



COSTLY AND CRUEL

How Misuse of the Baker Act Harms 37,000
Florida Children Each Year

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EXECUTIVE SUMMARY

In Florida, more than 37,000 children are “Baker Acted” each year.¹

That is, in this state, we authorize the involuntary arrest, transport, hold, and psychiatric examination of so many children under the Florida Mental Health Act,² known as the Baker Act, that it has become a verb. Even worse, Baker Acting has become a “normal” behavioral management tool for far too many Florida classrooms, schools and residential foster care facilities. Children as young as 5 and 6 are handcuffed and forcibly taken by police to psychiatric hospitals, where they legally can be held for up to 72 business hours in conditions that would harm and traumatize even adults.

Still, schools, residential facilities, and police often decide to subject children to this trauma without first notifying the child’s parent or guardian or over their parent’s objections, even when doing so isn’t necessary for the child’s safety. Because of understaffing or the desire to maximize fees, some psychiatric facilities make matters worse by holding overnight and longer than needed these frightened and traumatized children, some of whom they involuntarily sedate.

Involuntary psychiatric institutionalization is an extremely invasive and deeply traumatic intervention that is legal to use only when a child actually poses a danger of death or serious bodily harm to themselves or others that cannot be otherwise ameliorated. The Baker Act applies to both children and adults but does not distinguish between the two. By statute, this dire intervention should not even be considered unless a child has a mental illness that can be treated at such a facility and there are no less restrictive means to mitigate the immediate danger that child poses. Yet, schools, police, and foster care facilities in Florida routinely use the Baker Act

on: (1) children with disabilities, such as autism or other developmental disabilities; (2) children with a diagnosis of mental illness who can be appropriately treated in a less-restrictive setting than an inpatient psychiatric facility; and, (3) children who are exhibiting developmentally and age-appropriate behavior, who are merely disobedient, noncompliant or disruptive, and whose disruptive or concerning behaviors are not related to a mental illness or other disability.

In each of these instances, the Baker Act is not only an inappropriate intervention, it is a harmful and often illegal one. No child should be Baker Acted for exhibiting a behavior caused by a developmental disability (like autism), because the Florida legislature explicitly excluded such disabilities from the statute’s criteria and, more importantly, because developmental and intellectual disabilities are not mental illnesses and, therefore, mental health treatment facilities are not equipped to meet their needs.

The excessive rates at which Florida involuntarily holds and examines children in psychiatric facilities³ is unheard-of in other states.⁴ Worse, this overuse is growing: Over the last two decades, use of the Baker Act, including against children, has more than doubled — far outpacing growth in Florida’s population or rates of mental health diagnoses.⁵ This explosion in Baker Act use has coincided with a drastic increase in police presence in schools⁶, suggesting that the Baker Act is being used punitively in some cases, like juvenile arrests and incarceration, to target and remove children that teachers, administrators, and school police perceive as uncontrollable or undesirable. These children, and the school itself, would be better served if school staff and police had the resources and training to provide less-invasive, less-costly, and more-effective interventions that could

help them better manage the behavior and needs of children in their care.

Baker Act reform is not just a children’s mental health issue or one that only affects children with disabilities; it is also a racial justice issue. Like juvenile arrest and incarceration, the Baker Act is used disproportionately against children of color⁷ and has negative, long-lasting consequences. Implicit bias also affects the diagnosis and treatment of Black and Brown children, whose behaviors may be more likely seen as symptoms of conduct disorders or other mental health issues than similar behaviors by white children.⁸ Moreover, excessive use of the Baker Act contributes to the school-to-prison pipeline and the overall damaging, costly, and unnecessary institutionalization of children in Florida.

Though Baker Act misuse has been well-documented, reform has been elusive, in part because schools, law enforcement agencies, and local behavioral health systems fail to collect adequate data for analysis of why, when, where, and on which children the Baker Act is used. Better data must be collected at all levels and stages of the Baker Act process, so that policymakers can understand the full scope of the issue. In addition, better data collection can help with the implementation of common-sense changes, which also must be informed by the expertise of mental health professionals as well as the experience of children and families who have survived and borne the enormous cost of involuntary holds, forced medication, and unnecessary examinations.

There are significant changes Florida can and should make to move away from a culture of default institutionalization and to provide children with access to the supports they need within their own communities.⁹ But even basic changes in law, policy, and practice could prevent the majority of children who are at risk of being illegally or unnecessarily Baker Acted from experiencing the trauma of arrest and involuntary psychiatric hospitalization. These changes include:

- Providing robust training at schools, residential facilities, and in law enforcement regarding de-escalation methods and the narrow criteria for involuntary examination (including how to interpret the criteria standards and make evidence-based assessments of the alleged threat) and providing public education about the appropriate use and limitations of the Baker Act;
 - Notifying parents and guardians before a Baker Act is initiated and requiring their consent;
 - Fully integrating mobile crisis teams, telehealth services and credentialed school psychologists and social workers to help de-escalate and stabilize children experiencing crises and in determining whether to initiate an involuntary examination under the Baker Act;
 - When transporting a child is absolutely necessary and parents or guardians have consented to such a response, allowing parents, guardians, or medical professionals to transport children to psychiatric facilities or other non-traumatic crisis stabilization units instead of police and requiring that any police transport be done in the least-restrictive means possible for the child’s safety and well-being;
- Requiring schools to intervene – while complying with state and federal privacy laws and adhering to students’ Individualized Education Programs (IEPs)¹⁰ – so that law enforcement officials (school-based or otherwise) do not wrongfully Baker Act students with disabilities;





- Requiring a mental health professional at receiving facilities to make an independent assessment of whether a child qualifies for involuntary examination before admitting them, including screening for developmental disabilities that do not qualify under the Baker Act criteria; and
- Requiring those who Baker Act children to provide better data so lawmakers can understand its impact and identify systemic failures.

Florida lawmakers can and must reform the Baker Act to stop its overuse and save tens of thousands of children from needless harm every year. School administrators, police departments, psychiatric facilities, and residential foster care facilities can and must track and report critical information each time a child is Baker Acted. And they must be held accountable for any illegal or unnecessary use that fails to meet the stringent legal criteria required for such a consequential intervention.

This report offers a critical analysis of where the statutory protections of the Baker Act fall short, for children in particular, how it is often illegally and inappropriately implemented in violation of existing law, what impact its misuse has on children, and how we can fix it.

THE TRAUMATIC EXPERIENCE OF BEING BAKER ACTED

Shawn M was just 10 years old when he faced one of the most terrifying experiences of his young life.¹¹ To this day, Shawn is still afraid, haunted by the day in 2018 that he was taken from his school by a police officer, caged in the back of a police car, driven away from his distraught father, and held overnight without contact with his family in a psychiatric ward with older children — all because he expressed to a teacher some distress over losing a playground game.

Shawn is just one of tens of thousands of children in Florida on whom the Baker Act has been used at school — even though he did not meet the statutory criteria and his parents strenuously objected — in place of appropriate mental and behavioral health care and interventions in the community.

When he was taken and involuntarily committed, Shawn was a fourth-grade student in an Orange County public school. Shawn, who has autism spectrum disorder (ASD), had been placed in a class for children with ASD, with the goal of transitioning him to a general education classroom over time. Because of his autism, Shawn sometimes reacted strongly to situations that might not have generated the same reaction in other children, but his parents and teachers understood how to de-escalate him in those situations. That all changed one day in early 2018 when he was Baker Acted.


That day, he and his friends were playing a game called the “orange touch,” the equivalent of “cooties.” Shawn was touched and it triggered a strong reaction. He became upset and said something that a teacher interpreted as meaning he wanted to hurt himself. But there was no reason to think Shawn genuinely and imminently was going to do actual harm to himself. He had no actionable plan for self-harm, engaged in no self-harming behavior, and he calmed down after his initial outburst. However, instead of contacting Shawn’s parents or a counselor, the school took the drastic step of contacting the local sheriff’s department to take him to a psychiatric facility for involuntary examination and treatment. Even the responding officer wrote in his report that Shawn was “calm and talkative,” but he nonetheless con-



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tinued to Baker Act Shawn based on his layman’s diagnosis that Shawn wanted to hurt himself because Shawn allegedly made a reference to jumping off of a nonexistent bridge.

Shawn’s dad, Brian, was not contacted until after the school had already taken steps to Baker Act him. When the school finally informed Brian, he raced there as quickly as he could, but it still took him 45 minutes to arrive. To this day, Brian lives with the regret and guilt of being out of Shawn’s immediate reach. When he finally made it to campus, he saw the armed and uniformed sheriff’s deputy already



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questioning Shawn in the principal’s office. Brian explained to the deputy that Shawn had autism and was not always able to control his emotions, but these kinds of reactions were normal, and he knew how to help Shawn deal with them. He begged the officer to allow him to take his son home, assured them that Shawn wouldn’t try to hurt himself, and that he would stop Shawn and care for him if he tried. But the deputy refused, claiming that the law required him to take Shawn to a facility once the school called, regardless of his father’s ability to care for him appropriately, regardless of his wishes, and regardless of the fact that his son had a known developmental disability that accounted for his behavior.

Realizing that his pleas to take his son home were futile, Brian tried to convince the deputy to at least let him drive Shawn to the Baker Act receiving facility while the officer followed them, so that Shawn would not have to experience being put in a police car. That plea, too, was refused. Unrelenting in his advocacy to spare his son as much trauma as possible, Brian had to beg the deputy to persuade him not to handcuff Shawn — a practice that is common (and some police believe required) when children are Baker Acted. Brian still has difficulty describing what came next — the moment when he kneeled down in front of his son to try to explain what was happening. While doing his best to hold back tears, Brian tried to convince Shawn that, despite what he was experiencing, he was not in trouble, he was not being arrested, and he was not being sent to jail, but rather that everything would be all right. It is this nightmarish moment, of police tearing Shawn away from his father and driving him away in the back of a cop car, that has continued years later to affect Shawn the most.

Distraught but determined, Brian followed Shawn and the deputy to a local psychiatric facility, where Shawn was placed in the facility’s care. Brian again tried to explain that the school had overreacted to a normal manifestation of Shawn’s autism and that he was not a danger to himself or others. The intake person was sympathetic, telling Brian that they always “cringe” when a child with autism is brought in because the Baker Act can only legally be used when mental illness causes a child to be dangerous to themselves or others — not when a child has a developmental disability like autism. Shawn’s medical records show that facility staff wrote that,

because Shawn had autism, they were “unable to assess” most of the criteria they normally used to determine whether a child was a danger to themselves or others. Because developmental disabilities are not mental illnesses, a child with such a disability cannot be treated or helped for that disability by being in a psychiatric facility.

Nonetheless, because the Baker Act had already been initiated, the facility told Brian it could not release Shawn until he was examined by the only psychiatrist on staff, which could not happen until the next day. Brian was not allowed to visit Shawn, see the area where Shawn was being held, or even talk with him on the phone while he was in the facility. Brian was told visitation was only allowed on Saturdays and, because Shawn was brought in mid-week, he likely would be held over the weekend — that is, for more than five days. Defeated, Brian had to accept that the trauma of Shawn’s forcible removal from school would be compounded by an overnight stay — the first night ever in his young life outside the care of his family. Not only was Shawn away from the safety of his home, but he was being held in an institutional setting with teenagers and older children, some of whom exhibited behaviors Shawn found scary, without any understanding of what was happening to him or why his parents weren’t coming. Only because Brian was able to find and pay for a private attorney, who threatened to sue the facility if they didn’t let Shawn go, was Shawn released the next day.

While Shawn eventually returned to his loving family and did not ever attempt to harm himself, the effects of his experience linger to this day, years later. Even though the recurring nightmares about the incident have started to subside, Shawn has not fully healed. He frequently talks about not wanting to “go to jail” again — an indistinguishable experience in his mind from the experience of being Baker Acted. He is still fearful of law enforcement and terrified of getting in trouble at school when anything out of the norm occurs, sometimes resulting in an emotional breakdown. Rather than help Shawn, the school’s use of the Baker Act has caused him lasting harm. In Florida, Shawn’s story sadly is not unusual. Tens of thousands of children have this nightmarish experience every year and are left to put back the pieces of their lives when the worst of it is over, while still dealing with its lingering effects.



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HOW DOES THE BAKER ACT WORK?

What Does the Law Say?

