Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 5 Agenda

Senator Loni Hancock, Chair
Senator Joel Anderson
Senator Jim Beall

Thursday, March 19, 2015
9:30 a.m. or Upon Adjournment of Session
State Capitol - Room 113

Consultant: Julie Salley-Gray

ITEMS PROPOSED FOR DISCUSSION

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0540 HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Health and Human Services Agency: Office of Law Enforcement Support

Background. The 2014 budget act provided $787,000 and six permanent positions for the establishment of the Office of Law Enforcement Support (OLES) within CHHSA to provide uniform training, policies and protocols for the peace officers employed by the state hospitals and developmental centers. In addition, the Legislature approved $600,000 in one-time reimbursements for a contract with the California Highway Patrol that will assist with the development of the policies. Finally, the Legislature adopted trailer bill language requiring the California Health and Human Services Agency (CHHS) to work with system stakeholders to improve the quality and stability of law enforcement practices and develop uniform procedures. CHHS was required to report to the Legislature on the new procedures by January 10, 2015.

In early March 2015, CHHS provided the report to the Legislature, as required in 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*, is 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 and psychiatric programs.

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: (NOTE: A discussion on the components of the report related to the developmental centers will occur at an upcoming hearing of subcommittee No. 3 on Health and Human Services.)

- 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.

OLES was established in 2014 to change the OPS culture and provide oversight, and be directly involved in all OPS operations. Eventually the OLES will be organized as follows:

Organizational Development Section
- Training and Policy Development Unit
- Selections and Standards Unit

Professional Standards Section
- Serious Misconduct Review Team
- Use-of-Force Monitoring

The report includes 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.

Questions for the Administration. The agency should be prepared to present the proposal and to respond to any questions posed by members of the subcommittee.

Issue 2: Inspector General Assessment of Plan and Need for Independent Oversight

Background. During last year's budget process, the Legislature discussed the importance of independent oversight for the state hospitals and psychiatric programs. While the hospitals are therapeutic, treatment settings and not prisons, there remains a great deal of similarity between the patients in state hospitals and inmates in state prisons. Over 90 percent of patients in the state hospital system come into the hospitals through the criminal justice system. In addition, like the state's prisons, the state hospitals are closed institutions that house people 24 hours a day and are not generally open to the public. Therefore, without independent oversight, such as an inspector general, who is given full access to the hospitals, the Legislature and the public are unable to determine the quality of care provided and the safety of the institutions for both patients and staff.

As a possible interim step toward either expanding the scope of the current Inspector General's mission to include state hospitals and psychiatric programs or establishing a separate inspector general, budget committees in both houses of the Legislature:

- Approved $200,000 General Fund for the Office of the Inspector General.

- Adopted placeholder trailer bill language directing the Office of the Inspector General to prepare a recommendation for presentation to the appropriate Senate and Assembly committees to address oversight and transparency of the employee discipline process and use of force within the Department of State Hospitals. The recommendation is to include requirements for reporting of employee misconduct, and how the office of internal affairs within that department is organized, conducts investigations and reports. The recommendation is also to include a review of how the department presents employee misconduct and discipline cases to the State Personnel Board and any changes that should be made. Finally, the recommendation is to include the feasibility and cost of either bringing the state hospitals under the Inspector General's jurisdiction or creating a separate Inspector General's Office for the state hospital system.

- Adopted placeholder trailer bill language directing the California Health And Human Services Agency to cooperate with the Office of the Inspector General and provide unfettered access to all requested documents and personnel.

However, the final budget compromise that was reached by the Legislature and the Administration resulted in the plan presented in the previous item.

Questions for the Inspector General. The subcommittee asks that the Inspector General address the following questions and issues:

1. Please provide your assessment of the plan presented by the Health and Human Services (HHS) Agency.

2. Please describe your office's role in the development of the plan.

3. As noted above, one of the concerns raised by the Legislature last year was that the structure of the proposal put forward by the Administration during the May Revise process was very similar to the structure in place at the California Department of Corrections and Rehabilitation (CDCR), which ultimately led to the *Madrid v. Gomez* case in 1995. Does the HHS plan before the committee address that concern?

