# Report on **Involuntary Examinations** of Children

**Department** of **Children** and **Families**

OFFICE OF

**Substance Abuse** and **Mental Health**

November 1, 2021

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# Executive Summary

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

Chapter 394.463, (4). F.S. requires the Department to prepare a report on the initiation of involuntary examination of children age 18 years and younger. Specifically, the statute requires the Department to:

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

The Department is required to submit a report of its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1 of each odd numbered year.

# Background

In Florida, children who have a mental illness and pose a real and present threat to themselves or others as a result, may be evaluated involuntarily if they meet the criteria set forth in s. 394.463, F.S. The number of involuntary evaluations of children has risen substantially over the last several years. According to the Baker Act Reporting Center at the University of South Florida, from Fiscal Year 2015-2016 to Fiscal Year 2019-2020, statewide involuntary examinations increased by 10.80% for children. Involuntary examinations of children made up 17.75% (35,965) of all involuntary examination in Fiscal Year 2019-2020. As a result of these concerning increases, the Department is examining what the contributing factors may be.

In 2019, the Department published its first report entitled The Report on Involuntary Examination of Minors analyzing trends related to the increasing numbers of involuntary examination of children under the Baker Act. Although the report provided valuable insight, it is important to note that the data analyzed was based on numbers of involuntary examinations to a designated receiving facility, not the number of admissions.

Findings from the 2017 Task Force on Involuntary Examination of Minors and 2019 Involuntary Examination of Minors reports resulted in several key recommendations that were passed into law, including Senate Bill 7026, Senate Bill 7012, and House Bill 945 as summarized below.

### Marjory Stoneman Douglas High School Public Safety Act

The Marjory Stoneman Douglas High School Public Safety Act, passed in 2018 resulting in the appropriation of $18.3 million for statewide access to MRT services and $9.8 million to expand access to Community Action Treatment (CAT) team services. MRTs provide crisis intervention services in any setting for individuals 25 years old or younger. CAT teams serve individuals ages 11-21 with a mental health diagnosis or co-occurring mental health and substance use diagnoses, who are at risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care; having two or more hospitalizations; involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement; or poor academic performance or suspensions.

The expansion of statewide access to MRT and CAT services have strengthened services and supports available for children and families, but opportunities for improvement remain. MRTs provide immediate crisis response (within 60 minutes after prioritization) with the goal of diverting individuals from a more intensive level of care; this service is not designed to meet the long-term service needs of children and families. Additionally, because MRTs often function in partnership with external systems, such as schools and law enforcement, service coordination and procedural agreements are required to ensure coordination. CAT programs provide longer-term services, but children must meet specific criteria to be enrolled in the program. As of May 14, 2021, CAT providers reported 690 young people waiting for CAT services statewide. The average wait ranges from approximately 12 days to 140 days, with the most frequent average wait approximately 47 days.

### Senate Bill 7012

Senate Bill 7012 passed in 2020 requiring receiving facilities to include information regarding the availability of local MRT services, suicide prevention resources, social supports, and local self-help groups with the notice of the release provided to the patient's guardian or representative if the patient is a minor. These requirements were added to the Managing Entity contracts in 2020 and are drafted into proposed changes for administrative rule 65E-5, The Mental Health Act, which implements Baker Act requirements.

### House Bill 945

House Bill 945 requires the Department and the Agency for Health Care Administration (Agency) to identify children and adolescents who are the highest utilizers of crisis stabilization services and jointly submit quarterly reports to the Legislature that list the actions taken to meet the behavioral health needs of these children through Fiscal Year 2022. The Department and the Agency defined high utilizers as children or adolescents under 18 years of age with three or more admissions into a Crisis Stabilization Unit (CSU) or an inpatient psychiatric hospital within 180 days.

In 2020, the Department published The Standards of Care in facilities Providing Crisis Stabilization Services for Children and Adolescents which assessed the quality of care provided in designated receiving facilities to children and adolescents who are high utilizers of crisis stabilization services. The Department found that of the crisis stabilization services minimum expectations set by the Substance Abuse and Mental Health Services Administration; Florida is meeting six out of nine and three others are substantially met.