In Florida, involuntary psychiatric exams are appropriate only in rare emergencies — when a person is truly an imminent danger to themselves or others because of a mental illness. Currently, the law makes no distinction between involuntary examination criteria for children as compared to adults. Under the statute, these stringent requirements must be met to lawfully Baker Act someone, including a child:

- A reason to believe the person has a mental illness and *because of* that mental illness¹²;
 - The person refuses voluntary examination after a full explanation of its purpose; or
 - The person is unable to determine whether examination is necessary; and
- Without care or treatment, the person is likely to suffer from neglect, which poses a real and present threat of substantial harm to her/his/their well-being; and
 - It is not clear that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- Without care or treatment, there is a substantial likelihood (evidenced by recent behavior) that the person will cause serious bodily harm to self or others in the near future.¹³



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Though the criteria is the same for children and adults, children are more likely to be involuntarily Baker Acted under the last prong — i.e., the “likely to cause harm to self or others” criteria — because minors cannot generally receive voluntary inpatient services.¹⁴ Minors, moreover, are not expected to care for themselves, and so generally are not Baker Acted on the basis that they will not do so. Because the assessor is unlikely to use the self-neglect prong of the Baker Act criteria, the assessor is equally unlikely to consider whether supportive friends or family could prevent harm, negating an important failsafe that, for adults, would prevent unnecessary Baker Acts.

Who Can Initiate a Baker Act?

Involuntary examinations can be initiated by judges, medical professionals, or law enforcement officers.¹⁵ In schools, however, where at least a quarter of the Baker Acts against children happen,¹⁶ they almost always are initiated by law enforcement officers — often with limited and variable training.¹⁷ The standards of evidence and expertise required for each of these actors to initiate a Baker Act differ significantly, and these standards vary in illogical ways.

The statute directs that a medical professional who finds that someone has met the statutory criteria for involuntary examination may initiate an examination, but that law enforcement officers “shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system.”¹⁸

Many law enforcement officers interpret this to mean that they must Baker Act a child once a school asks them to do so or contacts them regarding a child.¹⁹ Indeed, guidance from the Florida Department of Children and Families emphasizes that, when deciding whether to subject a person to involuntary examination, the officer should err on the side of initiating an examination and “leave it to mental health experts to confirm whether the criteria have been met.”²⁰ Moreover, officers may rely

on “credible eyewitness accounts” to determine if a person appears to meet the criteria for involuntary examination.²¹ As a result of these provisions, officers who are informed that a child has acted in a way that might imply they could be a danger to themselves or others sometimes claim that they have no choice but to initiate an involuntary examination, even though they themselves have witnessed no concerning behavior and even though the strict legal requirements for involuntary psychiatric holds have clearly not been met.²²

In comparison, the law does not allow a medical professional — which includes a “[a] physician, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse ..., a mental health counselor, a marriage and family therapist, or a clinical social worker” — to initiate an involuntary examination unless they certify that they have directly observed within the previous 48 hours and documented behavior that meets the statutory criteria (that is, that the person has a mental illness and, because of that mental illness, poses an imminent risk of serious bodily harm to themselves or others).²³

In other words, even though they lack medical training, law enforcement officers are held to a far lower standard of evidence than medical professionals when deciding whether to Baker Act. This means children, who are more likely to be Baker Acted by police because of greater police presence and the lack of mental health professionals in schools, face a greater risk of being inappropriately or illegally Baker Acted without any actual evidence of a mental illness and without exhibiting recent behavior that shows they are likely to cause themselves or others serious bodily harm in the near future.

Once a police officer formally initiates a Baker Act, the child must be detained at the facility until a physician or a clinical psychologist, or, in certain circumstances, a psychiatric nurse, examines and releases the child, even if other highly trained mental health professionals at the facility (such as an advanced practice registered nurse, mental health

counselor, family therapist, or clinical social worker) recognize that the child does not need or does not meet the basic requirements for an involuntary psychiatric examination.²⁴ Ironically, if a parent instead of police brought the same child to the facility, any of those same trained medical staff would have the authority, using the higher evidentiary standard of medical professionals, to make the initial determination as to whether the child needed to be admitted.²⁵

The Baker Act thus irrationally gives greater weight to law enforcement officers’ decisions that are based on less information than to those of medical professionals with more training and higher evidentiary standards. Affording greater weight to law enforcement officers’ judgment over that of medical professionals is especially inappropriate and unusual given that no other situation in which law enforcement takes an individual for medical care operates in this manner.

For example, for other kinds of health-related emergencies, law enforcement may on occasion transport an individual to a hospital or an emergency room. However, in such a situation, once an officer has brought an individual to a medical facility, medical staff on site would determine whether that person needs in-patient care and if they should be admitted for treatment.

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Which Children Get Baker Acted?

No matter how it is initiated, far too often the behaviors that lead to a Baker Act in schools do not meet the legal criteria for involuntary examination under the Act.²⁶

There are three main categories²⁷ of children who are wrongly Baker Acted because they do not require or would not benefit from psychiatric hospitalization: (1) those who manifest developmentally appropriate behaviors, usually some form of sadness, which may require counseling or other mental health treatment²⁸; (2) those who manifest behaviors consistent with a disability; and (3) those who are “misbehaving” and are Baker Acted as a form of discipline or a deliberate effort to push them out of school.

Children in the first category — students doing things that are ordinary for children their age — do not typically require any intervention or services at all. For example, Braden H, who was 11, was Baker Acted in 2018 after telling a joke to his friends. Braden was walking across the grounds of his middle school with his sixth-grade classmates when he noticed a pile of ropes and, to make his friends laugh, joked, “oh look, ropes. Time to go hang myself.”²⁹ A substitute teacher overheard and referred him to a counselor, who asked if he was depressed. Braden replied that he had been sad because his grandmother recently died, but it was unrelated to his joke. Despite this, an officer decided to Baker Act him over his father’s objection. In another example, an 11-year-old girl in Pasco County was Baker Acted after she texted a friend sarcastically, “I have so much homework, I’m so stressed, I’m going to kill myself.” She was held in a psychiatric facility over her parents’ objections for five days, and the facility was so full that she spent the first night sleeping in a desk chair.³⁰

Some children in this category may simply be exhibiting behaviors that are appropriate and normal for their stage of development or circumstances but that are not an indication of mental illness and may not require any form of mental health inter-



vention at all. Other children in this category may benefit from, and may indeed already be receiving, counseling or care from a medical practitioner, such as children who are already diagnosed with depression or emotional and behavioral disorders, but do not require or benefit from involuntary psychiatric treatment. Even if they behave or express thoughts that alarm adults, involuntary hospitalization may be contraindicated. Nonetheless, under current practices, children who are already receiving treatment for a mental illness are often Baker Acted without any consultation with their physician.

The second category of children are students whose behavior is solely a manifestation of a disability rather than mental illness. Many of them, like Shawn, have intellectual or developmental disabilities such as autism, which cannot be the legal basis for a Baker Act. Adults who lack proper training, however, often falsely misinterpret behaviors that are caused by developmental and other disabilities as symptoms of dangerous mental illness.

For example, in the fall of 2018 in Coca, Florida, a 12-year-old boy with autism became upset at experiencing a new environment on his first day of school.³¹ He scratched his arms and made a reference to suicide. The school had an explicit written plan, as part of his IEP, about what to say and do in just such a situation, but the school decided to Baker Act him instead of following the IEP, as required under federal law. In this case, much like in Shawn’s, sending a boy with autism to a receiving facility solely because of his developmental disability not only violated the law, it was pointless and harmful. He had no mental crisis for the psychiatric facility to stabilize or treat, leaving him with only a damaging experience.

The third category of children — students who are Baker Acted in school as a form of discipline or pushout — are rarely a danger to themselves or others. Solan C, for example, was in 10th grade when he got into a dispute with another boy over a girl they both liked.³² The other boy wrote on a bathroom stall, “Solan, I will kill you,” to which Solan replied, “try me.” There was no indication of any kind to suggest Solan had a weapon or specific plans to cause actual harm to any of his classmates. Nor was there any evidence whatsoever that he was suffering from a mental illness. Yet, Solan was still tackled by four police officers, handcuffed, and Baker Acted.

The evidence suggests that, in cases like this,


police and school staff use the Baker Act as a form of punishment that allows them to physically restrain, detain and remove from school children whom they deem to be “problem students.”³³ At the same time, because Baker Act statistics are not included in arrest rates, the option of Baker Acting children allows them to avoid higher arrest numbers and influence crime statistics.³⁴ Given the well-documented disparities in exclusionary student discipline across the nation and in Florida specifically,³⁵ it is no surprise that using the Baker Act as a form of discipline also creates a greater risk for Black students and other students of color and students with disabilities, resulting, as discussed below, in similarly disproportionate rates of Baker Acting and further fueling the disproportionate rates of the other predictable negative consequences of exclusionary discipline (e.g., among other things, higher rates of school dropout as well as “decreased academic achievement, emotional well-being and self-concept.”³⁶)

What Happens to Children Once a Baker Act is Initiated?

Regardless of how or why a child is Baker Acted, the experience is often traumatizing.³⁷ When police arrive on the scene, an officer typically handcuffs the child and puts them in the back of a police car, just as they would if the child had committed a serious crime. The officer transports the child to a psychiatric facility authorized to conduct involuntary examinations under the Baker Act, known as a Baker Act Receiving Facility. In rural areas of the state, children may even be transported across county lines and over long distances because of the location of receiving facilities. This practice is routine, including for children as young as 5, even though this treatment is prohibited in all but extraordinary circumstances under Florida law, which states:

Procedures, facilities, vehicles, and restraining devices utilized for criminals or those accused of crime shall not be used in connection with persons who have a mental illness, except for the protection of the patient or others.³⁸

At the receiving facility, several things can happen. If the facility decides the child does not meet the statutory criteria for involuntary examination,

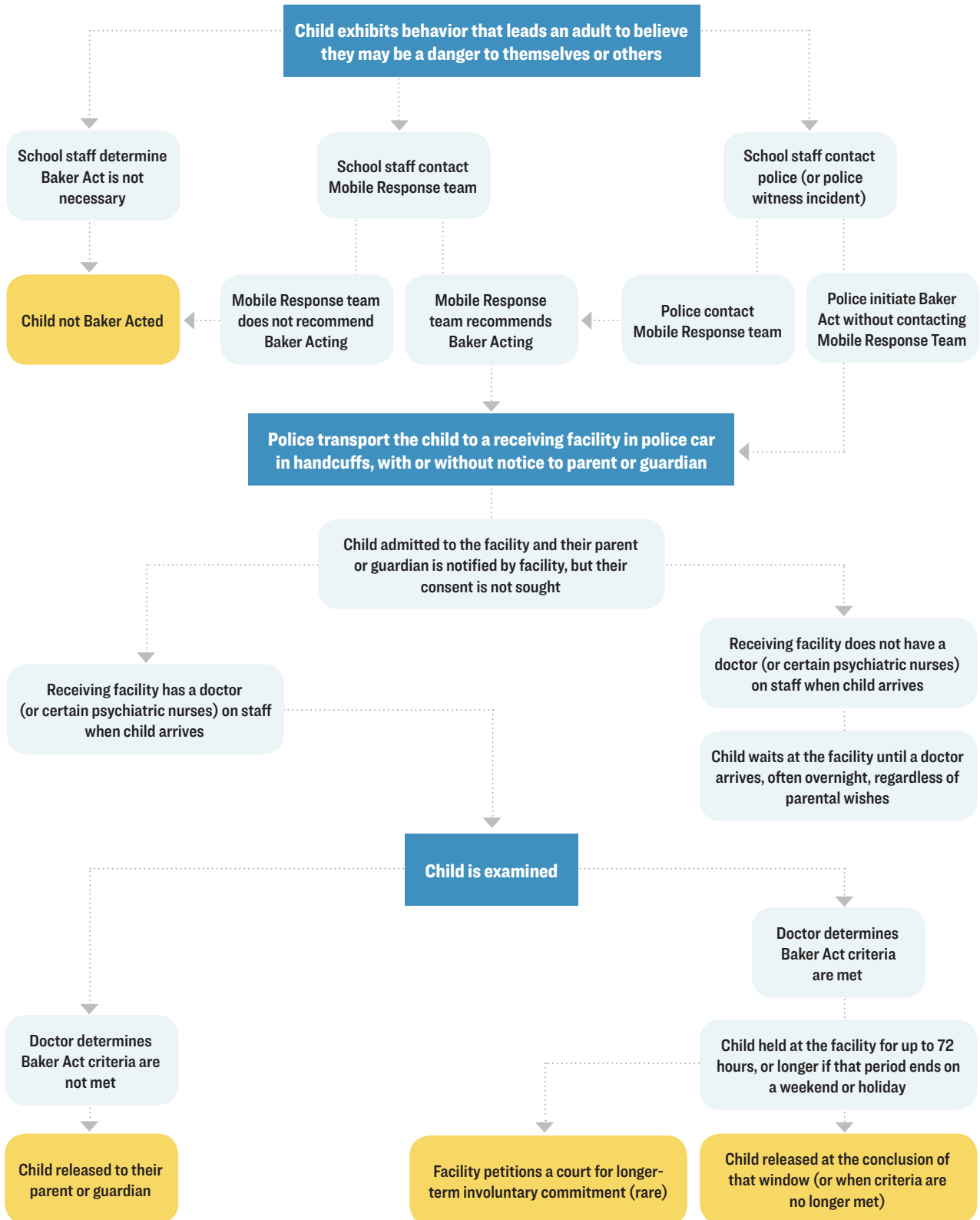

“[C]hildren who are already receiving treatment for a mental illness are often Baker Acted without any consultation with their physician.”

it sometimes releases the child to their parent or guardian. But this is not always possible. Once a police officer has formally initiated the Baker Act of a child (i.e., completed a simple form), the law allows only certain facility staff — a physician or clinical psychologist — to release the child back into their parent’s or guardian’s care.³⁹ The problem with this requirement is that, in many facilities, a physician or clinical psychologist is only present for part of the day and receiving facilities are only required to begin the examination process for a child within 12 hours of admission.⁴⁰

As a result, in many cases, when police initiate a Baker Act and bring a child to a receiving facility in the afternoon, that child is automatically held at the facility overnight — even if trained mental health professionals at the facility have concluded they should have never been brought there or that there is no reason to keep them there.

