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CRIME WITHOUT CRIMINALS? SENIORS, DEMENTIA, AND THE AFTERMATH

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

WASHINGTON, DC

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CONTENTS

	Page
Opening Statement of Senator John Breaux	1

PANEL OF WITNESSES

Commander Gary Gotham, USN, Woodbridge, VA	3
Donna Cohen, Ph.D., professor, Department of Aging and Mental Health, University of South Florida	43
Max Rothman, J.D., LL.M., executive director, The Center on Aging, College of Health and Urban Affairs, Florida International University	53
Constantine G. Lyketsos, M.D., MHS, professor of Psychiatry and Behavioral Sciences; co-director, Division of Geriatric Psychiatry and Neuropsychiatry, The John Hopkins University and Hospital; on behalf of the Alzheimer's Association	111

APPENDIX

Material submitted by the Crisis Response and Intervention Training Committee	135

CRIME WITHOUT CRIMINALS? SENIORS, DEMENTIA, AND THE AFTERMATH

MONDAY, MARCH 22, 2004

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 2 p.m., in room SD–628, Dirksen Senate Office Building, Hon. John Breaux presiding.

Present: Senator Breaux.

OPENING STATEMENT OF SENATOR JOHN BREAUX, RANKING MEMBER

Senator BREAUX. The committee will please come to order. Good afternoon to everyone, and thanks so much for our guests being with us, as well as our distinguished panel of witnesses this afternoon to talk about a very, very important subject that affects all of us in our country.

The panel's testimony is going to be, I think, of great value to the committee as we work to address some of the critical challenges that our country is facing in providing proper mental health care to our Nation's seniors. In addition, I would also like to thank Chairman Craig for his support of this hearing.

Our Nation confronts a pending wave of 77 million aging "baby boomers". The purpose of this committee is to help this country rethink and to redefine how we age and continue to find ways to further enhance the quality of life for our older Americans and for their families.

In the last Congress I initiated a series of hearings on ageism. To that end, this committee has examined various forms of ageism, this pervasive discrimination against seniors that permeates our health care system in our Nation. Last year I chaired several Aging Committee hearings that explored ageism in our Nation's health care system. We learned that medical ageism is pervasive. It can be found in the use of preventative screenings, in clinical trials for our valuable treatments, in the treatment of hospital-borne infections, and also in the way that mental health care is provided to our Nation's seniors.

With respect to ageism and mental health care, we learned that older Americans have the highest suicide rate in America, a rate that is four times the national average. Even more disturbing, 75 percent of the suicide victims saw their doctor within one month of their suicide, but they were not treated or referred for treatment for their depression.

Today, our committee will hear testimony about another form of ageism and mental health care for older Americans. We will examine dementia and the extreme level of tragedy that this condition can reach if it's left untreated by the health care system and misunderstood by law enforcement and judicial systems.

This hearing will focus on a recent tragedy in Florida that exemplifies a growing problem evident across the Nation facing older individuals suffering from dementia. I would like to particularly thank several members of Mr. Ivan Gotham's family, who I understand are here in the audience today and who have been very supportive in the preparation for this hearing.

I realize that it is an extremely difficult time for you, but I want to thank you for your support and also extend my sincerest condolences for the loss of your father. Your testimony may very well help prevent a similar tragedy from ever occurring anywhere else in the future.

Although violent crimes committed by older Americans with dementia appear to be rare, we cannot be certain this is true because of the scarcity of the research and the data collection that is available. Nonetheless, we continue to see an increasing number of instances of severe violence that is associated with dementia. In fact, we have compiled a number of stories of this nature from around the country.

We simply must find way to prevent even one unnecessary loss of life. This is particularly urgent, since it is possible to prevent these tragedies by encouraging more research and increased training for family members, for health care providers, for mental health care professionals, for law enforcement, and also for the court system.

I prepared the charts over here to my right to assist individuals in recognizing the symptoms of potential violent behavior in older individuals with dementia who may need some professional intervention. Further, I recognize that we must continue to balance the needs of individuals with dementia with the need also, of course, to protect the public.

I introduced the Positive Aging Act, which is S. 1456, to help seniors receive the mental health care that they need. It provides grants for demonstration projects to integrate mental health services for seniors into primary care settings. I also believe that the passage of the Elder Justice Act, which is S. 333, will provide the necessary research, data collection, and the training to enhance our understanding of the care and treatment that is needed for seniors.

Today we take another important step toward ensuring that seniors will have the mental health care that they need. I certainly look forward to hearing the testimony from all of our witnesses.

I will introduce our first witnesses, who is Commander Gary Gotham of the United States Navy. Commander Gotham is the son of Ivan Gotham, who was killed in February in Ocala, FL. We thank you very much for being with us. As I said, your testimony may in a very significant way, help to prevent similar tragedies from ever occurring again. So, Commander, we are delighted that you are with us. I am very pleased to have the Aging Committee receive your testimony.

You may go ahead and present it.

STATEMENT OF COMMANDER GARY A. GOTHAM, UNITED STATES NAVY, WOODBRIDGE, VA

Commander GOTHAM. Mr. Chairman, I want to thank you for the opportunity to come here today. It is an honor to speak before such a distinguished group of leaders in America about my dad, Ivan K. Gotham.

I have provided a longer written statement and ask that it be included in the written record.

Senator BREAUX. Without objection, so ordered.

Commander GOTHAM. In addition, I respectfully request that my sister's statement be included in the written record. It was provided to your office, sir. She is here today for the hearing and her written statement is very insightful.

Senator BREAUX. Without objection, it will be included.

Commander GOTHAM. My name is Commander Gary A. Gotham. I have been in uniform for 23 years, honorably and faithfully serving the United States Navy and my country.

I appear here today before the Senate Special Committee on Aging as a very humbled man. My father's death and the death of Deputy Brian Litz should cause us all alarm. It should serve as an example and case study for looking at mental health and how dementia patients are treated, or not treated, within the Medicare system by health care services, the police, and judicial system.

The death of my dad and Brian could have and should have been prevented. What mattered most to my dad was liberty, freedom and dignity. He had given me and many other people so many gifts throughout life, ensuring his dignity as he departed this Earth was the smallest gift we could give him in return. But we were robbed of this familial responsibility.

Respecting his freedom and liberty during the 3 weeks from January 12 through February 7, was our greatest challenge. He made it clear to all of us that he never wanted to be put in any kind of home. His home was in his house.

In finding the error chain, we have focused on the events of January 5–12, 2004, when my dad was involuntarily confined to a mental health hospital under Florida's mental health statute, the Baker Act. Despite the 72 hour maximum stay under the Florida statute, he remained confined for 7 days. The Florida statute requires a hearing and court order to keep someone beyond the 72 hours. However, my dad did not have such a hearing.

I contacted the elected Public Defender's office in Hernando County and they held no record of a hearing for my dad. He received no legal representation to discuss his civil rights and to explain why he was being kept beyond the 72 hours.

His diagnosis, severe dementia and delirium. His only aftercare was a follow-up appointment on January 29. My family was not aware of the true ramifications of his involuntary hospitalization until after he was shot and killed. The family was not notified that my dad was being held involuntarily. Despite the medical care that he had received from October through December from his primary care provider and other doctors, he was not identified as suffering from dementia or delirium. He was not even referred for counseling but, rather, was treated for depression with prescription drugs.

We have pieced together the last 6 months of my dad's life. In July he spent a month with me to celebrate July 4, and his 74th birthday. I had just returned from Operation Iraqi Freedom and he wanted to welcome us home. My dad had the highest pride in his kids. I left my shore tour at the Pentagon on September 10, 2001, the day before 9/11, and headed to Japan in a tour on board the USS JOHN S. MCCAIN. For the next 18 months, we fought in Operation Enduring Freedom and Operation Iraqi Freedom, supporting the global war on terrorism.

My dad and I spoke all the time about the 9/11 terrorist attacks. The tragedy of 9/11 was hard for him because he lived through the Japanese attack on Pearl Harbor. His brother fought in World War II. He was proud of the response from Congress, the President, and our military's actions.

He returned to Florida and bought a house in Ocala, and spent Thanksgiving and Christmas with my brother. His spirits were excellent. He had recently been to the doctor for a routine check up on his prostate, was being treated for a blockage in his ear, and in December he had some work done on one of his eyes and had turned his hearing aid in for repair. He had redone his "living will", his last will and testament, and a power-of-attorney.

I talked with my dad almost every day. He was my best friend. I thank God that we had the most remarkable relationship beyond just a father and son. We spoke often about the 2004 Presidential elections and he drilled me about the President's decision to go to war in Iraq. We spoke about the Democratic primaries and issues of drug prescriptions and Medicare reform. He remained lucid and engaging in our conversations.

My birthday was on January 5, and I was not able to reach my dad for the next 7 days. I regained contact with him on January 12, the day he got out of Springbrook. He was not my dad any more. For the next 3 weeks, we all encountered a troubled mental state with my dad. He was lucid at times and at others he spoke of events that were unreal. He was paranoid, spoke of having a discussion with Jesus, thought his second wife and step-daughters had committed suicide. His sense of reality had faded away.

In return calls to the police seeking help, I learned about the well-being check. That first week I called and requested they check on him. It went well. They called from inside his house, confirming that he was OK.

My dad had a second incident with the sheriff on January 24, and a deputy had been assisting my brother in providing contact information for senior services with the Department of Children and Families. We were trying to reach an agreement with my dad, that he would move to my brother's in Jacksonville, FL until he was stable again. Randy had contacted a lawyer to find out the mechanisms for us to take control over my father to get him some help.

Before we could take these actions, my father was killed. On February 7, we lost my dad in an incredible turn of events that has crushed my life, my beliefs, and has saddened me to depths that no one should ever be burdened with.

I called the Marion County sheriffs and requested a well-being check. As I had done during that first call, I made sure that the

dispatcher knew that my dad had a gun in the house, was having physical as well as mental problems and stability issues. I was adamant that I wanted to know that the police officer was told about the gun. I wanted to prevent a tragedy.

That call went out from the dispatch at 12:07 p.m., and by 12:32 my father, 74 years old and failing in mental health in ways we did not comprehend, shot and killed a sheriff's deputy, Brian Litz, who was 36 years old. Forty-two minutes later, in what is still shielded in confusion, misunderstanding, and lacking in truth, my dad, unarmed, was shot and killed in a blaze of gunfire from police and swat teams.

There is no eloquence of words that can describe the depths of my personal grief, sorrow, and guilt that I feel in the loss of Brian Litz and my father. My dad was still giving to his family, his country, and the world. Brian was just starting his own remarkable journey in life.

I knew my dad as a great man, an incredible father, a best friend, a legend. He handed down to me a puritan work ethic, hard work for God and country, family, love, church, neighborly kindness, freedom, respect for our parents and teachers, the military, our leaders, our service providers and police and firemen. These were the hallmarks of his teaching. He still cried during the national anthem when we went into a baseball game on July 4, 2003.

I can't help but question the ability of the medical care, and especially Florida's mental health care system, in providing appropriate care for my dad. If we had been notified of the involuntary confinement, if he had been properly treated with follow-up care, if we had been there to take him home from the hospital, I know in my heart he would still be alive, and so would Brian.

I can't avoid questioning the actions that resulted in his death. My attempt to seek out help from the Marion County Sheriff's office and to protect them and my father resulted in a police action and the use of lethal force that is beyond my comprehension. As a military man and a trainer in the uses of deadly force, even in combat, if I had directed or personally taken similar actions against an unarmed man, I would not be sitting here before the committee but would be sitting in Levenworth Federal Prison.

I spent the last 2 years fighting the global war on terrorism and returned to America only to learn that terrorism had struck my dad in Florida. We're all searching for answers to understand these tragic events. My own quest for answers is to alleviate the tremendous guilt that I bear in the personal responsibility for the deaths of my dad and Brian. Some need to blame us; some need to blame the State mental health care system; others need to blame the misuse of Florida's mental health act, the Baker Act, with the elderly.

I thank the committee for this opportunity today.

[The prepared statements of Gary Gotham and Rorie Lin Gotham follow:]

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STATEMENT OF

COMMANDER GARY GOTHAM

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

ON

22 MARCH 2004

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
SENATE SPECIAL COMMITTEE
ON AGING

Mr. Chairman, Senators, ladies and gentleman, I want to thank you for the opportunity to come here today and speak about caring for my dad, Ivan K. Gotham and the tragic and lethal consequences of his mental health condition. I appear here today before the Senate Special Committee on Aging as a very humbled man. "Dignity" is defined in Webster's dictionary as "*the quality or state of being worthy, honored or esteemed.*" It is a state of being that all of our elderly and aging senior citizens deserve.

My father's death and the death of Deputy Brian Litz should cause us all alarm. It should serve as the an example and case study for looking at mental health and how dementia patients are treated or *not treated* within the Medicare system, health care services, police and the judicial system. I would not be here today if this was simply a statistical anomaly, an event to be discounted because it is outside the bell curve and standard deviation. In finding the error chain, we have focused on the events of 05-12 January 2004 when my dad was involuntary confined to a mental health hospital. (Refer to Incident Report 04000783 CAD Event 0401060809, Classification 1301 Baker Act, Self-Initiated, 01/05/2004).

On 5 January, at 2230 at night, my father's life changed when he was involuntarily Baker Acted under Florida's Mental Health statute. The police report states my dad was confused about his actions that night, but knew where he lived. He was on his way to a date and got lost, went to a house and it was not the correct house. The man that answered the door called the police. When the police found my dad, he was walking with his dog. He had left his car in the man's driveway. His confusion about the events

caused the police to involuntarily Baker Act him. The officer stated to my brother that, "she really stretched the criteria in applying the law to my dad."

He was taken to the Marion Citrus Mental Health (The Centers) facility and on the 6th was transferred to Springbrook Mental Health Hospital due to an issue with his Medicare coverage. Despite the 72-hour maximum stay for Involuntary Examination under the Florida Statue Section 394.463, he remained confined for 7 days and was released on the 12th under his own cognizance. The Florida Statute requires a hearing and court order to keep someone beyond the 72 hours for Involuntary Evaluation and hold him or her under Involuntary Placement; however, my dad did not have such a hearing. I contacted the elected public defender's office in Herndon County, and they held no record of a hearing for my dad. He received no legal representation to discuss his civil rights and explain why he was being kept beyond the 72 hours. His diagnosis severe dementia and delirium - his only after care was a follow-up appointment with The Centers on 29 January. His only medication was for high blood pressure (Toprol XL 50MG, & Zestril 10 MG) and high cholesterol (Zocar 20 MG). It was not until 09 February that we began to understand everything that had happened to my dad.

My family was not aware of the involuntary hospitalization of my dad under the Baker Act until after he was shot and killed on 07 February. The family was not contacted nor notified that my dad was being held involuntarily. In addition, despite the medical care that he had received from October through December 2003, my dad was not

identified as suffering from dementia or delirium. He was not even referred for counseling but rather was treated with Paxil for depression.

Involuntary hospitalization under Chapter 394 The Florida Mental Health Act (The Baker Act) is meant for people suffering from serious mental health and/or individuals that will harm themselves, others or have indications of neglect. Florida has long struggled with Bi-Polar, Schizophrenia, and Alzheimer balancing protection of the public verses constitutional rights of citizens, even mentally ill citizens. The current reforms in SB 700/HB 463 are being lead by the Florida Sheriff's association to unburden law enforcement and strengthen mental health care services. We need look no further than the 1999 Florida Supreme Court Commission of the Baker Act though for its effects on the elderly (refer to Press Release and Executive Summary).

In the public release dated December 28, 1999, the Supreme Court Commission Study stated, "The Florida Supreme Court Commission on Fairness concluded that the Baker Act particularly impacts the state's elders, often in detrimental ways", ... "When Maxine Baker sponsored the Baker Act in the 1970s, her vision was to replace the century-old practice of institutionalization with community-based treatment programs. Though her efforts helped close many of the old psychiatric institutions, Florida has failed to develop an adequate system of community programs to meet the needs of its people," ... "Because of inadequate funding, hearings on petitions for involuntary placement are not always held within the time frames required by law, resulting in lengthier

detention," ... "Abuse of the Baker Act for monetary gain commonly involves elderly in nursing homes," ... "Some people detained under the Baker Act receive inadequate legal help, and some Baker Act hearings are so informal the detainees do not understand that their liberty is at stake."

In the Executive Summary, the report states, "The Baker Act was designed to require the state Department of Mental Health to offer community services to most patients with mental illness, and reserve confinement only if the individual is dangerous to himself or others," ... "Involuntary mental health examination and placement involve a balancing of individual rights with the state's parens patriae authority and police powers," ... "Public testimony before the Florida Legislature indicated that many elders faired poorly and some even died during or shortly after their hospitalization under the Baker Act," ... "The Baker Act is still being used to confine older people, many of whom may simply be confused or unable to care for themselves," ... "Obviously, an incorrect decision on the involuntary examination or placement of anyone, but particularly a vulnerable elder, can have disastrous effects."

What matter most to my dad - liberty, freedom and most importantly dignity? He had given me, and many other people so many gifts throughout life; ensuring his dignity as he departed this earth was the smallest gift I could give him in return, but we were robbed of this familial responsibility. Respecting his freedom and liberty during the three

weeks from 12 January thru 07 February was our greatest challenge, he made it clear to all of us that he never wanted to be put in any kind of home, his home was in his house.

Prior to 12 January he had his share of physical problems, a heart attack in 2000, prostrate cancer, a double aneurysm in November 2002 and the emotional fall out from the breakup of his second marriage of 25 years within the first month of the aneurysm. He had also emotionally suffered for the past 27 years from the tragic suicide of his high school sweetheart and wife of 30 years, my mother. He often told me that everyday he thought about how much he loved my mom and missed her. Suicide leaves carnage behind for the survivors to unburden themselves of and attempt to carryon. I always admired him for his strength in recovering from this.

Everything changed on February 07, 2004 when I lost my dad in an incredible turn of events that has crushed my life, my beliefs, and has saddened me to depths that no one should ever be burdened with. I have been overwhelmed with the feeling of being an orphan. It was a Saturday and my sister called that morning, upset and directing me to get in touch with my brother in Florida because my dad's phone was disconnected. It was around 11:30 AM when she called. I called my brother in Florida to talk over what we could do. He would see dad later that day, but we both felt we needed to have the Marion County Sheriff's office conduct a well-being check on him before Randy could get there. I recommended it because we had done it prior to this during the week of 12-17 January 2004. As I had done during the first call, I made sure that the dispatch knew that my dad had a gun in the house, was having physical as well as mental stability issues. I was

adamant that I wanted to know that the police officer conducting the well-being check was aware. I wanted to prevent a tragedy. The call went out from the dispatch at 12:07 PM and by 12:32 PM my father, 74 years old and failing in mental health in ways we did not comprehend shot and killed a Sheriff's Deputy, Brian Litz who was 36 years old. 42 minutes latter in what is still shielded in confusion, misunderstanding and lacking in truth, my dad, unarmed was shot and killed in a blaze of gunfire from police and SWAT at 1:17 PM. (Refer to Incident Report 04006553 CAD Event Classification 1701 Death, Homicide, 02/07/2004).

As a family with the help of neighbors and friends, we have pieced together the last six months of dad's life. In July he spent the month with me in Washington DC driving 1300 miles up in his RV from Florida to celebrate the 4th of July and his 74th birthday. I just returned from Operation Iraqi Freedom (OIF) and he wanted to welcome us home. I cannot tell you the pride that my dad had in his kids and in me for my 23 years of service in uniform with the Navy. I had checkout of the Pentagon 10 September 2001 and in October flew out of Dulles to Japan, he was the most scared he had ever been for my family and I knowing we would be flying. For the next 18 months I fought in Operation Enduring Freedom and Operation Iraqi Freedom supporting the Global War on Terrorism. We spoke all of the time about the September 11th terrorists attack. It was hard for him because he lived through the Japanese attacks on Pearl Harbor December 7th, 1941. We had a neighborhood party for his birthday, attended a baseball game with the local AAA Potomac Cannons and watched the fire works.

He returned to Florida and bought a house in Ocala. He spent Thanksgiving with a new female friend from Canada and my brother Randy and his fiancé. For Christmas I had bought him a stereo and he spent several days laughing about how much joy he had from music throughout his life, it was the happiest he had been since I returned. He bought a TV and hooked it up to watch DVDs. My brother and his fiancé saw dad the weekend after Christmas and his spirits were excellent. He sent his grand kids money for Christmas and a card for my birthday in January. He had recently been to the doctor for a routine checkup on his prostate cancer. He was being treated for a blockage in his ear. His primary care provider proscribed him Paxil due to his depression from the breakup of his marriage. In December he had some work done on one of his eyes. He had turned his left hearing aid into the doctor for repair in December. His physical health was in good shape and his recovery from the aneurisms was remarkable. He had redone his Living Will, his Last Will and Testament and a Power of Attorney for my Brother in December. We spoke about the 2004 Presidential elections and he drilled me about the President's decision to go to war in Iraq. We spoke about the democratic primaries and the issue of Drug Prescription and Medicare Reform. He remained lucid and engaging in our conversations.

I talked with my dad almost every day after I returned from Japan. He has been my best friend for years. I thank God that we had the most remarkable relationship beyond a father and son. We spoke on 31 December, New Year's Eve and again on New Year's Day. New Year's Eve is his wedding anniversary from his 2nd marriage. We all worry most about him during the holiday season. After loosing my Mom in 1977 in a

tragic death, the holidays are always hard for all of us. My birthday is on the 5th of January and I was not able to reach dad for the next week. It was the first time we had not spoke on my birthday as far back as I can remember. His neighbors, Carl & Mary, God bless them; let us know that dad had been in the Hospital for the past 7 days. Mary personally hounded the Springbrook Hospital to find out why they were keeping my dad beyond the allotted 72 hours for evaluation. Frantic calls in the family occurred to determine if anyone of us knew what had happened. I regained contact with him on 12 January, the day he got out of Springbrook – he was not my dad anymore. For the next 3 weeks we all encountered a troubled mental state with my dad. He was lucid at times and at others he spoke of events that were unreal. He was paranoid, spoke of having a discussion with Jesus, thought his second wife and stepdaughters had committed suicide, his sense of the reality had faded away.

Believing that something tragic had happened to my stepmother I contacted the county sheriff. She had not committed suicide. I called my stepsister and confirmed that our sisters were OK. When I tried to get my dad to listen, he felt betrayed; he felt that I did not trust him. In return calls to the police seeking help, I learned about the Well Being check. That first week I called and requested they check on him. It went well and they called from inside his house confirming that he was OK. But after the sheriff's left, again he returned to his unreal world. I was very concerned about the gun he kept in the house because I felt he might commit suicide. My brother Randy visited my dad and tried to get the gun out of the house. He even discussed the issue with the same deputy that had placed my dad under the Baker Act 05 January. My dad had a second incident with the

Sheriff on 24 January (Refer to Incident Report 04004142 CAD Event 0401240421, Classification 3311 Information, 01/24/2004). The deputy assisted my brother in providing contact information for Senior Services with the Department of Children and Family. We were trying to reach agreement with my dad that he would move up to my brothers in Jacksonville until he was stable again. Randy had contacted a lawyer to find out the mechanisms for us to take control over my father to get him some help. Before we could take these actions my father was killed.

There is no eloquence of words that can describe the depths of my personal grief, sorrow and guilt that I feel in the loss of Brian Litz and my father. My dad was still giving to his family, his country and the world; Brian was just starting his own remarkable journey in life. I knew my dad as a great man, an incredible father, a best friend - a legend. He handed down to me a Puritan Work Ethic – hard work, for God and country. Family, love, church, neighborly kindness, freedom, respect for our parents, teachers, the military, our leaders, our service providers in police, fireman, etc., these were the hallmarks of his teachings. He still cried during the national anthem when we went to baseball game 04 July 2003. I can't help but question the ability of the medical care and especially the mental health care system in providing appropriate care for my dad. If we had been notified of the involuntary placement, if he had been properly treated with follow-up care, if we had been there to take him home from the hospital, I know he would still be alive.

We are all searching for answers to understand these tragic events. My own quest for answers is to alleviate the tremendous guilt that I bear in the personal responsibility for the deaths of my dad and Brian. Some need to blame us, while others question the states ability to provide adequate care for the elderly and the frequent misuse of Florida's Baker Act with the elderly. I thank the Committee for this opportunity today.

Supreme Court of Florida

December 28, 1999
FOR IMMEDIATE RELEASE
For More Information Contact:
Craig Waters, Director of Public Information
(850) 414-7641

Supreme Court Commission Urges Changes to Baker Act

TALLAHASSEE — Florida's Baker Act—the law for authorizing civil commitment of some mentally ill persons—is in need of an overhaul, including statutory reforms, improvements in court procedures, and increased funding, a state Supreme Court commission has found.

In a report released Tuesday, the Florida Supreme Court Commission on Fairness concluded that the Baker Act particularly impacts the state's elders, often in detrimental ways.

"The report is especially appropriate," said Chief Justice Major B. Harding, "since Florida presently has the largest proportion of older adults in the United States. In fact, the combined population of Florida residents with psychiatric disabilities and Alzheimer's disease–nearly a million–is greater than the entire populations of some individual states."

Miami-Dade Circuit Judge Gill S. Freeman, Chair of the Fairness Commission, agreed.

"When Rep. Maxine Baker sponsored the Baker Act in the 1970s," said Freeman, "her vision was to replace the century-old practice of institutionalization with community-based treatment programs. Though her efforts helped close many of the old psychiatric institutions, Florida has failed to develop an adequate system of community programs to meet the needs of its people."

Among the findings:

- Florida has more than 600,000 persons with mental illness and more than 300,000 with Alzheimer's disease, together creating a group larger than the populations of some states.
- In 1997, over 70,000 Floridians were involuntarily examined under the Baker Act, and nearly 20,000 petitions for involuntary civil commitment for psychiatric treatment—which can result in lengthy detention—were filed.
- More funding for community-based mental services should be made available to avoid unnecessary institutionalization or criminalization of individuals with psychiatric disabilities.
- Because of inadequate funding, hearings on petitions for involuntary placement are not always held within the time frames required by law, resulting in lengthier detention.

- The Baker Act sometimes has been abused for financial gain or by persons who have a grudge against the detainee, like an estranged spouse or an angry neighbor. Abuse of the Baker Act for monetary gain commonly involves elders in nursing homes.

- Judicial and executive agencies that should have a role in preventing abuses of the Baker Act are too poorly funded to be effective and do not receive adequate training and education to prepare them to participate effectively in Baker Act proceedings.

- Some people detained under the Baker Act receive inadequate legal help, and some Baker Act hearings are so informal the detainees do not understand that their liberty is at stake.

- In some instances, state attorneys are not fully participating in the process.

Copies of the full report and executive summary are available on the Supreme Court Press Page of the Court's duplicate websites:

http://www.flcourts.org/ http://www.firn.edu/supct/

Executive Summary

Introduction

Chapter 394 of the Florida Statutes, known as "The Baker Act," governs mental health services, including voluntary admissions (section 394.4625), involuntary examination (section 394.463) and involuntary placement (section 394.467). Enacted in 1971, the law was designed to protect the rights and liberty interests of citizens with mental illnesses and ensure public safety.

According to media reports from 1971, the Baker Act, named in honor of its sponsor Representative Maxine Baker, strengthened the legal and civil rights of patients of state mental institutions. Perhaps more importantly, the Baker Act was designed to require the state Division of Mental Health to offer community services to most patients with mental illness, and reserve confinement only if an individual is dangerous to himself or others. During legislative debate on the sweeping revision of Florida's then 97-year-old mental health laws, Representative Baker told her colleagues that "only 9 percent of our patients are dangerous to themselves or others, yet 91 percent are under lock and key." She added that "for the 58 percent of our patients who are committed involuntarily, they lose all their civil rights and leave with an indelible stigma. In the name of mental health, we deprive them of their most precious possession--liberty." (See Times-Miami Herald Service report from May 11, 1971.)

The state is the only entity with the authority to restrict a person's liberty. Involuntary mental health examination and placement involve a balancing of individual rights with the state's *parens patriae* authority and police powers. There were 19,424 petitions for involuntary placement filed under the Baker Act in 1997, which is a 22.3 percent increase from 1996. And, according to data collected by the Department of Mental Health Law and Policy at the University of South Florida, there were more than 70,000 involuntary examinations in 1997. Thus, implementation of the statutory provisions governing involuntary examination and placement, and the accompanying deprivation of liberty, affect a large number of Floridians every year.

