IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT OF FLORIDA IN AND FOR THE COUNTY OF MIAMI-DADE

FINAL REPORT OF THE MIAMI-DADE COUNTY GRAND JURY

FALL TERM A.D. 2007

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FILED

August 11, 2008

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I N D E X

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SHIFTING THE FOCUS ON TREATING MENTAL ILLNESS:
A COMMON "CENTS" APPROACH

I. INTRODUCTION

On January 11, 2005, the 2004 Spring Term Grand Jury issued a report entitled Mental Illness & The Criminal Justice System: A Recipe For Disaster/A Prescription For Improvement (hereinafter the "2004 Spring Term Report"). The report listed a number of specific recommendations all designed to improve the lot (and life) of persons in our community suffering from mental illness.[1] Earlier this year, a Miami-Dade County Homeless Trust Coalition adopted a recommendation that a successor grand jury conduct an analysis on the extent of implementation of the recommendations set forth in the 2004 Spring Term Report. This Grand Jury decided to accept that assignment. We will address those findings at the end of this report.

Notwithstanding the charge given to us by the Homeless Coalition, we opted to begin this Report by looking at a tragic event that occurred two years after the release of the 2004 Spring Term Report. The incident drew worldwide attention and caused many to re-examine the laws and systems we have in place to deal with those suffering from mental illness. As our predecessor Grand Juries have done over the years, we issue recommendations in this report in hopes that, if adopted, they can help prevent such a tragedy from happening here. Our basic message in this report and the overriding theme from this Grand Jury is our laws and our focus on involuntary treatment of persons with mental illness should shift from, "Is the person a danger to himself or others?", to, "Does the person understand he is sick and can we provide treatment?" As set forth below, we believe making this shift will save lives and save money.

II. THE SHOTS HEARD 'ROUND THE WORLD

On April 16, 2007, Seung Hui Cho, a college student, shot and killed thirty-two (32) students and faculty members of Virginia Tech, wounded seventeen (17) more, and then committed suicide. The incident drew worldwide attention and caused nation-wide alarm

[1] The report can be found at http://www.miamisao.com/publications/grand_jury/2000s/gj2004s.pdf.

regarding the safety of students attending our nation's colleges and universities.[2] Immediately thereafter, Tim Kaine, the Governor of Virginia, appointed a panel comprised of professionals from different areas. The panel members, among other things, reviewed the events leading up to the massacre, including the mental health history of Seung Hui Cho. The final report from the panel was released in August 2007.[3]

The Review Panel's Summary of Key Findings, among other things, included a number of entries regarding Cho's long history of mental illness. It included the following:

- Cho exhibited signs of mental health problems during his childhood….In 1999, after the Columbine shootings, Cho's middle school teachers observed suicidal and homicidal intentions in his writings and recommended psychiatric counseling, which he received.
- During Cho's junior year at Virginia Tech numerous incidents occurred that were clear warnings of mental instability.
- The Cook Counseling Center and the university's Care Team failed to provide needed support and services to Cho during a period in late 2005 and early 2006. The system failed for lack of resources, incorrect interpretation of privacy laws, and passivity.[4]

In the months leading up to the mass murders, Cho was found to be an imminent danger to himself by the pre-screener[5] who also found that he was "unable to come up with a safety plan to adequately ensure safety." He was unwilling to contact his parents to pick him up. However, Cho was found *not* to be an imminent danger to self or others by both the independent examiner and the treating psychiatrist at St. Albans Behavioral Health Center of the Carilion New River Valley Medical Center, and accordingly neither recommended involuntary admission. At the commitment hearing, the special justice did find Cho to be an imminent danger to himself;

[2] [2] In an effort to avoid a repeat of the Virginia Tech incident, many of these educational facilities have now developed emergency communication networks that automatically send out phone, text and e-mail messages and warnings in the event of any dangerous condition on campus.

[3] The entire report can be found at http://www.governor.virginia.gov/TempContent/techPanelReport-docs/FullReport.pdf

[4] Mass Shootings at Virginia Tech, April 16, 2007 Report of the Virginia Tech Review Panel (hereinafter, "Virginia Tech Report") pp. 1-2.

[5] A pre-screen evaluation was conducted by a licensed clinical social worker for New River Valley Community Services Board (CSB). The pre-screener interviewed Cho a police officer, and then spoke with both Cho's roommate and a suitemate by phone. She recorded her findings on a five-page Uniform Pre-Admission Screening Form, checking the findings boxes indicating that Cho was mentally ill, was an imminent danger to self or others, and was not willing to be treated voluntarily. She recommended involuntary hospitalization and indicated that the CSB could assist with treatment and discharge planning. Virginia Tech Report, p. 47.

however, he agreed with the independent examiner and treating psychiatrist that a less restrictive alternative to involuntary admission, outpatient treatment, was suitable. Perhaps Cho presented himself differently at various stages of the commitment process or perhaps the professionals had differing evaluations of someone who did not speak much or perhaps they had differing interpretations of the standard set forth in the Virginia Code.[6]

At Cho's hearing, the only documents available to the special justice were the Uniform Pre-Admission Screening Form, partially completed Proceedings for Certification form recording the findings of the independent evaluator and a physician's examination form containing the findings of the treating psychiatrist. No prior patient history was presented; no toxicology, lab results, or physical evaluation from the treating psychiatrist were available.

The special justice ordered that Cho receive outpatient treatment; however, the order provided no information regarding the nature of the treatment other than to state "to follow all recommended treatments." The order did not specify who was to provide the outpatient treatment or who was to monitor the treatment.[7] It was the policy of the Cook Counseling Center to allow patients to decide whether to make a follow-up appointment. According to the existing Cook Counseling Center records, none was ever scheduled by Cho. Because Cook Counseling Center had accepted Cho as a voluntary patient, no notice was given to the [New River Valley Community Services Board (CSB)], the court, St. Albans, or Virginia Tech officials that Cho never returned to Cook Counseling Center.[8] The cumulative effect of all these failures was played out on April 16, 2007.

In addition to focusing on Cho's history of mental illness, the Review Panel's summary of Key Findings also included critical observations regarding Virginia laws that are supposed to help persons suffering from mental illness. It included the following criticism:

- Virginia's mental health laws are flawed and services for mental health users are inadequate. Lack of sufficient resources results in gaps in the mental health system including short term crisis stabilization and comprehensive outpatient services. The involuntary commitment process is challenged by unrealistic time constraints, lack of

[6] Id. at p. 56.
[7] Id at 58.
[8] Id. at 49.

> critical psychiatric data and collateral information, and barriers (perceived or real) to open communications among key professionals.[9]

In addition to this comment, the panel also noted two specific shortcomings regarding the law:

> 1) Statutory time constraints for temporary detention and involuntary commitment hearings significantly impede the collection of vital psychiatric information required for risk assessment; and
>
> 2) The Virginia standard for involuntary commitment is one of the most restrictive in the nation and is not uniformly applied.[10]

In light of those shortcomings the Review Panel made a number of recommendations for changes and amendments to Virginia law. Several of those recommendations impact this report and so we include them here. The Virginia Code . . . should be amended to:

> Extend the time periods for temporary detention to permit more thorough mental health evaluations; and
>
> Authorize magistrates to issue temporary detention orders based upon evaluations conducted by emergency physicians trained to perform emergency psychiatric evaluations.
>
> The criteria for involuntary commitment in the Code should be modified in order to promote more consistent application of the standard and to allow involuntary treatment in a broader range of cases involving severe mental illness.[11]

Why are we concerned about Seung Hui Cho, Virginia law and events that occurred hundreds of miles away from here? Because we discovered during our term that similar tragedies are occurring in our county on a regular basis on a much smaller scale. We too, have persons who are mentally ill who are falling through the cracks. They are not receiving appropriate treatment and end up killing innocent persons, usually relatives, or killing themselves. Often times they place themselves in situations where they end up getting killed by others, including by law enforcement officers who are usually the first ones called when a family member gets in crisis. Because of the dangerous nature and volatility of these encounters officers defending themselves or others sometimes are left with no options other than the use of

[9] Id. at pp.1-2.
[10] Id. at 60.
[11] Id.

deadly force.[12] We have a number of recommendations herein that we are certain will reduce the number of these tragedies in our community and prevent a repeat of the Virginia Tech tragedy here.