Once admitted, a child could be caught in the statutory web that authorized their detention for days. Even when they can and should release children, many facilities choose not to do so, particularly when children are covered by insurance, and instead hold most or all children for the maximum 72 hours permitted by the statute without court review.⁴¹ If that 72-hour period ends on a weekend or holiday, facilities may hold children for even longer until the next working day.⁴² At that point, the facilities usually release most children. But if a facility asserts that the child remains a danger to himself or others and

WHAT HAPPENS WHEN A CHILD IS BAKER ACTED?





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less-restrictive options are not appropriate, the law permits the facility to petition the court to hold the child for more time.⁴³

Unscrupulous facilities can further maximize the number of days they hold a child and, thereby, maximize their revenue, by filing such a petition to hold the child for longer, then dropping the petition shortly before the hearing is scheduled. This allows such facilities to detain the child beyond the 72-hour window without judicial review.⁴⁴ A recent media analysis found that, using this technique, one facility in the Tampa area holds patients of all ages on average 8.8 days, dropping 86 percent of the petitions it has filed before they are heard.⁴⁵ Sadly, this traumatizing practice of holding children for days in psychiatric facilities, without medical justification, parental consent, or judicial review, undermines the original intent of the Baker Act itself — to authorize immediate involuntary examinations for individuals who may need emergency psychiatric attention, not to authorize unchecked involuntary institutionalization for individuals who can receive no benefit from such treatment or confinement.

The experiences children have at receiving facilities vary as widely as the facilities themselves. Some have reported being left to sleep on a bare cot with no blanket in a cold room, with no change of clothes and no personal items or toiletries. Others have reported being housed with much older youth who

have intimidated or frightened them. Many report not being allowed to communicate with parents, guardians or family and feeling terrified, confused and alone. Some youth who were in foster care at the time the Baker Act was used against them explained it is common knowledge among youth in group residential homes that there are certain ways to answer questions at the receiving facilities in order to avoid being involuntarily medicated.⁴⁶ Even staff at some facilities with excellent reputations have indicated they were unaware that current law required them to permit parents and guardians to have immediate and ready access to their children by phone, correspondence or in person and that rules and restrictions regarding visitors and access are required to be in the “least restrictive possible manner.”⁴⁷

WHAT THE NUMBERS SHOW

FLORIDA IS AN OUTLIER IN EXCESSIVE AND UNNECESSARY USE OF THE BAKER ACT AGAINST CHILDREN, AND THIS PRACTICE IS OVERWHELMINGLY INEFFECTIVE AND HARMFUL

Stories like Shawn’s — that is, of children who are inappropriately or unnecessarily examined and committed — are unfortunately not aberrations. Statewide data, while flawed in many ways, shows that unnecessary use of the Baker Act against Florida children has become tragically routine.

From the 2001-2002 fiscal year to the 2018-2019 fiscal year, the percentage of children who were Baker Acted increased 152.6 percent.⁴⁸ This explosion in Baker Act use far outstrips Florida’s population growth. The rate of involuntary psychiatric examinations of children has more than doubled in the past two decades, from 547 to 1,240 Baker Acts per 100,000 children. Children now make up 18% of all people Baker Acted in the state, with wide variations across counties, from 6.24% in Monroe County to an astonishing 48% in Wakulla County.⁴⁹ In the 2018-2019 fiscal year, the Baker Act was used against children 37,882 times — a rate of approximately one time for every 86 children, or 1.2%, of all children age 5 and above. And, at least 30% of those children are involuntarily examined more than once over a five-year period.⁵⁰ Additionally, the available data suggests that Baker Act use in schools has increased significantly since the Parkland shooting; though, unfortunately, this data is not consistently available from all schools.⁵¹ The Baker Act is also used disproportionately on Black children; 25% of all children who were Baker Acted were Black in 2016-17 (the last year for which race data was reported statewide), despite Black children comprising only 15% of the under-18 population.⁵²

Florida involuntarily evaluates and commits adults and children at a rate far beyond any other state in the country. While not every state keeps comprehensive data, a recent nationwide analysis found that, of the 25 states that do, Florida is the only state that involuntarily commits more than 800 people per 100,000 people annually.⁵³ Only two other states, Colorado and Massachusetts, have rates exceeding 600 per 100,000 and only three more exceed 400. Thus, Florida’s rate of involuntary commitment is not only substantially greater than all states, but it is also at least twice the rate of 80% of the states that track this data.

Nor are other states experiencing the steady annual growth in involuntary examination rates seen in Florida; just four of the 24 states other than Florida have seen rates of involuntary examination increase in each year for which there is data.⁵⁴

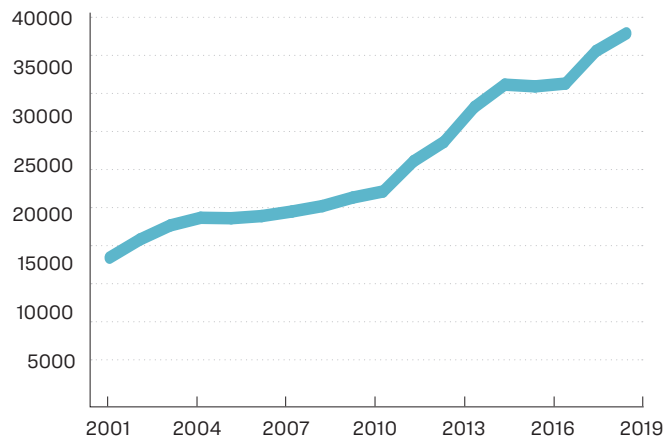
This widespread use of the Baker Act on children in Florida flies in the face of the recommendations of most medical professionals. Two recent national surveys of over 700 members of the American Psychiatric Association found that mental health professionals support severely restricted and extremely narrow grounds for involuntary commitment, a finding that may reflect their general ambivalence about the effectiveness of the practice.⁵⁵ Notably, none of the professionals surveyed considered disabilities or ordinary expressions of sadness to be appropriate cause for involuntary psychiatric examination.

Similarly, one of the few empirical studies⁵⁶ of involuntary psychiatric holds among school-age

Florida is the only state that involuntarily commits more than 800 people per 100,000 people annually.

A child under 12 in Florida could be over 10,000 times more likely to be Baker Acted than die by suicide.

BAKER ACTS OF CHILDREN PER YEAR



children under age 10 explains that the use of involuntary psychiatric holds against children ought to be rare, because they rarely have the means to seriously harm themselves or others, and that suicide⁵⁷ or homicide⁵⁸ by young children is extremely uncommon. Indeed, approximately one homicide by a child occurs for every million children in the U.S. and that rate declines to 1 in 10 million for children under age 10.⁵⁹ Moreover, even in these rare instances, involuntary mental health hospitalization is likely unhelpful because mental illness is not the primary cause or risk factor for even the extremely rare occurrences of homicide by a child.⁶⁰ Despite this data and the evidence that mental illness is not a prevalent cause of homicide by children, researchers have reported that involuntary psychiatric holds of minors and young children are actually not uncommon at all.⁶¹

Though clinicians and epidemiologists have found that suicide and suicidal ideation have significantly increased in the past few decades, especially among adolescents, and likely remain underreported,⁶² these increased rates are not enough to explain the even greater increase in the number of involuntary psychiatric hospitalizations of children in Florida. The increased rates of suicide and suicidal ideation among teenagers also cannot explain the frequent Baker Acting of young children, who are

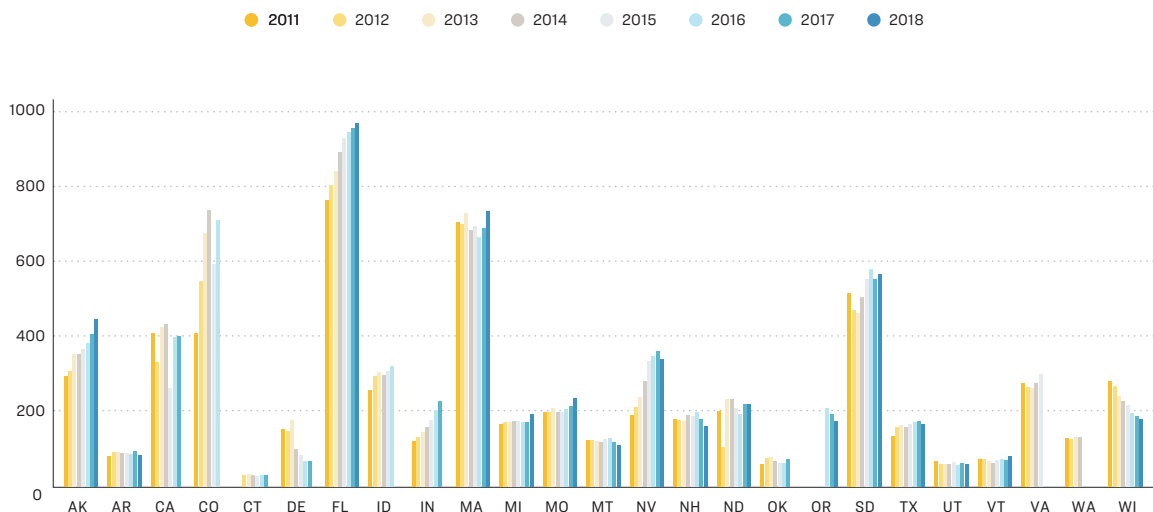


“Unnecessary use of the Baker Act against Florida children has become tragically routine.”

much less often suicidal. Even if one were to assume that the short-term forced hospitalization authorized by the Baker Act is an effective intervention — a proposition for which experts have not found evidence — it is nonetheless being widely overused. Data from the Center for Disease Controls used in one of the largest and most recent investigations of trends in child suicidality (which reported approximately one death by suicide for every 1 million children under age 12 in the U.S.),⁶³ shows that a child under 12 in Florida could be over 10,000 times more likely to be Baker Acted than die by suicide.

This incongruence raises questions about the validity of the practice of involuntarily committing children to psychiatric facilities altogether. The high number of Baker Acts of children in the 2018-

RATES OF EMERGENCY PSYCHIATRIC EXAMINATION PER 100,000 FOR ALL AGES



SOURCE: Gi Lee and David Cohen, *Incidences of Involuntary Psychiatric Detention in 25 US States, 7 Psychiatric Services in Advance (2020)*

2019 fiscal year far exceeds established rates of child suicidality, psychosis, and other serious mental illnesses, let alone those with serious mental illnesses whose conduct or level of emotional disturbance would create an imminent and substantial risk of serious bodily harm. One might expect that if children were at risk of harming themselves or others all 37,882 times they were Baker Acted, and if the Baker Act were an effective form of intervention and treatment, other states that do not have Florida’s practice of frequent involuntary hospitalization would have much higher rates of children harming themselves or others due to mental illness. Yet, there is no evidence whatsoever that this is the case. Nor have rates of mental illness and suicide in Florida gone down as Baker Act use has gone up in the past two decades. The high rate of repeat Baker Acts of the same children — at least 30% of all children Baker Acted within a five-year span⁶⁴ — also suggests that involuntary psychiatric holds fail to appropriately and accurately treat the underlying conditions that lead to these children being examined in the first place.

