Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 5 Agenda

Senator Nancy Skinner, Chair
Senator Joel Anderson
Senator Jim Beall

Thursday, March 16, 2017
9:30 a.m. or upon adjournment of Session
State Capitol - Room 113

Consultant: Julie Salley-Gray

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PROPOSED FOR VOTE ONLY

0530 HEALTH AND HUMAN SERVICES AGENCY – OFFICE OF LAW ENFORCEMENT SUPPORT (OLES)

1. **Information Technology and Leased Vehicle Funding.** The proposed budget requests $271,000 in 2016-17 and $146,000 ongoing General Fund for information technology and leased vehicles. Specifically, OLES requests funding to cover operating expenses for leased vehicles and contract costs for reengineering, implementation, licensing and support of their information technology systems.

5225 DEPARTMENT OF CORRECTIONS AND REHABILITATION (CDCR)

2. **Mental Health Crisis Beds.** The proposed budget includes a General Fund savings of $9.2 million General Fund and a reduction of 62.4 positions because CDCR was unable to activate 32 mental health crisis beds at the California Men's Colony.

ITEMS TO BE HEARD

0530 HEALTH AND HUMAN SERVICES AGENCY (HHSA) – OFFICE OF LAW ENFORCEMENT SUPPORT

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

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

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

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

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

The report also included the following recommendations for next steps:

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

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

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

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

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

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

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

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

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

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

Current Budget. Current funding for OLES is $2.7 million per year, which funds 21 permanent positions.

Issue 1: Overview of Findings from First Year of Semi-Annual Reports

Background. Similar to the OIG's semi-annual reports on CDCR, OLES is required to report semi-annually to the Legislature on the following:

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

Between July 1, 2016, and December 31, 2016, OLES reviewed 832 incident reports. The incidents included alleged misconduct by state employees, serious offenses between facility residents and reports of resident pregnancies and deaths. Of those incidents, OLES found that 230 of them required investigations and/or monitoring. For the full calendar year, 1,662 incidents were reported to OLES, which equates to more than four incidents a day, seven days a week. The number of incidents was more than double the number projected by OLES when it first began monitoring DSH and DDS.

The largest number of reported incidents from both departments involved allegations of abuse. Almost half of the reported incidents met the criteria for OLES to investigate and/or monitor. At DSH, the second largest category of incidents during the reporting period was allegations of sexual assault. Slightly over forty percent of the reports involved a patient sexually assaulting another patient.

As a result of the first year of oversight, OLES has made 39 recommendations to the departments – 19 at DSH and 20 at DDS.

Staff Recommendation. This is an oversight item. No action is necessary at this time.

4440 Department of State Hospitals and 5225 Department of Corrections and Rehabilitation

Issue 2: *Coleman* Overview

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

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

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

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

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

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[1] Historical background from The Stanford Law School Three Strikes Project, “When Did Prisons Become Acceptable Mental Healthcare Facilities?”
[2] Legislative Analyst’s Office “Major Milestones: 43 Years of Care and Treatment of the Mentally Ill”, March 2, 2000.

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

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

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

The Legislature also passed the Investment in Mental Health Wellness Act, SB 82 (Senate Budget and Fiscal Review Committee), Chapter 34, Statutes of 2013. The bill authorized the California Health Facilities Financing Authority (CHFFA) to administer a competitive selection process for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources. The budget provided $142 million General Fund for these grants. In addition, the bill implemented a process by which the Mental Health Services Oversight and Accountability Commission (MHSOAC) allocates funding for triage personnel to assist individuals in gaining access to needed services, including medical, mental health, substance use disorder assistance and other community services. The proposed 2017-18 budget provides $67 million ($45 million MHSA State Administrative Funds and $22 million federal funds) in on-going funding for this purpose.

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

Ralph Coleman, et al. v. Edmund G. Brown Jr, et al. Primarily because the prison system was severely overcrowded and the provision of mental health treatment was significantly lacking for inmates in need, a class action suit was filed in the United States District Court in 1991 arguing that prisoners with mental illness were subjected to cruel and unusual punishment, a violation of the inmates eighth amendment protections.

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

In 1995, following a 39-day trial, District Court Judge Lawrence Karlton found that current treatment for mentally ill inmates violated those inmates' eighth amendment protections against cruel and unusual punishment. Judge Karlton found "overwhelming evidence of the systematic failure to deliver necessary care to mentally ill inmates" who, among other illnesses, "suffer from severe hallucinations, [and] decompensate into catatonic states." Although a special master was appointed by the court to oversee implementation of a remedial plan, the situation continued to deteriorate, according to periodic reports from the special master.[3] Twenty-five years after the federal suit was filed, the state remains under the control of the federal court in *Coleman v. Brown* and is under regular review and oversight by the special master.

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

What follows is a detailed timeline of the major events related to *Coleman v. Brown* over the last 25 years.

Major Milestones in the *Coleman v. Brown* case

Year	Event
1991	The *Coleman* class-action lawsuit was filed in U.S. District Court, Eastern District, alleging that mental health care in state prisons violated the Eighth Amendment's ban of cruel and unusual punishment.
1995	The *Coleman* court found that the State was deliberately indifferent to the mental health needs of inmates in violation of the Eighth Amendment. A special master was appointed.
1997	The *Coleman* court approved a plan to address the inadequacies in mental health care.
2006	Plaintiffs in the *Plata* and *Coleman* cases requested the convening of a Three-Judge Panel to review whether overcrowding was the primary cause of the failure to provide adequate medical and mental health care.
2008	The Three-Judge Panel trial took place.