The *St. Petersburg Times* reported in 1995, based on a review of more than 4,000 cases and a statistical analysis of 3,151 petitions for involuntary examination, that "about two-thirds of the people forced into treatment in Pinellas [County] in 1993 and 1994 were 65 and over." Public testimony before the Florida Legislature indicated that many elders fared poorly and some even died during or shortly after their hospitalization under the Baker Act. While the Baker Act was overhauled in 1996 by the Florida Legislature in response to these allegations, according to a June 14, 1998, article in the *St. Petersburg Times*, "some mental health advocates, and the state records, suggest the Baker Act still is being used to confine older people, many of whom may simply be confused or unable to care for themselves."

Obviously, an incorrect decision on the involuntary examination or placement of anyone, but particularly a vulnerable elder, can have a disastrous effect. The Subcommittee believed it was imperative to review the judicial administration of Baker Act cases to determine whether there are additional precautions the State Courts System can implement to eliminate abuse or misuse of the Act.

Provisions of the Baker Act

Under the Baker Act, persons can be compelled into a local hospital or crisis unit (defined as "receiving facilities") for an involuntary examination for up to 72 hours. To qualify for an involuntary examination, persons must have a mental illness as defined in the statute and be unable or unwilling to provide express and informed consent to voluntary examination. The person, as a result of mental illness, must also be dangerous to themselves or others or seriously neglectful of themselves. The involuntary examination process may begin in one of three ways:

1. Any person may sign an affidavit that outlines why a person meets the criteria for an involuntary examination. A circuit judge then decides whether the affidavit adequately documents the legislatively-mandated criteria; if so, the judge enters an *ex parte* order for involuntary examination directing a law enforcement officer to take the person into custody and deliver that person to the nearest receiving facility.
2. A law enforcement officer encounters someone who meets the criteria and takes that person to the nearest receiving facility.
3. A doctor or other specified health care provider decides that a person meets the criteria for an involuntary examination, and a law enforcement officer takes the person into custody and delivers the person to the nearest receiving facility.

Within the 72-hour period of involuntary examination, one of the following four actions must be taken, based on the individual needs of the person being detained:

1. The person may be released; or

   The person may be released for outpatient treatment; or

3. The person may voluntarily agree to further inpatient treatment; or
4. The receiving facility may petition for involuntary placement. If a petition is filed, a hearing must be held within five days.

Section 394.467, Florida Statutes, authorizes a person to be involuntarily placed for treatment upon a finding of the court that:

- The person has a mental illness and because of the mental illness:
  - The person has refused voluntary placement for treatment or is unable to determine whether placement is necessary; and
  - The person is incapable of surviving alone or refuses to care for himself or herself and such neglect poses a real and present threat of substantial harm; or there is substantial likelihood that in the near future the person will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior; and
- All available less restrictive treatment alternatives which would offer an opportunity for improvement of the person's condition have been judged to be inappropriate.

Reasons for this Study

Inadequate processes and forms as well as errors or delays in the judicial administration of Baker Act cases may deny Florida citizens timely due process. Protecting rights and liberties is vital to the mission of the Florida State Courts System. This study sought to determine whether the rights of patients and the responsibilities of those charged with carrying out the laws were being properly observed.

There were several important reasons for studying the processing of cases involving vulnerable elders in Florida. Florida is the fourth largest state in the nation, with more than 14 million residents. The state presently has the largest proportion of older adults in the United States. More than 3.4 million Floridians are age 60 and older, and this population is expected to greatly increase in the future.

There is a sizeable population in Florida directly affected by the Baker Act. There are 601,206 Floridians with mental illnesses and 302,700 with Alzheimer's disease. In fact, the combined population of Florida residents with mental illnesses and Alzheimer's disease (903,906) is greater than the entire population of Alaska (614,010), Delaware (743,603), the District of Columbia (523,124), Montana (880,453), North Dakota (638,244), South Dakota (738,171), Vermont (590,883), and Wyoming (480,907) (Source: Population Estimates Program, Population Division, U.S. Bureau of the Census, Washington, DC 20233).

The need for this study was additionally identified through:

Horizon 2000, The 1998-2000 Operational Plan for the Florida Judicial Branch, Objective II-D, Enhance the Timely Processing and Management of Cases, which states that "the Fairness Committee is asked to develop and submit a report and recommendations on case processing issues as they relate to vulnerable elders;"

The January 1, 1994, *Action Plan* of the Florida Supreme Court Committee on Court-Related Needs of the Elderly and Persons with Disabilities;

House Bill 1705, enacted during the 1998 Legislative Session; and

Advocacy by the Department of Elder Affairs, Statewide Human Rights Advocacy Committee, and other individuals and groups.

The right to an impartial, fair, and timely hearing prior to involuntary placement is the keystone of the Baker Act. No comprehensive review of the judicial administration of Baker Act cases had been undertaken in the nearly three decades since the law has been in place. This study complements the 1996 legislative scrutiny of and modifications to the law, and will hopefully enhance the protection of rights of vulnerable elders who are involuntarily placed in mental health facilities.

The Study

Limited funding, time, and staff support were obstacles to this study. The Subcommittee applied for supplemental grant funding, but was not successful in securing the resources required to audit case files, observe judicial proceedings, or conduct personal interviews with participants. Nevertheless, the Subcommittee maximized its resources by conducting the following tasks:

- Reviewed judicial administration procedures and forms.

- Reviewed the applicable Florida Statutes and case law.
- Reviewed Florida and national literature, including law review articles, other legal research resources, and media reports.
- Conducted meetings in Tallahassee, Tampa, Fort Lauderdale, Miami, and Orlando to provide interested persons with the opportunity to submit written and oral presentations. Testimony was received from:
  - chief judges, administrative judges, other judges, and general masters;
  - court staff;
  - clerks of court;
  - disability advocates;
  - guardians;
  - public defenders, state attorneys, and other attorneys;
  - individuals with psychiatric disabilities; and
  - other interested persons.
- Conducted a comprehensive written survey of:
  - judges,
  - general masters,
  - state attorneys,
  - public defenders, and
  - clerks of court.

Findings, Conclusions, and Recommendations

Based on its research and deliberations, the Subcommittee presents the following overview of its findings, conclusions, and recommendations in regard to the Baker Act. These and other findings, conclusions, and recommendations are discussed in greater depth in the full report.

I. Increase the Availability of Quality Community Mental Health Services and the Use of Less-Restrictive Alternatives

The Subcommittee heard repeatedly that there is a chronic shortage of quality mental health resources in Florida, particularly community mental health services. Upon passage of the Baker Act in 1971, Representative Maxine Baker, for whom the law is named, told the *Times-Miami Herald Service* "there are so many people who are better treated in the community, through group therapy and other methods of treatment. With this bill, we can treat more persons with less money without subjecting many of them to institutionalization." Sadly, Representative Baker's vision has never been fully realized in Florida. As long as the critical shortage of community mental health resources continues in Florida, judicial consideration and determination of less restrictive alternatives, as required by the Baker Act, lacks the full significance it was intended to have.

According to Wayne Basford, an attorney with the Advocacy Center for Persons with Disabilities,

the Department of Children and Families acknowledges that approximately 60 percent of the individuals in South Florida State Hospital could be discharged if adequate community-based support existed. He reported that the mental health facility recidivism rate is substantially impacted by the availability of community services and supports, such as psychotropic drugs and assertive community treatment (ACT) teams.

Richard Durstein, a professional guardian and member of the Human Rights Advocacy Committee in Pinellas County, and others spoke to the Subcommittee about the new generation of medications for individuals with mental illnesses. These new drugs, while excellent, are extremely expensive and thus beyond the financial reach of many persons. The question that may need to be addressed is whether providing services to persons with mental illnesses who are unable to afford treatment and medication is more cost effective than rotating these individuals in and out of mental health facilities and the justice system.

Many survey respondents and speakers noted the relationship between ability to pay and the length and quality of confinement. They said the system is a "revolving door" for indigent patients, who are back on the street quickly. It is an issue of fairness in regard to the allocation of services. There should be equal protection under the law for persons with and without insurance or private funds.

Participants in the process agreed with the activists' assessment. A general master in southern Florida who responded to the Subcommittee's survey posed the rhetorical question, "how meaningful is an inquiry into whether the least restrictive alternative has been determined appropriate if there is no alternative but involuntary hospitalization?" That general master went on to lament the "woeful lack of services for juveniles, at least those juveniles who must rely on public resources for their treatment."

Another issue on which the Subcommittee heard testimony was the quality of some treatment. Hugh Handley, public guardian in the Second Judicial Circuit, expressed deep concern about the poor conditions in some assisted living and other facilities. Wayne Basford spoke of the ethical and moral concerns when society confines individuals to substandard treatment.

The Agency for Health Care Administration (AHCA) is authorized to impose fines and administrative penalties for violations by mental health facilities and professionals, in regard to both voluntary and involuntary placements. However, it was reported that AHCA lacks the funds and staff necessary to take vigorous and proactive enforcement action in regard to mental health facilities and professionals.

Paul Stiles, of the Department of Mental Health Law and Policy at the University of South Florida, reported that the Department of Children and Families is seeking legislative approval and funding for two pilot projects for a community team approach to address the mental health needs of elders. The Subcommittee applauds and supports the Department's efforts to address the needs of individuals with psychiatric disabilities, particularly vulnerable elders, in a manner that is more likely to preserve their dignity while being less disruptive and more cost effective.

Furthermore, the Subcommittee adds its voice to those who are pleading with the Florida Legislature

and other policymakers to divert additional resources to quality community supports and services that will enable citizens with mental illnesses to lead full and meaningful lives and avoid unnecessary institutionalization.

Related Recommendations

The Florida Legislature, the Department of Children and Families, and other policy makers should adequately fund quality community supports and services for persons with mental illnesses.

The Florida Legislature should fund positions within the Department of Children and Families for the purpose of exploring less restrictive alternatives to involuntary placement and require the Department to report to the court on same.

The Florida Legislature should review the statutes and regulations to ensure that community facilities are adequately regulated. The Florida Legislature should also require community facilities that house people who require mental health treatment to facilitate those persons' access to such treatment by qualified professionals.

The Florida Legislature should adequately fund the Agency for Health Care Administration and require the Agency to actively monitor and vigorously enforce regulations related to community facilities, such as assisted living and other facilities, to improve the quality of care and services for residents.

Judges, general masters, public defenders, and state attorneys should have a working knowledge of community mental health resources and visit the less restrictive alternatives available within their community.

The Florida Legislature should amend the statutes to expressly permit the use of less-restrictive alternatives to involuntary in-patient examinations.

The Florida Legislature should make funding available to jurisdictions that are willing to coordinate an interdisciplinary exploration of innovative alternatives designed to reduce the traumatic effect of involuntary examinations. Such pilot projects should be monitored and evaluated by independent entities, to determine their effectiveness.

At involuntary placement hearings, judges and general masters should require the state attorneys to comply with the statutory requirement to prove that all less restrictive alternatives have been investigated and found to be inappropriate.

Judges and general masters should ensure that the evaluation of less restrictive treatment alternatives (section 394.467(1)(b)) are given equal weight under the law with the criteria found in section 394.467(1)(a).

The Florida Legislature should consider amending Chapter 394 to permit Chapter 744 guardians and Chapter 393 guardian advocates to participate in alternative placement decisions and receive adequate

notice of the decision-making process.

II. Improve the Administration of Justice in Baker Act Cases

Testimony before the Subcommittee often touched on the timeliness of Baker Act proceedings. In fact, timely judicial review drew more passionate reactions from mental health activists than any other issue the Subcommittee studied. Some individuals expressed the opinion that persons with mental illnesses should be entitled to at least the same protections as criminal defendants, prior to further restrictions on their liberty. Judicial review early in the process would increase the public's trust and confidence in the involuntary examination and placement processes.

Involuntary examination and placement involves a weighing of liberty rights with the need for treatment. Chapter 394 contains the only provisions in Florida law that allow restriction of liberties for an extended period of time with no judicial review. Until or without a court hearing, there is no due process.

Florida statutes require involuntary placement hearings to be conducted within five days. There are differing interpretations as to whether that provision means five working days or five consecutive days. Even more troubling was the allegation that some courts ignore the five-day requirement altogether. In some jurisdictions, involuntary placement hearings are reportedly conducted only every other week.

System participants counseled that a balancing of due process rights is involved. While they agreed that no citizen should be detained without timely judicial review, they said that review loses its meaning without proper notice and effective representation. The Subcommittee found that because substantial liberty interests are adversely affected, the five-day calculation should be construed in the manner most favorable to the detained individual insofar as is reasonable.

Education was another issue of system-wide concern. Justice system participants reported that they are not always adequately trained on mental health issues. Judges, general masters, state attorneys, and public defenders are legal experts. Most of them possess no special knowledge or training about mental illnesses prior to being assigned to involuntary examination and placement matters. The Subcommittee found that training for justice system participants should go beyond a clear understanding of the applicable laws and procedures. It should also include an understanding of the problems and circumstances that often face elders and individuals with psychiatric disabilities.

Consistency and continuity go hand-in-hand with training to ensure an effective system. Oftentimes, there is no consistency or continuity in assignments of judges, state attorneys, and public defenders to Baker Act cases. In some jurisdictions, the newest judges, public defenders, and state attorneys are assigned to involuntary placement proceedings. In other jurisdictions, involuntary placement cases are rotated among the judges, public defenders, and state attorneys, so while many gain a little knowledge about mental illnesses, none develop a special expertise.

Individuals with psychiatric disabilities, advocates, and justice system participants appearing before the Subcommittee seemed to generally favor the use of general masters in involuntary placement

proceedings. General masters are currently presiding over involuntary placement hearings in at least 8 of the 20 circuits. They often have or develop expertise in the subject matter. However, some courts, particularly those in less populated or rural areas, lack the resources for general masters. This creates an inequity of services available to Florida citizens from jurisdiction to jurisdiction.

There appears to be confusion, a lack of consensus, or even a disregard of the statutes and case law in regard to the appropriate role of the county courts in Baker Act proceedings. Persons in favor of extending jurisdiction over Chapter 394 matters to county judges note that it would increase chief judges' flexibility in making judicial assignments. They also believe that in situations involving misdemeanor crimes, such a change may shorten the process and allow an individual to receive treatment more quickly. Activists were generally opposed to extending jurisdiction to county courts. Complicating the matter even further, some county court judges are currently presiding over involuntary placement proceedings, despite the fact that there may be no legal authority for them to do so. The Subcommittee commends continued research and debate on the appropriate roles of county courts and county court judges in mental health proceedings.

The location and formality of hearings are also somewhat controversial. In Florida, the majority of involuntary placement hearings are held in receiving facilities. According to testimony, conducting hearings in the facilities may confuse patients, particularly elder patients, who may be unaware that a court proceeding is underway at which their liberty interests are being determined. Certain jurisdictions are also considering conducting involuntary placement hearings by video. The Subcommittee learned that some individuals may react negatively to video hearings because of their mental illnesses. When individuals do not understand that a hearing has been held, they believe they have not been afforded their rights and are being held contrary to law.

Typical abuses of the involuntary examination process, the Subcommittee learned, include initiation of the ex parte process by estranged spouses, dishonest neighbors, and other persons who may harbor a grudge. The Subcommittee received testimony indicating that some abuses of the involuntary examination and placement processes might be alleviated through the use of model forms released by the Department of Children and Families in November 1998. The model affidavit form captures information a state attorney would need in order to pursue perjury charges against a petitioner making false allegations. Judge Mark Speiser advised the Subcommittee that the Seventeenth Judicial Circuit recently modified its forms based on the model forms. The revised forms provide substantially more details than before, which allows the judge to make a more informed decision.

Related Recommendations

The State Courts System, state attorneys, public defenders, and clerks of court should continue to seek, and the Florida Legislature should fund, adequate resources for proceedings under Chapter 394.

The Florida Legislature should amend the statutes to clarify whether the five-day requirement includes or excludes weekends and holidays. If the Legislature determines that involuntary placement hearings must be held within five consecutive days, adequate additional funding must be provided to the courts, clerks, state attorneys, and public defenders to enable them to conduct meaningful, as well as [illegible] proceedings.

While the five-day issue is being clarified by the Legislature, the Chief Justice of the Florida Supreme Court should contact every chief judge and probate judge and encourage them to ensure that involuntary placement hearings are conducted within at least five working days of the petition being filed, unless a continuance is requested by the patient with consent of counsel, and granted. In order to comply with the statute, in most jurisdictions hearings would have to be held at least twice a week.

The chief judge of every judicial circuit should immediately implement procedures to ensure that involuntary placement hearings are conducted within five working days, unless a continuance is granted. In order to comply with the statute, most circuits will need to hold hearings at least twice a week.

The Florida Legislature should direct and fund an interdisciplinary study on whether probable cause hearings should be held within 24 to 48 hours for all individuals who are involuntarily examined pursuant to Chapter 394.

Judges, general masters, assistant state attorneys, and assistant public defenders should be adequately trained and educated on general mental health and elder issues, including community resources and issues identified in this report, *prior* to being assigned to Baker Act proceedings.

The Executive Office of the Governor and the Florida Supreme Court should jointly sponsor a statewide interdisciplinary summit on mental health issues related to Chapter 394. The objectives of the summit should include:

- educating participants on mental health issues;
- sharing information on "best practices" in regard to Baker Act cases; and
- providing a forum for the participants to discuss new and emerging mental health issues.

Participants should include chief judges, probate judges, general masters, state attorneys, public defenders, clerks of court, administrative law judges, law enforcement officers, service providers, individuals with psychiatric disabilities, advocates, public and private guardians, and others involved in Baker Act proceedings.

Chief judges, state attorneys, and public defenders should ensure continuity and consistency of the judges, general masters, assistant state attorneys, and assistant public defenders assigned to Baker Act proceedings.

Continuing educational programs on elder, mental health, and disability laws and issues should be made available to all Florida judges and lawyers on an on-going basis.

The trial courts presently allowing county judges to preside over mental health proceedings, including Chapter 394, should review their practices to ensure that those practices comply with current Florida law.

The Florida Legislature should consider amending Chapter 394 to allow county courts to issue *ex parte* orders for involuntary examination, but maintain exclusive circuit court jurisdiction over

involuntary placements.

The Florida Legislature should consider improvements to the *ex parte* provisions of section 394.463, Florida Statutes, including but not limited to:

- requiring and funding a pre-screening process;
- requiring a hearing prior to the issuance of an *ex parte* order; and
- clarifying the time frame within which the behavior in question must be observed.

The Florida Legislature should review and correct any funding inequities that are created when residents of one county are involuntarily placed in another county.

The State Courts System should request, and the Legislature should approve, additional funding to allow the establishment of general masters for involuntary placement proceedings in every jurisdiction that needs and wants such a resource.

The Probate Section of the Florida Conference of Circuit Judges should immediately address the five-day issue with its members.

The Probate Rules Committee and the Civil Procedure Rules Committee of The Florida Bar should determine whether probate or civil rules apply to Chapter 394 proceedings. Then the appropriate rules committee should consider whether to propose rules to clarify the procedures in regard to involuntary placement hearings.

Each judicial circuit, which has not already done so, should review and consider adapting and adopting the model forms prepared by the Department of Children and Families.

The Florida Legislature should direct the Department of Children and Families to create a pamphlet that explains the purpose and statutory requirements of the ex parte process. The Department should provide copies of the pamphlet to the clerks of court for distribution to everyone seeking to file an ex parte petition. The Department should make the pamphlet available in large print and other accessible formats as required by the Americans with Disabilities Act, as well as in English, Spanish, Creole, and other common languages reflective of Florida's population.

Clerks of court and judges should implement a system whereby the clerk's office checks felony, misdemeanor, injunction, abuse, neglect, exploitation, and divorce records to determine if there are any cases pending within the jurisdiction for the respondent or petitioner. If there are any pending cases, the relevant files should be presented to the judge together with the ex parte petition.

III. Protect Individuals with Psychiatric Disabilities and Ensure that their Rights are Observed

It is incumbent upon society in general and the justice system in particular to safeguard the rights of individuals who are detained under the Baker Act. Moreover, due process rights demand that detained individuals receive adequate representation at involuntary placement hearings. In Florida, individuals for whom involuntary placement is sought are almost exclusively represented by public

defenders. Even so, there is reportedly no consistency in the quality of public defender representation in Baker Act proceedings from jurisdiction to jurisdiction.

The Subcommittee learned that some individuals who were detained under the Baker Act reported they had not met with counsel prior to the hearing, received no advice about their testimony, and had no opportunity to plan a defense with counsel. However, public defenders reported routinely undertaking considerable preparations prior to the hearing. They were also given high marks for their preparedness by presiding officers and their state attorney counterparts. Nearly 94 percent of the state attorneys responding to the survey said it appears the public defender's office has prepared its case ahead of time. Quality of public defender representation in Baker Act proceedings seems to hinge on two factors: (1) the priority placed on such cases by each public defender; and (2) the resources available to the public defenders.

The Subcommittee heard considerable testimony on the appropriate role of the patient's counsel in involuntary placement proceedings. Opinions on the appropriate role of counsel were primarily divided into two viewpoints: to advocate for the patient's rights and expressed desires versus to advocate for the patient's best interest. Proponents of the view that counsel's duty is to advocate for the patient's rights and expressed desires presented case law to support their position. They believe it is an ethical violation for counsel not to vigorously defend the client's rights and force the state to meet its burden of proof. Persons favoring the patient's best interest approach are concerned that an individual may be discharged without receiving necessary treatment and thereby come to harm.

The public defenders reported that their current primary position in involuntary placement hearings is to advocate for the patient's rights and expressed desires. Few indicated that their primary position is to advocate for the patient's best interest. While private counsel rarely appear, their primary position may occasionally differ from that of a public defender. Moreover, the role of private counsel sometimes depends on who is paying their fees.

The Subcommittee found that despite improved protections approved by the Florida Legislature in 1996, the *ex parte* process remains vulnerable to misuse by:

- mental health facilities and professionals for financial gain,
- family members who misunderstand the purpose of involuntary examination but are concerned about an individual who may be in need of mental health treatment, and
- anyone who may harbor a grudge against an individual.

A person may not be detained in a receiving facility for involuntary examination for more than 72 hours. Within that time, or the next working day thereafter if that time expires on a weekend or holiday, the statutes direct that certain action must be taken. The Department of Children and Families believes that if a facility has no intention of filing a petition for involuntary placement and the 72-hour period will expire on a weekend or holiday, the individual should be released within 72 hours and not unnecessarily detained until the following work day. Public defenders also expressed concern about this issue. One public defender responding to the survey believed the statute needs to be more specific about when the 72-hour period ends, in cases where no medical emergency exists.

The involuntary placement process is also vulnerable to abuse, and that abuse is often linked to financial gain or convenience of nursing homes, assisted living facilities, mental health facilities, or mental health professionals.

Problems exist as well in regard to voluntary admissions. In 1996, the Florida Legislature amended the Baker Act to strengthen patient rights. Despite these enhanced protections, the Subcommittee learned that because in-patient treatment is extremely profitable mental health facilities and professionals sometimes abuse the voluntary admission process. Moreover, some patients deemed to be "voluntary" may in reality lack the capacity to consent.

Florida law establishes two habeas corpus mechanisms to ensure that patient rights are protected. Individuals detained under the Baker Act may petition for a writ of habeas corpus (1) questioning the cause and legality of such detention, or (2) alleging that the patient is being unjustly denied a right or privilege or that a procedure is being abused. Although these avenues exist for seeking redress, the Subcommittee learned that individuals cannot always avail themselves of habeas corpus protections. The statutes do not provide for appointment of a public defender to represent voluntary mental health patients until after a habeas corpus petition has been filed.

Testimony before the Subcommittee also indicated that some judges defer consideration of habeas corpus petitions until the involuntary placement hearing. In some instances, this delay renders the habeas corpus petition moot and thereby denies the individual's right to judicial review. Further, individuals detained under the Baker Act report that sometimes their habeas corpus petitions are never acknowledged by the court.

Related Recommendations

Every attorney representing a patient in involuntary placement proceedings must vigorously represent the patient's expressed desires. Every attorney representing patients in involuntary placement proceedings must be bound to the same legal and ethical obligations of any lawyer representing a client.

To ensure quality representation of patients, each public defender should place a high priority on representing patients in involuntary placement proceedings and ensure that each case to which that office is appointed is adequately prepared prior to hearing. The Florida Legislature should provide adequate resources to enable public defenders to provide quality representation for all patients in involuntary placement proceedings.

Each public defender should ensure that experienced and trained attorneys are assigned to involuntary placement cases.

The Florida Public Defenders Association should develop a model curriculum or training videotape on involuntary examination and placement procedures, and associated issues.

The bar should be educated as to their responsibilities in handling involuntary placement proceedings.

The Florida Legislature should make funding available to jurisdictions that are willing to coordi an interdisciplinary exploration of innovative alternatives designed to reduce the traumatic effect of involuntary examinations. Such pilot projects should be monitored and evaluated to determine their effectiveness.

When involuntary placement hearings are held in receiving facilities, steps should be taken to increase the probability that patients understand that a formal court hearing is taking place:

- the proceedings should not be conducted by video;
- courtroom formalities should be observed; and
- the presiding officer should wear a robe.

The court should treat petitions for writ of habeas corpus as emergency matters and expeditiously resolve these issues and ensure that the petitioner receives notice of the disposition.

The Florida Legislature should extend standing to file petitions for writ of habeas corpus to the Statewide Human Rights Advocacy Committee and the local Human Rights Advocacy Committees, to further protect the rights of persons who are voluntarily and involuntarily hospitalized.

The Florida Statutes should be revised to mandate that the rights pamphlet prepared by the Department of Children and Families be distributed to every mental health patient–both voluntary and involuntary–upon admission. The pamphlet should be available in large print and other accessible formats as required by the Americans with Disabilities Act, as well as English, Spanish, Creole, and her common languages reflective of Florida's population.

The Department of Children and Families, Department of Elder Affairs, appropriate sections of The Florida Bar, and mental health activists should collaborate on the production of a videotape that explains the rights of individuals with psychiatric disabilities.

The Florida Legislature should consider authorizing and funding the Statewide Human Rights Advocacy Committee and the local Human Rights Advocacy Committees to meet with patients and make them aware of their rights.

The Florida Legislature should amend the statutes to clarify that the 72-hour involuntary examination period is not extended over weekends or holidays, unless a petition for involuntary placement will be filed on the next working day.

The Florida Legislature should provide the Agency for Health Care Administration with adequate funds and staff, and direct the Agency to vigorously enforce regulations in regard to violations by mental health facilities and professionals.

The Florida Legislature should review rights and protections afforded to individuals with mental illnesses under Chapter 394 and ensure that they are no less than the rights and protections afforded to nursing home residents under Chapter 400.

The Florida Legislature should consider revising the statutes to specify that violation of a mental health patient's rights constitutes "abuse" within the meaning of the law.

The Florida Legislature should consider authorizing and adequately funding the Statewide Human Rights Advocacy Committee and local Human Rights Advocacy Committees to assess the ability of all voluntary patients to give express and informed consent to treatment.

All participants should be mindful that patients must be treated with respect and consideration.

Judges, general masters, state attorneys, and public defenders should be educated on the financial relationships and incentives that may exist among mental health providers and the situations in which conflict of interest or abuses may occur.

The Florida Legislature should direct the Statewide Public Guardian to recommend a process and responsible entity to initiate a guardianship evaluation for persons who are mentally incapacitated and need intervention but who do not meet the statutory criteria of the Baker Act.

The Florida Legislature should consider amending Chapter 394 in regard to petitions for *ex parte* orders, to require a factual recitation of the circumstances that support the finding that the criteria for involuntary examination have been met.

The Florida Legislature should consider amending the statutes to provide an explicit right for independent examinations in continued involuntary placement proceedings.

e Division of Administrative Hearings should ensure that hearings on petitions for continued involuntary placement are conducted prior to the expiration of the original placement order.

The Florida Legislature should amend the statutes to clarify the duties, responsibilities, and authority of patient representatives.

