

AGENDA**ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
HEALTH AND HUMAN SERVICES****ASSEMBLYMEMBER TONY THURMOND, CHAIR****MONDAY, MARCH 16, 2015****1:30 P.M. - STATE CAPITOL ROOM 127**

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ITEMS TO BE HEARD

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: DEPARTMENT OF STATE HOSPITALS OVERVIEW

PANELISTS

- **Pam Ahlin**, Director and **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Michael Wilkening**, Undersecretary, California Health & Human Services Agency
- **Han Wang**, Staff Finance Budget Analyst, Department of Finance
- **Carla Castañeda**, Principal Finance Budget Analyst, Department of Finance
- **Sarah Larson**, Fiscal & Policy Analyst, Legislative Analyst's Office

The Department of State Hospitals (DSH) is the lead agency overseeing and managing the state's system of mental hospitals.

BACKGROUND

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 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 budget 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 other psychiatric facilities.

State Hospitals. California has five state hospitals and three prison-based psychiatric programs that treat people with mental illness. Approximately 92 percent of the state hospitals' population is considered "forensic," in that they have been committed to a hospital by the criminal justice system. The state hospitals are as follows:

- **Atascadero (ASH).** ASH is located on the central coast. It is an all-male, maximum security, forensic facility (i.e., persons referred by the court related to criminal violations).
- **Coalinga (CSH).** Located in the City of Coalinga, CSH is the newest state hospital, opened in 2005, and treats forensically committed and sexually violent predators.

- **Metropolitan (MSH).** Located in Norwalk, MSH serves individuals placed for treatment pursuant to the Lanterman-Petris-Short Act (civil commitments), as well as court-ordered penal code commitments.
- **Napa (NSH).** Located in the City of Napa, NSH is a low-to-moderate security state hospital.
- **Patton (PSH).** PSH is located in San Bernardino and cares for judicially committed, mentally disordered individuals.

Prison-Based Psychiatric Programs. There are three prison-based psychiatric programs, located in Vacaville, Salinas and Stockton (within the California Health Care Facility in Stockton).

Cost Over-Runs

Over 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 FY, 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 costs and significant overspending; inadequate data tracking and reporting systems; inflexible 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. These reforms included the reduction of 600 positions from throughout the state hospital system, of which 230 were vacant while 270 were filled. In addition to the reduction in positions, the 2012 budget package included key changes in the following areas:

1. Modified mail services, streamlined documentation, and reduced layers of management;
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; and,
4. Elimination of adult education. The Legislature strongly objected to the elimination of adult education in the state hospitals, but was unsuccessful in protecting it.

DEPARTMENT BUDGET

The Governor's proposed 2015-16 budget includes total funds of \$1.68 billion dollars, of which over \$1.56 billion is General Fund. The proposed 2015-16 budget is a modest 0.9 percent increase over current year funding.

DEPARTMENT OF STATE HOSPITALS					
<i>(Dollars in Thousands)</i>					
Fund Source	2013-14 Actual	2014-15 Projected	2015-16 Proposed	CY to BY Change	% Change
General Fund	\$1,440,792	\$1,538,796	\$1,551,830	\$13,034	0.8%
CA State Lottery					
Education Fund	\$153	\$25	\$25	\$0	0%
Reimbursements	\$126,384	\$127,560	\$129,764	\$2,204	1.7%
Total					
Expenditures	\$1,567,329	\$1,666,381	\$1,681,619	\$15,238	0.9%
Positions	10,359.9	11,234.0	11,398.1	164.1	1.5%

LAO Report

The LAO released a report on February 9, 2015, *The 2015-16 Budget: Improved Budgeting for the Department of State Hospitals*, which is an analysis of the budgeting methodology used by DSH. LAO concluded that the DSH budgeting process has several significant shortcomings, including the following:

1. DSH has a large amount of funded beds that are not used;
2. The level of staff needed to operate DSH facilities is unclear;
3. The budgeting methodology used by the department creates poor incentives for it to operate efficiently; and
4. Other state departments have more transparent, updated, and efficient budgeting processes than DSH.

In response to these findings, the LAO makes several recommendations to improve the DSH budgeting process. They recommend that the Legislature:

1. Require DSH to establish or update several key components used to develop its budget to ensure that they are accurate and adequate;
2. Direct DSH to use the updated information to develop its budget and staffing requests based on expected changes in the number and acuity (i.e., level of care) of its patient population, as well as make adjustments to its budget if the actual population differs from its projections; and
3. Require DSH to provide additional justification for its budget requests during the development and implementation of the new budgeting process.