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

Year	Event
2010	The Three-Judge Panel ordered the state to reduce its adult institution population to 137.5 percent of design capacity within two years and according to a schedule of four benchmarks at six-month intervals. The State appealed to the U.S. Supreme Court.
2011	In April, Public Safety Realignment, AB 109 (Committee on Budget) Chapter 15, Statutes of 2011, designed to bring about a significant reduction in the prison population, was enacted. It eventually reduced the adult institution population by 25,000.
2011	In May, the U.S. Supreme Court affirmed the Three-Judge Panel's order.
2013	In January, Governor Brown filed a motion to terminate the *Coleman* lawsuit and to end the requirement to reduce the prison population to 137.5 percent of design capacity. The *Coleman* court denied this motion.
2013	In May, the plaintiffs filed a motion in court alleging the unconstitutional use of force and an inadequate discipline process against the *Coleman* class members.
2013	In July, the court ordered the special master to monitor the psychiatric programs run by the Department of State Hospitals, particularly in regards to the adequacy of staffing and the use of handcuffs at all times for patients who are out of their cells.
2013	In December, the court ordered the state to develop a long-term solution for providing inpatient care for condemned inmates currently housed on California's death row.
2014	In April, the *Coleman* court ruled that California's use of force and segregation of mentally ill inmates violated the inmate's 8th amendment rights.
2014	In May, the special master released his report on the adequacy of inpatient mental health care, including the psychiatric programs run by DSH. The special master also filed an assessment of the San Quentin plan to provide inpatient care for condemned inmates and the court provided additional reporting orders.
2014	In August, the court issued further orders regarding segregation and use of force.
2015	In January, the Governor's budget proposal included a request related to complying with the 2014 court orders. In addition, the special master released his report on suicide prevention practices.
2015	Under the guidance of the court, CDCR made revisions to its Rules Violation Report (RVR) process.
2015	In July, the special master learned that despite having 256 low-custody treatment beds at DSH-Atascadero, the average monthly number of inmate admissions was "a mere nine patients." In August, the court ordered the *Coleman* parties to appear for a status conference.
2016	In May, the special master submitted both his 26th Round Monitoring Report on Compliance with Provisionally Approved Plans, Policies and his monitoring report on Mental Health Impatient Care Programs for Inmates.
2017	On March 8 the *Coleman* court accepted the findings in the special master's report on inpatient care programs and adopted in full the majority of his recommendations.

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

State Prison Population. CDCR is responsible for the incarceration of the most serious and violent adult felons, including the provision of training, education, and health care services. As of March 8, 2017, CDCR housed about 117,842 adult inmates in the state's 35 prisons and 43 fire camps. Over 114,000 of those inmates are in state prisons, which results in those institutions currently being at 134.3 percent of their design capacity. Approximately 4,318 inmates are housed in out-of-state contracted prisons, 6,086 are housed in in-state contracted facilities, and 3,567 are housed in fire camps. CDCR also supervises and treats about 45,000 adult parolees. Approximately 29.5 percent of inmates have been treated for severe mental illnesses within the last year.

The *Coleman* Class. As of March 6, 2017, there are currently 38,124 inmates in the *Coleman* class (35,681 men and 2,443 women). According to a December 24, 1998, court ruling on the definition of the class, the plaintiffs' class consists of all inmates with serious mental disorders who are now, or who will in the future, be confined within CDCR. A "serious mental disorder" is defined as anyone who is receiving care through CDCR's Mental Health Services Delivery System (MHSDS).

MHSDS provides four levels of care, based on the severity of the mental illness. The first level, the Correctional Clinical Case Management System (CCCMS), provides mental health services to inmates with serious mental illness with "stable functioning in the general population, an administrative segregation unit (ASU) or a security housing unit (SHU)" whose mental health symptoms are under control or in "partial remission as a result of treatment." As of March 6, 2017, 28,917 inmates with mental illness were at the CCCMS level-of-care.

The remaining three levels of mental health care are for inmates who are seriously mentally ill and who, due to their mental illness, are unable to function in the general prison population. The Enhanced Outpatient Program (EOP) is for inmates with "acute onset or significant decompensation of a serious mental disorder." EOP programs are located in designated living units at "hub institution[s]." As of March 6, 2017, 7,451 inmates with mental illness were receiving EOP services and treatment.

Mental health crisis beds (MHCBs) are for inmates with mental illness in psychiatric crisis or in need of stabilization pending transfer either to an inpatient hospital setting or a lower level-of-care. MHCBs are generally licensed inpatient units in correctional treatment centers or other licensed facilities. Stays in MHCBs are limited to not more than ten days. Currently, there are 375 inmates receiving this level-of-care.

Finally, several inpatient hospital programs are available for class members who require longer-term, acute care. These programs are primarily operated by the Department of State Hospitals (DSH), with the exceptions of in-patient care provided to condemned inmates and to female inmates. There are three inpatient psychiatric programs for male inmates run by DSH that are on the grounds of state prisons. Those programs are DSH-Stockton, on the grounds of the Correctional Healthcare Facility; DSH-Vacaville, on the grounds of Vacaville State Prison; and DSH-Salinas Valley, on the grounds of Salinas Valley State Prison. There are currently approximately 1,100 patients in those facilities and the DSH budget for those inmates is approximately $250 million General Fund per year. As of March 6, 2017, 1,381 inmates were receiving inpatient care, 44 of those patients were women receiving care at the California Institution for Women (CIW) and 37 were condemned inmates housed at San Quentin State Prison. The remaining 1,300 are receiving care in a DSH facility.

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

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

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

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

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

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

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

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

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

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

2016 Special Master's Report on the Mental Health Inpatient Care Programs for Inmates. As a follow up to the May 2014 report discussed previously, the special master released an updated report on inpatient care on May 25, 2016. In that report, the special master noted that the issue surrounding the transfer of *Coleman* inmate-patients to the least restrictive level-of-care discussed over two decades-ago remained a problem. Specifically, the 256 beds at Atascadero State Hospital designated for *Coleman* class members remained underutilized, despite the existence of a waiting list for inpatient care. In addition, the report expresses frustration with CDCR for raising the concept of taking over inpatient treatment for at least the last decade without following through. The report notes, "Each time the concept is raised but not followed through, the time and attention expended are wasted."

The report also notes the success of the California Institution for Women (CIW) psychiatric inpatient program and the San Quentin inpatient program. The special master states that the programs have taken root and are maturing as viable, successful programs. He further states that from a long-term perspective, they indicate some level of promise for CDCR's potential to successfully assume more responsibility for the inpatient care of its inmates. He writes that in building and maintaining these two inpatient programs, CDCR has learned much first-hand about operating its own inpatient programs at its prisons. Finally, he states, "If CDCR is serious about a 'lift and shift' at the three DSH psychiatric programs, now is the time for CDCR to proceed in that direction."

