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. 2009

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FILED

February 8, 2010

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I N D E X

MENTAL HEALTH ISSUES REVISITED

I. INTRODUCTION

Two years ago, the 2007 Fall Term Grand Jury (the "2007 Grand Jury") released a report entitled Shifting the Focus on Treating Mental Illness: A Common Sense Approach. A recommendation included in that report was for a successor grand jury to conduct a follow-up investigation to determine whether the suggestions included in the report were implemented and if so, whether any improvements resulted there from. This Grand Jury decided to accept that assignment.

A quick review of the entire list of recommendations reveals that executing many of them requires legislative action, an infusion of cash, and increased funding by federal, state and local governments. We agree with our predecessors that many of the recommendations included in their 2007 report ***will save money*** and we believe making those changes ***will also save lives***. That report was released on the eve of a significant increase in unemployment, a nationwide foreclosure crisis and an economic recession. In light of the present economic climate (double digit unemployment from the worst recession since the Great Depression of the 1930s) we understand that many of those recommendations could not be implemented then and cannot be implemented now. Nevertheless, we are pleased to report that even in these tough economic times some changes have been made. Unfortunately, many of the recommendations have not been put into effect.

The witnesses who appeared before us consistently opined that money (funding), or more appropriately a lack of funding, was the primary reason many of the changes have not been made. In light of that reality, instead of conducting a top-to-bottom analysis of what recommendations were or were not adopted, we decided to focus on some major issues that were brought to our attention during the course of our investigation. Not surprisingly, several of these issues relate to recommendations included in the prior report. Due to their importance and potential cost savings, once funding becomes available, we believe the specific recommendations from the prior report that we have highlighted herein should receive priority.

A brief description of the system in place in Florida that allows for the involuntary inpatient commitment of persons suffering from mental illness is provided below.

II. FLORIDA'S BAKER ACT (CIVIL INVOLUNTARY COMMITMENT) PROCESS

In Florida, under certain circumstances, persons believed to be suffering from severe mental illness may be involuntarily committed to a treatment facility or hospital and forced to receive medication and emergency mental health treatment. Approximately half the time, this involuntary commitment process is initiated by police officers who come into contact with persons in our community who appear to be experiencing a psychiatric crisis due to mental illness. If the behavior exhibited by such a person leads the officers to believe that there is a substantial likelihood that in the near future the individual will inflict serious bodily harm on themselves or another person, the law authorizes the officer to forcibly or otherwise take custody of the individual and transport that person to a Crisis Stabilization Unit (CSU)[1] or other appropriate facility for psychiatric evaluation and examination.

Similarly, persons suffering from mental illness and through neglect, pose a real and present threat of substantial harm to their well-being may also be forcibly taken to a hospital or other facility for emergency treatment. Once a patient is taken to such a facility against his will, a series of events are put in motion that may or may not result in the patient being involuntarily committed for a longer time to a mental hospital or other facility.

This temporary, forced mental health treatment and evaluation process, with law enforcement, mental health professionals and/or court involvement, is commonly referred

[1] The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay and shall be limited in size to a maximum of 30 beds. Florida Statute 394.875 (1)(a)

to as Florida's Baker Act process. The criteria for involuntary inpatient placement in Florida are found in Florida Statute 394.467 (1):

> (1) CRITERIA - A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:
>
> (a) He or she is mentally ill and because of his or her mental illness:
>
> 1. a. He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
>
> b. He or she is unable to determine for himself or herself whether placement is necessary; and
>
> 2. a. He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
>
> b. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
>
> (b) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

Other provisions of that statute require that persons taken to CSUs or receiving facilities must be evaluated by a psychiatrist within 72 hours of their arrival at the facility.[2] If the psychiatrist finds that a patient meets the criteria for involuntary commitment the administrator at the facility holding the patient ***shall*** file a petition for involuntary inpatient placement with the court.[3] Once the notice provisions of the statute

[2] A patient may be retained by a receiving facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of a receiving facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s.394.4599. The recommendation must be supported by the opinion of a psychiatrist . . .or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met… Florida Statute 394.467 (2).

[3] The petition is filed in the court in the county where the patient is located. Florida Statute 394.467 (3).

have been complied with[4] and an attorney has been appointed for the patient[5] a hearing on involuntary placement (Baker Act Hearing) must be held within 5 days in the county where the patient is located.[6] At that hearing the court determines whether the patient meets the criteria for involuntary placement. The statute specifically provides that one of the professionals who executed the involuntary inpatient placement certificate shall be a witness at the Baker Act Hearing.[7]

III. PREMATURE RELEASE OF PATIENTS FROM CSUs AND RECEIVING FACILITIES

One of the major concerns we have, and one addressed before by a Miami-Dade County Grand Jury, involves ***suspicions*** that doctors may be inappropriately (and prematurely) discharging patients from Crisis Stabilization Units and receiving facilities[8] as a means of avoiding the doctors' participation in the Baker Act hearings. Our suspicion is based primarily on three factors: 1) an alleged comment from a doctor working at one of the facilities; 2) anecdotal testimony, observations and interactions by parties involved in the civil commitment hearings; and 3) data provided by the CSUs to the Louis de la Parte Florida Mental Health Institute Department of Mental Health Law & Policy, Policy and Services Research Data Center (hereinafter, the Baker Act Reporting Center).[9] We will address each of these below.

A. The Comment

As reflected in the Fall Term 2007 Grand Jury Report, a witness who appeared before that grand jury testified about a statement made by a doctor working at a CSU.

[4] The clerk of the court provides copies to DCF, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located. Id.

[5] Within 1 court working day after the filing of a petition the court shall appoint the public defender to represent the person who is the subject of the petition. Florida Statute 394.467 (4).

[6] The court shall hold the hearing on involuntary inpatient placement within 5 days, unless a continuance is granted. Florida Statute 394.467 (6).

[7] Id.

[8] Receiving facilities that obtain contracted funds from the Florida Department of Children & Families (DCF) for Baker Act services are considered "public." Most public receiving facilities are licensed as "crisis stabilization units" or CSUs. Facilities not receiving DCF funds are considered "private." Therefore, the terms "receiving facility" and CSU are not interchangeable. All CSUs are receiving facilities but not all receiving facilities are CSUs.

[9] The Baker Act Reporting Center serves as the repository of all involuntary examination initiation forms and court orders for involuntary inpatient placement and involuntary outpatient placement, which are required to be sent by all receiving facilities to the Florida Agency for Health Care Administration, also known as AHCA. Id. at p. 3.