The full LAO report can be found on the LAO website:

<http://www.lao.ca.gov/Publications/Detail/3168>

DSH has provided a written response to the LAO's report, stating that the department agrees with the need to update its budget methodology to recognize changes in its capacity, population patient acuity and maturity of DSH as a hospital system. However, DSH also disagrees with much of the LAO's analysis. In particular, DSH's response focuses on the following three statements by the department:

1. DSH does not maintain on average 450 vacant beds at its hospitals nor does it maintain an 8% vacancy rate overall.
2. DSH does not maintain vacant beds to redirect staff or savings to other functions within the state hospitals.
3. DSH's growing wait list for its hospitals is not due to maintaining vacant beds or redirect staffing.

STATE HOSPITALS CASELOAD

The State Hospitals provide treatment to approximately 5,400 patients, who fall into one of two categories: 1) civil commitments (referrals from counties); or 2) forensic commitments (committed by the courts). Civil commitments comprise approximately 8 percent of the total population while forensic commitments approximately 92 percent. The DSH also operates a Conditional Release Program in which patients reside in community settings; this program currently has a caseload of 601.

The prison-based psychiatric facilities treat approximately 1,000 inmates. They include: 1) Vacaville Psychiatric Program; 2) Salinas Valley Psychiatric Program; and 3) Stockton Psychiatric Program. The following are the primary Penal Code categories of patients who are either committed or referred to DSH for care and treatment by the courts:

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 defendant cannot participate in trial because 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 developmental disabilities.

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* – Inmates who are found to be mentally ill while in prison, including some in need of urgent treatment.

State Hospitals & Psychiatric Programs Caseload Projections				
	June 30, 2014	2014-15 Estimate	2015-16 Projected	CY to BY Change
Population by Commitment Type				
IST – PC 1370	1,380	1,430	1,485	55 (3.8%)
NGI – PC 1026	1,381	1,377	1,379	2 (0.1%)
MDO	1,241	1,220	1,210	-10 (-0.8%)
SVP	936	953	967	14 (1.5%)
LPS/PC 2974	556	556	556	0 (0%)
PC 2684 (Coleman)	258	258	258	0 (0%)
WIC 1756 (DJJ)	8	8	8	0 (0%)
Subtotal	5,760	5,802	5,863	61 (1%)
Population by Psych Program				
Vacaville	328	366	366	0 (0%)
Salinas	244	244	244	0 (0%)
Stockton	514	480	480	0 (0%)
Subtotal	1,086	1,090	1,090	0 (0%)
Population Grand Total	6,846	6,892	6,953	61 (0.9%)

DSH projects a 0.9 percent increase in the overall population, and this small increase is primarily in the IST population. The increase in the IST population and resulting IST waiting list is discussed in more detail below under Issue 2.

STAFFING ISSUES

It has been very challenging for State Hospitals to fill positions and maintain reasonably-low staff vacancy rates. The 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; and

- Increasing competition from the private health care market in response to the move towards mental health parity.

The following chart shows the staff vacancy rates for the State Hospitals and for the prison-based psychiatric programs:

DSH Position Data as of January 1, 2015						
Classification	Filled	Vacant	FTE	Civil Service Vacancy Rate	Contractor FTE	Vacancy Rate With Contractors
State Hospitals						
Clinical Social Worker*	228.35	25.55	253.90	10%	4.31	8%
Hospital Police Officer	465.00	118.30	583.30	20%	0.00	20%
Medical Technical Assistant	0.00	0.00	0.00	N/A	0.00	N/A
Psychiatric Technician (Safety)*	2274.30	284.90	2559.20	11%	0.00	11%
Psychologist*	203.30	37.80	241.10	16%	7.17	13%
Registered Nurse (Safety)*	1232.70	177.60	1410.30	13%	0.07	13%
Rehabilitation Therapist	225.25	39.75	265.00	15%	0.00	15%
Staff Psychiatrist*	172.80	49.30	222.10	22%	25.21	11%
Prison-Based Psych Programs						
Clinical Social Worker*	61.00	10.40	71.40	15%	0.97	13%
Hospital Police Officer	0.00	0.00	0.00	N/A	0.00	N/A
Medical Technical Assistant	337.00	10.50	347.50	3%	0.00	3%
Psychiatric Technician (Safety)*	405.00	80.20	485.20	17%	2.40	16%
Psychologist*	53.00	13.40	66.40	20%	0.00	20%
Registered Nurse (Safety)*	266.00	28.00	294.00	10%	1.29	9%
Rehabilitation Therapist	57.00	13.40	70.40	19%	0.00	19%
Staff Psychiatrist*	51.00	21.40	72.40	13%	3.35	25%

*Civil Service vacancy rate offset by contract staff.

