California Behavioral Health Planning Council

Patients' Rights Committee

January 17, 2018

DoubleTree by Hilton

1515 Hotel Circle South, San Diego, CA 92108

Cabrillo Room 11:00 a.m. to 12:30 p.m.

Item	Time	Topic	Presenter or Facilitator	Tab
1	11:00 a.m.	Welcome and Introductions	Daphne Shaw, Chairperson	
2	11:05	Agenda Review	Daphne Shaw	
3	11:10	Review and approve October & December Meeting Minutes	Daphne Shaw	A
4	11:15	Update on the PRA White Paper	Daphne Shaw & Samuel Jain	
5	11:25	Discussion: What's Next?	All	B
6	12:20	Plan for Next Meeting/Report Out	All	
7	12:30	Public Comment/Adjourn		

Committee Members:

Chairperson:	**Daphne Shaw**	
Members:	Carmen Lee	Walter Shwe
	Darlene Prettyman	Catherine Moore
	Richard Krzyzanowski	Samuel Jain
Staff:	Justin Boese	

If reasonable accommodations are required, please contact the CMHPC office at (916) 552-9560 not less than 5 working days prior to the meeting date.

____	**INFORMATION**	**TAB SECTION**	**A**
__X__	**ACTION REQUIRED:**	**DATE OF MEETING**	01/17/18

MATERIAL PREPARED BY: Boese **DATE MATERIAL PREPARED** 12/8/17

AGENDA ITEM:	Review and approve meeting minutes from October 18th & December 6th
ENCLOSURES:	Minutes of PRC conference call on October 18th, 2017, and December 6th, 2017.

ISSUE:

Patients' Rights Committee review and approval of minutes from October 18th, 2017 and December 6th, 2017.

Patients' Rights Committee
Meeting Notes
Quarterly Meeting – October 18, 2017
11:00 am – 12:30 pm

Committee Members Present:
Daphne Shaw, Chair
Carmen Lee, Walter Shwe, Richard Krzyzanowski, Samuel Jain

Committee Members Not Present:
Catherine Moore, Darlene Prettyman

Staff Present:
Jane Adcock, Justin Boese

Others Present:
Robert Blackford, CMHPC
Autumn Boylan, DHCS

Welcome & Introduction:
Daphne Shaw welcomed all committee members. A quorum was reached.

Review and Approve Minutes:
The meeting minutes from August 25th were approved. Motion by Walter Shwe, seconded by Carmen Lee.

Discussion and Approval of Patient Rights Advocate (PRA) Survey White Paper:

The Committee discussed the final draft of the PRA white paper. There were no initial questions. Samuel Jain went through the paper and provided a brief overview for the committee. He started with the historical background of the PRA ratio issue, and then went on to explain the survey results and analysis, noting the diversity among survey participants and their responses. He highlighted findings of interest that led to the concluding recommendations.

Concerning the recommendation to provide whistleblower protections for county contractors in watchdog roles, Samuel clarified that the reason the recommendation only includes contractors is that county employees already have whistleblower protections. The issue is that these protections don't extend to contractors. Daphne Shaw brought up that some people think it is a conflict of interest issue that counties have oversight of PRAs. However, she said that changing this so that PRAs are employed by the state would be nearly impossible to achieve. Richard Krzyzanowski

commented that this is a conflict that will never be easily resolved, and that some county directors are very supportive of PRAs. The issue is that when that power is in the hands of one person, you're relying on that one person's attitude and approach, and things can quickly change if they leave and someone else comes.

Richard went on to suggest that there should be a state-level process to submit complaints and work towards a resolution. Daphne said that it seemed like the California Office of Patient Rights (COPR) would be the office to do that, but they don't have the capacity to conduct those kinds of investigations. She suggested strengthening their capacity in the future. Richard suggested housing that kind of function in another existing state entity, perhaps one that has less direct ties to the issue – which could be an advantage.

Jane Adcock asked if the PRC will be moving these recommendations forward. Daphne answered that the plan is for the committee to work on making these recommendations happen, including working with Assmemblymember Susan Eggman's office to pass relevant legislation. Jane said that we need to figure out how patients' rights work is currently funded if we are asking for any kind of expansion of services and duties. She thought the idea of having mandatory training and covering travel to PRAT is an excellent and doable place to start.

Richard expressed some reservations on the recommendations for PRA training, in particular the mention of qualifications, as he believes one of the best things about PRAs is their diverse experience and backgrounds. Samuel agreed, and said that is why the recommendations will focus on training and not qualifications.

The final draft of the white paper was approved. Motion by Richard Krzyzanowski, seconded by Samuel Jain. The motion passed with a vote of 5-0-0 with committee members Shaw, Lee, Shwe, Krzyzanowski and Jain voting Yes, 0 members voting No, and 0 members abstaining.

Q&A on Beneficiary Protections with Autumn Boylan:

Autumn Boylan spoke to the PRC about Beneficiary Protections. The federal Medicaid rules were revised and became effective July 1, 2017. Mental health plans, funded under the federal Medicaid plans, are classified as "prepaid inpatient health plans." Many of the "new" rules for beneficiary protections are just modifications of existing rules. A "grievance" is any expression of dissatisfaction on a matter other than an "adverse benefit determination." They can include: quality of care or services, aspects of interpersonal relationships with providers and employees, failure to respect an enrollee's rights regardless of whether remedial action is requested, and an enrollee's right to dispute an extension of time proposed by the plan to make an authorization decision.

One of the things the new rules do is that they clarify CMS' perspective that there is no difference between a grievance and a complaint. There is no such thing as an "informal" complaint, hence the phrasing "regardless of whether remedial action is requested." If you're a beneficiary and you complain about something, the plan must take that seriously and follow all requirements regarding grievances, including investigation, logging, timeline, etc. Plans have to report all of their grievances to their Quality Improvement Committee.

