Health, Inc.	Melbourne	32934	PROV-000657	SITE-00005394
Outpatient Treatment	Adolescents Only	Progressive Counseling Centers, Inc., d/b/a Brevard Outpatient Alternative Treatment	Satellite Beach	32937	PROV-000599	SITE-00003917
Outpatient Treatment	Children and Adolescents	Space Coast Health Foundation, Inc.	Cocoa	32922	PROV-001742	SITE-00004578
Outpatient Treatment	Adolescents Only	Specialized Treatment, Education & Prevention Services, Inc. (S.T.E.P.S.)	Cocoa	32922	PROV-000545	SITE-00004004
Outpatient Treatment	Adolescents Only	Specialized Treatment, Education & Prevention Services, Inc. (S.T.E.P.S.)	Melbourne	32935	PROV-000545	SITE-00004000
Broward						
Intensive Outpatient Treatment	Adolescents Only	AGAPE AIM Centers LLC	Wilton Manors	33305	PROV-000943	SITE-00006317
Intensive Outpatient Treatment	Adolescents Only	Broward Psychological Services, Inc.	Pembroke Pines	33028	PROV-001476	SITE-00005498
Intensive Outpatient Treatment	Adolescents Only	Principles Recovery Center LLC d/b/a AWA: Adolescent Wellness Academy	Davie	33314	PROV-000182	SITE-00000924
Intensive Outpatient Treatment	Children Only	The Beachcomber Rehabilitation, Inc.	Fort Lauderdale	33309	PROV-001208	SITE-00003123
Intensive Outpatient Treatment	Children and Adolescents	The Bougainvilla House, Inc.	Fort Lauderdale	33316	PROV-000759	SITE-00005776
Intensive Outpatient Treatment	Children and Adolescents	The Bougainvilla House, Inc.	Fort Lauderdale	33316	PROV-000759	SITE-00002408
Intensive Outpatient Treatment	Children and Adolescents	Thrive Mental Health and Substance Abuse Recovery Support Services, LLC	Sunrise	33351	PROV-002575	SITE-00006147
Outpatient Treatment	Adolescents Only	AMIkids Behavioral Health, Inc.	Fort Lauderdale	33315	PROV-000657	SITE-00005381
Outpatient Treatment	Children and Adolescents	Banyan Community Health Center, Inc.	Lauderdale Lakes	33313	PROV-000774	SITE-00006015
Outpatient Treatment	Adolescents Only	Broward Psychological Services, Inc.	Pembroke Pines	33028	PROV-001476	SITE-00005498
Outpatient Treatment	Children and Adolescents	Counseling Mediation Education and Treatment (CMET), LLC	Fort Lauderdale	33308	PROV-000110	SITE-00006415
Outpatient Treatment	Children and Adolescents	Harmony Development Center	Cooper City	33330	PROV-000582	SITE-00001548
Outpatient Treatment**	Children and Adolescents	Harmony Development Center	Tamarac	33319	PROV-000582	SITE-00006494
Outpatient Treatment	Children and Adolescents	Henderson Behavioral Health, Inc.	Fort Lauderdale	33309	PROV-001407	SITE-00000430
Outpatient Treatment	Children and Adolescents	Memorial Healthcare System	Pembroke Pines	33024	PROV-001463	SITE-00000527
Outpatient Treatment	Adolescents Only	Memorial Healthcare System	Davie	33328	PROV-001463	SITE-00006055
Outpatient Treatment	Adolescents Only	Principles Recovery Center LLC d/b/a AWA: Adolescent Wellness Academy	Davie	33314	PROV-000182	SITE-00000924
Outpatient Treatment	Adolescents Only	Smith Mental Health Associates, LLC	Plantation	33317	PROV-001127	SITE-00002184
Outpatient Treatment	Children and Adolescents	The Bougainvilla House, Inc.	Fort Lauderdale	33316	PROV-000759	SITE-00002408
Outpatient Treatment	Children and Adolescents	The Bougainvilla House, Inc.	Fort Lauderdale	33316	PROV-000759	SITE-00005775
Outpatient Treatment	Children Only	The Bougainvilla House, Inc.	Fort Lauderdale	33316	PROV-000759	SITE-00005776
Outpatient Treatment	Children and Adolescents	The Village South, Inc.	Pembroke Pines	33025	PROV-001003	SITE-00005151

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Broward *(continued)*						
Outpatient Treatment	Children and Adolescents	Thrive Mental Health and Substance Abuse Recovery Support Services, LLC	Sunrise	33351	PROV-002575	SITE-00006147
Outpatient Treatment	Adolescents Only	TLC Recovery of South Florida LLC	Fort Lauderdale	33309	PROV-000891	SITE-00004762
Calhoun						
Outpatient Treatment	Adolescents Only	Panhandle Therapy Center, LLC	Blountstown	32424	PROV-002371	SITE-00006489
Charlotte						
Outpatient Treatment	Children and Adolescents	Charlotte Behavioral Health Care, Inc	Punta Gorda	33950	PROV-000200	SITE-00000135
Outpatient Treatment	Children and Adolescents	Charlotte Behavioral Health Care, Inc	Port Charlotte	33952	PROV-000200	SITE-00005752
Citrus						
Outpatient Treatment	Adolescents Only	LifeStream Behavioral Center	Lecanto	34461	PROV-000334	SITE-00004941
Outpatient Treatment	Children and Adolescents	SMA Healthcare, Inc.	Inverness	34450	PROV-001344	SITE-00005701
Clay						
Outpatient Treatment	Adolescents Only	Clay Behavioral Health Center	Orange Park	32073	PROV-000249	SITE-00004814