4. Please provide your assessment of whether or not the five state hospitals and three psychiatric programs run by DSH would benefit from independent oversight.

4440 DEPARTMENT OF STATE HOSPITALS

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

	2014-15	2015-16
Population by Hospital*		
Atascadero	N/A	N/A
Coalinga	N/A	N/A
Metropolitan	N/A	N/A
Napa	N/A	N/A
Patton	N/A	N/A
Subtotal	**5,802**	**5,863**
Population by Psych Program		
Vacaville	366	366
Salinas	244	244
Stockton	480	480
Subtotal	**1,090**	**1,090**
Population Total	**6,892**	**6,953**
Population by Commitment Type		
Incompetent to Stand Trial (IST)	1,430	1,485
Not Guilty By Reason of Insanity (NGI)	1,377	1,379
Mentally Disordered Offender (MDO)	1,220	1,210
Sexually Violent Predator (SVP)	953	967
Lanterman-Petris-Short Act – Civil Commitments	556	556
Coleman Referral – Hospitals	258	258
Coleman Referral – Psych Programs	1,090	1,090
Department of Juvenile Justice	8	8

***** DSH is no longer able to identify the number of budgeted beds at their hospitals.

State Hospitals Budget

The Governor's proposed budget includes $1.7 billion for DSH in 2015-16 ($1.6 billion General Fund). This represents a $15 million increase over 2014-15 funding. The proposed budget year position authority for DSH is 11,398 positions, an increase of 164 positions from the current year. The department's budget includes increased funding for several proposals; including plans to operate 105 more Incompetent to Stand Trial (IST) beds than were budgeted in 2014-15, and establishes an involuntary medication policy for patients who are Not Guilty by Reason of Insanity (NGI).

(dollars in thousands)

Funding	2013-14 Actual	2014-15 Projected	2015-16 Proposed
General Fund (GF)	$1,440,792	$1,538,796	$1,551,830
Reimbursements	126,384	127,560	129,764
CA Lottery Education Fund	153	25	25
Total	$1,567,329	$1,666,381	$1,681,619
Positions	10,360	11,234	11,398

Cost Over-Runs. Over the past several years, state hospital costs had been rising at an alarming rate, and substantial current year deficiencies had become the norm, and even expected, from year to year. For example, in the 2010-11 fiscal year, the deficiency rose from $50 million to $120 million and the then-DMH staff could not explain why. In general, the department lacked any clear understanding of what the major cost drivers were and how to curb or stabilize costs in the system. In 2011, DMH leadership facilitated and oversaw an in-depth exploration and analysis of state hospital costs, resulting in a lengthy report that is available on the department's website. The research team identified the following system wide problems/cost drivers: increased patient aggression and violence; increased operational treatment models; and redundant staff work.

Based on the report described above, in 2012, the Administration proposed a comprehensive list of reforms, to reverse the rising cost trend, which addressed three stated goals: 1) improve mental health outcomes; 2) increase worker and patient safety; and, 3) increase fiscal transparency and accountability. Perhaps the most significant of these proposed reforms was the reduction of 600 positions throughout the state hospital system. Of these 600 positions, 230 were vacant. In addition to the reduction in positions, the 2012 budget package included key changes in the following areas:

1. Reduced layers of management and streamlined documentation.

2. Flexible staffing ratios, focusing on front-line staff, and redirecting staff to direct patient care.

3. New models for contracting, purchasing, and reducing operational expenses.

4. Elimination of adult education.

Issue 3: Incompetent to Stand Trial Population

Background. When a judge deems a defendant to be incompetent to stand trial, the defendant is referred to the state hospital system to undergo treatment for the purpose of restoring competency. Once the individual's competency has been restored, the county is required to take the individual back into the criminal justice system to stand trial, and counties are required to do this within ten days of competency being restored.

