Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 5 Agenda

Senator Loni Hancock, Chair
Senator Joel Anderson
Senator Jim Beall

Thursday, April 28, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 113

Consultant: Julie Salley-Gray

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PROPOSED FOR VOTE ONLY

4440 DEPARTMENT OF STATE HOSPITALS (DSH)

1. **DSH Hospital Injury and Illness Prevention Implementation.** The Governor's budget requests the authority to transition five existing two-year limited-term positions to permanent positions, which would require an on-going General Fund augmentation of $522,000. These positions would implement new Hospital Injury and Illness Prevention plans required under a settlement agreement with the Department of Industrial Relations. This request would allow for one analyst position at each of the five state hospitals.

2. **Patient Management Unit.** The Governor's budget proposes transitioning 10 limited-term positions into permanent positions for the on-going operation of the patient management unit (PMU), which provides centralized management of patient admissions and reporting on patient population trends. The transition would require on-going funding of $1.1 million General Fund.

3. **Third-Party Patient Cost Recovery System.** The Governor's budget proposes transitioning 15 limited-term positions to permanent full-time positions to continue improvements to the patient cost recovery system. This transition would cost $3.2 million General Fund ($2.8 million on-going and $400,000 one-time) and is estimated to save the General Fund over $5 million per year in state hospital costs.

ITEMS TO BE HEARD

0530 HEALTH AND HUMAN SERVICES AGENCY (HHSA)

Issue 1: Office of Law Enforcement Support Update

Over the last several years, the Legislature and the Administration have engaged in a discussion regarding the need for independent oversight of the state hospitals and developmental centers. The discussion included a wide range of options, including expanding the jurisdiction of the Office of the Inspector General (OIG) to oversee the facilities and establishing an office at the HHSA to provide oversight. The Legislature initially expressed concerns with HHSA's ability to provide independent oversight of departments that report directly to the agency. In response, HHSA enlisted the assistance of the OIG and the California Highway Patrol to develop a robust Office of Law Enforcement Support (OLES) that will be responsible for both providing oversight of the law enforcement and employee conduct at both departments, and will also establish uniform training for the law enforcement employees in the state hospitals and developmental centers and establish uniform policies and procedures regarding such things as the use of force and the appropriate procedures for processing and investigating allegations and complaints of mistreatment.

In early March 2015, HHSA provided a report to the Legislature, as required in a 2014 budget trailer bill, on the creation of the OLES. The report entitled, *Office of Law Enforcement Support Plan to Improve Law Enforcement in California's State Hospitals and Developmental Centers*, was required to contain specific and detailed recommendations on improving law enforcement functions in a meaningful and sustainable way that assures safety and accountability in the state hospitals and developmental center systems. The report contains a review and evaluation of best practices and strategies, including on independent oversight, for effectively and sustainably addressing the employee discipline process, criminal and major incident investigations, and the use of force within state hospitals, psychiatric programs and developmental centers.

The proposed creation of the OLES in last year's budget came about in response to underperformance by the Office of Protective Services (OPS) within each developmental center and state hospital. CHHS conducted an in-depth analysis of OPS operations within DSH which revealed the following critical deficiencies:

- Inability to recruit, hire, and retain qualified personnel
- Inconsistent and outdated policies and procedures
- Inadequate supervision and management oversight
- Inconsistent and inadequate training
- Inconsistent and deficient disciplinary processes
- Lack of independent oversight, review, and analysis of investigations
- Inadequate headquarters-level infrastructure
- Lack of experienced law enforcement oversight

The report states that inefficiencies in hiring practices and pay disparity led to fewer and less qualified employees, which resulted in more than 270,000 hours of overtime, at a cost of $10.1 million in 2013.

The report also included the following recommendations for next steps:

1. Establish a Professional Standards Section's Special Investigations Unit to monitor critical incidents, such as those involving sexual assault or other major assaults, and assist with complex investigations involving employee misconduct at state hospitals and developmental centers.

2. Establish a Professional Standards Section's Investigations Analysis Unit to provide quality control and analyses of administrative cases.

3. Hire vertical advocates who will ensure that investigations into allegations of employee misconduct are conducted with the thoroughness required for prosecution.

4. Conduct independent, comprehensive staffing studies of law enforcement duties and needs at the state hospitals and developmental centers.

As a result of the ultimate agreement between the Administration and the Legislature on the appropriate way to provide oversight of the state hospitals and developmental centers and to avoid potential bias if the individuals tasked with creating the policies and procedures are also investigating allegations of misconduct, OLES has been organized into the following units:

1. **Intake Analysis Unit**: This unit is comprised of staff who receive and review information pertaining to incidents occurring in DDS, DSH or in a psychiatric center located within a California Department of Corrections and Rehabilitation institution in order to determine whether OLES monitoring or investigation is appropriate under established procedures. The OLES Chief makes the final determination whether to monitor or investigate the incident during the daily Intake meeting.

2. **Investigations Unit**: Investigates any incident at a DDS or DSH facility that involves DDS or DSH law enforcement personnel and meets the statutory or alleges serious misconduct by law enforcement personnel or that the Chief of the OLES, the Secretary of the HHSA, or the Undersecretary of the HHSA directs the OLES to investigate.

3. **Investigation Monitoring/Oversight Unit:** Performs contemporaneous oversight of investigations and the employee disciplinary process, both serious criminal and administrative allegations against non-peace officer staff, investigated by the DSH involving an incident that meets the criteria of WIC §4023, and investigations conducted by the DDS involving an incident that meets the criteria of WIC §4427.5. The unit evaluates each investigation and the disciplinary process and completes a summary of its findings to be provided to the Semi-Annual Report Assessment Unit.

4. **Semi-Annual Report Assessment Unit**: Monitors and evaluates the departments' law enforcement implementation of policy and procedures, training, hiring, staff development, and accountability. This unit shall report these assessments as part of the semi-annual report along with making recommendations of best law enforcement practices to the departments.

In addition, similar to the OIG's semi-annual reports on the California Department of Corrections and Rehabilitation (CDCR), OLES is required to report semi-annually to the Legislature beginning October 1, 2016, on the following:

- The number, type, and disposition of complaints made against employees.
- A synopsis of each investigation reviewed by the Office of Law Enforcement Support.
- An assessment of the quality of each investigation.
- The report of any settlement and whether the Office of Law Enforcement Support concurred with the settlement.
- The extent to which any disciplinary action was modified after imposition.
- Timeliness of investigations and completion of investigation reports.
- The number of reports made to an individual's licensing board, in cases involving serious or criminal misconduct by the individual.
- The number of investigations referred for criminal prosecution and employee disciplinary action and the outcomes of those cases.
- The adequacy of the State Department of State Hospitals' and the Developmental Centers Division of the State Department of Developmental Services' systems for tracking patterns and monitoring investigation outcomes and employee compliance with training requirements.

Current Budget. Current funding for OLES is $2.7 million per year, which funds 21 permanent positions and six outside consultants from the Highway Patrol, CDCR and the OIG.

5225 CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION (CDCR) AND CALIFORNIA CORRECTIONAL HEALTHCARE SERVICES (CCHCS)
4440 DEPARTMENT OF STATE HOSPITALS (DSH)

Issue 1: *Coleman, et al, v Brown*

Background. Over the past few decades, state prisons have increasingly become mental health treatment facilities. Data suggests that the number of people with mental illness in prison has almost doubled in the last 15 years. Currently, 45 percent of inmates have been treated within the last year for a severe mental illness.

How Did Prisons Become Mental Health Service Providers? Prior to 1957, mental health services were delivered to some persons with serious mental illness by a state-operated and funded institutional system, which included state hospitals for persons with mental illness and two state hospitals serving persons with mental illness and/or a developmental disability.