Regarding the other inpatient programs, the special master found areas of concern including vacancy rates that remained high in the area of psychiatrists and psychologists (for example, a 68 percent psychiatry vacancy at Atascadero, which was reduced to a 37 percent functional rate due to the use of contract staff). In contrast, both the CIW and San Quentin programs did not have any vacancies in the area of psychiatrists and psychologists during the report period. In addition, the report found the use of treatment teams to develop individual treatment plans is lacking in the facilities run by DHS. In addition, the time and effectiveness of both group therapy and individual treatment were also lacking. Areas of concern for each facility are highlighted below.

DSH-Atascadero

- At the time of their review, 41 percent of the beds designated for *Coleman* patients were filled by non-*Coleman* patients.
- Behavioral therapy-based treatment plans were used minimally and not available to all patients for which they were clinically indicated.
- The hospital characterized discharge planning as "burdensome" and reported that it was difficult to make contact with CDCR's coordinators and correctional counselors.

DSH-Coalinga

- At the time of the review, the program had a 33 percent vacancy rate for psychiatrists but all psychology and social work positions were filled.
- Group therapy was by far the predominant treatment modality, comprising 99.7 percent of treatment.
- The average length of stay for *Coleman* patients was 288 days.

DSH-Salinas Valley

- Staff noted that the underutilization of individual therapy was due to insufficient staffing and the facility's requirement that they use medical technical assistants (MTAs), custody officers with medical training, to escort patients.
- MTAs remain in the room during individual therapy sessions, rather than standing outside the door.
- Even when clinically indicated, the facility underutilized behavioral plans and behavioral interventions.

DSH-Vacaville

- At the time of the review, the program had a vacancy rate of 12 percent for psychiatry; 26 percent for psychology; 24 percent for social work; 39 percent for senior RNs; and 70 percent for psychiatric technicians.
- Numerous administrative and supervisory clinical positions were vacant or filled by staff in acting capacities.
- Acute care patients reported that individual therapy was not available and, except for occasional cell-front assessments, psychiatry meetings only occurred within the treatment team setting.

DSH-Stockton

- In numerous cases, patients receiving acute treatment were assigned diagnoses without supporting documentation or evidence discernible from their records.
- Patients receiving acute treatment received very little out-of-cell treatment, which is inadequate for patients in that level of care, and particularly so in cases where treatment plans are insufficiently individualized.
- Treatment plans were overly vague and could not reasonably expected to work as a platform for actionable treatment interventions, objectives, and goals.

California Institution for Women Psychiatric Inpatient Program (CDCR)

- There were no clinical staff vacancies at the time of the review.
- Patients received an average of one hour per week of individual therapy and were offered approximately 15 hours a week of group therapy.
- No patients had access to jobs or educational classes.
- A performance improvement committee met monthly and established performance improvement goals.

San Quentin Condemned Inmate Psychiatric Inpatient Program (CDCR)

- The facility met or exceeded established clinical staffing ratios.
- Patients in both the acute care and intermediate care units received adequate and appropriate care.

- Some treatment plans were not individualized to include specific interventions to address identified mental health issues.
- Patients were offered unstructured out-of-cell activities including plans to offer unstructured yard time on completion of the construction of the yard.

As a result of the review of all of the inpatient programs, the special master provided the following recommendations:

1) CDCR and DSH and *Coleman* plaintiffs should meet in intervals of no less than 60 days to track and ensure appropriate mental health bed utilization.

2) DSH should continue to work on their staffing plan for their inpatient programs and they shall provide the special master with monthly updates on their implementation of their staffing plan.

3) DSH should develop a plan within 90 days for the creation of a continuous quality improvement process.

4) DSH should develop within 90 days a plan for the creation of a consistent and uniform patient level system to be utilized across all of its inpatient programs.

On March 8, 2017, the *Coleman* court adopted all but the first recommendation.

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

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

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

which is 50 percent more than the current ten hours. In the longer-term restricted housing, male and female inmates will be allowed 15 hours a week in out-of-cell time.

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

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

On March 8, 2017, the court entered an order adopting the second, third and fourth recommendations in the special master's *Monitoring Report on the Mental Health Inpatient Care Programs for Inmates.*[4] In addition, the order required DSH to continue working on developing staffing plans, a continuous quality improvement process, and the creation of a consistent and uniform patient level system to be utilized across all of its inpatient programs that treat *Coleman* class members. [5]

Staff Recommendation. This is an oversight item. No action is necessary at this time.

[4] ECF No. 5448

[5] ECF No. 5573

Issue 3: Transfer of Immediate and Acute Levels of Care from DSH to CDCR

Governor's Budget. The Governor's budget proposes to shift responsibility for the three inpatient psychiatric programs DSH operates in state prisons to CDCR beginning in 2017-18. Accordingly, the budget proposes a transfer of $250 million (General Fund) and 1,978 positions from DSH to CDCR effective July 1, 2017. Almost 90 percent of these positions are for treatment staff, including 495 psychiatric technicians and 374 registered nurses. The remaining 10 percent are administrative positions. According to the Administration, having CDCR operate these inpatient psychiatric programs would reduce the amount of time it takes for an inmate to be transferred to a program as only CDCR staff would need to approve referrals for the beds. Specifically, the Administration expects that the time needed to process an intermediate care facility (ICF) referral will decline from 15 business days to nine business days and from six business days to three business days for acute treatment program (ATP) referrals.

For the next two years, CDCR plans to operate the three inpatient psychiatric programs in the same manner as DSH. For example, CDCR plans to use identical staffing packages and classifications to provide care and security. The department indicates that it will assess the current staffing model during these two years and determine whether changes to these programs are necessary. The Governor does not propose shifting responsibility for the 306 beds in DSH-Atascadero and DSH-Coalinga that serve low-custody ICF inmates. According to the Administration, CDCR does not currently have sufficient capacity to accommodate the inmates who are housed in these beds. However, the Administration indicates that the long-term plan is to shift these inmates to CDCR when capacity becomes available.

