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

SPRING TERM A.D. 2004

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I N D E X

MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM: A RECIPE FOR DISASTER / A PRESCRIPTION FOR IMPROVEMENT

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MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM: A RECIPE FOR DISASTER / A PRESCRIPTION FOR IMPROVEMENT

INTRODUCTION

As you will soon appreciate from this report, mental illness is a major problem in our community, our state and this nation. For those who suffer from it, it is a chronic problem that very often leads to unemployment, strained family relationships, homelessness, substance abuse and criminal activity. Mental illness does not respect any particular race, gender, age, nationality or socioeconomic level.[1] It still carries a stigma and, left untreated, it creates problems for both the individual and the community.

We write and issue this report in hopes that we can help educate the general public and lawmakers about the nature of the problem, the impact it is having on all of our lives and how we can improve the plight of those who suffer from this disease. Although we recognize that problems and issues surrounding mental illness are multifaceted, we will only focus on two aspects herein – 1) Adults with mental illness who are recycled through our criminal justice system; and 2) Police encounters with persons suffering from mental illness.

I. MENTALLY ILL PERSONS IN OUR CRIMINAL JUSTICE SYSTEM

A. MENTAL INSTITUTIONS – An Historical Perspective

For years, concerned individuals sought to improve the plight of the hundreds of thousands of mentally ill patients who were being detained in mental hospitals across our country. Many of the patients were being held because they posed significant danger to themselves or others. Treatment at that time was described by one of our witnesses as barbaric and archaic. It included insulin-induced comas, cold baths with ice and shock therapy. However, during the late 1950's and early 60's, the entire mental health landscape changed with the discovery and development of anti-psychotic medications.

[1] See Appendix A

Treatment with these medications significantly reduced the danger posed by these patients and would allow them to lead relatively normal lives.

As a result of years of complaints (and abuse), the advent of these new medications and rulings by the United States Supreme Court, a decision was made to close many of the state mental hospitals, de-institutionalize (release) the patients and offer treatment at community-based facilities. The hope was to place the mentally ill in our communities and provide support and treatment that should permit them to lead productive lives. The majority of patients were released. However, there were insufficient local programs available to treat them. As a result, persons who had been receiving medication and were then stable were released into the community with no treatment and no means to ensure that they were taking their medications. The failure to provide treatment and the absence of sufficient treatment facilities was going to affect our criminal justice system in ways that no one could yet imagine.

One can appreciate the significance of this failure when we note that there were 560,000 patients in mental hospitals in 1955. Over the next four decades, while asylum populations nationwide decreased by 90 percent, the prison population grew by 400 percent. There are presently less than 40,000 patients in mental hospitals in the United States. Now, the majority of persons suffering from mental illness are in our jails, prisons and on our streets. A review of a few statistics puts the issue in focus.

A Good Idea Gone Bad

Nationally, more than 500,000 persons with mental illness are on probation. The United States ranks number one in the world in the number of persons suffering from mental illness. The United States also ranks number one with the largest number of untreated cases of mental illness. According to a recent report, **there are three times as many men and women with mental illnesses in U.S. prisons as in state psychiatric hospitals**. [2] Further, nearly half the inmates with a mental illness in state or federal custody in the United States are incarcerated for committing a nonviolent crime.[3]

[2] The Sheriff's Star, September / October 2004.

[3] Paula M. Ditton, Mental Health Treatment of Inmates and Probationers

On a local level, the state of **Florida has the highest rate of mental illness in the nation**. Further, due to our nice weather, poverty and a significant immigrant population, South Florida has the highest percentage of mentally ill persons in its general population. Based on the national average, 3% of the total population suffers from some form of mental illness. For Florida, it is 9%, or three times the national average. Further, it is estimated that from one-half to two-thirds of our homeless population suffers from mental illness. Drug problems or substance abuse disorders are also prevalent for 70 – 80 % of persons who suffer from mental illness.

With the release of patients from our state mental hospitals, what had been a state problem became a local issue. Because most of the mentally ill were locked up in asylums, the state was responsible for the operation of those state hospitals, doctors, medications, housing, treatment and inherent costs. Once all were released to local communities, the costs of dealing with the mentally ill has been primarily borne by our local county governments in the form of paying to house and treat thousands upon thousands of criminal defendants in our jails. It has been estimated that **Florida's local jails have become the largest public psychiatric hospitals**, housing five times more people with mental illnesses than the state's psychiatric institutions.

B. JAILS HAVE BECOME OUR NEW MENTAL INSTITUTIONS

In fact, one of the clearest indicators of the crisis that exists in our community is the present situation at the Pre-trial Detention Center, commonly referred to as the Dade County Jail. The jail has nine (9) floors. In 1985, inmates with psychiatric problems occupied 2 out of 3 wings on one floor in the jail. Each inmate had his own bed and there were approximately eighty (80) such inmates. Today, there are more than eight hundred to twelve hundred such inmates in the jail at any given time who are experiencing some form of mental illness. Some of their conditions are so severe, that they cannot be housed in the general population. Instead, these "chronic" cases now occupy 3 wings on three floors! Included in the group of inmates are defendants whose mental illness is so "acute" they are placed in safety cells and checked every fifteen minutes to prevent suicides or serious bodily injury.

In addition to the inmates on these three floors, there are hundreds of other inmates on any given day whose conditions are stable enough (or whose conditions were stabilized after being incarcerated) that they can be (and are) housed among the inmates in general population. Most of those inmates in the general population take medication daily to keep them from declining. All of the inmates on the three psychiatric floors receive daily medication. Some of the medications are administered in emergency situations against the will of the inmates. Daily visits are made by doctors and nurses while these defendants are locked up in the jail. In essence, the Department of Corrections is trying to run a psychiatric hospital in a facility that was designed to house persons who have engaged in criminal behavior. The costs for running this "hospital inside a jail" are staggering.

Many of the costs and expenses incurred in providing the limited medical care, counseling and medication are taken out of the budget of Jackson Memorial Hospital. Psychotropic medication alone is in excess of a million dollars per year. Moreover, many of the inmates receiving medications are "treated" at the jail several times a year.[4] To understand the significance of the costs incurred, we must look at some other numbers.

We recognize that this is not only a problem in our county or state. The Monroe County, New York Jail spends approximately $315,000 per year in overtime for deputies who are conducting twenty-four hour suicide watch.[5] The Pennsylvania Department of Corrections estimates that it costs $80 per day to incarcerate an average inmate and $140 per day to incarcerate an inmate with a serious mental illness.[6]

Locally, it costs Broward County taxpayers $78 per day to house an inmate at the Broward County Jail. It costs Broward County taxpayers $125 per day to house an inmate with a mental illness. In Miami-Dade County, the numbers are not any better. Miami-Dade County taxpayers spend $ 18 per day to house general population inmates at its jail. The cost for housing inmates with mental illness is $125. Statistics also indicate that the length of incarceration at the jail for a person suffering from mental

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[4] See pages11 - 13 infra, IV. D. The Criminalization of Mental Illness.
[5] Unpublished statistic courtesy of Captain John Caceci, Monroe County Sheriff's Office, Monroe County, New York.
[6] Unpublished statistic courtesy of John Shaffer, Ph.D., Pennsylvania Department of Corrections.

illness is eight times longer than an inmate in general population. That is only the beginning of the expenses.

An inmate arrested for a felony level charge who is determined to be suffering from a severe mental illness will, in all probability, be given a psychiatric evaluation ordered by the court. This evaluation is conducted by "outside" doctors who have agreed to "only" charge the county $150 per evaluation. The purpose of the evaluation is to determine whether the defendant is competent to understand the charges filed against him[7] and is able to assist his attorney in defending his case. Depending on the findings in the psychiatric evaluation report, the defendant's attorney and the prosecutor may each also want the defendant evaluated by "outside" psychiatrists, who will also charge $150 per evaluation. It takes several weeks for this process to play out. Meanwhile, the defendant resides at the jail at a cost of $ 125 per day.

If, after review of the three reports, the parties stipulate or the court finds that the defendant is incompetent to stand trial, the defendant will be sent to one of the state's forensic hospitals for treatment. The defendant will probably spend at least a month or two at the state forensic hospital, where he will be treated (given medication) to stabilize his condition.[8] He is evaluated by in-house psychiatrists at the state hospital and once they determine that he is competent to stand trial, he is shipped back to the Dade County Jail.

Upon his return to the jail (at $125 per day), another psychiatric evaluation is ordered (another $150) to confirm that the defendant is competent to stand trial. Once that evaluation is complete and the defendant is determined to be competent, his case is set for trial or the case is otherwise resolved (possibly through a plea bargain). If the case is resolved through a plea, it may very well include a period of probation and will also include special conditions for that probation. The defendant will usually be required to get outpatient mental health treatment and counseling during the course of his probation. If his condition is severe, he may be required to participate in a community residential

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[7] For ease of reading, we have decided not to add "or her" to our references to "him" or "his". All such references are intended by use to be gender-neutral and all references to the male pronoun are intended to also relate to females. This applies to subjects, inmates, judges and police officers.

[8] The costs for committing one person to a Florida State Forensic hospital is $112,000 per year.

mental health facility, to be followed by outpatient treatment. Failure to attend the programs constitutes a violation of his probation and will cause his case to be sent back to court.

If the defendant is arrested again, either for violating his probation and/or committing a new offense, this entire process and the resultant costs may begin anew. The aforementioned scenario describes the typical handling of a mentally ill defendant charged with a felony in Miami-Dade County. There are also significant jail costs associated with mentally ill defendants charged with misdemeanors offenses. However, the law provides different results if the highest charged offense is only a misdemeanor.

The law is designed to try to prevent sending individuals to forensic hospitals if they have only committed minor offenses. Therefore, even if the judge makes a determination that a defendant standing before him is mentally ill, and is incompetent to stand trial, the judge cannot commit the defendant to a forensic hospital. Moreover, if the defendant does not pose a danger to himself or others at the time he appears before the judge (probably because he was treated and stabilized while locked up in the jail), he is released from custody back onto the streets. In other words, the court cannot involuntarily hospitalize a misdemeanant offender who is incompetent to stand trial. Without any safety net such as aftercare or a case manager to help him obtain benefits and services, it will only be a matter of time before police will arrest the individual again for some other minor offense and the cash register for these costs will start ringing again. Many of these misdemeanant offenders will be arrested and/or Baker Acted several times a year. Every return visit usually requires stabilization.

Social Services in the Jail

In addition to providing medical care, the Department of Corrections Health Services unit also provides social services for inmates with mental illnesses. It is a daunting task. There are eleven social workers spread out over five (5) detention facilities in Miami-Dade County; Women's Detention Center (1 social worker); Metro-West (1 social worker); Pre-Trial Detention Center Jail (7 social workers); and Turner Guilford Knight (TGK) and the Stockade (2 social workers).

The social workers have individualized contact with the mentally ill inmates, participate in group therapy sessions, assist the psychiatrists in encouraging inmates to take their medication and conduct follow-up to help ensure that they are doing so. In addition, they assist in conducting assessments and evaluations of the inmates as well as collaborate with the courts, the Department of Corrections and community agencies to find services for the inmates after their release. Herein lies a major part of this problem.