In 1957, the California Legislature passed the Short-Doyle Act in response to the growing number of people with mental illness being confined in public hospitals, many of whom were institutionalized inappropriately or subject to abuse while residing in a state facility. The act, which provided state funds to local mental health service delivery programs, was developed to address concerns that some individuals with mental illness were better served by local, outpatient services rather than 24-hour hospital care. Lawmakers believed that local programs would allow people with mental illnesses to remain in their communities, maintain family ties, and enjoy greater autonomy. When first enacted, the Short-Doyle Act provided state funding for 50 percent of the cost to establish and develop locally administered-and controlled community mental health programs.

In 1968, the Legislature passed the Lanterman-Petris-Short Act (LPS), which further reduced the population of state mental health hospitals by requiring a judicial hearing prior to any involuntary hospitalization. The LPS also initiated increased financial incentives for local communities to provide of mental health services. As a result of this long-term transfer of state operation and oversight to a decentralized, community-based mental health care delivery model, the state mental health hospital population declined from 36,319 in 1956 to 8,198 in 1971. Three public mental hospitals closed during this time period. The Legislature intended for savings from these closures to be distributed to community programs. However, in 1972 and 1973 then-Governor Ronald Reagan vetoed the transfer of these funds. [1]

Throughout the 1970s and 1980s counties contended that the state was not providing adequate funds for community mental health programs. In addition, several counties were receiving less funds on a population basis than other counties. This disparity was addressed, with varying levels of success, in both the 1970s and the 1980s with the allocation of "equity funds" to certain counties. Realignment of mental health programs, enacted in 1991, has made new revenues available to local governments for mental health programs but, according to local mental health administrators, funding continued to lag behind demand.[2]

[1]Historical background from The Stanford Law School Three Strikes Project, "When Did Prisons Become Acceptable Mental Healthcare Facilities?"

[2] Legislative Analyst's Office "Major Milestones: 43 Years of Care and Treatment of the Mentally Ill", March 2, 2000.

In the past decade, California has made a significant investment in community mental health treatment funding. In November 2004, California voters approved Proposition 63, also known as the Mental Health Services Act. Proposition 63 provides state funding for certain new or expanded mental health programs through a personal income tax surcharge of one percent on the portion of a taxpayer's taxable income in excess of $1 million. Revenues generated by the surcharge are dedicated to the support of specified mental health programs and, with some exceptions, are not appropriated by the Legislature through the annual budget act. Full-year annual Proposition 63 revenues to date have ranged from about $900 million to $1.5 billion, and could vary significantly in the future. Between 2004-05 and 2013-14, the fund has collected over $11 billion for local mental health services.[3]

Proposition 63 funding is generally provided for five major purposes: (1) expanding community services, (2) providing workforce education and training, (3) building capital facilities and addressing technological needs, (4) expanding prevention and early intervention programs, and (5) establishing innovative programs.

In 2013, the federal Patient Protection and Affordable Care Act (ACA) (health care reform) significantly increased access to private and public health care coverage, including mental health services. Included in this healthcare expansion was the expansion of Medi-Cal coverage to adults with incomes up to 138 percent of the federal poverty level (FPL). Generally, these are childless adults who are nonelderly and nondisabled. Under the ACA, the federal government will pay for 100 percent of the costs for this population for the first three years (2014-2016), with funding gradually decreasing to 90 percent in 2020. Allowing single, childless adults to receive Medi-Cal should significantly increase access to mental health services for those adults who would otherwise only have access through public county services or the criminal justice system.

The Legislature also passed the Investment in Mental Health Wellness Act (SB 82 (Senate Budget and Fiscal Review Committee), Chapter 34, Statutes of 2013). The bill authorized the California Health Facilities Financing Authority (CHFFA) to administer a competitive selection process for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources. The budget provided $142 million General Fund for these grants. In addition, the bill implemented a process by which the Mental Health Services Oversight and Accountability Commission (MHSOAC) allocates funding for triage personnel to assist individuals in gaining access to needed services, including medical, mental health, substance use disorder assistance and other community services. The 2013-14 budget provided $54 million ($32 million MHSA State Administrative Funds and $22 million federal funds) in on-going funding for this purpose.

Currently, due to the expansion of Medi-Cal eligibility, the state has greatly increased its efforts to assure that anyone leaving prison or county jail is enrolled in Medi-Cal and has access to necessary health care services, including mental health treatment.

Ralph Coleman, et al. v. Edmund G. Brown Jr, et al. Primarily because the prison system was severely overcrowded and the provision of mental health treatment was significantly lacking for inmates in need, a class action suit was filed in the United States District Court in 1991 arguing that

[3] Mental Health Service Act (MHSA) – Revenue Summary, January 2015

prisoners with mental illness were subjected to cruel and unusual punishment, a violation of the inmates eighth amendment protections.

In order to find in favor of the plaintiffs, the court needed to determine that the violations were both objective and subjective in nature. In order to meet the objective standard, the court must find that the deprivations were sufficiently serious to constitute the unnecessary and wanton infliction of pain. For the subjective standard, the courts must find that the treatment constituted deliberate indifference, was wanton and showed a pattern of being malicious and sadistic.

In 1995, following a 39-day trial, District Court Judge Lawrence Karlton found that current treatment for mentally ill inmates violated those inmates' eighth amendment protections against cruel and unusual punishment. Judge Karlton found "overwhelming evidence of the systematic failure to deliver necessary care to mentally ill inmates" who, among other illnesses, "suffer from severe hallucinations, [and] decompensate into catatonic states." Although a special master was appointed by the court to oversee implementation of a remedial plan, the situation continued to deteriorate, according to periodic reports from the special master.[4] Twenty-five years after the federal suit was filed, the state remains under the control of the federal court in *Coleman v. Brown* and is under regular review and oversight by the special master.

In the original ruling, the court identified six areas in which CDCR needed to make improvements: mental health screening, treatment programs, staffing, accurate and complete records, medication distribution and suicide prevention. In subsequent rulings, the courts expanded the areas of concern to include use of force and segregation policies. In addition, the courts also required that condemned inmates in San Quentin State Prison have access to inpatient, acute-care treatment.

On the following page is a detailed timeline of the major events related to *Coleman v. Brown* over the last 25 years.

[4] Stanford Law School Three Strikes Project, "When Did Prisons Become Acceptable Mental Healthcare Facilities?"

Major Milestones in the *Coleman v. Brown* case

Year	Event
1991	The Coleman class-action lawsuit was filed in U.S. District Court, Eastern District, alleging that mental health care in state prisons violated the Eighth Amendment's ban of cruel and unusual punishment.
1995	The Coleman court found that the State was deliberately indifferent to the mental health needs of inmates in violation of the Eighth Amendment. A special master was appointed.
1997	The Coleman court approved a plan to address the inadequacies in mental health care.
2006	Plaintiffs in the Plata and Coleman cases requested the convening of a Three-Judge Panel to review whether overcrowding was the primary cause of the failure to provide adequate medical and mental health care.
2008	The Three-Judge Panel trial took place.
2010	The Three-Judge Panel ordered the State to reduce its adult institution population to 137.5 percent of design capacity within two years and according to a schedule of four benchmarks at six-month intervals. The State appealed to the U.S. Supreme Court.
2011	In April, Public Safety Realignment (AB 109 (Committee on Budget) Chapter 15, Statutes of 2011), designed to bring about a significant reduction in the prison population, was enacted. It eventually reduced the adult institution population by 25,000.
2011	In May, the U.S. Supreme Court affirmed the Three-Judge Panel's order.
2013	In January, Governor Brown filed a motion to terminate the Coleman lawsuit and to end the requirement to reduce the prison population to 137.5 percent of design capacity. The Coleman court denied this motion.
2013	In May, the plaintiffs filed a motion in court alleging the unconstitutional use of force and an inadequate discipline process against the Coleman class members.
2013	In July, the court ordered the special master to monitor the psychiatric programs run by the Department of State Hospitals, particularly in regards to the adequacy of staffing and the use of handcuffs at all times for patients who are out of their cells.
2013	In December, the court ordered the state to develop a long-term solution for providing inpatient care for condemned inmates currently housed on California's death row.
2014	In April, the Coleman court ruled that California's use of force and segregation of mentally ill inmates violated the inmate's 8th amendment rights.
2014	In May, the Special Master released his report on the adequacy of inpatient mental health care, including the psychiatric programs run by DSH. The special master also filed an assessment of the San Quentin plan to provide inpatient care for condemned inmates and the court provided additional reporting orders.
2014	In August, the court issued further orders regarding segregation and use of force.
2015	In January, the Governor's budget proposal included a request related to complying with the 2014 court orders. In addition, the Special Master released his report on suicide prevention practices.