For a portion of this population, the state hospital system finds that restoring competency is not possible. There is no statutory deadline for the county to retrieve these individuals, and therefore they often linger in the state hospitals for years. The state pays the costs of their care while in the state hospitals; whereas their costs become the counties' responsibility once they take them out of the state hospitals. This funding model creates a disincentive for counties to retrieve patients once it is determined that competency restoration is not possible.

Over the past several years, the state hospitals have seen a growing waiting list of forensic patients. The largest waiting lists are for IST and Coleman inmate-patient commitments from CDCR. As of February 23, 2015, the waitlist for all commitment types was 484, including 328 specifically IST. DSH has undertaken several efforts to address the growing IST waitlist including: 1) increasing budgeted bed capacity by activating new units and converting other units; 2) establishing a statewide patient management unit; 3) promoting expansion of jail-based IST programs; 4) standardizing competency treatment programs; 5) seeking community placements; 6) improving referral tracking systems; and 7) participating in an IST workgroup that includes county sheriffs, the Judicial Council, public defenders, district attorneys, patients' rights advocates, and the Administration.

DSH acknowledges that, despite these efforts, IST referrals have continued to increase. When queried about the potential causes of the growing number of referrals from judges and CDCR, the Administration describes a very complex puzzle of criminal, social, cultural, and health variables that together are leading to increasing criminal and violent behavior by individuals with mental illness.

Services for IST Patients. Under state and federal law, all individuals who face criminal charges must be mentally competent to help in their defense. By definition, an individual who is IST lacks the mental competency required to participate in legal proceedings. Individuals who are IST and face a felony charge are eligible for DSH-provided restoration services. At any given time, between 15 percent and 20 percent of the population in DSH facilities are committed as IST.

Long Waitlist for IST Treatment. As indicated above, as of February 2015, the department had 328 IST patients waiting to be placed in a DSH facility. Individuals on the waitlist are typically held in county jail until space becomes available in a DSH facility. The waitlists are problematic because they could result in increased court costs and higher risk of DSH being found in contempt of court orders to admit patients. This is because DSH is

required to admit patients within certain time frames and can be required to appear in court or be held in contempt, when it fails to do so.

2014 Budget Act. The 2014-15 budget included $7.87 million General Fund for 2013-14 and $27.8 million General Fund for 2014-15, to increase bed capacity by 105 beds to address the waiting list specific to IST patients.

Specifically, the funding allowed for three new units with 35 beds each, anticipating activation of the first unit in March 2014, the second in May 2014, and the third in July 2014.

Governor's Budget. The Governor's budget for 2015-16 includes proposals to expand treatment capacity in DSH for IST patients. Specifically, the budget proposes to activate existing beds at two state hospitals.

The budget proposes $17.3 million in additional General Fund support for the activation of 105 beds for IST patients in 2015-16. This amount includes:

- $8.6 million and 75.1 positions to activate 55 beds at DSH-Atascadero. (The Administration proposes to redirect $104,000 in savings in the current year for minor retrofitting of the facility.)

- $8.7 million and 74.6 positions to activate 50 beds at DSH-Coalinga. (The Administration proposes to redirect $2.9 million in savings and establish 25 positions in the current year to begin the activation process.) According to the department, these beds would be filled with MDO patients transferred from DSH-Atascadero. The beds made available from this transfer would then be filled with IST patients.

Legislative Analysts' Office. The LAO recommends that the Legislature not approve the Governor's proposal to expand IST capacity at DSH-Atascadero and DSH-Coalinga until the department provides the following additional justification:

- Additional Budget Information. LAO recommends the DSH provide (1) the number of budgeted and filled beds (particularly those authorized in the 2014-15 budget), and any justification for why the number of budgeted beds differs from the number of filled beds; and (2) detailed information about how its request for additional positions to activate the new IST capacity ties to its staffing ratios, along with justification for any staff in excess of those ratios.