Samuel asked for more information on the system for grievance procedures county by county. Autumn said that in terms of how it is organized by each county, it is not prescribed by the state. In some counties they have a specific grievance coordinator, in some counties it is the Patient Rights Advocate who handles grievances. In other counties it is part of their quality management program. There are rules about who can make decisions; the person making decisions can't be someone who was involved in a previous level of review. There is no set methodology for investigating a grievance, though there are some requirements for who can make a decision on a grievance. For example, if it is a clinical care issue, then it has to be a clinician with the appropriate level of expertise. Most requirements are federal requirements that are adopted by the state.

Samuel then asked what a PRA could do if they had concerns about how a county was handling grievances. Autumn said they could contact the Ombudsman office, or the Mental Health Services Division at DHCS. Handbooks do need to be posted online and linked to the state website. There are no specific performance indicators yet, but as they are part of the Medicaid rules, there will be indicators developed. The plan quality rating system is required starting in 2019.

Nominate Chair Elect:

Walter Shwe was nominated and elected to be Chair Elect for the Patients' Rights Committee.

Public Comment:

No public comments. Meeting adjourned at 12:30 pm.

Patients' Rights Committee
Meeting Notes
Conference Call - December 6th, 2017
10:00 am – 10:30 am

Committee Members Present:
Daphne Shaw, Chair
Carmen Lee, Walter Shwe, Darlene Prettyman, Catherine Moore

Staff Present:
Justin Boese

Welcome & Introduction:
Daphne Shaw welcomed all committee members.

Update on PRA White Paper:
Daphne Shaw updated the committee on the collaboration with Assemblymember Susan Eggman's office to draft legislation based on the recommendations of the PRA white paper. Daphne Shaw and Samuel Jain are working with Sage, an intern at Eggman's office, to answer a few questions about the recommendations, such as who would be considered "stakeholders" for the purpose of developing PRA education, and whether or not contracted employees currently have any whistleblower protections against retaliation. Daphne and Samuel will continue to keep the Committee informed and involved as work with Eggman's office proceeds.

January Agenda Planning:
With the PRA paper completed, the Patients' Rights Committee will be exploring topics of interest to identify new areas of focus. Daphne opened up the discussion for Committee members to suggest topics for the January 2018 meeting.

The managed care grievance process came up again as a topic of interest. Daphne expressed that there is still some lingering confusion on this issue and that not all of the Committee's questions were answered by Autumn when she returned for the October 2017 meeting. It was noted that many consumers and family members still don't know how to actually go about filing a grievance.

Another topic suggested was the current state of patients' rights in state hospitals. Daphne brought up that the PRC has visited hospitals in the past and could do so again. Daphne asked for some time on the agenda to discuss the topic of PRA work in jails as well, and said that Samuel could likely share information about that work.

Justin will be sending out information and resources regarding these topics, and will be putting them on the agenda for January.

Public Comment:
No public comments. Meeting adjourned at 10:30 am.

__X__	**INFORMATION**	**TAB SECTION**	**B**
_____	**ACTION REQUIRED:**	**DATE OF MEETING**	01/17/18

MATERIAL PREPARED BY: Boese

DATE MATERIAL PREPARED 12/20/17

AGENDA ITEM:	Discussion: What Next?
ENCLOSURES:	1) Q&A on Beneficiary Protections/ Grievance Process with Autumn Boylan 2) Medi-Cal Patients' Rights and Patients' Rights in State Hospitals (Excerpt from Dan Brzovic's guide) 3) CAMHPRA Advocate Manual, Ch. 11 Forensics 4) PRAT Inmate-Patient Advocacy in California County Jails

ISSUE:

With the PRA white paper finished, the Patients' Rights Committee is exploring various topics to determine what the committee should focus on next. Several topics of interest have been raised by committee members, including:

- Medi-Cal managed care grievance process
- Patient's Rights in State Hospitals
- PRA work in Jails

Informational materials for all of these topics have been included as enclosures.

1. The first is a document that summarizes what the committee learned from Autumn Boylan during the October 2017 meeting. Not all of the questions the PRC gave to Autumn were answered. At the end of the document there are also two links to web pages that summarize the grievance process.

2. The second enclosure includes two sections from Dan Brzovic's document on PRA Laws and Regulations: State Hospitals, and Medi-Cal Patient's Rights.

3. The third document is Chapter 11 from CAMHPRA's PRA manual, which is the chapter on Forensics. It has information on patients' rights in jails and state hospitals.

4. The fourth and final enclosure is a PowerPoint presentation titled Inmate-Patient Advocacy in California County Jails, which Samuel Jain presented at PRAT in 2016.

The Patients' Rights Committee will discuss these and other topics of interest, and identify areas of focus to direct future activities.

Medi-Cal Beneficiary Protections and Grievance Process

Follow up with Autumn Boylan:

1. **Are there new CMS rules that impact patient protections, and if so, what are they?**
    a. The federal Medicaid rules were revised and became effective July 1st, 2018. Mental health plans, under the federal Medicaid plans, are classified as "prepaid inpatient health plans." Many of the "new" rules for beneficiary protections are just modifications of existing rules.
2. **Is there a required protocol for grievances? Do different counties have different systems?**
    a. One of the things the new rules do is that they clarify CMS' perspective that there is no difference between a grievance and a complaint. There is no such thing as an "informal" complaint, hence the phrasing "regardless of whether remedial action is requested." If you're a beneficiary and you complain about something, the plan must take that seriously and follow all requirements regarding grievances, including investigation, logging, timeline, etc. Plans have to report all of their grievances to their Quality Improvement Committee.
    b. Samuel asked for more information on the system for grievance procedures county by county. Autumn said that in terms of how it is organized by each county, it is not prescribed by the state. In some counties they have a specific grievance coordinator, in some counties it is the Patient Rights Advocate who handles grievances. In other counties it is part of their quality management program. There are rules about who can make decisions; the person making decisions can't be someone who was involved in a previous level of review. There is no set methodology for investigating a grievance, though there are some requirements for who can make a decision on a grievance. For example, if it is a clinical care issue, then it has to be a clinician with the appropriate level of expertise. Most requirements are federal requirements that are adopted by the state.
3. **Are counties required to put member handbooks online? If no, why not?**
    a. Handbooks do need to be posted online and linked to the state website.
4. **As per the requirements for information content, what performance and quality indicators are plans required to provide?**
    a. There are no specific performance indicators yet, but as they are part of the Medicaid rules, there will be indicators developed. The plan quality rating system is required starting in 2019.
5. Are there required services that MHPs must provide? Are there a minimum set of services? If the "amount, duration and scope" must be no less than that is

furnished to beneficiaries under FFS Medicaid, what are the required services for FFS Medicaid?