III. INVOLUNTARY INPATIENT COMMITMENT & TREATMENT IN FLORIDA

Mentally ill persons in our community who are in a psychiatric crisis and in need of treatment routinely become involved in Florida's involuntary commitment process, also referred to as Baker Act proceedings. The law that allows for this process is Florida Statute 394.467(1). It provides as follows:

A person may be placed in involuntarily inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

(a) He or she is mentally ill and because of his or her mental illness:

1. a. He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or

b. He or she is unable to determine for himself or herself whether placement is necessary; AND

2. a. He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect of refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

b. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and

(b) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

Serious mental illness is often considered a genetically predisposed chemical imbalance and like any other illness, it needs treatment in order for it to get better. Persons with mental illness are not criminals, they are sick. There is no cure, only treatment. Fortunately, new medications work better and with fewer side effects. A mentally ill person often times does not

[12] People with untreated severe mental illnesses are four times more likely to be killed in an altercation with law enforcement than people in the general population. In 2006, forty-nine percent (49%) of all involuntary exams in the State of Florida were initiated by law enforcement officers. Requesting an involuntary exam is the first step in the Baker Act process. For explicit examples of the types of encounters that have actually taken place in this county see the Appendix to the 2004 Spring Term Report.

know that he/she needs treatment. In those cases, it is necessary to intervene so that the person can receive treatment and possibly be able to work, have an improved quality of life and maintain a place to live.

In comparison with other laws across the country, Florida's is considered to be very strict. The law, in its present state, requires a person to reach the point where they are in a total crisis situation before they can be forced to obtain treatment that can save them from causing harm to themselves or others. In light of the numerous devastating fires that raged in California during our term, we thought the following analogy would be fitting.

The result of this approach to forced treatment is akin to having a forest ranger posted in a forest to watch for fires. However, the law says the ranger cannot call for firefighters at the first sign of smoke. Instead, he must wait until he is absolutely certain there is a fire and that a dangerous condition exists. Of course, by the time he is able to confirm that a fire is in fact blazing, significant damage has already been done. The fire is out of control. The total costs, as it relates to the amount of time, effort and resources it will take to extinguish this raging inferno have grown exponentially from the point in time when the ranger spotted the first wisps of smoke. In the interim, lives have been lost, homes have been destroyed and beautiful national forest preserves have been forever scarred. This approach to treating mental illness mirrors Florida law (and that of many other states in this country). Unfortunately, it is how our system treats persons we **know** are mentally ill. Similar to Virginia Tech Review Panel's recommendations regarding Virginia law, this Grand Jury strongly believes that changes should be made to the mental health treatment laws in Florida.

IV. REPORTING OF THE DATA

As of 2005, Florida law requires that all involuntary inpatient and involuntary outpatient placement orders entered by courts in this state be submitted to the Florida Agency for Health Care Administration (AHCA). The Baker Act Reporting Center at the Louis de la Parte Florida Mental Health Institute (the "Center") receives, processes and analyzes these statewide submittals. The Reporting Center uses the data to prepare the statutorily required annual report of Baker Act data for AHCA.[13] As a result of these data compilations the legislature and

[13] Section 394.463 Florida Statutes requires ACHA to submit an annual report to the Department of Children and Families and to forward the report to certain designated officers of the Florida legislature.

policymakers can monitor what is happening in the state regarding, among other things, the number of involuntary examinations, who is initiating the examinations, and the number of involuntary placements.

The most recent available Florida data regarding involuntary inpatient and outpatient treatment is set forth in the 2006 Florida Mental Health Act (The Baker Act) Report (hereinafter referred to as the "2006 Baker Act Report"). In addition to the court orders mentioned above, the Center collects data from all of the receiving facilities in the state. However, according to the Center, "the current quality of inpatient placement data renders them of questionable usefulness to policymakers."[14]

The Center's extensive efforts to increase data submission compliance for all inpatient placement orders have not been very effective. The level of compliance from all of the receiving facilities spread out across the state is such that the Center does not have strong confidence in the numbers reflected for inpatient placements. The Center has suggested a change in the statutory language that would require the 67 Clerks of Court (as opposed to the more than 100 receiving facilities) to submit the inpatient placement orders. See Florida Statute 394.463. We think this is a good idea. We believe it is crucial for policymakers and lawmakers to have an accurate picture of the number of involuntary examinations, involuntary inpatient and outpatient examinations, and other reporting information required by the statute. As the Center believes that this change in the statute would also make tracking of data submission easier, we adopt it and include it as a recommendation in this report.

Accordingly, we recommend that the Florida legislature amend Florida Statute 394.463 to require that each Office of the County Clerk send to the Agency for Health Care Administration a copy of all court orders of involuntary inpatient and outpatient placement issued in its circuit.

The 2006 Baker Act Report includes many statistics, charts and summaries that are designed to show what is happening statewide with involuntary examinations, treatment and commitment of the mentally ill to various facilities. The 2006 Report Highlights include the following observations:

- There were at least **82,414** people who had at least one Baker Act involuntary examination initiated in 2006.

[14] 2006 Baker Act Report, p. 5.

- **Nineteen** percent of these people had more than one involuntary exam initiated in 2006 (range **2 to 33** involuntary exams).
- Law enforcement officials initiated almost half of involuntary exams (**49**%), followed by mental health professionals (**48**%) and judges (**3**%).
- The most common evidence type indicated was "harm only" (**66**%) followed by "neglect only" (**15**%) and "both neglect and harm" (**15**%).
- There were **22** involuntary outpatient placements documented for calendar year 2005 and **35** for 2006 for a total of 57 statewide.[15] [16]

V. FLORIDA'S BAKER ACT PROCEDURES

The Baker Act requires that a physician or a psychologist conduct the initial mandatory involuntary examination. It does not require a psychiatrist. The release of a person from a designated receiving facility requires the approval of a psychiatrist, psychologist, or emergency physician. The provisions of law governing this issue are included in s.394.463 (2). However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition.

The initial mandatory involuntary examination is required and includes:

- A thorough review of any observations of the person's recent behavior;
- Review of the "Transportation to Receiving Facility" form and
- Review of one of the following:
  - "Ex Parte Order for Involuntary Examination" or
  - "Report of Law Enforcement Officer Initiating involuntary Examination" or
  - "Certificate of Professional Initiating Involuntary Examination"
- Conduct a brief psychiatric history; and
- Conduct a face-to-face examination in a timely manner to determine if the person meets criteria for release.

If the patient is examined and is found, as a result of that examination, not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for

[15] There were 35 total involuntary outpatient placements for all of 2006. Thirty-five out of 82,414 interviews (.0004%)

[16] 2006 Baker Act Report, p. 2. We will address several of these items later in this report.

involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record.

If the examination reveals that the patient does meet criteria, filing a petition for inpatient placement allows the facility to hold the patient several days beyond the 72-hour Baker Act exam period, allowing more time to provide mental health services and to create a discharge plan. The hearing on involuntary commitment must be held within five-days of the filing of the petition. Although the respondent (patient) may request a continuance of the hearing, no such option is available for the State Attorney, who must present the evidence at the Baker Act proceedings. If circumstances are such that the State Attorney is unable to go forward with the hearing, in lieu of releasing the respondent, and for good cause shown, the state should be able to request a brief continuance. In shifting toward the goal of making sure that sick people are getting treated, we believe the statute should be amended.

We recommend that Florida's mental health laws be amended to allow the State, for good cause shown, to receive a brief continuance of time in which to hold the involuntary commitment hearing (no more than an additional three days).

We also believe that relaxing the initial 72-hour period may also be required in certain circumstances to ensure a thorough and complete examination of the patient.

Accordingly, we recommend that for good cause shown, Crisis Stabilization Units and receiving facilities may be granted a 24-hour extension if, in so doing, they will be able to make a more informed decision regarding the condition of the patient in their facility.

VI. ACCESS TO MEDICAL RECORDS OF BAKER ACT RESPONDENTS

When Baker Act cases are not resolved by voluntary placement for treatment or discharge, a hearing is required. The State Attorney has the burden of establishing that the patient meets the criteria for involuntary commitment, namely, that he or she is in danger of harming self or others. Further, Florida law recognizes that the state attorney for the circuit in which the patient is located shall represent the state. . . as the real party in interest in the proceeding. Obviously, the most important information needed to meet its burden may be contained in the patient's medical file/clinical record. However, presently, the law in Florida does not allow the prosecutor access to a respondent's clinical file for an involuntary inpatient

commitment hearing. We are at a loss to understand the logic behind this. We were informed that an earlier version of the statute allowed the State Attorneys Office pre-hearing access to the clinical records of the respondents. Witnesses testified that they believe the provision allowing that access may have been erroneously omitted in one of the amendments to the Baker Act statute.