Apparently, the doctor worked at a facility that was some distance away from Jackson Memorial Hospital, the location where the civil commitment hearings are conducted. The quote, "Why don't you come and hold the hearings here, then we won't be discharging the clients" contains a clear implication that patients who "meet criteria" and should probably be committed pursuant to the Baker Act are instead being discharged. Our conclusion is bolstered by other testimony.

B. The Anecdotal Statements

Due to our overwhelming concern about this issue, we discussed it with a number of the witnesses who appeared before us. Most of those witnesses have been involved with mental health issues for many years. They know the system, the facilities and the doctors who work at the CSUs. Similarly, many of those doctors have also worked for years treating mentally ill patients at such facilities. Surprisingly, grand jury witnesses advised that some of these doctors have **never** participated in a Baker Act hearing. This anecdotal evidence defies logic.

These doctors examine, treat and diagnose persons who are taken to CSUs because they are in crisis and exhibiting potentially dangerous behavior. The Grand Jury does not believe that all of the patients taken to certain facilities either voluntarily agree to treatment or are miraculously treated, cured and released within seventy-two (72) hours of their arrival at the CSU or receiving facility.[10] Instead, we believe there may be some credence to the sentiment expressed in the comment of the unnamed doctor. It appears that doctors may be discharging patients prematurely and inappropriately from certain facilities. Our review of data collected by the Baker Act Reporting Center supports that conclusion.

C. The Data on Repeat Involuntary Examinations

Receiving facilities are required to send to the Baker Act Reporting Center, a copy of every involuntary examination initiation form and copies of all court orders for involuntary inpatient and involuntary outpatient placement. These forms and orders are

[10] Attached as Exhibit 1 to this report is a Baker Act Flow Chart. This document, set forth in the State of Florida Department of Children & Families, Baker Act Handbook and User Reference Guide, is an updated version of a document provided to us by one of the witnesses to give us a snapshot of the entire commitment process. The grand jury found it helpful, and we have included it with this report.

reviewed by the Baker Act Reporting Center. This information, as well as other data about Baker Acts in Florida, is compiled in an annual report. The most recent report available is the, 2007, The Florida Mental Health Act (The Baker Act) Report (2007 Baker Act Report). Our review of certain data set forth in that report supports our belief that patients in need of psychiatric treatment are being prematurely released from CSUs and receiving facilities.

The Baker Act Reporting Center received forms reflecting that, for 2007, there were 83,629 people who experienced 122,454 Baker Act examinations.[11] Of that total number, the data collected reveal that 68,461 individuals (representing **81.88%**) had ***only one*** (1) involuntary exam within a two-year period. Another 9,465 individuals (representing **11.32%**) had ***only two*** Baker Act examinations. These two groups (totaling 77,926 patients) account for more than 93% of all of the Baker Act examinations tallied in the report. Our focus here is on the almost 5,000 remaining persons who had many more such examinations.

Data provided in the Baker Act 2007 Annual Report reflects that many persons in Florida had an extraordinary number of examinations within the same two year time period. One person in this state had thirty-five (35) involuntary examinations. One had thirty (30) and yet another had twenty-eight (28). Two persons had twenty-one (21) exams each. One person had nineteen (19) involuntary exams and two others had eighteen (18), all within a 24 month period.[12] The 2007 Baker Act Report does not identify the counties where these individuals are receiving their repeated examinations. However, the fact that ***eight persons*** (representing less than one one-hundredth of a percent of all persons examined) had a combined ***190 involuntary examinations*** within a two-year period (averaging one exam for each person every month) is a strong indication that the system is not being properly administered as to these individuals.

D. Data Reveals Increased Involuntary Examinations at Certain Facilities

Various tables in the 2007 Baker Act Report provide data that is specific to every CSU and receiving facility in the State of Florida. Information not previously reported in

[11] The Florida Mental Health Act (Baker Act) 2007 Annual Report, p. 2
[12] The Florida Mental Health Act (Baker Act) 2007 Annual Report, p. 11.

annual reports of Baker Act data includes statistics of involuntary examinations for each county and percentage increases / decreases at specific facilities from one year to the next. Our review of the data reveals that facilities that are located furthest away from the site of the Baker Act hearings have some of the highest percentage increases of involuntary examinations in the entire county.

One of the critical components missing from the Baker Act Report is the number of forms received for involuntary ***inpatient placement*** in relation to the number of ***involuntary examinations*** per facility. The reason for this shortcoming is facilities are not sending copies of involuntary inpatient placement orders to the Baker Act Reporting Center.[13] Extensive efforts to increase data submission compliance in this area have not been fruitful.[14]

We believe having specific knowledge of this correlation of numbers (number of involuntary examinations to number of involuntary placements) is critical to getting a clearer picture of the treatment and the effectiveness of treatment at each facility. In that regard, we recommend that a sanction be imposed against facilities that consistently fail to send the involuntary inpatient placement orders to the Reporting Center.[15]

As the quality of inpatient placement data is poor, we are unable to determine the number of persons who were actually involuntarily committed out of the 77,926 referred to above.[16] "It is also important to note that some individuals who experience a Baker Act examination are not admitted. Those admitted may be released, may be subject to additional involuntary treatment (via an involuntary placement order), or may remain for further treatment on a voluntary basis."[17] On one end of the spectrum, **93%** of all the persons represented in the 2007 Baker Act Report (those who only had one or two examinations) were either, 1) found to not meet criteria, 2) met criteria and voluntarily agreed to treatment, or 3) met criteria, attended a Baker Act hearing and were

[13] The Florida Mental Health Act (Baker Act) 2007 Annual Report, p. 32.
[14] Id.
[15] A recommendation in the 2007 Grand Jury Report was consistent with a recommendation made by the Baker Act Reporting Center in its 2006 **and** 2007 Reports. Instead of requiring that the facilities send in the orders, have the Clerks of Court submit the involuntary inpatient placement orders. See 2006 Baker Act Report, p. 5; 2007 Baker Act Report, p. 32. We support and encourage this change.
[16] The Florida Mental Health Act (Baker Act) 2007 Annual Report, p. 32.
[17] Id., at p. 5.

involuntarily committed or released. For whatever combination of results that ensued, the system and/or the treatment worked to keep 77,926 individuals from continually recycling through the state's mental health treatment facilities.