A mentally ill inmate who ends up in custody for acting out as a result of failing to take his medication may very well have his condition stabilized in jail. While in the jail, his condition may improve such that he can move from a psychiatric wing to a general population floor. The assessments, evaluations, counseling sessions and medications are designed to (and may) get him in a condition where he is able to function in a fairly normal fashion.

Once he is released, he will be transitioning back to his normal life style. He will carry with him his "poor insight," a condition that renders seriously mentally ill people incapable of understanding that they are sick, have symptoms and would benefit from treatment.[9] For a successful transition, a continuum of care needs to be provided. In other words, to remain stable, he will need to continue with the same type of treatment, counseling and medication he was receiving while in custody. The problem here is there are far too few facilities available to provide such services. Without such services, it will only be a matter of time before the inmate is re-arrested, returned to the jail and recycled through the system.

How Do We Address the Problem?

Community mental health centers ("CMHC's") would be the ideal place for former inmates to receive such service. Such centers would also be the ideal location for providing services to others in our community who suffer from mental illness. CMHCs offer residential programs, day treatment and some even provide assistance in finding employment for their clients.

[9] This condition is well known to family members and others on a regional basis. The condition is very aptly conveyed in the title of a very popular book circulating in the mental health community: I Am Not Sick, I Don't Need Help! By Xavier Amador.

However, as reported by the Chief Clinical Social Worker at the jail, approximately 90% of the persons identified in the jail who have mental health problems also suffer from alcohol or other substance abuse. This dual diagnosis / dual treatment reality exacerbates the transition problem for many of the former inmates. They have two major (treatable) conditions and not enough resources to draw on to deal with either.

The recycling of mentally ill inmates through the jails is also fairly predictable due to the absence of case managers. Having case managers available would allow for follow-up care. Case managers could assist the mentally ill patient in keeping appointments, obtaining medication, benefits and services and ensuring that he is taking his medication. The failure to provide case managers guarantees that huge sums of money spent in the jail are effectively being wasted.

When the mentally ill arrive in the jail, those in the criminal justice system spend time, resources and money for assessments, evaluations, medications, counseling and treatment. For many inmates, this quality of care restores their mental stability. They are then released back into the community with no case managers, no follow-up treatment and eventually their mental instability returns. For many, the instability is simply caused by a lack of available medication or the failure to take their medication. Eventually, they will do something that will bring them to the attention of the police and they will be arrested again. The cycle begins anew.

Alternatively, the failure to provide follow-up care and treatment may cause such a decompensation in their mental stability that the person must now be Baker Acted.[10] After having their conditions stabilized while in custody, they have deteriorated so badly on the streets that they pose dangerous risks to themselves or others. The costs for the Baker Acts is also a huge expense.

After being armed with some of this information, we decided that we would take a tour of the jail.

[10]Florida's Mental Health Act is set forth in Chapter 394, Florida Statutes. Section 394.467 describes the criteria and procedures for involuntary placement of persons suffering from mental illness. It is commonly referred to as the Baker Act. Under the Baker Act, persons who are mentally ill and determined to be a danger to themselves or others may be involuntarily hospitalized and treated.

C. OUR TOUR OF THE PRE-TRIAL DETENTION CENTER

> *Mission Statement: We, the Miami-Dade County Corrections and Rehabilitation Department serve our community by providing safe, secure and humane detention of individuals in our custody while preparing them for a successful return to the community.*

Nothing could have adequately prepared us for the sights and sounds we witnessed on our tour. We viewed the "acute" psych wing and observed inmates who were obviously suffering from some form of mental distress. The yelling from some of the inmates confirmed the existence of paranoia, hallucinations and delusions. Their stares were gripping.

The setting and the cells were cold and stark. Plexiglas covered the doors to allow correctional officers full, direct and unobstructed views into the cells at all times. The persons detained in these cells were at risk for suicide and were under almost constant watch with bed checks every fifteen minutes. The lights are on in the cells twenty-four hours a day and many of us found the area to be extremely cold. The beds are made of metal. To help prevent suicides, the cells are devoid of any items that could assist in that effort. Thus, no sheets, mattresses, toiletries or clothing is allowed. Neither are books, pens, papers or recreational activities. There is absolutely nothing for these inmates to do as they are confined to their cells. The inmates are offered Ferguson garments[11], if they choose to wear them. Notwithstanding all of these precautions, the seriously disturbed inmates still find ways to harm themselves. These include diving off the bed onto the concrete floor and banging one's head against the wall.

Witnesses informed us that as bad as the physical structure looks, it is an improvement over what the wing looked like before the $100,000 worth of renovations and improvements in 1998 and 2002. The most recent changes included retiling the floor and construction of an island in the center of the floor. The island serves as a nurses' station and guard post for the correctional officers working on the psych wing. An office for the psychiatrists was also included in the latest build out.

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[11] Paper garments were used before, however, some inmates tried to eat the paper to harm themselves. The Ferguson garment is used around the country. It is a one-piece "covering" that cannot be torn or shredded by hand. It provides a modicum of respect for the inmates who are unfortunate enough to be held on that floor.

Of all the sights from our tour, the most haunting image probably was an unoccupied cell, which did not have a regular metal bed. Instead, it contained a four-point restraint bed, which sat in the middle of the floor. The presence of that bed in the unit served as a vivid reminder that the correctional staff and medical personnel deal with severely ill persons who, at times, can be very dangerous. As described to us, the restraint device is used as a last resort. When medication, counseling and two-point restraint in the cells is insufficient, inmates may be placed in the four-point restraint bed to keep them from injuring themselves or others. For many of us, scenes from the movie, *One Flew Over the Cuckoo's Nest*, came rushing back.

The obvious threat of danger posed by these inmates results in more restrictions of their freedom of movement inside the jail and less socialization and recreation than that permitted for inmates in general population. For instance, on other floors, we observed that inmates are allowed to interact with each other and even share televisions and telephones in some of the common areas of their floors. Moreover, they are allowed to go down to the exercise yard (which is a concrete enclosed and concrete floor area) where they can at least get some fresh air and sunshine. Neither of these "perks" is available for the inmates in the acute psych wing. For obvious reasons, televisions are not included in their cells. Similarly, because of the danger they pose to themselves and others, they are not allowed to mingle or interact with other inmates. This safety risk also makes it impossible for correctional officers to take them to the exercise yard. These inmates are allowed out of their cells for fifteen (15) minutes every day and given the "opportunity" to shower. If they choose to do so, this activity is also monitored.

We found the setting and conditions less than ideal for treating persons suffering from mental illness. In fact, one witness opined that placing an individual with even marginal psychological issues in this environment is probably going to make the inmate's condition worse. Notwithstanding the bleak environment, we were also reminded that the primary function of the jail is to provide a secure facility to detain persons accused of committing crimes. The jail's primary goal of maintaining custody, providing security and preventing escape of inmates is at odds with providing medical care to very sick people. In fact, the persons who are providing security for the mentally ill are not given any training for dealing with this segment of the inmate population.

The mental health wings are staffed by a number of correctional officers who have volunteered to work on those floors. Over time, they have become adept at dealing with the inmates and the inmates develop relationships with the officers. On many occasions, a correctional officer who has established a relationship with an inmate who has been in and out of the system may prove more effective than the doctors, nurses and social workers in getting him to take his medications or follow other instructions. Unfortunately, there is no pay incentive for officers to work on those floors. This makes no sense to us when one considers the conditions under which they work. Therefore, we recommend:

1. In light of the close continuous contact between correctional officers and the mentally inmates they guard we recommend CIT Training for all correctional officers who work on those floors.
2. As there are with some of the police departments that have Crisis Intervention Teams, we recommend that the Department seek and award pay incentives to those correctional officers who elect to serve their shifts working on the floors where the mentally ill inmates are housed.

D. THE CRIMINALIZATION OF MENTAL ILLNESS

Chronically ill persons suffering from mental illness will end up coming to the attention of the police. They may be involved in minor infractions (walking in traffic on a busy street and talking to themselves) or they may have just become an eyesore for business owners or residents in a particular neighborhood. Either scenario will usually end up with police being called to the scene and often times will result in an arrest. The offenses charged are usually very minor, and in cases involving defendants who are not suffering from mental illness, are usually resolved within days of the arrest. "Credit for time served" is a normal sentence offered by the court at jail arraignments (which are held within 24 hours of a person's arrest). Thus, a "normal" defendant may spend one or two days in jail and his case is dismissed. The plight of the mentally ill defendant is much different.

Depending on the mental state of the defendant at the time of his arrest, the arresting officer may decide to Baker Act the defendant. Having a person Baker Acted is an involuntary process designed to get mental health treatment for the person who is posing a significant danger to himself or others and who is not able to take care of himself.[12] These persons are also recycled through the system. Recidivists Baker Act examinations increased 50% between 2000 and 2002.[13] In Fact, Florida law enforcement officers alone initiate nearly 100 Baker Act cases each day. Moreover, in 2000, there were 34 percent more Baker Act cases (80,869) than DUI arrests (60,337). [14] Many of them will be referred to the state forensic hospitals.

The costs for this treatment is staggering. In 2003, Miami-Dade County had 250 persons committed to a Florida state forensic hospital. The cost for treatment was $28 million – for Miami-Dade County alone.

If the officer decides to arrest the subject instead of Baker Acting him, the subject is taken to the jail. Again, the defendant is screened during processing and a determination is made as to the level of his present mental condition. Depending on that assessment, he will either be placed in general population, or if undergoing a more severe episode, placed on one of the psychiatric floors.

In an effort to identify the magnitude of the "revolving door" problem, a study was conducted of persons with mental illnesses in the jail who were arrested over a one-year time period.[15] Within that 12-month period (2002), 3,070 individuals with mental illnesses were arrested and booked into the jail. More than half of all the bookings were for 3rd degree felonies[16] (45%) and misdemeanor offenses (7%). The majority of the 3rd degree felonies were drug-related charges. The 3,070 individuals actually accounted for 3,452 bookings because many of them were arrested multiple times during the course of

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[12] Florida Statute 394.467

[13] The Sheriff's Star, September/October 2004, p. 16

[14] Ibid

[15] The determination of whether an inmate was suffering from mental illness was based on the inmate being assigned to a cell on a psychiatric wing in the Pre-trial Detention Center or Women's Detention Center.

[16] 3rd degree felonies are offenses which are the least severe under Florida's criminal laws. They include crimes such as grand theft; writing worthless checks; possessing illegal drugs; resisting arrest with violence; and battery on a police officer. Possible punishments may include fines, probation, county jail time or imprisonment in a state correctional facility for up to a maximum of five years.

the year. Of the total number of persons arrested, one in ten were arrested more than once during that year. Forty-one percent (41%) of the 3,070 arrests were made by officers with the Metro-Dade Police Department. Approximately thirty percent (30%) were made by the City of Miami Police Department. **It was estimated that half of the arrests might have been avoided by taking mentally ill persons in crisis to a receiving facility instead of to the jail.** Further, providing specialized training to more uniformed officers could assist the officers in identifying individuals who may have mental illnesses and de-escalating potentially volatile situations. Absent the specialized training and availability of Crisis Stabilization Units ("CSUs") those suffering from mental illness are arrested and the jail becomes the primary treatment facility for that segment of our community. The jail does little more than warehouse (on a temporary basis) and medicate thousands of mentally ill inmates every year. It is not intended, nor was it designed to treat persons whose primary problem is sickness, not criminality.