Source: Events through April 2013 are from CDCR's May 2013 "Timeline in the Plata (medical care), Coleman (mental health care) and Three-Judge Panel (prison crowding) cases"

State Prison Population. CDCR is responsible for the incarceration of the most serious and violent adult felons, including the provision of training, education, and health care services. As of April 20, 2016, CDCR housed about 116,903 adult inmates in the state's 34 prisons and 43 fire camps. Almost 113,000 of those inmates are in state prisons, which results in those institutions currently being at 134.5 percent of their design capacity. Approximately 4,942 inmates are housed in out-of-state contracted prisons, 5,645 are housed in in-state contracted facilities, and 3,536 are housed in fire camps. CDCR also supervises and treats about 44,000 adult parolees. Approximately 45 percent of inmates have been treated for severe mental illnesses within the last year.

The Coleman Class. As of April 18, 2016, there are currently 37,431 inmates in the Coleman class (35,335 men and 2,096 women). According to a December 24, 1998, court ruling on the definition of the class, the plaintiffs' class consists of all inmates with serious mental disorders who are now, or who will in the future be, confined within CDCR. A "serious mental disorder" is defined as anyone who is receiving care through CDCR's Mental Health Services Delivery System (MHSDS).

MHSDS provides four levels of care, based on the severity of the mental illness. The first level, the Correctional Clinical Case Management System (CCCMS), provides mental health services to inmates with serious mental illness with "stable functioning in the general population, an administrative segregation unit (ASU) or a security housing unit (SHU)" whose mental health symptoms are under control or in "partial remission as a result of treatment." As of April 18, 2016, 28,773 mentally ill inmates were at the CCCMS level-of-care.

The remaining three levels of mental health care are for inmates who are seriously mentally ill and who, due to their mental illness, are unable to function in the general prison population. The Enhanced Outpatient Program (EOP) is for inmates with "acute onset or significant decompensation of a serious mental disorder." EOP programs are located in designated living units at "hub institution[s]." As of April 18, 2016, 6,940 inmates with mental illness were receiving EOP services and treatment.

Mental health crisis beds (MHCBs) are for inmates with mental illness in psychiatric crisis or in need of stabilization pending transfer either to an inpatient hospital setting or a lower level-of-care. MHCBs are generally licensed inpatient units in correctional treatment centers or other licensed facilities. Stays in MHCBs are limited to not more than ten days. Currently, there are 414 inmates receiving this level-of-care.

Finally, several inpatient hospital programs are available for class members who require longer-term, acute care. These programs are primarily operated by the Department of State Hospitals (DSH), with the exceptions of in-patient care provided to condemned inmates and to female inmates. There are three inpatient psychiatric programs for male inmates run by DSH that are on the grounds of state prisons. Those programs are DSH-Stockton, on the grounds of the Correctional Healthcare Facility; DSH-Vacaville, on the grounds of Vacaville State Prison; and DSH-Salinas Valley, on the grounds of Salinas Valley State Prison. There are currently approximately 1,100 patients in those facilities and the DSH budget for those inmates is approximately $245 million General Fund per year. As of April 18, 2016, 1,304 inmates were receiving inpatient care, 45 of those patients were women and 36 were condemned inmates housed at San Quentin State Prison. The remaining 1,223 are receiving care in a DSH facility.

In addition to the patients in the prison-based psychiatric programs, approximately 250 Coleman class inmates are receiving care at Atascadero State Hospital and Coalinga State Hospital. The DSH budget for those patients is $52 million General Fund per year.

May 2014 Special Master Report Highlights Regarding Both CDCR and DSH Inpatient Mental Health Care. As part of the ongoing court oversight, the special master issued a key report in 2014 on the adequacy of mental health care for CDCR inmates housed in inpatient, long-term, acute care beds. The investigation found significant lapses in the treatment being provided to inmate-patients.

The special master noted that individual therapy was rarely offered, even to those patients who were not ready for group therapy or for who group therapy was contraindicated. At Coalinga State Hospital (one of the two state hospitals that houses CDCR inmate-patients), patients reported that their only individual contact with clinicians occurred on the hallways of the unit. Further, even when individual clinical interventions were indicated for a patient in a treatment team meeting, they were not included in the patient's treatment plan.

The report also noted that at Salinas Valley Psychiatric Program (SVPP), it was the default practice to have two medical technical assistants (MTA) in the treatment room based on institutional cultural perceptions of patient dangerousness rather than on an individualized assessment of the actual potential danger to clinicians and the need to have MTAs present. Similarly, Vacaville Psychiatric Program (VPP) required two escorts for any patient movement, regardless of the patients' custody status, classification, or behavior. In some instances, activities were cancelled due to the unavailability of MTAs to escort the patients. According to both clinical and administrative staff, this was the primary reason for limiting out-of-cell activities.

Condemned patients who require an acute level of treatment are currently treated at VPP. According to the investigation, these patients received far less treatment than other acute level patients and no access to group activities or an outdoor yard. In addition, they were only allowed one hour in the day room per week. Reportedly, these patients had weekly contact with a psychiatrist or psychologist. But that contact either happened through the doors of their cells or in a non-confidential setting.

Finally, patients at the Stockton State Hospital (on the grounds of the Correctional Health Care Facility) reported that it was considerable more restrictive than the prisons from which they were referred, stating that it was like being in a maximum security environment, spending 21 to 22 hours per day in their rooms.

Another prevalent theme throughout the report was the lack of uniform policies and procedures throughout all aspects of the program. The report notes that all six of the inpatient programs used their own distinct systems of orientation, cuffing, and restrictions for newly admitted patients, steps/stages through which patients had to progress in order to fully access treatment, and the imposition of restrictions on patients following behavioral problems or disciplinary infractions. In addition, the six program varied widely in terms of the amount and severity of restrictions on patients' movements, contact with others, and eligibility to receive treatment.

The special master also found that placement of new patients in extremely restrictive conditions was often based on the individual program's established procedures rather than on the severity of the

individual patients' mental illness, their propensity for aggressive or self-harming behavior, or their readiness for treatment.

The report found that there was a need for the development of a consistent, more therapeutically-oriented and less punitively-oriented system that could be applied across all six of the programs. More importantly, the report notes, the emphasis throughout needs to be redirected toward greater individualization of any necessary restrictions and staging of patients based on their unique needs and away from an automatic presumption of violent behavior, anti-therapeutic withholding of interaction with others, and deferral of much needed treatment.

According to the Administration, the special master has completed his most recent round of reviews and an updated report on the care being provided to inmates under both DSH and CDCR's care is expected in the coming months.

Recent Coleman Court Orders. On April 14, 2014, Judge Karlton ruled that California continued to violate the constitutional safeguards against cruel and unusual punishment by subjecting inmates with mental illness to excessive use of pepper spray and isolation. He gave the state 60 days to work with the special master to revise their excessive force policies and segregation policies, and to stop the practice of holding inmates with mental illness in the segregation units simply because there is no room for them in more appropriate housing. He also ordered the state to revise its policy for strip-searching inmates with mental illness as they enter and leave housing units. The 60-day deadline for some of the requirements was subsequently extended until August 29, 2014.