On the other end of the spectrum, something is clearly not working. When certain individuals are having involuntary examinations conducted on average of once a month, the most logical conclusions we can reach are persons who meet criteria are not receiving appropriate medical treatment, they are not having petitions for involuntary commitment filed against them, and/or they are being released inappropriately. There is one other factor that militates in favor of this latter conclusion.

In 2006, law enforcement officials initiated almost half (49%) of all involuntary exams in the state. At 48%, mental health professionals initiated a slightly smaller number of such exams.[18] Surprisingly, the percentages were identical for each group in 2007.[19] The large number of repeat examinations at CSUs and receiving facilities could suggest that 1) law enforcement officers are failing to appropriately identify persons who are meeting criteria for involuntary commitment, 2) mental health practitioners are misdiagnosing the persons presented at their facilities, or 3) the mental health practitioners are releasing patients prematurely.

As to law enforcement officers, many of the mentally ill patients in crisis end up at CSUs or receiving facilities as a result of citizens calling the police to report that someone is engaging in inappropriate or dangerous conduct. In Miami-Dade County, many of the officers responding to these calls are not regular patrol officers, but instead, are Crisis Intervention Trained (CIT) officers.[20] CIT officers have received special training conducted by psychiatrists and other mental healthcare providers such that they become adept at identifying persons who may be suffering from mental illness and are in crisis. For this reason, we do not believe that officers are transporting people who are not experiencing some severe mental episode.

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[18]The Florida Mental Health Act (Baker Act) 2006 Annual Report, p. 2.
[19]The Florida Mental Health Act (Baker Act) 2007 Annual Report, p. 2.
[20] More information about Crisis Intervention Training and the creation of this program in Miami-Dade County can be found in the Spring Term 2004 Grand Jury Report entitled Mental Illness and the Criminal Justice System: A Recipe for Disaster / A Prescription for Improvement. That report can be found online at http://www.miamisao.com/publications/grandjury reports.htm.

E. Follow The Money (Or Lack Thereof)

Hospitals and treatment facilities are businesses. Often times, the goals of healing and profit-making conflict, and too often when that happens, money wins. A description of this process follows.

When law enforcement officers are involved in transporting persons in psychiatric crisis, the law requires that the officers take those persons to the nearest CSU or receiving facility. Regardless of the type facility, the obligation to evaluate the patient and conduct an involuntary examination remains. Many such patients taken to private hospitals do not have insurance. Many are entitled to Medicare or Medicaid benefits and some may even have insurance. Some insurance companies do not provide coverage for mental illness. Many of those that do, provide a strictly limited number of hospital stays (per year) for this disease. Accordingly, many times there simply is no ability for the hospital to receive payment for treating such a patient. Regardless of the availability of private or federal insurance, the law obligates every hospital to treat and stabilize any patient who arrives in critical condition. Once the patient is stabilized, several options become available to the hospital.

If a patient is suffering from mental illness and has no insurance coverage, the hospitals have the option of transferring the patient to a public facility. The transfer is only an option when there is an available bed at a public treatment facility. If the patient has been examined and still meets the criteria for involuntary placement, the doctor at the hospital **should** file a petition for a Baker Act Hearing or attempt to get the patient to agree to voluntarily receive treatment. Either of those options creates a conflict for the hospitals. If they succeed in getting the patient to agree to treatment, they will be providing such treatment for free. As they have no way of knowing how long it will take for the treatment to be effective, this could prove to be a very costly decision for the hospital.

Even for a patient who continues to meet the criteria for involuntary commitment, there are several available options. After stabilizing the patient, one could falsely claim that he no longer meets criteria and discharge him. Alternatively, the doctor could sign a petition for involuntary commitment. That act starts the 5-day Baker Act hearing clock

running. Once the hearing is set, the hospital has another decision to make. They can participate in the hearing, which will require them to provide transportation for the patient and an attendant. The doctor who initially examined the patient will have to attend and testify at the hearing. Again, these services are being provided by the hospital to someone who cannot pay and who has no insurance coverage. It would be admirable if the hospitals faced with this option would do what was in the best interest of the patient, namely, proceed with the hearing and let the court determine whether the patient should be involuntarily committed.

Instead, the evidence and data indicates that many of the hospitals do not follow through with the Baker Act hearings. Very often, on the day before the hearing (or sometimes even on the day of the hearing) a determination is made that the patient no longer meets criteria and is discharged from the hospital. That simple act stops the meter from running and ensures that the hospital will not incur any additional medical expenses for that particular patient or for that particular stay in the hospital. We are pleased to hear that the hospitals have improved in this area.

Nevertheless, as to the hospitals, we recommend that DCF be alert for repeat involuntary examinations without any attendant participation in Baker Act hearings. To the extent they can, we recommend that DCF conduct investigations and impose sanctions for repeat violators.

F. Mandatory Discharge Plans

Florida's Department of Children and Family Services requires that anyone being released from a CSU or receiving facility must have a discharge plan in place. The reason for this is obvious. If there is a plan in place and services are made available to the patient, there is a decreased likelihood that the patient will be in crisis in the near future. For that reason DCF requires that the discharge plan for every patient must have at least these five components:

1) medication;
2) housing;
3) transportation;
4) assignment of and appointment with a case manager; and

5) a scheduled follow-up appointment with a psychiatrist.

If a patient is being discharged and there is such a plan in place, there is no reason for that patient to be in psychiatric crisis a mere thirty (30) days later. We encourage DCF to do all it can to ensure that CSUs and receiving facilities are providing appropriate and comprehensive discharge plans for all of its clients. Such increased oversight should also serve to reduce the number of repeat involuntary examinations.

Every visit to a CSU or receiving facility involves an expenditure of manpower in transporting these individuals to a facility and also taxes the limited resources of the mental health care providers involved in the examination, diagnosis and treatment of those persons. If these repeat examinations are being conducted on patients who would meet the criteria for forced treatment in connection with an involuntary commitment, then we are wasting time, effort, money and resources by failing to take more aggressive steps to stop this revolving door. If these recidivist patients were able to obtain appropriate support, then the number of involuntary examinations should drop significantly. The system would be targeting the persons who are using the most resources and utilizing the scant available bed space. This same argument also applies to persons suffering from mental illness who meet the criteria for involuntary **outpatient** treatment.[21]

G. A Plan to Address Repeat Baker Act Hearings

One result of persons having numerous involuntary examinations is the possibility that they will also have numerous Baker Act hearings. This has become such a concern here that the State Attorney's Office for the 11th Judicial Circuit (Miami-Dade County), working in conjunction with DCF, has a protocol in place now to identify and address specific problems with persons who are not just having repeat involuntary examinations, but who have repeated Baker Act hearings scheduled. The Assistant State Attorney assigned to the Baker Acts monitors the number of petitions filed against each individual within a 12-month period. If five (5) petitions are filed within that time frame, notice is sent to DCF to launch an investigation. A DCF team is sent in to review the patient's charts and files and to determine whether a statutorily required discharge plan was in

[21] A more detailed discussion of this issue and Assisted Outpatient Treatment is set forth herein at page 18.

place when the patient was released. The investigators also try to determine whether other Baker Act procedures and agency policies and guidelines were followed.