Outpatient Treatment	Adolescents Only	Clay Behavioral Health Center	Keystone Heights	32656	PROV-000249	SITE-00006276
Outpatient Treatment	Children and Adolescents	Florida Counseling and Evaluation Services	Orange Park	32073	PROV-001054	SITE-00000358
Collier						
Intensive Outpatient Treatment	Adolescents Only	Crossroads Behavioral Health Center, Inc.	Naples	34102	PROV-000417	SITE-00006279
Outpatient Treatment	Children and Adolescents	David Lawrence Mental Health Center, Inc	Naples	34116	PROV-000211	SITE-00000860
Outpatient Treatment	Children and Adolescents	David Lawrence Mental Health Center, Inc	Immokalee	34142	PROV-000211	SITE-00001203
Columbia						
Outpatient Treatment	Children and Adolescents	Meridian Behavioral Health Care, Inc.	Lake City	3202	PROV-000183	SITE-00003456
DeSoto						
Outpatient Treatment	Children and Adolescents	Charlotte Behavioral Health Care, Inc	Arcadia	34266	PROV-000200	SITE-00005951
Dixie						
Outpatient Treatment	Children Only	Meridian Behavioral Health Care, Inc.	Cross City	32628	PROV-000183	SITE-00003554
Duval						
Intensive Outpatient Treatment*	Children and Adolescents	Agape Health and Wellness Center, Inc	Jacksonville	32224	PROV-002702	SITE-00006523
Outpatient Treatment*	Children and Adolescents	Agape Health and Wellness Center, Inc	Jacksonville	32224	PROV-002702	SITE-00006523
Outpatient Treatment	Adolescents Only	AMIkids Behavioral Health, Inc.	Jacksonville	33634	PROV-000657	SITE-00005168
Outpatient Treatment	Children and Adolescents	Chrysalis Center, LLC	Jacksonville	32216	PROV-000959	SITE-00005116
Outpatient Treatment	Adolescents Only	Community Rehabilitation Center, Inc.	Jacksonville	32206	PROV-000296	SITE-00002040
Outpatient Treatment	Children and Adolescents	Community Rehabilitation Center, Inc.	Jacksonville	32206	PROV-000296	SITE-00003850
Outpatient Treatment	Children and Adolescents	Dialogical Interaction Recovery Corp	Jacksonville	32202	PROV-002101	SITE-00005208
Outpatient Treatment	Children and Adolescents	Florida Counseling and Evaluation Services	Jacksonville	32216	PROV-001054	SITE-00003210
Outpatient Treatment	Adolescents Only	Gateway Community Services, Inc.	Jacksonville	32205	PROV-000236	SITE-00001798
Outpatient Treatment	Adolescents Only	Gateway Community Services, Inc.	Jacksonville	32206	PROV-000236	SITE-00001824

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Duval *(continued)*						
Outpatient Treatment	Children and Adolescents	Inspire to Rise, Inc.	Jacksonville	32210	PROV-002117	SITE-00005232
Outpatient Treatment	Children and Adolescents	Inspire to Rise, Inc.	Jacksonville	32254	PROV-002117	SITE-00005864
Outpatient Treatment	Children and Adolescents	Northwest Behavioral Health Services, Inc.	Jacksonville	32254	PROV-000263	SITE-00002001
Outpatient Treatment	Children and Adolescents	Sophros Recovery LLC	Jacksonville	32246	PROV-002342	SITE-00005677
Outpatient Treatment	Adolescents Only	The LJD Jewish Family & Community Services Inc.	Jacksonville	32256	PROV-001965	SITE-00004740
Outpatient Treatment	Adolescents Only	Wayne Halfway House, Inc.	Jacksonville	32218	PROV-002537	SITE-00006393
Outpatient Treatment	Adolescents Only	Wayne Halfway House, Inc.	Jacksonville	32244	PROV-002537	SITE-00006048
Escambia						
Outpatient Treatment	Children and Adolescents	Chrysalis Center, LLC	Pensacola	32505	PROV-000959	SITE-00006348
Outpatient Treatment	Children and Adolescents	LAKEVIEW CENTER, INC.	Pensacola	32501	PROV-001570	SITE-00001272
Flagler						
Intensive Outpatient Treatment	Adolescents Only	Chance 2 Change	Bunnell	32110	PROV-000771	SITE-00002447
Outpatient Treatment	Adolescents Only	Chance 2 Change	Bunnell	32110	PROV-000771	SITE-00002447
Outpatient Treatment	Adolescents Only	EPIC Community Services, Inc.	Bunnell	32110	PROV-000432	SITE-00006017
Outpatient Treatment	Adolescents Only	Flagler Cares, Inc.	Palm Coast	32164	PROV-002653	SITE-00006265
Outpatient Treatment	Children and Adolescents	LifeStream Behavioral Center	Bushnell	33513	PROV-000334	SITE-00002109
Outpatient Treatment	Adolescents Only	SMA Healthcare, Inc.	Bunnell	32110	PROV-001344	SITE-00003223
Franklin						
Outpatient Treatment	Children and Adolescents	Apalachee Center, Inc.	Apalachicola	32320	PROV-000088	SITE-00001473
Outpatient Treatment	Adolescents Only	DISC Village, Inc.	Apalachicola	32304	PROV-000121	SITE-00005772
Gadsden						
Outpatient Treatment	Children and Adolescents	Apalachee Center, Inc.	Quincy	32351	PROV-000088	SITE-00001481
Outpatient Treatment	Adolescents Only	DISC Village, Inc.	Quincy	32351	PROV-000121	SITE-00001555