In the 2019 Report on Involuntary Examinations of Minors, the Department looked at children with more than 10 admissions to a Baker Act receiving facility. When HB945 passed, the language requiring action related to high utilization of crisis stabilization services was distinctly different then the required reporting elements of the Involuntary Examination of Minors report. The Department interpreted this to mean the Legislature is interested in multiple admissions for crisis services in a short period of time. Crisis stabilization services are provided when a person is admitted to a CSU or an inpatient psychiatric hospital while involuntary examinations do not always result in admission. Therefore, a different approach was pursued for these reports as described below.

Data from the Financial and Services Accountability Management System (FASAMS), Medicaid fee-for-service claims, and managed care encounters were used to identify children and adolescents under the age of 18 with three or more admissions into crisis stabilization units or inpatient psychiatric hospitals. The preliminary data obtained by this process indicated that from January 1 - September 30, 2020, 959 children and adolescents met the high utilizer criteria from both agencies. The Department has published five quarterly High Utilization of Crisis Stabilization Services reports outlining the activities being taken to address high utilization; key accomplishments and recommendation are discussed below.

**The CSU high utilizer workgroup identified the following goals and strategies:**

### Short-term Goals

1. Provide educational materials and training resources to key system stakeholders; and
2. Strengthen MMA health plan care coordination requirements.

### Long-term Goals

1. Increase communication between receiving facilities, health plans, schools, and parents;
2. Leverage technology;
3. Improve discharge planning; and
4. Make changes to Rule 65E-5 to add a definition of high utilizer; require implementation of policies and procedures regarding discharge planning for those identified as a high utilizer; and strengthen discharge planning language for designated receiving facilities.

HB 945 also required the Department to collaborate with the Managing Entities and MRT providers, in consultation with the Louis De La Parte Florida Mental Health Institute, to develop a model response protocol for schools titled Best Practices Response Protocol for Schools to Use Mobile Response Teams to effectively use MRTs. This includes ensuring facilities provide contact information for MRTs to parents and caregivers of children and young adults up to 25 years of age, who receive safety-net behavioral health service. See Appendix A.

High utilization is defined as children and adolescents under 18 years of age with three or more admissions into a crisis stabilization unit (CSU) or an inpatient psychiatric hospital within 180 days.

# Involuntary Examination Process

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

## Determine if Baker Act criteria is met

An individual may be taken to a receiving facility for involuntary examination under the Baker Act if there is reason to believe he/she has a mental illness and because of the mental illness:

- The individual has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination, or he/she is unable to determine whether examination is necessary.
- Without care or treatment, the individual is likely to suffer from neglect or refuse to care for self, such neglect or refusal poses a real and present threat of substantial harm to their well-being, and it is not apparent that the harm may be avoided through the help of willing family members, friends, or the provision of other services.
- There is a substantial likelihood that without treatment the individual will cause serious bodily harm to self or others in the near future, as evidenced by recent behavior.

## Initiate an Involuntary Examination

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

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

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

## Conduct a Clinical Examination

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

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

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

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

# Baker Act Data

This section of the report includes data regarding minors who receive involuntary examinations or inpatient psychiatric hospitalizations for crisis stabilization services.

### Involuntary Examinations of Minors

The Department contracts with the University of South Florida Baker Act Reporting Center to obtain Baker Act forms from receiving facilities, analyze the data and prepare the Annual Baker Act Report. Chapter 394.463, F.S. requires the Department to receive and maintain copies of:

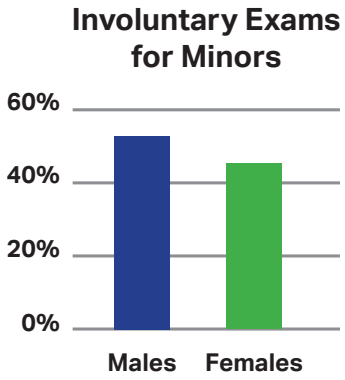
1. Documents to initiate involuntary examinations that are submitted by receiving facilities:
   - Law enforcement officers' reports;
   - Professional certificates; and
   - Ex parte orders for involuntary examination.