DCF has the authority to cite facilities that are not in compliance and also has the option to pull the designation that allows the CSU or receiving facility to operate. As reported to us, the majority of the violators are the private receiving facilities. Pulling a license is a **severe** punishment and one that is rarely used, in part, due to the overall shortage of available beds in our community. However, inasmuch as the failure to abide by the policies could result in the loss of life, we believe such a sanction would be appropriate for facilities repeatedly found in violation.

H. A Plan to Address Repeat Involuntary Examinations

Due to our concerns regarding these recidivist involuntary examinations, we recommend that DCF investigate the circumstances for all individuals who have more than ten examinations within a 12-month period. The investigation should include a review of the practices of the facility that is performing the examinations, particularly if no petitions are being initiated for involuntary inpatient placement. Based on the results of said investigation, DCF may determine whether it may be appropriate to remove that entity from the list of approved facilities.[22]

Similar to the collaborative effort in place between DCF and the State Attorney's Office to deal with recidivist Baker Act hearing patients, we believe there should be a system in place that provides notice to DCF wherever any individual receives five (5) or more involuntary examinations within a twelve-month period. Once DCF receives such notice, a team should be sent in to review the practices and procedures of the facility as well as to inspect the patient files. All discharge plans for each specific recidivist patient should be examined to ensure they are in compliance with DCF guidelines. Any deficiencies in any of these areas must be dealt with immediately.

We recommend that DCF institute a "step" disciplinary process for such offenders. "Hitting them in their pocketbook" is often a way of getting someone's attention and obtaining compliance. The Grand Jury was informed that the CSUs receive a certain amount of money for each bed occupied in the facility. If there was a two-tier

[22] The italicized portions in various sections of this report are the actual recommendations from the Fall Term 2007 Grand Jury Report.

system in place for payment, one for those in compliance and the other for those who were violators, there would be a greater incentive for the facilities to do all that was needed to be done for this population.

For repeat violators, we believe DCF should seriously consider non-renewal of the licenses for those facilities. We understand that there is a present shortage of bed space and facilities involved in treating this population of patients. Having a facility that is serving as a revolving door is probably worse than having no facility at all. If the offending facility did not have a license, then the patients would be taken to a different location, preferably one that was providing appropriate treatment and did not have such a high number of recidivist patients. Alternatively, maybe facilities that are operating appropriately could be authorized to open another facility or be granted additional beds. Either way, DCF needs to examine this issue and come up with a way to stop this waste of resources and money.

IV. THE LOCATION OF THE BAKER ACT HEARINGS

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

One of the other areas that was of great concern to us involved the "logistics" of the Baker Act hearings process. The Florida Statute governing Baker Acts provides that "the hearing shall be held in the county where the patient is located and shall be as convenient **to the patient** as may be consistent with orderly procedure. . ."(emphasis added)[23] As large as Miami-Dade County is, hearings are held in only one location, Jackson Memorial Hospital (JMH). JMH is in the Civic Center area, a short distance north and west of downtown Miami. We share the concerns of our predecessors, that having only one location for the hearings in a county this size is ill-advised. We believe this situation contributes to the failure of some doctors to attend and/or participate in the hearings. In short, the long-distance travel from the nether regions, the time involved with such travel and the hours spent waiting for the hearings to begin are impediments to

[23] Florida Statute 394.467 (6)(a)1.

the efficient administration of the Baker Act, to protect the needy, as well as the rights of those who are wrongfully held for emergency mental health treatment.

A. Video Teleconferencing

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

Conducting Baker Act hearings via video teleconferencing was suggested as a possible remedy for witnesses to avoid the hours of travel time involved in getting to and from the hearing and the time spent waiting to testify. Several witnesses who appeared before us advised that court staff and administrators conducted such a demonstration at the courthouse to see if the technology would work. The consensus opinion was it was unworkable. We are uncertain as to whether this was simply an equipment problem or a logistics problem.

As to logistics, witnesses raised several issues that could make use of the video technology impractical. One of the justifications offered was that switching to such technology would allow the court to receive the testimony of distant witnesses. Primarily, these "distant" witnesses would have been the doctors employed at the CSUs and other receiving facilities. Therein lies one of the logistical problems. The doctors routinely use patient records when they testify. If medical records from the file need to be reviewed or introduced as evidence, there is no mechanism in place to accomplish that when the documents are in one location and the court is in another. Further, Florida law provides that any attorney representing the patient shall have access to the patient, witnesses, **and records** relevant to the presentation of the patient's case and shall represent the interests of the patient. . ." (emphasis added)[24] regardless of the source of payment to the attorney. The attorneys for the patients often use the medical records or need the records to conduct cross-examination of the doctors. The failure to have the doctor and the records at the location of the hearing presents a problem for which we have not been able to create a solution. Instead, we have come up with an alternative.

B. Use of the Branch Courts for Baker Act Hearings

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

[24] Florida Statute 394.467 (4)

For more than twenty (20) years Miami-Dade County has had only one General Master handling Baker Act Hearings. As previously indicated, the hearings are only held in one location and only held on certain days of the week. Our predecessor grand jury recommended that the Chief Judge appoint another General Master. Since the release of that report one Chief Judge has stepped down from the position and another one has been elected. However, we still do not have another General Master to assist in handling these hearings. Again, we understand that there have been serious budget cuts within recent years and although those cuts did not result in any judges being cut they did result in the loss of a number of jobs for other court personnel and assistants. The state's budget deficits and legislatively imposed budget cuts have also ensured that there is no additional funding to support an increase in the number of judges or general masters. Reports on our state's economic future lead us to believe that this situation will not be changing for at least another couple years. In light of that reality we choose to modify this recommendation made by the 2007 Fall Term Grand Jury.