Once they are arrested, other disparities in the criminal justice system begin. As previously stated, mentally ill inmates in the jail stay eight times longer than inmates in general population. This also is not just a local problem. On Rickers Island, New York City's largest jail, the average length of stay for all offenders is 42 days; it is 215 days for inmates with serious mental illness.[17] The inmate undergoing a mental health crisis is also very likely to be placed in an administratively segregated section of the jail (psychiatric wings and suicide watch cells) which will afford him less comforts and privileges (including the right to visits from family members) in comparison to other inmates. Some of these conditions themselves are very likely to bring on or exacerbate the psychosis of those housed in such units. However, there is hope for improvement.

E. A PRESCRIPTION FOR IMPROVEMENT

In spite of all the dire information set forth thus far in this report, there is some good news to share regarding misdemeanor offenders who suffer from mental illness and/or substance abuse.

[17] Fox Butterfield, "Prisons Replace Hospitals for the Nation's Mentally Ill," New York Times, March 5, 1998.

In the year 2000, the Eleventh Judicial Circuit Criminal Mental Health Project was created. Under the leadership of the Honorable Steven Leifman, Associate Administrative Judge, Circuit Court Criminal Division, partnerships were formed with the Florida Department of Children and Families (DCF), Jackson Memorial Hospital ("JMH"), The National Alliance for the Mentally Ill ("NAMI"), several police departments and the criminal courts. The goal was to develop better ways of dealing with the number of repeat misdemeanor offenders who suffered from mental illness and were coming in contact with the criminal justice system. One of the greatest benefits thus far from that collaboration was the creation of the Jail Diversion Program.

The Jail Diversion Program is designed to make jail the place of "last resort" for persons with mental illness. It has two components (pre-arrest and post-arrest diversion program) and includes a comprehensive case management program that addresses transition and housing issues as well as substance abuse.[18]

As to the pre-arrest diversion, the program's intent is to prevent persons with mental illness from ever entering the criminal justice system. In coming to an understanding of how the program works, we also came to an understanding of why so many partners had to be included in this effort. It starts with the uniformed police officers on the street who are usually the first to encounter individuals who are in crisis due to mental illness. Ideally, the officer responding to the call has received Crisis Intervention Team Training and is a member of the police department's Crisis Intervention Team.[19] Based on the training the officer is able to recognize that he is dealing with someone with a mental illness and, using the tools developed during the training, bring the encounter to a non-violent end. Once the misdemeanor offender is in custody, the officer takes the individual to a county mental health receiving facility. Upon arrival, the individual is evaluated and treated (stabilized) and referrals are ultimately given for aftercare, housing and job training. The diversion to the mental health receiving facility is in lieu of taking the misdemeanor offender to jail.

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[18] At least three-quarters of people with mental illness who are incarcerated have a co-occurring substance abuse disorder.

[19] More information on this topic is provided in Section II of this report, p. 23 to 28.

However, even in situations where an arrest is made for a misdemeanor offense, the post-arrest aspect of the Criminal Mental Health Project may still be used to provide treatment outside of the jail setting. Under the County Court Jail Diversion program, a misdemeanor defendant suffering from a mental illness, who is taken to the jail, will have his charges and mental health history reviewed. If the defendant meets the criteria, within 24-48 hours after his arrest, he will be diverted to a community mental health facility for appropriate treatment. In many cases, after a review of the charges and the defendant's mental health history, the State Attorneys Office and the defense attorney may agree to have the charges dropped upon the defendant's stabilization **and** successful completion of a discharge plan. In situations where this is done, the defendant and his case have effectively been removed from the criminal justice system within 24-48 hours after his arrest.

The costs saved as a result of this diversion program include the following: daily jail costs for housing, feeding and treating the inmate in the jail; additional correctional officers who are needed to monitor the mentally ill jail population; court costs and expenses of the judge, court clerk, bailiff, prosecutor, defense attorney, court reporter, correctional officers and others who are present every time the case appears on a court calendar; and the costs of taking police officers off the street to appear for trials and hearings, sometimes at overtime rates because the court schedule is not within the officer's work schedule.

The primary reason that the recidivism rate for this population is so high is that traditionally, a lot of money is spent stabilizing the individuals after they are arrested and in the jail; however, no money (or thought) is given to providing a way to keep them stabilized once they are released. The Mental Health Project addresses this much needed strategy.

We were pleased to hear that, as a result of tremendous success, the Criminal Mental Health Project was awarded a one million dollar grant from the Substance Abuse & Mental Health Administration to expand the existing jail diversion program. The MMHP was only one of seventeen sites across the United States to receive funding specifically for jail diversion purposes.

As part of the expansion, the new program will provide more Crisis Intervention Team police training, which will allow more officers to be trained per year. The case management aspects of the program will also be expanded, allowing for individualized aftercare plans and continued reassessment of need for referrals for those involved in the program. Finally, the expansion will also focus on jail diversion research, so that data can be accumulated and evaluation of the program conducted.

The Florida Department of Children and Families is one of the partners in the Project. DCF has assigned a case manager to the Post-booking Jail Diversion Program to facilitate the discharge and aftercare planning for the misdemeanor defendants who are diverted from the jail to mental health facilities. The aftercare is designed to provide a full array of referrals, benefits and services to these individuals. It includes: an assessment by the Court to determine the specific needs of the individual; a housing component to ensure that adequate housing is available[20]; an ID Program that offers identification cards to individuals in the program[21]; assistance in obtaining and expediting access to certain benefits to which the individual may be entitled[22]; and providing a contingency fund that is available to indigent program clients for housing and medication needs. The aftercare plan also includes psychiatric follow-up, medication management, mental health treatment follow-up and treatment for substance abuse.

Does it work? Since the inception of the program, there has been a drastic reduction of arrests for this target population. Statistics reveal that 221 individuals were diverted by the Jail Diversion Program in 2002. The number increased to 283 in 2003. Prior to creation of the Jail Diversion program, the recidivism rate for this population was estimated to be approximately 70%. It was reduced to 18% in the first year of operation and dropped an additional 2% in 2003. A cost analysis[23] conducted at the end of the first

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[20] The Miami-Dade County Homeless Trust and other community housing organizations are involved in this aspect.

[21] Very often, individuals cannot apply for or receive certain benefits without appropriate identification. Camillus House assists in providing the identification cards.

[22] This is achieved through collaboration with the local Social Security Administration Office and the Court.

[23] For the cost analysis, a target population was chosen. The target population was the highest utilizers of services, recidivists in the Jail Diversion program. The only services and costs analyzed were costs for acute mental health services, such as crisis stabilization, psychiatric emergency room visits and inpatient

year of operation estimated that the program saved Miami-Dade County **$2.5 million** over the **one-year time period**. Although we believe this cost is conservative[24], it still amounts to a huge saving of taxpayer dollars.

For comparison purposes and to highlight the enormous costs that ensue due to a failure to have a coordinated response and treatment plan for this population, we obtained information from other jurisdictions that had done similar studies. During the year 2000, taxpayers in King County (Seattle) Washington **spent over $1.1 million** on drug and alcohol acute services and criminal justice resources **for just 20 individuals**.[25] Similarly, In Summit County (Akron) Ohio, during the year 2001, the cost to taxpayers **for a group of 20 individuals** was **$1.3 million**.[26]

In 2004, the Florida legislature took steps to reform our Baker Act statute and the way courts have dealt with the mentally ill. A Baker Act reform bill was passed that now allows court-ordered outpatient treatment for persons with severe mental illness.[27] The law became effective January 1, 2005 and is intended to enhance mental health intervention and treatment services. It has worked in other states.

For instance, New York has had a similar law for a few years. Review of statistics from the first three years reveals that of the persons placed in court-ordered outpatient treatment, 63% fewer were hospitalized, 55% fewer experienced homelessness, 75% fewer were arrested and 69% fewer were incarcerated.[28] The statistics are very encouraging and would bode well for our state. However, the Florida legislature did not fund any money for this new law. The monitoring of this population will result in more hearings, more court time, more work for prosecutors and defense

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hospitalization days following emergency room treatment; costs for time spent in jail; and psychological evaluations.

[24] The reason we believe the estimate to be conservative is that it does not include items such as: court administrative costs, police time costs, ambulance services, mental health outpatient services and substance abuse treatment.

[25] Unpublished statistic courtesy of Patrick Vanzo, Administrator, Cross Systems Integration Efforts, Department of Community and Human Services, King County, WA. This figure does not include the costs for police time, ambulance services, sobering van services, county designate mental health professional services, or administrative costs associated with these services.

[26] Unpublished statistic courtesy of Dr. Mark Munetz, Chief Clinical Officer, Summit County, Ohio, ADM Board.

[27] Florida Statute 394.4655, Involuntary Outpatient Placement

[28] The Sheriff's Star, September/October 2004, p.16.

attorneys and more treatment facilities. The results from New York's Kendra Law Program will not be replicated here with Florida's unfunded mandate.

More Good News

In the November 2004 election, voters in Miami-Dade County overwhelmingly approved the 2004 General Obligation Bond Program for Building Better Communities. Included in the list of projects is the creation of a Mental Health Facility that is specifically designed "to free up jail space and provide an effective and cost-efficient alternative facility to house the mentally ill as they await a trial date." Twenty-two million dollars will be used to upgrade the existing facility (the South Florida Evaluation and Treatment Center) to create a short-term residential and receiving facility. The plan is to have courtrooms and provide social services in the same building. The completion of the project is several years away, however, it is most definitely a step in the right direction.

We do not believe that persons who are sick have to go to jail before they can receive treatment for their illness. We also do not believe that officials should continue to spend tax dollars on persons being recycled through our criminal justice system while at the same time not adequately funding programs and services to help keep these persons from returning to our jails. It is definitely cheaper (and more humane) to treat these individuals outside of a jail setting.

1. We recommend that state and local governmental officials, in conjunction with the persons, agencies and entities involved in mental health issues, work collaboratively and expeditiously to construct a facility that can be used to house, treat and provide social services in one location to mentally ill inmates who are in custody awaiting trial.

2. Until construction of the facility referred to in Recommendation 3 above, we recommend that more doctors and more social workers be assigned to work in all local pre-trial detention facilities.

3. Having a new law that allows the court to order outpatient treatment for the mentally ill is useless if there are no programs or services available to which to

refer them. Accordingly, we recommend that our state legislature provide funding for the Baker Act reform bill in hopes that Florida will reap the same benefits as New York from passage of its statewide Kendra's Law.

4. In connection with the Baker Act reform bill, we recommend that our State legislature provide funding to increase the number of community based mental health facilities and thereby increase the number and level of services available to the mentally ill in our state.
5. The state is spending large sums of money for crisis care and stabilization of the mentally ill after they decompensate. We strongly recommend that the state legislature provide adequate funding for long term care, which will result in the creation of case management works who can assist the mentally ill in maintaining a stable lifestyle.
6. We recommend that our state and local government officials provide funding and/or matching dollars to assist in the expansion of the Eleventh Judicial Circuit of Florida Criminal Mental Health Project and its Jail Diversion Program.

