*Senate Budget and Fiscal Review—Mark Leno, Chair*

# SUBCOMMITTEE NO. 5 Agenda

**Senator Loni Hancock, Chair**
**Senator Joel Anderson**
**Senator Jim Beall**

**Thursday, May 7, 2015**
**9:30 a.m. or Upon Adjournment of Session**
**State Capitol - Room 113**
**Outcomes**
**Consultant: Julie Salley-Gray**



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## *PROPOSED FOR VOTE ONLY*

### 4440 Department of State Hospitals

1. **April Finance Letter: Patton State Hospital Fence.** The Governor requests the reversion of $14.5 million General Fund provided in the 2014 budget act for the upgrade of security fencing around Patton State Hospital.

### 5225 Department of Corrections and Rehabilitation

2. **Statewide Advanced Planning.** The Governor's 2015-16 budget proposal includes $500,000 (General Obligation Bond Funds) to support workload associated with planning capital outlay projects at youth and adult correctional facilities. This workload consists of site assessments, environmental reviews, and the development of scope, cost, and schedule projections.

### 5227 Board of State and Community Corrections

3. **April Finance Letter: Technical Correction and Recidivism Reduction Fund Reappropriation.** The Governor requests a decrease of the BSCC budget by $410,000. The funding was included in the budget for 2014-15 and was intended to be one time. It was inadvertently also included in the 2015-16 Governor's budget.

   The Governor requests the reappropriation of Mentally Ill Offender Crime Reduction Grant funding, including the funding provided for state operations.

**Action:** Approved all three vote-only items as budgeted.

**Vote:** 3 – 0

# ITEMS TO BE HEARD

## 4440 Department of State Hospitals

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

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

### California's State Hospital System

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

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

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

***Metropolitan State Hospital.*** Located in the city of Norwalk, this hospital's population is approximately 65 percent forensic. Metropolitan State Hospital does not accept individuals who have a history of escape from a detention center, a charge or conviction

of a sex crime, or a conviction of murder. As of December 2014, it housed about 700 patients.

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

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

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

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

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

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

***Committed Directly From Superior Courts:***

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

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

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

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

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

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

**State Hospitals & Psychiatric Programs**
**Caseload Projections**

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

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

## State Hospitals Budget

The Governor's proposed budget includes $1.7 billion for DSH in 2015-16 ($1.6 billion General Fund). This represents a $15 million increase over 2014-15 funding. The proposed budget year position authority for DSH is 11,398 positions, an increase of 164 positions from the current year. The department's budget includes increased funding for several proposals; including plans to operate 105 more Incompetent to Stand Trial (IST)

beds than were budgeted in 2014-15, and establishes an involuntary medication policy for patients who are Not Guilty by Reason of Insanity (NGI).

(dollars in thousands)

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

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

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

1. Reduced layers of management and streamlined documentation.

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

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

4. Elimination of adult education.

## Issue 1: Metropolitan Bed Capacity and Perimeter Fence

**Governor's Budget.** The budget proposes $1.9 million General Fund to develop preliminary plans to increase secure treatment capacity at DSH–Metropolitan, located in Norwalk, by 505 beds. This expansion includes (1) 232 new beds and (2) 273 existing beds currently activated but not considered secure capacity because they are not enclosed by secure fencing. The beds would be prioritized for Incompetent to Stand Trial (IST) patients. The project is estimated to cost $35.5 million in total and would be completed in 2019. The staffing costs for the 232 new beds are estimated to be $48 million annually.

If these new secure beds at Metropolitan were activated, along with the proposed IST beds at DSH–Atascadero and DSH–Coalinga, the department would have a total of 337 additional beds for IST patients, at an annual cost of $65 million.

**April Finance Letter.** The Governor requests an additional $1.7 million for the working drawings phase of the project. This addition increases the total funding request for 2015-16 to $3.6 million General Fund for both preliminary plans and working drawings.

**Previous Subcommittee Action.** On March 16, this subcommittee rejected the Governor's request for 105 additional IST beds at Atascadero and Coalinga due to a lack of adequate data to determine the need for the additional funding to activate more state hospital beds and a failure to expand the Restoration of Competency (ROC) program, which allows people who are mentally ill to be returned to competency either in their communities or in their local county jails.