Because the Baker Act is meant as an emergency option for “crisis” situations, it is inappropriate to frequently subject a child to Baker Acting in lieu of engaging the child and family in consistent, long-term, community-based services and treatment. While some police and school officials argue that the Baker Act is an effective way to ensure that children in need of mental health services get them, that baseless claim cannot justify depriving children of their liberty and causing them active harm when less-restrictive means of treatment, and more-effective services, are available. Moreover, it is simply not true. Children in receiving facilities may receive some stabilization, and, with their parents’ consent, medication, but they cannot and do not receive true treatment for any underlying conditions in such a short period. There is generally no follow-up care available for children after they have been Baker Acted, and certainly no continuity of care between facilities and outpatient, community-based treatment. Moreover, strategies that allow a child to cope in a receiving facility, including those that the child may adopt in order to be released, may not be effective after the child is released.

BAKER ACTING INFLECTS LONG-LASTING HARMS AND TRAUMA ON CHILDREN

The retort “better safe than sorry” cannot justify the vast gap between rates of youth Baker Acting and youth harm to self or others, because the very act of Baker Acting a child traumatizes them, and, for some, puts them at greater risk of harming themselves or others.

Even for adults, who have greater cognitive and emotional tools to understand and process what is happening to them, involuntary hospitalization is objectively traumatic.⁶⁵ In one of the most comprehensive studies of experiences in psychiatric facilities, researchers found that patients experienced physical assault and sexual assault at high rates in mental health facilities, and most individuals witness traumatic events while there.⁶⁶ In that study, 54% of individuals experienced being around frightening or violent patients as a harmful experience, 59% were subject to seclusions, 34% experienced being held in restraints, 29% faced forceful takedowns, 60% were handcuffed during transport, and 20% were threatened with medication as a form of punishment while they were in a mental health facility. Other studies have similarly found that 51% to 90% of individuals in mental health facilities experience trauma victimization and that 43% suffer from post-traumatic stress disorder as a result of their experiences in the psychiatric facility itself.⁶⁷ These experiences can be especially damaging or retraumatizing for patients in psychiatric facilities who may already be vulnerable or have experienced past trauma.⁶⁸

While these studies focused on adults, the findings of trauma as a result of psychiatric commitment are likely to be especially true — and even compounded — for Baker Acted children, especially those children with disabilities or others who are repeatedly Baker Acted and, therefore, particularly vulnerable.⁶⁹ Research, case studies, and a large body of scientific and medical evidence demonstrate that psychiatric hospitalization causes children a host of traumatic effects:

- Post-traumatic stress disorder, general anxiety, separation anxiety, depression, humiliation, emotional withdrawal;



- Missed school time (sometimes for weeks or months) during and after being held involuntarily;
- Educational disruptions, which can include a transfer of schools, lower grades, dropped classes, and/or being placed on a lower academic track;
- After-effects and side effects of medication, including forced medication that may be particularly traumatizing;
- Lack of stabilizing services once children return to their homes and communities⁷⁰ and the false assumption that the child is “fixed”;
- Lasting fear, making it less likely that needed mental health treatment or counseling will be sought, or that suicidal or homicidal ideations will be revealed, in the future, creating a greater risk of harm; and
- An erosion of trust in medical professionals, schools, teachers, law enforcement personnel and adults generally.

Even before the point of institutionalization, children can be harmed by the experience of being handcuffed and transported in police cars. Parents and guardians of Baker Acted children sometimes describe their children as saying that they “don’t want to go back to jail” when discussing their fears of being Baker Acted again or even returning to school. Moreover, the night a young child spends in a receiving facility is often their first away from their parents, something that is difficult for any child, let alone one forcibly confined without warning or explanation.⁷¹

But, even without research, case studies and anecdotes, the traumatic effect should be obvious to anyone who has a close relationship with a child. Imagine a 6-year-old child (one who has thus far been fortunate enough to escape the reality of being Baker Acted) having a hard day at school, when suddenly an adult in a police uniform seizes them, puts them in handcuffs, forces them into a cage-like back of a police car, and drops them off at a hospital with strangers who won’t let them even use a phone. Imagine that, perhaps for the first time in that child’s life, they can’t talk to their parents or go home to their own bed and, instead, find themselves locked in a cold, bare room without even a change of clothes or a blanket. Imagine that child having to navigate being housed with older children they have never met who may be aggressive, unkind, mocking, or exhibiting behaviors a 6-year-old child would have a hard time understanding. Imagine strangers peppering them with questions about traumatic experiences that are hard to relive and that they are not sure they should answer, especially because such questions may be

similar to the ones that landed them in “jail” in the first place. Imagine the child being given psychotropic medication against their will and experiencing its effects for the first time without the comfort or assurance of anyone they know or love being present. And imagine this child not knowing for days how long this hellish reality will last or when they’ll be able to see their family again.

Not surprisingly, such traumatic experiences, along with the lack of evidence that it is an effective treatment for children,⁷² have led researchers, mental health professionals, and advocates to generally recommend against involuntary psychiatric commitment as a practice.

THE BURDENS OF BEING BAKER ACTED ARE BORNE DISPROPORTIONATELY BY THE MOST VULNERABLE CHILDREN

Beyond the many harms suffered by all children who are subjected to involuntary psychiatric examination and commitment, Baker Acting is a damaging practice because it is used disproportionately against children who already face systemic barriers, such as children with disabilities, those in foster care, and children of color.

Children with Disabilities

Numerous accounts document children with disabilities being wrongfully Baker Acted, which as noted above is not only harmful and useless but also illegal. For example:

- A 6-year-old girl with “global developmental delay” and ADHD was Baker Acted in Jacksonville, held for 48 hours, and sedated without her parents’ consent after she allegedly “destroy[ed] school property” and “attacked” staff.⁷³
- A Broward child was confined by school police after a minor dispute with another child. His school told his mother that, unless she Baker Acted him herself, they would do so.⁷⁴
- A 10-year old autistic child in the Tampa area was Baker Acted twice for ordinary and non-dangerous manifestations of his disability.⁷⁵
- A 7-year-old autistic child in Miami-Dade County was taken from school in handcuffs after he allegedly hit and kicked a teacher.⁷⁶ The same day, a Miami-Dade 10-year-old was Baker Acted for the second time after he grew agitated following a dispute with a teacher because he feared, rightly, as it turned out, that he would be Baker Acted again.⁷⁷
- A boy in Pasco County with autism was Baker Acted four times by the same school between third and fifth grades, each time because he experienced sensory overload as a result of his condition. The local receiving facility concluded in each instance that he did not meet the criteria for involuntary examination.⁷⁸

Children in Foster Care

Likewise, children in foster care and within the child welfare system are particularly at risk of being over-Baker Acted and suffering harms related to psychiatric hospitalization. Children in the foster care system, for example, make up 28% of all Medicaid spending on in-patient psychiatric services.⁷⁹ Studies similarly have found high rates of psychotropic medication use⁸⁰ and contact with mental health systems among kids in the child welfare system.⁸¹ Moreover, youth admitted to inpatient psychiatric hospitals from foster care are more vulnerable than other children who are psychiatrically committed in that youth who are in foster care are hospitalized at younger ages, are more frequently subject to restraints while they are held, and are more often repeatedly hospitalized.⁸²





Further, child advocates and young adults who have experienced foster care have explained that foster care and group home caregivers are more likely to Baker Act children in their care for behaviors that overwhelm caregivers but would not cause parents to Baker Act their own children. Caregivers may also Baker Act children in foster care to give the caregiver a respite when they have no other option. Baker Acting may sometimes even be used as a respite for the child when their placement is perceived to be worse than the Baker Act receiving facility or when the child does not have a stable placement. Baker Act facilities are less likely to have access to the medical and psycho-social history and medication records for a child in foster care when making medication decisions, which means those children are more likely to be prescribed inappropriate medication. Discharge is equally problematic, and children can get stuck in the receiving facility because there is no place for them to go after discharge — that is, because responsibility for a child in foster care is diffuse, post-discharge care coordination is more difficult. Even beyond the likelihood of

being Baker Acted at higher rates than other children, being held longer and also suffering the trauma that all children may experience being involuntarily held in a facility, children in foster placement suffer the additional consequence of becoming more difficult to place because the Baker Act label may impair the willingness of caregivers to accept placement.

Clinicians note that the stress associated with a child's situation in foster care may erroneously present as multiple symptoms or behaviors that are associated with mental disorder.⁸³ They therefore recommend that a thorough assessment of the child, family history, and the child's current situation are critical before making any decisions regarding mental health treatment.⁸⁴ Unfortunately, the current practice of Baker Acting follows none of these recommendations and leaves no room for such important careful considerations. Finally, research also shows that the majority of children in foster care have already experienced multiple forms of maltreatment, abuse, and trauma⁸⁵—making it all the more important to protect them from the additional trauma of Baker Acting.

Children of Color

In addition to the racial disparities of the foster care system,⁸⁶ children of color are generally at greater risk of being wrongfully, unnecessarily and illegally Baker Acted. As has been widely studied and reported, across the country and in Florida in particular, students of color are disproportionately targeted for out-of-school (i.e., exclusionary) discipline, and are punished more harshly than white students.⁸⁷ Those trends hold true for the Baker Act as well. The Palm Beach County case study below further highlights these disparities. Implicit bias also occurs in the diagnosis and treatment of Black and Brown children, whose behaviors may be more likely seen as symptoms of conduct disorders or other mental health issues than similar behaviors by white children.⁸⁸

Experts and Advocates Agree Involuntary Psychiatric Hospitalization Should Be a Last Resort

National mental health advocates agree that involuntary mental health treatment can be very harmful and should be used only in the most extreme circumstances, particularly for children. Mental Health America (MHA), a national nonprofit dedicated to preventing mental illness through advocacy and services, with chapters across the country, believes that involuntary psychiatric treatment “must be used as a last resort,” “is only appropriate for a very small subset of people,” “should be limited to persons who pose a serious risk of physical harm to themselves or others in the near future,” and should be applied “in the least restrictive environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery.”⁸⁹ For involuntary treatment to be used, MHA emphasizes that stringent procedural safeguards and fair and regular review are essential. Unfortunately, the way Florida currently implements the Baker Act, there are few such procedural safeguards in place.

This is the same standard for which the highly respected Bazelon Center for Mental Health Law, which protects and advances the civil rights of adults and children with mental illness or developmental disabilities, advocates. In a position statement addressing involuntary commitment,⁹⁰ the Bazelon Center opposes involuntary inpatient civil commitment except in response to an emergency and only when based on a standard of imminent danger of

significant physical harm to self or others and when there is no less restrictive alternative. The Baker Act, in contrast, does not require that involuntary treatment be the least restrictive means when the basis for its invocation is danger to self or others, nor does it define the term “serious bodily harm” that it uses as the threshold for examination.

Mental Health America also emphasizes that authorities should adhere to certain principles in order to protect an individual’s autonomy when subjecting them to involuntary treatment. For example, there should be substantial evidence that no less-coercive arrangement would permit the person’s safety, and the need for involuntary treatment should be based upon a significant history of highly unsuccessful voluntary treatment despite the provision of comprehensive community supports. These positions are consistent with the latest best practices and the shifting trends in the field of psychiatry that recognize less-restrictive forms of treatment are both more effective and more humane.

Even organizations like the American Academy of Child & Adolescent Psychiatry, which publishes a fact sheet on suicide prevention strategies, focuses on providing school and community-based interventions.⁹¹ Notably absent from those strategies and interventions is involuntary hospitalization.⁹²

Unfortunately, the Baker Act in Florida continues to be implemented according to outdated modes of practice that default to in-patient hospitalization and institutionalization. The law has not fundamentally changed since its enactment 50 years ago, despite the evolution of child psychiatry and understanding of childhood mental health and trauma specifically. This is yet another reason that Baker Act reform is so critically needed and long overdue.