II. POLICE INTERACTION WITH MENTALLY ILL SUBJECTS

One of the obvious results of recycling the mentally ill through our criminal justice system is increased contact between law enforcement and this population. The interactions are fraught with danger for both the police and the subjects. Very often, police officers responding to calls involving subjects with mental illness are not sure what they are dealing with and resort to the techniques they were taught in training. The officers are trained to take control of the scene and the situation and their primary goal is to get the subject to obey and/or respond to the officer's commands. This is usually accomplished (or sought to be accomplished) through loud voice commands to the subject, calling for back-up and exhibiting a "show of force." Any level of resistance is met with a higher degree of force.

In many instances, the subjects are persons who are experiencing psychiatric episodes because they failed to take their medications. As a result, they are paranoid and feel that folks are out to get them. Although they may be relatively harmless when

properly medicated, they may very well pose a danger to themselves, caring family members, strangers and police when they fail or refuse to take their medications. While in this mental state, a loud, authoritative voice from a police officer only exacerbates the situation. Presenting a show of force and closing in on the subject confirm his paranoia and increase the likelihood that the confrontation will end in violence. There is a significant, tri-fold price tag associated with these police/citizen encounters.

First, police officers are injured and must seek medical care. Moreover, serious injuries to the officers may also lead to time lost from work and the filing of worker's compensation claims. Similarly, the mentally ill subjects also receive serious (sometimes fatal) injuries as a result of these encounters. Their medical care for the physical injuries suffered during these encounters, more often than not, is provided by the public hospital, Jackson Memorial Hospital. All of these costs are paid with taxpayer dollars. Finally, many of the injured subjects (or their surviving family members) file lawsuits against the individual police officers, the police department and sometimes, even the county government or municipality employing the police officer alleging that officers were not trained properly, should not have been hired and/or acted inappropriately or with excessive force in the encounter. As for this final category, millions of dollars have been paid out through settlements or as a result of damage awards by trial juries.

At this point, it is necessary to discuss the law in the State of Florida that governs officers in these sometimes-deadly encounters between police and civilians.

Deadly Force

Florida, like all states in this country, recognizes the inherent danger faced by police officers in their daily occupation. Their job requires that they come into contact with mean, vicious, sometimes sociopathic criminals on a regular basis. The acts of violence committed by these criminals include murder, armed robbery, sexual battery (rape), child abuse and home invasions. We, as law abiding citizens, do not want to deal with these persons and so, when we have problems, we call "911" to summon the police. We expect them to respond to the scene immediately and take care of whomever and whatever is causing the problem. These encounters are often deadly for the criminals and the police. In light of the dangerous nature of the job, the Florida legislature has granted

broad powers to police officers who are engaged in the lawful performance of their duties. One of the powers given to police is the right to use "deadly force."

Deadly force, as defined by Florida Statute 776.06 (1), means force that is likely to cause death or great bodily harm. This includes a law enforcement officer firing a firearm in the direction of a person to be arrested. The term deadly force **does not** include the discharge by a law enforcement officer of a firearm which is loaded with a less than-lethal munition. The statute defines "less than-lethal munition" as a projectile that is designed to stun, temporarily incapacitate, or cause temporary discomfort to a person without penetrating a person's body.[29]

In addition to the Deadly Force Statute, Florida also has a specific law governing the amount of force an officer can use in making an arrest. Under Florida Statute 776.05, (1), a law enforcement officer in Florida who encounters a person who is resisting or threatening resistance to being arrested is not required to retreat or desist from efforts to make a lawful arrest. In fact, the officer is justified in the use of any force (including deadly force), which he reasonably believes to be necessary to defend himself or another from bodily harm while making an arrest. This provision has proven fatal for many mentally ill subjects who were engaged in bizarre and dangerous behavior with the police.

For Failures in Providing Appropriate Treatment for the Mentally Ill, What Is the Cost In Lives?

Based on Florida Statute 776.05 (1) most of the shootings committed by police officers in this county are found to be "legally justified". In those situations, law enforcement officers have encountered persons armed with knives, machetes, pistols, rifles, shotguns, sword-length shards of glass, and other items that could be used to cause death or great bodily harm to the officer or to others. In some cases, the persons are not armed with weapons; however, they have things in their hands that cause officers to reasonably believe that they are in possession of a firearm or other weapon. Finally, there are instances where the subjects, in addition to not following the officer's

[29]Florida Statute 776.06 (2)(a)

instructions, reach in the area of their waistband (as if to pull a gun), reach under the seat of a car, reach for a glove compartment or drive a vehicle in the direction of an officer who is trying to make an arrest. Under Florida law, the use of deadly force by the officers in these situations has been determined to be "legally justified." Many subjects shot by police were suffering from mental illness and officers may have had little time to react to the violent situation confronting them. In other words, there were no alternatives. However, a great number of confrontations take place where, with more options and better training, lives could be saved.

For instance, some of the subjects shot by police officers are not armed, do not appear to be armed, but become involved in violent physical struggles with officers. Often, the police use other tools before resorting to deadly force (batons, pepper spray, etc.) In many of these instances, deadly force is used as a "last resort." These scenarios usually play out over a period of time after the initial encounter, and most likely involve an escalation of emotions and actions for both the officers and the subjects. A great number of the subjects involved in these struggles are also persons suffering from mental illness. Again, as reported to us, the overwhelming contributing factor to their behavior is that they failed to take their medications. They have no desire to commit a crime and may end up doing so only through failure to follow the officer's commands.[30]

The sometimes-tragic consequences from these encounters were significantly underscored with an incident that occurred near the end of our term.[31] According to eyewitness accounts, the incident involved a Miami-Dade Police Officer and a resident who had a history of mental illness, the onset of which began after the resident had served a stint in the armed forces. After an initial verbal exchange between the officer and the subject, there was an escalation of the encounter. Additional units were called to the scene and after their arrival, a physical struggle occurred between a number of officers and the subject. During the violent encounter, officers struck the subject with their A.S.P. batons. The subject punched one of the female officers and at some point

[30] A report issued by Human Rights Watch estimated that thousands of mentally ill people are imprisoned for crimes "they might never have committed had they been able to access therapy, medications and assisted-living facilities."

[31] As this was an open investigation, we did not receive any formal testimony or evidence about this incident. Our account and description of what transpired is based on information reported in the media from eyewitness accounts and statements issued by the police department's spokespersons.

during the confrontation he was able to obtain possession of one of the A.S.P. batons. A family member also became involved in trying to restrain the subject and he was also struck by one of the batons during the struggle. As the subject was preparing to strike one of the officers with the baton, he was shot several times by an officer and died as a result of those wounds.

Some of the more troubling aspects of this incident from our perspective relate to the fact that the subject was known in the neighborhood and was known to be suffering from some form of mental illness. If his condition was so well known, the officers patrolling in the area should also have known and the approach used with the subject should have been more appropriate.

We make note of this incident to highlight two (2) major trends that have been taking place in the law enforcement community for the past few years. We think each of them has reduced and will continue to reduce the number of deadly and violent encounters between police and persons suffering from mental illness.

Crisis Intervention Team Training and Less Than Lethal Weapons

One of the most significant changes that has taken place over the past several years has been the introduction of Crisis Intervention Team Training at many of the city and municipal police departments in Miami-Dade County. Coupled with the implementation of effective "less than lethal" weapons, there has been a sharp decrease in the number of deaths that result from police encounters with mentally ill subjects. To fully appreciate the impact of both of these developments, we must take another historical journey.

A. CRISIS INTERVENTION TEAM TRAINING

The Crisis Intervention Team ("CIT") model used by police departments in Miami-Dade County originated in 1987 in Memphis, Tennessee following a police shooting of a young black male. The CIT Training program is a 40-hour course that educates police officers about mental illness and trains them on the different tools they can use when they come into contact with persons suffering from schizophrenia, bipolar disorder or other severe mental illness. More often than not, the CIT training is much

different than that which was presented in the past to rookie officers in the police academy.

For instance, the police academy trains police officers that they are to take command upon their arrival at any given scene. Taking command is accomplished by a number of means: verbal command; a show of force demonstrated by calling for additional police units; yelling; physical force; surrounding and/or closing in on the subject; display of a weapon (A.S.P. expandable baton, firearm, etc.); and ultimately, use of a weapon. Employing any of these methods in an encounter with a mentally ill person will usually guarantee that there is going to be a violent encounter between the police and the subject. Each of the training tools taught in the academy is designed to work when dealing with sane, rational individuals. However, yelling, threatening, closing in upon, displaying weapons and using physical force exacerbate the paranoia of the schizophrenic. It creates fear in the mind of the paranoid subject (who may be experiencing such an episode solely because he failed to take his medications) and only serves to confirm what he believes in his mind, namely that people are "out to get him."

Officers who undergo Crisis Intervention Team Training are taught how to identify person with mental illness. They are educated about different tools to use when they encounter the mentally ill. They speak to them in calmer tones. They allow a safe distance between the subject and the officer as a means of reducing the paranoia. The use of these (and other) tools very often allows the police to "control" these subjects without the use of physical force. The benefits are fewer injuries to the officers and the subjects, reduced worker's compensation claims filed by officers injured on duty and fewer lawsuits filed against the law enforcement agencies. The results have been nothing short of astounding for the departments that have adopted the CIT Training program. The following police departments have participated in the program: Miami Police, Miami Beach Police, Key Biscayne Police, Pinecrest Police, Dade County School Police, Hialeah Police and North Miami Beach Police. Additionally, the following have expressed an interest in receiving CIT Training: Opa Locka Police Department, Sunny Isles Police Department, Florida International University Police Department and Miami Shores Police Department. We will review information regarding several departments that have seen benefits from Crisis Intervention Team Training.

City of Miami Police Department

The City of Miami Police Department (MPD) started its Crisis Intervention Team in late 2003. A group of trained professionals at Jackson Memorial Hospital's Crisis Intervention Center developed the 40-hour course and taught the first group of thirty-nine officers for free.[32] Since the graduation of that first group of officers, the MPD now has a team of eighty-three officers who have volunteered for and completed the training. In fact, all of the MPD's Field Training Officers (FTOs) are members of the Crisis Intervention Team.[33] An additional wave of MPD officers are being trained to serve as backup CIT members. Rookie officers are required to ride along with FTO's during their first three months as officers.

With eighty-three officers now certified in CIT Training, the City of Miami has CIT coverage geographically as well as across all three work shifts. This broad coverage increases the likelihood that whenever and wherever there is an incident involving a mentally ill offender, a CIT member will be available to respond to the call.

Pursuant to the MPD's protocol for handling calls with mentally ill subjects, regardless of the ranks of all officers at a scene, the Crisis Intervention Team member (regardless of his rank) takes charge of the scene upon his arrival. The CIT member becomes the exclusive person communicating with the subject. Rookie police officers who are present for these encounters will have the opportunity to watch their FTO identify, de-escalate and successfully handle a mental health crisis without violence or the use of deadly force. Through observation and interaction with the FTOs, the rookie officers gain additional tools to use in their encounters with mentally ill subjects. MPD's training regimen, in this regard, allows the FTOs to pass on the knowledge they have gained to the newest crop of officers who most definitely will have their share of mental health related calls.