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

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

Over the past several years, the state hospitals have seen a growing waiting list of forensic patients. The longest waiting lists are for IST and Coleman inmate-patient commitments from CDCR. As of February 23, 2015, the waitlist for all commitment types was 484, including 328 specifically IST. DSH has undertaken several efforts to address the growing IST waitlist, including: 1) increasing budgeted bed capacity by

activating new units and converting other units; 2) establishing a statewide patient management unit; 3) promoting expansion of jail-based IST programs; 4) standardizing competency treatment programs; 5) seeking community placements; 6) improving referral tracking systems; and 7) participating in an IST workgroup that includes county sheriffs, the Judicial Council, public defenders, district attorneys, patients' rights advocates, and the Administration.

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

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

**Waiting List for IST Treatment.** As indicated during the March 16th hearing on the IST expansion, there is an on-going waiting list for individuals in need of mental health treatment in order to be restored to competency to stand trial for a crime they are accused of committing. Individuals on the waitlist are typically held in county jail until space becomes available in a DSH facility. The waitlists are problematic because they could result in increased court costs and higher risk of DSH being found in contempt of court orders to admit patients. This is because DSH is required to admit patients within certain time frames and can be required to appear in court or be held in contempt, when it fails to do so. The waiting list has remained around 300 individuals for the last several weeks.

**Legislative Analyst's Office (LAO).** It is uncertain whether the plan to modify DSH–Metropolitan would provide usable capacity for IST patients. This is because there are limits on the type of patients that DSH can place in the facility. The DSH–Metropolitan has an agreement with the City of Norwalk and the Norwalk station of the Los Angeles County Sheriff's Department to only admit patients who have no history of attempted or successful escape from a locked facility and no charges or convictions for murder or a sex crime. According to the department, it does not anticipate having difficulty finding IST patients who fit those criteria. However, the department does not track the number of patients in its facilities or on its waitlist, who are eligible for placement at DSH–Metropolitan. As a result, it is difficult to assess whether the department would be able to fully utilize the additional 232 secure treatment beds proposed for IST patients at DSH–Metropolitan, once completed.

**LAO Recommendation.** As discussed earlier, the Governor's proposal to expand secure treatment at DSH–Metropolitan is estimated to cost $35.5 million to complete,

and $48 million to operate annually. Given such costs relative to more cost–effective options for expanding capacity, the LAO recommends that the Legislature reject the proposed expansion at DSH–Metropolitan at this time. There is significant uncertainty about the department's need for the additional capacity, and, even if such a need existed, the department may be unable to utilize the proposed capacity at DSH–Metropolitan.

**Questions for the Administration.** The Administration should be prepared to address the following questions:

1. Please provide updated data on the IST waiting list.

2. In the last hearing, the committee asked you to analyze the effect of Proposition 47 on the IST waiting list. Have you conducted that analysis yet?

3. Please provide the committee with the average length of time a person is on the IST waiting list.

4. During the March 19th hearing, the committee rejected the proposal for increased IST beds and directed the department to provide the committee with additional data justifying the need for an increase. Please provide that data and/or an update on your efforts to gather the required information.

5. Also during the March 19th hearing, you provided an overview of the department's efforts to expand the restoration of competency (ROC) program in county jails. The committee expressed frustration at the lack of progress the department has made. Please provide an update on your current efforts and explain what changes, if any, you have made to reduce the time it takes to establish ROC programs in the counties.

6. The LAO notes that you do not collect data on the number of people on waiting lists or in your facilities who would be eligible for DSH- Metro. How has the department determined that there are enough eligible forensic patients in the system to fill the 500 secure treatment area beds that would be made available through this proposal?

**Action.** Held open. The Administration is encouraged to put together a comprehensive plan for the expansion of the restoration of competency programs in the jails that includes entering into an inter-agency agreement with the Board of State and Community Corrections to work with county boards of supervisors and county sheriffs to expand the program to those counties that have an interest in either in-jail restoration of competency or restoration in community treatment facilities.