The DSH has undertaken a substantial array of varied strategies to increase hiring and decrease staff vacancies, most notably a substantial outreach effort and an increase in pay for psychiatrists. The DSH reported last year that it is exploring re-establishing psychiatric medical fellowships (or residency placements) within the State Hospitals, in partnership with medical residency programs.

The California Association of Psychiatric Technicians (CAPT) has shared information and concerns about State Hospitals staffing with the Subcommittee. In short, CAPT cites evidence of significant staff shortages, leading to mandated overtime at some of the hospitals. CAPT also points out that regularly there is a substantial number of staff not working because of "Industrial Disability, Enhanced Industrial Disability, or worker's comp." DSH states that it is aware of CAPT's concerns with mandated overtime and is working with them to resolve these issues. DSH also acknowledges that the staffing needs can be addressed by filling vacancies rather than by pursuing additional resources.

Budget Transparency

As described in more detail under Issue 2, the proposed DSH budget includes increased staffing that corresponds with a proposed bed capacity expansion to address the IST waitlist. The level of staffing being requested exceeds the level that staffing ratios in regulations would indicate. Specifically, DSH is requesting resources in order to add 105 beds for the IST population. According to the LAO, staffing ratios would indicate a need for 76.1 staff for 105 new beds, yet the DSH is requesting 149.7 staff. Legislative staff asked the administration for further detail or explanation for how the higher level of staffing has been developed, which was provided moments before this agenda was finalized. There has not been sufficient evidence that this higher level of staffing is justified or unjustified, however the lack of transparency makes it very challenging for the Legislature to provide effective oversight.

VIOLENCE & LAW ENFORCEMENT

Over the past approximately fifteen years, the state hospitals' population has changed dramatically, becoming an increasingly "forensic" population with the percentage of civil commitment in decline. Now, approximately 92 percent of the state hospital population is forensic, largely a result of key laws being passed, including: 1) legislation in 1995 (AB 888 Rogan and SB 1143 Mountjoy), which established a new category of commitment for sexually violent predators (SVPs), which requires certain SVP criminal offenders, upon release from prison, to be placed in state hospitals for treatment; and, 2) Proposition 83 ("Jessica's Law"), passed by voters in 2006, increased criminal penalties for sex offenses and eased the way for more SVPs to be placed in hospitals. As a result of these laws, as well as changes to the population, violence in the hospitals increased substantially. In October of 2010, a patient assault resulted in the death of an employee. The numbers of aggressive acts during calendar years 2009, 2010, and 2011 are outlined in the table below. Since 2010, violence and aggression rates have decreased.

State Hospital	Aggressive Acts Against Patients			Aggressive Acts Against Staff		
	2009	2010	2011	2009	2010	2011
NSH	1,212	2,688	2,085	141	928	436
PSH	2,231	2,894	1,795	854	1,208	646
MSH	2,318	2,438	2,598	684	1,324	1,802
ASH	636	647	573	349	415	505
CSH	477	707	565	277	719	676
TOTAL	6,874	9,374	7,616	2,305	4,594	4,065

Cal/OSHA has had significant and ongoing involvement with the State Hospitals as a result of insufficient protections for staff. The LA Times reported on March 2, 2012 that 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 NSH and MSH. Cal/OSHA found an average of 20 patient-caused staff injuries per month at Patton (2006-2011) and eight per month at Atascadero (2007-2011), including severe head trauma, fractures, contusions, lacerations, and bites. The former-DMH explained that they were working

closely with Cal/OSHA to resolve the issues and to take all necessary corrective measures to protect staff at all of the State Hospitals.

Sacramento Bee Editorial

On February 8, 2015, the *Sacramento Bee* published an editorial written by Dr. Stephen Seager, a staff psychiatrist at Napa State Hospital that calls attention to the violence in State Hospitals and the resulting danger level for staff in the hospitals. Dr. Seager states that Napa State Hospital has roughly 3,000 assaults per year, and that patients are most often the victims. Seager states that both staff and patients have been murdered. Seager asserts that the response from the administration is woefully inadequate and suggests the following solutions: 1) Move staff offices away from inpatient units; 2) Supply guards to escort staff; 3) Supply hall monitors and guards; 4) Create segregation for the worst offenders; and 5) Mandate that every forensic patient sent to a State Hospital come with a court order for the administration of anti-psychotic medications.