Outpatient Treatment	Children and Adolescents	Holistic Plan of Care, Inc.	Quincy	32351	PROV-001491	SITE-00005995
Outpatient Treatment	Children and Adolescents	Holistic Plan of Care, Inc.	Quincy	32351	PROV-001491	SITE-00005995
Gilchrist						
Outpatient Treatment	Children and Adolescents	Meridian Behavioral Health Care, Inc.	Trenton	32693	PROV-000183	SITE-00003570
Glades						
Gulf						
Outpatient Treatment	Adolescents Only	Chemical Addictions Recovery Effort, Inc	Port St. Joe	32456	PROV-000108	SITE-00001037
Hamilton						
Outpatient Treatment	Children and Adolescents	Meridian Behavioral Health Care, Inc.	Jasper	32052	PROV-000183	SITE-00003534
Hardee						
Hendry						

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Hernando						
Outpatient Treatment	Children and Adolescents	BayCare Behavioral Health, Inc.	Spring Hill	34606	PROV-000326	SITE-00006047
Outpatient Treatment	Children and Adolescents	BayCare Behavioral Health, Inc.	Brooksville	34613	PROV-000326	SITE-00002735
Highlands						
Outpatient Treatment	Children and Adolescents	Tri-County Human Services, Inc.	Avon Park	33825	PROV-000627	SITE-00003508
Hillsborough						
Intensive Outpatient Treatment	Adolescents Only	Ibis Healthcare, Inc.	Tampa	33605	PROV-000427	SITE-00006524
Intensive Outpatient Treatment	Adolescents Only	Phoenix Programs of Florida, Inc.	Brandon	33511	PROV-000343	SITE-00001379
Intensive Outpatient Treatment	Adolescents Only	Phoenix Programs of Florida, Inc.	Brandon	33511	PROV-000343	SITE-00001379
Intensive Outpatient Treatment	Adolescents Only	Phoenix Programs of Florida, Inc.	Tampa	33607	PROV-000343	SITE-00005972
Intensive Outpatient Treatment	Adolescents Only	Phoenix Programs of Florida, Inc.	Tampa	33607	PROV-000343	SITE-00005972
Intensive Outpatient Treatment	Adolescents Only	Stonebraker Florida, Incorporated	Tampa	33626	PROV-002247	SITE-00005833
Intensive Outpatient Treatment	Adolescents Only	The Process Treatment Center, LLC	Temple Terrace	33637	PROV-002127	SITE-00006353
Outpatient Treatment	Children and Adolescents	Behavioral Health Management Services, Inc.	Tampa	33607	PROV-000303	SITE-00001812
Outpatient Treatment	Children and Adolescents	Chrysalis Center, LLC	Tampa	33614	PROV-000959	SITE-00005114
Outpatient Treatment	Children and Adolescents	Ibis Healthcare, Inc.	Tampa	33605	PROV-000427	SITE-00006524
Outpatient Treatment	Adolescents Only	Northside Behavioral Health Center, Inc.	Tampa	33612	PROV-002538	SITE-00006051
Outpatient Treatment	Adolescents Only	Northside Behavioral Health Center, Inc.	Tampa	33612	PROV-002538	SITE-00006051
Outpatient Treatment	Adolescents Only	Phoenix Programs of Florida, Inc.	Brandon	33511	PROV-000343	SITE-00001379
Outpatient Treatment	Adolescents Only	Phoenix Programs of Florida, Inc.	Brandon	33511	PROV-000343	SITE-00001379
Outpatient Treatment	Adolescents Only	Phoenix Programs of Florida, Inc.	Tampa	33607	PROV-000343	SITE-00005972
Outpatient Treatment	Adolescents Only	Phoenix Programs of Florida, Inc.	Tampa	33607	PROV-000343	SITE-00005972
Outpatient Treatment	Adolescents Only	Stonebraker Florida, Incorporated	Tampa	33626	PROV-002247	SITE-00005833
Outpatient Treatment	Adolescents Only	The Process Treatment Center, LLC	Temple Terrace	33637	PROV-002127	SITE-00006353
Outpatient Treatment	Adolescents Only	Wayne Halfway House, Inc.	Wimauma	33598	PROV-002537	SITE-00006197
Holmes						
Outpatient Treatment	Adolescents Only	Chemical Addictions Recovery Effort, Inc	Bonifay	32425	PROV-000108	SITE-00002044
Indian River						
Outpatient Treatment	Adolescents Only	Thrive IRC Inc	Vero Beach	32960	PROV-000144	SITE-00006450
Outpatient Treatment	Adolescents Only	Thrive IRC Inc	Vero Beach	32960	PROV-000144	SITE-00006450
Outpatient Treatment	Adolescents Only	Thrive IRC Inc	Vero Beach	32960	PROV-000144	SITE-00002100
Outpatient Treatment**	Adolescents Only	Thrive IRC Inc	Sebastian	32958	PROV-000144	SITE-00006425
Jackson						
Outpatient Treatment	Adolescents Only	Chemical Addictions Recovery Effort, Inc	Marianna	32446	PROV-000108	SITE-00001524
Outpatient Treatment	Children and Adolescents	Life Management Center of N.W. Florida	Marianna	32446	PROV-000142	SITE-00001596
Outpatient Treatment	Adolescents Only	Twin Oaks Juvenile Development, Inc.	Graceville	32440	PROV-000162	SITE-00006038
Outpatient Treatment	Adolescents Only	Twin Oaks Juvenile Development, Inc.	Graceville	32440	PROV-000162	SITE-00001646

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Jefferson						
Outpatient Treatment	Children and Adolescents	Apalachee Center, Inc.	Monticello	32344	PROV-000088	SITE-00001485