We are inclined to agree. We think this was an oversight of the legislature. Surprisingly, such records may be released to the State Attorney in connection with an involuntary outpatient placement.[17] The Grand Jury refuses to believe that our elected officials would have a law in place that was designed to protect society and get medical help for someone in danger and then take away the tools to allow that to happen. The State Attorney has the obligation to prove that the respondent meets criteria. If there is information in the medical file that demonstrates or corroborates that fact, the information should be made available so that the judge or General Master has all of the relevant available information. The availability of all relevant information will allow the General Master to make the most informed decision possible. Again, our shift in focus is designed to make sure that all the parties involved do all they can to determine if the person is sick. If he/she is, then let them do all they can to make sure that treatment (even forced treatment) is provided. Our recommendation in this regard is similar to one of the recommendations from the Virginia Tech Review Panel. Their suggestion was the Virginia Code should be amended to ensure that **all entities involved with treatment** have full authority to **share records with** each other and **all persons involved in the involuntary commitment process,** while providing the legal safeguards needed to prevent unwarranted breaches of confidentiality. Our statute already provides that any person, agency, or entity receiving information pursuant to this section shall maintain such information as confidential.

Accordingly, we recommend that the legislature amend Florida Statute 394.4615 (3) to provide that for the purpose of determining whether a person meets the criteria for involuntary inpatient or outpatient placement or for preparing the proposed treatment plan pursuant to s. 394.4655, the clinical record shall be released to the state attorney, the public defender or the patient's private legal counsel,

17 For the purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan pursuant to s. 394.4655, the clinical record may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider identified in s. 394.4655(6)(b)2., in accordance with state and federal law. Florida Statute 394.4615 (3)

the court, and to the appropriate mental health professionals, including the service provider identified in s. 394.4655(6)(b)2., in accordance with state and federal law. (emphasis added)

VII. THE EVIDENCE

Florida law is very specific as to the types of evidence the General Master or Judge may consider in evaluating whether a patient meets the criteria for involuntary commitment. The law is also specific for the time frame to which the court may look in an effort to determine whether a certain individual is at substantial risk of serious bodily to himself or others. The substantial risk of harm must be "evidenced by **recent behavior.**" By the very language of the statute, the Florida legislature has determined that any and all of a respondent's prior mental health history is irrelevant. We believe that this is another area of the law that should be changed. Here in this area too, the Virginia Tech Review Panel made a recommendation for a change to the Virginia Code. The panel suggested that reports of prior psychiatric history be included in the list of documents that should be presented at a commitment hearing.[18] The Illinois mental health statute goes even further. It provides that in determining whether a person meets the criteria . . . the court may consider evidence of the person's repeated past pattern of specific behavior and actions related to the person's illness.[19] We believe the recommendation and statute are consistent with the shift we are hoping will occur within this state.

Accordingly, we recommend that Florida Statute 349.467 be amended to specifically allow that in determining whether a person meets the criteria, the court shall consider the respondent's prior psychiatric history.

We further recommend that Florida Statute 349.467 be amended to specifically allow that in determining whether a person meets the criteria, the court may consider evidence of the person's repeated past pattern of specific behavior and actions related to the person's illness.

VIII. THE LOGISTICS FOR THE HEARINGS

Baker Act hearings are held at Jackson Memorial Hospital (JMH) beginning at 8:00 a.m. on Mondays, Tuesdays and Thursdays. Doctors from the hospitals or Crisis Stabilization Units (CSU's) who initiate the petitions must testify at the hearings. There are a number of hearings set on any given day. The order in which the cases are called is determined by when the doctors arrive, on a first-come-first-served basis. Inasmuch as the hearings are held at JMH, the doctors

[18] Virginia Tech Report, p. 61
[19] Illinois Statute Section 405 ILCS 5/1-119.

who work there are invariably the first to arrive, the first to have their cases called and the first to get back to their regular duties. On the other hand, a number of the other CSU's and hospitals serving the population of mentally ill patients in our community are located in the extreme northern, western, and southern portions of Miami-Dade County.[20] Traveling in rush hour traffic from either of these locations for an 8:00 a.m. hearing is very time consuming and will ensure that those doctors will be among the last to arrive, will be the last to have their cases called and will be the last to return to their regular duties and responsibilities. We were informed that the morning wait at the hearings often lasts for hours. This built in delay is often dependent on the number of hearings set and the number of witnesses, and the amount of testimony and evidence that need to be presented at each of those hearings. We are concerned that these scheduling problems may be causing problems for the Baker Act process in Miami-Dade County.

First, several witnesses indicated that although all of the receiving facilities take in Baker Act candidates who arrive in psychiatric crisis, some of those facilities **never** have a doctor file a petition to initiate an involuntary commitment. Accordingly, they never appear at any Baker Act Hearings. If petitions are not being filed for the persons in psychiatric crisis taken to those facilities, we may conclude that subsequent to the mandatory involuntary examination, someone convinced the patient to agree to voluntary commitment or a doctor determined the patient did not meet criteria for involuntary inpatient placement.

One of the troubling issues for the Grand Jury was an alleged comment by a doctor who said, "Why don't you come and hold the hearings here [at the facility where the doctor worked] then we won't be discharging the clients." The implication is that doctors may be convinced that clients meet criteria but are discharging them from the facilities to avoid the requirement of traveling to and participating in the Baker Act hearings at JMH. If this is occurring, persons who are very sick are being released back on the streets, creating significant risks of harm to themselves and others. This scenario would be consistent with Seung Hui Cho. He was sick, he did not get needed treatment and he caused serious bodily harm to himself and many others. Unfortunately, this scenario has also been playing out in our community. At least one such case was presented to us during our grand jury term.

[20] Miami-Dade County has a total of twenty-one (21) receiving facilities. Six of them are CSU's. These facilities are the gateway to the Baker Act proceedings and they are spread throughout the county.

One of the cases for which we returned an Indictment involved a defendant who had a history of mental illness. Investigation revealed that the defendant had been exhibiting paranoid behavior for two weeks, including jumping out of a moving car. He was Baker Act-ed on February 29, 2008. A petition was not filed, nor did he agree to voluntary treatment. He was released. He lived with his girlfriend. Later that evening, the defendant told his girlfriend and her son, that he wanted to kill her since he believed that she was plotting against him. A few days after his release he murdered her. The defendant told police that he went into the kitchen and retrieved a large knife and returned to the bedroom where she was sleeping. The victim was rising up from the bed when he thrust the knife into her chest. It nearly went completely through the victim's body. The victim had plans to take the defendant back to the doctor that day.

Newspaper headlines remind us of other cases. For instance, the Miami Herald ran an article on January 11, 2008, with the caption: Mother's love led to death. The article described how the defendant, upset with his mother for repeatedly putting medication in his food, grabbed a knife and stabbed her three times in the neck. One of the puncture wounds severed her main artery. She died. The mother had previously asked the court to release her son back to her custody, after he had tried to kill his father by stabbing him. The defendant was actually on probation for the attempted murder of his father when he murdered his mother.

Witnesses recounted other similarly tragic incidents. A mother decided to have her son Baker Act-ed. He had an extensive mental health history but she had never sought to have him involuntarily committed. She took him to the facility. The doctor determined that he did not meet criteria and released him. He died later that day, having been killed by police in a violent confrontation after trying to break into his girlfriend's residence.

Another person was Baker Acted and after arriving at the receiving facility was found by the doctor to not meet criteria for involuntary commitment. He was released. He got behind the wheel of a car and tried to run down a total stranger. He was successful. The victim received serious injuries and almost died.

In most of these cases the family members and loved ones who care for these individuals watch them change over time. They see the patterns and know when there is an approaching escalation of violent behavior. They use the process the state has in place to protect them and their

loved ones. After taking them in for treatment and trying to get them help, the patient is released. The family members do not understand and are left to wonder why.

Assuming doctors are discharging patients to avoid the inconvenience of participation in the Baker Act hearings, those actions are contributing to the recycling of mental health patients through our already limited resources. Statistics from prior years reveal that in 2002, one person was Baker Act-ed 41 times, at a cost of approximately $81,000 - not including court costs, law enforcement resources, or short-term treatment. Recidivist Baker Act examinations increased 50 percent between 2000 and 2002; 540 individuals had eight or more Baker Act exams in one 24-month period (2000 to 2001), averaging at least one every three months.[21] More recent statistics set forth in the 2006 Baker Act Report indicate that more than 300 individuals had eight or more Baker Act exams in calendar year 2006, averaging at least one exam approximately every six weeks. Eleven individuals had fourteen involuntary examinations in 2006 – averaging more than one per month. Most startling, seven (7) individuals had 24 or more involuntary examinations, averaging at two exams per month.[22] If mentally ill persons are acting out in ways that are causing trained professionals to believe they need to be treated and they are receiving treatment, we do not expect that several weeks after treatment they should be returning to the crisis state they were in just a few days before. The existence of this high number of recidivist examinations indicates to this Grand Jury that persons who need treatment are not being ordered to get treatment and those who are being so ordered are receiving ineffective or insufficient short-term treatment. This is both costly and dangerous to the consumer and the public.