6. Are there required patient protection services that MHPs must provide?
7. Are there different issue resolution processes for Managed Care and MHSA programs?

Samuel then asked what a PRA could do if they had concerns about how a county was handling grievances. Autumn said they could contact the Ombudsman office, or the Mental Health Services Division at DHCS.

Medi-Cal Managed Care Ombudsman: http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx

Mental Health Ombudsman: http://www.dhcs.ca.gov/services/MH/Pages/MHOmbudsmanSrvcs.aspx

Resources:

California Health and Wellness: https://www.cahealthwellness.com/providers/resources/grievance-process.html

Office of the Patient Advocate: http://www.opa.ca.gov/Pages/Medi-CalComplaints.aspx

6. State Hospital Patients' Rights

9 CCR §§ 880-892 (Section 880 regulations)

9 CCR § 880

Chapter 4.5 applies to patients' rights and related procedures for all non-Lanterman-Petris-Short Act (LPS) patients placed in or committed to a treatment program in a Department of Mental Health facility, except when transferred to or placed in a federally certified program.

9 CCR § 882

(a) Upon admission to the facility, each non-LPS patient shall be informed of the rights specified in Sections 883 and 884 and given a copy of their rights in the language or modality understood by the patient.

(b) These patients' rights shall also be prominently posted in the predominant languages of the patients in patients' living areas.

9 CCR § 883

(a) The patient's parent, guardian, or conservator **may not waive** the rights listed in this Section unless authority to waive these rights is specifically granted by court order.

(b) Non-LPS Patients have the following rights:

(1) A right to **privacy, dignity, respect and humane care**.

(2) A **right to receive treatment** for a **diagnosed mental disorder** that is provided in a method **least restrictive of individual liberty** and **promotes personal independence**.

(3) A right to **medical care and treatment** for physical ailments and conditions according to accepted clinical standards and practices.

(4) A **right to refuse psychosurgery, electroconvulsive therapy, experimental and other hazardous procedures**.

(5) A **right to be free from harm including abuse or neglect, and unnecessary or excessive medication, restraint, seclusion, or protective or administrative isolation**. Medication, restraint, seclusion, or protective or administrative isolation shall not be used as punishment, as retaliation for filing complaints, for the convenience of staff, as a substitute for a treatment program or in quantities that interfere with the patient's treatment.

(6) A right **to confidential case discussions, consultation, examination, and patient records**. Confidential information shall only be provided to those people providing evaluation and/or treatment or as authorized by law.

(7) A right to be informed of the **procedures for filing complaints** and the process for appeals when complaints are not resolved to the patient's satisfaction.

(8) A right to access the services of a **Patients' Rights Advocate**.

(9) A right to **confidential communications with an attorney**, either through correspondence or through private consultation, during regularly scheduled visiting days and hours.

(10) A right to **religious freedom and practice**, within the context of the environment of a secure treatment facility.

(11) A right to **opportunities for physical exercise and recreational activities**.

9 CCR § 884

(a) The patient's parent, guardian, or conservator **may not waive** the rights listed in this Section unless authority to waive these rights is specifically granted by court order. These rights shall only be denied for good cause in accordance with Subsection (b) of this Section.

(b) Non-LPS Patients have the following rights, **subject to denial for good cause**:

(1) A right to keep and use **personal possessions as space permits, except items and materials that are listed as contraband** by the facility. Each facility shall make a copy of the contraband listing available on all treatment units and public areas within the facility. Each patient shall receive a copy of the contraband listing upon admission.

(2) A right to have access to **individual secured storage space** for personal possessions in accordance with the formal policies and procedures of the facility. Title 19, Section 314 and Title 22, Sections 71543 and 73507 require hospitals and licensees to comply with State Fire Marshall regulations.

(3) A right to **keep and spend** a sum of the **patient's own money** via the facility monetary replacement system.

(4) A right to personal visits during regularly scheduled visiting days and hours. The right to have visits shall not be denied except as is necessary for **reasonable security of the facility and the safety of persons**. The length and frequency of visits and the number of persons permitted to visit a patient at the same time may be limited consistent with safety, security, and to ensure that all patients have a fair opportunity to have visitors.

(5) A right to access **telephones** to make and receive confidential telephone calls, or to have such calls made for them. Telephone hours, frequency and duration of telephone calls, and method of payment may be limited to ensure access by all patients.

(6) A right to have access to **letter writing materials** and to mail and receive correspondence. Designated facility employees shall open and inspect all incoming and outgoing mail addressed to and from patients **for contraband**. **Confidential mail, as defined in Section 881(c), shall not be read**. Limitations on size, weight and volume of mail shall be specified by formal facility policy.

(7) A right to receive **packages**. Designated facility employees **shall open and inspect** all incoming and outgoing packages addressed to and from patients for **contraband**. Limitations on the size, weight and volume, and frequency/number of packages allowed shall be specified by formal facility policy.

(8) A right to have access to **legal reference material**. Limitations on the time, duration, frequency, and method of access shall be specified by formal facility policy to ensure opportunity for access by all patients.

(9) A right to participate in appropriate programs of **publicly supported education** that are consistent with the patient's treatment plan and with the secure treatment facility environment.

(10) A right to **social interaction**. The formation of supervised patient leisure time activity groups that promote educational, social, cultural and recreational interests of participating patients shall be permitted, except for activities that pose a threat to safety and security.