Background. As discussed in the previous item, several inpatient hospital programs are available for inmates who are members of the *Coleman* class who require longer-term, acute care. These programs are primarily operated by DSH, with the exceptions of in-patient care provided to condemned inmates and to female inmates. There are three inpatient psychiatric programs for male inmates run by DSH that are on the grounds of state prisons. Those programs are DSH-Stockton, on the grounds of the Correctional Healthcare Facility; DSH-Vacaville, on the grounds of Vacaville State Prison; and DSH-Salinas Valley, on the grounds of Salinas Valley State Prison. There are currently approximately 1,100 patients in those facilities and the DSH budget for those inmates is approximately $250 million General Fund per year. As of March 6, 2017, 1,381 inmates were receiving inpatient care, 44 of those patients were women and 37 were condemned inmates housed at San Quentin State Prison. The remaining 1,300 are receiving care in a DSH facility.

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

The San Quentin PIP is a 40-bed, fully-licensed, Joint Commission-accredited program that provides long-term acute and intermediate levels of psychiatric inpatient care to male condemned patients. Its mission is to provide effective and evidence-based psychiatric treatment to relieve or ameliorate acute

and refractory mental health disorders that disrupt the patients' expected level of functioning in the prison environment.

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

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

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

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

Legislative Analyst's Office (LAO). Given the uncertainty as to whether or not the proposed shift in responsibility would result in more cost-effective care being delivered, LAO recommends that the Legislature reject the Governor's proposal and instead shift a limited number of beds over a three-year period. Specifically, LAO recommends the Legislature implement a pilot program in which CDCR would provide inpatient psychiatric care to a portion of inmates who would otherwise get their care from DSH. Such a pilot would allow the Legislature to determine (1) whether wait times for these programs decrease as expected, (2) what particular staffing changes need to be made and the cost of making those changes, and (3) the effectiveness of the treatment provided. The LAO recommends that the pilot include both ICF and ATP units and be operated at more than one facility. For example, CDCR could have responsibility for an ATP unit at CHCF and an ICF unit at CMF. This would ensure that the pilot can test CDCR's ability to operate multiple levels of care at multiple facilities. In

addition, the LAO recommends that the pilot include one unit that is currently being operated by DSH, and one new unit that would be operated by CDCR.

In order to ensure that the Legislature has adequate information after the completion of the pilot to determine the extent to which inpatient psychiatric program responsibilities should be shifted to CDCR, LAO recommends that the Legislature require CDCR to contract with independent research experts, such as a university, to measure key outcomes and provide an evaluation of the pilot to the Legislature by January 10, 2019. These key outcomes would include how successfully CDCR was able to return inmates to the general population without additional MHCB or inpatient psychiatric program admissions, whether wait times decreased, and the cost of the care provided. The LAO estimates the cost of this evaluation to be around a few hundred thousand dollars.

Staff Comments. In recent years the Senate has expressed concern with the appropriateness of having DSH provide mental health treatment to CDCR's inmates. Under the current system, the special master has found that DSH is providing an inadequate level of treatment both due to lack of available staffing and out of apparent fear of the dangers related to providing services and treatment to inmates; the clear demonstration by CDCR that they are better suited to treat even the most potentially dangerous inmate patients, as evidenced by the robust services and treatment being provided to condemned inmate-patients at the San Quentin PIP; and the fact that CDCR does not appear to take a holistic approach to meeting increases in the need for care when the program is bifurcated between DSH and CDCR. On top of those issues, there appears to be an ambiguity regarding the healthcare provided to the *Plata* class inmates being housed in the co-located DSH PIP facilities needs to meet the same standards of care as that in CDCR's state-run prisons.

The Governor's proposal consists of a shift of the existing programs and the existing personnel from DSH to CDCR. While this is a positive step in terms of CDCR's ability to seamlessly provide care for inmates throughout their mental health system, it is unclear that just shifting the programs as they are currently structured will fundamentally improve the level of care being provided. The Administration notes that the initial transfer is just the first step in a multi-year effort to improve the quality of care. The committee may wish to continue to closely monitor the progress CDCR is making in improving the quality of care provided to inmates with acute mental health needs, with the expectation that CDCR will ultimately provide the same robust level of care that is currently provided at the San Quentin facility to all inmates in the *Coleman* class.

Staff Recommendation. Approve as budgeted.

5225 DEPARTMENT OF CORRECTIONS AND REHABILITATION

Issue 4: California Medical Facility – Psychiatric Inpatient Program

Governor's Budget. The budget requests $11.4 million General Fund to convert an enhanced outpatient unit into a 74-bed intermediate care facility (ICF) at the California Medical Facility.

Background. Inpatient psychiatric programs are operated in both state prisons and state hospitals. There are a total of 1,547 inpatient psychiatric beds. There are two levels of inpatient psychiatric programs:

> ***ICF.*** ICFs provide longer-term treatment for inmates who require treatment beyond what is provided in CDCR outpatient programs. Inmates with lower security concerns are placed in low-custody ICFs, which are in dorms, while inmates with higher security concerns are placed in high-custody ICFs, which are in cells. There are 784 ICF beds, 700 of which are high-custody ICF beds in state prisons. In addition, there are 306 low-custody ICF beds in state hospitals.
>
> ***Acute Treatment Programs (ATPs).*** ATPs provide shorter-term, intensive treatment for inmates who show signs of a major mental illness or higher level symptoms of a chronic mental illness. Currently, there are 372 APP beds, all of which are in state prisons.

In addition to these beds, there are 85 beds for women and condemned inmates in state prisons that can be operated as either ICF or ATP beds. As of January 2017, there was a waitlist of over 120 inmates for ICF and ATP beds.

Legislative Analyst's Office (LAO). Given that there is currently a 120 inmate waitlist for inpatient psychiatric beds, the proposal to provide 74 additional beds appears justified on a workload basis. The LAO also notes that activating these additional beds could help reduce the amount of time that inmates on the waitlist spend in comparatively more expensive MHCBs.

Staff Recommendation. Approve as budgeted.