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[32] Once the officers completed training, they were each given a new "less than lethal" weapon to use – a Taser. More information on Tasers is provided in Section II. B. below. See pages 29 - 35.

[33] FTOs are veteran police officers who are involved in further training of rookie police officers once they graduate from the police academy. Each rookie is required to ride along with a FTO for the first three months on duty.

Responding to calls involving mentally ill subjects is inevitable for all City of Miami Police Officers. Within their jurisdiction lies Jackson Memorial Hospital's Crisis Center, the Dade County Jail and a number of homeless shelters and treatment facilities. As many of those with mental illnesses are homeless, when they are released from the various facilities, they very often return to the same streets upon which they were last arrested. After Crisis Intervention Teams were established, the number of police shootings was drastically reduced. For instance, in 2003 alone the MPD's CIT handled 3,597 calls for service. Not one shot was fired by a MPD officer during that time period. In fact, the department went for more than 18 months without an injury to an officer or a shooting by an officer.[34]

Miami Beach

The Miami Beach Police Department has also had its officers trained for CIT. The department has also tried to get the community involved by sending out notices and information to residents with their utility bills. In the event residents are required to call the police for situations involving persons in crisis, residents are instructed to notify the 911 operator so that the information can be included in the dispatch to the police. The goal is to have the officers on notice before they arrive on the scene and increase the likelihood that a CIT member will respond to the call initially.

MDPD and CIT Training?

The Miami-Dade Police Department is the largest police force in Miami-Dade County. As expected, it has more arrests than any other department, and consequently, more police/citizen encounters. Over the past several years, there has been a rallying cry from elected officials and others to have MDPD adopt the CIT Program. These cries normally come on the heels of a police shooting of another mentally ill subject. To date, MDPD has not adopted the program. During the course of our term, the MDPD got a new Director for its Department and we met with him.

[34] The eighteen month long record was broken when an armed suspect turned toward officers while trying to flee after committing a robbery.

In 2001, the MDPD conducted an evaluation of the CIT Model. Recognizing that they were operating in a community with a significant mentally ill population and would have to train a large number of officers, MDPD determined that the Memphis Model was not workable for a department of its size in a jurisdiction that covers more than 2,000 square miles. Instead, what MDPD has done is to embark upon a multi-tiered approach to improve the manner in which the department's officers respond to and handle calls involving mentally ill persons.

The department's efforts to better equip its officers to deal with mentally ill subjects actually begin before they become sworn law enforcement officers. All persons desiring to become officers with the MDPD must successfully complete and graduate from the Department of Justice's Regional Community Police Institute, commonly referred to as the Police Academy. The training at the academy includes educating cadets on the Use of Force Matrix[35] (which has now been modified with the advent of the deployment of Tasers) and teaches them a tool called "verbal judo." Verbal judo is designed to train the officers how they can diffuse a situation by engaging a suspect verbally instead of by the use of physical force. This skill becomes invaluable when dealing with a paranoid schizophrenic subject who does not want to be touched or surrounded by a team of police officers. More importantly, beginning in July 2003, the academy also provides a two-day, 16-hour course on Managing Encounters With the Mentally Ill. This portion of the training is specifically designed to educate the cadets about mental illness and give them tools they can use when they interact with mentally ill subjects and suspects. All new recruits <u>must</u> pass this course before they can be sworn in as law enforcement officers with the MDPD. With 4 to 5 graduating classes per year, with approximately 35 students each, the department has a number of rookie officers who have been joining the ranks with some general knowledge and specific tools to use when responding to Baker Act calls or other interactions with the mentally ill.

The first tier of the Director's three-tiered approach was to get training for the uniformed officers who are usually the first responders to the dispatch calls. The

[35] A Use of Force Matrix is a guideline used by police departments to educate their officers on the different levels of force they can use when encountering subjects. The Matrix contains an escalation on the types of force which can be used and offers examples of the types of behavior that would legally justify the use of specific types of force.

department provided in-service trainings for 1,854 uniform patrol officers. The two-day, 16 hour training program is the same Managing Encounters with the Mentally Ill course that is presently being taught in the academy. To date, all uniformed officers with the MDPD have successfully completed this training program.

As part of the first tier, the Department will also provide the same training to specialized unit officers such as Detectives in the Robbery, Domestic Violence and Sexual Battery Units. Second only to the uniformed patrol officers, these detectives are likely to come into contact with suspects and subjects suffering from mental illness. Next on the list to be trained are the 415 support personnel. The department's Training Bureau is coordinating the two-day training for all of these individuals and departments.

The second tier will begin in January 2005 and encompasses a 40-hour training for all of the approximately 550 Field Training Officers ("FTOs"). The 40-hour Crisis Intervention Model type training for the MDPD FTOs and the Field Training Squad is similar to the Memphis model. It is conducted at JMH and the presenters are licensed mental health practitioners. The Director's plan is to have all FTOs trained by July 2005. Similar to the procedures in the other departments that adopted the Memphis Model CIT program, rookie officers are paired with FTOs. As FTOs are spread out over all of the department's districts and work on all three shifts, when a call comes in and the dispatcher knows there may be a mentally ill person involved, an FTO will be dispatched to the scene. Pairing the rookie officers with the FTOs allows the rookies to benefit from the FTOs 40-hour CIT training when responding to these calls.

In addition to the various training provided to the recruits, uniformed officers, specialized unit officers and FTOs, the department also has approximately thirty (30) Special Response Team Members. The Special Response Team Members, also referred to as Negotiators, have all successfully completed the 40-hour basic CIT course as well as an 80-hour advanced course that includes training on how to deal with mentally ill persons. The negotiators also receive monthly refresher training that may include mental health encounters. They comprise the third tier of the MDPD's department-wide training of its officers to handle mental health calls.

Through the training conducted for the MDPD officers at all levels in the department, Director Robert Parker is trying to change the way his officers handle calls involving the mentally ill. Although our preference would have been for the largest department in the county to adopt and buy into this very successful program, we recognize that we are not law enforcement officers and are not in a position to second-guess the department's decision that the Memphis model CIT Training Program is not workable for the department. We applaud the Director and his department's effort and encourage its brass to continue its efforts in developing and extending its progress on Crisis Intervention Teams.

1. We strongly recommend that every police department is Miami-Dade County create Crisis Intervention Teams with its uniformed officers.
2. We recognize that tragedies can be averted by swift reaction and response to crime scenes by CIT members. In that regard, we strongly recommend that area residents who call 911 when they observe a family member, friend, loved one or stranger in crisis, do the following:

   a. Inform the dispatcher that the nature of the call relates to someone who is suffering from mental illness;
   b. Inform the dispatcher of any relevant medical history of the subject, and
   c. Request that a Crisis Intervention Team member respond to the scene.

B. <u>TASERS</u>

One of the other major developments that has been occurring in our communities (and nationwide) is the use of an innovative "less than lethal" weapon – the Taser. Tasers, maybe more appropriately called "stun guns", are used by officers to temporarily immobilize and incapacitate subjects so that officers are able to dissipate threats or effectively apprehend otherwise unruly subjects. The popular models used by local departments fire two probes that are attached to wires. The probes can be fired from a distance of up to 21 feet. In close physical struggles, the Taser will also deliver its "stunning" effect by direct placement of the Taser against the subject. Upon contact with the probes or direct contact with the Taser, the individual receives 50,000 volts at very low amperage that neurologically causes the individual to lose control of his motor

functions. The "stunning" effect usually lasts only about five seconds and after that 5 second time period, the individual has total and complete control of his body and can continue whatever activity he was engaged in before he was tased.

We must first note that there have been several recent incidents involving Tasers used on children here in Miami-Dade County. As reported by the media, the children's ages were 6, 12 and 16 years. Although several of the incidents gained nationwide attention, the use of Tasers on children is not a focus of this report.

In that regard, however, many, if not all, of the police departments have specifications for classifications of persons who should not be Tasered. For instance, the policy for the Aventura Police Department provides that the Taser "should not be used on any juvenile under the age of 12 and/or a juvenile who appears to be physically under the age of 11. Similarly, it recommends that the Taser "shall not be used on females who are known to be pregnant or who appear to be pregnant." Although we offer no opinion on these guidelines and prohibitions, we do recognize that they indicate efforts by the departments to protect those who may be vulnerable to the stunning and immobilizing effect of the Taser. Further, even though the general use of Tasers as a tool in apprehending criminals and protecting officers and civilians is mentioned in this Grand Jury Report, it too is not the issue we want readers to focus upon. This section of the report is specifically written to address the issue of persons who suffer from mental illness who become involved in encounters with the police in Miami-Dade County. In light of the tremendous benefits that have been received from the use of this "less than lethal weapon", we strongly recommend that police departments in our community continue to train and equip its officers with Tasers. This Grand Jury strongly recommends the use of Tasers by police as a "less than lethal" weapon in their confrontations and dangerous encounters with mentally ill subjects. It saves lives!! Our justifications for these recommendations are set forth below.

We Believe Tasers Save Lives

Many community residents may take issue with this recommendation, as they believe it constitutes mistreatment of a segment of our population that is routinely misused and abused. However, the members of this Grand Jury have come to realize that

in many cases, if police do not have ready use of a "less than lethal" weapon, the likely end of the conflict will be the death of the mentally ill subject. Thus, when the choice is between five seconds of neurological incapacitation or death, we choose the former. As indicated earlier in this report, Florida law empowers officers to use deadly force in these situations.

We recognize that there is a possibility of abuse and that Tasers, as well as pepper spray, batons and firearms can be used inappropriately by some police officers. We do not see that as a justification to take these tools away from the officers. Instead, we think all of the police departments should adopt and/or refine their guidelines for use of these weapons. Further, we believe they should be consistent in imposing discipline against all officers that violate the guidelines.

Individuals in our community who are not knowledgeable about the information we received during our term may dispute our statement that the use of Tasers by police officers in our community has saved, and will save, lives of adults in our community, particularly those with mental health issues. To drive this point home, we decided to include some specific case scenarios we reviewed that ended in death or serious bodily injury, but which may have been avoided if the officers had Tasers available during the encounters.

State Attorney's Office Shooting Review Team

We must first point out that the State Attorneys Office has a Police Shooting Review Team that ultimately reviews every police shooting in Miami-Dade County that results in death or injury to a subject or other officer. It is a process that has been completely re-shaped by State Attorney Katherine Fernandez Rundle and we commend its design. The SAO's review chronologically begins when the Assistant State Attorney on call responds to the scene of the shooting. The SAO's review is specifically designed to determine whether the shooting was legally justified under Florida law. Each review is concluded with a close-out memo that is sent to the police department whose officer was involved in the shooting. Based on Florida law, most of the shootings are ruled "legally justified" even when they were also preventable. This was the conclusion in a number of the Police Shooting Review Team close-out memos.

In the Appendix we have provided descriptions of six of those encounters that actually occurred in recent years between officers and civilians in Miami-Dade County. The incidents involved persons who were in crisis as a result of mental illness or had a prior history of mental illness. One of the reasons for including so many incidents is to make the point that lives can be saved with the use of Tasers. One of the other reasons is to make our legislators and other elected officials intimately aware of the danger they are placing our officers in as a result of their failure to fund the necessary programs and services to treat the mentally ill population. We strongly encourage every reader to not put this report down until he has read all six incidents.