The recommendation above included a suggestion that Baker Act hearings be held at branch courts. The branch courts, just like the CSUs and receiving facilities, are spread out in various locations throughout the county. The law in Florida requires that Baker Act hearings be held in the county where the patient is located and further provides that the location of "the hearing shall be . . . ***as convenient to the patient*** as may be consistent with orderly procedure."[25] From our perspective, hearing locations that are closer to the treatment facilities, and which are already designed for conducting hearings are convenient to the patient (and we submit, are **more** convenient) than the process presently in place.

For instance, patients at some outlying facilities who are scheduled for Baker Act hearings pass **several** branch courts while traveling from their CSU or receiving facility to the Crisis Center located at JMH. An administrator at a CSU or receiving facility who files a petition for involuntary inpatient commitment is responsible for ensuring that the patient is present for the hearing. In that regard, the facility provides transportation for the patient and must also send an attendant or guard who is responsible for securing and

[25] Florida Statute 394.467 (6)(a)1.

controlling the patient during the trip and at the hearing. The statute further provides that one of the professionals who executed the involuntary inpatient placement certificate shall be a witness at the hearing.[26] Altogether, filing a petition for involuntary inpatient commitment can result in from 2-4 persons from one facility taking several hours out of their day just to get back and forth from the hearing. Although not covered by the statute, choosing to conduct the hearings at the branch courts will be more convenient for all of the other persons forced to leave their CSU or receiving facility to travel to the location of the Baker Act hearing.

C. Judges Assigned to the Branch Courts Can Conduct Baker Act Hearings

Florida Statute 394.467 (6)(a)2 provides that the court may appoint a general or special magistrate to preside at the hearing. Presumably, judges normally preside at such hearings. We interpret the appointment option for a special magistrate to be "in lieu" of having a judge preside over the hearing. Judges and representatives from the clerk's office are already assigned to each of the branch courts and those buildings are designed for conducting hearings. We believe that Baker Act hearings can be scheduled at specific branch courts and the judges (who are already assigned to those courts) can preside over those hearings. This option is more feasible than appointing additional magistrates in that it utilizes existing resources and can be implemented now.

Further, it is preferable to waiting for an economic turnaround that will then allow the Chief Judge to seek more funding such that an additional magistrate can be hired. As to the other parties who participate in these hearings, the Public Defender's Office already uses four attorneys to represent patients in Baker Act hearings. They should be able to staff Baker Act hearings at the branch courts without any increase in staffing. On the other hand, the State Attorney's Office, which only has one attorney assigned, would have to devote more resources to this area for this option to work. The statute provides that scheduling of the hearings is to be done "consistent with orderly procedure." This proposed change should not create an issue in that regard. Moreover, the fact that the law entitles the patient, with the concurrence of the patient's counsel, to at least one

[26] Florida Statute 394.467 (6)(a)1.

continuance of the hearing,[27] should assist in ensuring that due process is afforded to the patient and the hearings would still be scheduled and heard within the 5-day window.

We understand that judges receive training at judicial conferences on a fairly regular basis. Further, judges have testimony and evidence presented to them from scientific and expert witnesses as a matter of course. Developing expertise or a working knowledge in the area of mental illness, presiding over Baker Act hearings, evaluating the testimony of the witnesses and considering the medical records of the patient is something we are confident the branch court judges will be able to handle.

Scheduling Baker Act hearings at specified branch courts[28] could have another added benefit. It could ease the backlog of hearings at the JMH Crisis Center and significantly reduce the waiting time of the family members and doctors who have to travel there for the hearings. This could then create an added benefit to the treatment centers. The driver, medical attendant, doctor and other medical staff would be away from the facility for a shorter period of time, allowing them to be available to perform their normal duties at the treatment facility.

D. Transportation Exception Plans

Florida Statute 394.462 (3) (f) requires that law enforcement officers who have custody of persons meeting criteria be transported to the nearest receiving facility for examination.[29] In Miami-Dade County, this requirement can result in persons being transported to facilities that are not suitable or ideal for their particular needs. Often times, there are facilities in the county that are better options based on the patient's age, gender, disability or even prior treatment at a specific facility. Although family members may be aware of the existence of a "better facility" for a specific patient, they don't have the option of mandating that law enforcement transport their loved one to the more

[27] Pursuant to Florida Statute 394.467 (5) the patient is eligible to request a continuance for a period of up to 4 weeks.

[28] We would suggest one location in the north and one in the south. In that regard, the branch courts at the South Dade Government Center and the North Dade Justice Center could be utilized for this purpose. Hearings would then be located in North, Central and South Dade.

[29] When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination under this part, the law enforcement officer shall transport the person to the nearest receiving facility for examination. Florida Statute 394.462 (3) (f)

appropriate receiving facility. That practice may be about to change in Miami-Dade County.

The Board of County Commissioners is presently considering passage of a Transportation Exception Plan (TEP) pursuant to Florida Statute 394.462 (4).[30] That provision permits variances from the otherwise binding requirements of section (3) of the statute. Any such exceptions must be approved by the Board of County Commissioners and the Secretary of the Department of Children and Family Services. Statewide, eight counties have one or more Transportation Exceptions in place.[31] If approved, Miami-Dade County's TEP would permit officers transporting persons with mental illness to avoid the strictures of the present statute which sometimes results in patients being taken to facilities that are not the best choice for that particular individual. Having a Transportation Exception Plan in place permits a more efficient, effective and humane method of transporting persons in psychotic crises to designated receiving facilities that are most appropriate to meet their needs. Similarly, the proposal presently being considered by the Board of County Commissioners will allow transporting officers to do just that; take the individual to the most appropriate facility for treatment. We strongly recommend the approval of our county's TEP by the Board of County Commissioners and the Secretary of DCF.

V. ASSISTED OUTPATIENT TREATMENT

The report thus far has focused on Baker Act patients subject to involuntary inpatient placement. If at any time prior to the conclusion of the Baker Act hearing on involuntary inpatient placement it appears to the court that the person does not meet the criteria for involuntary inpatient placement, but instead meets the criteria for involuntary outpatient placement, the court may order the person evaluated for involuntary outpatient

[30] (4) EXCEPTIONS.--An exception to the requirements of this section may be granted by the secretary of the department for the purposes of improving service coordination or better meeting the special needs of individuals. A proposal for an exception must be submitted by the district administrator after being approved by the governing boards of any affected counties, prior to submission to the secretary.