(c) The rights specified in Subsection (b) of this Section shall be denied only for good cause. Good cause for denying a patient the exercise of a right exists when the facility director determines that:

(1) The exercise of the specific right would be injurious to the patient; or

(2) There is evidence that the specific right, if exercised, would seriously infringe on the rights of others; or

(3) The facility would suffer serious damage if the specific right is not denied, or;

(4) The exercise of the right would **compromise the safety and security of the facility and/or the safety of others**; and

(5) That there is no less restrictive way of protecting the interests specified in Subsections (c)(1) through (4) of this Section.

(d) The reason for denial of a right under this Section must be related to the specific right denied. A right specified in this Section shall not be withheld or denied as a punitive measure, nor shall a right specified in this Section be considered a privilege to be earned. A denial of a right shall not exceed thirty days without additional staff review. Treatment plans shall not include denial of any right specified in Subsection (b) of this Section.

(e) Each denial of a right specified in this Section shall be noted in the patient's treatment record. Documentation shall take place immediately whenever a right is denied. The notation shall include:

(1) Date and time the right was denied.

(2) Specific right denied.

(3) Good cause for denial of right.

(4) Date of review if denial was extended beyond 30 days.

(5) The facility director's signature authorizing the denial.

(f) The patient shall be told of the content of the notation and the process for restoration at the time of the denial.

(g) Each denial of a right specified in this Section shall be documented regardless of the reason for the denial, or the frequency with which a specific right is denied in a particular facility, or to a particular patient.

(h) A patient's right under this Section shall be restored when the good cause for its denial no longer exists. When a right has been denied, staff shall employ the least restrictive means of managing the behavior that led to the denial. The date that a specific right is restored shall be documented in the patient's treatment record.

(i) Information in the patients' treatment record pertaining to a denial of rights shall be available on request to the patient, their attorney/conservator/guardian, the Department, or excluding the patient identity, a member of the State Legislature.

9 CCR § 886

(a) Each facility director shall file quarterly reports with the Office of Patients' Rights, by the last day of January, April, July, and October. These reports shall list the number of patients whose right or rights were denied and the specific right or rights that were denied.

(b) The quarterly reports shall enable the Director of the Department and the Office of Patients' Rights to identify individual treatment records, if necessary, for further analysis and investigation.

W&IC § 7295

(a) To ensure its safety and security, a **state hospital** that is under the jurisdiction of the State Department of State Hospitals, as listed in Section 4100, **may develop a list of items that are deemed contraband and prohibited on hospital grounds, and control and eliminate contraband on hospital grounds**.

(b) The State **Department of State Hospitals shall develop** a list of items that **shall be deemed contraband at every state hospital**.

(c) A state hospital shall form a contraband committee, comprised of hospital management and employees designated by the hospital's director, to develop the list of contraband items. **The committee shall develop the list with the participation of patient representatives, or the patient government of the hospital, if one is available, and the Office of Patients' Rights.**

(d) Each hospital list of contraband items developed pursuant to subdivision (a), and the statewide list of contraband items developed pursuant to subdivision (b) are subject to review and approval by the Director of State Hospitals or his or her designee.

(e) A list of contraband items developed pursuant to subdivision (a) shall be updated and subject to review and approval by the director of the department, or his or her designee, no less often than every six months.

(f) If an item presents an **emergent danger to the safety and security of a facility, the item may be placed immediately on a contraband list** by the Director of State Hospitals or the executive director of the state hospital, but this placement shall be reviewed by the contraband committee, if applicable, and approved by the Director of State Hospitals or his or her designee within six weeks.

(g) **The lists of contraband items developed pursuant to this section shall be posted prominently in every unit of the hospital and throughout the hospital, and provided to a patient upon request.**

(h) **The lists of contraband items developed pursuant to this section shall be posted on the hospital's Internet Web site.**

(i) For the purposes of this section, "contraband" means materials, articles, or goods that a patient is prohibited from having in his or her possession because the materials, articles, or goods present a **risk to the safety and security of the facility**.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the hospital and the department may implement, interpret, or make specific this section without taking regulatory action.

7. Medi-Cal Patients' Rights

9 CCR § 1850.205-1850.215

9 CCR § 1850.205. General Provisions.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a problem or concern about any issue related to the MHP's performance of its duties under this Chapter, including the delivery of specialty mental health services.

(b) The MHP's beneficiary problem resolution processes shall include:

(1) A grievance process;

(2) An appeal process; and

(3) An expedited appeal process.

(c) For the grievance, appeal, and expedited appeal processes, found in Sections 1850.206, 1850.207 and 1850.208 respectively, the MHP shall ensure:

(1) That each beneficiary has adequate information about the MHP's processes by taking at least the following actions:

(A) Including information describing the grievance, appeal, and expedited appeal processes in the MHP's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 1810.360.

(B) Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of action pursuant to Section 1850.210. For the purposes of this Section, an MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain specialty mental health services.

(C) Making forms that may be used to file grievances, appeals, and expedited appeals, and self addressed envelopes available for beneficiaries to pick up at all MHP provider sites without having to make a verbal or written request to anyone.

(2) That a beneficiary may authorize another person to act on the beneficiary's behalf. The beneficiary may select a provider as his or her representative in the appeal or expedited appeal process.

(3) That a beneficiary's legal representative may use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf.

(4) That an MHP staff person or other individual is identified by the MHP as having responsibility for assisting a beneficiary, at the beneficiary's request, with these processes, including assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the MHP is the person providing specialty mental health services to the beneficiary requesting assistance, the MHP shall identify another individual to assist that beneficiary.

(5) That a beneficiary is not subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.

(6) That procedures for the processes maintain the confidentiality of beneficiaries.

(7) That a procedure is included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP for consideration in the MHP's Quality Improvement Program as required by Section 1810.440(a)(5).

(8) That the individuals making the decision on the grievance, appeal, or expedited appeal were not involved in any previous review or decision-making on the issue presented in the respective problem resolution process.