The department submitted a revised use of force policy to the courts that limits the use of pepper spray on inmate-patients and revises their cell management strategy. On August 11, 2014, the court accepted the new policies. Among other changes to the policy, correction staff is required to consider an inmate's mental health prior to using any controlled use of force. That consideration must include the inmate's demeanor, bizarre behavior status, mental health status, medical concerns and their ability to comply with orders. In addition, a mental health clinician must evaluate an inmate's ability to understand the orders, whether they are a Coleman class inmate or not. They must also evaluate whether the use of force could lead to a decompensation of the person's mental health.

On August 29, 2014, the state submitted a plan to comply with the remainder of the April 14 court order and the court accepted the plan. Under this court order, CDCR is required to create specialty housing units for inmates with mental illness who are removed from the general population. These specialized units must include additional out-of-cell activities and increased treatment. Under this plan, male inmates in short-term restricted housing will receive 20 hours of out-of-cell time each week, which is twice the amount of time offered to CCCMS inmates in the existing segregation units. Female inmates in short-term housing, however, will only receive 15 hours of out-of-cell time each week, which is 50 percent more than the current ten hours. In the longer-term restricted housing, male and female inmates will be allowed 15 hours a week in out-of-cell time.

The plan also requires that CDCR conduct a case-by-case review of all Coleman class inmates with lengthy segregation terms, in an attempt to decrease the length of stay for inmates in segregated environments. Additionally, the plan establishes a case review for all inmates being released from DSH or CDCR psychiatric inpatient beds who are facing disciplinary terms in segregation to ensure that the inmate is returned to appropriate housing and not to segregation.

In several areas, the plan presented by CDCR extended beyond the court order and included additional training and collaboration between mental health staff and custody staff. The plan also requires custody staff to make security checks on all inmates in specialized restricted housing twice every hour and requires that licensed psychiatric technicians conduct daily rounds to check on every inmate's current mental health status. The increased checks are designed to reduce suicides and suicide attempts among this population, which have been an ongoing concern of the court. Finally, the plan increases the amount of property allowed for inmates in short-term restricted units. For example, inmates will now be allowed one electrical appliance if their cell allows for it. If it does not, they will be provided with a radio.

Last Year's Budget Action. In response to the critical report by the Coleman special master and the Administration's failure to make progress in determining whether or not CDCR should resume control of the acute inmate-patients, the Legislature required DSH to submit a report before January 10, 2016, detailing steps they have taken to provide Coleman patients with treatment consistent with constitutional mandates. In addition, the report required an update on the Administration's discussions regarding shifting responsibility for care and treatment from DSH back to CDCR.

In response to the requirement, DSH submitted their report on April 1, 2016. In the report they note that DSH has taken the following steps to ensure that appropriate care is being provided to Coleman inmate-patients in their care:

- The formation of a centralized Recruitment Unit focused on recruiting and retaining qualified clinical staff.
- The formation of a multidisciplinary committee to assess the laundry and supply process.
- The development of new policies concerning the use of mechanical restraints.
- The establishment of a pilot project at the Vacaville Psychiatric Program to allow patients to attend treatment groups and have access to the yard more quickly without the use of restraints.
- The development of a patient reservation and tracking system.
- An increase in the number of group treatment hours and improved tracking of patient treatment.

In terms of the required update on the potential transfer of responsibility for patients from DSH to CDCR, the report fails to provide the required update. Instead, the report states, "DSH and CDCR continue to evaluate the feasibility, possible timing, and potential outcomes of returning the responsibility for the *Coleman* patients inpatient psychiatric treatment to CDCR."

Memorandum of Understanding (MOU) Between DSH and CDCR. Despite the Administration's statement that they are continuing to evaluate the transition of Coleman inmate-patients receiving acute-level treatment, the two departments entered into an MOU agreement in November of 2015 regarding their individual obligations surrounding the treatment of intermediate and acute care Coleman inmate-patients who are being treated in DSH facilities. The report provided by DSH to the Legislature does not discuss the MOU.

Questions for the Administration. Members may want to consider asking the following:

1. Your caseload projections for the coming year show a growing number of inmates with mental illnesses. How do you prepare your custody staff to interact safely and effectively in individuals who are mentally ill?

2. Why was the update on the potential shift of care of Colman inmate-patients from DSH to CDCR not provided, as requested in supplemental reporting language?

3. In addition, why did the report fail to mention the existence of the memorandum of understanding, the existence of which suggests that the Administration has indeed determined that DSH should continue providing care to Coleman inmate-patients?

4. Please present the MOU and describe what problems you believe are resolved through it.

Issue 2: Healthcare for *Plata* Class Inmates Under the Care of State Hospitals

Background. The California Correctional Health Care Services (CCHCS) receivership was established as a result of a class action lawsuit (*Plata v. Brown*) brought against the State of California over the quality of medical care in the state's 34 adult prisons. In its ruling, the federal court found that the care was in violation of the Eighth Amendment of the U.S. Constitution which forbids cruel and unusual punishment. The state settled the lawsuit and entered into a stipulated settlement in 2002, agreeing to a range of remedies that would bring prison medical care in line with constitutional standards. The state failed to comply with the stipulated settlement and on February 14, 2006, the federal court appointed a receiver to manage medical care operations in the prison system. The current receiver was appointed in January of 2008. The receivership continues to be unprecedented in size and scope nationwide.

The receiver is tasked with the responsibility of bringing the level of medical care in California's prisons to a standard which no longer violates the U.S. Constitution. The receiver oversees over 11,000 prison health care employees, including doctors, nurses, pharmacists, psychiatric technicians and administrative staff. Over the last ten years, healthcare costs have risen significantly. The estimated per inmate health care cost for 2015-16 ($21,815) is almost three times the cost for 2005-06 ($7,668). The state spent $1.2 billion in 2005-06 to provide health care to 162,408 inmates. The state estimates that it will be spending approximately $2.8 billion in 2016-17 for 128,834 inmates. Of that amount, $1.9 billion is dedicated to prison medical care under the oversight of the receivership.

Until the last few years, the receivership has focused mainly on improving the quality of care within the state-run prisons. However, in response to concerns from the receiver, CDCR has put forward funding requests in the last two years to increase the medical care provided to inmates housed in the state's contracted facilities. For example, the 2015 budget act included $3.2 million General Fund beginning 2015-16 for 24-hour registered nurse coverage for inmates housed in the six modified community correctional facilities (MCCFs) and one female community re-entry facility. The 24-hour coverage was required by the health care receiver, in order to provide the same level of coverage to inmates in contract facilities as is currently provided to inmates in the state-run prisons. This expansion of the receivership appears to be an acknowledgement that the scope of the receiver's oversight extends beyond the walls of the state's 34 prisons to all of the facilities that house CDCR inmates.

Coleman Patients Receiving Acute Care Treatment. As discussed in the previous item, several inpatient hospital programs are available for Coleman class members who require longer-term, acute care. These programs are primarily operated by the Department of State Hospitals (DSH), with the exceptions of in-patient care provided to condemned inmates and to female inmates.

Items of concern. As discussed in the previous item, last year the Coleman special master found significant lapses in the mental health treatment being provided to inmate-patients.

More recently, a lawsuit has been filed by the family of a Coleman inmate-patient under the care of DSH and CDCR who allegedly died from inadequate nutrition. Regardless of the merits of that lawsuit, it raises the question of the role of the healthcare receiver in ensuring that all the *Plata* class inmates who are permanently or temporarily housed outside of the state's 34 prisons are receiving a constitutional level of care.

Scope of the Inspector General's Medical Inspection Teams. In March 2015, the Plata court issued an order outlining the process for transitioning responsibility for inmate medical care back to the state. Under the order, responsibility for each institution, as well as overall statewide management of inmate medical care, must be delegated back to the state. The court indicates that, once these separate delegations have occurred and CDCR has been able to maintain the quality of care for one year, the receivership would end.