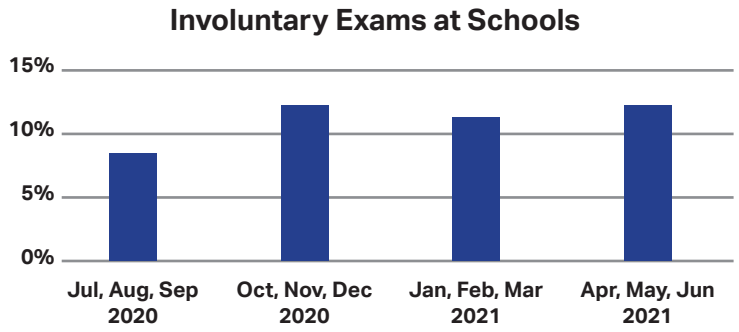
2. Documents related to involuntary outpatient services and involuntary inpatient placement submitted by the Clerk of the Court:
   - Involuntary outpatient services petitions and orders; and
   - Involuntary inpatient placement petitions and orders.

Certain limitations to the data should be noted. These forms are handwritten or typed and, at times, elements of the forms are missing or illegible, such as social security numbers. Social security numbers are necessary to count individuals and the number of forms missing social security numbers impacts the count of minors. Also, some involuntary examinations do not result in an admission to a Baker Act receiving facility because the clinical examination performed prior to admission determined they did not meet the criteria. The data do not include information on what occurred after the initial examination. For example, the data do not reveal how long individuals stayed at the facility; whether they remained on an involuntary or voluntary basis; or whether the involuntary examination was converted to a Marchman Act assessment.

### Trends Regarding Involuntary Examinations of Minors

According to the Reporting Center, during Fiscal Year 2019-2020 there were 128,193 individuals with at least one involuntary examination (this includes all ages). From this total, 24,171 minors under the age of 18 were involuntarily examined, accounting for 17.74% of those examinations. Of those, 55.39% were females and 44.19% were males. Preliminary data collected by the Reporting Center during Fiscal Year 2020-2021 indicate that most of the involuntary examination of minors occur outside of the school setting. Of note, this data was not reported on 8.15% of involuntary examinations. Graph 1 shows that the number of involuntary examinations initiated at schools was lower during July, August, and September of 2020 and nearly doubled the remaining months leading to June 2021.






## Repeat Examinations for all Minors

According to the Reporting Center, one quarter of the people with an involuntary examination had more than one during Fiscal Year 2019-2020; 23.97% of minors under 18 years of age had two or more involuntary examinations during the year. These are known as repeated involuntary examinations (See Table 1). Table 1 shows that more than 3,000 minors had two involuntary exams and a little more than 1,000 had three involuntary exams. The number of individuals decreased as the number of exams increased and the total count of exams decreased.