Due to our concerns regarding these recidivist involuntary examinations, we recommend that DCF investigate the circumstances for all individuals who have more than ten examinations within a 12-month period. The investigation should include a review of the practices of the facility that is performing the examinations, particularly if no petitions are being initiated for involuntary inpatient placement. Based on the results of said investigation, DCF may determine whether it may be appropriate to remove that entity from the list of approved facilities.

We have some concerns that these large numbers of evaluations with no petitions for involuntary placement being filed may reveal a flaw in the Baker Act process. We think this may be especially so in Miami-Dade County. The Baker Act hearings are presently being heard in one location, by one Special Master on specific days every week. Just as there are CSUs and

[21] Treatment Advocacy Center, Fact Sheet for Baker Act Reform, Senate Bill 700
http://www.treatmentadvocacycenter.org/stateactivity/Florida/doc7.htm
[22] Two persons had **thirty-three (33)** involuntary examinations within a 12-month period.

receiving facilities spread throughout the county, so too are our courthouses. There are branch courts in far South Dade,[23] Hialeah[24] and North Dade.[25] Changes can be made to have the present Special Master convene hearings at the Branch Courts on certain days. Alternatively, the Chief Judge may consider selecting another Special Master who can develop another permanent schedule for Baker Act proceedings in these three (3) Branch Courts. The second Special Master can "ride the Circuit" and have the hearings in the far reaches of this huge county. This should make it easier for the doctors to attend the hearing and reduce the amount of time they are away from their regular occupations. This might also result in petitions being filed by some of the facilities where doctors never appear for Baker Act hearings.

Another option that may be considered (with the consent of the respondent and/or his lawyer) is the use of video-teleconferencing. As to the actual Baker Act Hearings, the statute only requires that the witnesses be sworn and that the testimony be recorded. The testimony of the doctors in the outlying facilities could be provided via this technology. We were informed that video-teleconferencing is being used to take depositions, to facilitate the taking of Pre-file conferences by prosecutors and to conduct bond hearings. Using this method, we could keep the same Special Master and still not cause such major disruption for the doctors who need to testify at the hearings.

Accordingly, we recommend that the court consider the feasibility of using video technology to conduct the Baker Act hearings and to receive the testimony of distant witnesses.

We also recommend that regularly scheduled Baker Act hearings be conducted at the branch courts and at Jackson Memorial Hospital.

We further recommend that the Chief Judge appoint another General Master who will handle Baker Act hearings at the branch courts.

IX. A SHIFT TOWARD MORE HUMANE TREATMENT OF THE MENTALLY ILL: A MODEL LAW FOR ASSISTED TREATMENT

Since our state has taken the position that it will, in certain circumstances, force treatment on persons who are mentally ill, we believe that the decision to do so should be made as soon as the need for treatment becomes apparent (at the first wisp of smoke) instead of waiting until the

[23] 10710 SW 211th Street, Suite # 1200 Miami, Florida 33189
[24] 11 E. 6th Street Hialeah, Florida 33010
[25] 15555 Biscayne Boulevard, Suite # 100 Miami, Florida 33160

person has become dangerous (when there is a raging inferno). In that regard, we believe Florida should follow the lead of other states that have changed their approach (and their laws) to treating the mentally ill.

Illinois recently relaxed its standards to allow for involuntary placement and/or treatment at an earlier stage in the process. For instance, in response to efforts of family members of persons with mental illness and the National Alliance on Mental Illness (NAMI), Illinois Chapter, the Illinois state legislature has passed a bill that loosens the strict standard to allow earlier intervention for people with incapacitating symptoms of illness like schizophrenia and bipolar disorder. This was the result of a five-year effort.[26]

In trying to obtain a broader view of what other states were doing as it relates to involuntary inpatient placement, we reviewed a wealth of information at the website of the Treatment Advocacy Center (TAC).[27] Included on its website is a "Model Law for Assisted Treatment" (the "Model Law").[28] In creating the Model Law the TAC looked at the mental health laws in all the states. It took the best statutory provisions of each state and put them together in one document. To make the necessary shift, this Grand Jury believes the law in Florida should be expanded in accordance with several of the provisions of the Model Law.

For instance, if police officers in Florida respond to a call and find a person with a lengthy history of mental illness has taken a sledge hammer and trashed someone's residence, presently the judge presiding at a Baker Act hearing may not consider that behavior. Why? The act does not evince any harm to the patient or to others - just to property. Other states across the country are shifting on this issue to allow the court to consider "substantial damage to the property of another" in determining whether a person is likely to harm himself or others.

The Model Law prepared by the Treatment Advocacy Center has a relaxed standard that would allow the court to consider such evidence in deciding whether a person is in need of involuntary placement and treatment. Specifically, the TAC has a provision that re-defines the

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[26] See Treatment Advocacy Center Press Release, September 14, 2007. http://www.treatmentadvocacycenter.org/PressRoom/IllinoisLaw.htm

27 The Treatment Advocacy Center (www.treatmentadvocacycenter.org) is a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illnesses. TAC promotes laws, policies, and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.

[28] The Model Law may be found at http://www.treatmentadvocacycenter.org/LegalResources/ModelLaw.htm

evidence the court may consider in determining "danger to others." The Model Law provides as follows:

> **§ 2.8** ***Danger to others*****:** may be shown by establishing that, by his or her behavior, a person is in the reasonably foreseeable future likely to cause or attempt to cause harm to another. Evidence that a person is a danger to others may include, but is not limited to:
>
> a. that he or she has inflicted, attempted or threatened in an objectively serious manner to inflict bodily harm on another;
> b. that by his or her actions or inactions, he or she has presented a danger to a person in his or her care; or
> c. that he or she has recently and intentionally caused significant damage to the substantial property of others.[29]

There is also a relaxed standard in determining "danger to self". That provision of the Model Law states:

> **§ 2.7** ***Danger to himself or herself*****:** may be shown by establishing that, by his or her behavior, a person is in the reasonably foreseeable future likely to either attempt suicide, to inflict bodily harm on himself or herself or, because of his or her actions or inaction, to suffer serious physical harm in the near future. The person's past behavior may be considered.[30]

More importantly, the Model Law allows for emergency treatment to be initiated if a person is a danger to himself, herself or to others **or is gravely disabled**.[31] Gravely disabled may be shown by establishing that a person is incapable of making an informed medical decision and has behaved in such a manner as to indicate that he or she is unlikely, without supervision and the assistance of others, to satisfy his or her need for either nourishment, personal or medical care, shelter, or self-protection and safety so that it is probable that substantial bodily harm, significant psychiatric deterioration or debilitation, or serious illness will result unless adequate treatment is afforded.[32] Clearly, this definition allows for intervention and treatment to be initiated much earlier in the process. It does not require that the patient actually get to the point of being a danger to himself or herself. Coupled with Florida's involuntary outpatient treatment

[29] TAC Model Law at p. 11.
[30] Id.
[31] Id. at 13.
[32] Id. at 11

law mentally ill persons who are recycling through the system can be forced to get treatment before they end up in crisis. This will be a less costly alternative.

The TAC Model Law also has an expansive view on the evidence that can be considered at a commitment hearing. The specific provision allows a judge to consider the respondent's entire mental health history. It provides:

> **§ 6.6** ***Evidence admissible at hearing.*** The Psychiatric Treatment Board may review any information it finds relevant, material, and reliable, even if normally excluded under rules of evidence.[33]

This provision is consistent with the recommendations set forth on p. 10 herein.

We believe these provisions of the TAC Model Law should form the framework for changes to Florida's involuntary inpatient and outpatient treatment laws. Making these changes will surely cause a shift in the way we have dealt with the mentally ill for years. Lowering the standard and increasing the amount and type of evidence that can be considered by the court can only benefit those who are sick and in need of treatment. These changes to the statutes will also improve the lives and home situations of those caring for the mentally ill.

Accordingly, we recommend that the Florida legislature adopt these provisions from the Treatment Advocacy Center's Model Law For Assisted Treatment.

X. ASSISTED OUTPATIENT TREATMENT

In June, 2004 Florida reformed its Baker Act law to allow for Assisted Outpatient Treatment. The law allows court-ordered outpatient treatment for people with severe mental illnesses, like schizophrenia and bipolar disorder, who have a history of noncompliance combined with either repeated Baker Act admissions or serious violence. The provisions of the new law became effective on January 1, 2005. Florida Statute, section 394.4655 (1) provides as follows:

A person may be ordered to involuntary outpatient placement upon a finding of the court that by clear and convincing evidence:

(a) The person is 18 years of age or older;

(b) The person has a mental illness;

[33] Id. at 18.

(c) The person is unlikely to survive safely in the community without supervision, based on a clinical determination;

(d) The person has a history of lack of compliance with treatment for mental illness;

(e) The person has:

1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving facility or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or
2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months;

(f) The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;

(g) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1);

(h) It is likely that the person will benefit from involuntary outpatient placement; and

(i) All available less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.