## Issue 2: Enhanced Treatment Units

**Governor's Budget.** The governor's budget requests $11.5 million in General Fund for the Department of State Hospitals (DSH) to retrofit rooms at the following hospitals to create enhanced treatment units (ETUs):

- 12 rooms at Atascadero
- 12 rooms at Napa
- 12 rooms at Patton
- 8 rooms at Coalinga

**The 2014 budget act.** The 2014 budget included $1.5 million General fund for DHS and the Department of General Services (DGS) to prepare an analysis, estimate, and infrastructure design for the development of 44 locked ETUs in the five state hospitals. The budget also included language requiring the enactment of legislation authorizing the ETUs in order for the construction phase of the project to proceed.

**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 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 requests 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. 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 argues that the existing physical facilities are outdated and designed for a less violent population, therefore it is not possible to provide more security within existing facilities.

DSH has operated an ETU at Atascadero State Hospital since 2011. This proposal 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 2013. DSH reports that violence predominantly comes from repeat aggressors, reporting that 2 percent of patients are responsible for 35% 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 2013, there were a total of 3,344 patient-on-patient assaults and 2,586 patient-on-staff assaults at state hospitals. Of the total patient population, 62 percent are non-violent, 36 percent committed 10 or fewer violent acts, and 2 percent committed 10 or more violent acts. Of all the violent acts committed, 65 percent are committed by those with 10 or fewer violent acts, and 35 percent are committed by those with 10 or more violent acts. A small subset of the population, 116 people, commits the majority of aggressive acts. Assaults for the previous years are as follows: 3,803 patient-on-patient and 3,026 patient-on-staff in 2012; 4,022 patient-on-patient and 2,814 patient-on-staff in 2011; and 4,627 patient-on-patient and 2,703 patient-on-staff in 2010.

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

**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; Statutes of 2014, Chapter 718).** 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.

**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, enhanced treatment units (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 below, the *Coleman v. Brown* 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.

**Coleman Special Master's Report.** Last year the *Coleman v. Brown* special master released a report on the quality of treatment provided to Coleman class inmates being treated in DSH's psychiatric treatment programs and state hospitals. 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.

While this report was only focused on the treatment of Coleman patient-inmates being treated by DSH, it is one of the only independent evaluations available to the state hospital system. Absent some type of evaluation of the quality of treatment for other patients being treated by DSH, it is unknown whether the level of treatment being provided to non-Coleman patients is any more robust than the treatment provided to the Coleman class patients. In light of that fact, it may be that patients moved into a locked ETU setting will receive a similar level of treatment, or lack of treatment as the Coleman class patient-inmates.

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

**Questions for the Administration.** The Administration should be prepared to address the following questions:

1. The budget proposal notes that there have been three murders and "thousands of acts of aggression" in state hospitals since 2008. Please provide updated data on the number of incidents of serious aggression in the last three years of the level that would likely lead a patient to being placed in an ETU.

2. How do other states handle the increasing levels of violence in their mental health institutions?

3. Is seclusion in an ETU an appropriate action for patients who have not been convicted?

4. Please provide the committee with your current written policies and procedures surrounding staff and patient concerns about possible violence from other patients.

5. How many complaints did you receive from staff and patients in the last year regarding concerns about their safety? How many of those complaints resulted in attacks upon the individuals who expressed concern?

6. Please provide data on the number of patients in the last year who have had to be restrained due to violent behavior toward other patients or staff.

7. Please provide the department policies and procedures regarding the use of restraint.

8. Is there sufficient oversight to ensure that best practices will be implemented in using the ETUs?

9. Please provide the committee with any preliminary written policies or guidelines surrounding the use of locked individual rooms for patients housed in an ETU.

10. Using the widely publicized killing of a patient by his roommate at Atascadero State Hospital last May as an example, please describe how an ETU with locked rooms that are only to be used for therapeutic purposes would have better protected the patients and staff who came into contact with that individual. Also, was that individual being treated in the existing ETU at Atascadero?

11. Please describe how staff is trained to appropriately handle patient violence. Is this on-going training or one time? Is the training provided to staff at all of your hospitals and psychiatric programs? How many hours of training do they receive?

