SENATE COMMITTEE ON PUBLIC SAFETY

Senator Loni Hancock, Chair
2015 - 2016 Regular

Bill No:	AB 1962	**Hearing Date:**	June 21, 2016
Author:	Dodd		
Version:	June 6, 2016		
Urgency:	No	**Fiscal:**	Yes
Consultant:	JM		

Subject: ***Criminal Proceedings: Mental Competence***

HISTORY

Source: Union of American Physicians and Dentists; American Federation of State, County and Municipal Employees (AFSCME), Local 2620

Prior Legislation: SB 1412 (Nielsen) – Ch. 759, Stats. 2014
AB 2212 (Fuentes) – Ch. 671Stats. 2010
AB 366 (Allen) – Ch. 654, Stats. 2011
SB 1794 (Perata) – Ch. 486, Stats. 2004

Support: California District Attorneys Association; American Federation of Labor and Congress of Industrial Organizations (AFL-CIO); California Association of Psychiatric Technicians; California Psychiatric Association; Peace Officers Research Association of California; Judicial Council of California

Opposition: None known

Assembly Floor Vote: 79 - 0

PURPOSE

The purpose of this bill is 1) to direct the Department of State Hospitals (DSH) to adopt guidelines for training and education standards for a psychiatrist or psychologist appointed to evaluate a defendant who may be incompetent to stand trial (IST); 2) to direct DSH to convene a workgroup of interested and knowledgeable entities, as specified, to develop the guidelines; 3) to provide that the court shall appoint IST experts who meet the guidelines, or experts with equivalent experience and skills, as specified.

Existing law provides that a person cannot be tried to punishment or have his or her probation, mandatory supervision, postrelease community supervision, or parole revoked while that person is mentally incompetent. (Pen. Code, § 1367, subd. (a).)

Existing law states that a defendant is mentally incompetent for purposes of this chapter if, as a result of mental disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner. (Pen. Code, § 1367, subd. (a).)

Existing law specifies that if a doubt arises in the mind of the judge as to the mental competence of the defendant, he or she shall state that doubt in the record and inquire of the attorney for the defendant whether, in the opinion of the attorney, the defendant is mentally competent. (Pen. Code, § 1368, subd. (a).)

Existing law provides that if counsel informs the court that he or she believes the defendant is or may be mentally incompetent; the court shall order that the question of the defendant's mental competence is to be determined in a hearing. (Pen. Code, § 1368, subd. (b).)

Existing law requires a trial by court or jury of the question of mental competence to proceed in the following order:

a) The court shall appoint a psychiatrist or licensed psychologist, and any other expert the court may deem appropriate, to examine the defendant; (Pen. Code § 1369, subd. (a).)

b) In any case where the defendant or the defendant's counsel informs the court that the defendant is not seeking a finding of mental incompetence, the court shall appoint two psychiatrists, licensed psychologists, or a combination thereof; (Pen. Code § 1369, subd. (a).)

c) One of the psychiatrists or licensed psychologists may be named by the defense and one may be named by the prosecution; (Pen. Code § 1369, subd. (a).)

d) The examining psychiatrists or licensed psychologists shall evaluate the nature of the defendant's mental disorder, if any, the defendant's ability or inability to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense in a rational manner as a result of a mental disorder and, if within the scope of their licenses and appropriate to their opinions, whether or not treatment with antipsychotic medication is medically appropriate for the defendant and whether antipsychotic medication is likely to restore the defendant to mental competence; (Pen. Code § 1369, subd. (a).)

e) If an examining psychologist is of the opinion that antipsychotic medication may be medically appropriate for the defendant and that the defendant should be evaluated by a psychiatrist to determine if antipsychotic medication is medically appropriate, the psychologist shall inform the court of this opinion and his or her recommendation as to whether a psychiatrist should examine the defendant; (Pen. Code § 1369, subd. (a).)

f) The examining psychiatrists or licensed psychologists shall also address the issues of whether the defendant has capacity to make decisions regarding antipsychotic medication and whether the defendant is a danger to self or others; (Pen. Code § 1369, subd. (a).)

g) If the defendant is examined by a psychiatrist and the psychiatrist forms an opinion as to whether or not treatment with antipsychotic medication is medically appropriate, the psychiatrist shall inform the court of his or her opinions as to the likely or potential side effects of the medication, the expected efficacy of the medication, possible alternative treatments, and whether it is medically appropriate to administer antipsychotic medication in the county jail; (Pen. Code § 1369, subd. (a).)

h) If it is suspected the defendant is developmentally disabled, the court shall appoint the director of the regional center for the developmentally, or the designee of the director, to

examine the defendant. The court may order the developmentally disabled defendant to be confined for examination in a residential facility or state hospital; (Pen. Code § 1369, subd. (a).)