IV. Eliminate Unnecessary Delay in the Provision of Mental Health Treatment

Florida law provides that a patient is entitled, with the concurrence of patient's counsel, to at least one continuance of an involuntary placement hearing for a period of up to four weeks. Testimony indicated there are several ways a continuance can be used to the patient's advantage, including allowing the detained individual an opportunity to stabilize, obtain an independent evaluation, or obtain legal representation.

While only the patient is authorized to request a continuance, the Subcommittee learned that some continuances are requested not by the patient or patient's counsel, but by the state attorney, the patient's family, the petitioning institution, or others. Indeed, survey respondents indicated that in some locations, the facilities and prosecutors are requesting the majority of continuances. Other testimony indicated that in some jurisdictions automatic continuances are routinely granted, and sometimes even initiated by the court or clerk to address the five-day hearing requirement.

Martha Lenderman, on behalf of the Department of Children and Families, raised concerns about consent to treatment, particularly if the involuntary placement hearing is continued. If a continuance is granted and the patient lacks the capacity to consent, the individual does not receive needed treatment during the period of delay. Others suggested that some confusion may arise because of the current wording of the statute.

When a person with a psychiatric disability is adjudicated incompetent to consent to treatment, the statutes provide for the appointment of a guardian advocate. The Subcommittee found that when the capacity to consent is lacking, a substitute decision maker should be appointed at the earliest possible time, thus allowing the patient to receive immediate treatment. If the capacity to consent is lacking and the court grants a continuance in the involuntary placement hearing, the court should simultaneously appoint a guardian advocate if there is a pending request.

The Subcommittee learned that there is a lack of available persons who are willing, able, and trained to serve as guardian advocates. The statutes list, in order of preference, persons who are eligible to serve as guardian advocates. Following the health care surrogate, relatives occupy the first four spaces on the list of eligible persons. However, it is well established that many Florida residents, particularly elders, are geographically distant from family members who would normally be available to serve as guardian advocates should the need arise. Survey respondents reported that when no family members or friends are available, there are not enough trained and experienced persons available for appointment as a guardian advocate. Testimony indicated that liability concerns prevent many people from serving as a guardian advocate.

Individuals may designate a surrogate decision maker prior to the need for such a service. However, people may not be aware that this option exists or know how to exercise it. Many activists favor the pre-need designation approach as it allows the individual, not the courts, to decide who is best suited to serve in this capacity.

Another source of potential delay arises when a general master presides over the involuntary placement proceeding and issues a report. The master's report must be confirmed by a circuit court judge. The rule allows parties 10 days from service of the report within which to serve exceptions. Several people expressed concern that a patient may languish unnecessarily during the waiting period. It was the consensus of Subcommittee members and interested persons that everything possible should be done to support an expedited resolution of involuntary placement proceedings.

Related Recommendations

If a petition for the appointment of a guardian advocate is filed, the court should conduct a hearing and make a finding as to the patient's capacity to consent to treatment at the earliest possible time.

Family members and persons who are designated as mental health surrogates should participate in guardian advocate training prior to the time their service is needed, to avoid unnecessary delay in the provision of treatment.

The Florida Legislature should consider providing limited liability protection for family members,

friends, and individuals who serve as guardian advocates on a volunteer basis.

Community workshops should be conducted to educate qualified individuals about mental health issues and the opportunity to volunteer as a guardian advocate.

The courts should comply with section 394.467(5), Florida Statutes, and ensure that continuances are granted only when they are requested by the patient with consent of counsel.

At the time the court considers a motion for continuance, the court should conduct a hearing and make a finding as to the capacity to consent to treatment if there is a pending request. If the court finds that the capacity to consent to treatment is lacking, a guardian advocate should be appointed at the time the involuntary placement hearing is continued.

The Florida Legislature should consider amending section 394.467(5), Florida Statutes, as indicated hereinafter in this report.

The Florida Bar Probate Rules Committee and The Florida Bar Civil Procedure Rules Committee should consider amending the rules of procedure to allow parties to waive the waiting period for entry of a court order in Chapter 394 proceedings when no exceptions will be filed, or alternatively allow for procedures similar to those used for hearing officers in family law cases (Rule 12.491).

The Florida Legislature should fund a guardian advocate system that provides each geographical area with a readily available pool of guardian advocates who have training in mental health issues and psychotropic phamaracology, to serve on behalf of individuals with psychiatric disabilities for whom family or friends are willing or able to serve.

The Department of Children and Families, The Department of Elder Affairs, appropriate sections of The Florida Bar, the medical community, and mental health activists should publicize the availability of mental health advance directives, to allow individuals to maximize self determination.

The Department of Children and Families, The Department of Elder Affairs, local bar associations, and mental health activists should conduct community workshops to educate qualified individuals about mental health issues and the opportunity to volunteer as a guardian advocate.

V. Ensure Public Safety and Represent the State's Interests

Some state attorneys are not fully participating in the Baker Act process. In some instances the state attorney's office is not even represented at involuntary placement hearings. Involuntary mental health examination and placement involve a balancing of individual rights with the state's *parens patriae* authority and police power. The state is the only entity with the authority to restrict a person's liberty. Active participation by the state attorney's office is an integral part of the proceeding, according to Florida statutes and case law. The Subcommittee found that the office of the state attorney must be present at every involuntary placement proceeding in order to comply with the statutory mandate and to appropriately, adequately, and competently represent the state's interests.

Moreover, the Subcommittee learned that state attorneys are not always properly preparing their cases prior to the involuntary placement hearing. In an adversarial proceeding, the state attorney is required to meet a burden of proof for involuntary placement. The state has the responsibility to present evidence and testimony as to the elements and requirements of the applicable statutes.

It appears, however, that state attorneys generally take little action to prepare Baker Act cases. The Subcommittee heard testimony about instances where individuals who were believed to be dangerous were discharged because the state attorney did not subpoena witnesses and conduct other pre-trial preparations necessary to sustain the petition. The court was left with no alternative but to dismiss the petition and discharge the patient. This conduct may place the public's safety at risk. Meanwhile, the individuals do not receive necessary treatment.

The state attorney should gather information independently, and evaluate and confirm the information contained in the petitions. It is incumbent upon the state attorney to vigorously investigate and prosecute the petition. Further, if the state attorney's independent review does not show the statutory criteria are provable, then the state attorney should withdraw the petition.

Chapter 394 specifically authorizes the attorney representing the patient to have access to the clinical record, facility staff, and other pertinent information. However, the law is silent as to whether the state attorney has the authority to access the same information. Thus, a study should be conducted on whether the law should be amended to allow the state attorney access this information in order to evaluate the petition and prepare for the hearing.

Florida Statutes require a law enforcement officer to take a person who appears to meet the criteria involuntary examination into custody and deliver the person to the nearest receiving facility for examination. Testimony indicated that some law enforcement officers inappropriately arrest persons with mental illnesses rather than taking them to a receiving facility. Near the end of the study, the Subcommittee received reports that improvements are occurring in regard to law enforcement's understanding of and response to mental health matters. Nevertheless, there needs to be more training for them on mental illnesses. It may also be beneficial for state attorneys and public defenders to be provided with training on jail diversion programs for individuals with mental illnesses.

Related Recommendations

The state attorney's office must be represented at and actively participate in every hearing. The court should require the presence of the state attorney's office at every involuntary placement hearing. If a representative of the state attorney's office is not present at the hearing, the court should halt the proceeding while the state attorney is summoned.

Each state attorney's office should independently evaluate and confirm the allegations set forth in the petition for involuntary placement. If the information is found to be correct, the state attorney should vigorously prosecute the petition. If the allegations are not substantiated, the state attorney should withdraw the petition.

Each state attorney should place a high priority on involuntary placement proceedings and properly

prepare the cases on behalf of the state. The Florida Legislature should provide adequate resources to enable state attorneys to provide quality representation for the state in involuntary placement.

The Florida Association of Prosecuting Attorneys should develop a model curriculum and/or training videotape on involuntary examination and placement procedures and associated issues.

The Florida Association of Prosecuting Attorneys and The Florida Bar should ensure that continuing legal education programs on elder, mental health, and disability laws and issues are made available on an on-going basis.

Assistant state attorneys representing the state in involuntary placement proceedings must be bound to the same legal and ethical obligations of assistant state attorneys prosecuting other cases.

The bar should be educated as to attorneys' roles and responsibilities in handling involuntary placement proceedings.

Each state attorney should ensure that experienced and trained attorneys are assigned to involuntary placement cases.

The Florida Legislature should direct and fund an interdisciplinary study on whether state attorneys should be authorized to have access to clinical records, facility staff, and other pertinent information.

The Florida Department of Law Enforcement and the Department of Children and Families should jointly initiate a comprehensive training program for law enforcement officers, incorporating a minimum:

- A videotaped orientation to the Baker Act for statewide use, which emphasizes the criteria for initiating an involuntary examination; and
- Crisis intervention training for appropriate interaction with persons with mental illnesses.

State attorneys and public defenders should be provided with training on jail diversion programs for individuals with mental illnesses.

VI. Ensure that Our Most Vulnerable Citizens–Elders, Children, and Wards–Are Adequately Protected

As noted earlier, patient rights, including notice of rights and habeas corpus protections, may not always be adequately observed or protected in some circumstances. This is particularly true for the more vulnerable members of society: elders, children, and wards (persons adjudicated to be incapacitated).

Persons providing testimony before the Subcommittee expressed concern about the excessive and inappropriate involuntary examination and placement of elders, especially elders who reside in nursing homes and assisted living facilities. Certain misuses of the Baker Act for elders involve financial incentives. Others relate to behavioral problems. Some facilities purposefully use the Baker Act to

"dump" residents who are disruptive or require mental health treatment. In those situations, the nursing home or assisted living facility refuses to allow the individual to return when the individual is released from the mental health facility.

The Florida Legislature enacted legislation in 1996 to provide an increased level of protection for certain elders living in licensed facilities. The statute now provides that prior to an elder being sent to a Baker Act receiving facility on a voluntary basis, an initial assessment of their ability to provide express and informed consent to treatment must be conducted by a publicly-funded service. There was a consensus that these increased protections have improved the process. Nevertheless, everyone agreed that further modifications should be made to provide additional protections for vulnerable elders in both voluntary and involuntary admission situations.

Children with mental illnesses are deserving of the full protection of the justice system, but their rights under Florida law remain somewhat unclear. For example, it is not even settled whether children have a right to judicial review of their confinement under the Baker Act.

The Subcommittee learned that there are conflicting statutory provisions and interpretations as to what a "hearing" on the voluntary admission of a child means. Testimony indicated that the Department of Children and Family Services' regulations provided that a hearing consists of a meeting between the facility administrator and the child. Some people expressed the opinion that a court hearing is required. A Florida appellate court recently reviewed the question of whether a Chapter 394 involuntary placement hearing is required when a dependent child is in the legal custody of the Department of Children and Family Services and the Department seeks residential mental health treatment for the child. The appellate court concluded that these facts do not constitute an voluntary commitment requiring a Baker Act hearing. Review of the intermediate appellate court's decision is currently pending before the Florida Supreme Court.

The Broward County Multiagency Service Network for Children with Severe Emotional Disturbance (SEDNET) reported that most complaints in that jurisdiction regarding the admission and treatment of children involve the statute's requirement for consent from someone other than the child. The unfortunate result is that all too often a child who experiences a crisis sufficient to motivate the child to seek admission to a receiving facility is denied treatment for distressingly long periods of time. This is particularly true and troubling, SEDNET said, in the case of dependent children whose biological parents remain their guardians. In those instances, there is a regrettable paradox of a child's pressing need for immediate help being left to the discretion of adults who have a history of neglecting or abusing that same child. Equally disturbing is the scenario of a child who is voluntarily seeking treatment instead being involuntarily admitted because guardians cannot be located or their consent obtained. In all these cases, the statute needlessly forces upon a child the stigma and associated implications of being involuntarily placed. Furthermore, these circumstances sometimes result in the decompensation of the child's condition.

The Subcommittee is deeply concerned about protecting the rights of children. Consent issues are more complex in regard to children. The Subcommittee found there should be some type of oversight of the placement of children in mental health facilities. The Subcommittee also noted that a child's right to seek a writ of habeas corpus should be protected.

Chapter 744 provides for the appointment of a guardian when an individual is adjudicated to be incapacitated. A guardian appointed pursuant to Chapter 744 is not allowed to voluntarily place a ward in a mental health facility; a Baker Act hearing is required. A representative of The Guardianship Committee of The Florida Bar Elder Law Section addressed the Subcommittee on the issue of whether guardians should be allowed to voluntarily consent to placement on behalf of their wards.

Hugh Handley, public guardian in the Second Judicial Circuit, clarified that a guardian is authorized to advocate for wards to receive mental health services. Moreover a guardian can initiate the involuntary placement process either by seeking an *ex parte* order or by contacting a professional who can conduct an examination and then issue a certificate if appropriate. The Subcommittee found that the placement of a ward by a guardian is a serious decision that should be subject to judicial review. Screening by the courts is a safeguard and reveals any abuses of the process.

Related Recommendations

The Florida Legislature should direct and fund a comprehensive interdisciplinary study on the legal needs of children under the Baker Act, including but not limited to:

- whether children under the age of 18 should have the right to voluntarily consent to in-patient mental health treatment, without the consent of their guardian.
- whether the Human Rights Advocacy Committees or another independent entity should have the authority to make contact with a child confined to a mental health facility, to confirm the voluntariness of the child's consent.

  whether a child's right to petition for a writ of habeas corpus pursuant to Chapter 394 is adequately protected and whether legal counsel should be provided.
- whether judicial review of placement of children in mental health facilities should be required, to ensure the appropriateness of involuntary placements and the voluntariness of voluntary admissions. The Florida Legislature should consider amending the statutes to grant children under the age of 18 the right to voluntarily consent to in-patient mental health treatment, without the consent of their guardians.

The Florida Bar Commission on the Legal Needs of Children should study the legal needs of children under the Baker Act.

Judges, general masters, state attorneys, and public defenders should receive training on "dumping" and vigilantly guard against that or other abuses of the Baker Act in situations involving elder residents of nursing homes or assisted living facilities. If dumping or abuse is suspected, it should be immediately reported to the Agency for Health Care Administration and the Long-Term Care Ombudsman.

The Florida Legislature should consider the feasibility and appropriateness of extending the protections of section 394.4625(1)(c), Florida Statutes, to involuntary as well as voluntary examination situations.

The Florida Legislature should direct the Department of Children and Families, the Agency for Health Care Administration, the Long-Term Care Ombudsman, or other appropriate entity to study whether nursing homes and other facilities are "dumping" residents because of a lack of funding to treat conditions not covered by governmental programs and private insurance, as well as for fraudulent financial gain.

The Florida Legislature should consider whether the definition of mental illness should be amended to exclude dementia, Alzheimer's disease, and traumatic brain injury.

The Florida Legislature should consider expanding the list of professionals in 394.4625(1)(c) to prohibit the involvement of any professional who has a financial interest in the outcome of the assessment.

The Subcommittee strongly recommends against allowing guardians to voluntarily place a ward in a mental health facility without judicial review.

VII. Continuously Monitor, Study, and Improve the Florida Mental Health System

As noted earlier, limited funding, time, and staff support were obstacles to comprehensively evaluating some of the issues brought to the Subcommittee's attention. In fact, it appears there is a lack of available data which could be analyzed to reveal abuses of the Florida mental health system. In 1996, the Florida Legislature began to address this lack of data by requiring information on involuntary examinations to be submitted and collected.

Subcommittee concluded that because the potentials for misuse are so numerous and the consequences are so serious, Florida's mental health system should be continuously monitored, studied, and improved. Additional resources should be made available to gather and analyze appropriate data, the Subcommittee found.

Related Recommendations

Forms related to involuntary examination and placement, including disposition, should be collected, monitored, and analyzed by the Agency for Health Care Administration on an on-going basis in order to detect and address abuses in a timely fashion. All forms should include the patient's date of birth, race, gender, and other demographic information, so that the impact of Chapter 394 on elders, children, racial minorities, and other population groups can be collected and analyzed. The results of this statewide data collection and analysis should be reported to the Florida Legislature, Department of Children and Families, and the State Courts System on an annual basis. Adequate funding should be provided by the Legislature to permit such data collection, research, and analysis.

The Florida Legislature should direct and fund an interdisciplinary study on the continued involuntary placement process.

The Florida Legislature should require facilities to provide all petitions and orders for involuntary place nt to the Agency for Health Care Administration within one working day.

March 16, 2004

Senator John Breaux, Chairman
Ms. Lauren Fuller
US Senate
Special Committee on the Aging
Washington, DC

Dear Lauren:

This is my request to submit a Statement for the Record to the US Senate Special Committee on the Aging for the meeting on March 22, 2004. I understand you can assist me in doing so.

Submitted by:
Rorie Lin Gotham
Sky Ranch
Post Office Box 234
Washington, CA 95986
(530) 478-0258

Regarding the double tragedy in the deaths of Ivan K. Gotham, senior citizen, and Brian Litz, Marion County Sheriff Deputy, in Ocala, Florida on February 7, 2004:

The story of how our greatly loved Father died is very tragic and deeply sad. But there is so much more on the plate that we need to address, such as which priorities will help bring about the necessary changes we so importantly would like to realize.

The community in Marion County and his surviving family suffered a tremendous loss with the death of Deputy Litz as a result of the lack of proper training for law enforcement officers so they will understand how to deal with the mentally ill.

Certainly, creating a change in the way mentally ill people are perceived combined with training for law enforcement officers will lead to a better future for both.

I truly believe that this is the heart of the matter: MONEY - to fund mental health care and for training.

The current attitude of mental illness by enforcement officers is due to one point -- lack of awareness and training. Raising law enforcement standards of expertise is needed.

In Florida, the Baker Act Committee of Hillsborough County, in Tampa Florida formed following a tragedy involving a 34-year old severely mentally ill man who was shot and killed. This man was Baker Acted on more than 20 separate occasions.

This Committee has structured an intensive 5-day training program that addresses how to humanely handle the mentally ill in a dignified manner in times of crisis. Thus far, ten of Florida's 67 counties, have brought this training to their Law Enforcement Agencies.

All it takes is to provide law enforcement officers with proper training, followed by incorporating new procedures to handle "911" calls for mentally ill persons and for the "system" to address the most important issue at hand: mentally ill persons need proper treatment - **hence more funding** is required.

Right now in Florida there is an alarming abundance of enforcement related killings of those mentally ill. Perhaps I could deduce that this is not only a problem in Florida but throughout the United States.

I understand that a partner to this issue is that the number of senior citizens suicides and mentally ill suicides in Florida is astounding.

The number of incarcerations, via the Baker Act of those suffering from dementia, confusion, disorientation as well as bi-polar, schizophrenia, or just plain over-addicted symptoms in all age groups, is growing.

The number of beds AND facilities available is declining. There are few out-patient and follow up procedures for those "Baker Acted". A new announcement came out this week of yet another mental facility closing due to **lack of funds**.

And I have to ask:

Why is that? Because the state of Florida legislatures, as well as the United States Congress, are not appropriating monies in the right direction. Funding of mental health facilities and providing adequate mental health care is imperative.

Hiring law enforcement officers to identify and diagnose and incarcerate those suffering from mental illness should NOT be their job.

We must make this point and connection.

This is the way Florida is handling mental health problems! That is the reality.

Law enforcement officers are NOT qualified to make these decisions, yet that is where the responsibility lies and where the decisions are being made because <u>there are funds to hire officers – the myth is that the public will be safer.</u>

This is based on FEAR of the mentally ill not the desire to TREAT the mentally ill.

And these decisions to lock people away, that are being made after perhaps a one time event /encounter, are inappropriate, disrespectful, if not disgraceful, and the enforcement officers are spending little time understanding the health and well being of those individuals committed to their demise. It is not the officers fault – it is our fault, the tax-paying public and the legislators, for not dealing with the mental health issues in the right way.

Officers cannot possibly begin to understand the mentally ill individual they are dealing with. They are NOT trained to do so nor are they educated to do so nor are they experienced to do so.

From what I understand, officers who enroll in special courses and go through proper training on how to deal with those who are mentally ill, are shocked of the responsibility they have had on their shoulders. I recently heard second hand of one officer who attended a training session. He stated that he was so enlightened that he wonders how he ever made it through 12 years of service making the tough decisions he had to make. And more importantly he felt that he might have wronged victims due to his lack of this special training earlier in his career.

Since Florida is NOT handling the issue of mental health properly, and until the right leadership heads in a healthy direction, the same unfortunate, needless, senseless, killing will go on.

It is very important that we bring this to the attention of the Special Committee.

Florida is the fourth most populated state, as well as the fourth wealthiest state in this nation. But Florida is right on the very bottom of the list for providing mental health care.

Florida is a haven for seniors. These elderly people lose their prime sight, keen hearing, their peak ability to process information, survive heart failure and have their kidneys replaced. All this seems to be widely accepted as "normal" in the process of slowing down and aging.

The one point needed to be made is that mental illness has a negative stigma attached to it socially. When the human brain fails to operate in a healthy way (which can happen at any age) or it begins to slow down its ability to function normally and ages, it fails to process information quickly or completely and it is labeled mental illness. And for most folks in their later years, this is a real live occurrence of the aging process.

But we, as a nation, don't understand mental illness, so we fear it socially.

Why is there no support for understanding the brain's slowing down or being ill? The brain is just another organ that is changing. It may be as normal in the aging process as not being able to run as fast as we could when we were 45.

I would like to suggest that the mental health care in America be under intense scrutiny and needs to rise to the top of the list for attention by our leaders. We all need to wake up and ready ourselves ahead of the Baby Boomers arrival at this critical stage of their lives.

Right now the seniors suffering from decline in their mental capacity need our attention, our care and our commitment of funds to provide for their well-being properly, with respect and dignity at the last stage of their lives. Just as we have learned to provide for heart and kidney transplants, treatment of diabetes, eye care etc. we need to step up our ability to treat mental illness in a capable, accountable way.

We must demand and support training our law enforcement officers so they will understand how to deal with those who are mentally ill.

The problem and tragedy in our situation was avoidable.

It is my trust and hope that this message is clear as to the responsibility we hold.

Thank you for the opportunity to express my concerns and I am grateful for your attention.

Respectfully submitted.

Rorie Lin Gotham

List of those copied is attached

Senator BREAUX. Commander, thank you so very much for that very moving and very touching story, very tragic, and also very unfortunate. But again, we appreciate very much your being able to share it with the Congress, and hopefully contribute toward it not ever happening again to any other family. I think that's important.

We are delighted to have back with us Dr. Donna Cohen, who has been with us before and has testified in hearings before the Aging Committee. She is a professor in the Department of Aging and Mental Health at the University of South Florida. We appreciate very much her being with us again.

Dr. Cohen.

STATEMENT OF DONNA COHEN, PH.D., PROFESSOR, DEPARTMENT OF AGING AND MENTAL HEALTH, UNIVERSITY OF SOUTH FLORIDA, TAMPA, FL

Dr. COHEN. Thank you, Senator Breaux, for hosting this hearing. It's another indication of your great leadership in the areas of geriatric mental health care and elder justice issues, and your track record is one of great leadership.

Gary, thank you for coming here with your family to talk about this terrible tragedy in Florida on February 7.

I have spent the past 12 years studying these violent deaths among people with Alzheimer's disease, individuals with the disease who kill, family members stressed by care giving who kill their relatives out of desperation and depression. There are many instances of violent deaths among the dementia community.

As you put it so well in your Elder Justice bill introduced last year, with a companion bill in the House, we do not have good data to survey the incidence and prevalence of abuse and neglect, and homicide is one of the most powerful forms of abuse that can occur.

In my preparation for this hearing, I did do a search, using a newspaper cutting service which I have used before, which has been validated against medical examiner records, and we do have some preliminary data on the prevalence. But before going into this, I would like to add the voices of the community to the voices of the family of Ivan Gotham.

Among the hundreds of these sad tragedies that we have investigated, we were able to bring to this hearing a 911 call from January 11, 2001, in Jacksonville, FL, where Mr. Gotham's brother resides. This was a case where a man with dementia shot and killed his daughter and son-in-law, who lived next door, killed his wife by chasing her across the street behind a dumpster that was in the back of a school yard with an aftercare program, quite active, before shooting himself.

I ask if I may play this brief introduction.

[Transcription of 911 call:]

911: Sheriff's office.

Caller: Yes, ma'am. We have a man out behind our house shooting people.

911: He's shooting people?

Caller: Yes, ma'am. There's one laying down on the ground and he's chasing another one back behind the park.

911: Somebody has been shot?

Caller: Yes.

911: What's the address? What is the address?

Caller: It's a trailer on school ground. He just fired another shot. We heard three shots.

911: OK. Give me a description of him.

Caller: Hannah, what's he look like?

911: Is he a white male or black male?

Caller: He's a balding man, probably in his fifties.

911: Is he a white or—a white male?

Caller: Yes.

911: What color shirt and pants does he have on?

Caller: What color clothes? Oh, my god, he just killed her.

911: OK, ma'am. I need a description of him.

Caller: Navy blue.

911: Blue what?

Caller: He's shooting himself.

911: He just shot himself?

Caller: Oh, my god, he's going to shoot himself in the mouth.

911: Ma'am?

Caller: Yes.

911: OK. Who did he shoot?

Caller: We don't know.

911: OK. There's somebody laying on the ground, and didn't he just shoot himself?

Caller: We don't know.

911: OK. Well, give me a description of him. What does he have on?

Caller: What does he have on? All blue.

911: He has one all——

Caller: Navy blue.

911: Where is he? Is he behind your house?

Caller: Yes, ma'am. He's behind the house. He's got the gun in his mouth. He's walking toward my house. Please hurry. I have children here.

911: OK. Do you know where the person on the ground is shot at?

Caller: I don't know. I don't know.

911: OK. Has he shot himself?

Caller: No. He's walking around with the gun in his mouth. He's shot two people.

911: He shot two people?

Caller: Yes, ma'am. There's one laying on the ground. Oh, my god, he's loading the gun. Please hurry.

911: OK, ma'am. I've got police and rescue on the way, but I just need you to continue to talk to me.

Caller: Pardon me?

911: OK. What is he doing now?

Caller: What is he doing now? He's loading the gun. I can't——

911: He's loading the gun?

Caller: Yeah. I can't see him. My mother-in-law and my husband are watching. Oh, my god, just another shot, two more shots, four more shots.

911: Four more shots?

Caller: Five more shots. Kevin, no! He shot himself? [End of transcription.]

Dr. COHEN. Mr. Hurley shot himself. The city of Jacksonville is still stunned by this event in 2001.

One of the important points I would like to offer to the committee is that, even though these things probably are relatively rare compared to other forms of elder abuse, they have a long-lasting impact on families and communities.

I was surprised that we know so little. We have a mechanism for collecting data out of the Department of Justice, the National Incident Based Reporting System for Crime Statistics, but it only codes the offender's age and the relationship to the victim. There is a great deal of information about the victim.

The Centers for Disease Control, with funding from the Federal Government, has been implementing a National Violent Death Reporting System based upon about 5 years of pilot studies with 13 sites coordinated by the Harvard School of Public Health. I spoke with every single one of those sites, including the key individuals at Harvard, and they were the first to admit that they have very comprehensive data on the victims of suicide, homicide, and homicide-suicide, but even at the best sites, they don't even have 50 percent of information about the homicide offenders.

The sites that have the least data have maybe 10 percent of the information about the homicide offenders. For victims, they code for mental health antecedents, but do not separate out dementia.

Within State systems, we do have a reporting mechanism for resident violence in long-term care, but no State in the United States records deaths on residence violence. So, sadly, our current State and national systems for recording this information are neglecting to provide us the codes to answer the questions that you pose to us.

We did a newspaper surveillance of the United States 2 years retrospectively and found that there were ten incidents where someone with dementia killed another person. Ninety percent involved men, 90 percent were at home, 20 percent were homicide-suicides. The previous study we did showed that half of them occurred in long-term care. I submit that a newspaper surveillance study is not a scientific study, but it gives us an indication of the need to do further research on this.

One of the issues for law enforcement, for the Alzheimer's association, for health and mental health professionals, is the assessment of violence. Predicting violence is like predicting the weather. We have many programs and mechanisms to do this, but it is very difficult. The psychiatric literature tells us that there are ways of assessing dangerousness, and from my experience in the past 10 or 12 years, along with some studies that have been done in Europe as well as the United States, we know that there are some antecedent factors. We don't know if they are risk factors, but as you have aptly summarized, they are potential risk factors. Since they are there for the view of the public, I won't go over them.