12. The California Department of Corrections and Rehabilitations has established use of force policies and use of force training for custodial staff who are required to restrain violent or non-cooperative inmates. Does DSH have a written use of force policy that outlines the appropriate level of force that can be used to restrain a patient? Do you have use of force training for DSH staff? If so, which job classifications receive this training?

13. Presumably, the licensed mental health experts employed by DSH are well trained in techniques surrounding the de-escalation of situations involving patients at risk of becoming violent. Is that type of training provided to all DSH employees? If so, is it updated annually or is it one-time training?

**Action.** Held open. The Administration was strongly encouraged to expand the Inspector General's jurisdiction to include oversight of state hospitals and psychiatric programs in order to move forward with their ETU pilot project.

## Issue 3: State Hospitals Capital Outlay Proposals

**Governor's Budget.** The Administration proposes the following capital outlay projects:

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

**Background.** This issue covers the following five proposed capital outlay projects:

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

*Fire Alarm Upgrade at Patton ($731,000).* This project proposes to upgrade the existing Simplex Grinnell Fire Alarm Systems in psychiatric patient housing and provide a new central monitoring system located at Hospital Police Dispatch. The proposal states that the existing system is not compatible with the manufacturer's software and hardware, is not code compliant, and does not allow for serviceability and/or expandability. This is the first phase of this project. The total cost of the project is estimated to be $9.8 million General Fund.

*Courtyard Gates & Security Fencing at Napa ($2,029,000).* This project is to improve security in the courtyards in the patient housing buildings, including: replacement of gates and fabricating and installing extensions to raise the height of security fencing in specified buildings. This is the final phase of this project. The 2014 cost to develop working drawings was $191,000. The total cost of the project is estimated to be $2.3 million General Fund.

*Seismic Upgrades at Atascadero ($442,000).* This project is to perform a seismic retrofit at the main East-West corridor at Atascadero State Hospital. The retrofit will include construction of steel framed lateral frames in the upper third portion of the corridor. Construction also will include a security sally port and temporary access doors. It is anticipated that this project will reduce the Risk Level of the corridor from the current Level V to a Level III. The $442,000 requested is for the development of working

drawings. This project received $325,000 in 2014 for the development of preliminary plans and Department of Finance expects that there will be a follow-up request next year for actual construction. The total cost of the project is estimated to be $6.2 million General Fund.

*Courtyard Expansion at Coalinga ($219,000).* This proposal is for resources to design and construct a secure treatment courtyard at Coalinga, in addition to the current Main Courtyard area, to include a walking/running track and open air space to accommodate the full capacity of the facility (1,500 individuals). The Main Courtyard is undersized and does not provide the needed space for group exercise, social interactions, and other outdoor activities. This is the first phase of this project. The total cost of the project is estimated to be $3.6 million General Fund.

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

**Questions for the Administration.** The Administration should be prepared to address the following questions:

1. Please present these proposals and explain in which phase of the full project each proposal falls.

2. Please provide the business case for these three projects.

3. Please provide the subcommittee with information on alternative solutions explored by the department (for each project).

4. Please provide any on-going operating costs associated with these projects. For example, are there additional staffing costs associated with the courtyard expansion at Coalinga?

**Action:** Approved as budgeted.

**Vote:** 3 – 0

## 5225 Department of Corrections and Rehabilitation

Effective July 1, 2005, the California Department of Corrections and Rehabilitation (CDCR) was created, pursuant to the Governor's Reorganization Plan No. 1 of 2005 and SB 737 (Romero), Chapter 10, Statutes of 2005. All departments that previously reported to the Youth and Adult Correctional Agency (YACA) were consolidated into CDCR and include the California Department of Corrections, Youth Authority (now the Division of Juvenile Justice), Board of Corrections (now the Board of State and Community Corrections (BSCC)), Board of Prison Terms, and the Commission on Correctional Peace Officers' Standards and Training (CPOST).

The mission of CDCR is to enhance public safety through safe and secure incarceration of offenders, effective parole supervision, and rehabilitative strategies to successfully reintegrate offenders into local communities.