On February 22, 2015, the *Sacramento Bee* published a response to this editorial from DSH, which states, "By the end of 2013, our hospital system recorded reductions in aggressive incidents that translated into 180 fewer patient assaults and 30 fewer staff assaults per month from the peak of violence in 2010." The response describes some of the violence-prevention/reduction strategies already implemented in the state hospitals (listed in detail below), and identifies the following bills that were signed into law in 2014 that they expect will help:

- AB 1960 (Perea, Chapter 730) allows department clinicians to access the criminal history of all patients;
- AB 1340 (Achadjian, Chapter 718) allows for building enhanced treatment facilities where the most aggressive patients will receive specialized treatment (see Issue 4 of this agenda for more detail);
- AB 2186 (Lowenthal, Chapter 733) and AB 2625 (Achadjian, Chapter 742) streamline involuntary medication orders and court procedures to help staff treat those who are incompetent to stand trial.

DSH provided to the Legislature the following listing of the violence reduction strategies implemented so far in the State Hospitals:

"Assessment. In this domain, our goal is to train clinicians to understand the cause of, and improve our ability to predict, violent behavior. To accomplish this goal, we have:

- Implemented Violence Risk Assessments statewide; all patients receive some type of assessment depending on their commitment type and hospital.
- Completed statewide training in state-of-the-art violence risk assessment tools. Trainings will continue on a regular cycle.
- Begun working to leverage technology to ensure data from these assessments are incorporated into the treatment planning process.

Treatment. As our goal, we will optimize the treatment of violence. We have:

- Researched, created, published and disseminated to DSH clinicians the California Violence Assessment and Treatment Guidelines (Cal-VAT) last year, which is unique in the literature. Cal-VAT is based on University of California, Davis research demonstrating that psychiatric inpatient aggression can be categorized as psychotic, predatory or impulsive. DSH is currently developing guidelines targeting violence due to cognitive issues.
- Implemented the Psychopharmacology Resource Network led by national expert Stephen Stahl MD, PhD. This group of experts provides training and consultation to our doctors statewide on the pharmacological treatment of violence.
- Implemented a statewide Continuing Medical Education (CME) program that includes intensive focus on forensic training and training on the Cal-VAT guidelines. We have provided more than 100 hours of group CME training to DSH psychiatrists since January 2013.
- Implemented an internal Data Analytics, Treatment and Assessment team who aid in identifying, piloting and implementing best non-pharmacological practices such as Dialectical Behavioral Therapy. Based on the team's recent data analysis related to DSH's chronic assaulter analysis, they are now working to implement statewide cognitive rehabilitation programs.
- Established an online Education Connection for level-of-care staff; thus far, 970 users have received more than 25,000 hours of education in the last year to enhance their clinical skills.
- Creating a model called Forensic Focused Treatment Planning and recently had an article accepted for publication on this topic. This model identifies and focuses on salient forensic issues such as inpatient aggression.
- Working with other states to define and publish a forensic standard of care.

Environment. For this domain, our goal is to establish appropriate treatment environments. We have:

- Implemented the Personal Duress Alarm System at three of five hospitals and implementation is in process at the other two freestanding facilities.
- Implemented Specialty Unit Pilots: an Enhanced Treatment Unit at Atascadero State Hospital that treats patients whose severe violence is primarily driven by severe psychiatric symptoms; a Specialized Services Unit at Coalinga State Hospital that treats patients whose criminogenic behavior is primarily driven by characterological traits; a Substance Abuse Treatment Unit at Napa State Hospital that treats patients who are actively abusing substances, which is a major risk factor for violence.
- In process of evaluating an ecological approach to environmental violence reduction at Patton State Hospital.
- Begun developing the Enhanced Treatment Program, described in AB 1340. This legislation enabled the creation of specialized, safety-oriented settings for the treatment of violence that is likely to cause severe physical harm and is not containable in a regular treatment setting. The Department has launched a multi-focal plan for the design, construction and programmatic aspects of these units. The Enhanced Treatment Program will allow the Department to begin stratifying

our hospitals beds based on level of therapeutic security as well as treatment needs.

- Analyzed worker's compensation data and found that DSH staff are injured as often during containment as they are by assault. As a result, the Department is currently exploring best practices related to de-escalation training, as well as approaches in other countries.