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*

	2016-17	2017-18
Population by Hospital		
Atascadero	1,258	1,225
Coalinga	1,293	1,303
Metropolitan	807	807
Napa	1,269	1,269
Patton	1,527	1,507
Subtotal	**6,154**	**6,121**
Population by Psych Program		
Vacaville	392	0
Salinas	235	0
Stockton	480	0
Subtotal	**1,107**	**0**
Population Total	**7,261**	**6,121**
Population by Commitment Type		
Incompetent to Stand Trial (IST)	1,552	1,530
Not Guilty By Reason of Insanity (NGI)	1,421	1,404
Mentally Disordered Offender (MDO)	1,322	1,325
Sexually Violent Predator (SVP)	920	920
Lanterman-Petris-Short Act – Civil Commitments	625	628
Coleman Referral – Hospitals	306	306
Coleman Referral – Psych Programs	1,107	0
Department of Juvenile Justice	8	8
Jail-Based Competency Contracted Programs		
San Bernardino/Riverside ROC	40	40
San Bernardino JBCT	76	76
Sacramento JBCT	32	32
San Diego JBCT	25	30
Sonoma JBCT	10	10
Kern Admission, Evaluation, and Stabilization Center	0	60
Total	183	248

*The caseloads in this table are from the DSH 2017-18 January budget binder and reflect the estimated number of cases on the last Wednesday of the fiscal year. On average, the Governor's budget documents show an average daily caseload of 6,369 in 2017-18.

State Hospitals Budget

The Governor's proposed budget includes $1.6 billion for DSH in 2016-17 ($1.4 billion General Fund). This represents a $278 million decrease over 2016-17 funding. The proposed budget year position authority for DSH is 8,550 positions, a decrease of 1,932 positions from the current year. This decrease in funding and positions is a result of the proposed transfer of acute care treatment for CDCR inmates from DSH to CDCR.

(dollars in thousands)

Funding	2015-16 Actual	2016-17 Projected	2017-18 Proposed
General Fund (GF)	$1,606,390	$1,727,968	$1,443,593
Reimbursements	136,714	140,284	146,490
CA Lottery Education Fund	24	21	21
Total	$1,743,128	$1,868,273	$1,590,104
Positions	10,974	10,482	8,550

Issue 5: Incompetent to Stand Trial and Jail-based Competency Proposals

Governor's Budget

Admission, Evaluation and Stabilization (AES) Center. The Governor's budget for 2017-18 proposes to establish an AES Center, which would be located in the Kern County Jail. Specifically, the budget proposes a $10.5 million General Fund augmentation and two positions for DSH to activate 60 beds in the Kern County Jail in Bakersfield to provide restoration services for IST patients. This works out to be a cost of $175,000 per bed. According to the Administration, the AES Center would be used to screen jail inmates in Kern County, as well as some other Southern California counties, found to be incompetent to stand trial (IST) and determine whether they require the intensive inpatient treatment offered at state hospitals. If a patient does not require state hospital treatment, they would be treated at the AES Center. DSH would contract with Kern County to provide custody and treatment services to patients in the center.

The Administration is proposing budget trailer legislation to give DSH the authority to send any patient committed to DSH to the AES Center, even if that patient is not specifically committed to the AES Center by a judge. DSH indicates that this would generally allow the department, rather than trial court judges, to determine who is appropriate for the AES Center.

Jail-Based Competency Treatment Program. Due to the delayed activation of jail-based competency treatment (JBCT) programs in San Diego and Sonoma counties, the budget includes a General Fund savings of $948,000 in 2016-17 and $159,000 in 2017-18.

Background. When a judge deems a defendant to be incompetent to stand trial (IST), 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, with a 10 percent annual increase in IST referrals from courts to DSH. Currently, there are 525 ISTs on the waiting list. 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.

Jail-Based Competency Treatment 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, pursuant to 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.

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

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

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

Recent JBCT Program Expansions. During 2015, DSH expanded the JCBT program to include an additional 76 beds in the San Bernardino County Jail to primarily serve Los Angeles County IST patients. In addition, the Sacramento County Jail has a partnership with the University of California, Davis to run a 32-bed JBCT program to serve IST patients from Sacramento, Fresno, and San Joaquin counties.

Currently, there are 148 JBCT beds throughout the state in Riverside, San Bernardino and Sacramento counties. The majority of the beds, 96, are in San Bernardino County. As noted above, the budget proposes adding an additional 40 beds, 30 in San Diego and 10 in Sonoma. Finally, DSH is working with Mendocino County to develop a small bed model that will be flexible in scope and able to serve a small number of IST patients. This small-county model is intended to serve as a template for other counties with low IST patient referral rates.

Legislative Analyst's Office (LAO). In light of the IST waitlist and the lower cost of providing treatment through the contract with Kern County, the LAO recommends that the Legislature approve the funding and positions requested by the department. They also recommend the Legislature revise the proposed budget trailer legislation to give DSH the authority to determine who is admitted to JBCT programs. Such a change would help achieve the intended goals of the proposed AES Center, but in a much broader way that maximizes the number of patients that receive treatment without waiting for a bed in a state hospital and reduces future state costs.

Staff Comments. Expanding programs that allows people who have been deemed incompetent to stand trial by reason of insanity, to receive mental health services in the county jail or community-based facility, rather than being transferred to a state hospital, should help to reduce the IST waiting list for placement 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 a jail, 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, the JBCT program is only available in a county jail setting and not in community mental health facilities, despite language that allows for restoration of competency in either or jail or *a community setting*. 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 JBCT 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 JBCT program, the subcommittee may wish to explore ways of more quickly and efficiently expanding the number of JBCT beds.

The creation of an AES center designed to further assess individuals before they reach the state hospitals, appears to be a reasonable strategy for reducing the IST waiting list. In addition, it suggests that after many years of the Legislature urging DSH to establish competency programs outside of the state hospitals, DSH has begun to embrace the philosophy that not every person who has been found to be incompetent to stand trial needs to be in a state hospital setting in order to be successfully returned to competency.

Staff Recommendation. Approve the proposed budget and adopt the proposed trailer bill as placeholder language with the intention to modify the language based upon the LAO's recommendation.

Issue 6: Enhanced Treatment Program Staffing

Governor's Budget. In order to implement Assembly Bill 1340 (Achadjian) Chapter 718, Statutes of 2014, DSH is requesting staff and resources the Enhanced Treatment Program (ETP). DSH notes that the ETP will provide treatment for patients who are at the highest risk of violence and who cannot be safely treated in a standard treatment environment.