Outpatient Treatment	Children Only	Holistic Plan of Care, Inc.	Monticello	32344	PROV-001491	SITE-00005455
Outpatient Treatment	Children Only	Holistic Plan of Care, Inc.	Monticello	32344	PROV-001491	SITE-00005455
Lafayette						
Lake						
Outpatient Treatment	Children and Adolescents	LifeStream Behavioral Center	Eustis	32727	PROV-000334	SITE-00001980
Outpatient Treatment	Children and Adolescents	LifeStream Behavioral Center	Leesburg	34748	PROV-000334	SITE-00003126
Outpatient Treatment	Children and Adolescents	LifeStream Behavioral Center	Clermont	34711	PROV-000334	SITE-00003938
Outpatient Treatment	Children and Adolescents	Rite of Passage Inc.	Paisley	32767	PROV-001175	SITE-00004813
Lee						
Outpatient Treatment	Children and Adolescents	Centerstone of Florida, Inc.	Fort Myers	33901	PROV-000423	SITE-00006028
Outpatient Treatment**	Children and Adolescents	Centerstone of Florida, Inc.	Fort Myers	33916	PROV-000423	SITE-00006261
Outpatient Treatment	Adolescents Only	Major Impact Supports Inc	Fort Myers	33916	PROV-002491	SITE-00005942
Outpatient Treatment	Adolescents Only	Rite of Passage Inc.	Fort Myers	89423	PROV-001175	SITE-00006387
Outpatient Treatment	Children and Adolescents	SalusCare, Inc.	Fort Myers	33901	PROV-000251	SITE-00002272
Outpatient Treatment	Adolescents Only	The Center for Progress and Excellence Inc.	Fort Myers	33907	PROV-001648	SITE-00005804
Leon *(One inpatient programs with a total bed capacity of 12)*						
Inpatient Detoxification	Children and Adolescents	Apalachee Center, Inc.	Tallahassee	32308	PROV-000088	SITE-00004151
Outpatient Treatment	Children and Adolescents	Apalachee Center, Inc.	Tallahassee	32308	PROV-000088	SITE-00003614
Outpatient Treatment	Adolescents Only	DISC Village, Inc.	Tallahassee	32303	PROV-000121	SITE-00001514
Levy						
Outpatient Treatment	Children and Adolescents	Meridian Behavioral Health Care, Inc.	Chiefland	32626	PROV-000183	SITE-00004843
Liberty						
Outpatient Treatment	Children and Adolescents	Apalachee Center, Inc.	Bristol	32321	PROV-000088	SITE-00003610
Madison						
Outpatient Treatment	Children and Adolescents	Apalachee Center, Inc.	Madison	32340	PROV-000088	SITE-00001732
Outpatient Treatment	Adolescents Only	Twin Oaks Juvenile Development, Inc.	Greenville	32331	PROV-000162	SITE-00001748
Manatee						
Marion						
Outpatient Treatment	Adolescents Only	Choices, Chances, Changes	Ocala	34470	PROV-000882	SITE-00002634
Outpatient Treatment	Children Only	Guest House Ocala Outpatient Recovery, LLC	Ocala	34471	PROV-002174	SITE-00005343
Outpatient Treatment	Adolescents Only	Ocala Consulting & Prevention, LLC	Ocala	34471	PROV-001116	SITE-00005642
Outpatient Treatment	Children and Adolescents	SMA Healthcare, Inc.	Ocala	34474	PROV-001344	SITE-00005693
Outpatient Treatment	Adolescents Only	Youth Opportunity Investments LLC	Ocala	34482	PROV-001002	SITE-00006416

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Martin						
Outpatient Treatment	Children and Adolescents	New Horizons of the Treasure Coast, Inc.	Stuart	34994	PROV-000129	SITE-00001009
Outpatient Treatment	Children and Adolescents	Tykes and Teens, Inc.	Stuart	34994	PROV-000176	SITE-00006222
Miami-Dade (Two inpatient programs with a total bed capacity of four)						
Inpatient Detoxification (2)	Children and Adolescents	Community Health of South Florida, Inc	Miami	33190	PROV-000703	SITE-00003001
Inpatient Detoxification (2)	Children and Adolescents	Community Health of South Florida, Inc	Miami	33190	PROV-000703	SITE-00003001
Intensive Outpatient Treatment	Children and Adolescents	AMORE MENTAL HEALTH CORP.	Miami	33186	PROV-002388	SITE-00006469
Intensive Outpatient Treatment	Adolescents Only	Concept Health Systems, Inc.	Hialeah	33012	PROV-000719	SITE-00006180
Intensive Outpatient Treatment	Adolescents Only	Concept Health Systems, Inc.	Miami	33137	PROV-000719	SITE-00002458
Intensive Outpatient Treatment	Adolescents Only	Concept Health Systems, Inc.	Miami	33137	PROV-000719	SITE-00002454
Intensive Outpatient Treatment	Children and Adolescents	Integrity Behavioral Health, LLC	Miami Gardens	33169	PROV-001832	SITE-00004765
Intensive Outpatient Treatment	Children and Adolescents	Miami Dade Community Services, Inc.	Miami	33135	PROV-000856	SITE-00002407
Intensive Outpatient Treatment	Children and Adolescents	New Hope C.O.R.P.S., Inc.	Homestead	33030	PROV-000875	SITE-00003343
Intensive Outpatient Treatment	Adolescents Only	Principles Recovery Center LLC d/b/a AWA: Adolescent Wellness Academy	Miami	33173	PROV-000182	SITE-00006238