Data. Our goal is to improve the integrity, architecture and analysis of violence-related data to achieve ongoing performance improvement related to violence. We have:

- Established a unit tasked with accomplishing this goal.
- Begun expanding the University of California, Davis research program to all hospitals.
- Completed a violence data analysis project to determine trends in violence in the State Hospital System.
- Initiated a chronic aggressors project. The results of the violence data analysis indicated that 2 to 3 percent of the patient population was responsible for 30 to 40 percent of the hospital violence each year. DSH developed a coding process for reviewing these cases to find common risk factors in the hopes of developing targeted interventions for this portion of the patient population.
- Initiated a worker's compensation data analysis project. The violence data analysis indicated that patient-to-staff violence has not decreased as much as patient-to-patient violence. DSH developed this project to analyze data from the worker's compensation databases to better understand patient-to-staff violence and find areas to mitigate the risk of staff injury.
- Created a process for reporting to the DSH Governing Body on discipline specific outcomes and best practices on a statewide basis, some of which impacts violence reduction.
- Begun leading an effort to establish national forensic benchmarking data with partners in other states."

In April 2014, DSH published a report on violence in the State Hospitals that includes a substantial amount of data and other information, focusing on years 2010-2013. The full report can be accessed at:

http://www.dsh.ca.gov/Publications/docs/Docs/Final_Violence_Report_April_18.pdf

Office of Law Enforcement Support (OLES)

In early March 2015, the California Health and Human Services Agency (CHHS) provided a report to the Legislature, as required in 2014 budget trailer bill, on the creation of the OLES, also approved through 2014 budget trailer bill. The report, *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 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.

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.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to provide an overview of the department and the state hospitals system, provide a brief history of significant changes in the department and in the state hospitals system and present, the Governor's proposed 2015-16 budget for this department. Please also respond to the following:

1. Given that the staffing request exceeds what would be indicated by existing staffing ratios in regulation, please explain how the higher level of staffing was determined. Please provide a basic description of the main variables that lead to levels of staffing.
2. Please provide an overview of the trends in violence and injury rates at the State Hospitals, and describe what factors have had the greatest impact on reducing violence rates since 2010.
3. Please summarize the department's response to the LAO's report on DSH budgeting.

The Subcommittee requests LAO to summarize their report on DSH budgeting.

The Subcommittee requests the agency to provide an overview of the Office of Law Enforcement Support report and respond to any questions posed by Members of the Subcommittee.

Staff Recommendation: No action is recommended at this point in time.

ISSUE 2: EXPANSION TO ADDRESS INCOMPETENT TO STAND TRIAL WAITLIST**PANELISTS**

- **Pam Ahlin**, Director and **Stephanie Clendenin**, Chief Deputy Director, DSH
- **Irene Briggs**, Chief Financial Officer, DSH
- **Han Wang**, Staff Finance Budget Analyst, Department of Finance
- **Carla Castañeda**, Principal Finance Budget Analyst, Department of Finance
- **Sarah Larson**, Fiscal & Policy Analyst, Legislative Analyst's Office

In order to create additional State Hospitals capacity for Incompetent to Stand Trial (IST) patients, DSH requests:

1. \$8.6 million and 75.1 positions to activate 55 new IST beds at Atascadero; and
2. \$8.7 million and 74.6 positions to activate 50 new IST beds at Coalinga.

BACKGROUND

When a judge deems a defendant to be incompetent to stand trial, the defendant is referred to the state hospitals 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. For these individuals, the responsibility for their care returns to counties which are required to retrieve the patients from the state hospitals within ten days of the medical team deeming the individual's competency to be unlikely to be restored. AB 2625 (Achadjian, Chapter 742, Statutes of 2014) changed this deadline for counties from three years to ten days. Prior to this bill, many individuals in this category would linger in state hospitals for years.

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 commitments. 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.

The 2014 Budget Act includes \$7.87 million General Fund for 2013-14 and \$27.8 million General Fund for 2014-15 also for an expansion of 105 beds. DSH states that the last 35 of these beds will become available on March 17, 2015.

Restoration of Competency (ROC) In County Jails Program

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 \$278, well below the approximately \$450 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 on this issue. 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.

Administration Workgroup

The administration has convened a workgroup involving many of the major stakeholders in the state's criminal justice system, including the DSH, to discuss and collaborate on system-wide issues. One of the purposes of this workgroup is to identify reasons for the

increase in IST patient commitments and possible solutions for managing the resulting increase in this population.

Legislative Analyst

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.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal and provide an overview of what is known about the causes and solutions to the growing IST waiting list.

Please respond as much as possible to the LAO's recommendations.

Staff Recommendation: Staff recommends holding this item open to allow for more time for input and analysis.