DSH plans to establish three 13-bed ETP units at DSH-Atascadero and one 10-bed ETP unit at DSH-Patton. DSH is requesting $2.3 million in one-time funding and $5.6 million ongoing to support the activation of the first two ETP units at DSH-Atascadero, as well as 44.7 positions in FY 2017-18 and 115.1 positions in FY 2018-19. Resources for DSH-Atascadero's third unit and DSH-Patton's unit will be requested in the FY 2018-19 Governor's budget estimate.

Background. The state hospitals were initially designed to accommodate a population that did not exhibit the same level of violence that the hospitals face today. Currently, 92 percent of the population has been referred to the state hospitals by the criminal justice system. Consequently, evidence reveals an increasing rate of aggression and violent incidents at state hospitals.

The Administration argues that, in spite of this significant change in the state hospitals' patient population, there is currently no legal, regulatory, or physical infrastructure in place for 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 a short-term and 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 DSH states is labor intensive and does not necessarily improve safety.

DSH received funding to retrofit existing facilities to establish enhanced treatment units (ETUs) to provide a secure, locked environment to treat patients that become psychiatrically unstable, resulting in highly aggressive and violent behavior toward themselves, other patients, or staff. According to DSH, 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 has operated an ETU at Atascadero State Hospital since 2011. This pilot project is distinguished from the existing enhanced treatment program in that it allows DSH to lock individual patients in their rooms. Under the current enhanced treatment program, patients are not in locked rooms.

Violence in DSH. DSH has experienced a decrease in the number of violent incidents between 2010 and 2015. DSH reports that violence predominantly comes from repeat aggressors, reporting that one percent of patients are responsible for 35 percent of DSH violence. The state hospitals have utilized programming, which the department attributes to the overall reduction in the numbers of both patient-aggressors and patient-victims.

According to DSH, in 2015, there were a total of 3,758 patient-on-patient assaults and 2,586 patient-on-staff assaults at state hospitals. Of the 9,948 patients treated in the state hospitals in 2015, 77 percent were non-violent, 22 percent committed 10 or fewer violent acts, and one 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, 32 patients, commits the majority of aggressive acts. Assaults for the previous years are as follows: 3,486 patient-on patient-and 2,745 patient-on-staff in 2014; 3,372 patient-on-patient and 2,591 patient-on-staff in 2013; 3,844 patient-on-patient and 3,041 patient-on-staff in 2012; 4,075 patient-on-patient and 2,837 patient-on-staff in 2011; and 4,658patient-on-patient and 2,691 patient-on-staff in 2010.

DSH notes that they are committed to reducing violence in its system. DSH has implemented a number of measures to reduce violence and increase safety for staff and patients. Most notable, DSH implemented personal duress alarm systems at each of its five state hospitals, develop the California Violence Assessment and Treatment Guidelines (Cal-VAT), and conducts violence risk assessments on its patients.

Enhanced Treatment Unit Pilot Project at Atascadero State Hospital. DSH issued a report in May 2013, *Enhanced Treatment Unit: Annual Outcome Report*, on the pilot project at Atascadero, which has operated since December 2011, but does not allow for locked doors. The goal of the ETU is to decrease psychiatric symptoms of some of the most violent patients in order to enable DSH to simultaneously assist the patients in their recovery, and increase safety in the facility. Patients must meet certain criteria, based on the patient's mental illness and psychiatric symptoms, before being admitted to the ETU. DSH reviews patient referrals to determine if patients meet the following entrance criteria:

- The patient engages in pathology-driven behaviors.
- The patient engages in recurrent aggressive behaviors that have been unresponsive to mainstream therapeutic interventions.
- The patient commits a serious assaultive act that results in serious injury.

The report concludes that the ETU has been successful in decreasing aggressive incidents and that the program as a whole is likely effective. Some of the contributing factors cited include staff with expertise in treating difficult patients and decreased staff-to-patient ratios; the presence of the Department of Police Services (Atascadero state hospital law enforcement); and the "calm milieu" of the ETU, which is attributed to the added staff with greater expertise in treating difficult and violent patients, i.e., the staff reacts to an incident in a manner that does not escalate the situation that may otherwise result in a violent act. While successful, DSH states that the Atascadero ETU accepts only those with Axis 1 diagnoses, such as schizophrenia, major depression, bipolar, and schizoaffective disorder. The Atascadero ETU intentionally avoids patients with Axis 2 diagnoses, which are various types of personality disorders that are often present in the patients involved in predatory violence. Patients with Axis 2 diagnoses have been involved in three recent murders of staff and patients, and are the patients the ETPs will treat.

AB 1340 (Achadjian) Chapter 718, Statutes of 2014. This legislation permitted the DSH to establish and administer a pilot enhanced treatment program (ETP) at each state hospital, for the duration of five calendar years, for testing the effectiveness of treatment for patients who are at high risk of the most dangerous behavior. In addition, it authorized ETPs to be licensed under the same requirements as acute psychiatric hospital and makes significant changes to current requirements and procedures related to the admission of patients and the administration of care. This legislation provides the necessary policy guidance for the development and running of potentially locked ETUs in the state

hospitals. The legislation required DSH 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. The policies and procedures are also required to provide all of the following:

1) Criteria and process for admission into an ETP pursuant to Section 4144 of the Welfare and Institutions Code.

2) Clinical assessment and review focused on behavior, history, high risk of most dangerous behavior, and clinical need for patients to receive treatment in an ETP as the least restrictive treatment environment.

3) A process for identifying an ETP along a continuum of care that will best meet the patient's needs, including least restrictive treatment environment.

4) A process for creating and implementing a treatment plan with regular clinical review and reevaluation of placement back into a standard treatment environment and discharge and reintegration planning as specified in subdivision (e) of Section 4144 of the Welfare and Institutions Code.

Use of Solitary Confinement. There are a variety of treatment options to address aggressive patient behavior within the state hospitals. While levels of security (ie. strong boundaries, a highly structured environment, and a lack of access to dangerous materials) are essential in addressing violence, experts caution against the use of solitary confinement as it may contribute to a patient's mental distress and may seem punitive. Experts therefore suggest avoiding seclusion, physical restraint, and sedation whenever possible. If necessary, ETUs should only be used if the patient remains unresponsive to all other therapeutic interventions available in a standard treatment setting.