Intensive Outpatient Treatment	Adolescents Only	Principles Recovery Center LLC d/b/a AWA: Adolescent Wellness Academy	Miami	33173	PROV-000182	SITE-00006238
Intensive Outpatient Treatment	Adolescents Only	Progressive Medical Center, Inc.	Miami	33186	PROV-002583	SITE-00006159
Outpatient Treatment	Children and Adolescents	Agape Network, Inc.	Miami	33170	PROV-001644	SITE-00004352
Outpatient Treatment	Children and Adolescents	AMORE MENTAL HEALTH CORP.	Miami	33186	PROV-002388	SITE-00006469
Outpatient Treatment	Children and Adolescents	Banyan Community Health Center, Inc.	Miami	33189	PROV-000774	SITE-00000756
Outpatient Treatment	Adolescents Only	Banyan Community Health Center, Inc.	Miami	33134	PROV-000774	SITE-00002500
Outpatient Treatment	Children and Adolescents	Chrysalis Center, LLC	Miami	33126	PROV-000959	SITE-00005965
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Homestead	33033	PROV-000703	SITE-00004057
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Homestead	33030	PROV-000703	SITE-00002773
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Homestead	33033	PROV-000703	SITE-00004057
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Florida City	33034	PROV-000703	SITE-00002769
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Perrine	33157	PROV-000703	SITE-00000914
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Perrine	33157	PROV-000703	SITE-00000914
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	South Miami	33143	PROV-000703	SITE-00000484
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	South Miami	33143	PROV-000703	SITE-00000484
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Florida City	33034	PROV-000703	SITE-00002769
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Homestead	33030	PROV-000703	SITE-00002773
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Miami	33190	PROV-000703	SITE-00003001
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Miami	33186	PROV-000703	SITE-00001725
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Miami	33186	PROV-000703	SITE-00001725
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Miami	33190	PROV-000703	SITE-00003001
Outpatient Treatment	Adolescents Only	Concept Health Systems, Inc.	Miami	33137	PROV-000719	SITE-00002458
Outpatient Treatment	Adolescents Only	Concept Health Systems, Inc.	Hialeah	33012	PROV-000719	SITE-00006180

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Miami-Dade *(continued)*						
Outpatient Treatment	Adolescents Only	Concept Health Systems, Inc.	Miami	33137	PROV-000719	SITE-00002454
Outpatient Treatment	Children and Adolescents	Face to Face Mental Health Services, LLC	Miami	33157	PROV-002259	SITE-00005575
Outpatient Treatment	Children and Adolescents	Florida Personal Management LLC	Miami	33170	PROV-002490	SITE-00005941
Outpatient Treatment	Adolescents Only	Here's Help, Inc.	Miami	33157	PROV-000794	SITE-00003151
Outpatient Treatment	Adolescents Only	Here's Help, Inc.	Opa Locka	33054	PROV-000794	SITE-00003147
Outpatient Treatment	Adolescents Only	HOMESTEAD BEHAVIORAL CLINIC	Homestead	33030	PROV-002710	SITE-00006360
Outpatient Treatment	Children and Adolescents	Infinite Ways Network, Inc.	Miami Gardens	33179	PROV-000866	SITE-00006084
Outpatient Treatment	Children and Adolescents	Integrity Behavioral Health, LLC	Miami Gardens	33169	PROV-001832	SITE-00004765
Outpatient Treatment	Adolescents Only	Meraki Wellness & Healing, Inc.	Miami Lakes	33014	PROV-002512	SITE-00006001
Outpatient Treatment	Adolescents Only	Meraki Wellness & Healing, Inc.	Miami Lakes	33014	PROV-002512	SITE-00006001
Outpatient Treatment	Adolescents Only	Miami Dade Community Services, Inc.	Miami	33135	PROV-000856	SITE-00002407
Outpatient Treatment	Children and Adolescents	New Horizons CMHC, Inc.	Miami	33142	PROV-000880	SITE-00003347
Outpatient Treatment	Children and Adolescents	New Horizons CMHC, Inc.	Miami	33142	PROV-000880	SITE-00001115
Outpatient Treatment	Adolescents Only	Progressive Medical Center, Inc.	Miami	33186	PROV-002583	SITE-00006159
Outpatient Treatment	Children and Adolescents	Regis House	Miami	33157	PROV-000923	SITE-00003539
Outpatient Treatment	Children and Adolescents	Regis House	Miami	33125	PROV-000923	SITE-00005578
Outpatient Treatment	Children and Adolescents	Safe Future, LLC	Miami	33161	PROV-000838	SITE-00002530
Outpatient Treatment	Children and Adolescents	The Center for Family and Child Enrichment, Inc	Miami Gardens	33056	PROV-001955	SITE-00004689
Outpatient Treatment	Children and Adolescents	The Village South, Inc.	Miami	33126	PROV-001003	SITE-00006123