The federal court order outlines a specific process for delegating care at each institution back to the state. Specifically, each institution must first be inspected by the Office of the Inspector General (OIG) to determine whether the institution is delivering an adequate level of care. The receiver then uses the results of the OIG inspection—regardless of whether the OIG declared the institution adequate or inadequate—along with other health care indicators, including those published on each institution's Health Care Services Dashboard, to determine whether the level of care is sufficient to be delegated back to CDCR.

What is unclear about the current transition process is whether or not the Inspector General's investigations should include the healthcare being provided to the inmate-patients being treated in DSH's psychiatric inpatient programs that are housed within the three state prisons. Under the state's current model, the healthcare provided to the inmates being treated in DSH-Stockton receive their medical care from the receiver's medical staff at CHCF. However, at the other two psychiatric inpatient programs, DSH staff provide medical care to the inmates they are treating. Therefore, when the OIG medical teams evaluate the level of care being provided to inmates at Salinas Valley and Vacaville prisons, it is unclear if those evaluations should include the care provided to all inmates in those prisons or only to those under CDCR's jurisdiction. If the courts determine that the quality of care of all of the inmates is of concern, the IG's oversight authority and access would need to be statutorily expanded to include these particular DSH facilities.

Questions for the Administration. Members may want to ask the following:

1. The Inspector General has been given a specific role in determining whether or not an institution is providing a constitutional level of healthcare. Currently, the OIG does not have access to or jurisdiction over the inmates being housed and treated in the DSH facilities located within the California Medical Facility in Solano or Salinas Valley State Prison. Does that present a problem in their ability to adequately assess the quality of healthcare being provided at those prisons?

2. Given the ambiguity of the status of the inmate-patients under the care of DSH, why didn't the recent MOU between CDCR and DSH require that the psychiatric inpatient programs, at a minimum, follow all of CDCR's policies and procedures related to the medical care of its inmates housed in the co-located prison? Alternatively, why didn't CDCR agree to provide medical care for the inmate patients at the Salinas Valley and Vacaville PIPs, similar to the arrangement currently in place in the Stockton facility?

5225 CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

Issue 1: Update on the Condemned Inmate Psychiatric Inpatient Program at San Quentin Prison

Previous Budget Action. The 2015 Budget Act included 99.8 positions and $11 million General Fund for both CDCR and California Correctional Health Care Services (CCHCS) to provide clinical support, custody staff, equipment and training to operate a 40-bed acute level-of-care psychiatric facility to provide treatment for condemned inmates with mental illnesses severe enough to require inpatient care. $4.3 million General Fund is for CDCR and $6.7 is for CCHCS. With that funding, CDCR was able to convert 17 existing mental health crisis beds and 23 medical beds to psychiatric inpatient beds.

Background. As discussed in detail in the next item, in 2014 the Coleman v. Brown special master released a report detailing the lack of adequate care being provided to Coleman inmate-patients requiring long-term, acute levels of care. In particular, the report noted a particular lack of treatment provided to condemned inmate-patients being treated by the Department of State Hospitals (DSH) in their Vacaville Psychiatric Program (VPP). As a result of the Coleman courts on-going findings in regard to the lack of treatment provided to condemned inmate-patients at VPP, the Coleman court required CDCR to establish the San Quentin Psychiatric Inpatient Program (PIP), run by CDCR medical and mental health staff.

The San Quentin PIP is a 40-bed, fully-licensed, Joint Commission-accredited program that provides long-term acute and intermediate levels of psychiatric inpatient care to male condemned patients. Its mission is to provide effective and evidence-based psychiatric treatment to relieve or ameliorate acute and refractory mental health disorders that disrupt the patients' expected level of functioning in the prison environment.

The PIP opened on October 1, 2014, in response to the evolving clinical needs of the condemned population and in compliance with federal court orders. The opening and ongoing success of the PIP is the result of collaborative efforts between San Quentin State Prison, CDCR headquarters, the federal health care receiver, plaintiffs' counsel, and the *Coleman v. Brown* special master team. The average daily census has been 37 patients, with a maximum census of 40.

The evidence-based treatment provided in the San Quentin PIP is individualized and patient-centered to meet the unique needs of each patient. The PIP offers incentive-based rewards for certain behavior consistent with positive reinforcement theory. Treatment is offered seven days a week from the early morning through the evening hours. In addition to providing individual psychotherapy and psychiatric medication treatment, the PIP employs an active group and activities program. For example, group therapy, educational groups, substance use groups, recreational yards, outdoor therapeutic yards, and dayroom activities are consistently offered in order to address the chronic mental illness symptoms that diminish functioning and quality of life. Given the large volume of offered services, patients are able to choose the activities they attend. This patient-centered choice facilitates a greater sense of satisfaction, autonomy, and ownership over one's treatment. As a result, treatment becomes more tailored and efficacious at addressing the individual needs of the patient.

Each treatment team consists of the patient, a psychiatrist, a psychologist, a social worker, a recreational therapist, nursing staff, and custody staff. Additional disciplines may be involved based on

individual circumstances (e.g., clergy, primary care). Custody treatment team members may consist of correctional counselors, unit officers, and custody supervisors. Continuous collaboration between health care and custody staff is an essential component of the PIP treatment milieu. Incarceration in general, and condemned row more specifically, involves a unique set of social and cultural stressors that may impact the well-being of PIP patients. Custody staff is able to appreciate and communicate these correctional stressors to other members of the treatment team so a more complete appreciation of the challenges faced by the patient is obtained.

In preparation for discharge, extensive collaboration between inpatient and outpatient San Quentin health care and custody staff occurs so that the transition back to the Enhanced Outpatient Program (EOP) or Correctional Clinical Case Management System (CCCMS) treatment setting is organized, thoughtful, and therapeutic.

Issue 2: California Men's Colony Mental Health Crisis Beds

Governor's Budget. The Governor's budget requests $9.2 million General Fund and 62.4 positions to activate 32 mental health crisis beds (MHCBs) at the California Men's Colony (CMC) in San Luis Obispo. The positions requested include five psychiatrists, six clinical psychologists, and approximately 19 correctional officers.

Background. The most recent projections from CDCR suggest a significant increase over the 2015 budget assumptions. In the Governor's current budget proposal, the Administration anticipates that the population of inmates requiring mental health treatment will be 35,743 in 2015-16 and 36,825 in 2016-17. This is an increase of 571 and 1,653, respectively, over the 2015 Budget Act projections. As of April 18, 2016, there were 414 inmates receiving a crisis level-of-care through CDCR's MHCBs.

Legislative Analyst's Office (LAO). The LAO did not raise any concerns regarding this request.

Questions for the Administration. Members may want to ask the following questions:

1. The Legislature has consistently heard over the years that it is difficult to find and retain psychiatric clinicians at the state hospital in Atascadero. Presumably, CDCR has run into the same problem at CMC. If this is the case, why do you think this is the appropriate institution for mental health crisis beds?

2. While increasing the number of crisis beds at CMC may reduce your waiting lists for those beds, how will you ensure that this increase will not result in psychiatrists currently employed at Atascadero State Hospital from leaving that facility to work for CDCR, where they will both be paid more and feel that they are working in a more secure setting?

3. If this proposal does result in fewer clinicians being available to work at Atascadero State Hospital, would that potentially increase your waiting list for Coleman patients in need of on-going acute care treatment because the Atascadero State Hospital will no longer have enough clinicians to provide treatment?

Issue 3: Spring Finance Letter – Mentally Disordered Offenders (MDO)

Spring Finance Request. The Administration is requesting a $2.2 million General Fund augmentation for 16 additional correctional counselor positions to coordinate the MDO certification process. Upon completing their sentence, a portion of inmates with severe mental disorders are declared a danger to others and are paroled to the Department of State Hospitals (DSH) as an MDO.