The law authorized the use of deadly force in each of these situations. Absent any viable alternative, officers are forced to use deadly force to protect themselves or to secure an arrest. Training and use of the Taser gives an alternative for the officer that does not have a deadly consequence. Based on the information we received during our investigation, no deaths have been caused solely by the use of Tasers.[36] Tasers are not designed to kill nor are they used for that purpose. On the other hand, when an officer uses his gun, it is accurately described as "deadly" because that is exactly what it is intended to do – kill. Contrary to television entertainment programs and westerns, police officers are not trained to shoot weapons out of the hands of armed suspects nor are they trained to "wound" persons who are posing threats. They are trained to use "deadly force" to dissipate a threat. Again, "deadly force" is force that is likely to cause death or great bodily harm. We applaud all of the police departments in Miami-Dade County that have adopted use of the Tasers and we recognize that lives have been saved as a result.

Officers Believe Tasers Save Lives Too

In addition to our belief that the continued use of Tasers will save lives, we received testimony from law enforcement officers who agreed with us. A Major with the Miami-Dade Police Department described two specific recent incidents that occurred in

[36] We are aware of the numerous media reports that have aired regarding persons who have died after being stunned by Tasers. The implication in many of those reports was that the deaths were caused by the Tasers. In all of the instances we followed, autopsy reports revealed the cause of death to be drug overdoses and/or other underlying medical conditions. As a result of that information, we are not hesitant to make this recommendation.

the same week involving officers in his district. One involved a 6'9" tall male with a history of mental problems who was refusing to be Baker Acted. He was immobilized with the Taser, cuffed and taken away without injury to the officers or himself. The other incident involved a young female who also had a history of mental problems. She was wielding two butcher knives and slashing at officers and civilians. By placing chairs between the knife-wielding subject and themselves, the officers who initially responded to the scene were able to keep her at bay until an officer with a stun gun arrived. She was stunned, dropped the knives, was handcuffed and taken away. Absent the arrival of the Taser, officers may have had to use deadly force to dissipate the threat and/or prevent her from causing death or serious bodily injury to the officer or others.

Coupled with the three-tiered approach to educating its officers in handling calls involving the mentally ill, the department also initiated the use of Tasers in June 2003. Initially, 72 Tasers were issued only to sergeants. Four months later, after determining that Tasers were a viable option for its officers, a decision was made to begin issuing Tasers to the uniformed officers. As of November 2004, the MDPD had issued 422 Tasers. They are presently evenly distributed throughout the Department's 9 districts. Prior to receiving a Taser, each officer is required to complete an eight-hour training course on use of the Taser. Under the present policy, each officer is also stunned with the Taser as part of the training.

According to the Aventura Police Department, it is another police agency that has seen positive results with the use of Tasers. Aventura was the first department in Miami-Dade County to issue Tasers to all of its officers.[37] All officers were trained prior to receiving a Taser and they receive refresher training annually.

Use of Tasers by law enforcement also brings another benefit: it protects the health of the arresting officer. Many of our witnesses described incidents where they or their colleagues were bitten, scratched or spat upon by persons that they later discovered were HIV positive, had AIDS or hepatitis. One witness described how a Baker Act subject bit a plug out of his forearm. The same witness described how another veteran officer retired due to complications with liver disease. These complications were a direct

[37] The department had 76 officers at the time Chief Tom Ribel presented his testimony to the Grand Jury.

result of the officer contracting hepatitis C.[38] Most of us do not leave home wondering whether we will contract a life-threatening disease while at work. It is a daily occupational hazard for law enforcement officers, a risk that is sometimes diminished through use of the Taser.

The Aventura Police Department, though small in size, has a high arrest rate, primarily due to the presence of the Aventura Mall in its jurisdiction. The Aventura Hospital is also under its jurisdiction and as a result, officers regularly encounter persons with mental illnesses who decide to leave the hospital. Often times, the persons are acting out by the time police arrive at the scene. Taking these individuals into custody, either for return to the hospital or to jail, sometimes requires physical altercations. As previously stated, two of the direct consequences of these struggles are injuries to officers and subjects. Aventura's police department has seen a reduction in injuries to both groups with the deployment of the Tasers. The Chief of the Department provided us with some statistics to make his point.

From April 1, 1997 to September 15, 2004, the department had 131 use of force incidents.[39] Fifty-five (55) of the use of force incidents did not involve the use of Tasers; seventy-six (76) of them did. The comparisons of injuries to officers and offenders in both categories is very telling. Of the 55 non-Taser incidents, 17 officers (30%) and 25 offenders (45%) were injured. Conversely, of the 76 incidents where Tasers were used, there was a 41% decrease in injuries to officers and a 60% decrease in injuries to offenders. See Appendix C.

Policies on Use of Tasers by Officers

As with most of the police departments using Tasers, Aventura has specified policies dictating when the Taser can be used and requires that a report be written every time the Taser is discharged. This is designed to prevent (or discourage) any abuse or unauthorized use of the weapon. Each of the Tasers has a records storage function, which stores the time, date and type of discharge (prongs or direct contact). Additionally,

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[38] Intravenous drug users represent the largest single risk group for testing positive for hepatitis C infection. Prisoners have enormous incidence of infection and many inmates are drug abusers.

[39] Officers are required to file Use of Force Reports whenever they use force to subdue and/or take a suspect into custody. Most, if not all, departments have such a requirement.

when fired, the weapons release numerous small chads (confetti sized bits of paper), which contain the serial numbers for the Taser being fired. The chads provide physical evidence at the scene that Taser probes were fired from the cartridge. The information on the chads makes it easy to identify the officer(s) who fired a Taser cartridge during an encounter. The Aventura Police Department also conducts random checks of the Tasers. The policy requirement of random checks[40] of Tasers is another deterrent to abusive use of the Tasers.

1. We recommend that police departments continue with the deployment of Tasers to its officers and that the officers receive adequate training on proper use of Tasers.
2. To the extent they do not have them, we recommend that all police departments in Miami-Dade County that issue Tasers to its officers adopt policies and procedures that require, at a minimum:
   (a) Documentation and/or reports of every discharge of a Taser;

   (b) Random testing to ensure that officers are documenting all discharges of their Tasers;

   (c) Severe discipline for any officer who inappropriately uses his Taser or engages in abusive behavior with the Taser;

   (d) Specified guidelines on target populations for whom Tasers should not be used;

Each of these incidents corroborates our belief that the continued (and even expanded) use of Tasers by law enforcement officers in our community will save lives and prevent injuries to officers and offenders alike.[41]

CONCLUSION

During our term, this Grand Jury was made aware of a serious problem affecting our community and our state – the failure to provide effective, long-term treatment and care of the mentally ill who live among us. We are spending significant amounts of taxpayer

[40] During the random checks, the data from the Taser is downloaded into a software program. The data will include the date and time of each discharge for that particular Taser. That information will be checked against all reports and documented discharges. Any undocumented discharges are immediately reported to the Deputy Chief and Chief of Police.
[41] We understand that an "injury" is inflicted by the penetration of the small prongs from the stun gun. This pales in comparison to receiving gunshot wounds.

dollars on stabilization and crisis care when we could more effectively spend less money for long-term care and obviate the crisis. We trust that our elected officials reading this report will take heed to the recommendations contained herein. Their failure to do so will only result in more persons being recycled through our jails and prisons and, very probably, more deaths.

In that regard, this Grand Jury has also come to an understanding of the ever-present dangers and stresses faced by law enforcement officers as they engage in their daily occupations. We now recognize that uniformed officers with these departments will more than likely be the ones to respond to calls for assistance when the mentally ill are in crisis in our homes and communities. We hope the police departments will also take heed to the recommendations set forth herein. We believe adhering to these recommendations will result in better understanding of mental illness by the police, and less loss of life for those who are sick and in crisis.

RECOMMENDATIONS

With regard to Section I of the Report, we make the following Recommendations:

1. In light of the close continuous contact between correctional officers and the mentally inmates they guard we recommend CIT Training for all correctional officers who work on those floors.
2. As there are with some of the police departments that have Crisis Intervention Teams, we recommend that the Department seek and award pay incentives to those correctional officers who elect to serve their shifts working on the floors where the mentally ill inmates are housed.
3. We recommend that state and local governmental officials, in conjunction with the persons, agencies and entities involved in mental health issues, work collaboratively and expeditiously to construct a facility that can be used to house, treat and provide social services in one location to mentally ill inmates who are in custody awaiting trial.

4. Until construction of the facility referred to in Recommendation 3 above, we recommend that more doctors and more social workers be assigned to work in all local pre-trial detention facilities.

5. Having a new law that allows the court to order outpatient treatment for the mentally ill is useless if there are no programs or services available to which to refer them. Accordingly, we recommend that our state legislature provide funding for the Baker Act reform bill in hopes that Florida will reap the same benefits as New York from passage of its statewide Kendra's Law.

6. In connection with the Baker Act reform bill, we recommend that our State legislature provide funding to increase the number of community based mental health facilities and thereby increase the number and level of services available to the mentally ill in our state.

7. The state is spending large sums of money for crisis care and stabilization of the mentally ill after they decompensate. We strongly recommend that the state legislature provide adequate funding for long term care, which will result in the creation of case management works who can assist the mentally ill in maintaining a stable lifestyle.

8. We recommend that our state and local government officials provide funding and/or matching dollars to assist in the expansion of the Eleventh Judicial Circuit of Florida Criminal Mental Health Project and its Jail Diversion Program.

With regard to Section I of the Report, we make the following Recommendations:

9. We strongly recommend that every police department is Miami-Dade County create Crisis Intervention Teams with its uniformed officers.

10. We recommend that police departments continue with the deployment of Tasers to its officers and that the officers receive adequate training on proper use of Tasers.

11. To the extent they do not have them, we recommend that all police departments in Miami-Dade County that issue Tasers to its officers adopt policies and procedures that require, at a minimum:

    (e) Documentation and/or reports of every discharge of a Taser;

(f) Random testing to ensure that officers are documenting all discharges of their Tasers;

(g) Severe discipline for any officer who inappropriately uses his Taser or engages in abusive behavior with the Taser;

(h) Specified guidelines on target populations for whom Tasers should not be used;

12. We recognize that tragedies can be averted by swift reaction and response to crime scenes by CIT members. In that regard, we strongly recommend that area residents who call 911 when they observe a family member, friend, loved one or stranger in crisis, do the following:

    a. Inform the dispatcher that the nature of the call relates to someone who is suffering from mental illness;

    b. Inform the dispatcher of any relevant medical history of the subject, and

    c. Request that a Crisis Intervention Team member respond to the scene.

Appendix A: Demographic Information on Mentally Ill Subjects Arrested And Booked into the Dade County jails in 2002

Demographic Information for 3,070 individuals who were 1) arrested and jailed at the Pre-trial Detention Center or Women's Annex in 2002; and 2) suspected of having severe and persistent mental illness.