[31] For instance, the TEP in Pasco County permits the transportation of minors to a receiving facility with licensed beds for minors rather than to the nearest receiving facility. On the opposite end of the spectrum, Pasco County's plan also provides that persons 35 years old and older may be transported to a receiving facility providing specialized services for elderly patients. The Florida Mental Health Act (Baker Act) 2009 Annual Report, p. 20.

placement.[32] This option became available in 2004 when the Florida Legislature amended the statute and made involuntary outpatient treatment on option in this state. Unfortunately, this was the equivalent of an unfunded mandate, as the legislature never appropriated any money to fund the community based mental health services, personnel or facilities to make this an effective option.

Nevertheless, one of the areas of recommendation from our predecessors involved creating a pilot program modeled after the outpatient commitment pilot program implemented by Seminole County in 2005.[33] Using grant funding, they hired an Assisted Outpatient Treatment (AOT) coordinator whose job responsibilities included working with clients and their families to ensure that:

(a) A case manager was assigned;
(b) Patients were taking their medication;
(c) Patients obtained any and all benefits to which they were entitled;
(d) Patients got assistance in obtaining supportive housing;
(e) Patients showed up for doctor's appointments; and
(f) Patients attended any appropriate job skills programs.

The targets of the Seminole County pilot program were recidivists who disproportionately used mental health criminal justice and court resources. By hiring the one coordinator and using existing resources, Seminole County was able to reduce the number of days these persons were spending in hospitals, jails, crisis stabilization units and forensic hospitals.

The Grand Jury was hoping to mirror Seminole County's success and cost savings by recommending a pilot program where an AOT Coordinator would be responsible for performing tasks (a) through (f) above for the top five (5) misdemeanants offenders recycling through the criminal justice system here in Miami-Dade County. We are aware of budget cuts to the courts, clerks, judges, state attorneys, public defenders and DCF. We are also mindful of the fact that notwithstanding those cuts, Seminole County's

[32] Florida Statute 394.467 (6)(c).

[33] As reflected in the 2007 Report, Seminole County and the Sheriff's Association lobbied heavily for the change in the statute after a Seminole County Deputy Sheriff was killed by a person with a history of mental illness.

program is **still operating** and **still saving money and resources**. We commend Seminole County for achieving this accomplishment in such an economic climate.

This grand jury has not lost sight of the fact that the size of Seminole County pales in comparison to Miami-Dade County. However, regardless of the size of our county, we still believe it is practical (and prudent) for those involved in the mental health field here to try this pilot program. Making sure that someone attends a doctor's appointment, takes their medication, applies for and obtains all eligible benefits, etc. does not use or require any additional mental health resources. Similar to Seminole County, we would expect the AOT Coordinator to use the resources we already have here. Why is this still a priority for the Grand Jury? Setting up such a pilot program could stop that revolving door and reduce the drain on our scant community based mental health resources.

VI. BAKER ACT HEARINGS AND THE STATE ATTORNEY'S OFFICE

The law that allows our courts to issue orders of involuntary commitment for persons suffering from mental illness is designed to prevent these individuals from doing harm to themselves. Another purpose of the law allows the court to issue orders of civil commitment so that those who are mentally ill and who meet criteria cannot hurt others. However, we believe one specific portion of the Baker Act statute in its present form runs counter to achieving that goal.

A. Safety Necessitates a Change In Statute

Florida Statute 394.467(5) allows the patient, with the concurrence of his public defender, to request the continuance of a Baker Act hearing for a period of up to 4 weeks. The statute does not have a similar provision for the other party in interest, the State Attorney's Office. We believe this is a fatal flaw. Under the present system, the State Attorney's Office gets a docket that lists the specific cases that are set for Baker Act hearings. The assistant state attorney handling those cases gets that docket the day before the hearing. If there is any type of scheduling problem with an essential witness or even a family emergency, the State may not be able to move forward on that particular case. The State is also unable to ask for a continuance; the statute does not provide that option.

As a result of that short-coming, there may be on the docket a case of a person who is suffering from mental illness and for whom there is a substantial likelihood that in the near future he will inflict serious bodily harm on himself or another person. If there is a technical or other problem that makes it impossible for the state to proceed on the day of the hearing, the patient will have to be released. A mental patient who meets criteria should not be released back into the community. Such an act creates a risk to the patient, his family members or other caregiver, law enforcement officers and the community at large.[34] We refuse to believe that the legislature would enact such a statute if they realized it could cause such a result.

We are mindful of the fact that patients in these situations have been held against their will up to the point where they are brought before the judge or general master to make a determination of whether they should remain in that posture. The statute allows the patient to request a continuance for up to four weeks, during which time he will remain held against his will and will still be without a judicial ruling on his case. We think it is both fair and prudent, that "for cause shown," the state can also request a continuance. We would limit the State's continuance to a period of up to one (1) week.

B. <u>State Access to Medical Records</u>

The final area we choose to address concerns the State's access to medical records. Florida law places the burden on the State Attorney to present sufficient evidence at the Baker Act hearing that the patient meets criteria for involuntary inpatient placement. The State is required to meet this burden without access to one of the critical pieces of evidence; the patient's medical records. We believe this may have been a scrivener's error when the legislation was updated.[35] We recommend that our legislature correct this shortcoming and enact an amendment that grants access of patients' medical records to the State Attorney.

[34] Descriptions of several such encounters that occurred here in Miami-Dade County (several of which resulted in death) are attached as an Appendix to the Spring Term 2004 Grand Jury Report.

[35] This contention was noted in the prior report. The irony is that such records are available to the State in determining whether someone meets the criteria for involuntary outpatient placement. Florida Statute 394.4615. (3)

VII. CONCLUSION

The 2007 Fall Term Grand Jury released a wonderful report with some great recommendations for improvement with our involuntary civil commitment process and for Assisted Outpatient Treatment. Unfortunately, that report was issued on the eve of a major economic and financial collapse that has reverberated throughout our county, state and nation. Unfortunately, many of their recommendations would have a significant financial impact upon implementation.[36] Not surprisingly, many of the recommendations have not been implemented.

This Grand Jury has included in its report some recommendations for better and closer oversight of the process in hopes that we can help reduce the amount of money being wasted on recycling patients through the system. We have reiterated and/or refined some of the recommendations of our predecessors and hope that these will be implemented. We are not unmindful of our state's projected budget deficit, which we understand is expected to be in excess of $3 billion dollars. Many, if not all, of our recommendations will not cost anything to implement, but will instead save money. Civil treatment options are much more cost-effective than criminalizing the behavior of the mentally ill, and the expensive prosecutions, incarcerations and treatments in that system. More importantly, it will assist greatly in ensuring that those suffering from mental illness will get the treatment they need. Accordingly, we urge those who have jurisdiction and power over these areas to implement these recommendations.