Background/Justification. MDO certifications are coordinated by correctional counselors. As recently as 2011-12, CDCR had MDO coordinator positions to specifically conduct these certifications. However, in 2012-13, these positions were incorporated into overall correctional counselor workload. As a result, the MDO certification workload is now spread amongst all CDCR correctional counselors. The department generally uses an inmate-to-correctional counselor ratio of 150:1 for these positions. Accordingly, as the overall prison population declined, the number of correctional counselors also declined. However, during this same period, the number of MDO certifications increased, likely because the population of mentally ill inmates increased despite a reduction in the total inmate population. According to the department, due to the combination of reductions in correctional counselor staffing and increases in the mentally ill population, it has not been able to complete the increasing MDO workload in a timely manner.

Legislative Analyst's Office (LAO). The LAO notes the following concerns:

> *While we acknowledge that MDO workload has increased, the administration's proposal to add 16 positions on an ongoing basis does not resolve the problem that MDO certification workload is tied to the mentally ill population, not the overall inmate population. A more reasonable approach would be to create a ratio to allocate MDO coordinator positions based on the mentally ill population. This additional ratio would ensure that the department has the appropriate number of MDO coordinators needed to complete MDO certifications on an ongoing basis. Accordingly, we recommend rejecting the current proposal and directing the department to develop a ratio to budget MDO coordinator positions based on the mentally ill inmate population and make a corresponding adjustment to the correctional counselor ratio to account for the reduced workload. Once the department has an opportunity to develop ratios that accurately reflect these changes in workload, the Legislature can review any corresponding budget changes at that time.*

Questions for the Administration. Members may want to ask the following questions:

1. Please explain the correctional counselors' role in determining whether or not an inmate receives a designation as a mentally disordered offender upon their release. In addition, what type of specialized training do these correctional counselors have to prepare them to serve as an MDO coordinator?

4440 DEPARTMENT OF STATE HOSPITALS (DSH)

The Department of State Hospitals (DSH) is the lead agency overseeing and managing the state's system of mental health hospitals. The DSH seeks to ensure the availability and accessibility of effective, efficient, and culturally-competent services. DSH activities and functions include advocacy, education, innovation, outreach, oversight, monitoring, quality improvement, and the provision of direct services.

The Governor's 2011 May Revision first proposed the elimination of the former Department of Mental Health (DMH), the creation of the new DSH, and the transfer of Medi-Cal mental health services and other community mental health programs to the Department of Health Care Services (DHCS). The 2011 budget act approved of just the transfer of Medi-Cal mental health programs from the DMH to the DHCS. In 2012, the Governor proposed, and the Legislature adopted, the full elimination of the DMH and the creation of the DSH. All of the community mental health programs remaining at the DMH were transferred to other state departments as part of the 2012 budget package. The budget package also created the new DSH which has the singular focus of providing improved oversight, safety, and accountability to the state's mental hospitals and psychiatric facilities.

California's State Hospital System

California has five state hospitals and three psychiatric programs located on the grounds of the prisons operated by the California Department of Corrections and Rehabilitation (CDCR). Approximately 92 percent of the state hospitals' population is considered "forensic," in that they have been committed to a hospital through the criminal justice system. The five state hospitals provide treatment to approximately 6,000 patients. The psychiatric facilities at state prisons currently treat approximately 1,000 inmates.

Atascadero State Hospital. This facility, located on the Central Coast, houses a largely forensic population, including a large number of incompetent to stand trial patients and mentally disordered offenders. As of December 2014, it housed more than 1,000 patients.

Coalinga State Hospital. This facility is located in the city of Coalinga and is California's newest state hospital. The hospital houses only forensic patients, most of whom are sexually violent predators. As of December 2014, it housed more than 1,100 patients.

Metropolitan State Hospital. Located in the city of Norwalk, this hospital's population is approximately 65 percent forensic. Metropolitan State Hospital does not accept individuals who have a history of escape from a detention center, a charge or conviction of a sex crime, or a conviction of murder. As of December 2014, it housed about 700 patients.

Napa State Hospital. This facility is located in the city of Napa and has a mix of civil and forensic commitments. Napa State Hospital limits the number of forensic patients to 80 percent of the patient population. As of December 2014, it housed nearly 1,200 patients.

Patton State Hospital. This facility is located in San Bernardino County and primarily treats forensic patients. As of December 2014, it housed 1,500 patients.

Salinas Valley Psychiatric Program. This program is located on the grounds of Salinas Valley State Prison in Soledad and provides treatment to state prison inmates. As of December 2014, it had a population of more than 200 patients.

Stockton Psychiatric Program. This program is located on the grounds of the California Health Care Facility in Stockton and is the state's newest psychiatric program. The program provides treatment to state prison inmates. As of December 2014, it had a population of about 400 patients.

Vacaville Psychiatric Program. This program is located on the grounds of the California Medical Facility in Vacaville and provides treatment to state prison inmates. As of December 2014, it had a population of about 350 patients.

The following are the primary Penal Code categories of patients who are either committed or referred to DSH for care and treatment:

Committed Directly From Superior Courts:

- *Not Guilty by Reason of Insanity* – Determination by court that the defendant committed a crime and was insane at the time the crime was committed.

- *Incompetent to Stand Trial (IST*) – Determination by court that the defendant cannot participate in trial because the defendant is not able to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. This includes individuals whose incompetence is due to a developmental disability.

Referred From The California Department of Corrections and Rehabilitation (CDCR):

- *Sexually Violent Predators (SVP)* – Hold established on inmate by court when it is believed probable cause exists that the inmate may be a SVP. Includes 45-day hold on inmates by the Board of Prison Terms.

- *Mentally Disordered Offenders (MDO)* – Certain CDCR inmates for required treatment as a condition of parole, and beyond parole under specified circumstances.

- *Prisoner Regular/Urgent Inmate-Patients (Coleman Referrals)* – Inmates who are found to be mentally ill while in prison, including some in need of urgent treatment.

State Hospitals & Psychiatric Programs
Caseload Projections*

	2015-16	2016-17
Population by Hospital		
Atascadero	1,252	1,252
Coalinga	1,293	1,293
Metropolitan	803	803
Napa	1,177	1,177
Patton	1,533	1,533
Subtotal	**6,058**	**6,058**
Population by Psych Program		
Vacaville	392	392
Salinas	235	235
Stockton	480	480
Subtotal	**1,107**	**1,107**
Population Total	**7,165**	**7,165**
Population by Commitment Type		
Incompetent to Stand Trial (IST)	1,477	1,477
Not Guilty By Reason of Insanity (NGI)	1,411	1,411
Mentally Disordered Offender (MDO)	1,385	1,385
Sexually Violent Predator (SVP)	907	907
Lanterman-Petris-Short Act – Civil Commitments	614	614
Coleman Referral – Hospitals	256	256
Coleman Referral – Psych Programs	1,107	1,107
Department of Juvenile Justice	8	8

*The caseloads in this table are from the DSH 2016-17 January budget binder and reflect the estimated number of cases on the last Wednesday of the fiscal year. On average, the Governor's budget documents show an average daily caseload of 6,982 in 2015-16, growing to 7,165 in 2016-17.

State Hospitals Budget

The Governor's proposed budget includes $1.8 billion for DSH in 2016-17 ($1.7 billion General Fund). This represents a $6.5 million decrease over 2015-16 funding. The proposed budget year position authority for DSH is 10,301 positions, a decrease of five positions from the current year.

(dollars in thousands)

Funding	2014-15 Actual	2014-15 Projected	2015-16 Proposed
General Fund (GF)	$1,525,443	$1,620,485	$1,631,202
Reimbursements	124,237	155,265	138,022
CA Lottery Education Fund	141	24	24
Total	$1,649,821	$1,775,774	$1,769,248
Positions	10,844	10,306	10,301

Issue 1: Bureau of State Audits *Improper Activities* Audit

Background. The California State Auditor puts out regular reports on their investigations of whistleblower complaints. In February of 2016, the State Auditor released a report on their most recent investigations of improper activities by state agencies and employees. The report contained two findings related to the Department of State Hospitals (DSH).