With these laws, the state is able to step in for individuals who have a history of deterioration and refusing treatment *before* they reach the point of imminent and active dangerousness. Families and treatment professionals are not forced to wait with their hands tied until an individual has becomes so symptomatic that he is unable to refrain from committing an act of violence.

XI. **A BRIEF LOOK AT KENDRA'S LAW**[34]

One of the most well-known statutes providing for Assisted Outpatient Treatment (AOT) is New York's Kendra's Law. Florida's Assisted Outpatient Treatment statute closely follows

[34] Kendra's Law was named in memory of Kendra Webdale, a young woman who died in January, 1999 after being pushed in front of a New York City subway train by Andrew Goldstein, a man with a history of mental illness and hospitalizations. The law became effective in November of 1999. Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment, p. 1. The Final Report can be found at http://www.omh.state.ny.us/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf

that of New York. Kendra's Law (and Florida Statute 394.4655 (1)) provides a statutory framework for court-ordered AOT to ensure that individuals with mental illness and a history of hospitalizations or violence participate in community-based services appropriate to their needs. Kendra's Law requires that New York City and each county in New York State establish a local AOT program to implement the statute's requirements, and charges [New York's Office of Mental Health] OMH with the responsibility for monitoring and overseeing the implementation of AOT statewide. Implementation of Kendra's Law and AOT has been a joint responsibility and collaboration between OMH and local mental health authorities.[35]

Of all AOT participants treated within the first five years of New York's program, more than half (52%) were reported as having a co-occurring mental illness and substance abuse condition with mental illness as a primary diagnosis.[36] Initial court orders for those AOT participants were generally six months in duration. However many of the orders were renewed upon expiration of the previous court order. Statistics included in the Final Report reveal that about one third of AOT recipients (36%) spent only six months under court order. For the other 64%, after expiration of the initial court orders, renewals were obtained for additional outpatient treatment. Yet, more than half of all recipients (55%) required only 12 months or less of AOT. The most frequently cited reason for non-renewal of a prior court order was that the individual had improved and was no longer in need of court-ordered services (76%).[37]

By all accounts, use of Kendra's Law has been a tremendous success for the mentally ill in New York. During the entire time of participation in AOT, large decreases in the incidence of hospitalization, homelessness, arrest and incarceration were seen for recipients when compared to pre-AOT levels. Three years prior to AOT, 23% of AOT recipients had at least one incarceration. While in AOT, only 3% of recipients experienced an incarceration, a decrease of 87%. Over the same time comparison, 83% fewer experienced an incidence of arrest, 77% fewer experienced psychiatric hospitalization, and 74% fewer experienced homelessness.[38] Further, violent episodes were reduced and medication compliance improved. Finally, while receiving court-ordered treatment, recipients' days hospitalized dropped to an average of 22 days per six

[35] See *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment*, p. 2.
[36] *Id.*, at 10.
[37] *Id.*, at 8.
[38] *Id.*, at17. The numbers cited herein represent an increase from the numbers set forth in the 2004 Spring Term Report. It appears that the success of the Kendra's Law program is improving over time. 2004 Report, p. 20.

month period, a reduction of 56%. Days hospitalized continued to decline even after the end of court-ordered treatment: during the first six months after termination of the court order, total days hospitalized dropped to an average of 13 days, a reduction of 74% from the pre-AOT total. Overall quality of life was also restored for many. Clearly, Kendra's Law has been a tremendous success. Although Florida has a similar law, it is vastly underused.[39]

XII. FLORIDA'S UNDERUTILIZATION OF AOT

In similar fashion to Kendra's Law, Florida's AOT statute was also borne out of tragedy. On July 8, 1998, Seminole County Sheriff's Deputy Eugene Gregory was killed in a standoff with a man with untreated schizophrenia. During the course of the 13-hour standoff, two other deputies were injured and Alan Singletary, the man with the untreated mental illness, was killed. Seminole County Sheriff, Donald F. Eslinger, leading the Florida Sheriff's Association (FSA), made it his mission to get changes made to help those suffering from mental illness. AOT became the top legislative priority for the FSA. With the help of several key members of the legislature the bill was passed in 2004.

Unfortunately, when the law was enacted, the Florida legislature appropriated no funds for implementation of the provisions of the new AOT law. As a result, most counties within the state do not utilize this treatment option. A "lack of funding" is the primary reason given by most. In light of the obvious benefits and savings obtained through use of AOT in New York, we find this unacceptable.

In the midst of a state of non-compliance, we found a beacon of light in Seminole County. Since Florida passed its first outpatient commitment law in 2004, about half of the orders issued under the law have been in Seminole County. In June 2005, the Seminole Community Mental Health Center (SCMHC), the Treatment Advocacy Center and the Seminole County Sheriff's Office implemented a pilot outpatient commitment program in Seminole County. A program coordinator was hired, but otherwise the program used existing services and

[39] Forty-two states have laws for assisted outpatient treatment (although far fewer make effective use of those laws). http://www.treatmentadvocacycenter.org/LegalResources/statechart.htm. Florida became the 42nd state to authorize assisted outpatient treatment. New York, with the passage of Kendra's Law, was the 41st.

resources and took advantage of an excellent relationship between the mental health center and local law enforcement.

For calendar years 2005 and 2006, only 57 involuntary outpatient placement orders were submitted to the Baker Act Receiving Center. Of those, thirty (30) originated within DCF District 7 which includes Seminole County (12 in 2005 and 18 in 2006). More than 50% of the 2006 outpatient placements in the entire state of Florida originated with Seminole County. As of September 7, 2007, District 7 reported an additional 11 outpatient placement orders. Just as New York's office of Mental Health has tracked results for its AOT participants, so has the SCMHC for the patients participating in its program. SCMHC's AOT has also proven to be a huge success.

Some of their primary goals were to reduce the use of emergency services (i.e., admissions to CSU's, private or state hospitals), emergency transport services, arrests, days of incarceration, the costs of all the above, and homelessness. Diverting patients from the forensic hospitals was another stated goal of the pilot project.

The Statistical Report prepared by SCMHC was designed to track two specific outcome measures; hospital stays and jail stays. **The information provided to the Grand Jury by the Seminole County Deputy Sheriff involved with the AOT program revealed across-the-board reductions for every monitored category.** For the time period December 1, 2006 through November 30, 2007, SCMHC calculated the total number of days the AOT patients spent in the hospital for the 12 month period before entry of an AOT Order. Later, they counted the total number of days the AOT patients spent in the hospital[40] for the 6 month period **after** entry of the AOT Order. Cumulative hospital stays for the AOT patients dropped from 1,865 days to 364 days, an eighty percent (80%) reduction.[41] As to jail stays, for the participants in the AOT program, the SCMHC calculated the cumulative total number of arrests (6) and days spent in jail (68) during the 12 month period prior to entry of an AOT Order. Six months after the

[40] "Hospital days" included admissions to and days spent in Crisis Stabilization Units, Private Hospitals and State Forensic Hospitals.

[41] Although we do not have the figures for this calculation, we are certain that the legislature has an idea of what it costs to keep one mental health patient in a CSU, private or forensic hospital. The cost savings for 1,521 days **not** spent in the hospital should encourage all stakeholders of the need to take advantage of this option.

AOT Order had expired, there were **no** arrests for any of the participants and therefore, **no** days spent in jail - - **a 100% reduction** for both categories![42]

Under Florida's law, AOT orders have to include case management services or assertive community treatment team services and may also include: medication; blood or urinalysis tests to determine compliance with prescribed medications; individual or group therapy; day or partial day programs; educational and vocational training; supervised living; alcohol or substance abuse treatment; alcohol and/or substance abuse testing; and any other services prescribed to help prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization. Following the tragic loss of its Sheriff's Deputy in 1998, Seminole County is committed to doing all it can to reduce the likelihood that they will have a repeat of that incident. Absent funding, how were they able to implement the pilot project?

They were able to obtain grant funding which they used to hire one person - - an AOT coordinator. After getting the coordinator on board, they simply used existing resources in their community to make the program work. The coordinator ensures that the patient is assigned a case manager. Together they reach out to family members, make sure that the patients obtain their medication, ensure they take their medication, assist them in obtaining any and all benefits for which they are eligible (Medicare/Medicaid) and assist them in obtaining supportive housing. They also assist in making sure the patients make it to doctor appointments. Depending on the functioning level of the patient, they may seek participation in job skills training. Seminole County, with a vested interest in the success of the AOT program, is making this model work in its jurisdiction.