Descriptive statistics for the 3,070 are:

- **Gender**
  - Male 78.4% (2,407)
  - Female 21.6% (663)
- **Age**
  - Under 21 4.6% (134)
  - 21-29 23.4% (719)
  - 30-39 26.2 % (803)
  - 40-49 35.7% (789)
  - 50-59 14.0% (430)
  - 50 and older 6.4% (195)
- **Race**
  - Black 51.9% (1,593)
  - White 48.1% (1,476)
  - Unknown < 1% (1)

Appendix B: Actual Police Encounters With Violent Subjects

Actual Police Encounters With Violent Subjects

Incident #1

On Saturday, February 8, 2003, around midnight, two officers with the Miami-Dade Police Department responded to a call regarding a disturbance at a residence in North Dade. One officer had been with the department 10 months. The other, a trainee, had been in training for 6-7 months. Upon arrival, the officers observed a male subject with shirt, pants and no shoes holding what appeared to be a 10-inch knife in his hand. The officers made repeated requests to the subject to drop the "knife." Instead of dropping it, the subject advanced towards the officers with the "knife." To defend themselves, the officers would have been authorized at that point to use deadly force. Instead, they jumped into the police car and retreated from the subject. The subject continued to advance upon the officers in the police car as the officers continued their demand that he drop the weapon. In an effort to avoid a confrontation, the officers actually backed up approximately 2-3 houses away from the scene of the original call. At some point, the subject turned away from the police and headed back to the residence where the incident began.

The officers followed the subject back to the house because of concerns for the persons who were inside. The subject had broken the front living room window of the residence before the police arrived. Officers exited their police car again and the subject began the same behavior. He was now yelling for the officers to shoot him. The officers retreated to the safety of their police car and started backing up again. The officers were still yelling over the public address system in the police car for the subject to drop the weapon and get down on the ground. He continued his advancements on the police car.

Additional back-up officers arrived on the scene after these events had transpired. The two back-up officers got out of their cars and also ordered the subject to drop his weapon and get on the ground. The subject began charging the back-up officers in a threatening manner while displaying the weapon. When he got within approximately 10 feet of the officers, they opened fire with their guns. They each fired several times, striking the subject about the body until he fell to the ground. He expired on the scene.

Follow-up investigation revealed that the weapon in the subject's hand was not a knife, but instead, was a huge piece of glass from the broken living room window. Friends and relatives of the subject confirmed that he had health problems for which he took medications. A friend of the subject indicated that he had stopped taking his medication and was not acting normally on the day in question. The subject had had a conversation with his girlfriend during the early morning hours of February 8th wherein he told her that he was an angel of God named Michael and that on March 24th something

very bad was going to happen in the world and he was going to be there to help. He had also told his girlfriend that he was going to die. The medical examiner's office discovered during their investigation that the subject suffered from bipolar disorder and had been treated for that mental condition. Officers may have been able to use Tasers in this instance to disable and disarm the subject. It would have avoided the use of deadly force, protected the officers and civilians and saved the life of the subject.

Incident #2

On May 31, 2002, a detective with the City of Miami Springs Police Department stopped by a convenience store to get a cup of coffee. As he was leaving the store, he saw a disheveled-looking man in a hospital gown who appeared to be talking to himself. The man was also carrying a metal pipe in his hand. The pipe measured twenty-two and one half inches (22 ½) in length and one and one eighth inch (1-1/8) in diameter. The detective decided to investigate. He drove across the street, exited his car and called out to the man with the pipe. The subject turned and started walking toward the detective. As he got closer, the subject charged at the detective. The detective started back pedaling while trying to unholster his weapon and ordering the subject to stay back. The subject kept charging and began beating the detective with the pipe. The beating caused the detective to drop his gun. He bent down to retrieve his weapon while the subject continued to beat him. The detective raised his arm to ward off the blows. After gaining control of the weapon, the detective fired twice. The subject was struck in the left groin area and in the lower left buttocks. Notwithstanding being shot twice, the subject grabbed the detective's weapon and they became engaged in a life-and-death struggle over control of the gun.

One of the convenience store employees who knew the detective saw most of the confrontation and began running toward the fracas when he heard the gunshots. The detective was screaming for help at that point. The store clerk grabbed the subject in a chokehold, kneed him in the ribs and tried to pull the subject away from the detective. The subject steadfastly maintained his grip on the gun.

The store clerk then called out to another civilian he knew who happened to be standing nearby. That civilian got involved and was able to wrestle the gun away. Eventually, the subject weakened and the civilians were able to pull him off of the detective. The subject survived the shooting. Officers who arrived at the scene moments after the incident was over indicated that the detective was dazed, bleeding from the head, looked pale and was not able to communicate. He could not hear out of his left ear and thought he had been shot. The detective suffered blunt trauma to his head and a broken wrist.

Investigation by law enforcement officers revealed that on the day before this incident, the subject had been taken to the Jackson Memorial Hospital Crisis Center by an officer with the City of Miami Police Department. The City of Miami Officer had responded to Camillus House because the subject was threatening people. Based on that

officer's observations, he determined that the subject was suffering from mental problems. Surprisingly, the subject was detained and transported without incident the day before. We are uncertain as to what transpired that resulted in the subject walking around on the streets the very next morning in a hospital gown.

The subject was charged with the attempted murder of the detective. Psychiatric evaluations conducted after his arrest concluded that he was incompetent to stand trial. Approximately two years later, his competency has been restored and his case was set for trial.

Incident #3

On Tuesday, May 28, 2002 at approximately 7:00 p.m., a 66-year-old man flagged down a Miami-Dade Police Department uniform patrol officer. He advised the officer that an unknown male had become irate, begun swinging a knife and had attacked him. The victim was placed in the police car and driven back to the scene (an apartment complex) where he identified his assailant.

The officer called out to the subject for him to stop walking. The subject cursed the officer and continued walking away. He pulled what appeared to be a knife from his waistband. Upon seeing the knife, the officer called for back-up. Several officers responded to the scene. The subject began yelling obscenities and profanity at the officers, all of whom were ordering him to drop his weapon. The subject was challenging the officers to shoot him as he waived his weapon in the air.

While facing the officers, he began backing away in an attempt to leave the area. The subject then began stabbing himself repeatedly while stating he could kill all the officers. In an attempt to disarm him, one officer pulled out his A.S.P. baton and tried to flank the subject to knock the weapon out of his hand. The subject cut off the officer's approach and threatened him with the weapon. One of the officers described the subject as acting "very, very crazy." The group of officers followed the subject for more than half a mile as he walked across a golf course near the apartment complex. The officers were in a semi-circle formation as they followed the subject with their weapons drawn.

At some point, the subject stopped and confronted the officers again with more name-calling and threats. The officers were able to determine at that point that the subject had an ice pick. The subject lunged at the officers in front of him and three of the officers fired, striking the subject in the chest, back and legs. He died on the scene. In addition to numerous gunshot wounds, the subject had forty-one (41) puncture type abrasions in the center of his chest area. A toxicology report revealed a blood alcohol level of .20 % (more than three times the legal limit) and a drug alprazolam, popularly known as Xanax. Many of the civilians who had contact with the subject on the day in question indicated that he had been acting strangely.

Use of a Taser in this situation could have saved the life of this subject.

Incident #4

On October 16, 2001, Miami-Dade Police Department officers were dispatched to an area in Northwest Miami-Dade. The call initially went out as an emergency disturbance. It was later upgraded to an assault between two females. Upon their arrival, the officers encountered an elderly woman (67 years old) in the front yard who indicated she had been assaulted by her niece (the subject) who lived in the residence with her. The subject's ten year old son called 911 as a result of the fight between his mother and great aunt. The aunt indicated to the officers that she wanted her niece removed from the residence.

As officers approached the front porch, the subject was standing inside the doorway with her hands behind her back. However, the subject came at her aunt with a pair of scissors raised over her head and tried to stab her. The subject grabbed her aunt by the throat, pinned her against the wall with one hand and attempted to stab her with the scissors with the other. As the officers yelled for the subject to drop the scissors, the aunt continued to struggle and dodge the subject's continued efforts to stab her. When the subject refused to drop the scissors, one of the officers fired twice, striking the subject in the abdomen and the hip. She survived her injuries.

Subsequent investigation and discussion with the subject's aunt revealed that the subject had just been released from the JMH Crisis Center and transported to the aunt's residence. The subject had a history of hearing voices and engaging in violent behavior. According to the aunt, the subject also abused drugs and alcohol. The subject admitted to officers that she heard voices telling her to kill and further explained that she has been hearing voices for years. She indicated that she never heard the officers telling her to drop the scissors.

The circumstances of this case required the officer to use deadly force to protect the aunt from death or serious bodily injury at the hands of her niece, the subject. This was another situation where a Taser could have been used to stun and disarm the subject.

Incident #5

On February 9, 2002, at about 10:20 a.m. a truck driver in the vicinity of the railroad tracks near 107th Avenue and Northwest 127th Street observed a bearded man wearing several layers of clothing. The subject was carrying three foot long, 2" x 2" board that he was swinging like a club. The board contained nails or spikes, which had been driven into the board in several areas.

The witness called the police. Because of confusion over jurisdiction, officers from both Hialeah Gardens and Miami-Dade County were dispatched to the scene. Upon arrival, the officers got a description and determined that the subject had gone into an overgrown, wooded area near the tracks. As they approached the area, the subject emerged and started walking towards them, still armed with the spike-and-nail encrusted board. The officers retreated and started walking backwards. They ordered the subject to drop the club.

Two officers decided to use Mace in an effort to stop the subject from advancing. The subject used a raincoat and jacket he had on to shield his face. Thus, the Mace was not effective. After ordering him again to drop the club, the subject turned and began to walk away. Officers followed at a distance. The subject walked behind a group of boxcars on the track. Officers pursued the subject on both sides of the boxcars. He continued to walk away in spite of commands to stop and drop to the club.

Eventually, the subject stopped, turned toward the officers and raised the club. He charged at the officers with the club. One of the officers slipped on the gravel next to the railroad tracks. As the subject got within 8 to 10 feet of the fallen officer, other officers began to fire. The subject fell with the club in his hand. He died at the scene. A homemade sheath and a long knife were in the subject's waistband. The entire incident lasted 20 – 30 minutes.

Investigation revealed that the subject was living in a couple of empty construction culverts nearby. Sharpened knives, spears, homemade crossbows and Mace were found in the subject's "residence." Several of the officers recalled during the incident that the subject was shouting that he was God. Workers in the area indicated that the subject had become a problem and that they had to shut down one of the rail lines that day because the subject was blocking the path of the train.

Incident #6

During the early morning hours of June 6, 2001, a 55-year old man with a history of mental illness was involved in an altercation at a cafeteria located near West Flagler Street and 12th Avenue in the City of Miami. He left the scene. The manager of the cafeteria flagged down two officers with the Miami Police Department ("MPD") and informed them that the man had threatened him with a knife. One of the uniformed officers knew the subject from prior incidents and knew him to be a "Baker Act." The officers saw the subject as he was walking away from the cafeteria and tried to get him to stop. He continued walking away while carrying an pen pocket knife with a 3 ¼ inch blade. Repeated commands in English and Spanish were give to the subject to drop the knife. He refused to do so. As a result, a call went out over the police radio advising officers that there was a "man walking northbound on Northwest 12th Avenue swinging a knife." Others recall the dispatch as a "Baker Act with a knife." A number of officers responded to this "walking chase" which proceeded north from Flagler Street, across the bridge to Northwest 12th Street.