The CDCR is organized into the following programs:

- Corrections and Rehabilitation Administration
- Juvenile: Operations and Offender Programs, Academic and Vocational Education, Health Care Services
- Adult Corrections and Rehabilitation Operations: Security, Inmate Support, Contracted Facilities, Institution Administration
- Parole Operations: Adult Supervision, Adult Community-Based Programs, Administration
- Board of Parole Hearings: Adult Hearings, Administration
- Adult: Education, Vocational, and Offender Programs, Education, Substance Abuse Programs, Inmate Activities, Administration
- Adult Health Care Services

The 2014 budget act projected an adult inmate average daily population of 136,530 in the current year. The current year adult inmate population is now projected to decrease by 633 inmates, a 0.5 percent decrease, for a total population of 135,897. The budget year adult inmate population is projected to be 137,002, a 0.8 percent increase of 1,105 inmates over the current year. The current projections also reflect an increase in the parolee population of 1,360 in the current year, compared to budget act projections, for a total average daily population of 43,226. The parolee population is projected to be 40,467 in 2015-16, a decrease of 2,759 over the current year. These projections do not include the impact of the passage of Proposition 47, which reduced various felonies to misdemeanors.

As of February 18, 2015, the total in-custody adult population was 131,469. The institution population was 116,556, which constitutes 136.3 percent of prison capacity. The most overcrowded prison is the Central California Women's Facility in Chowchilla, which is currently at 167.3 percent of its capacity. For male inmates, Mule Creek State Prison is currently the most overcrowded at 165.9 percent of its capacity.

The Governor's budget proposes total funding of $10.2 billion ($9.9 billion General Fund and $300 million other funds) in 2015-16. This is an increase of approximately $1 billion ($833 million General Fund) over 2013-14 expenditures. The following table shows CDCR's total operational expenditures and positions for 2013-14 through 2015-16.

(dollars in thousands)

| Funding | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|
| General Fund | $9,156,505 | $9,827,940 | $9,989,790 |
| General Fund, Prop 98 | 16,530 | 18,385 | 18,635 |
| Other Funds | 56,080 | 67,250 | 62,329 |
| Reimbursements | 167,644 | 185,074 | 185,064 |
| Recidivism Reduction Fund | -103,199 | 25,968 | 28,227 |
| SCC Performance Incentive Fund | -1,000 | -1,000 | -1,000 |
| **Total** | $9,292,560 | $10,123,617 | $10,283,0451 |
| **Positions** | 52,260 | 60,812 | 61,579 |

## Issue 4: April Finance Letter: Board of Parole Hearings

**Spring Finance Letter.** The Governor requests seven permanent positions, two two-year limited term positions, and a six-month extension of one limited-term position to accommodate increased workload due to the new parole process for second-strike offenders and youthful offenders. The Governor notes that these additional positions will allow the board to complete comprehensive risk assessments every three years and promulgate regulations surrounding the new petition to advance a parole suitability hearing and administrative review process related to recent federal court rulings.

There is no funding included in the request. The Board of Parole Hearings (BPH) will absorb the cost within its existing budget.

**2014 Budget.** The 2014 budget act included $3.1 million dollars General Fund and 23.8 positions for the workload associated with expanded medical parole, implementing an elderly parole program, and establishing a parole process for non-violent, non-sex related second strikers that have served 50 percent of their sentence, and to reduce the hearing preparation timeline.

In addition, the 2014 budget included $1.586 million General Fund and 3.5 positions on a one-year limited-term basis (decreasing to approximately $315,000 and 1.5 positions in 2015-16, to conduct the additional youthful offender parole hearings required by SB 260 (Hancock; Chapter 312, Statutes of 2013). Of the $1.586 million, $1.298 million and 3.5 positions were BPH and the remaining $288,235 was for CDCR's Case Records Unit.

**Legislative Analyst's Office (LAO) Recommendation.** The LAO originally raised a concern that CDCR had not provided a full accounting of the savings in BPH's budget that the department proposes to redirect to support the requested positions. However, the department has provided additional information regarding those savings and the LAO no longer has concerns with the proposal.

**Action:** Approved the spring finance letter.

**Vote:** 3 – 0

## Issue 5: Armstrong Accessibility

**Governor's Budget.** The Governor's budget proposal requests $38 million from the General Fund—$19 million in 2015-16 and $19 million in 2016-17—to construct Americans with Disabilities Act (ADA) improvements at 14 prisons.