The pilot program in Seminole County has proven that outside assisted supervision in this state works for persons who previously had a long history of medication non-compliance. Witnesses repeatedly informed us that if patients are not compliant with their mediation they **will** re-offend, end up in psychiatric crisis and/or get arrested. Non-compliance with medication that leads to crisis is one of the leading causes for initiation of Baker Act proceedings. Seminole County's reform efforts have been focused on a small subgroup of those meeting existing

[42] Again, we do not have the figures for this calculation; however we are certain that the legislature knows what it costs to keep one mental health patient in jail for one day. The cost savings for 68 days **not** spent in jail should encourage all stakeholders of the need to take advantage of this option.

involuntary examination criteria, recidivists who disproportionately use mental health, criminal justice, and court resources. It has saved a lot of money on the back-end by making sure that supportive services and treatment are being provided on the front-end.

One of the simple benefits of Florida's AOT law is it empowers a judge to order the consumer to take his/her medication. We were informed that studies have now been done which reveal that, for many persons, the simple act of having a judge (a person in authority) inform the participants that they have to take the medication results in higher levels of medication compliance. This would seem to indicate that even with no wrap-around services in the community, the law may work for some members of this population. If they regularly take their medication, many of them can be functioning members in society, with jobs, who do not end up in violent confrontations with family members, friends or law enforcement. Most importantly, they do not become a "danger," possibly causing deaths of others, nor do they unwittingly facilitate their own demise. Creating another judicial calendar to accomplish this goal seems a small price to pay. Helping these consumers with mental illness return to some semblance of a normal quality of life will also, over time, result in tremendous costs savings. Even in tight budget times, the legislature can *redirect* some of the savings to the community health centers to ensure that the level of supportive services for this population increases. The larger the size of the population receiving assistance, the greater the amount of savings on the back-end will be. We just have to start utilizing the statute.[43]

In light of the tremendous success the Seminole Community Mental Health Center, the Treatment Advocacy Center, and the Seminole County Sheriff's Office have had with their AOT pilot program we make the following recommendations.

We strongly recommend that the stakeholders on mental health issues in Miami-Dade County[44] designate and/or hire an AOT coordinator within sixty (60) days of the release of this report.

[43] The 2006 Baker Act Report reflects that one Involuntary Outpatient Placement Order was issued in District 11 (Miami-Dade County) in 2006. p. 11. Although the report gives no indication that any such order was issued in 2007, we will remain hopeful and expect to see numbers listed when the totals are revised later. See comment re: tentative numbers for 2007 Involuntary Outpatient Placement Orders. Id.

[44] For expediency and convenience, we would recommend that the Mayor's Mental Health Task Force lead the charge in fulfilling this recommendation. We were informed that the Task Force had a subcommittee that was directly involved in looking into this issue. We recommend that the subcommittee take charge of these items.

We further recommend that once the coordinator is selected, the stakeholders on mental health issues in Miami-Dade County identify at least five (5) persons who have been recycling through the mental health resources in our community and start an 18-month pilot program with them.[45]

We also recommend that similar to Seminole County and the New York Office of Mental Health, the committee 1) calculate the individual and cumulative incidences of arrests and days the participants spent in hospitals, CSU's and jails for the 6-month and 12-month period prior to entry of an AOT Order; and 2) track the same information for the 6-month and 12-month period after entry of an AOT Order. We recommend that the statistics and findings be reported to the committee at the end of the pilot program.

XIII. THE AFTERMATH OF THE 2004 SPRING TERM GRAND JURY REPORT

Following the release of the 2004 Spring Term Grand Jury Report, Miami-Dade County Mayor, Carlos Alvarez, convened the Miami-Dade County Mayor's Mental Health Task Force. The Task Force consisted of more than 40 different individuals who are leaders and experts from the criminal justice, mental health, social services, government, and business communities. The Task Force members were charged with finding ways to implement the Grand Jury's recommendations to improve treatment and services provided to people with mental illnesses who become involved in the criminal justice system, minimize the inappropriate criminalization of people with mental illnesses, and to create a model continuum of mental health care for the residents of Miami-Dade County.[46] In pursuit of its mission, the Task Force created several sub-committees to address specific areas of the Grand Jury recommendations.

The Task Force submitted its Final Report to Mayor Alvarez on February 14, 2007. As set forth in the Executive Summary, "to date, the Task Force has accomplished or is in the process of accomplishing nearly every recommendation put forth by the Grand Jury." Our review and comparison of the Grand Jury report and the Final Report confirm the pronouncement of the Task Force. In lieu of repeating the work of the Task Force here in this report, we will simply direct those who are desirous of seeing the actual accomplishments to do so by reviewing the Task Force's Final Report. See footnote 44. The recommendations that have not yet been fully implemented are in the process of being finalized.

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[45] We would commend to the Task Force's subcommittee, Seminole County Deputy Sheriff, Shannon Seiple for information and guidance on how SCMHC implemented its pilot AOT program.

[46] *Mental Health Task Force Final Report*, (the "Final Report") p. 10 The Final Report can be accessed at: http://www.miamidade.gov/mayor/library/03.29.07-Miami-Dade-County-MMHTF-Final-Report.pdf

Although we choose not to replicate the work of the Task Force here, we do have a couple of observations and additional recommendations regarding some aspects of the 2004 Report.

XIV. CORRECTIONAL OFFICERS ON THE 9th FLOOR OF THE PRE-TRIAL DETENTION CENTER

Several recommendations were made to improve the situation for the Correctional Officers who work with the most disturbed mentally ill inmates at the Miami-Dade County Pre-Trial Detention Center. The recommendations included providing Crisis Intervention Training (CIT) for the officers, as well as implementing a pay incentive for the officers who choose to work with those inmates under such dire (and dangerous) conditions on the 9th Floor. Both of these recommendations were implemented. In discussions with witnesses during our term, it appears that there is still work that needs to be done. The officers have received CIT training. However, their experiences with the mentally ill persons are totally different than those encountered by law enforcement officers on the street.

Police officers on the street often are having encounters and trying to determine whether the suspects they have come into contact with are suffering from mental illness. That is not an issue for the correctional officers on the 9th Floor. The officers know that inmates on that floor are all there because it has been conclusively determined that they do have a mental illness. Notwithstanding, the Department of Corrections has no training program in place to teach the officers about mental health or the illnesses suffered by the patients they are guarding. Providing basic education on topics such as schizophrenia or bi-polar disorder may assist the correctional officers in having a better understanding and obtaining greater cooperation from the inmates who are mentally ill.

Accordingly, we recommend that Correctional Officers working with the mentally ill inmates at Pre–Trial Detention Centers in Miami-Dade County receive educational training regarding mental illness that extends beyond the information presented during the traditional CIT training.

Further, if additional CIT models have been developed that are specific for correctional officers, we recommend that CIT training following that model be provided in lieu of the traditional CIT training developed for law enforcement officers on the street. If not, then these models must be developed promptly.

XV. INMATES AND OUR TOUR OF THE PRE-TRIAL DETENTION CENTER

Just as our predecessors did during their investigation, we also decided to take a tour of the Pre-Trial Detention (PTD) Center, particularly the 9th Floor that houses inmates with the most severe mental illness. Not much has changed. The description of the physical surroundings set forth in the 2004 Grand Jury Report is still fitting.[47] The setting was not appropriate for treatment then. It is not appropriate now.

Our hope for improvement in the area of treatment of the severe mentally ill inmates in our jail still lies with the continued efforts of County and State officials to acquire the facility currently occupied by *South Florida Evaluation and Treatment Center* and to obtain an appropriate level of funding to allow the delivery of services at that location. Fortunately, we also had the opportunity to take a tour of this facility. The physical plant there is as different as night and day when compared to the PTD Center. We believe the new building is in an ideal location (close proximity to the criminal courthouse) and although it will be a secure facility, the primary focus will be on treatment and not incarceration.

We recommend that the first order of business, once the facility becomes functional, is the immediate transfer of the severely mentally ill inmates from the 9th Floor of the PTD Center.

XVI. THE HOMELESS TRUST SECURES IMPROVEMENTS FOR THE MENTALLY Ill

One of the most positive developments in our county involves the Miami-Dade County Homeless Trust. The mission of the Trust is to eliminate homelessness in our community. Through use of 1400 emergency beds, 2400 units of transitional housing and 2500 permanent supportive housing units, the Trust has made a significant dent in the number of chronic homeless persons in Miami-Dade County (from 8,000 to 1380).[48] Many of the emergency housing beds are contained in two Homeless Assistance Centers (HACs). A 400-bed HAC is located near downtown Miami. A smaller 300-bed HAC is located in Homestead.