- ***Patton State Hospital.*** The auditor found that four psychiatrists at Patton State Hospital regularly worked an average of 22 to 29 hours per week during the 2014-15 fiscal year, rather than the required 40 hours per week. In total, the report notes, the psychiatrists worked 2,254 hours less than required. In addition, two of the four psychiatrists engaged in other employment during their regularly scheduled state work hours and were dishonest regarding their attendance and outside employment. According to the audit findings, both supervisors and the executive management were aware of the psychiatrists' failure to work 40 hours per week and did not attempt to resolve the situation.

  Beyond the specific finding, the audit report notes that this problem is likely not limited to these four psychiatrists or to Patton State Hospital. The report includes the following concerns:

  > *During our investigation we learned that the practice of failing to work an average of 40 hours per week and misusing state resources may not be isolated to the four psychiatrists we investigated. The staff we interviewed, including supervisors, managers, and officials, informed us that the majority of psychiatrists, as well as some psychologists and social workers, average less than 40‑hour workweeks. They based their comments on their own observations and on information provided to them by other employees. Managers were able to list nearly 35 employees whom they believe regularly arrived late, left early, or worked fewer than 40 hours per week.*
  >
  > *A senior executive at Patton informed us that his observations suggest that none of the psychiatrists at Patton work the 10‑hour days for which they are scheduled and that the average is probably closer to 6 hours per day. He also told us that officials at the other state hospitals have shared with him that the attendance patterns of their psychiatrists and other doctors is similar to, or even worse than, those at Patton. . . .*
  >
  > *Managers also told us that the problem of psychiatrists failing to work their required hours has existed since the 1990s and that over the years it has become part of the culture at Patton that psychiatrists can come and go as they please without accountability. They stated that the psychiatrists have a sense of entitlement and do not believe that the 40‑hour workweek applies to them.*
  >
  > *Perhaps the most disconcerting aspect of the psychiatrists' attendance behavior is the negative impact it could have on patient care and staff safety. Supervisors, managers, and hospital officials pointed out that when psychiatrists work fewer hours, it limits patient care. Although we found no specific examples of patient neglect, the hospital could provide more robust care to its patients if the psychiatrists worked the hours in their regularly scheduled shifts. An official in charge of medical services explained that when psychiatrists work fewer hours, they have limited interactions with their patients. Conversely, if they were to work their required*

number of hours, they could see more patients, interact with them longer, and provide more therapeutic treatment. The official also noted that the risk to staff and patients increases when the most highly trained and skilled clinicians are not present.

- ***Medical Director Conflict of Interest.*** A medical director at one of the state hospitals violated financial disclosure laws when he failed to report his financial interest in a pharmaceutical company. Specifically, the psychiatrist received almost $30,000 in income from the company while he was acting as the medical director. In addition, the audit found that DSH failed to provide adequate oversight to ensure that designated employees file their financial disclosure forms.

Questions for the State Auditor. Members may want to ask the following:

1. During the course of your investigation, were you able to determine how long the executive management team had known about the clinicians working reduced hours?

2. Your report indicates that the problem regarding DSH staff working reduced hours may be systemic. What recommendations do you have regarding system-wide changes for DSH?

Questions for the Administration. Members may want to ask the following:

1. What steps have you taken throughout the state hospital system, including psychiatric programs, to determine the extent of the problem and to ensure that the state is not paying clinicians, or other staff, for full-time work when they are not, in fact, working 40 hours per week?

2. As previously discussed, the last special master report on the treatment of Coleman patients under the care of the state hospitals found that very little treatment was being provided to the inmate-patients in your care. When this issue was discussed last year, you attributed a significant amount of the problem to your failure to keep adequate records detailing how much treatment individuals were receiving. In addition, you noted a high vacancy rate among your clinicians as contributing to the problem.

   Given the findings of the State Auditor, would it be fair to assume that this culture of not requiring your mental health professionals to work the required number of hours may be a large contributor to the problem? Have the findings in this report been discussed with the special master?

Issue 2: Proposition 47 Savings

Background. As discussed in detail during this subcommittee's April 7, 2016, hearing, in November 2014, the voters approved Proposition 47, which requires misdemeanor rather than felony sentencing for certain property and drug crimes and permits inmates previously sentenced for these reclassified crimes to petition for resentencing. The proposition requires that state savings resulting from the proposition be transferred into a new fund, the Safe Neighborhoods and Schools Fund (SNSF). The new fund will be used to reduce truancy and support drop-out prevention programs in K-12 schools (25 percent of fund revenue), increase funding for trauma recovery centers (10 percent of fund revenue), and support mental health and substance use disorder treatment services and diversion programs for people in the criminal justice system (65 percent of fund revenue). The expected state savings will come from a reduced number of individuals in both state prison and state hospitals and reduced costs to the trial courts.

Governor's Budget. The proposed budget assumes an initial Proposition 47 savings in 2016-17 of $29.3 million, growing to an annual on-going savings of $57 million per year. Of the 2016-17 amount, the Department of Finance assumed that $8.7 million would come from a savings to the DSH as a result of fewer individuals accused of felonies being committed to state hospitals as a result of being deemed incompetent to stand trial (IST).

Rather than reflect that savings in the DSH budget, the Administration chose to reinvest the funding in the DSH budget to fund IST placements in order to further reduce the IST waiting list.

Legislative Analyst's Office (LAO). The LAO recommends that the Legislature reduce the program budgets of DSH by $8.7 million General Fund to account for savings associated with the reduced workload. The LAO notes that the Administration's proposal for DSH to keep savings they are estimated to realize as a result of Proposition 47 reduces legislative oversight by allowing DSH to redirect their savings to other programs and services without legislative review or approval. Essentially, instead of simply redirecting the Proposition 47 savings, the Administration should have put forward proposals to both reduce the DSH budget by $8.7 million GF and a separate proposal to increase funding for the IST population due to an estimated increase in workload.

Issue 3: Conditional Release Program

Governor's Budget. The proposed budget includes an additional $3.8 million General Fund in 2016-17 for increased costs related to DSH" Conditional Release Program (CONREP). The increased costs are primarily related to an expected increase in the CONREP-sexually violent predator (SVP) caseload ($3 million General Fund). The remaining amount ($800,000 General Fund) is due to a change in the contracting, away from an allocation-based methodology to a service-based methodology.

Background. CONREP provides community treatment and supervision for individuals who have been found to be not guilty by reason of insanity (NGI), incompetent to stand trial (IST), or have been designated as mentally disordered offenders (MDO) or sexually violent predators (SVP).

CONREP offers individuals direct access to mental health services during their period of outpatient treatment. These services are provided by specialized forensic mental health clinicians and include individual and group therapies, home visits, substance use disorder screening and psychological assessments. Currently, DSH contracts with 11 providers for these services. DSH estimates that the non-SVP CONREP caseload will be 654 individuals in both 2015-16 and 2016-17.

CONREP for Sexually Violent Predators. SVP patients in the state hospital system are individuals who are convicted of a sex offense and also found to have a mental disorder that makes him a danger to others and likely to engage in sexually violent behavior in the future. After the completion of the prison term of a person convicted of committing a sexually violent crime, both DSH and the CDCR evaluate the individual to determine whether or not he meets the criteria to be designated as an SVP. If a person is designated as an SVP and the courts agree with the designation, that individual is then committed to DSH upon completion of their prison term. Every year, DSH will evaluate their SVP patients to determine whether or not they meet the criteria to be released to CONREP or conditionally discharged. That consideration includes whether the release is in the best interest of the individual and whether or not conditions can be imposed upon the release that would adequately protect the community.