i) The regional center director shall recommend to the court a suitable residential facility or state hospital. Prior to issuing an order pursuant to this section, the court shall consider the recommendation of the regional center director. While the person is confined pursuant to order of the court under this section, he or she shall be provided with necessary care and treatment; (Pen. Code § 1369, subd. (a).)

j) The counsel for the defendant shall offer evidence in support of the allegation of mental incompetence; (Pen. Code § 1369, subd. (b)(1).)

k) If the defense declines to offer any evidence in support of the allegation of mental incompetence, the prosecution may do so; (Pen. Code § 1369, subd. (b)(2).)

l) The prosecution shall present its case regarding the issue of the defendant's present mental competence; (Pen. Code § 1369, subd. (c).)

m) Each party may offer rebutting testimony, unless the court, for good reason in furtherance of justice, also permits other evidence in support of the original contention; (Pen. Code § 1369, subd. (d).)

n) When the evidence is concluded, unless the case is submitted without final argument, the prosecution shall make its final argument and the defense shall conclude with its final argument to the court or jury; (Pen. Code § 1369, subd. (e).)

o) In a jury trial, the court shall charge the jury, instructing them on all matters of law necessary for the rendering of a verdict. It shall be presumed that the defendant is mentally competent unless it is proved by a preponderance of the evidence that the defendant is mentally incompetent. The verdict of the jury shall be unanimous; and (Pen. Code § 1369, subd. (f).)

p) Only a court trial is required to determine competency in any proceeding for a violation of probation, mandatory supervision, postrelease community supervision, or parole. (Pen. Code § 1369, subd. (g).)

Existing law specifies that a person cannot be tried, or have his or her probation, mandatory supervision, postrelease community supervision, or parole revoked while that person is mentally incompetent.

Existing law states that an incompetent defendant charged with a violent felony (Pen. Code § 667.5, subd. (c), may not be delivered to a state hospital or treatment entity that does not have a secured perimeter or a locked and controlled treatment facility. The court must determine that public safety will be protected. (Pen. Code § 1370, subd. (a)(1)(D).)

This bill provides that the State Department of State Hospitals (DSH) shall, on or before July 1, 2017, adopt guidelines for education and training standards for a psychiatrist or licensed

psychologist to be considered for appointment by the court to evaluate a defendant who is possibly IST

This bill directs DSH to convene a workgroup comprised of the Judicial Council and groups or individuals representing judges, defense counsel, district attorneys, counties, advocates for people with developmental and mental disabilities, state psychologists and psychiatrists, professional associations and accrediting bodies for psychologists and psychiatrists, and other interested stakeholders to develop the guidelines for education and training standards for psychiatrist and psychologists in IST cases.

This bill provides that the court shall appoint IST experts who meet the established guidelines, or experts with equivalent experience and skills. If there is no reasonably available expert who meets the criteria or who has equivalent qualifications, the court may appoint an expert who does not meet the guidelines.

RECEIVERSHIP/OVERCROWDING CRISIS AGGRAVATION

For the past several years this Committee has scrutinized legislation referred to its jurisdiction for any potential impact on prison overcrowding. Mindful of the United States Supreme Court ruling and federal court orders relating to the state's ability to provide a constitutional level of health care to its inmate population and the related issue of prison overcrowding, this Committee has applied its "ROCA" policy as a content-neutral, provisional measure necessary to ensure that the Legislature does not erode progress in reducing prison overcrowding.

On February 10, 2014, the federal court ordered California to reduce its in-state adult institution population to 137.5% of design capacity by February 28, 2016, as follows:

- 143% of design bed capacity by June 30, 2014;
- 141.5% of design bed capacity by February 28, 2015; and,
- 137.5% of design bed capacity by February 28, 2016.

In December of 2015 the administration reported that as "of December 9, 2015, 112,510 inmates were housed in the State's 34 adult institutions, which amounts to 136.0% of design bed capacity, and 5,264 inmates were housed in out-of-state facilities. The current population is 1,212 inmates below the final court-ordered population benchmark of 137.5% of design bed capacity, and has been under that benchmark since February 2015." (Defendants' December 2015 Status Report in Response to February 10, 2014 Order, 2:90-cv-00520 KJM DAD PC, 3-Judge Court, *Coleman v. Brown, Plata v. Brown* (fn. omitted).) One year ago, 115,826 inmates were housed in the State's 34 adult institutions, which amounted to 140.0% of design bed capacity, and 8,864 inmates were housed in out-of-state facilities. (Defendants' December 2014 Status Report in Response to February 10, 2014 Order, 2:90-cv-00520 KJM DAD PC, 3-Judge Court, *Coleman v. Brown, Plata v. Brown* (fn. omitted).)