**April 1st Finance Letter.** The Governor requests a $6.3 million reduction to the 2015-16 Governor's budget request, and a $6.5 million General Fund reduction to the 2016-17 estimate, to reflect a revised plan to spend $12.7 million in 2015-16 and $12.5 million in 2016-17 on the construction costs associated with making ADA improvements at a total of 13 prisons.

The Governor's April 1st finance letter provided the following list or prisons that will be undergoing ADA updates if funding is approved:

| 2015-16 | 2016-17 |
|---|---|
| Central California Women's Facility | CSP – Corcoran |
| CSP – Los Angeles County | Ca. Substance Abuse Treatment Facility |
| CSP – Sacramento | Deuel Vocational Institution |
| Salinas Valley State Prison | High Desert State Prison |
| San Quentin State Prison | Kern Valley State Prison |
| Wasco State Prison | North Kern State Prison |
| | Pleasant Valley State Prison |

**Background.** In response to a federal class action lawsuit (Armstrong), the CDCR created the Disability Placement Program (DPP) in the mid 1990's. The DPP is CDCR's set of plans, policies, and procedures to assure nondiscrimination against inmates with disabilities. One component of this plan was the selection of designated DPP prisons for individuals with mobility, hearing, visual and speech impairments. Limited physical plant upgrades to accommodate the needs of these inmates were performed; the scope of these upgrades was not intended to make the prison fully compliant with the ADA. The purpose of designating specific DPP prisons was to enable CDCR to best serve the housing, programming, and/or service needs of the inmates with disabilities in a cost effective manner, while maintaining the integrity of the security classification system and without compromising legitimate penological interests such as safety and security.

Prior to 2014-15, the Legislature provided two one-time appropriations for construction of ADA accessibility improvements. Assembly Bill 986 (Chapter 28, Statutes of 1998) appropriated $6.6 million GF for construction of initial ADA modifications related to the establishment of the DPP. An additional $3.7 million GF was appropriated in the 2008 Budget Act for construction of a specified list of ADA modifications. The 2008 budget

act also contained an ongoing support appropriation of $1.9 million GF annually, intended for maintenance and repair of existing accessibility features.

During the 15 years since the DPP prisons were designated, the ability to find appropriate housing for DPP inmates has become increasingly complex. In addition to an inmate's security level, various factors to be considered include general population or sensitive needs yards, medical and mental health needs, and susceptibility to illnesses caused by environmental factors. Reception centers must provide housing and services for inmates newly committed to CDCR that require accessible accommodations, and high security housing ,such as for condemned inmates and Security Housing Units, must be able to accommodate inmates requiring accessible housing. This requires a broader range of disabled accessible housing (as well as services and path of travel) than presently exist at the DPP prisons.

In addition to these concerns, the Armstrong plaintiffs are contending that existing DPP prisons are non-compliant with ADA accessibility guidelines. The plaintiffs sent a consultant to several prisons to develop a list of accessibility deficiencies. The list developed by this consultant would have resulted in construction costs of between $10 million and $15 million per prison. CDCR was concerned that this report would potentially form the basis of an expensive court order, and that the consultant's report may require a greater degree of modifications than CDCR would agree was required.

To forestall a potential challenge in court, the Armstrong plaintiffs agreed to allow CDCR to conduct surveys to determine the post-realignment housing needs for inmates with disabilities requiring accessibility, and use this to determine the most appropriate prisons for designation as DPP facilities, along with assessing each prison's physical plant to determine the scope of accessibility upgrades that would be required at the DPP facilities. Different types of accessibility upgrades are required at each prison; the types of upgrades include, but are not limited to, the following: cell modifications, housing unit modifications including bathrooms and accessible tables; path of travel sidewalk improvements from housing unit to programs and services; accessible chairs and tables at visiting; access ramps meeting grade requirements; and accessible gym and yard exercise equipment.

The 2014-15 budget act appropriated $17.5 million GF to CDCR to begin implementing the results of these surveys. Of this funding, $13.5 million was for construction of improvements at four prisons that had completed design plans, and $4 million was to complete design activities at 15 prisons. The modifications at these prisons will be necessary to provide CDCR with the variety of housing and programs necessary to appropriately house inmates requiring accessibility accommodations. The conceptual construction cost for improvements to these additional prisons is approximately $38 million GF.