Precipitating factors are very difficult to identify, and the literature really supports what Commander Gotham said. You have individuals who are fearful, who have had experiences of being scared in the past, and they have catastrophic reactions. You and I would be afraid if an officer came to our door, and we really didn't know what they were there for.

Someone with dementia, like Mr. Gotham, clearly scared—and I know from the family stories, this is a very compelling story. I echo what you said. I hope that this story will bring about some change.

There are many legal and policy challenges, which some of my colleagues will be talking about here today, one of them the major legal challenges to law enforcement, but also the judiciary, prosecutors, and defense attorneys.

There are model programs, and I think you will hear about one from my colleague from Johns Hopkins and from my colleague from Florida International University.

I have made several recommendations to you, Senator Breaux, and I will echo the themes that were in your bill, the Elder Justice bill, of the need for more lethal violence research, for surveillance, education and training for law enforcement. The Department of Justice does fund some of this, and your bill provides a mechanism to further this.

The development of programs like Crimes Against the Elderly, which are actually programs within law enforcement, actually provide officers training on a daily basis, so that we can have a better educated law enforcement program.

We need education and training for health care professionals. We also need the consideration of State laws about allowing persons with dementia to possess firearms. A case in Eugene, OR where a man with dementia killed his wife and another man with dementia has led the State of Oregon to consider this kind of legislation. Minnesota has begun to consider this kind of legislation, but we get into issues of an individual's civil rights.

In conclusion, Senator Breaux, and the committee and audience, lethal violence by dementia may be rare, but as you said, we need to understand this. Violence by formal and informal caregivers is probably more common, but the circumstances have a common denominator: the need to identify, intervene, and prevent the abuse, the injury, and the unnecessary death of Detective Litz and your father, Mr. Gotham.

Thank you, sir.

[The prepared statement of Donna Cohen follows:]

VIOLENT CRIMES AND DEMENTIA

STATEMENT OF

DONNA COHEN, PH.D.

PROFESSOR AND HEAD
VIOLENCE AND INJURY PREVENTION PROGRAM
DEPARTMENT OF AGING AND MENTAL HEALTH
LOUIS DE LA PARTE FLORIDA MENTAL HEALTH INSTITUTE
UNIVERSITY OF SOUTH FLORIDA

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

A HEARING ON

CRIMES WITHOUT CRIMINALS?
SENIORS, DEMENTIA, AND THE AFTERMATH

MARCH 22, 2004

Chairman Craig, Ranking Member Breaux, and Members of the Committee:

My name is Donna Cohen. I am a professor in the Department of Aging and Mental Health and Head of the Violence and Injury Prevention Program in the Louis de la Parte Florida Mental Health Institute at the University of South Florida. I am one of the original founders of the national Alzheimer's Association and a founding member of the association's Medical and Scientific Advisory Board. I also serve on a caregiving panel within the Roslyn Carter Institute on Human Development dealing with end of life issues regarding Alzheimer's disease.

Thank you for convening this important hearing about how persons with dementia are treated in our health care and criminal justice systems. This is another welcome demonstration of your vital concerns about improving geriatric mental health care and clarifying critical elder justice issues.

Thank you also for inviting me to testify about my research, experiences, and recommendations with regard to crimes involving older persons with dementia. There are many compelling issues, including but not limited to, assault and battery, sexual assault, vehicular injury, attempted homicide, homicide, and homicide-suicide. My comments before you today will focus on two types of lethal violence perpetrated by individuals with dementia—homicide and homicide-suicide—and I will address the following areas.

- The Magnitude of the Problem
- Risk Assessment for Dangerousness
- Legal Challenges
- Recommendations

However, I would first like to put a face on the lethal circumstances.

In August 1996, Howard Darst, an 89-year old man in Sarasota, Florida, was accused of beating his 88-year old wife to death with his cane. Both had been diagnosed with dementia. The night of the killing the couple had arranged with their home health aide to sleep on recliners in the living room, rather than their bedroom, in order to watch the closing ceremonies of the Olympic games in Atlanta. It appeared that Mr. Darst, who had been diagnosed for about ten years, had awakened sometime during the night in unfamiliar surroundings. He was probably frightened by something and beat his wife, not knowing who she was. Although an arrest warrant was issued after the law enforcement investigation, charges were dropped after the family agreed to place him in a secure nursing home. Mr. Darst had no memory or insight into what he had done but he did miss his wife. He became progressively frail and died six months later.

In November 2003, Frank Kuykendall, an 86-year old resident of an assisted living facility in Eugene, Oregon, shot and killed another resident, 89 year-old Joe Bruscia, in a commons area. He then went to the room he shared with his 86-year old wife, Ruby, and shot her before turning the gun on himself. Mr. Kuykendall died at the scene, but Mrs. Kuykendall and Mr. Bruscia died later at the hospital. Mr. Kuykendall had been

increasingly upset with Mr. Bruscia's many visits with his wife, including one the day of the killings. The homicide-suicide was the tragic end-result of an ongoing dispute among the three individuals, all of whom had been diagnosed with dementia.

The Context of the Challenge of Lethal Violence by Individuals with Dementia

There is an emerging literature on severe violence and dementia, but little is known about the prevalence and clinical patterns of severe violence leading to death perpetrated by individuals with Alzheimer's disease, vascular dementia, and related dementias towards other persons at home and in long term care. To my knowledge, there are no empirical studies of the prevalence, risk factors, and clinical patterns. Dementia homicides are probably rare, but they are of increasing concern to family members, health care providers, mental health care professionals, community leaders, and law enforcement.

It is important to underscore that there are several types of severe violence involving individuals with dementia and their family/formal caregivers that also have important and complex clinical, legal, and policy implications. Patients as well as caregivers can be perpetrators and victims of abuse, injury, and lethal violence.

Although lethal violence is relatively uncommon at the moment, it is possible that homicide and severe violence may increase as the population ages, accompanied by increasing numbers of individuals with Alzheimer's disease and related dementias. The American Public Health Association has classified dementia as an emergent epidemic. Alzheimer's disease is 1.5 times more common than stoke or epilepsy and as common as congestive heart failure.

In 2000 there were at least 4 million persons with Alzheimer's disease and related dementias in the U.S., and that number is estimated to increase to between 11.3 million to 16 million Americans by 2050. There were an estimated 36 million afflicted persons in the world in 2000, and this number is conservatively projected to increase to more than 85 million by mid-century. If we add another 18-16 million Americans with Mild Cognitive Impairment (MCI), a condition that may be a precursor to Alzheimer's disease, and add 170-340 million persons around the world with MCI to the projections for 2030, we are indeed facing a world crisis in caring.

Magnitude of the Challenge and Need for Surveillance

Research is needed to determine incidence and prevalence of dementia offenders. It has long been known that homicide rates for older persons are very low compared to younger persons. In the U.S. older offenders commit 3-6% of homicides, but there are no national or state data on homicide offenders with dementia.

The national reporting system of the Department of Justice (DOJ) is focused on crimes and victim characteristics, with little information about offenders. The National Incident-Based Reporting System (NIBRS) for crime statistics only codes the offender's age and relationship to the victim.

The Centers for Disease Control (CDC) has been implementing a National Violent Death Reporting System (NVDRS) to better understand the characteristics of violent deaths and find ways to prevent them. The NVDRS is based on the work of a research consortium developing a National Violent Injury Statistical System (NVISS). Discussions with staff at the coordinating site in the Harvard School of Public Health and staff at several of sites around the country confirmed that offender data are less comprehensive than victim data, given limitations in the law enforcement and medical examiner/coroner reports. The NVISS does not have a diagnosis specific code for dementia, but does code for the presence of mental health problems in offenders, when the information is available.

In the absence of national data, my Violence and Injury Prevention Program at the University of South Florida, conducted a two-year retrospective newspaper surveillance study using the BurrelleLuce's Information Service to ascertain news stories where a patient with dementia killed another person. The BurrelleLuce service surveyed 1734 United States daily newspapers from 2002-2003. A total of 9 cases were identified where a dementia patient, ranging in age from 74-68 yrs., committed homicide: 90% were men, 90% killed a spouse or intimate, 20% were homicide-suicides, 80% used a firearm, and 90% of the incidents occurred at home. Although newspaper surveillance has methodological limitations, my previous studies with Burrelle have shown congruence between medical examiner newspaper data for homicide-suicides. The observed estimated prevalence for dementia perpetrated homicide-- 0.22 per 100,00 persons with dementia--is likely an underestimate.

A previous newspaper surveillance study on homicide and dementia in our program showed that more than half of all incidents reported occurred in long term care facilities. Long term care reporting systems at the state level record resident-on-resident violence, but, unfortunately, they do not specify fatalities.

Over the past ten years my research team has been tracking homicide-suicides in Florida, and individuals with dementia perpetrate less than 1% of these incidents. Although homicide-suicides are rare compared to suicides and homicides, they have a dramatic and long term impact on family members and communities where they occur.

Risk Assessment for Dangerousness

There is a significant literature on the assessment of violence and dangerousness in persons with psychiatric disorders, but research on patients with dementia is limited. The best predictor for violence is a history of previous violence, and if there is no history, clarification of the closest the person ever came to being aggressive or violent. Active paranoia and psychotic symptoms are also risk factors. However, the prediction of the risk for dangerousness is difficult.

Research is critical to identify and clarify factors that increase vulnerability to homicidal behavior in persons with Alzheimer's disease and related dementias as well as to predict and prevent homicides. My clinical research and legal experience suggests that the

following antecedent factors increase the risk for homicidal behavior in persons with dementia:

- History of previous violence or "other-directed" behaviors
- History of alcohol abuse
- Active paranoia and other psychotic symptoms
- Psychotic depression
- Vascular dementia
- History of catastrophic reactions
- Traits such as low frustration tolerance and aggressivity
- Military/law enforcement/firefighter history

Precipitating factors are more difficult to identify. Homicides perpetrated by individuals with dementia are often violent. A 76-year old husband with dementia stabs his wife in the head with a pick-ax, killing her. A 62-year old daughter shoots her 90-year old mother before turning the gun on herself. An 80-year old husband beats his wife to death with a telephone and cane. An 85-year old man stuffs plastic in the mouth of a bedridden assisted living resident and smothers her with a pillow.

However, in almost all cases, these are not willful and intentional acts to injure and kill. They are tragic outcomes of a combination of circumstances: the individual's sensory, cognitive, emotional, and physical status; the individual's fearfulness and ability to communicate; awareness and preparedness of others who interact with the patient; biopsychosocial and environmental stressors; and the availability of firearms, knives, heavy objects, and other lethal means.

Random circumstances (e.g., food fights, sudden confrontations) or long term frustrations (e.g., jealousy) may escalate rapidly at home or long term care settings when patients are frightened, angered, or have catastrophic reactions to other persons, events, or circumstances. The testimony of U.S. Navy Cmdr. Gary Gotham about the death of his father, Ivan Gotham, February 7, 2004 should compel us, as professionals and human beings, to find ways to prevent these unnecessary tragedies in our communities.

Legal and Policy Challenges

Homicides and other crimes present complex legal challenges for law enforcement, prosecutors, defense lawyers, judges, mental health professionals, government officials, and caregivers to balance the humane needs of individuals with dementia with the need to protect the public.

Law enforcement officers are usually the first responders when violence occurs, and they often lack training to understand and handle individuals with dementia. Patients are often arrested, interrogated, and jailed for months because alternatives are not available. Model programs exist in many states that provide training programs for law enforcement, monitor jails on a daily basis for dementia patients, and provide mental health/law enforcement dementia response teams in the community.

Within the criminal justice system lawyers and judges are faced with considerations about the nature of the killing, the severity of the dementia, and competency to stand trial. Legal issues include decisions about whether to charge the patient, prosecute the case, transfer the patient to forensic wards, geriatric facilities, or other options. Most individuals are not prosecuted when they are clearly incompetent, but the determination can be difficult when the patient is mildly impaired. When killings occur in long term care facilities, lawsuits may be filed by a victim's family against the nursing home or assisted living residence.

Recommendations

There are several priorities for the future, including but not limited to the following:

- Lethal violence research, including surveillance, intervention studies to prevent violence and the effectiveness of traumatic family support
- Education and training for law enforcement
- Development of programs such as Crimes Against the Elderly Units within law enforcement agencies
- Active dementia violence policy and program development within the Attorney General offices of each state
- Education and training for health care professionals in acute and long term care
- Development of collaborative community efforts and programs to respond to the needs of patients who are violent and the victims of violence
- Consideration of state laws to not allow persons with dementia to possess firearms
- Consideration of state laws to ban firearms in assisted living settings

Commentary

Lethal violence by individuals with dementia may be a rare phenomenon, but abuse and violence by formal and informal caregivers towards patients is much more common. Both circumstances have a common denominator—the need to identify, intervene, and prevent the abuse, injury, and death.

I thank you for the opportunity to speak before you today.

Senator BREAUX. Thank you very much, Dr. Cohen, for a very thorough and extensive statement. It was very informative.

Our next witness is Mr. Max Rothman, who is executive director, the Center on Aging, Florida International University. We welcome you, Mr. Rothman, and we are pleased to receive your testimony.

STATEMENT OF MAX B. ROTHMAN, J.D., LL.M., EXECUTIVE DIRECTOR, THE CENTER ON AGING, COLLEGE OF HEALTH AND URBAN AFFAIRS, FLORIDA INTERNATIONAL UNIVERSITY

Mr. ROTHMAN. Thank you very much, Senator Breaux.

I have been asked to address challenges facing the judiciary in response to the growing incidence of crime among elders with dementia and mental health conditions. In fact, quite little is known about the impact older people will have on the courts. There has been limited effort to examine the implications of aging on judicial administration, access to the courts, appropriate jurisprudence for elders who perpetrate crime, or resolution of underlying issues.

There is little evidence that courts in general have addressed these issues, other than to achieve compliance with ADA requirements. We need to understand more about the complex reasons that lead older people to the courts, how courts respond, and what policies, resources and administrative actions are required in the future.

The demographics of aging and the special needs of elders will impel judicial systems to accommodate larger numbers. Diversity of race, ethnicity, language, culture and education will overlay increasingly complex physiological, psychological, and social profiles.

There will be more victims, arrests, and incarceration for violent crimes like domestic violence and sex offenses, as well as nonviolent crimes of theft and drug related offenses. Misdemeanors, shoplifting, trespass, also will increase. These may well involve people with dementia, mental illness, substance abuse, and complex medical conditions.

Now, based upon data from our current research on judicial responses to an aging America, we do not believe that most jurisdictions are addressing issues of aging. However, site visits that we have made corroborated the identification of many similar concerns on the part of judges, court administrators, and health care professionals.

The philosophy of therapeutic jurisprudence and the expansion of problem solving courts reflect emerging trends and best practices in related areas. They share common goals of improved access, closer ties to the community, and more effective use of available services to reduce recidivism.

Elder justice centers in West Palm Beach and Tampa, FL share a common mission to remove access barriers to the system and to enhance linkages between elders and courts as well as with legal, health, and social service systems. Although Tampa focuses on victims and West Palm Beach on offenders, both serve as offices of the courts, not as independent advocates.

Mental health court judges are specially trained and sensitive to the situations of these victims and offenders. Their broad perspective emphasizes health and treatment, coordination with commu-

nity resources, and monitoring offenders to ensure future accountability.

Now, as we have heard, services are quite limited, especially for those with special needs in most communities. Most providers are not closely linked to the courts or to law enforcement. If victims and offenders end up in guardianship—an area that's been labeled the next ticking time bomb for the courts by the President of the National Judicial College—they face a lack of well-trained guardians and little accountability for delivery of services or financial management.

Some preliminary conclusions from our research are in order. Leadership of the Judicial branch is going to be essential. Elder justice centers and perhaps elder courts represent models for replication. Professional staff, working for the courts, can establish community linkages and boundary spanning.

The judiciary, the bar and law enforcement need education about the complex profiles and issues of aging. Standards of accountability and guardianship are typically nonexistent. Services for older victims and offenders with dementia and mental illness are very limited. Information and data on elders is not routinely collected by the courts or used to identify recurrent problems.

In summary, issues of an aging America have not been identified as a judicial priority and addressed with passion and innovation.

Thank you very much.

[The prepared statement of Max Rothman follows:]

JUDICIAL RESPONSES TO THE GROWING INCIDENCE OF CRIME AMONG ELDERS WITH DEMENTIA AND MENTAL ILLNESS

March 22, 2004

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JUDICIAL RESPONSES TO THE GROWING INCIDENCE OF CRIME AMONG ELDERS WITH DEMENTIA AND MENTAL ILLNESS

Max B. Rothman, J.D., LL.M.
March 22, 2004

Senator Craig, Senator Breaux, and members of the Committee. I am Max B. Rothman, Executive Director of The Center on Aging of Florida International University in Miami, Florida.

Introduction:

I have been asked to address the challenges facing the courts in appropriately and effectively responding to the growing incidence of criminal behavior and victimization that may result when elders suffer from dementia and other mental health conditions. In fact, little is known about the impact older people will have on the judiciary. Considerable work has been undertaken concerning specific substantive areas of "elder law," notably with respect to tax and estate planning, other end-of-life issues, and guardianship. However, there has been no effort to examine the implications of aging in America on judicial administration, access to the courts, appropriate jurisprudence for elders with dementia and other conditions who perpetrate violent crimes, or resolution of underlying issues that often precipitate court involvement. In fact, there is little evidence that courts in general have addressed these issues other than to achieve compliance with ADA requirements. As this Committee clearly recognizes, it is important today to understand more about the complex nature of situations that will lead these older

people to the courts, how courts respond to them, and what policies, additional resources, and court administrative actions are needed to prepare for the future.

Background:

Individuals 65 and older today constitute nearly 13% (36,000,000) of the US population. Between 2025 and 2030, this figure will grow to 70 million. While more and more older adults remain relatively healthy well into their retirement years, they often must contend with vision, hearing, and mobility impairments as well as emotional, cognitive and mental health disabilities. Courts, now and increasingly in the future, have to make special accommodations to ensure that all older adults experience ready access to justice.

The need to assure that elders with dementia and other conditions receive fair, equal and appropriate treatment under the law will be even more challenging for the justice system. According to the 2000 U.S. Census data, almost 11% (3,592,912) of persons age 65 and older have a mental disability, defined as some problem with learning, remembering or concentration that makes it difficult to perform certain activities. Although dementia is most often associated with Alzheimer's Disease, many other conditions lead to dementia, including Amyotrophic Lateral Sclerosis (ALS), dementia with Lewy bodies, frontotemporal dementia, hypotoxic-anoxic brain injury, Huntington's Disease, multiple sclerosis, Parkinson's, stroke, traumatic brain injury and Wernicke-Korsakoff Syndrome. The U.S. Congress Office of Technology Assessment estimates that 1 to 5 million Americans have mild to moderate dementia and another almost 2 million Americans have a severe form of dementia.

The Alzheimer's Association predicts that by the year 2040, the number of people with Alzheimer's Disease alone may exceed 6 million.

It is these staggering numbers that fueled our Center's interest in studying issues surrounding elders, crime and the justice system. In order to better understand state-of-the-art knowledge regarding this broad topic, The Center's Research Director, Burton D. Dunlop, and I compiled and edited a book published by Springer Publishing Co. in 2000 entitled Elders, Crime, and the Criminal Justice System: Myth, Perceptions, and Reality in the 21st Century. This book, which brings together the work of experts in many specific areas relevant to the broader topic, highlights the pressing need for more research. As a result, The Center decided to place strategic emphasis on increasing knowledge and public awareness about the many issues surrounding elders and the justice system. Under this umbrella we have conducted research regarding older jurors, elder abuse in the context of family violence, domestic violence and older women, and court-based elder justice centers.

Currently The Center is engaged in a national study, "Judicial Responses to an Aging America", jointly funded by the Borchard Foundation on Law and Aging and the Quantum Foundation of Palm Beach County. We are completing the second year of a National Institute of Justice-funded project examining domestic violence and older women, and completing the third year of the evaluation component of an Administration on Aging Title III-E National Family Caregiver Support Demonstration Program that included primary data collection regarding violent behavior between caregivers and care recipients, many of whom suffer from dementia. Recently The Center completed an assessment of the Elder Justice Center (EJC-PBC)

administered by the Fifteenth Judicial Circuit of Palm Beach County, Florida, also funded by the Quantum Foundation, and we are continuing to work with the EJC-PBC on issues related to information management. The reports from this project, which have been filed with the Chief Judge of the Circuit Court, are included as an attachment to this statement.

Profile of Elders in the Courts:

Although the demographics of aging in America will impel judicial systems to accommodate larger numbers of older adults in the courthouse, it is the special needs of many elders that present the administrative challenge for court administrators and judges. The increases in numbers, of course, represent only part of the equation. There also will be increasing diversity of race, ethnicity, language, education and income, and living arrangements. Moreover, the physiological, psychological, and social profiles of older people will become increasingly complex. We know there is a greater incidence of disease with increasing age, including dementia, cancer, bone and joint diseases, vision and hearing loss, loss of memory and cognition, as well as increased use of prescription medications, some of which produce powerful emotional and physical side effects. In a broader social context, older adults experience loss of roles through retirement, widowhood and bereavement, isolation and loneliness, depression, and substance abuse.

These factors, individually or in an endless panoply of combinations, will result in much greater numbers of older people coming into contact with court systems nationwide. While today's hearing focuses on issues surrounding elders with dementia and mental health conditions, and the lethal events that they may experience or perpetrate, it is important for the Committee to understand that social

factors such as diversity, poverty, education and family relationships, and health factors such as chronic disease and functional limitations exponentially increase the complexity of each such situation the judicial system will encounter.

For example, the number of petitions for guardianship, involuntary civil commitment, and end-of-life issues will climb in both numbers and complexity. Likewise, the number of arrests and incarceration of older people will increase for violent crimes like domestic violence and assault as well as non-violent crimes such as burglary, theft or drug-related offenses. Arrests for misdemeanors such as shoplifting, trespassing, or disturbing the peace also will increase.

Motor vehicle violations of all kinds, including criminal charges and moving infractions, can be expected to grow with expanding numbers of older adults in the community. Civil matters arising from landlord-tenant and other property disputes, contracts, negligence, and an infinite variety of other factual situations, will ensure there are more older people regularly entering the courthouse. Indeed, there also will be more elders selected for jury duty, called as witnesses, seeking divorces, or simply looking for information or assistance.

Any of the matters just described, not untypically, may involve persons with dementia, mental illness, substance abuse or addiction, complex medical conditions, as well as some or all of these disabilities in combination.

Linkage with Community Services:

Any one factor or co-occurrence of circumstances documented above may represent the underlying cause for an older adult to be thrust into the courts. Even if not the underlying cause, some of these conditions may well be present in a given

situation and they need to be taken into account by a judge in dispensing justice effectively. For example, the 78 year-old man jailed for battering his spouse may be in the early stages of dementia. The battered spouse may be mentally competent and strongly opposed to legal sanctions against her husband. The mentally competent 82 year-old sued for foreclosure for failure to pay her taxes may be suffering from depression and lapses in memory but fearful of allowing anyone else to assist her in her financial affairs. Other older persons in both civil and criminal courts may have health and social services needs, exacerbated by dementia, that challenge the typical judge's ability to respond in a meaningful and timely manner.

The policy issue raised by these circumstances is whether the courts have the capacity for early identification of these problems as well as the practical ability to mobilize appropriate services. It is, of course, not unusual that a court may not actually see an individual until a petition for guardianship is filed, at which time meeting any service needs simply may be delegated to the guardian. However, the myriad of civil and criminal cases that may reach a judge where an assessment and/or services are needed prior to any further court actions raises important questions about how judicial districts will plan to meet this emerging need. Increasingly, courts have been experimenting with "problem-solving courts" to obtain services for specialized populations such as drug courts, mental health courts, domestic violence courts, community courts, and family courts. There may be important lessons to be learned from these experiences with regard to elders.

Experience in Other Jurisdictions:

In our national survey of state courts of general jurisdiction the response rate was disappointing, but probably reflects the reality that most courts had little to report. In fact, most courts that did respond are not engaged in specific efforts to address issues of an aging society, either because they want to treat everyone the same or they do not yet experience the volume and complexity of criminal and civil matters involving elders that characterize Hillsborough and Palm Beach Counties, Florida. However, site visits to selected jurisdictions across the country corroborated the identification of many of the same concerns on the part of judges, court administrators, and social service professionals and helped to identify selected programs or program components that merit closer examination for potential replicability.

It is useful to briefly review recent developments in judicial philosophy and administration in order to identify emerging trends and best practices in related areas that may be applicable, and to understand the potential that exists for the judiciary to become more responsive to these complex issues. These developments are all related by a common thread that seeks to improve access to the courts, build closer ties to the community, and ensure more effective use of available services to reduce recidivism. These goals, also, of course, are critically important in the context of older people and the courts.

Therapeutic Jurisprudence

Some courts and judges, following the lead of legal scholars, have adopted the philosophy of "therapeutic jurisprudence" in their adjudicatory roles. The

therapeutic jurisprudence perspective has been described by its founders as suggesting: "that the law itself can be seen to function as a kind of therapist or therapeutic agent. Legal rules, legal procedures and the role of legal actors.... constitute social forces that, like it or not, often produce therapeutic or anti-therapeutic consequences. Therapeutic jurisprudence proposes that we be sensitive to those consequences, rather than ignore them, and that we ask whether the law's anti-therapeutic consequences can be reduced, and its therapeutic consequences enhanced, without subordinating due process and other justice values." (Wexler and Winick, 1996). TJ has been applied primarily in criminal matters, particularly non-violent drug or mental health cases. Interested in more than criminal cases, we view TJ as a "lens" of underlying concepts that looks beyond what's on paper for older adults engaged with the law. The value of TJ is that it attempts to get at underlying issues and to address them as appropriate within the court context.

According to Rottman and Casey (1999), community problems such as substance abuse, mental illness, and familial breakdown inevitably enter the courtroom and judges search for services and treatment to respond to them. Courts, sensitive to the importance of their relationships to their communities, have recognized the need to be more relevant and responsive to the public and to address "the breakdown of social and family support networks." The authors conclude that TJ is based on the principle that judges seek "the selection of a therapeutic option – an option that promotes health and does not conflict with other normative values of the legal system." In addition to application in specific cases, it "may be practiced at the organizational level of the court by devising new

procedures, information systems, and sentencing options and by establishing links to social services providers to promote therapeutic outcomes."

Problem-Solving Courts

Specialized problem-solving courts are a logical and practical systemic application of TJ. As noted earlier, The Center on Aging is currently engaged in a national study that focuses on judicial responses to aging constituents. In the process of this study, we have learned a great deal about problem-solving courts. There are four primary types of specialized or problem-solving courts: drug courts (the first was established in Miami, Florida in 1989), mental health courts, domestic violence courts, and community courts (Casey and Rottman, 2003). Family courts, which may handle divorce, domestic violence, guardianship, and end-of-life matters, represent another hybrid-type of problem-solving court (Casey and Hewitt, 2001). The creation of these courts reflects the reaction of trial courts to dockets filled with too many repeat cases (the "revolving door") in which judges had worked out solutions that addressed symptoms rather than root causes or problems underlying repeated court appearances and convictions. In effect, courts have adopted a TJ approach at an organizational level by using its principles as the underlying legal theory (Rottman and Casey, 1999).

It is instructive to explore the unifying themes connecting these courts. According to one judge, "one of the principal themes... is partnership. They all rely on outsides agencies – to provide social services, to monitor offenders, to supervise community service sentences." (Judge John Feinblatt, Judicial Roundtable, 2000). Indeed, given considerable variance among these courts by jurisdiction and types of cases, an analysis of trends underscored the importance of

community service linkages and stressed "a collaborative, multidisciplinary, problem-solving approach to address the underlying issues of individuals appearing in the court."(Casey and Rottman, 2003).