For SVPs, state law requires that all SVPs who are conditionally released into their original communities must be provided with both treatment and supervision. Currently, DSH contracts with one provider who provides both the required specialized treatment and supervision for these individuals. DSH estimates that there will be 14 SVP-designated individuals in CONREP in 2015-16. However, there are currently 12 additional SVP-designated individuals who have court petitions for release into CONREP. If the court approves all of the petitions, DSH assumes the CONREP-SVP caseload will grow to 26 individuals in 2016-17.

The cost for the CONREP-SVP cases is significantly higher than regular CONREP cases, primarily due to the security requirement. Courts may order 24 hour-a-day, seven day a week security of people in the CONREP-SVP for time-limited period during transition from state hospital to community setting (several weeks to several months, depending on circumstances). Currently, one individual has been has been receiving 24 hour-a-day security for over a year due to safety concerns. DSH does not know when security for this individual can be suspended. The 2014-15 average cost-per-case, excluding security, is approximately $258,000 for CONREP-SVP services and treatment. The cost rose to an

average of $310,000 per year when security was included. In contrast, the annual cost-per-case for the regular CONREP cases during 2014-15 was $34,000 per year.

New Contracting Methodology. Historically, DSH has entered into annual contracts with providers that required the payment of a fixed monthly rate, regardless of the services provided to individuals in CONREP. However, a recent audit by the Department of Finance's Office of State Audits and Evaluations found that this contracting process for CONREP had inadequate internal controls in place and lacked fiscal accountability and transparency. In response, DSH has developed a new funding methodology that relies, in part, on the services provided to people in CONREP. Specifically, according to DSH, the department will work with their contractors to establish a rate based both on the anticipated caseload and the services the contractors are expected to provide.

Legislative Analyst's Office (LAO). The LAO did not raise any concerns with this proposal.

Questions for the Administration. Members may want to consider asking the following:

1. Your proposal assumes that all 12 individuals with petitions before the court will be released to the CONREP program by July 1, 2016. Why do you assume that will be the case? In the last five years, how many individuals have petitioned the court for release? Of those petitions, how many were accepted and how many were denied? Why does the budget assume the court will rule on the petitions by July 1?

2. Given your new contracting methodology, if the 12 cases do not appear as of July 1, will the payments to the contractor only reflect the actual caseload? In addition, if all 12 cases do not materialize, given the high cost per case, will the unspent funding revert to the General Fund or will you simply spend it elsewhere in your budget?

3. In reviewing your caseload projections for your inpatient SVP program, it appears you are assuming a static caseload of 907 for both 2015-16 and 2016-17. If you are expecting 12 of those cases to move into CONREP-SVP, why don't you assume a corresponding reduction in caseload and funding for 2016-17 in the inpatient SVP caseload?

4. Given that these individuals are most likely eligible for the state's Medi-Cal program, why are the treatment services provided through CONREP funded with General Fund rather than through the Medi-Cal program, which allows the state to draw down federal funding to cover at least half of the cost of treatment?

5. There has been a concerted effort in recent years in county jails and state prisons to ensure that all individuals who are eligible for Medi-Cal are enrolled in and receiving benefits through the program upon their release. Please describe your efforts at ensuring that all patients who leave the state hospitals are enrolled in Medi-Cal, if eligible.

Issue 4: Jail-Based Competency Treatment Program Expansion

Governor's Budget. The proposed budget includes $1.5 million General Fund to establish a new 10-bed jail-based competency treatment program (JBCT - formerly the ROC program) in Sonoma County.

Background. The 2007 Budget Act included $4.3 million for a pilot program to test a more efficient and less costly process to restore competency for IST defendants by providing competency restoration services in county jails, in lieu of providing them within state hospitals. This pilot operated in San Bernardino County, via a contract between the former Department of Mental Health, San Bernardino County, and Liberty Healthcare Corporation. Liberty provides intensive psychiatric treatment, acute stabilization services, and other court-mandated services. The state pays Liberty a daily rate of $278 per bed, well below the approximately $450 per bed cost of a state hospital bed. The county covers the costs of food, housing, medications, and security through its county jail. The results of the pilot have been very positive, including: 1) treatment begins more quickly than in state hospitals; 2) treatment gets completed more quickly; 3) treatment has been effective as measured by the number of patients restored to competency but then returned to IST status; and, 4) the county has seen a reduction in the number of IST referrals. San Bernardino County reports that it has been able to achieve savings of more than $5,000 per IST defendant, and therefore total savings of about $200,000. The LAO estimated that the state achieved approximately $1.2 million in savings from the San Bernardino County pilot project.

The LAO produced a report titled, *An Alternative Approach: Treating the Incompetent to Stand Trial*, in January 2012. Given the savings realized for both the state and the county, as well as the other indicators of success in the form of shortened treatment times and a deterrent effect reducing the number of defendants seeking IST commitments, the LAO recommends that the pilot program be expanded.

2014 Budget Act. The 2014-15 budget included an increase of $3.9 million GF to expand the JBCT program by 45 to 55 beds. In addition, trailer bill language was adopted expanding the JBCT program to secured community treatment facilities. Finally, the budget required that any unspent funds revert to the General Fund. The budget did not include an increase in state staffing positions related to the expansion of JBCT.

Prior Year Budget Augmentation. The 2015 Budget Act included $6.1 million General Fund to support the expansion of DSH's existing jail-based competency treatment program in San Bernardino County. In addition, the budget included $4 million General Fund to support up to 32 additional beds in other interested counties.

Recent JBCT Program Expansions. During 2015, DSH expanded the JCBT program to include an additional 76 beds in the San Bernardino county jail to primarily serve Los Angeles county IST patients. In addition, the Sacramento county jail now has a partnership with the University of California, Davis to run a 16-bed JBCT program to serve IST patients from Sacramento, Fresno, and San Joaquin counties. The Sacramento JBCT is ultimately expected to expand to 32 beds; however, the county has delayed activation of the remaining 16 beds.

Legislative Analyst's Office (LAO). The LAO did not raise any concerns with this proposal in their analysis of the Governor's budget.

Questions for the Administration. Members may want to the following questions:

1. Please provide the committee with an update of your jail-based competency programs, including the reason for Sacramento County's delay in adding their remaining 16 beds.

2. Other counties, including Alameda and San Diego, have expressed an interest in participating in the JBCT program. Please provide an update on which counties you are currently in contact with regarding the potential for expansion.

3. Given the growing interest among counties, why are you only including a small, 10-bed expansion in the budget, rather than a proposal that would allow for greater expansion to other interested counties during 2016-17?

Issue 5: Jail-Based Competency Treatment – IST Evaluator Request

Governor's Budget. The budget includes two positions and $336,000 General Fund at the request of Los Angeles County to provide two IST patient evaluators to determine the appropriate care and placement for patients.

Justification. Prior to the availability of restoration of competency (ROC) programs, placement options for patients requiring placement in a secure treatment facility were essentially limited to a state hospital program. With the addition of the ROC programs as an option for placement, the Los Angeles County Mental Health Court interprets the statute that the court must make the placement determination between the state hospital and ROC. To ensure equal consideration of placement to a ROC or state hospital program, clinical review and evaluation of an IST's medical and mental health records are required and in cases where documentation is inadequate, IST evaluators will conduct interviews with the patients for a proper determination and recommendation to the court for placement at either a state hospital or the ROC program.

With the majority of new referrals coming from LA County, the workload to determine the most appropriate placement option has significantly increased. The DSH is unable to absorb this workload and is requesting funding to establish 2 psychologist positions to serve as the IST evaluators.

Legislative Analyst's Office (LAO). The LAO did not raise any concerns with this proposal in their analysis of the Governor's budget.

Questions for the Administration. Members may want to ask the following questions:

1. According to the budget documents, these two positions have been included in the budget at the request of Los Angeles County. Please explain why, other than its size, Los Angeles needs these additional evaluators and other counties do not? Shouldn't the goal for all of your patients, including the IST population, be to ensure that they are being placed efficiently and in the most appropriate treatment setting?