EXISTING DATA HAS SERIOUS GAPS THAT PREVENT SCHOOLS AND ADVOCATES FROM UNDERSTANDING AND MEETING THE NEEDS OF CHILDREN

As this report shows, Florida has collected enough statewide data to make clear that the Baker Act is widely overused, and it should be commended for that. Few states have gone even that far. Nonetheless, that data has serious limitations. It is not collected consistently across the state, does not make clear how many Baker Act initiations may be appropriate because the individual in question presented an actual imminent risk of serious harm to self or others, and fails to show precisely how often children are Baker Acted specifically in schools or foster homes. The absence of comprehensive and accurate data makes it difficult to target reform and monitor the statute's successes and failures.

Currently, school districts are not required to keep and report data, and many do not keep any records at all of the number of times that students are Baker Acted, let alone how many of those children have disabilities, how much school they miss, or whether the same children are being repeatedly Baker Acted.⁹³ Districts that do collect data about Baker Act use, like Palm Beach County Schools, often do not do so comprehensively, or in ways that can be compared from one district to another. The youth dependency system also is responsible for a disproportionate share of Baker Acts, according to advocates who have seen that practice on a routine basis, but it does not track or publicly report use of the Act on children in its care.

Police and receiving facilities are the source of the statewide data that does exist, and the data is reported by the Baker Act Reporting Center. The facilities and police are required to fill out forms that provide basic information about each involuntary examination. The forms, however, do not answer important questions like how long a child was held at a facility, whether the child was released after they first met with a psychiatrist (suggesting the psychiatrist did not think an examination was merited), or



“Currently, school districts are not required to keep and report data, and many do not keep any records at all of the number of times that students are Baker Acted.”

with what mental illness the child is diagnosed or suspected to have. Police, likewise, are not currently required to report if they considered less-restrictive means than Baker Acting, whether they contacted a minor's parents, or whether they consulted mental health experts when making the decision to initiate an examination. Moreover, police and receiving facilities often lack critical data, and, therefore, the forms are often incomplete or inaccurate. For example, facilities, but not police, are required to report whether children were Baker Acted from school, even though receiving facilities do not necessarily know this information.⁹⁴ As a result, the location the Baker Act was initiated is listed as unknown for most children in the existing statewide data that the Baker Act Reporting Center collects.

Because of the resulting inconsistency and complete absence of necessary data, reforms to statewide data collection procedures are urgently needed for purposes of accountability, tracking and informed policymaking.

CASE STUDY

THE SCHOOL DISTRICT OF PALM BEACH COUNTY'S DATA EXEMPLIFIES THE HARMS OF THE BAKER ACT

In addition to statewide data available on the use of the Baker Act against children, some districts have individually tracked their use of the Act more carefully, and that data shows deeply troubling trends consistent with the broader ones discussed above.⁹⁵ In the 2019-20 school year alone, the School District of Palm Beach County (“the District” or “Palm Beach County Schools”), a district with a student population of approximately 190,000 students, Baker Acted children 323 times; this figure rises to 1,217 over the four-year period since the 2016-2017 school year. Moreover, the 323 Baker Acts the District recorded were only through the end of in-person instruction; the total would have risen to at least 438 had the District continued to Baker Act children at the same rate for the remainder of the planned school year.⁹⁶ There is no evidence to suggest Palm Beach County Schools is an outlier among other districts.

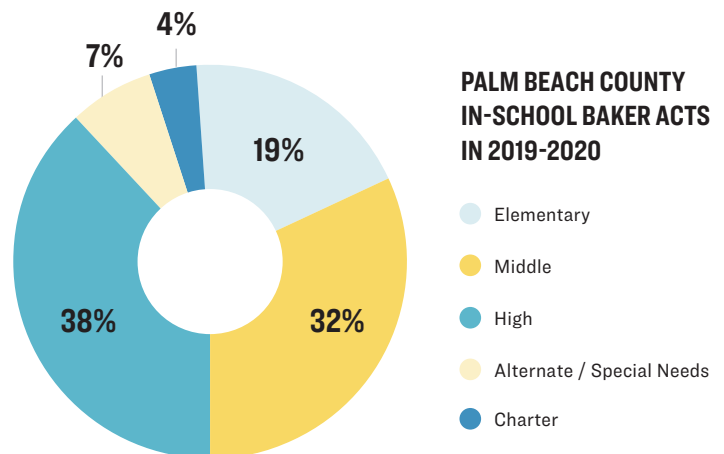
The trends in the District are not only alarming because of the excessive use of the Baker Act, but also because they reveal a clear disparate impact based on race and disability. That is, children with disabilities and Black children are significantly overrepresented in this Baker Acted population, when compared with their rates in the District overall. The District also Baker Acts a shockingly high number of young children, especially Black and disabled ones. Records from the District also reveal that these disturbing numbers are accompanied by inadequate district training and policies.

Discriminatory, Disproportionate and Inappropriate Targeting of Children in Palm Beach

Overall, Palm Beach County Schools data shows high and increasing rates of Baker Act use, just as we know is the case statewide. Based on the latest student population data reported to the Florida Department of Education and Baker Act data, the District conducted 170 Baker Acts for every 100,000

students in even the pandemic-shortened in-person 2019-2020 school year. Like the excessive rates statewide, these rates are far higher than epidemiologically established rates of child suicidality or psychosis.

The additional data Palm Beach County Schools collects demonstrates the need for similarly specific data about Baker Act use in all Florida school districts. From the 2016-17 school year to the 2019-20 school year, the District Baker Acted elementary school children 254 times, comprising one-fifth of all reported incidents of Baker Act use in the District. During that same four-year period, 5-year-old children were Baker Acted eight times, and children under 8 were Baker Acted 59 times.



Palm Beach County Schools Baker Acted elementary school children 254 times, comprising 1/5 of all reported incidents of Baker Act use in the District.

These numbers are especially concerning given the low likelihood, discussed above, that such young children are capable of seriously harming themselves or others as a result of mental illness.

The data also shows troubling racial disparities that should be examined statewide.⁹⁷ Of the 323 children Baker Acted in Palm Beach County in the 2019-2020 school year, 24% were non-Hispanic white while 40% were Black. Comparatively, the Palm Beach County student population is 33% white and 28% Black.

This means that Black students are highly overrepresented among the population of Baker Acted children in the District, while white non-Hispanic students are underrepresented and comprise a smaller share of the percentage of students Baker Acted than they do the total student population. Even more concerning, 40 out of the 59 children who were 5, 6, or 7 years old when they were Baker Acted over the last four years were Black children — consistent with data that shows adults routinely target and push out Black children and falsely perceive them as older and more threatening.⁹⁸ In total, in the 2018-19 school year, 240 out of every 100,000 Black children in the District were Baker Acted — almost twice the rate of white children (130 out of 100,000).

These statistics echo racial disparities in youth arrest data in Palm Beach County: Black students in the District are doubly at risk of both disproportionately high criminal arrest and involuntary

psychiatric commitment by police. For example, the Florida Department of Juvenile Justice reports that Black students in Palm Beach County are arrested at four times the rate of white students,⁹⁹ even higher than the disproportionate state average for the arrest of Black youth. While comprising only 25% of the youth population over 10 years of age in Palm Beach, Black youth made up 58.4% of all youth arrests, translating to six out of every 100 Black youth being arrested each year.¹⁰⁰ While the lower

racial disparities in Baker Act rates as compared to the more dramatic racial disparities for arrest rates may suggest to some more equitable application, in all likelihood the less drastic disparities still reflect bias on the part of police, who appear to view Baker Acting as a “nicer” alternative¹⁰¹ to arrest, which they may be more inclined to afford white children.

Finally, Palm Beach County Schools’ frequent use of the Baker Act against children with disabilities is disturbing. By its terms, the Baker Act can be used only against children with a mental illness. Any child with a mental illness that causes an emotional disturbance severe enough to require involuntary hospitalization likely has a mental illness that meets the statutory definition of disability. But, in reality, as discussed above, the Baker Act is regularly used against children who have developmental disabilities for which they should not be Baker Acted, and against others without any mental illness. Police reports produced by

“Black students in the District are doubly at risk of both disproportionately high criminal arrest and involuntary psychiatric commitment by police.”



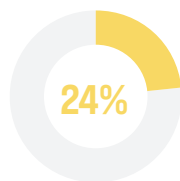
While comprising only 25% of the youth population over 10 years of age in Palm Beach, Black youth made up 58.4% of all youth arrests, translating to six out of every 100 Black youth being arrested each year.

the department for each Baker Act use in response to public records requests show officers Baker Acting children they know to have autism and other disabilities that do not constitute a mental illness. These records show that the District is not adequately preventing its officers from using the Act on children who do not meet the statutory criteria. Conversely, one school that specializes in children with emotional and behavioral disorders has Baker Acted children 105 times over the last four years, despite having a student body of only 111. While some of these children likely have mental illnesses, as that term is defined by the statute, the regularity with which the Baker Act is being used shows the lack of adequate systems of support to more appropriately deal with the needs of these children who the District itself has identified as needing special services. Using the Baker Act on any child with a known disability is always problematic, because it will inevitably interfere with their right to education.¹⁰²

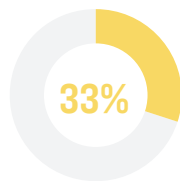
Inadequate Baker Act Training and Policies in Palm Beach

One reason the Baker Act is routinely overused, is that school officials and police are given false and incomplete training about what the statute says. Beyond a partial quote of the statutory language, Palm Beach County Schools’ official policy gives little guidance to educators and police about when they should use the Baker Act. The District’s “Baker Act Decision Tree” does not require contacting parents before using the Act, nor does it require decision-makers to consider whether district staff or the child’s parents could prevent the child from harming themselves or others, which would eliminate the purported need to send to child to a psychiatric facility.

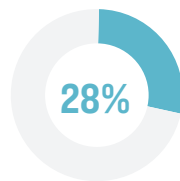
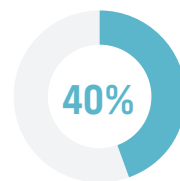
● White Students ● Black Students



Of the children Baker Acted in Palm Beach County in 2019-20, 24% were white while 40% were Black.



Comparatively, the Palm Beach County student population is 33% white and 28% Black.



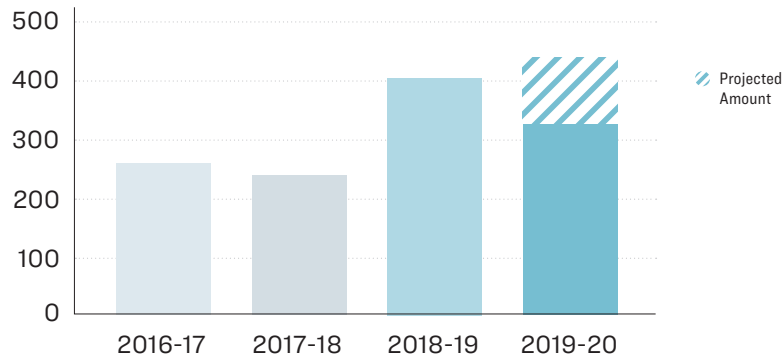
Moreover, the guidance is wrong. For example, it incorrectly states: “Criteria for an involuntary exam are that the individual: presents a danger to self or others; and/or appears to have a mental illness as determined by a licensed mental health professional.” This short statement contains at least four false claims or crucial omissions about the Baker Act:

- It states that an individual must present a danger to self or others or appear to have a mental illness when in fact both are necessary.

40 out of 59 children who were 5, 6, or 7 years old when they were Baker Acted over the last four years were Black children.

240 out of every 100,000 Black children in the District were Baker Acted— almost twice the rate of white children during the 2018-19 school year.

PALM BEACH COUNTY IN-SCHOOL BAKER ACTS PER YEAR:



**In person instruction for the school year ended on March 13, 2020, at which time 132 of the scheduled 179 days of instruction had occurred and the District had Baker Acted 323 children. Had the District continued to Baker Act children at the same rate it would have done so 438 times.*

- It omits the statutory requirement that the danger posed by the person be of “serious bodily harm.”
- It omits the statutory requirement that the danger posed to self or others be “in the near future.”
- It omits the statutory requirement that the danger to self or others be “evidenced by recent behavior.”

Training is similarly inadequate. According to the District’s responses to public records requests, the only training that school police officers receive from the District on when children can be Baker Acted is one non-interactive video with less than 15 minutes of training. The video simply repeats the bulletin’s false summary of the Baker Act and then recites the text of the Baker Act statute — rather than interpreting it and applying it to real-life scenarios. Nor does it mention the trauma an inappropriate Baker Act can cause, clarify the distinction between developmental disabilities and mental illness, provide guidance for how officers should make this distinction when determining whether to Baker Act a child, or emphasize the fact that developmental disability is an illegal basis for subjecting a child to involuntary psychiatric institutionalization.