Outpatient Treatment	Children and Adolescents	West Miami CMHC, Inc	Miami	33126	PROV-001210	SITE-00005349
Monroe						
Intensive Outpatient Treatment	Children and Adolescents	Guidance/Care Center, Inc.	Key Largo	33037	PROV-001267	SITE-00000157
Intensive Outpatient Treatment	Adolescents Only	Guidance/Care Center, Inc.	Key West	33040	PROV-001267	SITE-00000144
Outpatient Detoxification	Adolescents Only	Guidance/Care Center, Inc.	Key West	33040	PROV-001267	SITE-00000144
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Marathon	33050	PROV-000703	SITE-00003140
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Key Largo	33037	PROV-000703	SITE-00006501
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Key Largo	33037	PROV-000703	SITE-00006501
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Key West	33040	PROV-000703	SITE-00005786
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Key West	33040	PROV-000703	SITE-00005786
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Marathon	33050	PROV-000703	SITE-00003140
Outpatient Treatment	Children and Adolescents	Community Health of South Florida, Inc	Tavernier	33070	PROV-000703	SITE-00003136
Outpatient Treatment	Children and Adolescents	Guidance/Care Center, Inc.	Key Largo	33037	PROV-001267	SITE-00000157
Outpatient Treatment	Children and Adolescents	Guidance/Care Center, Inc.	Key West	33040	PROV-001267	SITE-00000144
Outpatient Treatment	Children and Adolescents	Guidance/Care Center, Inc.	Key West	33040	PROV-001267	SITE-00000148
Outpatient Treatment	Children and Adolescents	Guidance/Care Center, Inc.	Marathon	33050	PROV-001267	SITE-00000154
Nassau						
Outpatient Treatment	Children and Adolescents	Nassau Cty MH Alc & Drug Abuse Council, Inc.	Yulee	32097	PROV-000255	SITE-00001972
Outpatient Treatment	Children and Adolescents	Nassau Cty MH Alc & Drug Abuse Council, Inc.	Hilliard	32046	PROV-000255	SITE-00001978

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Nassau (continued)						
Outpatient Treatment	Adolescents Only	Nassau Cty MH Alc & Drug Abuse Council, Inc.	Fernandina Beach	32034	PROV-000255	SITE-00005949
Outpatient Treatment	Children and Adolescents	Nassau Cty MH Alc & Drug Abuse Council, Inc.	Callahan	32011	PROV-000255	SITE-00006326
Okaloosa						
Outpatient Treatment	Adolescents Only	Bridgeway Center, Inc.	Fort Walton Beach	32548	PROV-000029	SITE-00005331
Outpatient Treatment	Adolescents Only	Bridgeway Center, Inc.	Crestview	32536	PROV-000029	SITE-00002585
Okeechobee						
Outpatient Treatment	Children and Adolescents	New Horizons of the Treasure Coast, Inc.	Okeechobee	34972	PROV-000129	SITE-00001018
Orange						
Intensive Outpatient Treatment	Children and Adolescents	Central Florida Recovery Centers, Inc.	Orlando	32819	PROV-000047	SITE-00004130
Intensive Outpatient Treatment	Adolescents Only	Specialized Treatment, Education & Prevention Services, Inc. (S.T.E.P.S.)	Orlando	32808	PROV-000545	SITE-00003987
Outpatient Treatment	Adolescents Only	AMIkids Behavioral Health, Inc.	Apopka	32704	PROV-000657	SITE-00004949
Outpatient Treatment	Children and Adolescents	Central Florida Recovery Centers, Inc.	Orlando	32819	PROV-000047	SITE-00004130
Outpatient Treatment	Children and Adolescents	Central Florida Recovery Centers, Inc.	Apopka	32703	PROV-000047	SITE-00004534
Outpatient Treatment	Children and Adolescents	Change in Motion	Maitland	32789	PROV-001798	SITE-00005655
Outpatient Treatment	Children and Adolescents	Chrysalis Center, LLC	Maitland	32751	PROV-000959	SITE-00006128
Outpatient Treatment	Children and Adolescents	Limitless & Infinite Transformations LLC	Orlando	32803	PROV-002703	SITE-00006507
Outpatient Treatment	Adolescents Only	Specialized Treatment, Education & Prevention Services, Inc. (S.T.E.P.S.)	Orlando	32808	PROV-000545	SITE-00003987
Outpatient Treatment	Adolescents Only	Specialized Treatment, Education & Prevention Services, Inc. (S.T.E.P.S.)	Apopka	32703	PROV-000545	SITE-00002711
Outpatient Treatment	Adolescents Only	Youth Opportunity Investments LLC	Orlando	33702	PROV-001002	SITE-00006372
Osceola						
Outpatient Treatment	Children and Adolescents	Jones Family Services, LLC.	Kissimmee	34741	PROV-002143	SITE-00005749
Outpatient Treatment	Adolescents Only	Park Place Behavioral Healthcare	Kissimmee	34741	PROV-000495	SITE-00002576
Outpatient Treatment	Adolescents Only	Park Place Behavioral Healthcare	Kissimmee	34741	PROV-000495	SITE-00002412
Outpatient Treatment	Adolescents Only	Park Place Behavioral Healthcare	Kissimmee	34746	PROV-000495	SITE-00002416
Palm Beach *(Four inpatient programs with a total bed capacity of 65)*						