More broadly, these courts share five common elements (Rottman and Casey, 1999):

1. Immediate intervention
2. Normative social adjudication
3. Hands-on judicial involvement
4. Treatment programs with clear rules and structured goals
5. Team approach including judge, prosecutor, defense counsel, treatment provider, and correctional staff

Although each of these types of special courts are primarily used for non-violent violations of the criminal law (some community courts are multi-jurisdictional), it is their emphasis on early identification of underlying problems, collaboration with human services providers, and individualized treatment approaches that warrant further investigation. A resolution passed by the Conference of Chief Justices and the Conference of State Court Administrators in 2000 called for "the careful study and evaluation of the principles and methods employed in problem-solving courts and their application to other significant issues facing state courts." (Casey and Rottman, 2003). One challenge, then, is to understand how these principles and experiences of problem-solving courts can be utilized to improve how courts address issues involving older people, including any lessons that may be learned and applied to elders with dementia and mental illness who commit violent crimes.

Trial Court Performance Standards:

Another major development during the last 17 years has been the implementation of Trial Court Performance Standards (TCPS). Initiated in 1987 by the Bureau of Justice Assistance and the National Center for State Courts, the TCPS were published in 1997. They emphasize the careful conceptualization and measurement of specific indicators of input, output, and outcomes, with the ultimate goal of improving the outcome performance of the courts. Outcomes are conceptualized as changes in the well-being of the public and the community served by a court. As of 2000, approximately one-third of state courts had adopted the TCPS to one degree or another (Keilitz, 2000). The five performance area of TCPS, which encapsulate the purposes or goals of the courts are: 1) Access to Justice; 2) Expedition and Timeliness; 3) Equality, Fairness, and Integrity; 4) Independence and Accountability; and 5) Public Trust and Confidence.

The TCPS are more than simply an internal procedure for measuring a jurisdiction's traditional operations. They are particularly useful in providing a basis for examining how courts address the need for addressing service issues (Casey, 1998). In this context, then, they "represent a shift from thinking about courts as individual judges making individual decisions (one judge, one court) to thinking about courts as organizations – as a system of structures, people, methods, and practices brought together to achieve specific ends."(Keilitz, 2000).

Problem-solving courts, as described above, are excellent venues for the application of TCPS because one of their primary characteristics is their relationship to community providers of treatment and services (Casey and Hewitt, 2001). Because identification of service needs and the ability to mobilize resources

in response to those needs is particularly critical in matters involving elders, the experiences of these courts need to be analyzed carefully. Although not specifically discussed in this context, nine promising components for effective court-based service coordination have been identified (Casey and Hewitt, 2001):

1. Acknowledged court role in service coordination
2. Judicial and court leadership
3. An active policy committee of stakeholders
4. Case-level service coordinators
5. Centralized access to a service network
6. Active court monitoring of compliance with orders
7. Routine collection and use of data
8. Creative use of resources
9. Training and education related to service coordination

It remains to be determined whether these components would work as well in general jurisdiction trial courts, in both civil and criminal jurisdictions. Thus, it is particularly important to learn to what extent this experience will improve how courts respond to the emerging challenges of an aging society!

Gender and Race/Ethnic Bias

During the 1980's and 1990's, the Supreme Courts of many states initiated studies of gender and race/ethnic bias in the courts. These efforts typically engaged the judiciary, bar associations, court administrators, private attorneys, law school faculty, researchers, and others in producing detailed analyses of existing issues and recommendations to address them. Gender and race are protected classes under the US Constitution and these efforts were motivated by a desire to ensure that the judiciary itself was administered fairly and equitably consistent with prevailing legal standards and sound public policy ("*Gender Bias Study*", 1989).

These efforts, in many states, produced exhaustive reports that examined specific areas of concern in great detail and led to ongoing efforts to educate judges, administrators, attorneys and others about problem areas and standards of appropriate conduct.

Although age has not been determined to be a protected class, the demographics of aging ensure nonetheless that courts must address similar issues in the years ahead. The Massachusetts Report defined gender bias as existing "when decisions made or actions taken are based on preconceived or stereotypical notions about the nature, role, or capacity of men and women" (1989). The Pennsylvania Report was not as specific but similarly studied whether individuals were "treated" differently as "a party, witness, litigant, lawyer, court employee, or potential juror" based on racial, ethnic, or gender bias" (Final Report, 2003).

It is instructive that these studies examine everything from jury selection, court employment practices, and courthouse interactions, to domestic violence processes, criminal justice and sentencing disparities, family law decisions, and civil damage awards. Recommendations are made to the judiciary, legislature, bar associations, law schools, and others as appropriate together with specific avenues for further research and education. The courts have made significant progress in identifying problem areas and in producing vigorous efforts to rectify them. Age is the next frontier!

Elder Justice Centers in Florida:

Elder Justice Centers represent one model for judicial response to the complex issues presented when elders interact with the courts. This problem-

solving type model has been developing in two judicial districts in Florida, where The Thirteenth Judicial District (Hillsborough County) and the Fifteenth Judicial District (Palm Beach County) have both created Elder Justice Centers (EJC's) to address issues of elders. The overarching mission of each Center is to remove access barriers to the judicial system and to enhance linkages between elders and the court system, as well as the legal, health and social service systems. They differ significantly, however, in focus. Hillsborough directs two thirds of its resources to the Probate Court to assist with establishing accountability in guardianship cases, and the balance to serving victims of abuse and other crimes and to general assistance for elders with other matters. Palm Beach has a strong focus on elders arrested for crimes, including elders placed in jail, as well as a broad variety of other legal matters that are referred to the EJC by the court. Recently EJC-PBC staff began assisting the Probate Court by reviewing guardianship reports, and conducting court-ordered investigations to ascertain the status and well-being of wards of the court.

Both EJCs function as offices of the judicial system, not as independent advocates for particular elders. They do provide information and referrals to elders, as appropriate, while also serving as experts to judges on the backgrounds and needs of individual defendants or victims. Both Centers try to address the inevitable fear, confusion, uncertainty, and lack of confidence experienced by many elders confronting the courts for perhaps the first time, especially those with dementia or mental health issues. These experiences can be quite traumatic regardless of an individual's status as victim, defendant, or witness.

The following examples illustrate how the EJC in Palm Beach County provides assistance both to the court and to the accused elder:

CASE 1: A 76- year old female charged with domestic battery (spouse abuse). After screening this woman in jail the caseworker recommended that the court order a mental health evaluation. Based upon further observation in the home, the caseworker made a referral to the Alzheimer's Community Care Association, which diagnosed dementia with delusions. The spouse was referred to a psychiatrist. The Court accepted a plea agreement at the arraignment and both parties were eventually placed in an assisted living facility.

CASE 2: A man lashed out at his wife, who has dementia, by slapping her across the face several times. A neighbor who is a police officer witnessed the occurrence while off duty. The man was arrested and his wife was brought to an unknown, safe location. The EJC was notified of the arrest through pre-trial services and immediately responded at First Appearance. The EJC contacted the local Alzheimer's agency for information and referral, and recommended to the court that the defendant be educated about Alzheimer's Disease and that the victim be placed at an area hospital. The defendant was immediately released to care for his wife and to continue receiving training as a caregiver for a spouse with Alzheimer's Disease. The court ordered EJC staff to provide periodic supervisory review of the case to ensure no further incidents.

CASE 3: A 67-year old woman was charged with domestic battery against her daughter and jailed. Initial screening prior to the First Appearance revealed a history of psychological conditions, including bi-polar disorder. The woman had ceased taking prescribed medication because of severe side effects. The caseworker recommended an inpatient hospital mental health evaluation. A psychiatrist saw the perpetrator and prescribed new medications. The caseworker recommended continuation of this treatment plan, which was accepted by the court in connection with a plea agreement between the woman and the State Attorney.

CASE 4: A 70-year old woman was arrested and jailed for shoplifting $8.00 worth of merchandise. The caseworker noted indications of dementia at the screening prior to the First Appearance. The worker contacted the perpetrator's daughter who confirmed that her mother lived in Gainesville where she had been diagnosed with Alzheimer's Disease. Upon recommendation of the State Attorney, the case was dismissed at the arraignment.

In each of these situations, EJC staff -- typically social workers or persons with a mental health or criminal justice background -- appear in open court and provide the information to the prosecutor, public defender and judge. Without the

presence of the EJC, these matters probably would have resulted in different outcomes. Specialized staff allowed the courts to consider the totality of circumstances, not just the criminal behavior. A more complete description of the EJC in the Fifteenth Judicial Circuit is included in the attached report.

There are, of course, an infinite array of potential situations that can result in crime and victimization, especially elder abuse. As the Committee is well aware, persons with dementia and/or mental illness are prone to exhibit violent behavior as well as being at increased risk for victimization, and have specialized needs whether victims or offenders. For example, in a telephone survey of 277 caregivers who receive at least some state or federally-funded home and community-based services conducted by The Center on Aging in 2003, 12.4% of caregivers of elders with Alzheimer's Disease or other dementia reported that they had been slapped or kicked within the last year by the elder they cared for compared to less than 1% for caregivers of elders without dementia. Of course, many of these situations are never reported to protective services or law enforcement and solid research on these types of data is lacking.

Lessons Learned:

Although data collected from surveys and site visits in our national study are still being analyzed by project staff, it is possible to identify some key findings and draw preliminary conclusions as related to the subject of this hearing. In addition to drawing upon knowledge of Palm Beach County, we made site visits to Reno, Nevada, Phoenix, Arizona, Tampa, Sarasota, and Ft. Lauderdale, Florida, Wilmington, Delaware and Minneapolis, Minnesota. Although Tampa is the only one

of these other jurisdictions that has a specific program designed for elders, judges, court administrators and human services professionals provided relevant background information on new initiatives and insights on issues affecting other special populations as well as elders.

Mental health courts and other problem-solving courts, as described above, represent a judicial philosophy that examines individual cases from a more global than traditional and narrow justice perspective. In other words, although the court's starting point is a violation of the law, its focus is on "recovery" of the offender, consistent with "justice" for the victim, i.e., a determination that something wrong has been committed and that appropriate actions have been taken to try to prevent a re-occurrence. There is an emphasis on identifying health and service needs, coordination with resources in the community, and ensuring a motivated defendant and accountability for future behavior. To achieve this, the court needs both the availability of services and professional support to "boundary span" and coordinate them. Judges in these courts typically commit considerable time and effort to overcome barriers to service.

Issues about availability of and access to services, especially for persons with dementia and/or mental health problems, are substantial in most communities. Services are limited. Many service providers are not closely linked to the courts or law enforcement. In Palm Beach County, Florida, one group of providers of services to persons with Alzheimer's Disease or related disorders, is proposing "A Model for a Dementia – Specific Stabilization Process" that would eliminate forced and inappropriate entry to the mental health system, and provide a "Circle of Care" for at-risk persons. The courts need to be able to identify appropriate services and

to access them effectively. This is particularly relevant for both victims and offenders in abuse cases and other types of crimes.

Guardianship proceedings, in every jurisdiction, represent a major challenge in terms of the availability of trained guardians and accountability for the delivery of required services and financial management. This area has been called the next "ticking time bomb" in the courts by the President of the National Judicial College. It is fundamentally an issue of what resources a court can create, or otherwise obtain, to help ensure that the court's responsibilities and court orders are fully executed. We have been informed that too often probate or courts in other jurisdictions handling guardianship (or conservatorship) matters are still the court's stepchild and without resources. Maricopa County, (Phoenix) and Hillsborough County (Tampa) are two examples of jurisdictions with guardian review projects that have addressed this area successfully. Reno, Nevada has a unique program that provides the equivalent of a "guardian ad litem" to assist wards and to provide independent information to the courts. Because of the critical importance of guardianship in the area of abuse for those with dementia and/or mental illness, additional research is essential.

Older victims of abuse and other crimes, particularly those with mental health issues, need emergency assistance. Whether provided by a court program (Tampa) an outside agency (the Delaware Department of Justice), or a private non-profit agency (Palm Beach and Delaware), victims are often fearful of the law and judicial process. They are concerned about potential repercussions and loss of social support, and are often devastated by the reality of what has happened to them. They need specialized assistance by professionals trained in serving elders,

including immediate services, transportation, assistance with filing for restraining orders and victims' claims, guidance about the judicial process and, most importantly, the skill to examine and address underlying issues beyond the immediate problem. The professional must be an advocate with the prosecutor's office which often will decline prosecution without a "competent" victim/witness. We heard that prosecution of "elder cases" today is where domestic violence and sexual assault cases were 25 years ago, i.e., difficult to pursue without a strong, capable victim/witness and overwhelming physical evidence. Indeed, the victim advocate must be able to detect and overcome ageist behavior at all stages of the process.

Conclusions:

There are a number of conclusions that begin to emerge from analysis of data and interviews that are relevant to the theme of today's hearing:

1. Leadership of the judicial branch, in collaboration with professionals in health and social services for elders, is essential to successfully address these issues.
2. The concept of a specialized problem-solving "Elders Court" should be pilot-tested in interested jurisdictions.
3. "Elder Justice Centers" should be further implemented and rigorously evaluated.
4. Specialized staff support is necessary for establishing community collaboration.
5. Education of the judiciary, the bar, and law enforcement about the physical, psychological, and social characteristics of aging is a primary requirement.

6. Standards of accountability are required for courts with jurisdiction over guardianship/conservatorships proceedings.
7. The judiciary should collaborate with community leadership to ensure availability of dementia specific and mental health specific services for older victims and offenders.
8. Each jurisdiction should establish the capability to recruit, train, and manage volunteers, especially older volunteers, to provide direct, personal support to elders engaged with the court system.
9. Each jurisdiction should develop an information system capable of tracking data on elders in the court system and of identifying recurrent problem areas that require system-wide community attention.
10. The issues of an aging America should be identified as a judicial priority and addressed with a spirit of innovation and experimentation!

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CONSULTATION WITH THE
FIFTEENTH JUDICIAL CIRCUIT
ON THE
OPERATIONS OF THE ELDER JUSTICE CENTER

By
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October 3, 2003

Introduction:

This report documents an assessment of the Elder Justice Center (EJC) administered by the Fifteenth Judicial Circuit in Palm Beach County, Florida. The assessment, funded by the Quantum Foundation and conducted by The Center on Aging of Florida International University, consists of two Phases. Phase I addresses a variety of operational issues identified during the first year activity of the EJC and was completed December 31, 2002. It includes a series of recommendations for the Administrative Office of the Court as well as the Office's responses.

Phase II focuses primarily on creation of an effective information system for the EJC that enables it to document case activity and track referrals of individual older people who received services from it. This was a major recommendation in the Phase I report and its importance was magnified in the early months of 2003 when the EJC experienced substantial turnover in staff. The Center on Aging provided technical assistance to new EJC staff to help design a more comprehensive system. This system, now in the process of becoming fully operational, will enable the EJC to track and document outcomes and to compile regular reports on needs and issues affecting older people who have court-related problems. Phase

II also updates EJC activity in selected areas previously identified, such as its role in guardianship matters, and includes recommendations for future consideration.

Overview:

The Elder Justice Center was established in 2001 by the Chief Judge of the Fifteenth Judicial Circuit to improve access to the courts, both civil and criminal, by older people and to enhance linkages between the legal system and health and social services systems in the community that can help remove barriers that might impede effective access. The Palm Beach County Commission recognized the importance of addressing this issue and currently funds the EJC with approximately $150,000 through June 2004. There was a growing recognition that the demographics of aging in Palm Beach County were having an increasing impact on the courts and justice system. For example, professionals who work with the older population were identifying cases of arrests and jailing of persons with dementia. The court system itself was experiencing an increase of older people, particularly in guardianship cases. In general, there were more older people in the courthouse whose legal problems were not the real underlying problems that caused them to be there. It is the fundamental goal of the EJC to identify those underlying problems and to assist the courts in getting them addressed by appropriate community resources.

Furthermore, in addition to increasing numbers of older people in the community, there also has been an increasing diversity of race, ethnicity, language, education and income, and living arrangements. The physiological, psychological and social profiles of older people have become more complex. Likewise, there is a greater incidence of disease with increasing age, including dementia, cancer, joint and bone diseases, vision and hearing loss, and memory loss and loss of cognition. There is more use of prescription medications. In a broader social context, of course, older adults also may experience loss of roles through retirement, widowhood and bereavement, isolation, depression, and substance abuse. These factors, individually or in many combinations, result not only in more older people coming into contact with the court system, but presenting with more much more varied and complex personal circumstances as well.

In recognition of these factors, the Elder Justice Center represents an important effort by the Administrative Office both to respond to the needs of older people and to promote the

more effective administration of the court system. It builds upon the Fifteenth Circuit's experience and tradition, as well as those of other jurisdictions, of creating specialized offices that can enhance the court system's capacity to streamline operations and improve responsiveness to people engaged in the system. Specific examples include the Self-Help Center, the Domestic Violence Intake Unit, and mediation offered by the Alternative Dispute Resolution Office.

The emerging role of the EJC, nonetheless, is still very unique among judicial circuits in Florida and the United States. A number of conceptual and operational issues are still in the process of evolving. Therefore, it is important to continue to analyze the further development of the EJC and the ways in which it addresses and prioritizes the following issues:

1. Ensure physical access to the courts, including appropriate assistance for those with vision and hearing problems.
2. Assess older adults who are incarcerated following arrest or booking in order to assist courts with making appropriate decisions about dementia, mental illness, or physical health problems that could impact the next steps in legal proceedings.
3. Educate the judiciary and courthouse staff about issues of aging and the special concerns and problems of elders engaged in the legal system.
4. Ensure that older adults who otherwise come into contact with the court system are referred, as appropriate, to publicly-funded or private attorneys, and to health, mental health, and social services organizations to address non-legal problems that may affect the older adult's participation in the legal system.
5. Educate law enforcement, and health, mental health and social services organizations about issues and barriers affecting elders' involvement with the court system.
6. Educate older adults and the general community about issues of access to the courts and typical legal issues that may affect them.
7. Address both the availability of sufficient numbers of guardians and the court's capacity to review and monitor guardianship reports.
8. Maintain an information system capable of tracking the case status of individual older adults, documenting outcomes, and compiling summary data on the legal, health and social service needs of older adults entering the Judicial system in order to help

identify patterns or issues for legislative, programmatic and/or budgetary improvements.

9. Utilize technology, e.g., video linkages, to help improve access and effective participation by older adults in the court system.
10. Obtain resources and staff to appropriately carry out any or all of these functions.

PHASE I

CONSULTATION WITH THE FIFTEENTH JUDICIAL CIRCUIT ON THE OPERATIONS OF THE ELDER JUSTICE CENTER

By
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December 31, 2002

In August 2002, the Quantum Foundation requested that The Center on Aging of Florida International University provide consulting services to the Fifteenth Judicial Circuit on the current and future operations of the Elder Justice Center (EJC). The EJC is funded by Palm Beach County and administered by the Fifteenth Circuit. This report summarizes the issues identified and recommendations made to the Chief Judge and the Court Administrator.

METHODOLOGY

In order to assess the operations of the EJC and its capacity to achieve its stated goals, we engaged in the following:

1. Interviews with the Chief Judge, Court Administrator, EJC and other court administration staff, and two other judges of the Fifteenth Judicial Circuit.
2. Interviews with members of the original Advisory Panel, including representatives of the State Attorney, Public Defender, Legal Aid Society, Area Agency on Aging, the private bar, Alzheimer's Community Care, and a state representative.
3. Interviews with representatives of law enforcement.
4. Review of various materials and reports provided by the EJC.

5. Interviews and review of materials of the Elder Justice Center of the Thirteenth Judicial Circuit in Hillsborough County, a similar program now completing its third year of operation.

The purpose of the consultation was to provide the Chief Judge and Court Administrator with an independent assessment of the operations of the EJC as well as recommendations to enhance its future effectiveness in serving older adults.

PURPOSE OF THE EJC

The stated mission of the EJC is "to identify and remove barriers within the local court system and to develop and enhance linkages between older adults, the legal system, medical and social services to ensure that the elderly of this circuit are provided a fair and reasonable voice in, and access to, the courts." In carrying out this mission, one of the original primary objectives, strongly advocated by some members on the Advisory Panel, was to ensure intervention on behalf of older adults, particularly those with dementia or mental illness, who were arrested and jailed. Intervention is defined as meeting with the incarcerated person as early as possible following arrest, conducting an assessment of the individual's health, psychological and social status, assisting directly or through collaboration with other organizations, and recommending appropriate next steps to the Judge at First Appearance. In general, EJC staff are responsible for providing vital information to the Court and for making appropriate linkages with other legal, health and social organizations and agencies on behalf of all elders who seek their assistance.

CRIMINAL COURT

The EJC is an office of the Fifteenth Judicial Circuit. It is not a "law office" that offers legal representation to incarcerated or other elders charged with a criminal offense. Any court, of course, must ensure neutrality in all of its actions and decisions. Therefore, based upon its prior experience, and in recognition of the often special circumstances that may affect some persons among the Circuit's growing older population, the Fifteenth Circuit determined that the EJC should carry out those responsibilities described above.

Thus, the EJC is not in an "adversarial" position. Rather, it functions as a unit of the Court in providing information and advocating actions that a Judge should take in furtherance of the pursuit of justice in a given case, including conditions for release from jail such as a mental health assessment that might indicate dementia or mental illness. Both the State Attorney and defense counsel, either public or private, have the opportunity to challenge an EJC recommendation at First Appearance or thereafter (in those matters in which EJC staff remain involved on behalf of the Court). Interviews with these attorneys, and with one Judge who sits at First Appearances, reflect agreement that the role as described above is vital to the administration of justice as well as the protection of vulnerable older adults. The EJC also reviews the criminal docket and routinely intervenes in cases involving those 70 and older even if not incarcerated. Staff attend the hearing or trial and consult with the judge as appropriate.

There is a major concern, however, expressed by some members of the Advisory Panel, that EJC staff are not intervening early enough in the process to prevent unnecessary incarceration prior to First Appearance. One judge noted that this is an issue on weekends, typically in domestic violence cases involving elders, when there is little attention available from counsel on either side. This judge recommends that no elder be jailed until the Duty Judge is called and approves, thereby enabling the Court to notify the EJC for appropriate and timely intervention. We agree.

LINKAGES WITH ATTORNEYS AND OTHER ORGANIZATIONS AND AGENCIES

Developing linkages with the private bar and with health, mental health, and social services organizations is a primary function of the EJC. In matters both criminal and civil in nature, EJC staff assess individual situations and provide information and referral services to help guide older adults and their families to appropriate other professionals or organizations who can assist them. Because of the highly skilled backgrounds of the MSW and retired attorney who currently staff the EJC, it appears to provide high quality service to a caseload averaging over 80 individuals per month. This can be expected to increase during the winter months.

This responsibility represents a very unique contribution by the Fifteenth Judicial Circuit to older adults in Palm Beach County. There is only one other similar program, in Hillsborough County that operates in either Florida or the United States. Although there is a need to understand more about the nature and outcomes of referrals, the Fifteenth Circuit's program represents a potential model for providing meaningful access to the court system and to legal services. Nearly every key informant testified to the growing importance of this function in Palm Beach County.

ACCESSIBILITY

There is uniform agreement that the existence of the EJC in the County Courthouse helps to facilitate improved access by older adults to all services available. Some persons are referred to the EJC office by other Courthouse personnel and some call for assistance by phone. Judges and judicial staff also call upon EJC staff to assist in specific situations.

These situations occur daily and are not always captured for data and informational purposes. One area, access to jury duty, has not yet been addressed by the EJC and offers a unique opportunity to work on issues first identified in the January, 1994 Action Plan of the Supreme Court of Florida Committee on Court-Related Needs of the Elderly and Persons with Disabilities. There is also a geographic issue related to accessibility in other courthouses in the Circuit.

EDUCATION

Education is a critical responsibility which, given the limits of EJC staffing, still needs to be more fully addressed. There has been no sustained effort to educate older adults throughout the community about the EJC and its services. This would include providing an overview of typical legal areas which may affect older people (based on actual EJC experience, these include consumer fraud, mortgage foreclosure and landlord-tenant problems, incapacity and guardianship, abuse, neglect and exploitation, planning for long-term care, and general understanding of the court system) and how they can access services to assist them. Community education is carried out extensively in Hillsborough County by its Senior Program Manager and appears to add greatly to the effectiveness and credibility of the EJC and the judicial system there.

There has been an ongoing, informal effort by EJC staff to educate the judiciary and some courthouse staff about aging and the needs of older adults. This area could be organized more systematically to improve knowledge and understanding by court personnel about issues of aging and to facilitate more effective utilization of EJC expertise. Efforts to educate other organizations, including law enforcement, about the EJC have been limited. Many do not know very much about what the EJC is actually doing at the present time and at least one was unsure whether the EJC was still operating. This requires greater attention in the immediate future.

GUARDIANSHIP

The draft study on guardianship commissioned by the EJC addresses two important issues also raised by the Probate Judge of the Fifteenth Judicial Circuit: the lack of public guardians and the lack of capacity by the Court to review and monitor guardianship reports. The former is outside the scope of the EJC and must be revisited by the judicial system, Palm Beach County Government and the State of Florida. The latter is a resource issue that can be addressed by additional EJC staff and volunteers. Given the excellent experience and the high level of judicial satisfaction in Hillsborough County in this regard, this option offers an appropriate and meaningful approach to resolution of this serious problem. It is essentially a matter of ensuring quality control over guardianships, preventing abuse, and maintaining the integrity of the Circuit Court's Probate function.

STAFF

The EJC currently employs an MSW and an attorney (retired from another jurisdiction), both 80% time, and a clerical assistant. Although the social worker is the nominal "director" of the office, she does not have that title and is not recognized as having that authority by outside organizations or attorneys. One social worker in the Self-Help Office provides coverage for First Appearances on weekends. A second half-time MSW recently has been hired by the Court Administrator to be located at the County Jail to handle First Appearances. There is no regular use of volunteers. The MSW and attorney are both highly motivated and dedicated professionals who bring many years of experience to the program.

Two issues emerge. First is the question of whether there should be an Attorney Director or Senior Program Manager, as in Hillsborough County, who is publicly identified with the EJC. Although it is not absolutely essential to the daily operations of the program, an attorney with administrative skills would enhance the credibility of the EJC with many key players in the legal system. This person who should function full-time, would bring legal knowledge and some level of experience to the position. A Director or Senior Manager needs to help establish program priorities, organize and manage human resources and budgets, and serve as the public face of the EJC with older adults, the courts, referral organizations and the broader community. If a decision is made, however, not to have an attorney in this role, someone with legal experience should definitely continue to work in this program.

The second issue concerns additional staffing, particularly in South County and in other judicial venues within the circuit. In the near term, the EJC should seek volunteers from the Senior Leadership Institute managed by the area agency on aging. They can be trained to serve as effective liaisons with the older adult community and can provide routine assistance such as regular follow-up or transportation to the courthouse under the supervision of the EJC's professional staff.

INFORMATION SYSTEM AND DATA

The information system utilized to collect and organize data for the EJC is currently undergoing some changes to improve effectiveness. Written forms for intake, including a specific form for use at First Appearances, are utilized to capture relevant case information. This data will then be input into the program's computers and used for case tracking as well as regular monthly reporting. As of this date, however, EJC staff have not had the time nor programming capability to discern trends or compile summary data on needs of those coming into the system. Information management is an area that clearly needs further attention.

The "Monthly Intake Summary Report" for October shows 59 new clients and 97 served in total. Thirty-six of them were criminal, including 6 domestic battery cases that typically involve incarceration upon arrest. The November Report shows 45 new clients and

74 served in total, including 43 criminal, of which 14 were domestic battery. The latter appears to be an area of increasing significance. However, although there is a daily log summarizing "significant' cases, it is difficult to assess the relative importance of each of them in terms of significance or expenditure of staff time. Again, this area should be the subject of further review.

FUNDING SOURCES

County funding currently supports the EJC. However, there is uncertainty whether it will continue following the State of Florida's assumption of funding for the court system. Although a strong argument should be made for continuation of local revenue support, the EJC should aggressively pursue alternative sources as well. These would include local and national foundations, United Way, OMEGA, the area agency on aging, and others. Fund-raising should be a primary responsibility of a full-time Director.

GEOGRAPHIC COVERAGE

There was considerable concern expressed by many key informants about the limited services available in other parts of the Fifteenth Judicial Circuit, particularly South County. Much of this concern focused on the areas of guardianship and community education. With additional staff, including a full-time Director, and creative use of volunteers, the EJC should be able to more effectively address this issue. The increasing numbers of older adults in South County, as well as throughout most of Palm Beach County, will make this a more serious ongoing problem if not resolved in a timely manner.