Inadequate Data Monitoring and Enforcement in Palm Beach County Schools

Unfortunately, Palm Beach County Schools’ use of the Baker Act is not uniquely bad. While the District does collect some useful data on Baker Act

use it does not make that data public and struggled to even locate it when asked to produce it by public records request. Moreover, its data collection, and all school districts’ data collection, should be comprehensive enough to understand how significantly its Baker Act policies disrupt the education and lives of its students, including how long students are kept in psychiatric facilities when the Baker Act is used against them and how much school they miss as a result of their involuntary arrest and confinement and the resulting trauma.

And while the District does not publish this data, it is also unclear what, if anything, it does with that information internally. For example, until asked to do so by public records request, the District did not appear to have ever analyzed which Baker Acted students had disabilities — information it was able to generate simply by querying its own student database. Local education advocates similarly report no systematic efforts by the District to investigate Baker Act incidents after the fact to determine how they could have been prevented or if they were warranted.

None of these failures of data collection or analysis are unique to Palm Beach County Schools. To the contrary, they are present in every district in the state. Moreover, they show that clear overuse of the Baker Act, racial disparities, and inappropriate use against children with disabilities, will continue in Palm Beach and statewide unless accountability and oversight measures are adopted.

POLICY RECOMMENDATIONS AND ALTERNATIVES

To fully address the overuse of involuntary psychiatric examinations, we must know when, where, how, to whom, and with what frequency they are happening. The Baker Act Reporting Center is an important resource to track the use of involuntary commitment across the state. Unfortunately, the data it receives is flawed in important ways. Only when we know where and how the Baker Act is being used against children — including in schools — can we ensure accountability for overuse and target resources where children are most impacted. Policymakers must take action to improve data collection and transparency on the use of Baker Act against children at every level — schools, school districts, law enforcement agencies, mental health receiving centers, the Baker Act Reporting Center, and state agencies — and, then, use this data to implement meaningful reforms that end the overuse of this practice.

Moreover, serious reforms are needed to ensure that the Baker Act is used only on children in the narrow and rare situations in which it is truly necessary. Schools, the dependency system, police, receiving facilities, and the state must all commit to slashing Florida's wildly excessive Baker Act rates. Exploring every possible policy change that could achieve this necessary goal is beyond the scope of this report, which focuses on understanding the current situation facing Florida's children. But our research has suggested a series of common-sense reforms that could begin to address the gaps in our knowledge about how the Baker Act is currently used, reduce that use and increase accountability and transparency.

Core Reforms to How the Baker Act is Used Across Agencies

- Train and educate all school districts, school staff, police and sheriff department first responders, school resource officers, parents and guardians, foster care providers and caregivers about the serious consequences and traumatic effects of inappropriately using the Baker Act against children.
- Provide the parents or guardians of minors who are Baker Acted with access to a public defender at public cost, if they want one, as soon as their child is involuntarily admitted.
- Eliminate the practice of handcuffing or otherwise physically or chemically restraining children who are Baker Acted except in very extreme and rare circumstances.
- Ensure that regulations or statutory changes provide law enforcement, schools, mental health professionals, and others with greater clarity about the kinds of behavior that indicate children pose a genuine and imminent risk of serious bodily harm to themselves or others because of mental illness that requires involuntary treatment.
- Center parents' and guardians' rights to make decisions in the best interests of their children by ensuring that parents and guardians who can safely assume responsibility for the care of a child and prevent them from harming themselves or others without an involuntary examination, and who want to assume this responsibility, be legally authorized and unimpeded from doing so.
- Improve data collection to enable the Baker Act Reporting Center to compare the rates of admission between districts to show in which districts the Baker Act is being overused and require the Baker Act Reporting Center to publicly publish those reports at regular intervals.

For the Baker Act Receiving Facilities and the Department of Children and Families That Regulates Them

- Require medical staff at receiving facilities who are authorized to initiate Baker Act exams to conduct an independent evaluation when a child is brought to a facility to determine if they meet the criteria for examination, including screening for developmental disabilities, and, if not, empower them to immediately release the child, even if a physician is not present.
- Revise the Baker Act receiving facility reporting form to include whether a child was admitted or released upon first examination.

- Require Baker Act receiving facilities to give daily notice and status update reports to parents/guardians of children they hold and to provide information and accessible resources for seeking judicial review of the involuntary examination.
- Hold Baker Act receiving facilities accountable for failing to follow patient rights guidelines: (i) that allow children to freely and privately communicate with their parents or guardians; (ii) that allow parents, guardians, family members, advocates, and attorneys to have immediate access to any patient and daily visits; and (iii) that require the least restrictive appropriate available treatment.
- Ensure Baker Act receiving facilities do not house or provide group treatment to children of any age with adults. House and provide treatment to elementary-aged children in an age-appropriate manner and separately from youth who are older.
- Attempt to review records and communicate with treating practitioners before changing medication and seek the child’s medical and mental health records, including the Comprehensive Behavioral Health Assessment, medication history along with contact information for the child’s treating practitioner.

For Schools and School Districts

- Expand schools’ capacity to provide effective behavioral and mental health services and supports in school, including intensive services to students with serious emotional disturbances, and other whole-school approaches to supporting student behavior, such as PBIS, trauma-informed practices, and restorative practices.
 - Ensure that youth and families are aware of where and how to access such services, including referrals and connections to services that may go beyond those available at school.
 - Ensure that every child and youth is able and knows how to readily access a trained and certified school counselor.
- Regularly train school staff on the legal, appropriate use of the Baker Act, as well as on de-escalation techniques, and how to safely manage a child who does not immediately respond to de-escalation.

This should include training on the traumatic effects involuntary hospitalization has on children and the counterproductive effect of a “better safe than sorry” approach to Baker Act use as well as training about inherent biases that currently result in disproportionate discipline, including discriminatory use of the Baker Act against Black, Indigenous and other children of color, children with disabilities and children in foster care.

- Allow Baker Acts in schools to be initiated only after assessment by appropriate mental health professionals, including school psychologists, or Mobile Crisis Teams (which exist in all districts to address youth mental health crises), not law enforcement officers.
- Require schools to collect and report to the state the following aggregate information for Baker Acts:
 - Circumstances surrounding the referral to law enforcement, including details about any threat or suicide assessment process used to determine the need for outside intervention.
 - Child’s age, race, gender identity, and any identified disabilities, including whether the child has an IEP or 504 plans.
 - Whether the child’s parent or guardian was contacted, present and agreed to the Baker Act initiation.
 - Whether other de-escalation methods were employed.
 - Whether chemical or physical restraint was employed by school officials or law enforcement officers prior to or during transport.
- Require schools to make law enforcement aware if a child does not meet the statutory criteria for Baker Acting, to the extent permitted by federal privacy law, including if the child’s behavior is likely due to something other than a mental illness (for example, a disability known by the school, but for which the federal Family Educational Rights and Privacy Act [FERPA] protects the child from revealing), and hence is not a legal basis for a Baker Act.
- Require districts to report aggregate data about their Baker Act use, broken down by individual

school, racial, age, gender and disability status demographics, to the Florida Department of Education so that they can target additional resources to help reduce inappropriate Baker Act use and determine which programs are effective at preventing it.

- Ban the use of handcuffs and other forms of mechanical or physical restraint on Baker Acted children unless objectively necessary to prevent immediate bodily harm.
- Require districts to provide non-police forms of transportation to receiving facilities.
- Require districts disclose to the Department of Education each time they require mandatory mental health treatment of a child, whether through the Baker Act or not. Mandatory mental health treatment means any time a student is required to undergo mental health treatment or examination as a condition of attendance at school or participation in any school activity.
- Require schools to track the number of days of education lost to Baker Acts initiated or reported to the school and the after-effects; provide affected children with compensatory education and safety planning to prevent additional hospitalizations; and ensure immediate and easy return to school.
- Vigorously guard the privacy of students who are Baker Acted and allow only the limited staff with a need to know to access any information or data about an individual student's involuntary hospitalization.
- Prioritize funding and resources to provide adequate mental health supports at each school.

For the Florida Department of Education

- Ensure schools and districts have training on the appropriate use of the Baker Act and on alternatives to supporting student behavior and responding to behavioral issues, serious emotional disturbances and mental health crises.
- Regularly review data reported by school districts on the use of the Baker Act to monitor for overuse or discriminatory, disproportionate, inappropriate, or illegal use of the Baker Act.



- Report this collected, aggregate data and make it publicly available on its website on an annual basis prior to the deadline for school enrollment applications.
- Compare and report the rates of admission between districts to show in which districts the Baker Act is being overused and make those reports available to the public.
- Prioritize funding and resources to provide adequate mental health supports at each school and in every school district and, at a minimum, ensure that each district meets the ratios recommended by the National Association of School Psychologists for counselors (250:1), school psychologists (500-700:1) and social workers (400:1).

For Law Enforcement Agencies

- Provide regularly recurring and extensive training to all law enforcement officers, including on de-escalation techniques, the statutory restrictions on Baker Acted children with disabilities, the long-term trauma caused by involuntary psychiatric hospitalization, and how to collaborate with mental health professionals on Mobile Crisis Teams or other behavioral health responders in responding to Baker Act calls.

- Conduct detailed oversight reinforcing the last-resort nature of Baker Acting children and ensuring that the statutory criteria is met. Prohibit all use of the Baker Act where the statutory criteria are not met.
 - Notify and seek consent from parents or guardians prior to initiating the Baker Act on a child.
 - Revise the Baker Act reporting form used by law enforcement to specify whether a Baker Act was initiated in school, as well as the following information about any children who are Baker Acted:
 - Child’s age, race, gender identity, and any identified disabilities.
 - Whether the child’s parent was contacted, present and agreed to the Baker Act initiation.
 - Require law enforcement agencies to report aggregate data about their Baker Act use against children, broken down by county, demographics, and disability status, to the Department of Law Enforcement so that they can target additional resources to help reduce inappropriate Baker Act use and determine which programs are effective at preventing it.
 - Require the Florida Department of Law Enforcement to report this collected data and make it publicly available on its website.
 - Give parents and guardians or their designee the right to transport their child to the Baker Act receiving facility rather than using police transport where such transportation can be provided safely.
- The precipitating events and efforts at de-escalation, including techniques used; and
 - The length of time the child was in the Baker Act facility, the number of days the child remained past the time for discharge, the reason the child remained longer than necessary (e.g., because child welfare did not have a placement available, no practitioner was available to release the child).
- Implement robust quality assurance measures to ascertain that existing statutes, rules, and policies concerning Baker Acts are fully and accurately implemented and used to improve performance. This includes but is not limited to:
 - Incident Reports: Ensure the preparation of complete and accurate critical incident reports for each Baker Act; the timely distribution of those reports to the CBC, all parties, the court, the caregiver and the child’s counsel. Ensure that DCF and the CBCs use the information in the incident reports to improve quality of all providers.
 - Multi-disciplinary team meetings: Ensure that appropriately staffed and documented Multi-disciplinary team meetings are held no later than 72 hours after discharge from Baker Act facility. Ensure that DCF and the CBCs use the information in the incident reports to improve quality of all providers.
 - Discharge Reports: Ensure that discharge reports are timely distributed to all appropriate parties, including the court, the caregiver and the child’s counsel, and confirm that recommended follow up steps are taken in a timely fashion.
 - Follow up with caregivers to ensure that they have everything they need to continue to provide good care for children after discharge, including appropriate medication, access to the therapy prescribed for the child and the support they need as caregivers, including respite and behavioral health consultation.
 - Medication Management: Ensure that all children prescribed medication are timely receiving the appropriate medication at all

For the Department of Children and Families and its Contracted Providers

- Require the Community Based Care Lead Agencies (CBCs) to collect and report to the state the following information for each Baker Act of a child in state care:
 - The location from which each child in state care was taken to a Baker Act facility. (e.g. placement by specific type [relative or non-relative placement, foster home, group home, therapeutic foster home, therapeutic group home], school, aftercare, community);

times and regardless of placement and that medication administration is accurately documented. Ensure that caregivers are educated about the intended effects and are empowered to work with providers and children to ensure the medication is safe and efficacious.