While significant gains have been made in reducing the prison population, the state must stabilize these advances and demonstrate to the federal court that California has in place the "durable solution" to prison overcrowding "consistently demanded" by the court. (Opinion Re: Order Granting in Part and Denying in Part Defendants' Request For Extension of December 31, 2013 Deadline, NO. 2:90-cv-0520 LKK DAD (PC), 3-Judge Court, *Coleman v. Brown, Plata v.*

Brown (2-10-14). The Committee's consideration of bills that may impact the prison population therefore will be informed by the following questions:

- Whether a proposal erodes a measure which has contributed to reducing the prison population;
- Whether a proposal addresses a major area of public safety or criminal activity for which there is no other reasonable, appropriate remedy;
- Whether a proposal addresses a crime which is directly dangerous to the physical safety of others for which there is no other reasonably appropriate sanction;
- Whether a proposal corrects a constitutional problem or legislative drafting error; and
- Whether a proposal proposes penalties which are proportionate, and cannot be achieved through any other reasonably appropriate remedy.

COMMENTS

1. Need for This Bill

According to the author:

> Existing law prohibits a person from being tried or adjudged to punishment if that person is deemed mentally incompetent. Existing law establishes a process by which a defendant's mental competency is evaluated, which includes requiring the court to appoint a psychiatrist or licensed psychologist, and any other expert the court may deem appropriate.
>
> By definition, an individual who is incompetent to stand trial (IST) lacks the mental competency required to participate in legal proceedings. In California, there is a monthly statewide waitlist that averages between 200 and 300 individuals alleged to have committed felonies who the courts have deemed mentally incompetent to stand trial. These individuals are waiting for a bed to become available in a state hospital so they can undergo evaluation and receive treatment to restore them to competency.
>
> It is estimated that between 15 and 20 percent of patients that are deemed mentally incompetent and unable to stand trial, and thereby sent to a state hospital, are malingering. Malingerers are patients who fake mental illness – specifically, in this case, to avoid going to prison. Malingerers in state hospitals are threats to both hospital staff and patients.
>
> Currently, there are no standards that court-appointed psychologists and psychiatrists must meet specific to evaluating mental competence and identifying malingering. It is important to aid the Department of State Hospitals, by ensuring correct diagnoses of patients. Having qualified experts diagnosing defendants will help reduce violence in state hospitals, while ensuring that those who require hospitalization receive needed help and treatment.

2. Violence in DSH Facilities – Asserted Links to Substandard Evaluations of Potential Forensic Patients by Appointed Experts in IST Cases

The sponsors have stated that a significant percentage of the IST defendants in DSH who are faking their symptoms and that these defendants are particularly likely to be violent. The sponsors have concluded that this problem is caused or exacerbated by substandard evaluations of potential ISTs by appointed experts at the trial court level. The sponsors argue that raising the standards for expert evaluators will reduce violence in DSH facilities by limiting the number of malingering IST patients committed for treatment.

Violence among the IST population is part of an ongoing problem with violence in DSH facilities. According to DSH, in 2013, there were a total of 3,344 patient-on-patient assaults and 2,586 patient-on-staff assaults at state hospitals. Of the total patient population, 62 percent are non-violent, 36 percent committed 10 or fewer violent acts, and 2 percent committed 10 or more violent acts. Of all the violent acts committed, 65 percent are committed by those with 10 or fewer violent acts, and 35 percent are committed by those with 10 or more violent acts. A small subset of the population, 116 people, commits the majority of aggressive acts.

The Division of Occupational Safety and Health, known as Cal/OSHA, within the California Department of Industrial Relations, has had significant and ongoing involvement with DSH as a result of insufficient protections for staff. According to a Los Angeles Times article from March 2, 2012, Cal/OSHA has issued nearly $100,000 in fines against Patton and Atascadero, alleging that they have failed to protect staff and have deficient alarm systems. These citations are similar to citations levied in 2011 against Napa and Metropolitan. Cal/OSHA found an average of 20 patient-caused staff injuries per month at Patton from 2006 through 2011 and eight per month at Atascadero from 2007 through 2011, including severe head trauma, fractures, contusions, lacerations, and bites. DSH states they have been working closely with Cal/OSHA to resolve the issues and take all necessary corrective measures to protect staff at all of the state hospital facilities.

3. Wait List for IST Patients to be Treated by DSH – Consequences and Litigation

An IST jail inmate often must wait a substantial period of time before being admitted to DSH for treatment. An untreated IST defendant could decompensate and become more difficult to return to competency. Such a defendant would also be more likely to need to be placed in a conservatorship if not timely and adequately treated.