[36] For instance, one of the recommendations involved amending the Baker Act statute to lower the standard and criteria for involuntary commitment. Lowering the standard would most likely result in more examinations, more Baker Act hearings, more involuntary commitments and a need for more beds and mental health providers in our communities. Translated simply, there would be a need for more funding.

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
PASSION LATRICE CARR (A), STEVENSON CHARLES (B), and FRANTZ DEUS (C)	Murder First Degree Robbery Using Deadly Weapon or Firearm Grand Theft 3rd Degree/Vehicle	True Bill
KWAME KEON TURNER and AMARI LAQUAN WRIGHT	Murder First Degree Robbery using Deadly Weapon or Firearm Robbery/Armed/Conspiracy	True Bill
BRENNAN MARTIN WILSON	First Degree Murder	True Bill
TOMMIE MCCLENNEY JR., also known as THOMAS MCCLENNY, also known as BLACK MCCLENNY, also known as TOMMIE MCCLENNY, also known as GARY THOMAS PITTS	Murder First Degree Murder/Premeditated/Attempt/Deadly Weapon or AGG Batt Burglary With Assault or Battery Therein While Armed Murder/Second Degree/Attempt/Deadly Weapon/Prejudice Murder/Second Degree/Attempt/Deadly Weapon/Prejudice Murder/Second Degree/Attempt/Deadly Weapon/Prejudice Murder/Second Degree/Attempt/Deadly Weapon/Prejudice Murder/Second Degree/Attempt/Deadly Weapon/Prejudice Child Abuse/No Great Bodily Harm Child Abuse/No Great Bodily Harm Child Abuse/No Great Bodily Harm Child Abuse/No Great Bodily Harm Child Abuse/No Great Bodily Harm Unlawful Possession of a Firearm/Weapon By a Violent Career Criminal	True Bill
DWAIN KELVIN HUNTE	First Degree Murder Burglary with Assault or Battery Therein While Armed Murder/Premeditated Attempt Deadly Weapon or Aggravated Battery Murder/Premeditated Attempt Deadly Weapon or Aggravated Battery	True Bill
LARRY JEROME JOHNSON	First Degree Murder Robbery Using Deadly Weapon or Firearm	True Bill
JONATHAN ROBELO, also known as JONATHAN ALEXANDER ROBELO, TOM GONZALEZ and FERNANDO E. LEIVA, also known as FERNANDO EDISON LEIVA, also known as "TK"	Murder First Degree Murder/Premeditated/Attempt/Deadly Weapon or Aggravated Battery Murder/Premeditated/Attempt/Deadly Weapon or Aggravated Battery Murder/Premeditated/Attempt/Deadly Weapon or Aggravated Battery	True Bill
GEOFFREY AARON KNOWLES	First Degree Murder Child Abuse Aggravated Great Bodily Harm Torture Attempted Second Degree Murder Deadly Weapon / AGG Battery Attempted Second Degree Murder Deadly Weapon / AGG Battery Shooting or Throwing Deadly Missile	True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
CHRIS HAYES, also known as MARK HAYE	First Degree Murder Attempted Armed Robbery	True Bill
RICHARD G. ESPINOZA, also known as RICHARD CARLIN, also known as ROBERT MORENO, also known as ELFAIN LOPEZ	First Degree Murder First Degree Murder	True Bill
NELSON NICOLAS PEGUERO	First Degree Murder	True Bill
NELSON NICOLAS PEGUERO, Also known as NICOLI	Aggravated Battery/Deadly Weapon	No True Bill
EXZAVIER DEON ROBINSON (A) and KEENYA TINESE YOUNG (B)	Murder First Degree Robbery/Deadly Weapon Vehicular Homicide Reckless Driving/Serious Bodily Injury	True Bill
(A) ROBERT ALTMAD SHAW, a/k/a 'CHICO", (B) EMMANUEL CADILLON, a/k/a "MANO", (C) SAMUEL CADILLON, a/k/a "SAM" and (D) JUNIOR SYLVIN, a/k/a 'RAH RAH"	Murder First Degree/Conspiracy (A-D) First Degree Murder (A-D) First Degree Murder (A-D) First Degree Murder (A-D) Murder/Premeditated/Attempt/D Weapon Or Agg Battery (A-D) Shooting or Throwing Deadly Missile (A-D) Unlawful Possession of a Firearm/Weapon By a Violent Career Criminal (A) Firearm/Weapon/Ammuniton/Possn by Convicted Felon or Delinquent (B) Firearm/Weapon/Ammuniton/Possn by Convicted Felon or Delinquent (C)	True Bill
ENEL CHARLES (A), and JACQUIRIE LIVINGSTON (B)	First Degree Murder (A&B) Robbery Using Deadly Weapon or Firearm (A&B) Robbery Using Deadly Weapon or Firearm (A&B) Robbery Using Deadly Weapon or Firearm (A&B) Firearm/Weapon/Ammunition/Posn by Convicted Felon or Delinquent (A) Unlawful Possession of a Firearm While Engaged in a Criminal Offense by a Convicted Felon (A) Unlawful Possession of a Firearm While Engaged in a Criminal Offense by a Convicted Felon (A)	True Bill
RAFAEL ANGEL AQUILERA, FELIX D. SOTO (B) and GEOVANNY PADRON (C)	First Degree Murder Murder/Premeditated/Attempt Burglary With Assault or Battery Therein While Armed Aggravated Battery / Deadly Weapon	True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
LOUIE BING III	First Degree Murder	
	First Degree Murder	
	Murder/Premeditated/Attempt/D Weapon or AGG Battery	
	Murder/Premeditated/Attempt/D Weapon or AGG Battery	
	Robbery/Home Invasion/Armed	
	Shooting or Throwing Deadly Missile	True Bill
MARCO STEVEN DAVIS (A) and RODNEY LABOSSIERE (B)	First Degree Murder (A&B)	
	Accessory After the Fact (B)	
	Unlawful Possession of a Firearm WhileEngaged in a Criminal Offense (A)	True Bill
JAMEL LEE SMITH	First Degree Murder	
	Child Abuse/Aggravated/Great Bodily Harm/Torture	True Bill
ERIC ANTWON POLLARD	First Degree Murder	
	Carrying a Concealed Firearm	True Bill
MIKE GONZALEZ	First Degree Murder	
	Murder/Premeditated/Attempt/D Weapon or Agg Battery	
	Robbery/Home Invasion/Armed/Attempt	
	Trespass in Structure or Conveyance	
	Burglary With Assault or Battery Therein While Armed	
	Carrying a Concealed Weapon	True Bill
RAMONE McNEIL	First Degree Murder	
	Robbery Using Deadly Weapon or Firearm	
	Unlawful Possession of a Firearm While Engaged in a Criminal Offense	True Bill

ACKNOWLEDGMENTS

The jurors of the Spring Term 2009 Grand Jury wish to thank the Honorable Gisela Cardonne Ely for the opportunity to participate in this integral part of the judicial process and to serve our community. Our deepest appreciation also goes to those who guided, encouraged and assisted us through these nine months of Grand Jury service:

State Attorney Katherine Fernandez-Rundle for her advice, dedication and years of distinguished service to Miami-Dade County and its judicial system.