- ROC Delays and Potential for ROC Expansion. LAO recommends the department report on why there has been a delay in activating the additional ROC beds authorized in the 2014-15 budget and on the potential for the ROC program to serve additional IST patients in the future.

- Impacts of Proposition 47. LAO recommends DSH report what changes it has seen in the IST patient population and waitlists since the passage of Proposition 47, as well as estimates on the long-term impacts of the proposition on the IST population (such as by reviewing a sample of IST patient data to determine the proportion of IST patients who were committed for Proposition 47 eligible offenses). To the extent that DSH identifies reductions in the patient population as a result of Proposition 47, the Legislature should require the department to submit updated population budget proposals.

Questions for the Administration. The Administration should be prepared to present the proposal and to address the following questions:

1. It appears that the waiting list has been going down in recent weeks, possibly due to the impact of Proposition 47. How does your budget proposal account for the reduced number of eligible IST patients due Proposition 47?

2. Does the length of the waiting list vary from month-to-month? If so, please provide the subcommittee with data on the last 12 to 24 months.

3. How many ISTs are left by counties at state hospitals after their competency is restored and what is the average length of stay for this population that is left lingering in the hospitals?

4. Is this only a problem with certain counties? If so, which ones?

5. Has the Administration considered charging a per-day rate for those patients who should have been retrieved by the county responsible for their commitment?

6. Has the Administration done an inventory and analysis to determine whether the state has the appropriate mix of types of treatment beds throughout the system to meet the needs of its current population?

7. How flexible are the bed types within the system? For example, can vacant SVP beds be used to serve MDOs or IST patients?

Issue 4: Restoration of Competency (ROC) Programs

Panelists

Captain Jon Pacewiczh, and **Health Administrator Terry Fillman**, San Bernardino County Sheriff's Department

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.

In 2012, budget trailer bill authorized the state to continue the pilot on an ongoing basis, and the DSH is in the process of actively encouraging expansion to other counties. The DSH reports that they have had significant discussions with 14 counties and that they are close to signing contracts with Sacramento and Los Angeles counties. A ROC program in Los Angeles County could have a very significant impact on the IST waiting list given that an estimated 1/3 of the individuals on the waiting list are in Los Angeles County.

2014 Budget Act. The 2014-15 budget included an increase of $3.9 million GF to expand the restoration of competency program (ROC) by 45 to 55 beds. In addition, trailer bill language was adopted expanding the ROC 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 ROC. To date, DSH has not expanded the ROC program.

Staff Comments. Expanding this program, which allows people who have been deemed incompetent to stand trial (IST) by reason of insanity to receive mental health services in the county jail, rather than being transferred to a state hospital, should help to reduce the IST waiting list for those who are waiting for space to open up in a state hospital.

In addition, expanding the program to more counties allows county jails to properly assess and treat inmates who have been found incompetent and are waiting in county jails for a bed in the state hospital system. By treating those individuals who are easy to restore either in a community mental health facility or in the jails, counties should be able to reduce the pressure on their jail systems and more quickly move individuals with serious mental illnesses through the court system and either into long-term treatment or, if found guilty, to begin serving their jail or prison terms.

Currently, two counties, Riverside and San Bernardino, have a restoration of competency program. The proposed augmentation would expand the ROC program to Los Angeles and Alameda counties. Currently, the ROC program is only available in a county jail setting and not in community mental health facilities. As noted earlier, last year's budget included funding to expand the program. However, DSH appears to be struggling in its ability to contract with counties to provide community restoration. This difficulty comes despite significant interest on the part of the county sheriffs to find ways to treat and restore people on the IST waiting list.

The annual cost of the ROC program is approximately $78,000 per bed, as opposed to an IST bed in a state hospital that costs approximately $250,000 per year. Given the significant general fund savings associated with the ROC program, the Legislature may wish to explore ways of more quickly and efficiently expanding the number of ROC beds. DSH, to date, does not appear to be equipped with the expertise to significantly expand the program, despite the pressures they face due to the IST waiting list.