The HACs are campus-style facilities that are "one stop centers" seeking to address all of the needs of the homeless persons at those sites. Not surprising, forty-five percent (45%) of the clients served by the Trust have some form of mental illness. Thirty-two percent (32%) of those

[47] 2004 Report, pp.12-13.
[48] http://www.miamidade.gov/homeless/releases/08-01-09-hud_award.asp

clients also have substance abuse problems.[49] Recently, the Trust has been able to secure an agreement with health care providers to offer psychiatric services at the downtown HAC site. Doctors actually visit the HAC twice a week to meet with mentally ill homeless persons residing at the Center. In addition to this new development, the Trust has also entered into Memoranda of Agreement that empowers them to enter into agreements with other agencies to direct to the Trust persons who are about to be discharged from jail, pre-trial detention, or Crisis Stabilization Units, etc. As part of this effort, case managers visit with those persons about to be discharged from the jails or detention facilities to allow them an opportunity to build a rapport with the case manager before they reach the HAC. Upon arrival at the HAC, clients will meet with housing experts who will assist them in finding appropriate housing. Having a stable living situation assists those who are suffering from mental illness. This relatively new Miami-Dade project is unique in that it focuses on a low demand model allowing homeless individuals, who are service resistant, to engage in services at their own pace while they receive permanent supportive housing. This design, which has been in place for over a decade, is now being designated to be used with a population which cycles in and out of jails, emergency rooms and mental health hospitals. The Trust has seen an eighty-nine percent (89%) success rate for the persons who have participated in the program.[50] Specifically, in total, the Homeless Trust now provides more than a half-million dollars in funding to support housing and wrap-around services for people with mental illnesses exiting the criminal justice system through the Jail Diversion Program.[51]

One of the negative consequences for mentally ill persons who are arrested is that they often lose their benefits while in custody. Once they are released from custody they encounter another problem with trying to obtain medication, services, etc. Without Medicaid or Medicare benefits, the consumers cannot pay for services or treatment. It takes months for restoration of those benefits. The Homeless Trust has stepped up to the plate again to assist the homeless population in acquiring their benefits. For those who need medication or other services, the Trust has secured a revolving fund that it uses to pay for services and/or medication while clients are awaiting the restoration of their benefits. Once those benefits are reactivated, the client

[49] This high percentage of co-occurring (mental health and substance abuse problems) is not restricted to the homeless population. This has been a constant obstacle to getting appropriate treatment for persons with mental illness. As prevalent as this condition is, it was reported that there is not one secure facility in the entire state that treats consumers with co-occurring conditions. In order to be successful both conditions must be treated together.
[50] Success is defined as someone who moves from emergency housing to a stable housing situation.
[51] *Mayor's Task Force Report*, p. 45.

reimburses the Trust so that the funds will be available for use again with similarly situated persons.

We recommend that if these funds run out, the county or the state provide a sum of money to allow the Homeless Trust to continue operation of this revolving fund to assist consumers who lose insurance benefits while jailed or subjected to involuntary treatment centers.

For persons living at the HAC there is a wide array of other social services provided at no cost to the residents. The services include:

- on site legal aid;
- Veterans Affairs assistance;
- Florida Department of Children and Families services;
- employment placement programs;
- Social Security Administration processing for benefits; and
- child care, which is provided by YWCA (at the Downtown HAC) and by Miami-Dade County Head Start (at the South Miami-Dade HAC).

The wide-range of services offered by the Trust are the types of wrap-around services needed at our community health centers. CHCs should be staffed with case managers who are interested in taking a holistic approach to dealing with the mentally ill persons they are charged with assisting. We commend the Homeless Trust for the tremendous steps it has taken which will inure to the benefit of those homeless persons who suffer from mental illness.

XVII. CONCLUSION

As we stated at the beginning of this report, we believe this is a time for our state to shift the manner in which it has been treating those who suffer from mental illness. The shift needs to move from asking whether someone has become a danger to asking whether someone needs treatment. Providing treatment earlier in the process is cheaper. As reflected by the statistical results of the involuntary outpatient treatment conducted in Florida, providing such treatment is also effective in cutting down on arrests, hospital stays and trips to receiving facilities. To accomplish the shift it will take the work of the legislature (to make reforms to the law), our court system (to appoint at least one other Special Master and schedule additional Baker Act hearings at the branch courts) and our local mental health stakeholders (to ensure that we start taking advantage of the AOT law that the legislature gave us in 2004). If we work with a cooperative and collaborative effort we are confident it will improve the lives of those with

mental illness, their families and our communities. We know it will save money. This really is a "common cents" approach to handling this problem. Because we want to ensure that there is movement on these recommendations, we will encourage a successor group of Grand Jurors to review the results of changes made and steps taken to address the issues raised in this report.

Accordingly, we also recommend that a successor grand jury conduct an analysis of the extent of implementation of the local and statewide recommendations set forth herein.

XVIII. RECOMMENDATIONS

1. *We recommend that the Florida legislature amend Florida Statute 394.463 to require that each Office of the County Clerk send to the Agency for Health Care Administration a copy of all court orders of involuntary inpatient and outpatient placement issued in its circuit.*
2. *We recommend that Florida's mental health laws be amended to allow the State, for good cause shown, to receive a brief continuance of time in which to hold the involuntary commitment hearing (no more than an additional three days).*
3. *We recommend that for good cause shown, Crisis Stabilization Units and receiving facilities may be granted a 24-hour extension if, in so doing, they will be able to make a more informed decision regarding the condition of the patient in their facility.*
4. *We recommend that the legislature amend Florida Statute 394.4615 (3) to provide that for the purpose of determining whether a person meets the criteria for involuntary inpatient or outpatient placement or for preparing the proposed treatment plan pursuant to s. 394.4655, the clinical record shall be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider identified in s. 394.4655(6)(b)2., in accordance with state and federal law. (Emphasis added)*
5. *We recommend that Florida Statute 349.467 be amended to specifically allow that in determining whether a person meets the criteria, the court shall consider the respondent's prior psychiatric history.*
6. *We further recommend that Florida Statute 349.467 be amended to specifically allow that in determining whether a person meets the criteria, the court may consider evidence of the person's repeated past pattern of specific behavior and actions related to the person's illness.*
7. *Due to our concerns regarding these recidivist involuntary examinations, we recommend that DCF investigate the circumstances for all individuals who have more than ten examinations within a 12-month period. The investigation should include a review of the practices of the facility that is performing the examinations, particularly if no petitions are being initiated for involuntary inpatient placement. Based on the results of said investigation, DCF may determine whether it may be appropriate to remove that entity from the list of approved facilities.*

8. *We recommend that the court consider the feasibility of using video technology to conduct the Baker Act hearings and to receive the testimony of distant witnesses.*

9. *We also recommend that regularly scheduled Baker Act hearings be conducted at the branch courts and at Jackson Memorial Hospital.*

10. *We further recommend that the Chief Judge appoint another General Master who will handle Baker Act hearings at the branch courts.*

11. *Accordingly, we recommend that the Florida legislature adopt these provisions from the Treatment Advocacy Center's Model Law For Assisted Treatment.*

12. *We strongly recommend that the stakeholders on mental health issues in Miami-Dade County designate and/or hire an AOT coordinator within sixty (60) days of the release of this report.*

13. *We further recommend that once the coordinator is selected, the stakeholders on mental health issues in Miami-Dade County identify at least five (5) persons who have been recycling through the mental health resources in our community and start an 18-month pilot program with them.*

14. *We also recommend that similar to Seminole County and the New York Office of Mental Health, the committee 1) calculate the individual and cumulative incidences of arrests and days the participants spent in hospitals, CSU's and jails for the 6-month and 12-month period prior to entry of an AOT Order; and 2) track the same information for the 6-month and 12-month period after entry of an AOT Order. We recommend that the statistics and findings be reported to the committee at the end of the pilot program.*

15. *We recommend that Correctional Officers working with the mentally ill inmates at Pre–Trial Detention Centers in Miami-Dade County receive educational training regarding mental illness that extends beyond the information presented during traditional CIT training.*

16. *Further, if additional CIT models have been developed that are specific for correctional officers, we recommend that CIT training following that model be provided in lieu of the traditional CIT training developed for law enforcement officers on the street. If not, then these models must be developed promptly.*

17. *We recommend that the first order of business, once the facility becomes functional, is the immediate transfer of the severely mentally ill inmates from the 9th Floor of the PTD Center.*

18. *We recommend that if these funds run out, the county or the state provide a sum of money to allow the Homeless Trust to continue operation of this revolving fund to assist consumers who lose insurance benefits while jailed or subjected to involuntary treatment centers.*

19. *We also recommend that a successor grand jury conduct an analysis of the extent of implementation of the local and statewide recommendations set forth herein.*