In fact, it is widely accepted that solitary confinement of people with mental health disorders can cause those illnesses to worsen. Psychological research has found that a lack of social interaction can lead segregated housing unit inmates in prison to suffer from a variety of psychological and psychiatric illnesses. These can include chronic insomnia, panic attacks, and symptoms of psychosis (including hallucinations).

As discussed previously, the *Coleman* special master's investigation of programs for mentally ill inmates run by DSH found that patient-inmates at the Stockton State Hospital complained of being confined to their cells 21 to 22 hours per day and received very little human interaction or treatment, despite the damaging effects of confinement for people who are mentally ill. However, this report involved inmates who are in prison and being treated for a mental illness and the ETUs are designed for state hospital patients who are not inmates. Presumably, DSH will develop regulations and protocols that will prevent patients in an ETU from being confined to their room without human interaction for an extended period of time. However, the department does not have those written policies available at this time.

Legislative Analyst's Office (LAO)

Permanent Positions and Funding Not Necessary Given Pilot Is Only for Four Years. The Administration is requesting ongoing funding and positions to operate ETP units. However, AB 1340 only authorizes each ETP unit to operate for four years. To the extent that the required evaluation of each ETP unit finds that the program is effective, the Legislature could consider providing ongoing funding to operate the units as part of its budget deliberations in future years. Thus, the LAO finds that it is premature at this time to provide the department permanent funding and positions for ETP units.

Required Evaluations Will Allow Legislature to Assess Whether Pilot Units Should Continue After Four Years. The statutorily required evaluations should allow the Legislature to assess the effectiveness of the ETP pilot units and the extent to which such units should continue and be expanded on an ongoing basis. While DSH is required to provide various data in the evaluation reports (such as the length of time patients spend in the program), the department is not specifically required to provide some of the key outcomes that are necessary to measure whether ETP units are effective at reducing violence in state hospitals. These key outcomes are (1) whether ETP patients are able to return to the general population without additional violent incidents, (2) the effect of ETP units on overall rates of patient violence, and (3) whether the ETP pilot units could be modified in order to improve these outcomes.

Approve Funding and Positions on Limited-Term Basis. In view of the above, the LAO recommends the Legislature approve the funding and associated positions for each of the first two ETP units on a limited-term basis as envisioned in AB 1340, rather than on an ongoing basis as proposed by the Governor.

Adopt Budget Trailer Legislation to Provide Additional Detail on Required Evaluations. The LAO recommends that the Legislature adopt budget trailer legislation to require DSH, as part of its annual evaluation reports on ETP units, to provide information on the following key outcomes: (1) whether ETP patients are able to return to the general population without additional violent incidents, (2) the effect of ETP units on overall rates of patient violence, and (3) whether ETP units could be modified to improve these outcomes.

Staff Comments. Despite the passage of the initial legislation in 2014, and requests from the Legislature in 2015 and again in 2016, DSH has not developed any written policies and procedures surrounding the ETP units. Absent the Legislature reviewing those written policies to ensure that they include appropriate patient protections and a limited use of locked rooms, the committee may wish to reject funding for activating ETP units, pending a thorough vetting of the policies and procedures.

Staff Recommendation. Due to the absence of written policies and procedures, reject funding for the ETP unit activation until such time as those policies are provided to the Legislature for review.

Issue 7: Provisional Language: State Hospital Financial Activity Report

Governor's Budget. The Administration proposes removing provisional language regarding the requirement for the Department of State Hospitals (DSH) to submit the annual report on state hospital financial activity. Their rationale is that the requirement was included in response to the transition from the Department of Mental Health (DMH) to DSH. According to the Administration, now that DSH operates all facilities in a more centralized manner, the need to compare across institutions is no longer necessary and preparing this report is time-consuming.

Legislative Analyst's Office (LAO)

2015-16 LAO Budget Report: Improved Budgeting for the Department of State Hospitals. For several years the Legislature has expressed concern regarding the lack of transparency in the DSH budget. In 2015, the LAO provided an in-depth review of DSH's budget and provided a series of recommendations for improving DSH's budgeting methodology. The following is a brief summary of their findings:

> *The state provides about $1.6 billion in funding to the Department of State Hospitals (DSH) to provide inpatient treatment to mental health patients in the eight DSH facilities. This includes funding for both clinical and nonclinical staff, as well as non–staff costs (such as food and clothing). In determining how much funding to request for the upcoming fiscal year, DSH uses the amount of funding it received in the state budget for the current year as a base budget or starting point. The department then requests adjustments to the base budget to account for projected increases or decreases in the patient population during the budget year.*
>
> ***DSH's Budgeting Process Has Several Shortcomings.*** *Based on our review, we find that the current DSH budgeting process has several shortcomings. Specifically, we find that (1) the department 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.*
>
> ***Redesigning DSH's Budgeting Process.*** *In view of the above findings, we make several recommendations to improve the DSH budgeting process. First, we recommend the Legislature require the department to establish or update several key components used to develop its budget to ensure that they are accurate and adequate. Second, we recommend that the Legislature direct DSH to use the updated information to develop its budget and staffing requests based on expected changes in the number and acuity (or level of care) of its patient population, as well as make adjustments to its budget if the actual population differs from its projections. Given the resources and time necessary to implement these recommendations, we also recommend that the Legislature require DSH to provide additional justification for its budget requests during the development and implementation of the new budgeting process. In combination, we believe our recommendations will (1) ensure that DSH receives the appropriate amount of funding to account for changes in its patient population and the services*

> *it provides, (2) improve incentives for the department to operate efficiently, and (3) allow the Legislature to provide increased oversight of DSH's budget and operations.*[6]

State Hospital Financial Activity Report. While the LAO understands that the state hospitals are operated in a more centralized fashion than used to be the case, they still think that the report provides useful information and do not think it should be eliminated entirely. However, it could be focused to provide the Legislature with more useful information. Some of the useful information already included in this report is the vacancy rates, overtime costs, and the total operating expenses and equipment (OE&E) costs. This allows the Legislature to get a picture how much it costs to operate a state hospital.