**Table 1: Minors with Repeated Involuntary Exams**

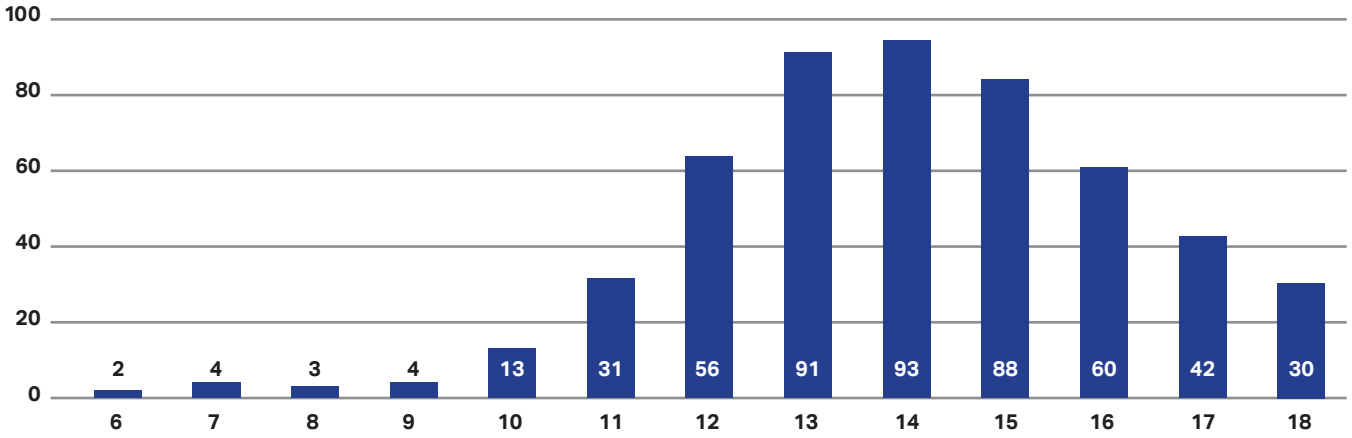
| # of Involuntary Exams | Count of People | % of People | Count of Exams | % Exams |
|---|---|---|---|---|
| 1 | 18,378 | 76.03% | 18,378 | 51.06% |
| 2 | 3,393 | 14.04% | 6,786 | 18.85% |
| 3 | 1,143 | 4.73% | 3,429 | 9.53% |
| 4 | 498 | 2.06% | 1,992 | 5.53% |
| 5 | 271 | 1.12% | 1,355 | 3.76% |
| 6-10 | 409 | 1.69% | 2,943 | 8.18% |
| **11+** | **79** | **0.33%** | **1,113** | **3.09%** |

Counts of exams for children with 11 or more involuntary exams during the year are grouped together to redact for cell sizes lower than 10.

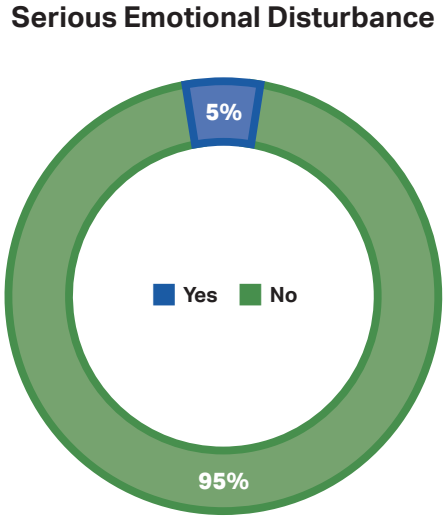
## Hospitalization of High Utilizers

Using Medicaid claims and encounter data and Managing Entity utilization data, the Department and the Agency looked at admissions to inpatient psychiatric hospitals and CSUs. Using the high utilizer criteria, from July 2019 to March 2020, there were 517 females and 402 males with three or more inpatient hospitalizations within 180 days for a total of 919 minors. Graph 2 shows an increase from age 8 to age 14 then a slow decline from age 15 to age 30.

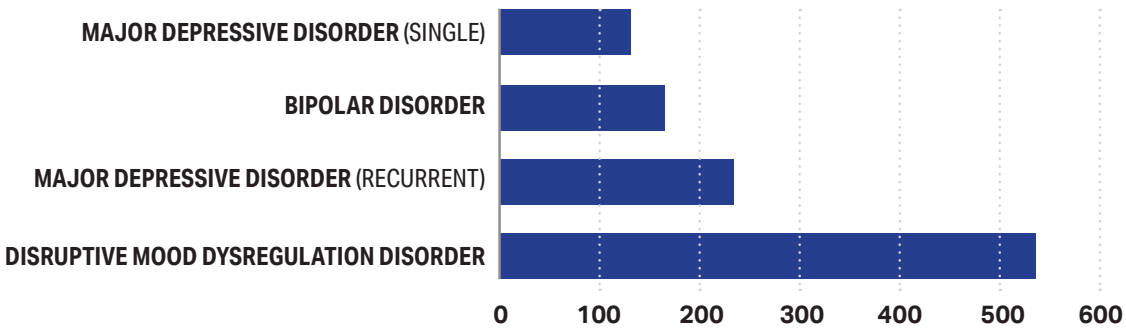
**Graph 2:** Age of Minors




The top four primary diagnoses as shown in Graph 3 were Disruptive Mood Dysregulation Disorder; Major Depressive Disorder, Recurrent, Severe Episode; Bipolar Disorder; and Major Depressive Disorder, Single Episode. Overall, 95 percent of minors had a serious emotional disturbance while 5 percent did not.