Inpatient Detoxification (18)	Adolescents Only	Archstone Behavioral Health, LLC	Lantana	33432	PROV-002129	SITE-00005257
Inpatient Detoxification (20)	Children and Adolescents	Drug Abuse Foundation of Palm Beach County, Inc.	Delray Beach	33444	PROV-001051	SITE-00000920
Inpatient Detoxification (11)	Adolescents Only	Evernia Health Center, LLC	Boca Raton	33486	PROV-002113	SITE-00006283
Inpatient Detoxification (16)	Adolescents Only	Evernia Health Center, LLC	West Palm Beach	33401	PROV-002113	SITE-00005244
Intensive Outpatient Treatment	Adolescents Only	Bright Futures Boynton Beach LLC	Boynton Beach	33435	PROV-000078	SITE-00000612
Intensive Outpatient Treatment	Adolescents Only	Evernia Health Center, LLC	West Palm Beach	33401	PROV-002113	SITE-00005244
Intensive Outpatient Treatment	Adolescents Only	Family First Adolescent Services LLC	Palm Beach Gardens	33410	PROV-001420	SITE-00005178
Intensive Outpatient Treatment	Adolescents Only	Resilience Recovery Resources LLC	West Palm Beach	33407	PROV-002347	SITE-00006146

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Palm Beach *(continued)*						
Intensive Outpatient Treatment	Adolescents Only	THE COUNSELING CENTER	West Palm Beach	33401	PROV-002273	SITE-00006478
Intensive Outpatient Treatment	Adolescents Only	The Process Treatment Center, LLC	West Palm Beach	33407	PROV-002127	SITE-00005936
Outpatient Treatment	Adolescents Only	Bright Futures Boynton Beach LLC	Boynton Beach	33435	PROV-000078	SITE-00000612
Outpatient Treatment	Children and Adolescents	Chrysalis Center, LLC	Lake Worth	33460	PROV-000959	SITE-00004143
Outpatient Treatment	Children and Adolescents	Drug Abuse Treatment Association, Inc. (DATA)	West Palm Beach	33407	PROV-001058	SITE-00000067
Outpatient Treatment	Adolescents Only	Evernia Health Center, LLC	West Palm Beach	33401	PROV-002113	SITE-00005244
Outpatient Treatment	Children and Adolescents	Inspire Recovery, LLC	West Palm Beach	33401	PROV-000220	SITE-00001032
Outpatient Treatment	Adolescents Only	Resilience Recovery Resources LLC	West Palm Beach	33407	PROV-002347	SITE-00006146
Outpatient Treatment	Children and Adolescents	Sygnity Wellness, LLC	Palm Beach Gardens	33410	PROV-002712	SITE-00006344
Outpatient Treatment	Adolescents Only	The Process Treatment Center, LLC	West Palm Beach	33407	PROV-002127	SITE-00005936
Outpatient Treatment	Children and Adolescents	Tri-County Human Services, Inc.	Wauchula	33873	PROV-000627	SITE-00001708
Pasco						
Outpatient Treatment	Children and Adolescents	BayCare Behavioral Health, Inc.	New Port Richey	34653	PROV-000326	SITE-00001148
Outpatient Treatment	Children and Adolescents	BayCare Behavioral Health, Inc.	Dade City	33523	PROV-000326	SITE-00001160
Pinellas						
Intensive Outpatient Treatment	Children and Adolescents	Florida Behavioral Institute, LLC	Largo	33770	PROV-002216	SITE-00005427
Intensive Outpatient Treatment	Adolescents Only	Spencer Recovery Centers Florida, Inc.	St. Petersburg Beach	33706	PROV-000469	SITE-00000811
Outpatient Treatment	Children and Adolescents	BayCare Behavioral Health, Inc.	St. Petersburg	33716	PROV-000326	SITE-00006007
Outpatient Treatment	Children and Adolescents	Directions for Mental Health, Inc.	Largo	33773	PROV-000353	SITE-00001922
Outpatient Treatment	Children and Adolescents	Directions for Mental Health, Inc.	Clearwater	33764	PROV-000353	SITE-00000170
Outpatient Treatment	Adolescents Only	Operation PAR, Inc.	St. Petersburg	33709	PROV-000239	SITE-00001689
Outpatient Treatment	Children and Adolescents	Solution Behavioral LLC.	Largo	33773	PROV-000465	SITE-00002465
Polk						
Intensive Outpatient Treatment	Children and Adolescents	Tri-County Human Services, Inc.	Lakeland	33801	PROV-000627	SITE-00006327
Outpatient Treatment	Children and Adolescents	Families First of Florida, LLC	Lakeland	33803	PROV-001334	SITE-00006198
Outpatient Treatment	Adolescents Only	Polk County Drug Court	Bartow	33830	PROV-000624	SITE-00002809
Outpatient Treatment	Children and Adolescents	Tri-County Human Services, Inc.	Winter Haven	33881	PROV-000627	SITE-00001569
Outpatient Treatment	Children and Adolescents	Tri-County Human Services, Inc.	Lakeland	33801	PROV-000627	SITE-00006327
Putnam						
Outpatient Treatment	Children Only	Meridian Behavioral Health Care, Inc.	Palatka	32177	PROV-000183	SITE-00004978
Saint Johns						
Outpatient Treatment	Adolescents Only	EPIC Community Services, Inc.	St. Augustine	32084	PROV-000432	SITE-00006515
Outpatient Treatment	Adolescents Only	EPIC Community Services, Inc.	St. Augustine	32092	PROV-000432	SITE-00005470