ISSUE 3: METROPOLITAN STATE HOSPITAL SECURITY FENCE CAPITAL OUTLAY**PANELISTS**

- **Pam Ahlin**, Director and **Stephanie Clendenin**, Chief Deputy Director, DSH
- **George Maynard**, Deputy Director for Strategic Planning & Implementation, DSH
- **Carlos Ochoa**, Finance Budget Analyst, Department of Finance
- **Sarah Larson**, Fiscal & Policy Analyst, Legislative Analyst's Office

This proposal is for \$1,930,000 to provide secured fencing to enclose two buildings and add secured fencing around the adjacent park, add restroom facilities to the park, renovate and increase the capacity of the visitor's center and parking facilities, install sally ports, and security kiosks, alarms, cameras, lighting and perimeter roads. The total project cost is estimated to be \$35,530,000, and this request is specifically for the development of preliminary plans.

BACKGROUND

The primary purpose of this proposal is to help address the projected shortage of "secure" state hospital beds. DSH expects the forensic populations to continue to grow, thereby increasing the need for secure beds. This project is expected to eventually create 505 additional secure beds and will include the following components:

- Enclose the Continuing Treatment West Building (CTW) with secure fencing to secure 376 forensic beds.
- Enclose the Skilled Nursing Facility (SNF) Building with secure fencing to secure 129 forensic beds.
- Enclose the adjacent park next to the CTW Building for recreation activities.
- Renovate and increase the square footage of the existing visitor center and expand parking facilities.
- Install required sally ports, security kiosks, security alarms, security cameras, security lighting, perimeter roads to ensure surveillance and access for emergency response vehicles around new secured areas.

Legislative Analyst

The LAO recommends the Legislature reject this proposal to develop preliminary plans to expand secure capacity at DSH–Metropolitan. The LAO points out that there are limits on the type of patients that can be treated at Metropolitan, as the state has an agreement with the City of Norwalk and the Los Angeles County Sheriff's Department to

only admit patients who have no history of attempted or successful escape from a locked facility and no charges or convictions for murder or a sex crime. Therefore, LAO believes that it is difficult to assess whether the department would be able to fully utilize the additional secure treatment beds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the administration to present this proposal and please explain how DSH has the confidence to fill secure treatment beds at Metropolitan given the limits on patient type that the state agreed to with the City of Norwalk.

Staff Recommendation: Staff recommends holding this issue open to allow for more time for input and analysis.

ISSUE 4: STATEWIDE ENHANCED TREATMENT UNITS CAPITAL OUTLAY**PANELISTS**

- **Pam Ahlin**, Director and **Stephanie Clendenin**, Chief Deputy Director, DSH
- **George Maynard**, Deputy Director for Strategic Planning & Implementation, DSH
- **Carlos Ochoa**, Finance Budget Analyst, Department of Finance
- **Sarah Larson**, Fiscal & Policy Analyst, Legislative Analyst's Office

The budget proposes \$11,467,000 General Fund for renovation to provide 44 Statewide Enhanced Treatment Units at State Hospitals, as follows: Atascadero (12), Napa (12), Patton (12), and Coalinga (8). Funding of \$1.5 million was provided in 2014 for an analysis, estimate, and infrastructure design for this project, as described in more detail below.

BACKGROUND

The state hospitals were designed and constructed for a patient population that was quite different than the population currently in the state hospitals. Now, 92 percent of the population is forensic, having been referred to the state hospitals by either courts or prisons. Substantial evidence demonstrates a significant rate of aggression and violent incidents at state hospitals.

Last year's proposal explained that, in spite of this significant change in the state hospitals' patient population, there was no legal, regulatory, or physical infrastructure in place for the DSH to effectively and safely treat patients who have demonstrated severe psychiatric instability or extremely aggressive behavior. As a result, often the only option available to a state hospital dealing with an extremely violent patient is the use of emergency seclusion and restraints, which is short-term only and a more extreme response. Subsequent to the use of seclusion and restraint, a violent patient must be placed in "one-on-one or two-on-one observation," which the DSH states is labor intensive and does not necessarily improve safety.

DSH states that the proposed ETUs will provide a more secure environment to address patients that become psychiatrically unstable resulting in highly aggressive and violent behavior towards themselves, other patients, or staff. Candidates for an ETU would exhibit a level of physical violence that is not containable using other interventions or protocols currently available in the state hospitals. DSH also points out that the existing physical facilities are so old, and designed for a different population, that it is not possible to provide more security within existing facilities.