(9) That the individual making the decision on the grievance, appeal, or expedited appeal has the appropriate clinical expertise as determined by the MHP to treat the beneficiary's condition, if the grievance is regarding the denial of a request for an expedited appeal or if the grievance, appeal, or expedited appeal is about clinical issues.

(d) For the grievance, appeal, and expedited appeal processes found in Sections 1850.206, 1850.207, and 1850.208, the MHP shall:

(1) Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry shall include but not be limited to the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem.

(2) Record in the grievance and appeal log or another central location determined by the MHP the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary, or document the reason(s) that there has not been final disposition of the grievance, appeal, or expedited appeal.

(3) Provide a staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal.

(4) Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing.

(5) Identify the roles and responsibilities of the MHP, the provider, and the beneficiary.

(6) Notify those providers cited by the beneficiary or otherwise involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

(e) No provision of an MHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code, Section 5520.

9 CCR § 1850.210. Provision of Notice of Action.

(a) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP denies or modifies an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary.

(1) Except as provided in Subsection (c), when the denial or modification involves a request from a provider for continued MHP payment authorization of a specialty mental health service or when the MHP reduces or terminates a previously approved MHP payment authorization, notice shall be provided in accordance with Title 22, Section 51014.1.

(2) Notice is not required when a denial is a non-binding verbal description to a provider of the specialty mental health services that may be approved by the MHP.

(3) Notice is not required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request MHP payment authorization of additional specialty mental health services before the end of the approved duration of services.

(4) Except as provided in Subsection (b), notice is not required when the denial or modification is a denial or modification of a request for MHP payment authorization for a specialty mental health service that has already been provided to the beneficiary.

(b) A Notice of Action is required when the MHP denies or modifies an MHP payment authorization request from a provider for a specialty mental health service that has already been provided to the beneficiary when the denial or modification is a result of post-service, prepayment determination by the MHP that the service was not medically necessary or otherwise was not a service covered by the MHP.

(c) The MHP shall deny the MHP payment authorization request and provide the beneficiary of the MHP with a Notice of Action when the MHP does not have sufficient information to approve or modify, or deny on the merits, an MHP payment authorization request from a provider within the timeframes required by Sections 1820.220 or 1830.215.

(d) The MHP shall provide the beneficiary of the MHP with a Notice of Action if the MHP fails to notify the affected parties of a grievance decision within 60 calendar days, an appeal decision within 45 days, or an expedited appeal decision within three working days. If the timeframe for a grievance, appeal or expedited appeal decision is extended pursuant to Sections 1850.206, 1850.207 or 1850.208 respectively, the MHP shall provide a beneficiary of the MHP with a Notice of Action if the MHP fails to notify the affected parties of the grievance, appeal or expedited appeal decision within the extension period.

(e) The MHP shall provide a beneficiary of the MHP with a Notice of Action if the MHP fails to provide a specialty mental health service covered by the MHP within the timeframe for delivery of the service established by the MHP.

(f) The MHP shall comply with the requirements of Section 1850.212 regarding the content of Notices of Action and with the following timeframes for mailing of Notices of Action:

(1) The written Notice of Action issued pursuant to Subsections (a) or (b) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action, except that a Notice of Action issued pursuant to Subsection (a)(1) shall be provided in accordance with the applicable timelines of Title 22, Section 51014.1.

(2) The written Notice of Action issued pursuant to Subsections (c) or (d) shall be deposited with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires.

(3) The written Notice of Action issued pursuant to Subsection (e) shall be deposited with the United States Postal Service in time for pick up on the date that the timeframe for delivery of the service established by the MHP expires.

(g) When a Notice of Action would not be required under Subsections (a), (b), or (c), the MHP shall provide a beneficiary of the MHP with Notice of Action under this Subsection when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2), (b)(3)(C) or 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. A Notice of Action pursuant to this Subsection is not required when a provider, including the MHP acting as a provider, determines that a beneficiary does not qualify for a specific service covered by the MHP, including but not limited to crisis intervention, crisis stabilization, crisis residential treatment services, psychiatric inpatient hospital services, or any specialty mental health service to treat a beneficiary's urgent condition, provided that the determination does not apply to any other specialty mental health service covered by the MHP. The Notice of Action under this Subsection, shall, at the election of the MHP, be hand delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with Subsection (f)(1) and shall specify the information contained in Section 1850.212(b).

(h) For the purpose of this Section, each reference to a Medi-Cal managed care plan in Title 22, Section 51014.1, shall mean the MHP.

(i) For the purposes of this Section, “medical service” as cited in Title 22, Section 51014.1, shall mean specialty mental health services that are subject to prior authorization by an MHP pursuant to Subchapters 2 and 3, beginning with Sections 1820.100 and 1830.100, respectively.

(j) The MHP shall retain copies of all Notices of Action issued to beneficiaries under this Section in a centralized file accessible to the Department, the Department of Health Services and other appropriate oversight entities as specified in the contract between the Department and the MHP.

FORENSICS

The rights of people receiving mental health treatment vary depending on which forensic commitment they are being held under, otherwise known as their legal status, as well as their current placement (state hospital, jail, etc.). In recent years, there have been two significant changes to the rights of forensic patients—one is in the area of adoption of regulations to clarify patient rights for forensic commitments in state hospitals; the other is case law and subsequent legislation regarding the right to refuse psychotropic medications for certain forensic commitments.

JAIL INMATES

Mental health services in a jail must include: screening for mental health problems, crisis intervention and management of acute psychiatric episodes, stabilization and treatment of mental disorders, and medication support services (California Code of Regulations (CCR) Title 15, § 1209(a)). Use of restraints is governed by CCR Title 15, section 1058, while other rights such as library, correspondence, visiting, exercise, reading materials, access to phones, religion, and grievance procedure can be found at CCR Title 15, sections 1061-1073.