Numerous court cases have considered treatment delays for IST. The Second District Court of Appeal in *Freddy Mille v. Los Angeles County* (2010)182 Cal.App. 4th 635, 649-650, ruled that a person determined to be IST must be transferred to a state hospital within a "reasonable amount of time" to allow DSH to report to the trial court on the likelihood of restoring the IST to competence. Penal Code Section 1370 (b)(1) requires the initial report to be made within 90 days. Disability Rights California has reported that this 90-day report timeline is routinely missed. The IST defendant in Mille was only transferred to DSH on the 84th day following the finding of his incompetence.

Litigation on delays in treatment for IST is ongoing. In several counties, attorneys have asked the court for orders to show cause and some have filed class action lawsuits. There appear to be federal court orders concerning the waitlist for IST defendants to be admitted to DSH. The

ACLU has filed a lawsuit in Alameda County – *Stiavetti v. Ahlin*. On April 26, 2016, the court dismissed a motion by DSH to strike the complaint. The court also overruled a demurrer, which is essentially an argument that a complaint or lawsuit does not state a valid legal claim.

4. Background on Change in DSH Population to Nearly Only Forensic Patients – Those Committed Through or From the Criminal Justice System

According to DSH, the state hospital patient population has shifted over the past 20 years, from a 20 percent forensic population in 1994 to the current 96 percent. Forensic patients are committed for a variety of reasons, including IST, NGI, mentally disordered offenders (MDO), and SVP. DSH housed and treated approximately 9,400 patients in 2014. According to the April 4, 2016 weekly census there were approximately 6,730 patients in DSH, excluding those on leave. Of the total, 1,200 were MDO patients and 1,381 were NGI patients[1]

The 2104 DSH Violence Report[2], published in October of 2105, included the following summary:

> During 2014, the Department of State Hospital's (DSH) five freestanding hospitals treated almost 9400 patients (depicted above in Figure 1). While most of these patients were not violent (shown in green above, approximately 77%), violent patients comprised 23% of those treated in 2014. Of the violent patients, a very small number had 10 or more violent acts during 2014 (designated as "repeatedly violent patients"). While numbering only 123 patients total during 2014, these repeatedly violent patients were responsible for 36.6% of all the assaults on patients as well as staff assaults during 2014.

Existing law includes procedures and substantive rules for involuntary commitment to DSH of a person from the criminal justice system of a defendant who has a mental disorder that renders him or her incompetent to stand trial or too dangerous to release without treatment. The major categories of forensic patients are described below:

- Incompetent to Stand Trial: A criminal defendant who, because of a mental disorder, can neither understand the court process nor assist his attorney in conducting his defense is incompetent to stand trial or face punishment. An IST defendant is returned to court upon restoration of competency. (Pen Code § 1367 et seq.)

- Not Guilty by Reason of Insanity (NGI): One is NGI if he or she has a mental disorder rendering him or her incapable of knowing or understanding the nature and quality of the charged act, or he or she could not distinguish right from wrong at the time of the offense. (Pen. Code §§ 25 and 1026 et seq.)

    - An NGI defendant is committed to a state hospital for treatment. He or she can be held as long as the sentence for crime for which the not guilty by reason of insanity verdict was rendered.

[1] There are also 1,444 IST patients and 896 SVP patients, apparently including those pending trial, in DSH as of April 4, 2016

[2] http://www.dsh.ca.gov/Publications/docs/Docs/Violence_Report_2015.pdf

- An NGI defendant can petition for release on the grounds that his or her sanity has been restored. The NGI defendant has the burden of proof in a hearing in the superior court in which the defendant was tried. (Pen. Code §§ 1026, subd. (b), 1026.2)
- An NGI patient can be confined for as long as the maximum sentence for the underlying offense. At the expiration of the normal maximum confinement time, the commitment can be extended if the person's mental disorder makes him or her a danger of substantial harm to others. (Pen. Code § 1026.5, subd. (b).)

- Mentally Disordered Offenders (MDO)

An MDO is an inmate who committed a specified violent crime that was caused or exacerbated by his or her mental disorder and who cannot be safely released into society. An MDO is involuntary committed for treatment during parole. The commitment can be extended without limitation in one-year increments. (Pen. Code § 2960 et seq.)

- Sexually Violent Predators

An SVP is a person who has committed a specified sex crime and has a mental disorder that renders him likely to violent sex crimes if released. At the time an SVP would otherwise be released on parole, he is indeterminately committed for treatment in a state hospital. Annual evaluations are performed to assess the person's status as an SVP.

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