- Ensure that the CBC has an identified placement prior to discharge so that no child is forced to remain in a facility because the CBC has no place for them to go.
- Ensure that all caregivers are trained on de-escalation techniques and use them appropriately.
- Ensure that Mobile Response Teams are active and responding to caregiver and school requests for help.
- Improve communication between Baker Act receiving facilities and the Child Welfare System.
 - Provide a single point of contact at the CBC so that the facility always has access to a person who can obtain information and connect them with the appropriate individuals (i.e., parents, caregivers, treating practitioners, guardians ad litem and attorneys).
 - Ensure that the receiving facility has access to the child's medical and mental health records including the Comprehensive Behavioral Health Assessment and medication history along with contact for the child's treating practitioner.
 - Require the single point of contact to promptly notify all parties, the court, the caregiver and the child's counsel that the child has been admitted to the facility. The single point of contact should notify the facility which persons have the lawful right of access to the child (including the child's guardians ad litem and child's attorney and, where authorized, the child's parents, caregivers and caseworkers).
 - Task the single point of contact with helping the facility locate appropriate persons to participate in the discharge process.
- Amend §39.01305 to provide an attorney for every child in Chapter 39 proceedings who has been subject to a Baker Act proceeding and does not already have counsel.

ENDNOTES

- 1 Annette Christy, et al., Fiscal Year 2018-19 Report (“Baker Act Reporting Center 2018-19 Report”), University of Florida Baker Act Reporting Center, (November 2020), at 4 (stating that 37,882 children were Baker Acted in 2019-20), https://www.usf.edu/cbcs/baker-act/documents/ba_usf_annual_report_2018_2019.pdf. §§ 394.451-394.47892, Fla. Stat.
- 2 §§ 394.451-394.47892, Fla. Stat.
- 3 Florida Department of Children and Families Office of Substance Abuse and Mental Health, Task Force Report on Involuntary Examination of Minors (hereinafter “Baker Act Task Force Report”), myflfamilies.com, (Nov. 15, 2017), at 12-18.
- 4 Gi Lee and David Cohen, Incidences of Involuntary Psychiatric Detention in 25 US States, 7 *Psychiatric Services in Advance* (2020), on file with SPLC.
- 5 Baker Act Task Force Report, *supra* note 3 at 9-13.
- 6 F. Chris Curran, The Expanding Presence of Law Enforcement in Florida Schools, UF Educational Policy Research Center (2020) at 8-11, <https://www.acluf.org/en/expanding-presence-law-enforcement-florida-schools>.
- 7 Annette Christy, et al., Fiscal Year 2016-2017 Report (“Baker Act Reporting Center 2016-17 Report”), University of Florida Baker Act Reporting Center, (June 2018), at 8-9, https://www.usf.edu/cbcs/baker-act/documents/annual_report_2016_2017.pdf.
- 8 Daniel J. Losen, Disabling Punishment, Center for Civil Rights Remedies, (April 2018), at 3, 8; Matthew C. Fadus, et al., Unconscious Bias and the Diagnosis of Disruptive Behavior Disorders and ADHD in African American and Hispanic Youth, *Academic Psychiatry* (2020), 44:95-102, (Nov. 11, 2019), at 96, 98, <https://doi.org/10.1007/s40596-019-01127-6>.
- 9 With good systems of care, preventative wellness measures and early mental health interventions, child advocates expect Baker Acts would be almost entirely preventable. Compared to other states, Florida has the least per capita mental health spending in the country and the ratios of school-based mental health professionals to students is much higher than the 250-to-1 ratio recommended by the American School Counselor Association and well above national averages. Amy Sherman, *PolitiFact Florida: Yes, Florida Lags Behind in Mental Health Funding*, Tampa Bay Times, (Jan. 23, 2017), <https://www.tampabay.com/news/politics/stateroundup/politifact-florida-yes-florida-lags-behind-in-mental-health-funding/2310138/>; American Addiction Centers, *Mental Health Spending By State Across the US*, National Rehabs Directory, <https://www.rehabs.com/explore/mental-health-spending-by-state-across-the-us/#:~:text=The%20state%20with%20the%20lowest,Florida%20with%20%2436.05%20per%20capita> (last visited Feb. 11, 2021); American Civil Liberties Union, *Cops and No Counselors*, <https://www.aclu.org/issues/juvenile-justice/school-prison-pipeline/cops-and-no-counselors?redirect=copsandnocounselors> (last visited Feb. 11, 2021).
- 10 The Individuals with Disabilities Education Act (IDEA), 20 USC §§ 1400-1482, protects the right of children with disabilities to a Free and Appropriate Public Education (FAPE), in the Least Restrictive Environment through an Individualized Education Program (IEP), which must be developed with the child’s parent or guardian. Children with disabilities are also protected under federal law by the Americans with Disabilities Act (ADA), 42 USC §§ 12101-12213, which prohibits discrimination against all people, including children, with disabilities, and Section 504 of the Rehabilitation Act of 1973, 29 USC § 794(a).
- 11 This section reflects interviews with Shawn’s father, Brian, and supporting records.
- 12 Importantly, the statute explains that mental illness “does not include a developmental disability . . . intoxication, or conditions manifested only by dementia, traumatic brain injury, antisocial behavior, or substance abuse.” § 394.455(29), Fla. Stat. Baker Acting someone who is exhibiting a behavior as a result of a developmental disability, therefore, is not only inappropriate and ineffective, but it is also illegal.
- 13 § 394.463(1), Fla. Stat.
- 14 There is a procedure for voluntary inpatient treatment of minors, with their parent or guardian’s consent, but it requires a hearing to determine the voluntariness of that consent, and most facilities have no way to seek such a hearing. § 394.4625(1)(a), Fla. Stat.
- 15 § 394.463(2)(a), Fla. Stat.
- 16 The Baker Act Reporting Center noted that, in 2016-2017, 22% of kids Baker Acted had “school” listed as the place they were when the process began by the receiving facility on a government form. However, it also noted that 8-10% of forms did not have that question answered and that the number of kids Baker Acted in school is likely undercounted because “receiving facility staff may not know the details of the location at the time of the involuntary examination initiation.” Baker Act Reporting Center 2016-17 Report, *supra* note 7 at 13. Monthly data also sharply falls, more than 25%, over the summer months when school is not in session, particularly in recent years. Baker Act Task Force Report, *supra* note 3, at 12.
- 17 Currently, 68% of Baker Acts for youth are initiated by law enforcement - more than any other age group - who have very little training in crisis de-escalation. Annette Christy, et al., Fiscal Year 2017-2018 Report (“Baker Act Reporting Center 2017-18 Report”), University of Florida Baker Act Reporting Center (June 2018), at 8, https://myflfamilies.com/service-programs/samh/publications/docs/BA%20FY%2017-18%20Report.DCFFeedbackMay6_USFRevisionsJune4_V9a.pdf. In contrast, according to the most recently available statewide data, only about 52% of all Baker Acts in Florida were initiated by law enforcement. Id. Yet, more than one-fourth of School Resource Officers report having no training in mental health and twelve percent report no training in de-escalation. Ed Week Research Center, *School Policing: Results of a National Survey of School Resource Officers*, Research Center Reports (June 2018), at 15, <https://www.edweek.org/media/school-resource-officer-survey-copyright-education-week.pdf>
- 18 § 394.463(2)(a)2., Fla. Stat.
- 19 Florida Department of Children and Families, Mental Health Program Office & Department of Mental Health Law & Policy, et al., 2014 Baker Act User Reference Guide: The Florida Mental Health Act (hereinafter “Baker Act Manual”), Louis de la Parte Florida Mental Health Institute Publication, Baker Act Series, No. 253-5, App. G-2 (2014), <https://www.myflfamilies.com/service-programs/samh/crisis-services/laws/BakerActManual.pdf>.
- 20 Id.
- 21 Id.
- 22 Id. at G-3. As a “Quick Reference Guide for Law Enforcement Officers” written by the Department of Children and Families puts it: “Sometimes it’s hard to know whether or not you should ‘Baker Act’ someone. You want to be a responsible officer and do the right thing to protect individuals and those nearby, but you’re not sure whether or not to take a person to jail or to initiate The Baker Act and take the person to a receiving facility.” Id. at G-10.
- 23 § 394.463(2)(a)3., Fla. Stat.
- 24 § 394.463(2)(f), Fla. Stat.; Fla. Admin. Code R. 65E-5.2801(1); see also Baker Act Manual, *supra* note 19 at xiii.
- 25 § 394.463(2)(a)3., Fla. Const. Art. IX, § 1.
- 26 Unless otherwise noted, descriptions in the following section reflect more than two dozen interviews conducted by the Southern Poverty Law Center with parents, advocates and youth, and related media accounts.
- 27 These categories are not meant to be exhaustive, but rather encompass a large portion of the cases the authors of this report have identified.
- 28 This category includes children who have legitimate mental health issues and are under the care of a physician. Such children are often Baker Acted for exhibiting symptoms of their mental illness though they are not in crisis and/or they would be able to receive support from their treatment provider.
- 29 Megan Reeves & Jack Evans, *Florida’s Flawed Baker Act Rips Thousands of Kids from School*, Tampa Bay Times, (Dec. 10, 2019), <https://www.tampabay.com/news/education/2019/12/10/floridas-flawed-baker-act-rips-thousands-of-kids-from-school/>.
- 30 SPLC interview.
- 31 CBS Miami, *Florida’s Baker Act Under New Scrutiny After 6-Year-Old Committed To Mental Health Facility*, CBSlocal.com, (Feb. 13, 2020 at 5:54 p.m.), <https://miami.cbslocal.com/2020/02/13/florida-baker-act-scrutiny-child-committed-mental-health-facility/>
- 32 Frank Gluck, *Florida Kids are Getting Sent to Psychiatric Units Under the Baker Act in Record Numbers*, The News-Press, (updated Dec. 15, 2019 at 11:07 p.m.), <https://www.news-press.com/in-depth/news/2019/08/21/florida-children-baker-act-record-numbers-mental-health/3247904002/>.
- 33 Clark Fouraker, *Former cop says district uses Baker Act to reduce arrest*, First Coast News (Aug. 17, 2016), <https://www.firstcoastnews.com/article/news/education/former-cop-says-district-uses-baker-act-to-reduce-arrests/295152933>.
- 34 To be clear, critically examining this particular misuse of the Baker Act is by no means meant to suggest that arresting children who have committed no crime and are not a real threat of harm to themselves or others would be a better or more appropriate alternative. Rather, it highlights the need for more resources and training so that adults in these systems are better equipped to intervene when children need help mediating conflict or navigating other difficult circumstances for which misbehavior at school may be a manifestation.
- 35 Manouchka Pierre, *The Push Out: A Disproportionality Study on Discipline in the State of Florida*, 2019. Electronic Theses and Dissertations, 2004-20196725, (Fall Term 2019) <https://stars.library.ucf.edu/cgi/viewcontent.cgi?article=7725&context=etd>.
- 36 Id. at 33.
- 37 Reeves & Evans, *supra* note 29.
- 38 § 394.459(1), Fla. Stat.