Transfer of patients from jail to acute psychiatric hospital

An inmate who had been identified as “mentally disordered” and who appears to be a danger to oneself or others, or to be gravely disabled, shall be transferred for further evaluation to a designated Lanterman Petris Short (LPS) treatment facility. They may be involuntarily held on an LPS hold where they will have the same rights as other LPS clients, including the right to change to voluntary status (Penal Code §§ 4011.6, 4011.8; CCR Title 15 § 1209(b)).

Upon transfer to the LPS designated facility, the transferee can only be held under the same provisions that apply to any other civilly committed individual, i.e., Welfare and Institutions Code sections 5150, 5250, 5260, 5300 and 5350. The transferee has a right to judicial review of the detention as specified in Welfare and Institutions Code section 5275 and all rights afforded patients under Welfare and Institutions Code sections 5325 et seq. (Penal Code §4011.6).

If the person is detained in a mental health facility, the time spent in the facility counts as part of the person's sentence. The person in charge of the jail or juvenile facility must inform the person in charge of the mental health facility of the expiration date of the person's sentence. If the person is to be released from a mental health facility before the completion of their sentence the facility must notify the jail or juvenile detention facility. The person would complete his sentence in jail or juvenile detention facility.

STATE PRISONERS

In general, before a prisoner can file a lawsuit regarding conditions in prison/conduct of staff, they must pursue an administrative appeal. California Department of Correction & Rehabilitation (CDCR) Form 602 must be used for this appeal.

Prison conditions

There has been extensive recent litigation regarding prison conditions. Much of this information can be accessed through the Prison Law Office, http://www.prisonlaw.com

Some of the major cases include the following:

Plata v. Davis (Schwarzenegger): Prisoners alleged that California officials inflicted cruel and unusual punishment by being deliberately indifferent to serious medical needs – has resulted in the courts ordering that California's prison medical care system be placed under the control of a court-appointed receiver. (case no. C01-1351 TEH). The case can be found at 2005 WL 2932253 (N.D. Cal).

Coleman v. Wilson: The court found that the entire mental health system operated by the California Department of Corrections was unconstitutional and that prison officials were deliberately indifferent to the needs of mentally ill inmates. All thirty-three institutions in the CDCR are presently being monitored by a court-appointed special master to evaluate the CDCR's compliance with the Court's order. The case is reported at 912 F.Supp.1282 (E.D. Cal. 1995).

Armstrong v. Davis (BPT): The trial court judge issued an order for the Board of Prison Terms to remedy its failure to comply with the Americans with Disabilities Act during parole hearings. The case was upheld by the Ninth Circuit Court of Appeals 275 F.3d 849 (2001)

Armstrong v. Wilson: After finding that the California Department of Correction was violating the Americans with Disabilities Act and the

Rehabilitation Act, the Court issued an injunction to improve access to prison programs for prisoners with physical disabilities at all of California's prisons and parole facilities. The case is reported at 942 F.Supp. 1252 (N.D. Cal. 1996) aff'd 124 F.3d 1019 (9th Cir. 1997).

Mental Health Treatment

Regulations regarding mental health services for prisoners can be found starting at CCR, Title 15 section 3360. Under CDCR regulations (CCR, Title 15, sec. 3363), inmates/Parolees shall be informed any time they are the object of particular mental health diagnosis or treatment program. They have the right to refuse such assignment without being subject to discipline or other deprivation, except:

(a) When mental health evaluation is required by law or court ordered

(b) When an inmate is placed in a mental health program for diagnostic study by the action of a classification committee, acting on specified information. A physician or other licensed practitioner may act in an emergency situation to place an inmate in psychiatric segregation under observation and treatment for a period of up to five working days pending classification action, providing the reasons for this action are documented.

(c) When diagnostic study has led to a diagnosis of existing or recurrent mental illness which renders the inmate dangerous to self or others, or gravely disabled.

(d) If there is a special condition of parole requiring attendance at a parole outpatient clinic, interviews may be imposed upon the parolee. However, no medication will be administered by these clinics without the specific informed consent of the patient

In a recent unpublished case, the Sixth District Court of Appeals found that imposing a probation condition of taking psychotropic medications as prescribed was not a violation of rights given the facts of the case. People v. Romayor, 2005 WL 3418274 (December 14, 2005, case no. H028599). The test for whether a condition of probation which requires or forbids conduct which is not itself criminal is valid is if that conduct is reasonably related to the crime of which the defendant was convicted or to future criminality." People v. Lent (1975), 15 Cal.3d 481 at 486, 124 Cal.Rptr. 905.

Prisoners and Psychotropic Medications

The state may only involuntarily medicate a prisoner in an *emergency situation* for up to 72-hours (Keyhea injunction Section III(J)[1]; CCR, Title 15 sec. 3364(a), and 1217; Penal Code § 2600) or after a judicial determination in compliance with the injunction process specified in Keyhea v. Rushen (1986), 178 Cal. App. 3d 526, 223 Cal.Rptr. 746. The Keyhea process is summarized below.

Certification for Involuntary Medication for Up to 21 Days

If either the prisoner doesn't meet the criteria for emergency medication or the facility wishes to administer involuntary psychiatric medications longer than 72 hours, a certification review hearing must take place to determine if probable cause to involuntarily medicate exists.

A notice of certification must be delivered to the prisoner and a hearing held before an administrative law judge within ten days (unless the prisoner files a writ of habeas corpus prior to the hearing) to determine if either the prisoner is:

1. Gravely disabled and incompetent to refuse medication; or,

2. Poses a danger to self or others as a result of a mental disorder. (Keyhea injunction, Section II(A)). Danger to others is defined in substantial accord with Welfare and Institutions Code section 5300 with "custody" being defined as confinement in an inpatient psychiatric unit (Keyhea injunction, Section I(4),(5))

Process for Involuntary Medication Beyond 24 Days

Involuntary medication beyond 24 days (including the initial 72 hours) requires a petition and court order from the superior court. The order authorizing involuntary medication must find, by clear and convincing evidence that the prisoner, as a result of mental disorder, is gravely disabled and incompetent to refuse medication or is a danger to self or others. (Keyhea injunction Section III(F))2 . The court has the authority to

[1] A copy of the Keyhea injunction may be found at http://www.documents.dgs.ca.gov/oah/forms/KEYHEA-67432.doc

[2] Keyhea injunction, Section I(4), III(I)(2); Department of Corrections v. Office of Admin. Hearings (1998) 66 Cal.App.4th 1100, 1108.

order an independent forensic psychiatrist to assist inmates in the hearing.3

Transfer of State Prison Inmate for Mental Health Treatment to Correctional Medical Facility (CMF)

Prison inmates transferred to Correctional Medical Facility for inpatient psychiatric treatment because of acute mental illness have the right to a hearing conducted by an independent psychiatrist regarding the necessity for transfer, if requested. The hearing must take place within seven days of the transfer. An adverse decision may be appealed within 30 days and is entitled to a ruling within 20 working days (California Code of Regulations (CCR), Title 15 § 3379(d)(3)).