DSH shared the following three examples of the types of patients who would be appropriate candidates for the proposed ETUs:

1. "The case of psychotic aggression in a patient who has a history of strangling people to death in the night in response to certain delusions and hallucinations: He reports to DSH staff he is experiencing the same delusions and hallucinations that previously caused him to kill people in the middle of the night. He is currently housed in a hospital with dormitory style rooms with no locks on the doors or other physical plant control to mitigate the risk of strangling other patients. Prior to ETUs, the only option for containment of risk is seclusion or restraint, and it's questionable as to whether he would meet the existing criteria for seclusion and restraint.
2. A case of chronic predatory aggression in a patient who had previously murdered a peer: In this case, the patient tells DSH staff he does not like a particular peer and states: "You know what I do when I don't like someone." Given his history, this indirect verbal threat indicates a high risk of severe violence (murder). However, current legal and regulatory authority does not allow for restraint and seclusion to contain this threat despite the high risk this patient presents.
3. A case of a chronically assaultive patient who assaults so frequently that he required constant restraint in a hospital: He describes the assaults as impulsive, and explains that he just gets the urge to attack people and he cannot control himself. Upon being interviewed, he states unequivocally that he prefers being treated in the lower stimulation and external controls offered by a locked room in the higher safety environment of a state prison."

Statutory Authority

The 2014 budget includes:

- \$1.5 million in funding for the development of preliminary plans and working drawings to implement the ETUs; and
- Provisional language that prohibits DSH from proceeding with the construction phase of this project (the subject of this proposal) until legislation is enacted authorizing the use of the ETUs. Such legislation was passed and signed into law last year in the form of AB 1340 (Achadjian, Chapter 718, Statutes of 2014). Specifically, AB 1340:
 - 1) Establishes legislative intent regarding the purpose and need for additional enhanced treatment units (ETU) and states findings and declarations accordingly.
 - 2) Permits DSH to establish and maintain a pilot ETU at each state hospital to test the effectiveness of providing treatment for patients who are at high risk of the most dangerous behavior.
 - 3) Permits each pilot ETU to exist until January 1st of the fifth calendar year after each pilot ETU has admitted its first patient.

- 4) Permits DSH to adopt emergency regulations, in accordance with the Administrative Procedure Act (APA), for the administration of ETUs.
- 5) Establishes ETU requirements, including:
 - a) Maintaining a staff-to-patient ratio of one to five;
 - b) Limiting each room to one patient;
 - c) Requiring that each patient room be allowed visual access by staff 24 hours per day;
 - d) Requiring that each patient room have a toilet and sink in the room;
 - e) Requiring that each patient room door have the capacity to be locked externally;
 - f) Permitting the door to be locked when clinically indicated and determined to be the least restrictive treatment environment for the patient's care and treatment;
 - g) Providing emergency egress for ETU patients;
 - h) Requiring that, in the event seclusion or restraints are used in an ETU, all state licensing and regulations be followed; and,
 - i) Requiring that a full-time independent patients' rights advocate who provides patients' rights advocacy services be assigned to each ETU.
- 6) Deletes the requirement for a new license for an ETU and instead authorizes ETUs to be licensed under existing hospital licensing requirements for acute psychiatric hospitals.
- 7) Exempts the development of regulations by the Department of Public Health (DPH) from the requirements of the APA.
- 8) Requires DSH to monitor the pilot ETUs, evaluate outcomes, as specified, and report on its findings and recommendations to the Legislature.
- 9) Requires ETUs to adopt and implement policies and procedures necessary to encourage patient improvement, recovery, and a return to a standard treatment environment, and to create identifiable facility requirements and bench marks, as specified.
- 10) Establishes procedures for the evaluation, assessment, and creation of a treatment plan for each admitted patient, as specified.

The DSH also proposes to create a Forensic Needs Assessment Panel (FNAP), consisting of the DSH Medical Director, the referring hospital Medical Director, and the ETU hospital Medical Director, to discuss patient placement issues. The DSH also proposes to create and utilize a system-wide team, Forensic Needs Assessment Team (FNAT), consisting of a panel of psychologists with expertise in forensic assessment and violence risk assessment.

ETU Admissions & Evaluation Procedures

DSH plans to utilize an 8-step process that will be required for a patient to be admitted to an ETU. Generally, the proposed admissions criteria includes time frames for clinical evaluation, placement, reconsideration of ETU placement, standards for treatment and case management time frames, and increases in clinical oversight and treatment. For example, the process would require that within 3 business days of placement in an ETU, a dedicated forensic evaluator, who is not on the patient's treatment team, must complete a full clinical evaluation of the patient. Further, within 7 business days of placement in the ETU, with 72-hours notice to the patient and patient advocate, the FNAP would be required to conduct a placement evaluation meeting with the referring clinician, the patient and his/her patient advocate, and the dedicated forensic evaluator who performed the full clinical evaluation.