In addition, the LAO thinks including the following items would make the report more useful. Specifically, they would find the following three items useful: (1) Temporary help blanket positions by institution, (2) overtime breakdown between voluntary overtime and mandatory overtime (both hours and costs), and (3) vacancy rates for key positions by institution.

Staff Comments. Given the long-term concerns regarding DSH's budgeting practices and DSH's lack of improvement in its budgeting methodology, it appears unwise to remove any reporting requirements that may provide the Legislature with additional clarity and information as to how the department is using state General Fund dollars.

Staff Recommendation. Reject the removal of the provisional language and direct the LAO and Department of Finance to update the language to include the information recommended by the LAO. In addition, request that the LAO report on any improvements in the DSH budgeting process as it relates to their 2015 recommendations.

[6] Larson, Sarah. *The 2015-16 Budget: Improved Budgeting for the Department of State Hospitals*. Legislative Analyst's Office. January 1, 2015.

Issue 8: Conditional Release Program Funding

Governor's Budget

CONREP Transitional Housing Cost Increase ($976,000 GF). For the continuation of the Statewide Transitional Residential Program (STRP) for CONREP patients, DSH is requesting $976,000 in General Fund authority. STRP beds provide temporary housing to CONREP patients unable to live in the community without direct supervision. DSH activated 16 beds in FY 2016-17 and this request provides the ongoing funding for the continued operation of these beds.

CONREP Sexually Violent Predator (SVP) Program Cost Increase ($2.4 million GF). Based on anticipated court-ordered release dates, DSH estimates the cost of releasing two additional SVP patients (with housing available) and two additional transient SVP patients in FY 2017-18 to be $2.4 million. This funding will increase the current caseload for conditionally released SVPs from 19 in FY 2016-17 to 23 in FY 2017-18. Given the security requirements for this population, DSH is unable to absorb the cost increase with existing resources.

Background. The California Forensic Conditional Release Program (CONREP) oversees patients who have been conditionally released from DSH by a judge. DSH's medical directors recommend patients for release when their symptoms have been stabilized and they no longer present a danger to society. Only the courts have the authority to order a release. SVPs in CONREP receive an intensive regimen of treatment and supervision that includes at least weekly individual contact by supervision staff, specialized sex offender treatment, weekly drug screening, surveillance, polygraph examinations, and active Global Positioning System tracking.

CONREP was mandated as a state responsibility in 1984, and began operating in 1986. Its patients have typically experienced lengthy hospital stays and in some cases served full prison sentences. The goal of CONREP is to ensure public protection in California communities while providing an effective and standardized outpatient treatment system.

Most patients in the CONREP program have gotten there after a lengthy stay in a state hospital. Once psychiatric symptoms have been stabilized and the patients are considered no longer to be a danger, the state hospital medical director recommends eligible inpatients to the courts for outpatient treatment under CONREP.

Individuals must agree to follow a treatment plan designed by the outpatient supervisor and approved by the committing court. The court-approved treatment plan includes provisions for involuntary outpatient services. In order to protect the public, individuals who do not comply with treatment may be returned to a state hospital.

CONREP patients receive an intensive regimen of treatment and supervision that includes individual and group contact with clinical staff, random drug screenings, home visits, substance abuse screenings and psychological assessments. The department has performance standards for these services which set minimum treatment and supervision levels for patients in the program. Each patient is evaluated and assessed while they are in the state hospital, upon entry into the community, and throughout their CONREP treatment.

The state budget provides 100 percent of the funding for CONREP's intensive level of assessment, treatment and supervision. The department contracts with county mental health programs and private agencies to provide services.

Coverage for Mental Health Treatment. The Affordable Care Act provided one of the largest expansions of mental health and substance use disorder coverage in a generation, by requiring that most individual and small employer health insurance plans, including all plans offered through the health insurance marketplace cover mental health and substance use disorder services. Also required are rehabilitative and habilitative services that can help support people with behavioral health challenges. These protections built on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provisions to expand mental health and substance use disorder benefits and federal parity protections to an estimated 62 million Americans.

All state Medicaid programs, including Medi-Cal, provide some mental health services and some offer substance use disorder services to beneficiaries, and Children's Health Insurance Program (CHIP) beneficiaries receive a full service array. These services often include counseling, therapy, medication management, social work services, peer supports, and substance use disorder treatment. In addition, coverage for the Medicaid adult expansion populations is required to include essential health benefits, including mental health and substance use disorder benefits, and must meet mental health and substance abuse parity requirements under MHPAEA in the same manner as health plans.

Despite the Medicaid expansion through the Affordable Care Act in 2010, all care provided through CONREP continues to be funded through the state General Fund.

Reporting Requirements in the 2016 Budget Act. During last spring's subcommittee hearings, the Senate raised questions related to why DSH and their CONREP providers were not using Medi-Cal funding to offset the mental health and medical costs of individuals in CONREP. Specifically, the budget provided one-time funding for CONREP transitional housing and included provisional language requiring the department to prepare this report by January 10, 2017 and start seeking reimbursement by July 1, 2017.

The report submitted by DSH states that the majority of CONREP patients are currently enrolled in Medi-Cal and access medical and prescription medication services through Medi-Cal providers. The report goes on to mention that recent guidance from the Centers for Medicare and Medicaid Services (CMS) suggests that CONREP patients may not be eligible at all. The department sent a letter seeking clarification in November 2016, and has not yet received a response from CMS. As a result of this uncertainty, the department says further analysis is required before including Medi-Cal reimbursement into the CONREP model.

Legislative Analyst's Office (LAO). The Governor's proposed budget does not include language directing the department to continue to pursue Medi-Cal reimbursement. The LAO recommends directing the department to continue to pursue Medi-Cal reimbursement and submit an updated report as part of next year's budget process on its effort to do so.

Staff Comment. Given the federal government's interest in dismantling the Affordable Care Act, it is unclear whether this coverage will remain in the coming years.

Staff Recommendation. Approve the proposed budget on a one-time basis. In addition, adopt the LAO's recommendation requiring DSH to submit and updated report on January 1, 2018, with the expectation that the county mental health departments and private contractors seek Medi-Cal reimbursement for all reimbursable medical and mental health treatment by July 1, 2018, absent clear direction from the federal government that the medical and mental health costs for CONREP patients are not eligible.