**Graph 3:** Primary Diagnosis



## Children's Care Coordination

To better understand the potential impact that children's care coordination could have on high utilizers, it is important to consider care coordination for adult high utilizers, which the Department implemented in 2016. The focus of adult care coordination is to divert individuals away from admission to State Mental Health Treatment Facilities (SMHTF) and to provide a bridge for individuals being discharged from SMHTFs to long-term community services and supports. The population served was initially limited to uninsured or underinsured adults due to limited funding and most children already having some type of private insurance or Medicaid coverage, which should have accounted for better access to care coordination. Adult care coordination resulted in positive outcomes and was recognized as effective and efficient. Over time, care coordination became the standard of care for the population and is regularly touted as an integral piece in the effort to transition from an acute care model to a recovery-oriented system of care.

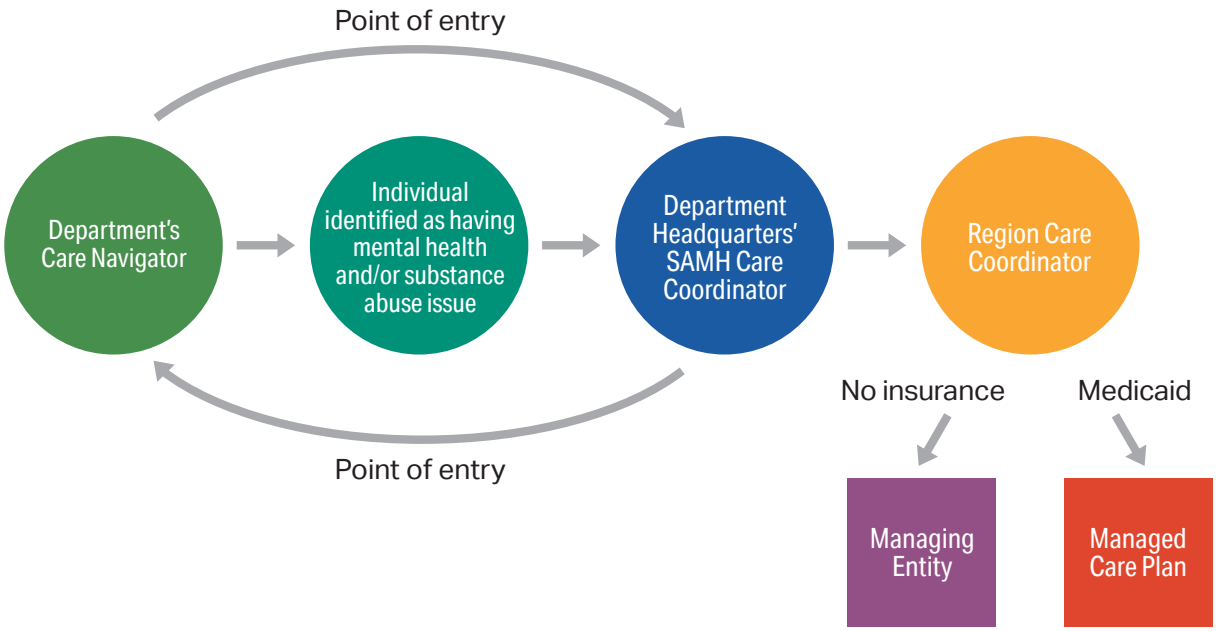
Care coordination links an individual to formal and long-term community services. Upon discharge, care coordination can engage an individual sooner than a traditional referral to long-term community services. The average length of time, in days, from acute care setting discharge to linkage to services in the community for adults enrolled in care coordination was two days in Fiscal Years 2019-2020 and 2020-2021. Care coordination also shows positive results with reducing readmission. Adults enrolled in care coordination and were readmitted to a CSU/inpatient facility or inpatient detoxification facility within 30 days decreased from 22% to 12% from Fiscal Year 2019-2020 to Fiscal Year 2020-2021.