Chief Assistant State Attorney Don L. Horn for his integrity, professionalism and steadfast commitment to the Grand Jury. As both jurors and citizens, we have been enriched by his knowledge and guidance.

Assistant State Attorney Susan Dechovitz for her contributions and enthusiasm.

Rose Anne Dare, Administrative Assistant to the Grand Jury, for graciously providing flawless assistance to the Grand Jury. Our arduous tasks were alleviated by her supporting efforts and dependability.

Bailiff Nelido Gil for always greeting each of us with a warm smile, ordering lunch on long days and ensuring our meetings ran smoothly. Neil's ability to liven our spirits with his humor was appreciated by all.

Our court reporter, Tina Settel, for fulfilling her responsibilities with integrity.

To the detectives, witnesses and experts who took time to come before us, we also acknowledge their professional courtesy and cooperation. Thank you for patiently answering all our questions as we endeavored to fulfill our duties as jury members. We appreciate your contributions and guidance throughout this process.

It has been both a privilege and an honor to serve on the Miami-Dade County Grand Jury. Our journey throughout these nine months encompasses challenging, enlightening, disconcerting and inspiring moments. Despite the personal and professional sacrifices made, it is an extraordinary experience regarded by all. We encourage our fellow citizens to participate when they are called to serve in this important civic duty.

Respectfully submitted,

Arlyn Rull, Foreperson
Miami-Dade County Grand Jury
Spring Term 2009

ATTEST:

_____
David L. Deehl
Vice Foreperson and Acting Clerk

Date: February 8, 2010

Involuntary Examination

s. 394.463, F.S. Chapter 65E-5.280, F.A.C.

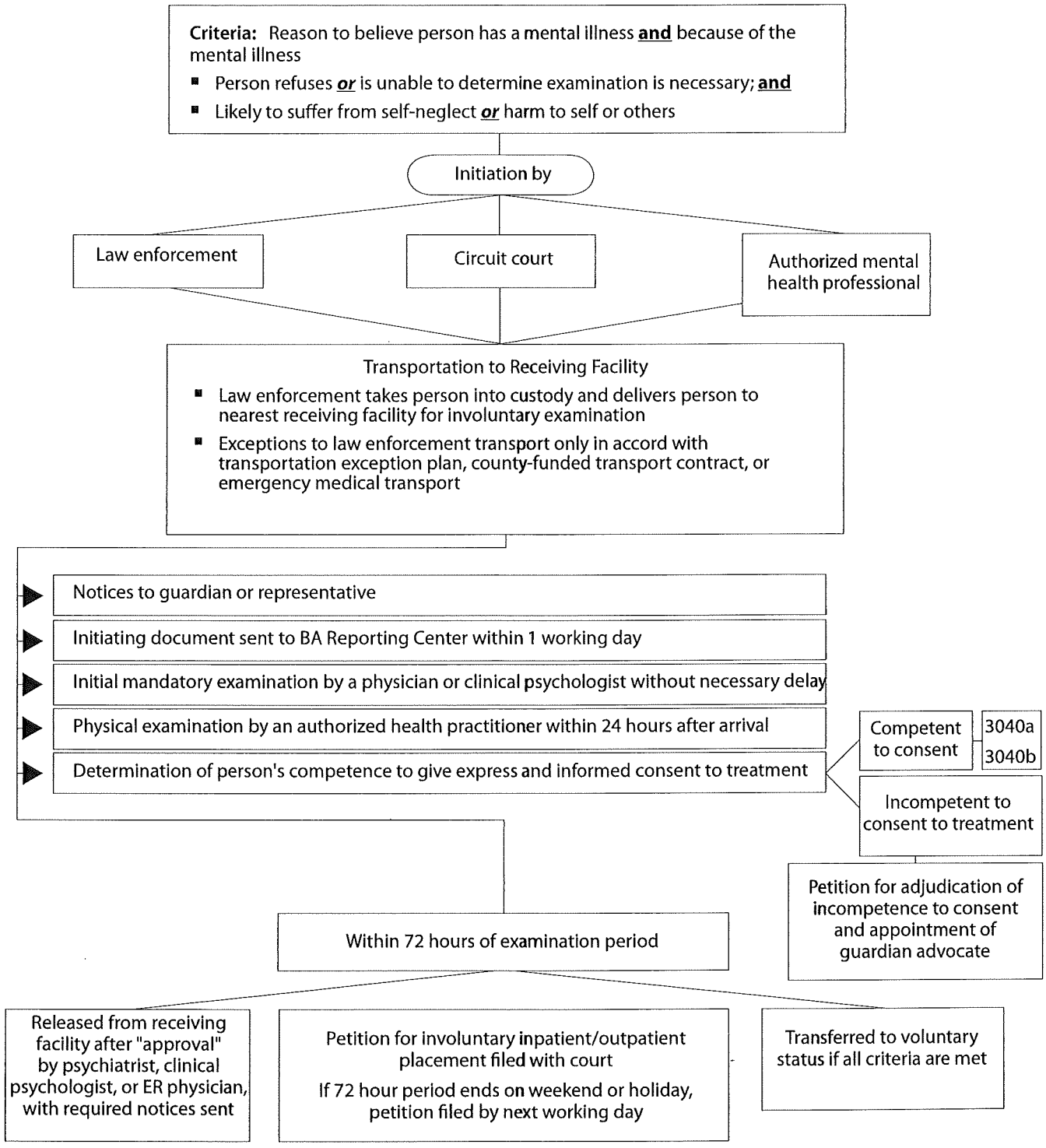

Exhibit 1