- 39 See note 24, supra.
- 40 § 394.463(2)(g), Fla. Stat.
- 41 *Id.*
- 42 *Id.*
- 43 §§ 394.463(2)(g)4., 394.467, Fla. Stat.
- 44 In order to challenge such a detention, a parent or guardian would have to have the knowledge, resources and resolve to file a writ of habeas corpus — a right that is left to receiving facilities to apprise them of. §§ 394.459(8)(a), 394.4599(c)(2), (d), Fla. Stat.
- 45 Neil Bedi, *You're Trapped. They're Cashing In*, Tampa Bay Times (Sept. 28, 2019), <https://projects.tampabay.com/projects/2019/investigations/north-tampa-behavioral-health/>.
- 46 SPLC interview.
- 47 § 394.459(5)(a)-(d), Fla. Stat.
- 48 Baker Act Reporting Center 2018-19 Report, supra note 1, at 4.
- 49 *Id.* at 22-24.
- 50 Florida Department of Children and Families, *Report on the Involuntary Examination of Minors* (Nov. 1, 2019), at 11, <https://www.myflfamilies.com/service-programs/samh/publications/docs/Report%20on%20Involuntary%20Examination%20of%20Minors.pdf>. This figure certainly understates the rate of multiple examinations because only about half of all reports to the state about Baker Act use include the child's social security number, the only way of tracking whether they have been Baker Acted before. *Id.*
- 51 Adrianna Iwasinski, *Orlando-Area Schools See Increase in Baker Acts on Students After Parkland Shooting*, ClickOrlando.com (Nov. 5, 2018), <https://www.clickorlando.com/news/orlando-area-schools-see-increase-in-baker-acts-on-students-after-parkland-shooting>.
- 52 Baker Act Reporting Center 2016-17 Report, supra note 7, at 9; United States Census Bureau, *American Community Survey Demographic and Housing Estimates* (2016), <https://data.census.gov/cedsci/table?g=0400000US12&d=ACS%205-Year%20Estimates%20Data%20Profiles&tid=ACSDP5Y2016.DP05>.
- 53 Lee & Cohen, supra note 4 at 5.
- 54 *Id.*
- 55 Robert A. Brooks, *U.S. Psychiatrists' beliefs and wants about involuntary civil commitment grounds*, 29 *International Journal of Law and Psychiatry* 13-21 (2006).
- 56 Genevieve Santillanes, et al., *Involuntary Psychiatric Holds in Preadolescent Children*, *Western Journal of Emergency Medicine*, (2017), vol. 7, at 1159-1165, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5654888/>.
- 57 Jeffrey A. Bridge, et al., *Suicide Trends Among Elementary School-Aged Children in the United States From 1993 to 2012*, 169 *JAMA Pediatrics* 673 (2015), <https://pubmed.ncbi.nlm.nih.gov/25984947/>, <https://jamanetwork.com/journals/jamapediatrics/article-abstract/2293169>.
- 58 Brian G. Sellers & Kathleen M. Heide, *Male and Female Child Murderers*, *International Journal of Offender Therapy and Comparative Criminology* (2011), vol. 56, at 691-714, <https://pubmed.ncbi.nlm.nih.gov/21659338/>.
- 59 David Hemenway & Sara J. Solnick, *The Epidemiology of Homicide Perpetration by Children*, *Injury Epidemiology* (2017), vol. 4, <https://pubmed.ncbi.nlm.nih.gov/28164258/>.
- 60 Michael Baglivio & Kevin Wolff, *Prospective Prediction of Juvenile Homicide/Attempted Homicide Among Early-Onset Juvenile Offenders*, 14 *International Journal of Environmental Research and Public Health* 197 (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5334751/>; F. Jeane Gerard, et al., *An Exploration of the Current Knowledge on Young People Who Kill: A Systematic Review, 19 Aggression and Violent Behavior* 559-571 (2014), <https://westminsterresearch.westminster.ac.uk/download/0225758c5de350536d99f63a245d8f5aa8ae-6b4a47cb227d329cea1c3447913/179108/FJG%20Systematic%20review%20JHO%20CURVE.pdf>; Kathleen M. Heide & Brian G. Sellers, *Girls Arrested for Murder: An Empirical Analysis of 32 years of U.S. Data by Offender Age Groups*, 32 *Behavioral Sciences & the Law* 467-482 (2014), <https://onlinelibrary.wiley.com/doi/abs/10.1002/bsl.2130>; David Hemenway & Sara J. Solnick, *The Epidemiology of Homicide Perpetration by Children*, 4 *Injury Epidemiology* (2017), <https://pubmed.ncbi.nlm.nih.gov/28164258/>; David M. Shumaker & Ronald J. Prinz, *Children Who Murder*, 3 *Clinical Child and Family Psychology Review* 97-115 (2000), <https://pubmed.ncbi.nlm.nih.gov/11227064/>.
- 61 Genevieve Santillanes, et al., *Involuntary Psychiatric Holds in Preadolescent Children*, *Western Journal of Emergency Medicine*, (2017), vol. 7, at 1159-1165, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5654888/>.
- 62 *Youth Risk Behavior Survey (YRBS) | Florida Department of Health, Floridahealth.gov* (2020), <http://www.floridahealth.gov/statistics-and-data/survey-data/florida-youth-survey/youth-risk-behavior-survey/index.html> (last visited Oct 27, 2020).
- 63 Bridge, et al., supra note 57 (reporting 0.11 deaths by suicide for every 100,000 children aged 5 to 11 years old).
- 64 Baker Act Task Force Report, supra note 3 at 14-16
- 65 Karen J. Cusack, et al., *Trauma Within the Psychiatric Setting: A Preliminary Empirical Report*, 30 *Administration and Policy in Mental Health* 453-460 (2003).
- 66 B. Christopher Frueh, et al., *Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting*, 56 *Psychiatric Services* 1123-1133 (2005), <https://ps.psychiatryonline.org/doi/pdfplus/10.1176/appi.ps.56.9.1123>.
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- 68 Frueh, et al., supra note 66.
- 69 Genevieve Santillanes, et al., *Involuntary Psychiatric Holds in Preadolescent Children*, 18 *Western Journal of Emergency Medicine* 1159-1165 (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5654888/>.
- 70 Indeed, whatever approaches or strategies may stabilize the child in the hospital or other institution are likely not transferable to community-based settings, like the child's home.
- 71 *Id.* See also ABA, *Trauma Caused by Separation of Children from Parents: A Tool to Help Lawyers*, (May 2019) at 6-10, https://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/child-separation-memo-parent-child-separation-trauma-memo.pdf (citing research that shows "how stress from separation can impact a child's brain within the first few minutes of removal").
- 72 Leslie C. Hedman, et al., *State Laws on Emergency Holds for Mental Health Stabilization*, 67 *Psychiatric Services* 529-535 (2016).
- 73 Jasmine Aguilera, *After a 6-Year-Old Girl Acted 'Out of Control' in School, She Was Involuntarily Committed to a Mental Health Facility*, *Time* (Feb. 18, 2020), <https://time.com/5784757/nadia-king-florida-baker-act-school/>.
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- 75 Katie LaGrone & Matthew Scott Apthorp, *Children in Crisis, Florida's Baker Acted Kids*, WFTX (updated Mar. 2, 2018), <https://www.fox4now.com/longform/children-in-crisis-floridas-baker-acted-kids>.
- 76 Kyra Gurney, *Handcuffs and a Psych Exam for a 7-year old? Schools Do That Too Often*, *Parents Say*, *Miami Herald* (Feb. 2, 2018), <https://www.miamiherald.com/news/local/education/article197958454.html>.
- 77 *Id.*
- 78 SPLC interview.
- 79 Rob Green, Anna Sommers & Mindy Cohen, *Medicaid Spending on Foster Children*. Washington, D.C.: Urban Institute (2005), <https://www.urban.org/sites/default/files/publication/51676/311221-medicaid-spending-on-foster-children.pdf>.
- 80 J. Curtis McMillen, et al., *A Crisis of Credibility: Professionals' Concerns About the Psychiatric Care Provided to Clients of the Child Welfare System*, *Adm Policy Ment Health* (Oct. 26, 2006), 34(3):203-212. doi:10.1007/s10488-006-0096-5, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3394428/>. The paper explains that numerous studies have documented the unneeded and ineffective over-prescription of psychotropic medication — medicine impacted mood and emotion — to children in residential psychiatric settings, especially for children in foster care who are committed to inpatient treatment. For all children, careful standards are recommended by clinical experts before prescribing psychotropic medication. These include: a comprehensive biopsychosocial treatment/care plan for any use of psychotropic medication, using a framework of system of care values and principles; development of policies and monitoring systems regarding patient safety and the appropriate use of psychotropic medications in children and youth; and the responsiveness of prescribers to questions regarding the role of psychotropic medications in the overall treatment plan.
- For those in foster care, in particular, child welfare professionals report concerning outcomes for the children in their care who are prescribed psychotropic drugs while institutionalized, often without regard for and in conflict with existing medication regimens.
- 81 *Id.*
- 82 Joe Persi & Megan Sisson, *Children in Foster Care: Before, During, and After Psychiatric Hospitalization*, *PubMed.gov, Child Welfare*. 2008;87(4):79-99. PMID: 19391468.
- 83 M. Lynn Crisman & Tami Argo, *The Use of Psychotropic Medication for Children in Foster Care*, *Journal of the Child Welfare League of America, Inc.*, vol. 88, no. 1 at 71 (2009), https://www.researchgate.net/profile/Peter_Jensen/publication/26715707_Best_Practices_for_Mental_Health_in_Child_Welfare_Parent_Support_and_Youth_Empowerment_Guidelines/links/0deec5184118139614000000.pdf#page=71.
- 84 *Id.*
- 85 Sylvia H. Oswald, PhD, Katharina Heil, Lutz Goldbeck, PhD, *History of Maltreatment and Mental Health Problems in Foster Children: A Review of the Literature*, *Journal of Pediatric Psychology*, Volume 35, Issue 5, June 2010, at 462–472, <https://doi.org/10.1093/jpepsy/jsp114>.
- 86 U.S. Department of Health & Human Services, *Children's Bureau Child Welfare Outcomes State Data Review Portal*, <https://cwoutcomes.acf.hhs.gov/cwodatasite/pdf/florida.html> (showing that, as of 2018, Black children made up 20% of the general child population in Florida, but at least 30% of the children in foster care (children of two or more races (3.7% of the overall population but 6.6%

of the children in foster care) are counted separately and may also include children who are identified by themselves or others as Black) (last visited Feb. 13, 2021).

87 See, e.g., Pierre, *supra* note 35; Grace Chen, Students of Color Disproportionately Disciplined in Schools, Public School Review (Aug. 13, 2019), <https://www.publicschoolreview.com/blog/students-of-color-disproportionately-disciplined-in-schools> (“data, . . . collected from 97,000 public schools from across the country, paints a troubling picture:

Black and Latino students are consistently punished more severely than white students for the same infractions.

Nearly 50 percent of preschool children who are suspended multiple times are black, yet black children represent less than one-fifth of the preschool population. Black students are far more likely to be referred to law enforcement or arrested for a school-based offense than white students or other students of color.

Black girls are suspended at a much higher rate than girls of any other race.

Students with disabilities, who represent only 12 percent of the public school population, account for almost 60 percent of students who are placed in seclusion.”)

88 Daniel J. Losen, *supra* note 8, at 3,8; Matthew C. Fadus, et. al, *supra* note 8, at 96,98,

89 Mental Health America, Position Statement 22: Involuntary Mental Health Treatment (2020), <https://www.mhanational.org/issues/position-statement-22-involuntary-mental-health-treatment>.

90 Judge David L. Bazelon Center for Mental Health, Position Statement on Involuntary Commitment, Bazelon.org (2000), <http://www.bazelon.org/wp-content/uploads/2017/04/Position-Statement-on-Involuntary-Commitment.pdf>

91 American Academy of Child & Adolescent Psychiatry, Suicide Prevention (Sept. 2010), https://www.aacap.org/App_Themes/AACAP/docs/Advocacy/policy_resources/Suicide_Prevention_Fact_Sheet_2010.pdf

92 *Id.*

93 Public Records Requests. As part of research for this brief, SPLC sent public records requests regarding Baker Acts to 15 different districts across the state. Some districts replied that they did not keep any records of Baker Act use and had no Baker Act use policies. Others had records of individual incidents but no aggregate data.

94 As of July 2020, data is collected on whether the police officer is serving as school resource officer when a Baker Act is initiated, but even this data cannot sufficiently answer whether the child was Baker Acted from school given that all schools do not use SROs to initiate Baker Acts.

95 Unless otherwise noted, all data in this section is from records produced by the Palm Beach Public Schools in response to public records requests by SPLC and on file with SPLC staff.

96 In person instruction for the school year ended on March 13, 2020, at which time 132 of the scheduled 179 days of instruction had occurred. Palm Beach County Public Schools, 2019-2020 Academic Calendar, https://www.palmbeachschools.org/UserFiles/Servers/Server_270532/File/School%20Calendar/2019-2020/12.11.2019DistrictCal2019-2020BdApproved12.11.2019.pdf (last visited Feb. 15, 2021).

97 The Baker Act Reporting Center collects race data but does not publish it in every year and does not report on racial disparities in school-based Baker Acting. It also lacks schools’ more detailed information on how students self-report their race, relying on receiving facilities to provide this information from unknown sources.

98 Phillip Goff et al., The Essence of Innocence: Consequences of Dehumanizing Black Children, *Journal of Personality and Social Psychology* (2014).

99 Florida Department of Juvenile Justice, Disproportionate Minority Contact: Racial Ethnic Disparity Profile FY2018-19, <http://www.djj.state.fl.us/research/reports/reports-and-data/interactive-data-reports/disproportionate-minority-contact-reports/dmc-red-profile-fy2018-19> (last visited Oct 27, 2020).

100 *Id.*

101 Clark Fouraker, Former Cop Says District Uses Baker Act to Reduce Arrest, First Coast News (Aug. 17, 2016), <https://www.firstcoastnews.com/article/news/education/former-cop-says-district-uses-baker-act-to-reduce-arrests/295152933>.

102 20 USC §§ 1400-1482.

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