As the care coordination work with high utilizer adults progressed, HB 945 was passed in 2020, and the Department published the Standards of Care in Facilities Providing Crisis Stabilization Services for Children and Adolescents report, it became clear that expanding care coordination to children would be beneficial.

In April of 2021, new federal funding opportunities including the Coronavirus Aid, Relief, and Economic Security (CARES) Act and supplemental block grant became available, and the Department saw an opportunity to allocate funds to create children's care coordinator positions at the Substance Abuse and Mental Health regional, Managing Entity, and provider levels. Children's care coordinators participate in local, regional, and state level staffings and carry out care coordination activities in between staffings. The Department's children care coordinators support children and families through a team-based approach, including outreach to providers, community supports, and community agencies.

The children's care coordination framework provides linkages to programs that meet the child's individualized needs, including economic self sufficiency, peer support, Medicaid health plans, and facilitates discharge transitions from crisis stabilization units. The children's care coordinators ensure that key stakeholders are engaged with the child to provide ongoing input and support to reduce the need for high utilization services to include crisis stabilization and residential treatment. The children's care coordinators work directly with children and their families connecting them| with services and supports. They participate in local staffing meetings and visit CSUs, Statewide Inpatient Psychiatric Program (SIPP) facilities, CAT teams and MRT providers and engage in efforts to reduce high utilization.

The children's care coordination process includes initial and ongoing case reviews and ensures coordination of services and collaboration with system partners and setting prioritized goals to aid in reducing admissions into crisis units. Interventions may include face-to-face visits for communication with the family/caregiver/legal guardian, the treating physician, and other providers as needed to collaboratively address identified behavioral health needs. The Department is currently implementing a children's care coordination framework as shown in the diagram below.



## Moment of Impact

The situation presented in this section show the impact that children's care coordinators have on the children and families they serve. The child's name has been changed to maintain confidentiality.

The Central Region children's care coordinator was informed by a child protective investigator of a 5-year-old adopted child having an increase of admissions to a CSU. The child was adopted at the age of three, and was displaying concerning behaviors. The care coordinator contacted the CSU and Medicaid health plan to discuss the child's situation.

The child has diagnoses of Attention Deficit Hyperactivity Disorder, Autism, and Oppositional Defiant Disorder. The child was first Baker Acted in May 2021 and three more times in June 2021 due to showing physically and verbally aggressive behaviors towards the family, including the 18-month old sibling. The child was receiving therapeutic services once a week but lacked other services. The family recently reached out to the post-adoption agency with their concerns, which then prompted a referral to the local review team for a staffing in June 2021.

During the Local Review team staffings, the following recommendations were made:

- Increase therapy from once a week to twice a week;
- Home health aide;
- Trauma-based therapy;
- An educational advocate for in-school supportive services;
- Applied Behavioral Analysis;
- Connection to the MRT; and
- Follow up with neurologist for medication management and concerns about the child's sleeping habits.

As of this writing, the child is stabilized and no further admissions to a CSU have occurred. The children's care coordinator linked the child's family to wraparound services and the parents describe improvements in the child's aggressive behaviors, sleeping, and eating habits.

## Mobile Response Teams

In 2018, the Florida Legislature allocated $18.3 million in general revenue funding through the Marjorie Stoneman Douglas High School Public Safety Act for the Department to expand MRT services statewide. The goal of the MRT program is to conduct an independent assessment to determine if the individual may be safely diverted from involuntary examination. In addition to helping resolve the crisis, MRTs work with individuals and families to identify resources, provide linkages, and develop strategies for effectively managing potential future crises. There are 39 MRTs covering all 67 counties in Florida available 24 hours a day, seven days a week within 60 minutes for calls that require an acute response.