Issue 5: Recruitment and Retention Report

DSH Staffing Issues. Similar to challenges faced by the California Department of Corrections and Rehabilitation, which this committee discussed on March 12, it has been challenging for State Hospitals to fill positions and maintain reasonably-low staff vacancy rates. DSH cites several causes for the difficulty in hiring staff, including:

- Undesirable locations.
- Lower pay than CDCR for very similar work.
- Insufficient number of qualified mental health professionals, in California and nationally.
- Increasing competition from the private health care market in response to the move toward mental health parity.

2014 Budget Act. The 2014 budget contained supplemental reporting language that required DSH to prepare a report on recruitment and retention of staff at the state hospitals and psychiatric programs. Specifically, the language stated:

On or before January 10, 2015, Department of State Hospital (DSH) shall submit to the relevant fiscal committees a report assessing the department's salary and benefits for clinical staff and supervisors. The report shall include the following information:

a) A detailed accounting of the minimum, maximum, and average salaries for all DSH clinical staff and supervisors, including medical and behavioral health care providers.

b) A detailed accounting of the minimum, maximum, and average full compensation packages (including salary, benefits, and any other forms of compensation such as bonuses or loan forgiveness) for all DSH clinical staff and supervisors, including medical and behavioral health care providers.

c) A comparison of the average salaries and full compensation packages for clinical providers at DSH, California Department of Corrections and Rehabilitation (CDCR), and a comparable private provider.

d) The average annual vacancy rates for all DSH clinical staff, by classification and location in 2013‑14.

Questions for the Administration. The Administration should be prepared to present the findings from the report and address the following question:

1. According to the prison healthcare receiver's office, they no longer use a higher pay scale than that allowed by the state. Given that assessment, have you determined why there continues to be a difference in pay between CDCR and DSH?

2. One of the findings in the receiver's recruitment and retention report was that there were no significant disparities due to geography. There were, however, problems with the reputation of individual prisons or the culture of those facilities, that led to high turn-over or higher vacancy rates. Have you determined whether or not the same problems are occurring within the state hospitals and psychiatric programs?

3. Please provide a detailed description of your recruitment and retention efforts including:

    a. The number of staff dedicated to recruitment and retention.

    b. The total budget for your office of recruitment and retention.

    c. The specific efforts they are undertaking to improve retention.

    d. Strategies the department has put in place since the release of the *Coleman v. Brown* special master report which found that inadequate treatment, if any, was being provided to patients in state hospitals and psychiatric programs who were part of the Coleman class, largely due to a shortage of mental health clinicians.

Issue 6: Not Guilty By Reason of Insanity – Involuntary Medication

Governor's Proposal. The Governor's budget proposes $3.2 million from the General Fund and 14.4 positions in 2015-16 for DSH to establish and implement an involuntary medication (IM) process for NGI patients that includes trial court review. These positions include clinical staff positions to provide patients with information and testimony in court, as well as legal positions to represent DSH during initial court hearings and annual review hearings. According to the Administration, the NGI involuntary medication process will be based on the existing involuntary medication process for other DSH patient types.

Background. DSH currently has a hearing process in place to protect patient rights for the three other populations for which IM is used, including Incompetent to Stand Trial, Mentally Disordered Offenders, and Sexually Violent Predators. The IM hearing process enables the state hospitals to provide psychotropic medications to patients refusing consent and believed to be unable to provide adequate consent due to one or more of the following:

- The patient is unaware of his situation and/or does not acknowledge his current condition.
- The patient is unable to understand the benefits and risks of the treatment.
- The patient is unable to understand and knowingly, intelligently, and rationally evaluate and participate in the treatment decision.
- The patient poses a risk to himself or others (determined by attempts or demonstrations of dangerous behaviors intended to inflict harm).