As officers responded to the moving scene, a number of efforts were made to disarm the subject and take him into custody. Officers tried boxing the subject in with their patrol cars (he would roll over the top of their patrol cars), using pepper spray approximately five times (it had no apparent effect), giving voice commands through the public address system of the police cars (he continued to slash the knife at the officers, the windshields and the cars themselves), walking parallel to the subject to box him in (he continues walking with the knife), attempting to strike him with an A.S.P. baton to knock the knife out of his hand (the subject realized what was happening, turned toward the officer with the baton and made a stabbing motion with the knife), and attempting to pin him against a fence with one of the patrol cars (he rolled off the bumper and lunged at the driver's side window).

By the time the subject got to northwest 12th Street, there were approximately ten officers on foot, walking near and/or parallel to the subject, a number of police in marked cars with lights flashing, who were shouting commands. At one point, the subject lunged toward one of the officers who was walking near him. The officer fired repeatedly, striking the subject numerous times and causing his death. At the time of the shooting, there were more than fifteen officers in the vicinity, including a number of sergeants and a lieutenant. Many of the officers who responded to the dispatch knew the subject and knew that he "was a little bit crazy, wacko."

A review of the subject's background revealed a number of arrests for Aggravated Assault on police officers, as well as resisting Arrest With Violence. He was usually sent to a mental health program from the jail and at one point was found by the court to be incompetent.

This last incident took an incredibly long time to come to its violent conclusion. The time involved also included waiting for the 12th Avenue bridge to come down before the subject could continue his northbound walk up 12th Avenue. Obviously, a Taser in the hands of either one of these officers could have safely and effectively ended this pursuit long before its tragic end. Predictably, officers recalled that the subject grew more agitated as the "show of force" increased.

The failure to have effective police treatment plans in place in our community contributed to the likelihood of this encounter. The failure to have a Crisis Intervention Team member with a less-than-lethal weapon contributed to the death. We hope through this Grand Jury Report that we have raised such an alarm that there will be no repeats of the predictable, avoidable scenarios described herein.

Appendix C

Aventura Police Department Use of Force
April 1, 1997 to September 15, 2004

Total Use of Force Incidents – 131
Non-Taser -55
Taser-76

Non Taser Incidents
30% resulted in injuries to officers (17 officers injured)
45% resulted in injuries to offenders (25 offenders injured)

Taser Incidents
13% resulted in injuries to officers (10 officers injured) 41% decrease
13% resulted in injuries to offenders (10 offenders injured) 60% decrease

We strongly believe that under these circumstances, lives can be saved (and as was reported to us, lives have been saved) as a result of having a "less than lethal weapon" to use when the conflict is spiraling out of control or alternatively, becomes too dangerous for the officer or other citizens.

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
JOHN MOLINA and ULY S. GRANT	Murder First Degree	True Bill
CALVIN P. MOORE	Murder First Degree	No True Bill
DANIEL ZEBULON DUNCAN	Murder First Degree Firearm/Weapon/Possession by Convicted Felon/Delinquent Aggravated Assault	True Bill
DAVID DWAYNE BROWN, also known as "DABO", and COLLIES JASPER ROBINSON	Murder First Degree (A&B) Murder First Degree (A & B) Murder First Degree / Attempt (A & B) Firearm / Concealed Weapon / Possession by Violent Career Criminal (A) Firearm/Use, Display While Committing a Felony (A) Firearm / Weapon / Possession by Convicted Felon (B) Firearm/Use, Display While Committing a Felony (B)	True Bill
ANTWANN L. ROGERS	Murder First Degree Firearm/Weapon/Posn by Convicted Felon/ Delinquent Robbery/Armed/Attempt	True Bill
VICTOR GUZMAN	Murder First Degree	True Bill
DEMETRIUS ANDRE COOPER, also known as "MIMI"	Murder First Degree Murder First Degree Firearm/Possession by Convicted Felon Firearm/Use, Display While Committing Felony	True Bill
THOMAS MOBLEY, JR.	Murder First Degree Burglary / With Assault or Battery Child Abuse / No Great Bodily Harm	True Bill
ISRAEL MEDINA ROMAN	Murder First Degree Arson First Degree	True Bill
EMMANUEL ETIENNE	Murder First Degree Burglary / With Assault or Battery/Armed	True Bill
ANTHONY EROMOSE BANMAH, (A) OKEFFE OMAR LEWIS, (B) and JASON ALPHONSO NEWBOLD (C)	Murder First Degree Murder First Degree Robbery / Armed/ Firearm Firearm / Possession by Convicted Felon (A only) Firearm / Possession by Convicted Felon (B only) Firearm / Possession by Convicted Felon (C only)	True Bill

NAME OF DEFENDANT	CHARGE		INDICTMENT RETURNED
RAMON MACHIN GONZALEZ, also known as RAMON GONZALEZ MACHIN	Murder First Degree Arson First Degree Stalking / Aggravated	True Bill	07/14/04
ALONSO VALENCIA	Murder First Degree	True Bill	07/14/04
RAFAEL ENRIQUE GIL (A), ANDY HERNANDEZ (B), ALEX ABREU (C), CONTRELL WORSLEY (D)	Murder First Degree Robbery / Carjacking / Armed		True Bill
GIVIOR JEAN (A) and JAMES PARET (B)	Murder First Degree Murder First Degree / Conspiracy		True Bill
ARIEL HERNANDEZ	Murder First Degree Sexual Battery / Deadly Weapon or Serious Injury		True Bill
DERRICK BROCKINGTON	Murder First Degree Murder First Degree Murder / Premeditated / Attempt		True Bill
LARRY ROBERT WILLIAMS	Murder First Degree Deadly Missile/Shoot, Throw		True Bill
LEWIS ANTHONY DRAYTON	Murder First Degree Arson First Degree Burn to Defraud Insurer		True Bill
ALEXANDER TRAVIS BELL	Murder First Degree		True Bill
GARVEY ALEXANDER BURROWS (A) TEDDRICK ALLEN (B)	Murder First Degree		True Bill
JOSEPH ALLEN MORGAN, also known as "BULLET", (A), DAVID RUSSELL SUTTON, also known as "THE KID" (B), and DAVID LASH HANNA (C)	Murder First Degree Robbery / Armed / Weapon		True Bill
CHARLES WILLIAM CARTER	Murder First Degree Robbery/Armed/Attempt Firearm/Weapon/Posn by Convicted Felon/Delinquent		True Bill
OVIDIO BORROTO	Murder First Degree Robbery/Armed/Attempt/Mask Con Wea/Felon/Mask Murder Second Degree/Felony		True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
COREY SMITH, also known as "BUBBA" (A), LATRAVIS GALLASHAW, also known as 'TRAV" (B), ANTONIO GODFREY, also known as "GARHEAD" (C), JULIUS STEVENS, also known as "JUDOG" (D), ERIC STOKES, also known as "ERIC STEWART, Also known as "CRAZY E" (E), JEAN HENRY, also known as 'HAITIAN JEAN" (F), EDDIE HARRIS, also known as "EDDIE BO" (G), and CHAZRE DAVIS, also known as "CRIP" (H)	I. RICO/Conspiracy (A-H) II. Racketeering/RICO (A-F) III. Cannabis/Conspiracy to Traffick (A,B,C,D,E.F) IV. Cocaine/Conspiracy to Traffick (A,B,C,D,E.F) V. Conspiracy to Commit First Degree Murder (A) VI. First Degree Murder (A) VII. First Degree Murder (A,C) VIII. Murder/Premeditated /Attempt (C) IX. Conspiracy to Commit First Degree Murder (A,H) X. First Degree Murder (A,H) XI. Conspiracy to Commit First Degree Murder (A,D,E,F) XII. First Degree Murder (A,D,E,F) XIII. Murder Second Degree/Firearm (A,B) XIV. First Degree Murder (B) XV. Conspiracy to Commit First Degree Murder (A,D,E,F,G) XVI. First Degree Murder (A,D,E,F,G) XVII. First Degree Murder/Solicit (B)	True Bill
GUSTAVO JAVIER GUERRA	Murder First Degree Robbery/Strongarm	True Bill
ALBERTO F. REAL, also known as ALBERTO FALCON REAL, also known as FRANCISCO SANCHEZ HERNANDEZ, also known as ALBERTO REAL, also known as "ALBERTO THE BARBER"	Murder First Degree Firearm/Weapon/Possession by Convicted Felon/ Delinquent	True Bill
JULES DUCAS	Murder Fist Degree Murder/Premeditated/Attempt Attempted Felony Murder Robbery/Armed/Firearm or Deadly Weapon Firearm/Weapon/Posn by Convicted Felon/ Delinquent	True Bill
MELISSA M. NADER	Murder First Degree Child Abuse/Aggravated/Great Bodily Harm/Torture	True Bill
CAMERON COTTON	Murder First Degree Murder/Premeditated/Attempt/Firearm Deadly Missile/Shooting, Throwing Firearm/Possession by Minor	True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
COREY LAMONT EDWARDS (A), RICHARD BERNARD LATSON (B), CHARLIE THOMAS (C) and DAVON MONTRELL FRANCIS (D)	Murder First Degree Murder/Premeditated/Attempt/Firearm Attempted Felony Murder/Deadly Weapon Murder/Premeditated/Attempt/Firearm Attempted Felony Murder/Deadly Weapon Robbery/Armed/Firearm Assault/Aggravated/With a Firearm	True Bill
RICHARD BERNARD LATSON (A) and DAVON MONTRELL FRANCIS (B)	Murder First Degree Robbery/Armed/Firearm	True Bill
BRANDI NICOLE SMITH (A) and GERARD WILLIAMS (B)	Murder First Degree Kidnapping / With a Weapon Robbery/Armed/Firearm Arson Second Degree Firearm/Use, Display While Committing a Felony ("B" only) Firearm/Possession by Convicted Felon ("B" only)	True Bill
DERRICK LAMAR EVANS (A) and ERIC LASCHON JOHNSON (B)	Murder First Degree Burglary/With Assault or Battery Robbery/Strong Arm	True Bill
RUBEN MALDONADO	Murder First Degree	True Bill
CESAR EDUARDO RUANO, JR.	Murder First Degree Burglary/With Assault or Battery Armed	True Bill
JOSE LEONEL LONDONO	Murder First Degree Burglary/With Assault or Battery/Armed	True Bill

ACKNOWLEDGMENTS

As the selected group for the Miami-Dade County Grand Jury for the Spring Term of 2004, we would like to thank the Honorable Judge Judith L. Kreeger and Miami-Dade County State Attorney Katherine Fernandez Rundle.

We sincerely want to thank Chief Assistant State Attorney Don Horn, our legal advisor, for his expert guidance and broad knowledge. He has personally inspired our belief, educated and proctored us in the criminal justice system.

We also take this opportunity to thank Rose Anne Dare, Administrative Assistant, and Nelido Gil, Bailiff, who graciously attended to the myriad of administrative details of the Grand Jury.

Our Grand Jury's term was filled with representatives from our multi-ethnic community. Our six month term proved to be a most memorable and worthwhile experience for all of us that were chosen to serve our community.

Respectfully submitted,

Jose A. Martinez, Foreperson
Miami-Dade County Grand Jury
Spring Term 2004

ATTEST:

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Lorraine Duarte
Clerk

Date: January 11, 2005