During Fiscal Year 2020-2021 MRTs received 22,160 calls; of those, 6,581 were from a school and 16,651 required an acute response. Of the 16,651 calls requiring an acute response, only 3,145 resulted in an involuntary examination. The expansion of MRT services has proven to be successful at diverting children and young adults from involuntary examinations approximately 80% of the time. The use of MRTs to serve individuals through community-based services is associated with better outcomes and can lower costs when an admission to a receiving facility is prevented.

Beginning in Fiscal Year 2021-2022, the Department will expand MRT with $2,482,362 in Community Mental Health Block grant funding.

## Community Action Treatment Teams

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

The CAT model has demonstrated positive outcomes, such as improved family functioning, improved school attendance, and keeping children in their homes. Fiscal Year 2020-2021 outcome measures for the CAT teams, included in provider contracts, show:

- 98 percent of providers met targets for school attendance;
- 93 percent of providers met targets for improved level of functioning – based on several standardized assessments;
- 100 percent of providers met targets for living in a community setting; and
- 98 percent of providers met targets for improved family functioning.

Serving youth in foster care, residential mental health treatment, and juvenile justice programs is typically more expensive than serving them in the community behavioral health system. For example, effective January 2021, the rate for Medicaid-funded SIPP is $478.04 per day, with an average length of stay of six months, totaling to $87,003.28 for a six-month treatment episode. During Fiscal Year 2020-21, CAT teams served 3,423 families. The average cost per child and family served is approximately $8,983.35 for the total cost of treatment and the total allocation was $30,750,000. In addition to the financial return on investment, CAT teams focus on keeping young people at home with their families and connected to their communities. This includes addressing school attendance, successful transition to adulthood, and involvement in activities that lead to career exploration and employment. Table 2 displays the discharge data for CAT teams over the last six fiscal years, demonstrating that most children remain in the community with their families at the time of discharge from CAT teams.

**Table 2:** Discharge Data for CAT teams Fiscal Year 2015/2016 - 2020/2021

| Table 2: Discharge Data for CAT teams Fiscal Year 2015/2016- 2020/2021 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Discharge Disposition** | **FY15-16** | **FY16-17** | **FY17-18** | **FY18-19** | **FY19-20** | **FY20-21** | **Total # FYs 15-21** | **% FYs** |
| CAT Participants Removed from Home due to Child Welfare Involvement | 20 | 16 | 31 | 32 | 37 | 27 | 163 | 1.98% |
| CAT Participants Discharged to a Residential Treatment Program | 60 | 78 | 80 | 120 | 106 | 82 | 526 | 6.36% |
| CAT Participants Discharged to Juvenile Justice Commitment | 27 | 35 | 31 | 49 | 40 | 30 | 212 | 2.56% |
| CAT Participants Living in the Community at Discharge | 694 | 938 | 1,061 | 1,440 | 1,615 | 1,620 | 7,368 | 89.1% |
| **Total Discharges:** | **801** | **1,067** | **1,203** | **1,641** | **1,798** | **1,759** | **8,269** | **100%** |

## Recommendations

**Funding for Respite Services**

Respite services are designed to temporarily sustain a family or other primary caregiver by providing time-limited, temporary relief, from the ongoing responsibilities of care giving. These short respites allow the caregiver the time to do something for themselves, have a sense of normalcy while the child participates in activities and engages in social interaction in a safe place. Provided at the right moment, respite services could reduce reliance on Baker Acting children when caregivers are having trouble effectively managing challenging behaviors. According to feedback from behavioral health providers, respite is underutilized due to low reimbursement rates, creating a service delivery gap. Therefore, increasing access to respite services through restructuring funding through the Managing Entities and Medicaid could be considered. Additional discussion is needed to determine the details of the delivery model, payment structure, and required federal authority.

Additionally, the Department could explore using the Living Room model with children which is a walk-in respite center for individuals in crisis. These centers offer calm, home-like settings. The goal of the Living Room Model is to provide a safe and secure environment where multidisciplinary professionals can observe and treat individuals in crisis. This has been successfully used in other states, mostly with adult high utilizers, and research has shown that the Living Room Model is effective at treating adults in crisis in a very cost-effective manner and in diverting adults from psychiatric inpatient hospitalization.