RELATIONSHIPS WITH AGENCIES, ATTORNEYS, AND ADVOCATES

There is at present a sense of frustration expressed by those representatives who participated on the original Advisory Panel for the EJC. They do not believe they know "what the EJC is doing" or whether it is carrying out its original goals. Intentionally, there has been no formal communication during the period of this consultation other than interviews with them as key informants. Although most of the original panel have their own sense of "original

goals," and their own priorities for the EJC, their collective sense of concern should be addressed promptly.

This can be accomplished by reviewing with them the major areas addressed herein and by periodic, perhaps quarterly, meetings to review progress and issues. Since these well-known professionals all represent major interests and constituencies throughout the County, the EJC director also should maintain ongoing, informal communication and relationships with them individually. Undoubtedly, new and distinct concerns will emerge over time that are best resolved through close collaborative relationships.

SUMMARY

The EJC represents a substantial and innovative undertaking and investment by the Fifteenth Judicial Circuit. It has not been without controversy, but it represents a potential state and national model to improve the quality of access both to the judicial system and to health and special services by substantial numbers of older adults. Furthermore, the EJC has the potential to address effectively each of the areas identified herein and to continue to improve the availability of its services. The Fifteenth Judicial Circuit should continue to build upon its record as a leader on behalf of older adults.

RECOMMENDATIONS

The following are recommendations for the Fifteenth Judicial Circuit to address issues identified above. They are sequenced in order of ease of implementation in order to achieve maximum impact.

1. Staff

a. Name a director or senior manager.
b. Recruit volunteers from the AAA's Senior Leadership Institute.

2. **Criminal Court**

   a. Develop a strategy to ensure that older adults incarcerated upon arrest do not remain in jail overnight without the opportunity to be assessed by an EJC staff member.

3. **Linkages and Relationships**

   a. Meet with members of the original Advisory Panel to inform them of issues identified herein and actions taken or planned to address them.

   b. Charge the director with responsibility to maintain effective ongoing relationships and communication with them and, very importantly, with other referral organizations and agencies.

4. **Education**

   a. Develop a strategy to systematically inform older adults and their families about the existence and role of the EJC and about typical legal areas that may affect them. This strategy should include the use of trained volunteers.

   b. Develop a strategy to educate the judiciary, courthouse staff and, especially, law enforcement, about the role and functions of the EJC.

5. **Geographic Access**

   a. Develop a strategy, including use of Self-Help Centers, volunteers, and video linkages, to provide access to the EJC by older adults in courts throughout the County.

6. **Guardianship**

   a. Develop a strategy to implement recommendations from the draft study on guardianship concerning review and monitoring of guardianship reports.

   b. Review the current availability and quality of public guardians in the Circuit and develop a strategy to resolve current issues.

7. **Information System**

   a. Develop a strategy to implement an information system that can track referrals and case status of individual older adults.

   b. Design the system to track the outcomes of individual cases and referrals from the EJC.

   c. Design the system to compile summary data on the legal, health, and social service needs of older adults entering the system in order to help identify issues for legislative, programmatic and/or budgetary improvements.

8. **Funding**

   a. Charge the director with the responsibility of securing alternative funding sources for the future operations of the EJC.

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ADMINISTRATIVE OFFICE OF THE COURT
FIFTEENTH JUDICIAL CIRCUIT
OF FLORIDA

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COURT ADMINISTRATOR

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February 11, 2003

Max B. Rothman, J.D., LL.M.
3000 N.E. 151st Street, AC1-234
North Miami, Florida 33181

Dear Mr. Rothman:

On behalf of the 15th Judicial Circuit, thank you for your insightful report on our Elder Justice Center. Toward that end, staff has reviewed your recommendations and is responding with respect to the anticipated action(s) to be taken.

In the meantime, our offices look forward to working with you to further develop the services and resources of our Elder Justice Center.

Sincerely,

Susan D. Ferrante
Court Administrator

cc: Chief Judge Edward Fine
Timothy Henderson, Quantum Foundation
Mayra Amador, Elder Justice Center

Responses to Recommendation

1. *Staff*

   a. The 15th Circuit will closely monitor program activities to determine need for a program director. .

   b. The 15th Circuit will actively pursue volunteer recruitment.

2. **Criminal court**

   The 15th Circuit concurs with this recommendation and will work closely with law enforcement, Pretrial Services and Elder Justice Center to ensure reasonable accommodations.

3. ***Linkages and Relationships***

   a. The 15th concurs with this recommendation

   b. The 15th concurs with the assignment of these duties when and if a director selection is made.

4. ***Education***

   a. The 15th concurs with this recommendation

   b. The 15th concurs with this recommendation

5. **Geographic Access**

   a. The 15th concurs with this recommendation

6. ***Guardianship***

   a. The 15th concurs with this recommendation and will work closely with Legal Aid and the community in developing a reliable and cohesive guardianship-monitoring program.

   b. The 15th concurs with this recommendation.

7. ***Information System***

   a. The 15th concurs with these recommendations and will evaluate programs in other jurisdictions for possible implementation in Palm Beach County.

   b. The 15th concurs with these recommendations and will evaluate programs in other jurisdictions for possible implementation in Palm Beach County.

   c. The 15th concurs with these recommendations and will evaluate programs in other jurisdictions for possible implementation in Palm Beach County.

8. ***Funding***

   The 15th concurs with the recommendation that the program director be charged with the task of securing alternative funding sources.

PHASE II

CONSULTATION WITH THE
FIFTEENTH JUDICIAL CIRCUIT
ON THE
OPERATIONS OF THE ELDER JUSTICE CENTER

By
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October 3, 2003

The primary objectives of Phase II are as follows:

a. Develop a strategy to implement an information system that can track referrals and case status of individual older adults who come in contact with the EJC.

b. Design the system to track the outcomes of individual cases and referrals from the EJC.

c. Design the system to compile summary data on the legal, health, and social service needs of older adults entering the system in order to better understand the nature of issues affecting them in the justice system so that legislative, programmatic, or budgetary improvements can be considered, and to help identify issues for future community resolution.

d. Provide assistance on operational issues raised by the EJC staff.

Background

Phase II of this assessment began in April 2003. In early 2003, the EJC experienced turnover in staff affecting the program director and the clerical staff member responsible for creating a physical file as well as entering data electronically. Staffing also included a non-licensed Florida attorney working a part-time schedule. The Court Administrator then named a new Director, an MSW who had worked part-time with the EJC while a member of the Self-Help Center, and also approved a full-time position combining the responsibilities of a caseworker with some clerical duties. This person has an educational background in criminal justice and began in April. She had been working for the past seven months in another branch of the court. Finally, in August, another MSW with experience in guardianships and background as a care manager, was added to the staff specifically to handle guardianship matters in the Probate Division. In total, there are now four staff members working specifically on elder justice cases. However, given the increasing volume of cases handled by the EJC, staff in the Self-Help Center have been cross-trained to assist EJC staff as needed.

Information System

The information system in place to log and enter data is an ACCESS database. The system is divided into two main components: EJC-Generated Information and Outside Agency Information. Each area has its respective screens that are used to capture relevant data. The EJC-Generated information contains: 1) an index screen which captures basic demographic information; 2) an intake screen which captures general information on the case, including referral sources; 3) a criminal and civil screen that captures information such as case numbers, booking numbers, and charges; and finally, 4) a case notes screen in free-form format that allows the user to enter narratives and notes related to the case. The Outside Agency Information component is not being used by the EJC at this time, partly because screens contained in this section are more appropriate for recording information gathered in drug court.

In general, the database was not being used all the time to capture information that the EJC caseworkers were collecting. This was mainly due to two reasons:1) EJC staff had very little training on how to use the database, and 2) the fields were not defined so the user was able to type in any answer in the data fields and the database would accept and record it. For

example, a data field in the intake screen may ask "reason for intake", and the EJC caseworker could type in I&R, or information and referral or just leave it blank. Regardless of the answer, and how the answer was typed in, the database would accept and record the transaction.

The reporting capabilities in an ACCESS database are very strong. It allows the user to create a large variety of reports that can be used for management as well as produce case statistics defined by the user. To produce valid and complete reports, it is essential that the data fields within the respective data screens 1) identify and give a selection of the most common responses for the data field in question, and 2) be given an operational definition, which would ensure that the data collected and inputted into the database are treated in a consistent manner. EJC staff were not fully trained as users of the database and were unfamiliar with the full capability of the system and availability of reports. These challenges were quickly recognized and, shortly thereafter, the MIS Director of the Fifteenth Circuit Court was contacted to provide initial user training. At the same time, The Center on Aging staff began the process of defining and documenting the purpose and use for the data fields. This began by identifying the most commonly used screens pertinent to the work of the EJC, i.e., the index and intake screens of the database. This effort would ultimately ensure that information being entered could be outputted and interpreted in a consistent and understandable manner, thereby ensuring reliable back-end reports. The goal of standardizing the data has been a main focus for Phase II of this project.

The process began by identifying the source documents in place and the process flow of information used for purposes of capturing and recording specific case information. There was a one-page "intake and inquiry form" used by EJC staff for jail cases only. The inquiry form captured basic demographic information and included space for medical and psychological history. The intake and inquiry form would eventually become part of the client physical file. Client physical files had been created and maintained by the former clerical staff. The Center on Aging staff discussed with the EJC Director possible methods for maintaining the physical files in consistent order to supplement information being captured in the database. At this time, the EJC staff is in the process of establishing a filing methodology.

Aside from the intake and inquiry form that was being used to gather information for jail cases, there was no other source document being used to record and note user information gathered at different points of contact. Lack of an adequate and more comprehensive source document for recording most types of cases and contacts, and actual work being performed, precluded the EJC staff from clearly documenting and recording their volume of work or producing statistics on types of cases handled. Thus, over several months The Center on Aging staff worked closely with EJC staff to create two new source documents that would be all-inclusive of their daily activities and contacts: a Comprehensive and a Short Intake and Information form. (See addenda I & II). These newly created forms contained specific data field responses for each of the questions most commonly asked by the EJC case worker across contacts, meaning it could be used to document information for phone contacts, jail cases, criminal and civil cases, and information inquiries, etc. The source documents were tested by the EJC staff for several weeks and went through many revisions before they became final. Today, staff are consistently using the source documents for gathering and recording all types of client contact information. The next step in completing this part of the project is to have the court MIS Director add the detailed data menu guided by the source documents for each of the fields previously discussed as they relate to the index and intake screens of the database. Once this step has been accomplished, the EJC staff will be able to identify the type and frequency of reports they will produce. The Center on Aging staff has had some preliminary discussion with the EJC staff on the categories of reports that can be created in the system (i.e., client reports by status, incident, month, and caseworker). This type of report will assist the EJC staff manage their caseloads and ensure timely follow-up on assignments of the EJC caseworker. Furthermore, it is important that the EJC's information system be utilized to produce other types of operational, client and management reports. For example, it appears that although relatively few in number, jail cases account for a substantial expenditure of time of one member of the staff. Misdemeanors, serious motor vehicle offenses, and guardianships, however, appear to be areas generating the most cases. This needs to be documented through regular reporting. Likewise, guardianship data need to be captured in the monitoring process in order to generate regular reports.

Outcomes

EJC staff provide information to individual older persons, make referrals, conduct screenings, collect background data for the Court, and make recommendations to judges to assist in reaching the most appropriate outcomes for each case. Ultimate outcomes, of course, vary on a case-by-case basis and will differ depending on the specific circumstances and facts pertaining to each case. The EJC, it is worth mentioning, bears no responsibility for ultimate litigant outcomes. Much that determines such end results does lie within the purview of the Court system, however.

Nonetheless, there are some intermediate outcomes at the aggregate level, which the EJC should pursue. Actions leading to these intermediate outcomes could be expected to increase the chances of positive impacts for litigants and older adults otherwise engaged in the court system as well as assist in the processes of the court:

Information System

EJC staff are able to produce from the information system accurate and up-to-date monthly and yearly as well as ad hoc reports on all cases processed by the EJC by type of case.

Individual physical files on all cases processed by the EJC are maintained in standardized, complete, and up-to-date form and can serve as a reliable back-up to the computerized system.

Prioritizing Cases

Specific standards are in place and consistently followed pertaining to: the types of cases that will be accepted for potential assistance from the EJC and type and extent of services to be provided by type of case, including procedure for receiving and responding to weekend notification of arrests and jailing of older persons.

Jail Cases

All jail cases referred by Corrections are screened and, when appropriate, recommended to the Court for a full physical or mental assessment.

Linkages with Providers

All provider agreements are replaced with ones that require on-going feedback to the EJC on persons the EJC refers.

The EJC obtains a signed release from all persons served that allows the EJC to access their medical records for use in providing recommendations to the court when appropriate.

Guardianships

The roles and level of training required for EJC staff and volunteers involved in investigation of guardianship cases are clearly specified and consistently followed.

All cases on the list of wards assigned to the EJC are categorized as open, closed, or deceased and their addresses as well as contact information on their guardians and attorneys are all updated.

Trained volunteers check on the well-being of all wards whose annual reports have not been filed by their guardians or whose situations are identified by the Probate Judge as needing investigation.

Other Objectives

I. Prioritizing cases

The EJC receives referrals from numerous sources including the Clerk's Office, the State Attorney's Office, the Public Defender's Office, family members and, of course, older

people themselves. The most consistent referral source for the EJC is pre-trial services. Because the EJC receives referrals from so many different sources, however, staff has developed through time certain informal processes to assist them in prioritizing their involvement with cases.

The Fifteenth Circuit Clerk's Office faxes to the EJC a daily "EJC criminal docket" (it is also available to the EJC caseworker online). This docket is specific to the EJC in that it lists only those individuals 60 or older who are scheduled for court that day. The EJC docket also is specific to the type of court the older person is scheduled for and is inclusive of both the South Court appointments located in Delray Beach and the North Court located in West Palm Beach. The EJC caseworker attempts to contact each individual listed on the docket at North Court in order to remind each of his or her court appointment. It also allows the EJC caseworker to introduce herself and explain the EJC's role. Not all older persons listed on the EJC criminal docket become clients of the EJC. In fact, those individuals who already have private attorneys are not contacted at all. This recent effort by EJC staff was undertaken to reduce the substantial number of older persons who miss their court appearances and appointments. While commendable, EJC staff do not have access to demographic information for them and, therefore, spend a considerable amount of time attempting to obtain telephone contact information.

The other most common referral source is pre-trial services located at Gun Club (the County jail). Jail cases are a high priority for the EJC caseworker. Each weekday morning, after receiving a phone call from pre-trial services whenever a person 60 or older has been placed in jail within the previous 24 hours, the EJC receives a formal document from pre-trial services titled, "Arrest Record". The arrest record provides the EJC caseworker with necessary information relative to the case, including the charges. These cases are all scheduled for First Appearance in court located at the jail either first thing in the morning or early in the afternoon. The EJC caseworker will visit the older person, usually just prior to First Appearance, to conduct a preliminary screening. Typically, the EJC caseworker has only ten to fifteen minutes to explain the purpose of the EJC and to interview the older individual. This brief visit presents a major challenge to the EJC caseworker because it may not always provide enough time to gain a level of trust necessary for gathering information concerning health or mental status or other background detail needed by the Court. This suggests the

need to work with the Palm Beach County Sheriff's Office to address arrests of persons 60 and over in a more timely and responsive manner. On the other hand, the EJC staff have established relationships with many Public Defenders and the State Attorneys' Office, allowing the caseworker to interact with them constructively and coordinate efforts relative to this stage of the case. While this coordinated effort is becoming more prevalent and customary, some private attorneys remain hesitant in their interaction and coordination with the caseworker because of a level of uncertainty about the EJC's role.

While the two most common referral sources for the EJC remain pre-trial services and the Clerk's Office, EJC's method of prioritizing cases to ensure they are aiding those older persons most in need of assistance continues to evolve. Cases involving domestic violence and theft are current priorities; however, all cases are discussed and "staffed" with the Director to ensure that staff time remains focused on cases identified as high priority.

II. Linkages with providers

The EJC has referral agreements with many community providers, including mental health, social services, legal aid, alcohol and substance abuse organizations. In instances where the EJC caseworker makes a recommendation to a judge regarding a mental health evaluation, the older person's insurance coverage may be adequate to pay for it; if not, the EJC caseworker will make a referral to the public mental health facility. However, due to strict privacy laws surrounding mental health, the EJC staff rarely receives feedback from the service provider on the outcome of the evaluation (the evaluation results are provided directly to the Court). Other types of referrals to providers such as social services or home health agencies are sometimes made by the EJC caseworker. However, because of loosely worded referral agreements, providers are not contractually obligated to accept a referral from the EJC and, if they do, they are not obligated by contract to provide feedback. Since the provider does not receive any reimbursement directly from the EJC for referrals, little incentive exists to report back client outcomes.

In fact, this issue is symptomatic of what is a major underlying gap in the health and social services fabric of most communities in Florida and throughout the United States: the inability to identify, assess, and provide appropriate residential treatment options for older persons with mental health problems and/or dementia. This is a quality of life issue that goes

to the heart of the revolving cycle of arrests, guardianship proceedings, serious motor vehicle violations and other situations that ultimately produce the burgeoning numbers of elders in the courthouse. The EJC can take a leadership role in the community by clearly documenting these phenomena and by working with the human services community, law enforcement, Palm Beach County government, and funding organizations to fashion realistic solutions.

III. Guardianship

In Phase I, The Center on Aging raised two specific issues relating to the Guardianship program: the inadequate number of guardians and the lack of capacity by the Probate Court to review and monitor guardianship reports. In May 2003 the EJC inherited responsibility for assisting the Probate Court for the north part of Palm Beach County (at this time, it does not have responsibility in the south part of the County). As of August, there were 1800 wards that needed to be contacted to update their information with the Clerk's Office. Given this new responsibility, EJC staff have attended basic training, but will require more in-depth training in order to provide effective direction to five older volunteers who were recruited to assist in this process.

As noted above, in order to address these important tasks, the EJC hired a full-time person possessing experience working with guardianship issues in the community to serve as guardianship project leader. The EJC's current responsibilities are as follows:

a. categorize every case on the 1800 person list as open, closed or deceased,

b. update ward information on living arrangements/addresses and names of guardians and attorneys,

c. check on the well-being of wards whose annual reports have not been filed by their respective guardians, and

d. investigate (when necessary) cases that are identified by the Probate Judge for review (i.e., may require a visit to the ward's home and an assessment of his or her well-being, finances, and physical surroundings).

Responsibilities for guardianship matters likely will continue to evolve and the volunteer component will most likely become a major component of the process. The guardianship project leader believes the volunteer component is key to future improvement and a strong, viable system for monitoring guardianships. Volunteers will be thoroughly screened and trained appropriately to handle both routine and more complicated cases. Monitoring of cases is scheduled to begin as soon as training is completed, which the EJC project leader estimates will be in November. In addition to volunteer recruitment and training, the EJC will propose a standard fee structure for guardians. This will help ensure that guardian fees and rates are reasonable and commensurate with services rendered as well as protect the assets of wards against excessive charges.

The Center on Aging provided information to the EJC guardianship project leader regarding a new State advisory group on guardianship. Through contact with this group, the EJC can assist the State in developing new protocols and standards for ensuring the safety, protection and overall well being of elder wards in Florida's system as well as stay abreast of statewide developments in this increasingly visible arena of public policy.

RECOMMENDATIONS-PHASE II

During the next 12 months, the EJC should undertake the following activities:

Information System

1. Create operational definitions for data fields in the database as related to the relevant system screens utilized by EJC staff.

2. Establish written policies and procedures particular to the database and how information is captured and subsequently entered.

3. Standardize the type of information that will be kept in the individual physical file as well as establish a methodology for the filing system.

4. Identify type and frequency of operational, client and management reports that will be generated from the system.

5. Document the type of cases handled by the EJC on a monthly basis and yearly basis, including jail cases, misdemeanors, motor vehicle offenses, and guardianships.

6. Work to incorporate measures of the guardianship monitoring process into the information system.

Outcomes

1. Operationalize all proposed outcome measures, including making use of the information system whenever applicable.

Prioritizing Cases

1. Develop specific standards for matters that will be accepted by the EJC, including such factors as type of case, age of older person, or other factors defined by the EJC in collaboration with the Court Administrator's Office.

2. Develop specific guidelines for the type and extent of services to be provided by EJC staff in each different type of case.

3. Work with the Palm Beach County Sheriff's Office to standardize procedure for receiving and responding to evening and weekend notification of arrests and jailing of older persons.

Linkages with providers

1. Review the current provider agreement to strengthen language that would require on-going feedback to EJC staff on persons referred to providers.

2. Obtain authorization from persons referred for access to personal and medical information (post-referral) in order to assist with providing recommendations to the court for appropriate disposition.

3. Initiate a community-wide effort to address the needs of older persons with problems of mental health and/or dementia.

Guardianship

1. Review the specific roles and level of training required for staff and volunteers involved in the investigation of guardianship cases.

General

1. Further define the mission and objectives of the EJC and communicate this consistently to older persons, court staff, providers, and the community-at-large.

2. Educate court offices that most typically interact with the EJC on the role of the EJC caseworker in relation to routine cases.

3. Prepare one or more proposals for pilot projects to enhance EJC capacity.

Addendum I

Elder Justice Center
Comprehensive Information & Intake Form

Demographic Information

EJC Case Manager: _____
EJC Case Number: _____

Date _____

New Client: _____Yes _____No
Gender: _____ Male _____Female

First name_____
Last Name_____
Social Security No._____/____/_____
Date of Birth: _____/_____/____ Age _____
Phone Number: ( ) _____
Address: _____
Other Address: _____
Family Contact: (Name) _____ Tel: ( ) _____
Race: _____White _____ Black _____ Hispanic _____Asian _____Indian
Marital Status: _____Married _____ Single _____ Separated _____ Widow _____ Divorced
Spouse/partner name: _____DOB: _____/_____/_____ Age_____

1. **Initial Contact was made:**
   _____In-court _____ Walk-in _____ By mail or fax
   _____By phone _____ In jail _____EJC daily docket
   _____Third party: Name: _____

2. **Reason for Intake:**
   _____Information (only) _____ Information & referral

   _____Civil legal matter (specify)
   - ___lawsuit
   - ___probate
   - ___eviction
   - ___ejection
   - ___small claims
   - ___bankruptcy
   - ___divorce

   _____Criminal legal matter (specify):
   - ___DIU
   - ___simple battery
   - ___domestic violence/assault
   - ___speeding
   - ___leaving the scene of an accident
   - ___driving w/suspended/revoked license
   - ____other: _____

   booking # _____ case # _____

3. **Referred by:**
   _____Pre trial services _____Self-help _____Family member
   _____Judge _____ Self-referral _____Court records
   _____State Attorney _____Public Defender
   _____Other _____

4. **Medical Information:**
   Treating Physician: Name _____
   Phone Number ( ) _____
   Current Meds: _____
   Medical history (conditions): _____
   Psychological history: _____

Alcohol/drug history: _____

5. **Insurance Information: (What kind of health insurance coverage do they have)**
   ____VA ____Medicaid only ____Medicare only ____Dual eligible
   ____Private insurance _____

6. **Income Information: (sources of income)**
   ____Social security Total Monthly Income $_____
   ____Pension
   ____Employment ____F/T ____P/T
   ____Alimony ____Other _____

7. **Initial Services provided:**
   - IF IN JAIL
     ____Face to face assessment date: _____/_____/_____
     ____Assistance at 1st appearance date: _____/_____/_____
     ____Other _____
   - IF A COURT CASE
     ____Assistance in finding the court room
     ____Accompany the client to court
     ____Other _____

     CONDITIONS BY THE COURT
     _____
     _____
     _____
     Division _____ Room # _____
     Judge _____
     Name: _____

PD Appointed: ____ Yes ____No
Private Attorney: ____Yes ____No
Name: _____

   - IF INFORMATION & REFERRAL
     ____Social service provider ____Private attorney
     ____Mental health provider ____Legal aide
     ____Self-help center ____Housing Authority
     ____Alcohol and substance abuse provider
     ____Other: _____

8. Case Status: ____Open ____Closed: date ____/____/____ ____Not applicable

9. Follow-up required: ____Yes ____No

10. Reason for follow-up:
   ____Court date ____ Pending information ____On-going assistance
   ____State Recommended action: _____
   - Begin date: ____/____/____ End date: ____/____/____

Comments:
_____
_____
_____

Addendum II

Elder Justice Center
Short Information & Intake Form

Demographic Information

EJC Case Manager: _____
EJC Case Number: _____

Date _____ New Client: _____Yes _____No
Gender: _____ Male _____Female

First name_____ Last Name_____
Social Security No.____/___/____ Date of Birth: ____/____/___ Age ____
Phone Number: ( ) _____
Address: _____
Other Address: _____
Family Contact: (Name) _____Tel: ( ) _____
Race: _____White _____ Black _____ Hispanic _____Asian _____Indian
Marital Status: _____Married _____ Single _____ Separated _____ Widow _____ Divorced
Spouse/partner name: _____DOB:____/____/____ Age____

8. Initial Contact was made:

_____In-court _____ Walk-in _____ By mail or fax
_____By phone _____ In jail _____EJC daily docket
_____Third party: Name: _____

9. Reason for Intake:

_____Information (only) _____ Information & referral

_____Civil legal matter (specify)
- ____lawsuit
- ____probate
- ____eviction
- ____ejection
- ____small claims
- ____bankruptcy
- ____divorce

_____Criminal legal matter (specify):
- ___DIU
- ___simple battery
- ___domestic violence/assault
- ___speeding
- ___leaving the scene of an accident
- ___driving w/suspended/revoked license
- ____other: _____

booking # _____case # _____

10. Referred by:

_____Pre trial services _____Self-help _____Family member
_____Judge _____ Self-referral _____Court records
_____State Attorney _____Public Defender
_____Other _____

11. Initial Services provided:

- IF INFORMATION & REFERRAL

____Social service provider ____Private attorney
____Mental health provider ____Legal aide
____Self-help center ____Housing Authority
____Alcohol and substance abuse provider
____Other: _____

5. Case Status: ____Open ____Closed: date ____/____/____ ____Not applicable

6. Follow-up required: ____Yes ____No

7. Reason for follow-up:

____Court date ____ Pending information ____On-going assistance
____State Recommended action: _____

- Begin date: ____/____/____ End date: ____/____/____

Comments:

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Addendum III

Case Examples

1. Civil Court--- assisted an 83-year old woman whose adopted daughter had engaged in identity theft involving the woman's credit cards. The EJC caseworker counseled the woman who had been sued by a credit card company, accompanied her and her son to court, provided background about the case to the judge and explained to the woman that the judge recommended that they (the credit card company) pursue another option for collection. The final disposition of the case has not been determined.

2. Criminal Court--- assisted a 73-year old man in jail for carrying a concealed weapon and resisting arrest. The caseworker investigated background information on the case and recommended a mental health intervention. The judge placed him under house arrest, probation and ordered regular contact with the EJC. Because of issues of non-compliance, the caseworker is investigating further details on his health status and the case remains open.

3. Traffic--- assisted an 81-year old woman arrested for driving with a suspended license. A preliminary screening indicated the need for an assessment from the Memory Disorder Clinic. This resulted in confirmation of vascular dementia. The caseworker made a recommendation to the woman's daughter that she seek an attorney and provided to her about information on guardianship.

4. Criminal--- assisted a 76- year old female charged with domestic battery (spouse abuse). After a screening in jail, the caseworker recommended that the court order a mental health evaluation. Based upon further observation in the home, the caseworker made a referral to the Alzheimer's Community Care Association, which diagnosed dementia with delusions. The spouse was referred to a psychiatrist. The Court has accepted a plea agreement at the arraignment and both parties were eventually placed in an assisted living facility.

5. Criminal--- assisted a 70-year old woman arrested and jailed for shoplifting $8.00 worth of merchandise. The caseworker noted indications of dementia at the screening prior to the First Appearance. The worker contacted her daughter who confirmed that her mother lived in Gainesville where she had been diagnosed with Alzheimer's Disease. Upon recommendation of the State Attorney, the case was dismissed at the arraignment.