Working Drawings

The Department of Finance reports that the working drawings phase of this project is 6 months behind, and therefore they expect the final working drawings to go before the State Public Works Board in December, 2015.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the DSH to present this proposal and respond to the following:

1. Please share in as much detail as possible what the ETUs will look like and how they will operate.
2. Given the delay in working drawings, when does the administration expect to begin operating ETUs?

Staff Recommendation: Staff recommends holding this issue to allow for more time for input and analysis.

ISSUE 5: OTHER CAPITAL OUTLAY PROPOSALS**PANELISTS**

- **Pam Ahlin**, Director and **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Carlos Ochoa**, Finance Budget Analyst, Department of Finance
- **Sarah Larson**, Fiscal & Policy Analyst, Legislative Analyst's Office

The DSH proposes the following capital outlay projects:

1. \$7,634,000 to upgrade the fire alarm system at Metropolitan
2. \$731,000 to upgrade the fire alarm system at Patton
3. \$2,029,000 for courtyard gates and security fencing at Napa
4. \$442,000 for seismic upgrades at Atascadero
5. \$219,000 for courtyard expansion at Coalinga

BACKGROUND

This issue covers the following five proposed capital outlay projects:

Fire Alarm Upgrade at Metropolitan (\$7,634,000). This proposal is to completely upgrade the existing Notifier Fire Alarm Systems in patient housing and to provide a new central monitoring system located at Hospital Police Dispatch. The total project cost is estimated to be approximately \$9 million. According to the proposal, the existing system is not code compliant and does not provide serviceability and/or expandability. The 2014 request for \$712,000 was for the working drawings phase of the project. Development of preliminary plans was funded in the prior fiscal year at \$633,000, and construction is proposed to be funded in 2015-16 for \$7,634,000.

Fire Alarm Upgrade at Patton (\$731,000). This project proposes to upgrade the existing Simplex Grinnell Fire Alarm Systems in psychiatric patient housing and provide a new central monitoring system located at Hospital Police Dispatch. The proposal states that the existing system is not compatible with the manufacturer's software and hardware, is not code compliant, and does not allow for serviceability and/or expandability.

Courtyard Gates & Security Fencing at Napa (\$2,029,000). This project is to improve security in the courtyards in the patient housing buildings, including: replacement of gates and fabricating and installing extensions to raise the height of security fencing in specified buildings. The 2014 cost to develop working drawings was \$191,000.

Seismic Upgrades at Atascadero (\$442,000). This project is to perform a seismic retrofit at the main East-West corridor at Atascadero State Hospital. The retrofit will include construction of steel framed lateral frames in the upper third portion of the corridor. Construction also will include a security sally port and temporary access doors. It is anticipated that this project will reduce the Risk Level of the corridor from the current Level V to a Level III. The \$442,000 requested is for the development of working drawings. This project received \$325,000 in 2014 for the development of preliminary plans and Department of Finance expects that there will be a follow-up request next year for actual construction.

Courtyard Expansion at Coalinga (\$219,000). This proposal is for resources to design and construct a secure treatment courtyard at Coalinga in addition to the current Main Courtyard area to include a walking/running track and open air space to accommodate the full capacity of the facility (1,500 individuals). The Main Courtyard is undersized and does not provide the needed space for group exercise, social interactions, and other outdoor activities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the administration to present these proposals and explain in which phase of the full project each proposal falls.

Staff Recommendation: Staff recommends holding these proposals open to allow for more time for input and analysis.

ISSUE 6: INVOLUNTARY MEDICATION BUDGET CHANGE PROPOSAL**PANELISTS**

- **Pam Ahlin**, Director and **Stephanie Clendenin**, Chief Deputy Director, DSH
- **Irene Briggs**, Chief Financial Officer, DSH
- **Han Wang**, Staff Finance Budget Analyst, Department of Finance
- **Carla Castañeda**, Principal Finance Budget Analyst, Department of Finance
- **Sarah Larson**, Fiscal & Policy Analyst, Legislative Analyst's Office

DSH is requesting 14.4 positions and \$3.2 million General Fund to implement an Involuntary Medication (IM) authorization process for the Not Guilty by Reason of Insanity (NGI) population.

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

The LAO states that, given the ruling in *In re Greenshields*, it is reasonable for the Governor's budget to propose some funding and staff to address the workload associated with the involuntary medication process for NGI patients. However, the LAO believes that the budget proposal does not sufficiently justify the estimated increase in workload in 2015–16. Thus, 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.

STAFF COMMENTS/QUESTIONS

The Subcommittee request DSH to present this budget change proposal.

Staff Recommendation: Staff recommends holding this item open to allow for more time for input and analysis.