Transfer of State Prison Inmate for Mental Health Treatment to Department of State Hospital

If the CDCR believes that treatment in a state hospital may expedite rehabilitation of a prisoner with a mental disability, it may, (with the approval of the Board of Parole Hearings for processing an indeterminate sentence), refer such prisoners to the Department of Mental Health (DMH) or to the Department of Developmental Services (DDS) (Penal Code § 2684).

Before the CDCR can transfer an inmate involuntarily under Penal Code section 2684, it must provide certain procedural rights. In Vitek v. Jones, the U.S. Supreme Court set out minimum due process requirements that must be met before transferring inmates to mental health facilities. Vitek v. Jones, 445 U.S. 480 (1980); CCR, Title 15 sec. 3369.1

[3] Department of Corrections v. Anthony, 53 Cal.App.4th 780, 790 (1997) (stating that the right to refuse treatment "is rendered meaningless if a person cannot adequately and through competent assistance of counsel and necessary experts challenge a psychiatric determination that he or she is competent to refuse antipsychotic medication.").

INCOMPETENT TO STAND TRIAL (IST) - Penal Code 1370

Defendants found incompetent to stand trial are those who, as a result of a mental disorder or developmental disability, cannot understand the nature of the criminal proceedings or assist their attorneys in conducting their defense (Penal Code § 1367).

Procedure

If, prior to judgment, a doubt arises in the mind of the judge as to the mental competence of the defendant, he or she shall state that doubt in the record and inquire of the attorney for the defendant whether, in the opinion of the attorney, the defendant is mentally competent, and then the court may order a hearing on the issue of mental competence in the superior court (by judge or jury) (Penal Code §§ 1368, 1369).

When a doubt regarding competency to stand trail is raised regarding a defendant with a developmental disability,[4] the court follows the procedures enumerated under Penal Code sections 1370.1 and 1370.4, including referring the defendant to a regional center for evaluation. These sections apply to all defendants with a developmental disability charged with either a felony or misdemeanor.

The law specifies that before a decision is made whether to hold a formal competency hearing for a defendant charged with only misdemeanors, the court must first refer him or her to a county mental health facility for evaluation and treatment pursuant to Penal Code section 4011.6 (involuntary commitment to a county facility for mental health evaluation under the LPS Act) (Penal Code 1367.1). This code section was held unconstitutional on equal protection grounds (a felony defendant is not required to undergo evaluation and treatment under LPS prior to a competency determination) by the Second District Court of Appeals (Pederson v. Superior Court (2003) 105 Cal.App.4th 931, 130 Cal. Rptr.2d 289). At this time, this decision is only binding (required to be applied) in the counties that the Second District Court of Appeals covers; advocates

4[7] "Developmental disability" means a disability that originates before age 18, continues indefinitely, and constitutes a substantial handicap. It includes mental retardation, cerebral palsy, epilepsy, and autism but excludes conditions solely physical or psychiatric in nature. Penal Code §1370.1(a)(1)(H).

are encouraged to research the state of the law in this area to see if there have been more recent changes.

The court may order the appointment of one psychiatrist or licensed psychologist (two if the defendant feels competent to stand trial). The psychiatrist or psychologist shall evaluate the defendant to determine if they are competent to stand trial, whether treatment with anti-psychotic medication is medically appropriate and likely to restore the defendant to competency, whether the defendant has the capacity to refuse anti-psychotic medicaiton, and whether the defendant is a danger to self or others (Penal Code § 1369).

Placement

If a Misdemeanor Incompetent to Stand Trial (MIST) defendant is found mentally incompetent after the 1369 hearing, the defendant cannot be committed to a state hospital unless there are no less restrictive placements available, and a contract for state hospital treatment exists between the county and the Department of Mental Health (Penal Code § 1370.01 (a)(2)(A)).

Misdemeanor defendants may also be placed directly in the Conditional Release Program (CONREP) for outpatient treatment (Penal Code § 1601(b)). The Conditional Release Program is discussed in section VIII of this chapter.

Felony incompetent to stand trial defendants usually receive evaluation and treatment at state hospitals. If the crime charged is a serious felony, inpatient treatment is mandatory. After six months at the state hospital, the felony defendant becomes eligible for CONREP outpatient treatment.

Felony defendants charged with nonviolent felonies may be placed directly in CONREP without spending any time as an inpatient (Penal Code §§ 1601(a) & (b), 1603).

For people committed as developmentally disabled IST commitments, the court considers the regional center's recommendation for placement. Placement may be in the state hospital, developmental center, or other specified residential or outpatient placements (Penal Code § 1370.1). If the defendant is charged with certain offenses requiring registration as a sex

offender or offenses considered a violent felony, options for placement may be restricted (Penal Code § 1370.1(a)(1)(B)(ii-iii)).

Maximum Commitment Term

The maximum commitment for a misdemeanor incompetent to stand trial defendant is one year or the longest permitted prison sentence for the crime charged, whichever is shorter (Penal Code § 1370.01(c)(1)). At the end of this time, conservatorship proceedings may be initiated (Penal Code 1370.01(c)(2)).