DSH currently does not have an IM hearing process for NGI patients, reflecting court decisions that concluded that NGI patients already have undergone due process determining that the individuals were suffering from a mental illness and that the designation of NGI identifies them as a potential danger to others; therefore, the courts concluded, NGIs are not entitled to a hearing to determine incompetence. However, a more recent Appellate Court decision, In Re Greenshields (2014) 227 Cal. App. 4th 1284, ruled otherwise, indicating that DSH cannot administer IM to NGI individuals without a proper authorization process.

Workload. The NGI population makes up approximately 21 percent of DSH's patient population, with an average daily census of 1,345 for recent months. An IM hearing process would require all of DSH's current NGI patients to either provide consent for their medications or the hospitals must seek authorization through the hearing process. The requested increase in staff is needed to address this new workload associated with the required hearing process.

DSH proposes to model the hearing process after the process used for other DSH populations, called the "Qawi and Calhoun" process, which requires two in-hospital panel hearings. The first hearing authorizes initial use of IM for a patient. The second hearing provides authorization to continue use of IM until a superior court hearing is scheduled. A superior court hearing must be scheduled within 180 days of the second in-hospital hearing. An annual authorization renewal hearing is also held in the superior court in the county of treatment. The in-hospital hearings are staffed either by two psychiatrists and one psychologist or by three psychiatrists, none of which can be the treating psychiatrist. The treating psychiatrist must present to the panel why it is believed that the patient is in need of IM.

The workload resulting from these hearings includes: 1) coordinating the hearings; 2) serving documentation to the patient; 3) completing all required reports and documentation; 4) filing documentation with the courts; 5) scheduling the hearing with the panelists; 6) coordinating scheduling of panelists; and 7) preparing for the hearing.

Legislative Analyst's Office Concerns. While it is reasonable for DSH to establish an involuntary medication process for NGI patients in response to the In re Greenshields decision, the department has not provided adequate justification for the level of resources that is being requested. Specifically, the department's proposal lacks data justifying the assumed workload increase in 2015-16 and does not account for the reduction in workload that will occur in the future.

Lack of Data Justifying Workload in 2015-16. The department does not know how many of the roughly 1,350 NGI patients statewide currently receive medications involuntarily. In addition, DSH does not know what percentage of NGI patients might refuse their medications under the new process. Thus, it is very difficult to assess the amount of workload and the number of positions required to obtain involuntary medication orders for NGI patients in the near term.

Future Reduction in Workload Not Taken Into Account. The establishment of an involuntary medication process for NGI patients could require significant workload in 2015-16, given the large number of NGI patients statewide and the potential need for a hearing for every patient that refuses medication. However, in future years, the workload associated with involuntary medication will likely decrease for two reasons. First, ongoing medication renewal orders require about 50 percent less staff time than new orders. Thus, the LAO would expect workload associated with the current patient population to decline once all the initial orders for this population are completed. Second, once the workload associated with establishing new orders for the portion of the 1,350 current NGI patients that refuse medication is completed, the department will only need to develop new orders for the portion of the 180 new NGI patients committed to DSH each year that refuse medication. Despite these factors, the Administration's plan does not reflect a reduction in funding or positions in future years.

Legislative Analysts' Office Recommendation. The LAO recommends that the Legislature direct DSH to provide a revised request for funding and staff for 2015-16 based on an analysis of the number of NGI patients expected to refuse medication. LAO also recommends that the Legislature only provide funding and staff positions on a one-year, limited-term basis and that it direct the department to submit a proposal for future funding as part of the 2016-17 budget. At that time, the department may have a better estimate of the ongoing workload related to the involuntary medication process.

Questions for the Administration. The Administration should be prepared to present their proposal and address the following questions:

1. Please provide the subcommittee with data on the number and percentage of NGI patients who currently refuse medication. In addition, please provide the number and percentage of patients who currently refuse medication, especially IST patients.

2. Why would the proportion of NGI patients refusing meds be so much higher than IST patients and other types of patients who do so?