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
CHRISTOPHER RODRIGUEZ	Murder First Degree Controlled Substance/Sell/Manufacture/Deliver/ Possession With Intent	True Bill
ERIC RIVERA, JR., JASON SCOTT MITCHELL, CHARLES WARDLOW, and VENJAH HUNTE	First Degree Murder Burglary With Assault or Battery Therein With a Firearm	True Bill
(C) JAMES S. LAPOINTE, (B) JOHANNE HILAIRE	Murder First Degree (C) Robbery/Armed/With a Mask (C) Accessory After The Fact (B)	True Bill
(A) VENICES L. HAWKINS, (B) JAMES JOSEPH POWELL, (C) DAVOWN T. DRAYTON	First Degree Murder Robbery Using Deadly Weapon or Firearm	True Bill
DARBYN ANTHONY TEMPLE	Murder First Degree Robbery/Armed/With a Mask Aggravated Assault with a Firearm	True Bill
MICHAEL BRITTON	Murder First Degree	True Bill
DUANE ISAAC WALKER	Murder First Degree Child Abuse/Aggravated	True Bill
JUAN ORTEGA LIMA	Murder First Degree Aggravated Assault With Deadly Weapon	True Bill
HOWARD WATERS (A) SEAN ERIC JOHNSON (B), CLEVELAND BELL (C) and BRANDON DEVON WILLIAMS	Murder First Degree (A&D) Murder Second Degree/Felony (A&D) Robbery/Carjacking/Armed (A&D) Robbery Using Deadly Weapon or Firearm (A&D) Robbery /Carjacking/Armed (A&D) Robbery /Carjacking/Conspiracy (A,B,C,D) Resisting an Officer Without Violence to His/Her Person (A)	True Bill
JAMES LORENZO YOUNG	Murder First Degree	True Bill
ERIC GABRIEL BARRIENTOS	Murder First Degree Burglary With Assault or Battery Therein While Armed Stalking/Aggravated/Court Order/Prior Injunction/Restraint Violation of Injunction Against Domestic Violence Violation of Injunction Against Domestic Violence Violation of Injunction Against Domestic Violence	True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
EDUARDO COHEN PADRON	Murder First Degree Murder First Degree Firearm/Weapon/Ammunition Posn by Convicted Felon or Delinquent Firearm/Weapon/Ammunition Posn by Convicted Felon or Delinquent Unlawful Possession of Cannabis Grand Theft 3rd Degree/Vehicle	True Bill
NAKEVA EDWARD THORNTON, Also known as "K" (A) and DICKEVENS PETITHOMME, Also known as "D" (B)	Murder First Degree (A&B) Firearm/Weapon/Ammunition/Possession by Convicted Felon or Delinquent (A) Firearm/Weapon/Ammunition/Possession by Convicted Felon or Delinquent (B)	True Bill
MICHAEL GONZALEZ	Murder First Degree Robbery/Armed/Weapon Burglary/With Assault or Battery/Armed Grand Theft Third Degree	True Bill
RICKEY J. RYLAND	Murder First Degree	True Bill
JOSE BENITO ZAMORA, JR.	Murder First Degree Robbery/Carjacking Burglary With Assault or Battery	True Bill
RICHARD RAYNARD JENKINS	Murder First Degree Murder/Premeditated/Attempt Murder/Premeditated/Attempt	True Bill
RANDALL WILLIAMS, Also known as BOX	Murder First Degree Firearm/Weapon/Ammunition/Possession by Convicted Felon or Delinquent	True Bill
CLAUDIO WILLIAM TORRES	Murder First Degree	True Bill
JOSUE JOSEPH, also known as ABBY (A), YVES NAZIEN (B) and JEAN DENIS PAUL, also known as DADA, Also known as JEAN DISNE SYLVERSTER (C)	Murder First Degree (A,B,C) Murder/Premeditated/ Attempt/Deadly Weapon or Aggravated Battery (A,B,C) Firearm/Weapon/Ammunition/Possession by Convicted Felon or Delinquent (A) Firearm/Weapon/Ammunition/Possession by Convicted Felon or Delinquent (C)	True Bill
ROBERT WILLIS SAUNDERS	Murder First Degree Robbery Using Deadly Weapon or Firearm	True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
OVIDIO BORROTO	Murder First Degree Burglary with Assault or Battery Therein While Armed/Mask Possession Firearm by Convicted Felon/Mask Murder Second Degree/Felony	True Bill
(A) JEAN RICHARD BAPTISTE, and (B) JOHNSON JOSEPH	Murder First Degree Accessory After the Fact	True Bill
TIMOTHY EVANS	Murder First Degree Armed Robbery – Weapon Firearm/Weapon/Ammunition Possession By Convicted Felon or Delinquent	True Bill
LEONEL ALBERTO HECHAVARRIA	Murder First Degree Burglary with Assault or Battery Therein Child Abuse/No Great Bodily Harm	True Bill
(A) GEORGE TRISTON CAMPBELL, and (B) NATHELIE ECHEVARRIA	Murder First Degree (A&B) Robbery Using Deadly Weapon or Firearm (A&B)	True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED	DATE
(A) JOHNNY CHARLES, also known as JC also known as Boy, also known as Kid, also known as Angel of Death, also known as Black (B) BENSON CADET, also known as B-Boy, also known as INTREPID (C) MAX DANIEL, also known as Might Max, also known as M-16, also known as 16 (D) FRANTZY JEAN-MARIE, also known as Z, and (E) ROBERT ST. GERMAIN, also known as Bird	RICO/CONSPIRACY (A-E) RICO (A-E) Attempted First Degree Murder (C) Attempted First Degree Murder (C) Attempted First Degree Murder (C) Attempted First Degree Murder (A,B,E) First Degree Murder (A,B,C) Attempted First Degree Murder (A,B,C,D) Attempted First Degree Murder (A,B,C,D) Attempted First Degree Murder (A,B,C,D) Attempted First Degree Murder (A,B,C,D) Attempted First Degree Murder (B) First Degree Murder (A,B,C,E) Murder First Degree/Conspiracy (A,B,C,E) Attempted First Degree Murder (A,B,C) Attempted First Degree Murder (B,D) Attempted First Degree Murder (B) Attempted First Degree Murder (B) Attempted First Degree Murder (B) Attempted First Degree Murder (B) First Degree Murder (A,B,C) Attempted First Degree Murder (A,B,C) First Degree Murder (B,E) Attempted First Degree Murder (B,E) Attempted First Degree Murder (B,E) Attempted First Degree Murder (B,E) Attempted First Degree Murder (B,E) Attempted First Degree Murder (B,E) Attempted First Degree Murder (B,E) Attempted First Degree Murder (D) First Degree Murder (A,D) First Degree Murder (A) First Degree Murder (A,D) First Degree Murder (A,D) First Degree Murder (A,D) First Degree Murder/Conspiracy (A,D) Solicitation of First Degree Murder (A,D)	True Bill	

ACKNOWLEDGEMENTS

Nine months ago twenty-one randomly selected individuals were brought together to form the Miami-Dade Grand Jury, Fall Term 2007. These jurors, initially separated by age, ethnicity and cultural diversity, were able to unify as a group to form a motivated team. The experience resulted in a greater knowledge and lifelong respect and appreciation for our judicial system.

It was an honor to serve on the Miami-Dade County Grand Jury and encourage our fellow citizens to participate in this important civic duty when our local government calls them to serve. We are also grateful for having the opportunity to be an influential part of the judicial process. We would like to take this opportunity to express our heartfelt thanks to the following, who have all managed innumerable duties with a cheerful and friendly attitude:

- Honorable Judge Gisela Cardonne Ely, who not only stressed the importance of serving on a grand jury, but also the significance of being involved in the community.
- State Attorney Katherine Fernandez Rundle, for her advice, commitment and years of service to the Miami-Dade County community and its judicial system.
- Chief Assistant State Attorney Don Horn, for his professionalism, dedication and support. His endless knowledge and guidance not only educated us but made our service a truly rewarding experience. Our deepest thanks for making our job easier.
- Rose Anne Dare, who flawlessly took care of all administrative details for each and everyone of us. Her professionalism and skills made our task easier to perform.
- Nelido Gil, our Bailiff, who every day greeted us with a smile, served tirelessly and made our days as jurors run as smoothly as possible. His ability to keep us in good spirits was definitely appreciated by all.
- Our court reporters, for their professionalism and commitment.
- To those witnesses and experts who took time to come before us and answered all of our questions and concerns, we also thank you.
- Susan Dechovitz, Assistant State Attorney, for her professionalism and enthusiasm.

Our task was difficult and our journey through the judicial system was at times disturbing, frustrating, surprising and enlightening. Ultimately, despite the personal and professional sacrifices made by each of us, it was an experience we will never forget. It has truly been a privilege and honor to serve our community.

Respectfully submitted,

Ann-Margaret Hew, Foreperson
Miami-Dade County Grand Jury
Fall Term 2007

ATTEST:

Alfonso Chao
Clerk

Date: August 11, 2008