6. Criminal--- assisted a 67-year old woman charged and jailed with domestic battery against her daughter. The initial screening prior to the First Appearance revealed a history of psychological conditions, including bi-polar disorder. The woman ceased taking medication because of severe side effects. The caseworker recommended an inpatient hospital mental health evaluation. A psychiatrist saw her and new medications were prescribed. The caseworker recommended continuation of this treatment plan, which was accepted by the court in connection with a plea agreement by the woman with the State Attorney.

Senator BREAUX. Thank you, Mr. Rothman, very much for your statement. It was very helpful and informative.

Our final witness is Dr. Constantine Lyketsos.

STATEMENT OF CONSTANTINE G. LYKETSOS, M.D., MHS, PROFESSOR OF PSYCHIATRY AND BEHAVIORAL SCIENCES; CO-DIRECTOR, DIVISION OF GERIATRIC PSYCHIATRY AND NEUROPSYCHIATRY, THE JOHNS HOPKINS UNIVERSITY AND HOSPITAL; ON BEHALF OF THE ALZHEIMER'S ASSOCIATION

Dr. LYKETSOS. Thank you, Senator Breaux. Let me begin by thanking you and the Senate Special Committee on Aging for holding this very important hearing and for inviting me to testify.

I am delighted to be testifying today on behalf of the Alzheimer's Association and want to once again acknowledge their staunch advocacy for people with Alzheimer's and their families.

I am a physician. I am also a researcher and clinician in the Alzheimer field, and apropos to today's meeting, it is noteworthy that, with my fairly limited clinical practice, I have already been in the past week involved in two similar cases, although not to this extent, obviously, involving violence of people with Alzheimer's disease.

The topic that brings us here today is the psychiatric and other behavioral features of dementia. The public usually thinks of Alzheimer's as a condition that only affects memory. Since this is a widespread disease of the brain, it should be no surprise that upwards of 90 percent of people with Alzheimer's develop psychiatric and related behavioral features. Doctors Cohen and Rothman, and especially the Gotham family, have very eloquently brought to life the sorts of issues we're talking about.

Now, let me address a few questions that revolve around the issue. First, how common are the psychiatric and behavioral symptoms of dementia and what is their cause. I reiterate, that as our research has shown at Hopkins that over 90 percent of Alzheimer's patients develop psychiatric and belated behavioral features. Among the most troubling that we're heard about today include depression, delusions, hallucinations, delirium and agitation. Physical violence is exhibited by about 15 to 18 percent, every year. When you multiple this by the number of people with dementia alive today, you appreciate how big the numbers really are.

The vast majority of such violence occurs against care-givers, is short lived, and does not result in significant injury. Most of the time we probably never hear about it. Occasionally violence gets out of hand and we hear about the cases that we heard of today. Typically, violence gets out of hand when currently available treatments are ineffectively applied.

Turning to the cause of the symptoms, the primary cause is the brain damage brought about by Alzheimer's or other dementias. The disease damages brain centers that regulate mood, the ability to perceive the environment, and the ability of the patient to control his behavior and his impulses.

With regard to violence specifically, just as with any behavior, it is affected by many factors, sometimes many contributing at once. Both patients and environmental factors play a role. Brain damage is the major patient factor, but there are important environmental

factors, such as lack of structure, changes in routine, and what we refer to as unsophisticated caregiving.

Well, how good are the treatments that we have available at present? Current treatments consist of prevention, removal of provocations, rapid response to early symptoms, psychiatric hospitalization, and use of certain medications.

Prevention focuses on putting into place good dementia care practices for all patients. Involvement of the family is a critical aspect of good dementia care. Certain medicines have been shown to reduce some of the symptoms, but medicines carry significant risks. Yet, in the hands of seasoned clinicians, treatments are successful in reducing these symptoms to a manageable level well over 80 percent of the time. In fact, these are some of the most treatable symptoms of Alzheimer's. Yet, in many cases success is not complete and these symptoms can trouble patients and care-givers for many years. Obviously, we have a lot more to learn about how to treat the symptoms.

How does our health care system fall short in treating these aspects of the disease? Let me try and summarize that in four points:

First, the system fails to detect the symptoms. Second, it fails to disseminate the currently available treatment know-how. Third, it doesn't pay adequately for the care of patients with these symptoms. Fourth, we do not have enough well-equipped treatment settings that can effectively manage these symptoms.

Detection rates for dementia itself—not just the symptoms but the dementia itself—is unacceptably low. Only about 30 percent of people with dementia are given this diagnosis in the primary care setting, and only about half to two-thirds in the other major care setting for dementia people long-term care, which includes both assisted living and nursing homes. These are major missed opportunities to intervene early and prevent severe behavior problems.

While the know-how for preventing and managing these symptoms is rather good, this knowledge has not been transferred to the settings where they are cared for. Part of the problem is that costs associated with treating these symptoms are very high, and Medicare reimbursement structures are not conducive to clinicians getting paid adequately for managing these symptoms.

I will briefly turn to talking about what research is needed to improve treatments. Research obviously is an essential part of battling and conquering Alzheimer's, and the ultimate goal must be to find treatments that will cure, prevent, or delay the brain disease itself. At the same time, we must focus our energies on improving the care of the 4.5 million people with Alzheimer's who are currently alive, and of their caregivers, and of the many more patients who are going to arrive on our doorstep in the next 20 to 30 years.

It is critical that we dedicate adequate resources to the care research effort. In the interest of time, I will not make additional remarks about treatment research, but my written testimony has several additional examples.

What are some of the community responses that we've seen to this issue? Well, the Alzheimer's Association has been the leader in this effort through it's nationwide chapter network. In my written testimony I highlight several examples. Let me just bring one to life today.

In Wisconsin, when mandatory arrest in domestic abuse cases became State policy, the Alzheimer's Association enlisted community service providers, adult protective services, local enforcement agencies and the Governor, to develop a community response to cases involving persons with dementia. As a result, all police officers in the State receive mandatory training in dementia care. Further, nursing homes and community based residential facilities have been recruited to provide temporary placement as an alternative to jail when a violent person with dementia needs to be removed from the home. Mr. Richard Langen, a retired police lieutenant who spearheaded the Wisconsin program, is in the audience today.

Let me leave you with a few conclusions. Ultimately, the management of a person with Alzheimer's and behavioral symptoms who is at risk for violent behavior will depend upon direct response from physicians, law enforcement personnel, long-term care providers, and community agencies. But Congress and the Federal Government have a lot to say about making these responses possible.

My specific recommendations are: (1) provide adequate funding for the essential research and understanding, managing and treating behavioral symptoms in persons with dementia, research that will be jeopardized unless funds are added beyond the President's budget for Alzheimer research at the NIH. (2) continue support funds through the Department of Justice for the Safe Return program. (3) maintain funds and the quality requirements attached to those funds for State Medicare long-term care program. (4) and this is probably the most important—change Medicare reimbursement policy to provide payment, not just for evaluation and diagnosis, but for the ongoing management and care coordination for beneficiaries who have Alzheimer's disease and related conditions that might require such medical care.

Thank you, Senator.

[The prepared statement of Dr. Lyketsos follows:]

TESTIMONY OF

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Good morning. I am Constantine Lyketsos, Professor of Psychiatry and Behavioral Sciences and Co-Director, Division of Geriatric Psychiatry and Neuropsychiatry, at the Johns Hopkins University and Hospital. I also serve as the Academic Director of The Copper Ridge Institute and chair the Medical and Scientific Advisory Board of the Maryland Chapter of the Alzheimer's Association.

Let me begin by thanking the Senate Committee on Aging for holding this very important hearing and for inviting me to testify. I am thankful that the Senate continues to rise to the occasion in our ongoing fight to conquer Alzheimer's disease. I am delighted to be here with my friends from the Alzheimer's Association and want to acknowledge their staunch advocacy on behalf of people with Alzheimer's disease and their families. I also want to acknowledge the central role of the NIH, esp. the National Institute on Aging (NIA), the National Institute of Mental Health (NIMH), and the National Institute of Neurological Disorders and Stroke (NINDS) in our effort to find the answers to Alzheimer's disease.

I speak to you today as a research scientist, as a physician who has cared for thousands of patients with Alzheimer's disease and their families, but also as the husband of a woman whose grandmother suffered greatly before dying from this horrible illness. Alzheimer's has touched me personally, as it has so many here in this room today.

The topic that brings us here today has to do with a very common but inadequately recognized aspect of Alzheimer's disease and related dementias: the psychiatric and other behavioral features of the disease, including verbal or physical aggression, and violence. The public usually thinks of Alzheimer's disease as a condition that affects memory. Since this is such a widespread disease of the brain, it should be no surprise that upwards of 90% of people with dementia develop one or more of these psychiatric and related behavioral features over the typical decade-long clinical course of the disease. Professor Cohen and the others testifying before you today have very eloquently brought to life through examples the sorts of issues that we are talking about.

My testimony will focus on the following questions: (1) How common are the psychiatric and behavioral symptoms of dementia and what is their cause? (2) How do we treat them, and how good are our treatments? (3) How does our health system fall short in treating these aspects of the disease? (4) What research is needed to improve treatments? (5) What are some of the community responses to this issue? As you can imaging large volumes have been written on each of these questions, but I will be brief and hit the main points.

1. How common are the psychiatric and behavioral symptoms of dementia and what is their cause?

Our work from two population-based studies, coupled with that of many others, has found that over the course dementia over 90% of patients develop one or more psychiatric and related behavioral features. Among the most troubling to patients and caregivers are depression, delusions, hallucinations, and otherwise unexplained agitation. Physical violence is not uncommon, being exhibited by about 15-18% of patients per year. When you multiply this by the number of people with dementia alive today, you will appreciate how big the numbers are. The

vast majority of such violence occurs against caregivers, both at home and in assisted living or nursing facilities, is short lived and does not result in significant injury. In fact, most of the time we never hear about it, sometimes because the caregivers feel embarrassed or ashamed to report it, or may blame themselves. Occasionally, violence gets out of hand and we hear about cases like the ones presented today. In my experience, typically violence gets out of hand when treatments are ineffectively applied, although we should be clear that even the most effective treatments cannot prevent all cases of violence.

What is the cause of these symptoms and of violence in particular? The primary cause is the brain damage brought about by Alzheimer's disease. The disease, as it spreads in the brain, damages centers that regulate mood, perceptions, or the patient's ability to control his impulses. As a result, we see moodiness, depression, irritability, delusions, hallucinations, and loss of inhibitory control.

With regard to violence specifically, as with any behavior, it is affected by many factors, sometimes many contributing at once. The best way to think of this is that both patient and environmental factors play a role. With regard to patient factors, the brain damage brings loss of inhibitory control that may limit the patients' ability to stop themselves once provoked. Specific symptoms such as depression, delusions, and hallucinations may drive patients to respond or act in aggressive ways to provocations that to others are rather minor. Many times depression, delusions, and hallucinations are the primary cause of big outbursts, such as the ones we heard about today. The cognitive loss may make patients less able to "read" what is going on around them. Men are more likely to be violent than women. When patients get sick, such as with colds or bladder infections, they are more likely to act out.

With regard to environmental factors, lack of structure, boredom, change in routine, even changes in room temperature may serve to provoke violence. In some cases, caregivers who are not sophisticated may rush patients too much during care, or may respond inappropriately to the symptoms patients are exhibiting resulting in physical aggression from the patient who is unable to communicate her needs well. Some caregivers do not quite know how to deal with delusional ideas or suspicions and may feed in to them making matters worse. Caregivers who are tired and overwhelmed may lose their patience and become angry leading to fear and agitation in the patient.

2. How do we treat behavioral symptoms, and how good are our treatments?

Current treatments consist of prevention, removal of causes and provocations, psychiatric hospitalization, and/or use of certain medications. The use of these is articulated in great detail in our book Practical Dementia Care (Oxford University Press, 1999). Prevention focuses on putting in place good "Dementia Care" practices for all patients, such as:

- meticulous medical care
- removal of unnecessary medications
- implementation of a structured day to day schedule, sometime adult day care
- early detection of psychiatric symptoms
- de-escalation of agitation in its early phases

- caregiver education
- caregiver skill instruction
- and many other activities.

Medications have been shown in some cases to reduce delusions, hallucinations, depression, or non-specific agitation. Medications can carry significant risks especially in frail older people.

Overall, our treatments in the hands of seasoned clinicians are successful in reducing or eliminating psychiatric and other behavioral symptoms to a manageable level well over 80% of the time. However, in many cases success is not complete and patients and caregivers are troubled for years with these symptoms. Little scientific is known about how well treatments available today are able to prevent violence, even though common sense would tell us that they do. These treatments have been shown to delay nursing home placement that is often driven by behavioral issues. Much more needs to be learned about how to treat the psychiatric and behavioral symptoms of dementia. Despite this, these are some of the most treatable symptoms of Alzheimer's disease.

3. How does our health system fall short in treating these aspects of the disease?

The health and long-term care systems falls short in several ways. Detection rates for ***dementia itself*** in primary care, assisted living homes, and nursing homes remains unacceptably low. Only about 30% of people with dementia are given this diagnosis by their primary care doctor, only about half to two-thirds in long-term care. Detection rates for behavioral problems before they escalate and get out of hand, such as in the recent Florida case, are probably much lower. This is a major missed opportunity on the part of our healthcare system to intervene early to prevent severe behavior problems among Alzheimer sufferers.

While the know-how for preventing and managing these symptoms is rather good, this knowledge has not been transferred to the vast majority of care settings. Most primary care doctors have very little background or training on how to treat these symptoms. The same is true for staffs at nursing and assisted living homes that are confronted with these symptoms many times a day. Part of the problem is that the costs associated with treating these symptoms are high, and Medicare fee and reimbursement structures are not conducive to clinicians getting paid for managing theses symptoms. Doctors working in this area—such as those on my team—and their staff, often nurses or social workers, may spend many hours a day on a single patient and only get paid for part of that. The fees paid by Medicare are so low that our ablest doctors are not interested in learning how to care for these symptoms. Alternative treatment models, using telemedicine, and physician extenders would probably be very successful but are currently either not reimbursable or reimbursement is very cumbersome.

A third problem has to do with the setting in which patients with the more severe forms of these symptoms are to be treated. Nursing and assisted living homes are unable to care for the more serious case for many reasons. We could do better on this by raising the level of expertise of assisted living and nursing home staff in managing these symptoms. Hospitals are usually not well equipped with specialty units and end up managing these patients on typical medical surgical wards or emergency departments often through restraint or sedation. Staffs here usually

do not know what to do or how to approach and manage the symptoms. Specialty units are slowly springing up around the country but are faced with reimbursement pressures due to the long lengths of stay and complexities of caring for some of these very ill Alzheimer's patients. On our specialty unit at Johns Hopkins, length of stay is on the order of 18-20 days, and it is not unusual for some patients to end up staying with us for several months until their violent behaviors get better after complicated treatment efforts.

4. What research is needed to improve treatments?

Research is an essential part of the battle to conquer Alzheimer's. The ultimate goal must be to find treatments that will cure, prevent, or delay this illness. At the same time, we must focus our energies on research to ***improve the care*** of the 4.5 million people with Alzheimer's currently alive in the United States, and of their caregivers, who are just as affected by the disease. It is critical that we as a nation dedicate adequate resources to this effort.

We at Johns Hopkins are proud to be at the forefront of both research and care of Alzheimer's and related disorders. Our memory disorders clinical program, one of the first ever established in the United States, spanning the several Johns Hopkins Medical Institutions and our affiliated long-term care facility, Copper Ridge, provides diagnostic evaluations and ongoing care "from diagnosis to the end of life" for thousands of patients with Alzheimer's every year. As well, much of the Alzheimer's related research going on at Johns Hopkins exemplifies the sort of work that is going on around the country.

We are here today to discuss the research needs for the future. In the interest of time I will only make a few remarks about treatment research.

We must substantially and immediately increase research into the treatments of Alzheimer's disease. The most exciting possibility comes from recent knowledge of the pre-clinical phase of Alzheimer's disease. It turns out that the disease is damaging the brain for many years before the onset of any symptoms. This offers an opportunity to intervene and stop or slow it before symptoms occur. That is the key to preventing Alzheimer's. One estimate indicates that if the disease could be delayed by five years, the number of people suffering from the disease would be reduced by half. To this end the National Institute of Aging has initiated prevention studies to find out whether certain medications can prevent the onset of Alzheimer's symptoms and other Institutes are now joining NIA in that effort.

At Johns Hopkins we are proud to have a leadership role in such prevention studies. By way of example, I mention the Alzheimer's Disease Anti-inflammatory Prevention Trial or ADAPT in which I have a leadership role. ADAPT is designed to find out whether healthy people 70 and older without memory symptoms are less likely to develop the disease if treated with non-steroidal anti-inflammatory medications. This study has already enrolled 2200 people at six sites nation-wide, about 400 here in the Baltimore-Washington area. We eventually plan to enroll a total of about 4,000 participants over the next few years. These sorts of studies are very expensive, costing tens of millions, but they are the only way we will find safe and effective ways to stop Alzheimer's. Each study takes several years and involves scores of clinicians and thousands of participants. The most promising studies involve healthy seniors who must be

enrolled in sufficient numbers over long enough periods of time. These studies also require substantial investment in outreach efforts to recruit and retain enough study participants, including those from the diverse ethnic and cultural backgrounds affected by Alzheimer's disease.

We must also pay special attention to understanding better the causes and treatments of the behavioral symptoms of Alzheimer's. Both medication and non-medication treatments and their combinations must be studied. Similarly we must study treatment benefits on a wide range of outcomes, including quality of life, and functional decline. For example, we are conducting a study of treating depression in Alzheimer's Disease (DIADS-2) with support from NIMH where we are looking to see not only if depression can be treated but also if treatment can benefit caregivers, patient quality of life, and possibly delay the functional decline of Alzheimer's. Many more studies of this sort are needed. I want to emphasize that we must not limit ourselves to medication treatments since a variety of other interventions greatly benefit patients. With our affiliate, the Copper Ridge Institute, we are investigating the benefits of several non-medication treatments for Alzheimer's patients and their caregivers. Increased funding in this area, thus far primarily supported by the Alzheimer's Association, will also be necessary. I encourage the NIH to place special emphasis on developing better treatments in the area of psychiatric and behavioral symptoms of Alzheimer's.

Finally, we need to be sure that we can deliver treatments where they are needed. I specifically want to mention the primary care and long-term care environments. Most people with Alzheimer's disease are seen in primary care in the early stages of the disease. This is a great opportunity to detect and intervene early with behavioral symptoms. We must educate primary care doctors in detection and treatment of these symptoms, and make available to them methods of implementing the necessary care regimens. We must also create the necessary incentives for doctors to do this without losing money.

Currently, millions of people with Alzheimer's disease live in residential care facilities. We have known for many years that a very large portion of the nursing home population has Alzheimer's or another dementia. We are only now finding this out about assisted living. In our Maryland Assisted Living Study (funded by the National Institute of Mental Health), our findings indicate that as many as 75% of residents suffer from memory disorders and that the detection and treatment of these disorders in that environment is sorely lacking. It is critical that we understand better the presence and course of Alzheimer's in assisted living, and that we deliver the most effective available treatments to these patients as well.

With my deep appreciation for your invitation for me to speak at this hearing, I would like to strongly emphasize that Alzheimer's is a disease that affects us all at a personal, an economic, and a societal level. Research is the key that will allow us as a society to manage this scourge. Redoubling research efforts in the laboratory, looking for risk factors and protective factors, improving diagnosis, understanding of the course of the disease, and developing a wide range of preventive and other treatments, with a special emphasis on drug discovery, and improving care for psychiatric and behavioral symptoms must be our mission for the future.

5. What are some of the community responses to this issue?

Through its nation-wide chapter network, the Alzheimer's Association is engaged in a wide range of efforts to develop community responses to these complex issues.

- Its national Safe Return program, supported with funds from the U.S. Department of Justice, links communities across the country to a single emergency alert network. Designed specifically to locate and return people with Alzheimer's who get lost, the program has had a much wider impact as it has trained law enforcement and emergency personnel to recognize and understand the signs and symptoms of Alzheimer's disease.

- In at least a dozen states – from Massachusetts, to Texas, Kansas, and California -- the Alzheimer's Association has worked with Attorneys General and state and municipal police departments to integrate dementia training into curricula at state police academies and in regular police roll calls.

- In Wisconsin, when mandatory arrest in domestic abuse cases became state policy, the Association enlisted community service providers, adult protective services, local law enforcement agencies and the Governor to develop a community response to cases involving persons with dementia. As a result, all police officers in the state now receive mandatory dementia training. And, nursing homes and community based residential facilities have been recruited to provide temporary placement, as an alternative to jail, when a violent person with dementia needs to be removed from the home.

- In Indiana, as a result of a highly publicized incident of deadly assault by one nursing home resident against another, the Association convened a broad-based working group of long term care providers, state law enforcement and mental health agencies, consumers and others to address the issue of aggressive behavior within nursing homes. The group identified the real scope of the problem, identified underlying reasons, and made specific recommendations to improve the ability of facilities to deal with difficult residents and for a high quality alternative care facility for the small number of cases that could not be managed in regular facilities. A copy of the Executive Summary of this important study is attached to my statement.

- The Alzheimer's Association continues to educate law enforcement and judicial personnel about dementia, through presentations at their national meetings and publications like the recent article that appeared in a national journal widely read by state and local judges (which is also attached to my testimony.)

Conclusion

Ultimately, management of a person with Alzheimer's disease who is at risk of violent behavior will depend upon very direct response from physicians, from law enforcement personnel, from long term care providers, and from community agencies. But Congress and the federal government have a lot to say about making those responses possible. In that regard, I have some very specific recommendations to make to you:

- Provide adequate funding for the essential research on understanding, managing and treating behavioral issues in persons with dementia -- research that will be jeopardized unless you agree to add funds beyond the President's budget for Alzheimer research at the NIH.

- Continue funds to the Department of Justice to support Safe Return.

- Maintain funds, and the quality requirements attached to those funds, for state Medicaid long term care programs.

- And, perhaps most important, change Medicare policy to provide payment not just for evaluation and diagnosis but for ongoing management and care coordination for beneficiaries who have Alzheimer's disease and other chronic health conditions that require such medical care.

Senator BREAUX. Thank you very much, Dr. Lyketsos, for your presentation. I thank everyone for being with us. I think your statements speak for themselves and they have been very helpful and very illuminating. Hopefully, it can lead to Congress having a greater awareness of the problems we are talking about.

Commander Gotham, why was your father initially confined as he was under the Baker Act? Was there a specific complaint by someone? How did that happen?

Commander GOTHAM. On the evening of January 5, approximately 10:30 at night, he had gone to a woman's house that he had met on the Internet for a date. He had gotten lost and was in an unfamiliar neighborhood and had gone to the wrong door.

He also suffered because of his prostate from bladder control and had told me that he gotten out of the car to urinate and had forgot to zip up his zipper. So when he went to the door, the gentleman did not know who he was, his zipper was unzipped, and he did not like the responses he was getting from my father and called the police.

When the police responded, my dad had left his car in this man's driveway and was walking away with his dog. The police approached him and he was able to respond where he lived, but was confused about where he was and didn't know how to get back to his car or the house.

Senator BREAUX. Was he on any kind of medication at the time or in treatment for dementia?

Commander GOTHAM. No, Senator. The only thing he had had was in November, where his primary care provider felt that his depression was bad enough that she had put him on Paxil. He had taken himself off of that at the same time his primary care provider had moved on, mainly because he said he was suffering from hallucinations on the medication, at the dosage.

Senator BREAUX. After they picked him up and incarcerated him for this period of time, was he seen by a doctor or anyone during that period, to find out what the problem was that he was suffering from?

Commander GOTHAM. We're in the process now, working with the assistant state attorney, to get the Springbrook Hospital records. He was actually seen by two facilities. The first facility in Marion County, because of his Medicare insurance, refused treatment for him. He had to be taken down to Springbrook in Hernando County. He was seen there. We have not seen the complete medical report, but he is required under the statute to be seen both physically and mentally within 24 hours, and then at the 72 hour mark he was required to either be brought before a hearing and a decision made if he was not able to make his own decisions about his treatment, that a court could order him placed involuntarily for extended treatment up to 6 months.

Senator BREAUX. Was the family notified at any time when he was picked up, or how long was it before the family was notified?

Commander GOTHAM. It was not until January 12, and it was due to his two neighbors that had worked with the hospital, trying to find out why they were keeping him. They went into his house because he had actually left his dog that he had with him that night with one of the neighbors. The police went back, got that

neighbor, and brought her back to the car, took the dog and the car. So she had gone in my dad's house with one of the other neighbors, and they had e-mailed me. But that was on January 12.

This was the first time that we knew my dad was in the hospital. It took about a week before——

Senator BREAUX. They picked him up on what date?

Commander GOTHAM. On January 5.

Senator BREAUX. So from the 5th to the 12th, the family had not been notified?

Commander GOTHAM. That's correct, sir.

Senator BREAUX. If you pick up a juvenile, I think the law requires that you notify the parents, that you have picked up the juvenile for misbehavior and incarcerated them.

Did they say they attempted to find the children or any family members so that they could let you know they had this gentleman who was picked up for what they would call abnormal behavior? Were they trying to contact the family members to let them know?

Commander GOTHAM. No, sir. Springbrook Hospital was very reluctant to discuss much with me. The police basically, once they turn the individual over to the medical community, they're off the hook for anything.

He did have a yellow piece of paper in his wallet with all of our phone numbers on it. There were two immediate locations in the house where he had all of our phone numbers. But there was no attempt to contact the family.

In reading the statute, it does say that the second person to be notified would be a subordinate, like a son or a daughter, if he didn't have a spouse. But they did not answer any of my questions. It took me contacting the assistant state attorney to even have his medical records released to us, and we still don't have those.

Senator BREAUX. How long was it from the time that the police picked him up before he was turned over to medical authorities, do you know?

Commander GOTHAM. It looks like he was picked up about 10:30 at night, and he was not taken to Marion Citrus, the first facility, until after midnight. Because they refused him, he was driven to Hernando County, which I drove that actual route and it took over an hour to reach the Springbrook Hospital. So he would have gotten there between 1:00 and 2:00 in the morning.

Senator BREAUX. But apparently the police, after they picked him up based on this complaint, attempted to bring him to a medical facility, the first one turned him down, and they got him to the second one within a matter of hours?

Commander GOTHAM. I believe the total time was probably in excess of 2 or 3 hours. I don't know exactly yet. But the officer that actually initiated the Baker Act spoke with my brother. She had worked with my brother several times about getting the gun out of the house and things to do with my dad. She explained to my brother that she did have his best interests in mind, that she did want to try and provide him some help, but under the Baker Act, she said she had stretched the criteria that applied to my dad but felt he needed some kind of help.

Senator BREAUX. The incarceration that he had during this first period was at the hospital facility?

Commander GOTHAM. That's correct. I have actually been down at the facility and walked around inside of it. It is a treatment facility recovery for drug and alcohol abuse. The average age appeared to be—I saw probably 60 patients as I walked around in the facility, and the average age was probably 48 to 55 years old. There were young people there, semi-private rooms. It did not look like it was very supervised in terms of being able to walk out of your room, and walk the common areas.

It is locked. You are restricted in certain areas that you have access to leave the facility.

Senator BREAUX. So after he was there for a period of time of about 7 days, then they released him. Did they diagnose that he had dementia at that time and say, look, we recommend that he take the following medications; we're releasing him and here's the prescription for what he should be on?

Commander GOTHAM. We have seen one discharge paper. He was given three medications. Two of them were for high blood pressure and one was for cholesterol. He was on those medications, or a derivative of them, prior to going to the hospital.

He was diagnosed with dementia and severe delirium. He was not given any medical prescription drug for those conditions. He was given one follow-up appointment on January 29, to go to the Marion Citrus mental health facility.

Senator BREAUX. So at no time after this first period was he under any kind of treatment or on medication for dementia or delirium?

Commander GOTHAM. Absolutely not, sir.

Senator BREAUX. Tell me what happened that brought him to make the call the second time to the sheriff's department to check on him. What happened there?

Commander GOTHAM. On that morning, a Saturday, I was actually supposed to go down and visit him. But because of my job, I had to brief a flag Officer on a Sunday. My sister called me that morning and my dad's phone was disconnected. She was leaving for work, so I called and confirmed that his phone was disconnected. I called my brother, Randy, who lives in Jacksonville, about 2 hours away, and he——

Senator BREAUX. Your sister lives where?