Outpatient Treatment	Adolescents Only	EPIC Community Services, Inc.	St. Augustine	32084	PROV-000432	SITE-00002340
Outpatient Treatment	Adolescents Only	Youth Opportunity Investments LLC	St. Augustine	32085	PROV-001002	SITE-00006250
Outpatient Treatment	Adolescents Only	Youth Opportunity Investments LLC	Hastings	32145	PROV-001002	SITE-00005690

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Saint Lucie						
Intensive Outpatient Treatment	Children and Adolescents	The Academy at Ambrosia LLC	Port St. Lucie	33483	PROV-002597	SITE-00006153
Outpatient Treatment	Adolescents Only	Drug Abuse Treatment Association, Inc. (DATA)	Fort Pierce	34981	PROV-001058	SITE-00000885
Outpatient Treatment	Children and Adolescents	New Horizons of the Treasure Coast, Inc.	Fort Pierce	34981	PROV-000129	SITE-00001001
Outpatient Treatment	Children and Adolescents	The Academy at Ambrosia LLC	Port St. Lucie	33483	PROV-002597	SITE-00006153
Santa Rosa						
Outpatient Treatment	Children and Adolescents	LAKEVIEW CENTER, INC.	Milton	32583	PROV-001570	SITE-00001286
Sarasota						
Outpatient Treatment	Children and Adolescents	Lightshare Behavioral Wellness & Recovery	Sarasota	34234	PROV-000887	SITE-00005412
Seminole						
Intensive Outpatient Treatment	Children and Adolescents	IMPOWER	Winter Springs	32708	PROV-001995	SITE-00000315
Intensive Outpatient Treatment	Adolescents Only	Promise of Hope Counseling	Longwood	32779	PROV-002284	SITE-00005590
Outpatient Treatment	Children and Adolescents	EMERGEN, INC.	Lake Mary	32746	PROV-002068	SITE-00005136
Outpatient Treatment	Children and Adolescents	IMPOWER	Winter Springs	32708	PROV-001995	SITE-00000315
Outpatient Treatment	Adolescents Only	Sojourners Recovery and Wellness Center, LLC	Lake Mary	32746	PROV-000190	SITE-00000941
Sumter						
Suwannee						
Taylor						
Outpatient Treatment	Children and Adolescents	Apalachee Center, Inc.	Perry	32348	PROV-000088	SITE-00001736
Union						
Outpatient Treatment	Children and Adolescents	Meridian Behavioral Health Care, Inc.	Lake Butler	32054	PROV-000183	SITE-00003591
Volusia						
Intensive Outpatient Treatment	Adolescents Only	Chance 2 Change	Daytona Beach	32114	PROV-000771	SITE-00000610
Intensive Outpatient Treatment	Adolescents Only	Chance 2 Change	Daytona Beach	32114	PROV-000771	SITE-00000610
Intensive Outpatient Treatment	Adolescents Only	Chance 2 Change	Daytona Beach	32114	PROV-000771	SITE-00000610
Outpatient Treatment	Adolescents Only	Chance 2 Change	Daytona Beach	32114	PROV-000771	SITE-00000610
Outpatient Treatment	Adolescents Only	Chance 2 Change	Daytona Beach	32114	PROV-000771	SITE-00000610
Outpatient Treatment	Adolescents Only	Chance 2 Change	Daytona Beach	32114	PROV-000771	SITE-00000610
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	Daytona Beach	32117	PROV-000410	SITE-00002023
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	Daytona Beach	32117	PROV-000410	SITE-00002023
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	South Daytona	32119	PROV-000410	SITE-00002233
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	South Daytona	32119	PROV-000410	SITE-00002233
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	Port Orange	32129	PROV-000410	SITE-00001094
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	Port Orange	32129	PROV-000410	SITE-00001094
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	Orange City	32763	PROV-000410	SITE-00002889
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	Orange City	32763	PROV-000410	SITE-00002889
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	Edgewater	32132	PROV-000410	SITE-00006117

Program Type[73]	Group Serviced	Legal Provider Name in PLADS	City	Zip	Provider ID	Site ID
Volusia *(continued)*						
Outpatient Treatment	Adolescents Only	Oasis Treatment Center	Edgewater	32132	PROV-000410	SITE-00006117
Outpatient Treatment	Children and Adolescents	Outreach Community Care Network	Daytona Beach	32114	PROV-002201	SITE-00005401
Outpatient Treatment	Adolescents Only	SMA Healthcare, Inc.	Debary	32713	PROV-001344	SITE-00003231
Outpatient Treatment	Adolescents Only	SMA Healthcare, Inc.	Daytona Beach	32114	PROV-001344	SITE-00003234
Wakulla						
Outpatient Treatment	Children and Adolescents	Apalachee Center, Inc.	Crawfordville	32327	PROV-000088	SITE-00001477
Outpatient Treatment	Adolescents Only	DISC Village, Inc.	Crawfordville	32327	PROV-000121	SITE-00001563
Walton						
Outpatient Treatment	Children and Adolescents	LAKEVIEW CENTER, INC.	Defuniak Springs	32435	PROV-001570	SITE-00005146
Washington						

Appendix I: References

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