**Explore Sustainability of Children's Care Coordinators**

The Department is currently testing the effectiveness of children's care coordination to reduce high utilization of crisis stabilization services by funding positions through the non-recurring supplemental block grant funds ending in 2024. A children's care coordination protocol is under development to identify the appropriate case load ratio, minimum number of contacts per week, and the specific educational and work experience that are necessary for children's care coordinator positions. To maintain improvements to the system; benefits to children and families in need of behavioral health services and supports; and reduce the number of children repeatedly admitted to crisis stabilization services; evaluation of children's care coordination effectiveness should be considered when considering sustainability.

**Statutory Language Addressing Baker Acts**

Chapter 394, F.S. can be revised to better support high utilizer children by adding a definition and specific authority to continue services while safe discharge plans are arranged, including access to residential services when recommended. Develop specific discharge criteria for high utilizer children that must be in place prior to discharge and address how to maintain the child if there is not a favorable response to services to ensure safety and support the family's needs.

Additional statutory changes can include removing the requirement for a minor to undergo a judicial hearing to verify the voluntariness of consent prior to a voluntary admission to a Baker Act receiving facility for evaluation and crisis stabilization in section 394.4625(1)(a), F.S. Amongst other factors, recent increases in the use of involuntary examination on minors indicates that the requirement for a judicial hearing prior to a voluntary admission, while intended to protect minors, has deprived children

and their parents of the right to seek treatment voluntarily in the least restrictive manner possible. As the need for an emergency evaluation can occur at any time of the day or night, seven days a week, most communities do not have the capacity to conduct judicial hearings to the degree needed to comply with this law.

While only a few studies focus on the experience of involuntary psychiatric hospitalization among youth, especially the post-discharge impact of these experiences the research demonstrates that Florida statute provision requiring an administrative hearing for voluntariness determination may be creating an artificial and unnecessary barrier to best-practice treatment services. Studies focusing on this topic consistently demonstrate that involuntary hospitalizations should occur less often than voluntary hospitalizations, and involuntary admissions are less therapeutic.

In one study, three quarters of the youth reported negative impacts of involuntary hospitalizations on trust, including unwillingness to disclose suicidal feelings or intentions. Factors identified by the youth as contributing to distrust included perceptions of inpatient treatment as more punitive than therapeutic, staff as more judgmental than empathetic, and hospitalization overall failing to meet therapeutic needs.[1]

In the first large cohort study on involuntary versus voluntary treatment of children and adolescents in Germany, about every fourth patient was treated involuntarily. Group comparisons showed 70.8 percent of patients were voluntarily and 29.2 percent involuntarily admitted. The strongest predictor of being admitted involuntarily was a diagnosis of intellectual disability. Adolescence, substance abuse, and psychotic disorders were also strongly associated.[2]

Finally, a study reviewing the voluntariness for inpatient psychiatric settings in the United States demonstrated that voluntary admissions for all treatment settings exceed involuntary admission by at least two to one on average.[3]

In *National Guidelines for Behavioral Health Crisis Care*, the "Percentage of involuntary commitment referrals converted to voluntary" is recommended as a key performance metric for crisis care. Also, best practice guidelines for implementing a Crisis Care system include: "Working to convert those with an involuntary commitment to voluntary so they are invested in their own recovery."[4]

[1] Jones, N., Gius, B.K., Shields, M. et al. Investigating the impact of involuntarypsychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Soc Psychiatry Psychiatr Epidemiol* 56, 2017–2027 (2021). https://doi.org/10.1007/s00127-021-02048-2

[2] https://www.semanticscholar.org/paper/Voluntary-versus-involuntary-hospital-admission-in-Jendreyschak-Illes/54fd598d0412a7613ce67878c4202bc709bd3c86J, Jendreyschak, F. Illes, +9 authors I. Haussleiter, European Child & Adolescent Psychiatry, 2013.

[3] Psychiatric inpatient settings: voluntary/involuntary patient share by type U.S. 2014 | Statista

[4] A Best Practice Toolkit Knowledge Informing Transformation, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), 2020