**Legislative Analyst's Office (LAO).** Unlike when funding was requested for ADA improvements for 2014-15, the Administration's proposal for 2015-16 currently lacks sufficient information for the Legislature to evaluate it. While the Administration indicates

that the proposed $19 million would support projects at 14 prisons, it has not indicated (1) which prisons will receive modifications, (2) what specific problems exist at those prisons, (3) what specific projects will be undertaken at each prison to address the associated problem, and (4) the cost of each project and potential alternatives. Moreover, according to CDCR, the department has been working with Armstrong plaintiffs to achieve compliance. Based on those discussions, the department will identify the specific projects that would be funded from this proposal. The department stated that a list of accessibility improvements is not currently available. Without this information, the Legislature cannot assess whether the planned projects are the most cost-effective method of achieving ADA and Armstrong compliance.

**LAO Recommendation.** Information provided in the April 1st finance letter addressed the concerns raised by the LAO in their analysis of the January budget proposal.

**Questions for the Administration.** The Administration should be prepared to address the following questions:

1. Please provide an update on your on-going discussions with the plaintiffs. Have they indicated that this approach will address their concerns about compliance?

**Action:** Approved the modified spring finance letter.

**Vote:** 3 – 0

## Issue 6: Kitchen Activation – California Medical Facility

**Governor's Budget.** The Governor's budget requests $580,000 General Fund ($150,000 of which is one-time), and 3.5 positions, to upgrade and activate an existing kitchen currently not in use, in order to feed Disability Placement Wheelchair inmates from ADA converted dormitory housing units at the California Medical Facility in Vacaville.

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

**Action:** Approved as budgeted.

**Vote:** 3 – 0

## Issue 7: Capital Outlay Projects

**Governor's Budget.** The Administration proposes the following capital outlay projects:

1. $18,071,000 General Fund to replace the boiler facilities at San Quentin.

2. $792,000 General Fund to replace the cell fronts at Deuel Vocational Institution.

3. $997,000 General Fund to replace the kitchen and dining facilities at the California Correctional Center.

**Background.** This issue covers the following three proposed capital outlay projects:

*New Boiler Facility – San Quentin*. $18.071 million General Fund to support the construction phase for a new high pressure boiler at San Quentin State Prison. The proposed boiler replacement is required for compliance with the Bay Area Air Quality Management District (BAAQMD) regulations for gas-fired boiler emission. Failure to move toward compliance with BAAQMD regulations could result in the CDCR being assessed upwards of $5 million in fines and $2.2 million in fines each year, until compliance is met. The overall cost of this project is estimated to be $18.671 million.

*Solid Cell Fronts – Deuel Vocational Institution*. $792,000 (General Fund) to support the working drawings phase for the replacement of the barred cell fronts in the Administrative Segregation Unit (ASU) at Deuel Vocational Institution (DVI) with solid cell fronts. This project will also address heating/ventilation issues, electrical system issues, asbestos issues, lead paint concerns, and the addition of a fire/smoke detection system. The ASU at DVI contains 144 cells and six showers that do not currently have solid cell fronts. The proposed modifications would also address suicide risk concerns raised in the *Coleman v. Brown* court case. The overall cost of this project is estimated to be $9.4 million.

*Kitchen and Dining Building Replacements – California Correctional Center.* $997,000 General Fund to support the working drawings phase for the replacement of two existing kitchen/dining buildings at the California Correctional Center, Susanville. The proposed projects would address identified need at the California Correctional Center, Susanville on the Arnold Unit and Antelope Camp living units (both built in the 1980's). The kitchens on these living units have surpassed their expected useful lifespan by 20 years and have exceeded the point of economical repair. CDCR contends that these buildings also present a health and safety risk to inmates and staff. The overall cost of these two pre-engineered metal kitchen/dining buildings, along with a loading dock and related paving, is projected to be $16.2 million. The 2014-15 budget included $1 million General Fund to support phase one of this project (the planning phase). The Governor's budget request would fund phase two of the project.

**Action:** Approved as budgeted. **Vote:** 3 – 0