Commander GOTHAM. In California.

Randy was about 4 hours away from seeing him because he had two meetings to go to that day before he would see my dad. I said I was concerned about it and should we do another wellness check, since the first one had gone OK. We made the decision to do that.

That is when I contacted the sheriff's dispatch and talked with the dispatch about having them do another well-being check on my dad.

Senator BREAUX. When was the first wellness check done? Was that after the incident when he was picked up and brought to the hospital?

Commander GOTHAM. Yes, sir. That first week after the 12th, when he got out of the hospital, because there was such a dramatic change in my dad—he was talking about things that just were not real. In my process of contacting the sheriff and verifying information because he thought my step-mom had committed suicide. I was

asking them how to get help. They said "Well, we have something called the wellness check."

So I did that the first week, from the 12th through the 17th, and then it was not until February 7, that I made the call for the second wellness check.

Senator BREAUX. What generated the need to make that second wellness check again?

Commander GOTHAM. Because we couldn't get in touch with him. His phone had been disconnected, and my brother was not going to see him until later that night.

Senator BREAUX. When that second wellness check commenced, can you tell us the details, to the extent you know what happened from the report? I mean, I take it that's a physical check, that the sheriff's department comes up to the house, knocks on the door to see if everything is all right.

Commander GOTHAM. Yes, sir. Actually, I am incredibly familiar and too familiar with the details. I was kept on the phone through the entire event. Because I had warned them about my dad having a gun in the house and warned them about his mental condition, they actually made the call for two officers, a primary and a backup.

The backup arrived on the scene first. What we know from eyewitnesses, neighbors who both saw it and actually took pictures of it, is that it quickly got into a verbal confrontation between this officer and my dad. In listening and reading the transcript of the 911 dispatch call, he said that my dad did have a gun in his hand. This officer drew his weapon and approached the house, in addition calling for a SWAT negotiator and other backup officers.

About this time the second officer arrived on the scene, too. The first officer was maneuvering around the house and was crouched underneath one window and was approaching a second window, and based on the ballistics and the FDLE report, my dad had positioned himself behind the couch, underneath the window, and was looking up at an angle to the window at the same time that this officer then was looking down and into the window. My dad fired two rounds and struck the officer in his neck and tore his jugular vein and his aorta. The bullet actually traveled down through his aorta.

After that, it appears that my dad had placed the gun on the table and had been running or moving inside the house as additional officers and SWAT team members had arrived on the scene. They had the house surrounded. They were attempting to decide to make a rescue or a recovery. A sergeant was placed in tactical control, even though there was another senior officer there. He had actually approached Brian Litz, who was on the ground, and had signaled to everybody that it was now a recovery, that Brian was obviously dead.

He then changed his mind and decided that he did not like him being there on the ground and wanted to continue with a rescue, as if Brian was alive.

As the SWAT team arrived on the scene, a two-man team, one of them placed a shield over the window that my father had fired out of. He has a window in that shield and he maintained eye con-

tact with my dad, as well as another officer that maintained eye contact with my dad.

It appears—and there is some conflict in the testimony and the statements by several of the officers—that they were able to get Brian Litz away from the house, carried him or dragged him about 25 feet, and then all the way down a driveway about 50 feet, and then the shooting started happening at the scene from multiple directions from both handguns and from shotguns.

At no time did they see a gun in my dad's hand. They said, "Well, we were screaming at your dad to show his hands, to put himself on the ground," to pay attention to them. At one point one of the officer's statement was that my dad was, in fact, on the ground, was kneeling in the house.

The officer that had the shield clearly could see my dad but couldn't see his hands, is what he is describing. One of the other officers made the decision that he felt the movements of my dad somehow threatened the rescue, even though apparently by the statements the shooting started after the officer had been completely removed.

Senator BREAUX. All the officers were outside, just shooting into the house?

Commander GOTHAM. That is correct, sir. One of the officers that actually fired the lethal round at my dad came in through a screened-in carport and then broke the glass and stuck his shotgun in through the house. My dad had been running from one side of the house to the other as they were firing different weapons at him, missing each time, miraculously, 74 years old and running like that. Then as he came back toward the kitchen where this officer was, the description is that either he tried to push the gun out of the way or grab the barrel and the shotgun went off and it fired a 12 gauge lethal shot and two of the pellets entered, one in his heart and one in his lung.

Senator BREAUX. Had your dad had any experience with weapons? Had he been in the service or anything before?

Commander GOTHAM. He was in the Navy, but he was only there for about 2½ years. He had traveled on the ocean in a sailboat with my older brother. I insisted, because of piracy on the high seas, that both he and my brother have weapons in the boats.

Senator BREAUX. He didn't have combat experience in the military, though?

Commander GOTHAM. No, sir. In fact, the gun that was used in this incident which he had, because he had traveled in an RV in America, he had never even fired that particular gun. That was the first day that it was ever even fired.

Senator BREAUX. I hate to ask you to speculate, but to the extent you know, where do you think the system broke down from the time that you called to make the second check on your father? Where do you think the system broke down in order to have the tragic results that occurred?

Commander GOTHAM. I think there is three key areas. One is that the family was not notified of the initial Baker Act, and the fact that he was kept there for 7 days. I wouldn't want to be kept for those 7 days like that, confined like that.

Second is that there was nobody there to receive him. They just let him go from the hospital. They took him home and dropped him off. No family was notified, no safety net, nobody to be there with him to help him, no counseling appointment for 2 weeks, until January 29.

The other key for me is the distinction between the two officers that made the wellness checks the officer from first time the officer that not only had Baker Acted him on the 5th, but had another incident with my dad on January 24. She had a certain ability about her, that she said when she approached the house on the 29th, my dad was clearly agitated, clearly was feeling that she was there to take him away again. He did not want to be taken. She was able to talk to him, get him to calm down, and they had a pretty good conversation on the 24th.

I contrast that to the events that happened on February 7, where it is clear that a confrontation happened within seconds of that officer arriving, based on eyewitness accounts, and then it progressed from there, starting off with an argument to then having weapons drawn and shots being fired.

Senator BREAUX. It seems that you're expressing a feeling that they had taken your dad away under the Baker Act and incarcerated him for 7 days, and then they came back to the house a second time to do a wellness check. He was agitated and sort of felt they may have been coming back to take him back to the place where he would have been confined. Then the second time they came back again to do a wellness check. I guess you're speculating that your dad probably thought they were coming back to take him back again to the place where he had been confined before for 7 days.

Commander GOTHAM. Yes, sir. On the first wellness call, actually my dad and I joked about it, that here was his son, his youngest son, calling the cops on him, as if we were joking back and forth. So it was not that big a deal with him on the first one.

In hindsight, and in listening to the police officers and then all of us talking, it's like suicide. It is clear that all the indicators were there, but we did not have all the pieces of how scared he was about the police. His neighbors talked about conversations they had had with my dad, saying "I never want to go back to that facility". These were not things that I knew on the morning of the 7th. Had I known all these things, I would have done something different than calling the police. I just did not have an idea of the extent that he had, No. 1, interacted with the police, did not know the full extent about this involuntary incarceration, and didn't understand just the extent of how his mind had deteriorated.

Senator BREAUX. Well, this is a tragic story. I'm just concerned that the potential of this occurring in the future is very, very high because of the larger and larger number of people that are becoming more elderly as we live longer and longer, and also because of the necessity for families to be located throughout the United States.

I mean, you're in Washington, one child is in Jacksonville, far away, and another one was in California, all looking after their families and earning a living. That's very common. You just can't run next door and check on mom and dad any more.

My father lives in Louisiana by himself, and I can't just knock on the door and say "how you doing?" So it's very, very typical that these family arrangements are such.

Dr. Cohen, in listening to the situation, what do you think could have been done differently? I guess I'm again asking where was the breakdown. I'm surprised that he was released after being picked up the first time under the Baker Act with no medication being prescribed for dementia and delirium. They gave him, I guess, cholesterol medicine and high blood pressure medicine. But it seems today, with the miracles of medication that we're finding, that there are medications that can be of assistance. That struck me as being unusual.

Where do you think it could have gone differently and preventing this tragic event from happening?

Dr. COHEN. Well, building on the themes of Dr. Lyketsos' testimony, and with the knowledge of the limited details, all the vivid details from the Commander, the breakdown was in the involuntary commitment and the enforcement, the process and the discharge.

The Baker Act in Florida, implemented in the Seventies, was a model of its time, one of the first in the Nation. In the Nineties—and I was actually a part of this research effort—older people were being Baker Acted and voluntarily committed multiple times in several parts of Florida——

Senator BREAUX. How often is this used in Florida?

Dr. COHEN. How often is it used?

Senator BREAUX. Yes. Not the exact number, but is it used frequently, infrequently, or is it unusual to have a person Baker Acted?

Dr. COHEN. It is used frequently to deal with individuals who have a mental illness and are a danger to themselves and others. In the Nineties, we found——

Senator BREAUX. Regardless of age?

Dr. COHEN. Regardless of age. In fact, sadly, the discharge issues that we had, the issues you have in the use of the Baker Act, with children and adults being kept for longer periods of time until a hearing can be held, and the problems in the discharge, also occur with four, six, and 8-year-olds, 10-year-old children.

The Baker Act, in many areas of Florida, is used appropriately. In Hillsborough County, where the University of South Florida is located, we have very specific criteria about the receiving facilities. Your dad was taken to one facility and then moved on to another, as I understood your comments.

The use of the Baker Act now in many parts of the State is appropriate.

Senator BREAUX. It seems to me that I think the first thing is the requirement of the Act, according to Commander Gotham, would be that when you have a person who is picked up alone in a house, and Baker Acted into a facility, the first thing I would want to do, after assuring of their safety, is to find out who they are. I mean, is there a son or a daughter. Who is this person connected to. If it's a child, you say where's the parents. If it's an elderly person, where's the children, where's the guardian, to start immediately trying to find out where the family is, to let them

know that their dad or grandfather, mother or grand-mother, has been picked up for irrational behavior. That's a requirement of the Act, right?

Dr. COHEN. That's correct. Indeed, from talking with the Gotham family prior to the hearing, the wallet was recorded as being on your father's body when he was brought in. There is a piece of paper with the names, the relationship, and the phone numbers of the children. That was a significant deviation from the appropriate admission of this gentleman.

Also, sometimes there's a difficulty in scheduling a hearing within the 72 hours, and sometimes individuals are kept longer. But my understanding is they lost his paperwork and, therefore, a hearing was never called. So as you look at the details—and I'm just learning these details as you do—there were violations of the Baker Act at this point.

As was said, we do have medications that can be effective in controlling this condition. Your dad wasn't seeing primary care physicians. There should have been in the discharge some appropriate follow up with his primary care. The police picked him up and he was taken over to the facility. They have the responsibility to reconnect him with a system of care. It's not like there weren't neighbors around who knew, not only that he was seeing other physicians, but also knew the family could be involved to provide this information. So I think there was a significant breakdown in the implementation of the Baker Act.

I know that our State legislature prior to this has been concerned about some of these difficulties.

Senator BREAUX. Commander, how did you ultimately find out that he had been incarcerated under the Baker Act?

Commander GOTHAM. In the days after he was killed, I was able to get copies of the police report from the 5th, from the newspaper, the Ocala Star Banner.

Senator BREAUX. But you knew about it before then, didn't you?

Commander GOTHAM. My dad and I talked about it, but his details of what happened, other than he was in a hospital, were very sketchy for him to say, to talk with me about.

There are two things I would like to share with you, Senator. The 2003 report required in the State of Florida for the Baker Act had over 120,000 Baker Act incidents, of which 9 percent of those placed were 65 and older.

Senator BREAUX. Ninety percent?

Commander GOTHAM. Nine percent of 120,000.

Senator BREAUX. Only 9 percent.

Commander GOTHAM. Yes, sir.

Senator BREAUX. Again, no one ever contacted you to let you know that your dad had been picked up, or your other brother and sister were notified by authorities that he had been picked up under the Baker Act? It was your father who told you ultimately?

Commander GOTHAM. That is absolutely correct. It was the neighbor, on January 12, who e-mailed me and said your dad has been in the hospital for the past 7 days; you need to give him some help.

When I started calling around to my brothers and sister, saying "Does anybody know what the heck's been going on, the answer

was no." None of us knew. I was able to establish contact on that very day, the 12th, with my dad.

He did tell me that he had been in a hospital. He explained to me the incident that had happened. I think he was very embarrassed about his zipper being down, or whatever the details were that happened. He had explained to me why he was kept beyond the 72 hours, that there was a paperwork problem, that he should have been just in and out. It was tragic for him. He was having a very difficult time being able to tell me what happened. I did not know those details, what the Baker Act was, that he was in a mental hospital and not a regular hospital. I had felt that he probably had had a stroke and was in an actual hospital being treated for another stroke.

Senator BREAUX. Mr. Rothman and Dr. Lyketsos, you both have heard the Commander's testimony and what I asked of Dr. Cohen. Do either one of you have any comments before I ask you some specific questions, in general about the situation?

Mr. ROTHMAN. I am aware that in Palm Beach County, there is a group of Alzheimer's providers that are working to address the very issue that's been described with respect to the Baker Act, in that it's inappropriate for people with Alzheimer's or dementia anyway. They do not have access to services that are dementia-specific, as I understand it.

Dr. COHEN. Right.

Mr. ROTHMAN. So a group in Palm Beach County is currently trying to work with the State of Florida to address that issue.

The other thing that comes to mind is that, in this particular case, had his father ever come to the attention of the courts, if he had not been in Palm Beach County, I doubt anyone would have responded any differently than anyone else did in this process. Perhaps in Palm Beach County, where there is an Elder Justice Center that does get involved with offenders, particularly those who are placed in jail, they do go in and try to identify what underlying causes exist in a particular case and make an appropriate recommendation to the judge for assessment and potential follow-up services.

Senator BREAUX. Who does this in Palm Beach County? What association?

Mr. ROTHMAN. Well, it's called the Elder Justice Center. It's an office of the court. It functions under the authority of the judicial administrator for the jurisdiction. They do send, on a regular basis, their staff into the jail to see an older offender, 60 and above, although most of the people they see I understand are over 70, and they will make a recommendation to the judge at the first hearing, that there should be an assessment and potentially there should be services provided in a given case, that it would or would not be appropriate to keep that person in jail pending further hearings, and——

Senator BREAUX. It seems like there should be a referral, that when a person picked up under the Baker Act is released from custody, there should be a referral to some agency or some medical doctor, to say that Mr. so and so was picked up and we evaluated him and let him go, but here's what our concerns are.

Dr. LYKETSOS. Senator, I just wanted to comment that the events prior to February 7, are very familiar to me. This is a very common issue.

I want to emphasize a piece that the Commander did not bring out, which is that his father had seen his primary care doctor in November and was being followed for prostate problems, and yet it was not detected that he had dementia. I would therefore like to move the timeframe much earlier and wonder about whether a lot of this could have been managed within the health care system much earlier without having this level of escalation.

Senator BREAUX. That's the whole series of questions I wanted to get to you about, and that is a lack of trained medical professionals and the area of recognizing dementia. Too many times we hear the report that well, he or she is just getting old and they're supposed to act like that, not recognizing there is a dementia problem or the advent of Alzheimer's or the advent of vascular dementia or some other problem that really is a serious medical problem that may be able to be handled differently, other than just letting them go and saying"Well, he or she is just old, and old people are supposed to act like that."

I note that at Johns Hopkins you are a professor of a department that most medical schools don't have. Most medical schools have very little training in geriatric specialties for general practitioners. There are very few specialty programs at all.

So what should we do about that?

Dr. LYKETSOS. It's a very complicated answer.

One thing would be to create incentives in the primary care setting, so that dementia can be recognized and treated better. For example, primary care physicians—and I've had this conversation with several of them over the years—don't feel that there is much reason to detect dementia because it alienates patients, they don't get paid for it, that family members——

Senator BREAUX. Any time you diagnose an illness, it probably alienates the patient who doesn't want to hear they have cancer, for instance, but you don't not tell them that because it may alienate their affections.

Dr. LYKETSOS. That's usually my answer to that. What I actually add is that their role in prevention of this kind of incident, or even a much smaller level of severity of this, which ends up being fairly common, is really important.

Senator BREAUX. In the Medicare bill that was just passed and signed into law we provide for the first time, in essence, a baseline physical for someone coming into the Medicare program. This is so that the person who becomes eligible for Medicare will at least be entitled to a baseline physical, conducted by a medical professional, to give them a baseline study of what the problems are that this person is experiencing, or what are the potential problems if they in fact are not treated properly in the future, instead of waiting for someone to be on Medicare for 10, 12, 13 years before they ever see a doctor for the first time.

If you're 65 and you have your baseline physical and Medicare is going to pay for it, so you go do it, can that type of physical provide any helpful information in determining whether someone is on the advent of dementia?

Dr. LYKETSOS. Yes, it can. It's possible to incorporate in the physical exam assessments of cognitive state that would determine whether someone has early dementia or not. In fact, what we refer to as the very old, over age 80, it is probably critical that everyone have a cognitive assessment. Something called the mini-mental state is probably the most quoted method of doing that. But there are many others. Primary care physicians, as a rule, do not incorporate that sort of an assessment within their physical.

Senator BREAUX. Do we find in the medical profession that these incidents of violence among dementia patients is all of a sudden, where someone snaps and creates a violent act, or is it more of a gradual movement toward increasing violence which may ultimately lead to real serious violence?

Dr. LYKETSOS. The vast majority are of the latter kind, with a gradual increase. Occasionally there is the big snap, but that's very uncommon. It is therefore possible to recognize this sort of thing coming on most of the time.

Senator BREAUX. Mr. Rothman or anybody can comment on this, but is there any requirement that a physician report to law enforcement officers when they are treating a person for anything, but particularly for dementia that, in that doctor's professional opinion, may lead to potential violence?

Dr. LYKETSOS. As far as I know—it's likely to State dependent. But as far as I know, this would come under the Tarasoff type rules that exist within a given State. So in Maryland, for example, I could only breach confidentiality if I know the specific person that is being threatened by the patient. As a rule, I don't.

But to step back before we even get there, probably the most critical involvement early on is the family. What one does with early dementia detection in primary care is involve the family in the care of the person and put into place alternative decisionmaking routes that often involve the family, so that when you have an escalating crisis, you have other people involved in decisions about moving out of your home, about removing guns from the home and so forth, the kinds of things that would have been preventive interventions in the Gotham case.

Senator BREAUX. Dr. Cohen.

Dr. COHEN. Just to go back to your comment about the Medicare reimbursing for a physical, Medicare does not reimburse for time that physicians spend with family members. Along these lines, when it comes to evaluating the patient, I think that we need more reimbursement for family time.

Also, a physical exam does not necessarily——

Senator BREAUX. If I was a smart doctor, I would just bill the whole thing as advising the patient while I was talking to the children.

Dr. COHEN. Some of them do that.

Senator BREAUX. I would think some of them could figure that out pretty quick.

Dr. LYKETSOS. Doctors are scared of felony charges.

Dr. COHEN. Exactly. [Laughter.]

Senator BREAUX. They're also very clever.

Dr. COHEN. The physical exam doesn't include the psychiatric exam. Again, the primary care community is not trained in the rec-

ognition of depression, as has come up in other hearings, or other psychiatric problems.

Senator BREAUX. That's why I asked the question, whether it would be recognizable under a normal physical exam. It's really questionable.

Dr. LYKETSOS. I think the primary care physicians should change their practice, what I would rather approach this as, and incorporate this in the physical exam.

Senator BREAUX. If they had the training, which we don't provide in most medical schools, they could probably recognize it more than "he's just getting old and is supposed to act like that."

Dr. COHEN. That's correct.

Senator BREAUX. The lack of information I think is really key. I think a part of the Elder Justice Act, which we're trying to get through the Congress, is in order to try to provide greater information so that we can make more rationale decisions and more intelligent decisions.

Commander.

Commander GOTHAM. Senator, if I could, one of the dynamics of this that was somewhat shocking to us is that we had found out that my dad had turned in his hearing aid, one of two hearing aids, in December. The woman that worked with my sister in describing that had talked about how patients with one or two hearing aids out, that their loss of hearing can lead to states of confusion and misdiagnosis. It calls into question some of the actions of police.

My dad clearly only had one of two hearing aids in that day. Yelling at him, and yelling from multiple directions, and with a dog in the house, you're not going to get any kind of response from somebody like that.

Senator BREAUX. Like I always say, at least you got your dad to wear a hearing aid. I have not been successful in getting my dad to do that.

All right. This has been a very informative hearing. It will be a matter now of the public record of the Senate Aging Committee and the U.S. Senate. We will make sure that the proper people who are in positions, myself included, who make a difference in these areas will have the benefit of what was said and your testimony. I appreciate it very, very much, particularly you, Commander, and your family here in the audience, for being with us. You're making a real contribution, so that the tragedy that you have experienced is not to be repeated in the future, hopefully, if we do the right thing. So we thank you in particular for that contribution.

With that, the hearing will be adjourned.

[Whereupon, at 3:20 p.m., the committee was adjourned.]

APPENDIX

Crisis Response and Intervention Training Committee

14007 Lake Magdalenen Blvd.
Tampa, Fl. 33618

May 5, 2004

Senator John Breaux, Ranking Member
Special Committee on Aging

Dear Senator Breaux:

We are writing you today for a number of reasons, with the most important one acknowledging the tragedy that occurred on February 7, 2004. A Marion County Sheriff's deputy encountered a 74-year-old gentleman, who recently had an acute onset of dementia resulting from a series of strokes in November of 2003. Both lost their lives. The local chapter of the Marion County's National Alliance of the Mentally Ill (NAMI) has since contacted us for any assistance we might lend to this unfortunate situation. They have heard about the training we have been doing with the Hillsborough County Sheriff's Office and the Tampa Police Department over the past four years. That effort has led to approximately 400 Law Enforcement Officers being trained in how to humanely handle the mentally ill in a dignified manner during a crisis.

At present, the local NAMI group is establishing a memorial fund in the names of the slain deputy and the elderly gentlemen. Additionally, we have been asked if we would assist in developing positive outcomes. This is the wish of Gary and Rorie Lynne Gotham, two of the three children of the 74-year-old gentleman, Ivan Gotham. Gary and Rorie Lynne Gotham will be addressing your committee March 22, 2004.

We suggested to NAMI that they engage the family in a dialogue telling them of the resources available to them and hope they would take advantage of our up -coming training the week of April 12, 2004. Hopefully, your committee will gather enough anecdotal information that will enable them to conclude that the time is now to form a national partnership between law enforcement and the mental health professionals. With the training that is accessible to these two groups (see attachment of last session), along with the expertise, tragedies such as these will hopefully become a thing of the past.

The accumulated experience we have in the combined fields of mental health and law enforcement has been recognized nationally with a program you may be familiar. In New Orleans it is called the Crisis Transportation Service. This program was started during Chief Woodfork's tenure (begun in 1982, receiving one of the Presidential Thousand Points of Light Award in 1995). In Tampa, Fl, a "best practices" program, modeled after the Memphis Police Department's Crisis Intervention Team concept was begun by a Major in the Tampa Police Department. The Memphis program was another Presidential Thousand Points of Light Award winner. This program is the on-going training referenced earlier in this letter.

We thank you for taking the time to inform yourself, and the Special Committee on Aging on how such a tragedy could have a positive outcome. Any additional information you or your committee would like is readily available by contacting Rick Wagner at (813) 695-5490 or you may fax any requests to (813) 908-7176.

Sincerely,

Rick Wagner, Co-chair
Crisis Response and Intervention Training

Rick Duran, Co-chair
Crisis Response and Intervention Training

Organizational Grid
Monday October 6, 2003

Time of Day	Topic	Presenter
0800	Administrative Tasks Introduction to CRIT	Major Rick Duran, Ret. Rick Wagner
0830	Police Role in Mental Health Emergencies	Major Rick Duran, Ret. Rick Wagner
0925	Intro Mental Disorders Mood Disorders Major Depression	Dr. David Kershaw
1030	Psychotic Disorders - *Schizophrenia*	Dr. David Kershaw
1130	Substance Use Disorders Medical Conditions that Mimic Mental Disorders	Dr. Sean Harvey
1430	Children's Mental Health Issues	Dr. Nancy Pape
1545	Psychotropic Medication	Wendy Morriarty

Organizational Grid
Tuesday October 7, 2003

Time of Day	Topic	Presenter
0800	Family Perspective	Carol Skipper
0925	Consumer Perspective	TBA
1100	Travel to and Site Visits A- Project Return (Lunch) B-Safe Place (Lunch) C- Transitional Living Community (TLC) / Graham Home (Lunch))	Mike Ross Mary Smith Mary Myles
1300	Travel to and Site Visit Orient Road Jail	Dr. Nancy Pape Rich Homand
1415	Travel to and Site Visits A-Children's Crisis Center B-Adult Emergency Services C-Adult Emergency Services	Dr. Nancy Pape Rich Homand
1430	Travel to and Site Visits A-Adult Emergency Services B-Children's Crisis Center C-Children's Crisis Center	Joan Carver
1545	Travel back to Faulkenburg	Rick Wagner

Crisis Response Intervention Training
On-Site Schedule October 7, 2003

Time	Activity	Group A	Group B	Group C
1100 – 1130	Travel	Project Return 304 W. Waters Ave. Tampa, FL 33604 (813) 933-9020 Contact: Mike Ross	A Safe Place 2015 Central Ave. Tampa, FL 33602 (813) 272-2168 Contact: Mary Smith	Transitional Living Community (TLC) / Graham Home 2400 E. Henry Ave. Tampa, FL 33610 (813) 272-3290 Contact: Mary Myles
1130 – 1200	Tour	Project Return	A Safe Place	Transitional Living Community (TLC) / Graham Home
1200 – 1300	Lunch	Project Return	A Safe Place	Transitional Living Community (TLC) / Graham Home
1300 – 1330	Travel	Orient Road Jail	Orient Road Jail	Orient Road Jail
1330 – 1415	Tour	Orient Road Jail	Orient Road Jail	Orient Road Jail
1415 –1445	Travel	Adult & Children's Emergency Services 2212 E. Henry Ave. Tampa, FL 33610 (813) 272-2958 Contact: Dr. Dave Kershaw Dr. Nancy Pape	Adult & Children's Emergency Services 2212 E. Henry Ave. Tampa, FL 33610 (813) 272-2958 Contact: Dr. Dave Kershaw Dr. Nancy Pape	Adult & Children's Emergency Services 2212 E. Henry Ave. Tampa, FL 33610 (813) 272-2958 Contact: Dr. Dave Kershaw Dr. Nancy Pape
1445 –1515	Tour	Children's Crisis Center	Adult Emergency Services	Adult Emergency Services
1515 –1545	Tour	Adult Emergency Services	Children's Crisis Center	Children's Crisis Center
1545 –1615	Travel	Return to Faulkenburg	Return to Faulkenburg	Return to Faulkenburg

Organizational Grid
Wednesday October 8, 2003

Time of Day	Topic	Presenter
0800	Administrative Tasks/Debriefing	Rick Wagner
0915	CAF Communication Skills & Verbal De-Escalation	Robert Tungate
1315	Police Suicide Situation, Environment, Subject's Condition	Robert Tungate
1410	Risk Assessment Suicide/Violence Risk	Rick Wagner
1530	Developmental Disabilities	Dr. Rick Zawlocki

Organizational Grid
Thursday October 9, 2003

Time of Day	Topic	Presenter
0800	Marchman Act	Michelle Smith
0925	Baker Act Triage/Decision Making	Dr. Dave Kershaw
1315	Community Resources	Tom Mueller
1415	Elderly	Det. Georgia Veitch

Organizational Grid
Friday October 10, 2003

Time of Day	Topic	Presenter
0815	Administrative	Rick Wagner Major Rick Duran, Ret.
0830	Legal Issues, Discretion, Decision-Making and Handling of Criminal Charges	Maria Marino John Johnson
0930	Homeless	James J. Joyce
1045	Wrap-up	Major Rick Duran, Ret. Rick Wagner
1200	Lunch & Graduation Sam Seltzer's Restaurant 4744 Dale Mabry North	