The maximum confinement time is the same for either an IST defendant who is charged with a felony or for an IST defendant who has a developmental disability: either 3 years or the maximum term of imprisonment provided by law, whichever is shorter. (Penal Code § 1370(c)(1)).

Restoring Competency

The commitment ends when (1) the IST defendant has spent the maximum allowable time in the treatment facility, or (2) the IST defendant is judged competent to stand trial.

The treatment facility makes regular written reports to the court about the IST defendant's mental condition (Penal Code §§ 1370(b)(1), 1370.01(b)), 1370.1(b)(1)).

If the treatment facility believes that the defendant has regained competence, the facility files a Certificate of Restoration of Competency with the court, which then holds a hearing to determine competency (Penal Code § 1372). Likewise, after 18 months, the court shall hold another hearing to determine competency (Penal Code §§ 1370(b)(2), 1370.1(b)(2)).

If the defendant believes that competency has been regained, but the treatment facility or community program director disagrees, the defendant may challenge the commitment by writ of habeas corpus (Welfare & Institutions Code § 7250; Penal Code § 1473).

Involuntary Medication of Incompetent to Stand Trial Commitments
An individual committed as incompetent to stand trial (IST), may only be involuntarily medicated with psychotropic medication if:

(1) There is an emergency (short term),
(2) Or if a court has found that
(a) An individual lacks capacity to refuse,
(b) The individual meets the Welfare and Institutions Code section 5300 criteria for dangerousness,
(3) Or, specific criteria regarding the necessity to medicate for restoration of competency to stand trial are met. (Cal. Penal Code § 1370(a)(1)(F)(2)(B)(ii) (I-III), 1370.01(a)(2)(B)(ii)).

The following requirements must be met, pursuant to Penal Code section 1370(a)(2)(B)(ii)(1)(III) and People v. O'Dell (2005) 126 Cal.App.4th 562, 23 Cal.Rptr.3d. 902 for the court to issue orders to involuntarily medicate an individual for the purposes of restoration of competency to stand trial:

- the people have charged the defendant with a serious crime against the person or property;
- involuntary administration of antipsychotic medication is substantially likely to render the defendant competent to stand trial;
- the medication is unlikely to have side effects that interfere with the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner;
- less intrusive treatments are unlikely to have substantially the same results; and
- Antipsychotic medication is in the patient's best medical interest in light of his or her medical condition (Penal Code section 1370(a)(2)(B)(ii)(1)(III)).

In any hearing on such a request the court shall make specific findings of fact with respect to:

(1) The important governmental interest at stake in bringing defendant to trial, considering the facts of defendant's individual case;
(2) The manner in which the governmental interests of timely prosecution and a fair trial are furthered by the medication, i.e., whether involuntary medication is substantially likely to render defendant competent to stand trial and is unlikely to have side effects

that interfere with defendant's ability to understand the nature of the criminal proceeding or assist counsel in the conduct of a defense in a reasonable manner;
(3) The necessity of the specific medication to further those interests, i.e., whether less intrusive treatments are unlikely to have substantially the same results; and
(4) The appropriateness of the specific medication to serve defendant's best medical interest in light of his medical condition.

The State must identify the following:
(1) The medical (psychiatric) condition it proposes to treat with the antipsychotic medication,
(2) The specific antipsychotic medication it proposes to administer,
(3) The likelihood the medication will render defendant competent to stand trial,
(4) The medication's side effects, and
(5) Any alternative, less intrusive treatments (People v. O'Dell (2005) 126 Cal.App.4th 562, 573-4, 23 Cal.Rptr.3d. 902, 908).

Continued Treatment
An IST defendant can be kept in treatment beyond the maximum commitment time if the defendant is placed on an LPS conservatorship or a *Murphy* conservatorship, or committed to the Department of Developmental Services under Welfare and Institutions Code section 6500.

MURPHY CONSERVATORSHIP – Welfare & Institutions Code 5358

If at the end of the commitment period, the defendant meets the criteria for a *Murphy* conservatorship, the commitment may be "extended."
This extension beyond the maximum period of commitment may be ordered for an IST defendant who:

(1) Remains incompetent,
(2) Has been charged with a violent felony which has not been dismissed, and
(3) Represents a substantial danger of physical harm to others (Penal Code § 1370(c)(2), Welfare & Institutions Code § 5008(h)(1)(B)).

The court may order the county public conservator to initiate *Murphy* conservatorship proceedings at any time after the defendant has served

the maximum term of confinement, or if treatment facility indicates there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future (Penal Code §§ 1370(c)(2), 1370(b)(1)).

Individuals Diagnosed with Mental Retardation

In addition, individuals diagnosed with mental retardation may be committed to the State Department of Developmental Services (DDS) under section 6500 et. seq. of the Welfare and Institutions Code if they are a danger to themselves or others. The definition of dangerousness to self or others includes being found incompetent to stand trial on charges of enumerated violent felonies. If the individual is confined in a facility, there is no requirement of a recent overt act to make a finding of dangerousness (Welfare & Institutions Code § 6500).

The DDS may place the individual in a state hospital, a developmental center, a licensed community care facility or a health facility for "suitable treatment", which is defined as the least restrictive residential placement necessary to achieve the purposes of treatment (Welfare and Institutions Code § 6509). The commitment lasts for a year and can be renewed (Welfare and Institutions Code §6500).

NOT GUILTY BY REASON OF INSANITY, NGI– Penal Code 1026

Defendants found Not Guilty by Reason of Insanity (NGI) are those who, because of a mental condition, were unable to understand the nature and quality of the crime committed, and (*or*) were unable to tell right from wrong when committing the crime (Penal Code § 25).

Placement

When the judge or jury finds a defendant NGI, the court will commit the defendant to a state hospital, a mental health facility, or an outpatient program (Penal Code § 1026). Before making any placement decision, the court must refer the defendant to the local community program director for a recommendation, which the court usually follows. If the underlying charge is a serious felony, as defined in Penal Code section 1601, the defendant must remain in a state hospital for at least six months before becoming eligible for outpatient treatment.

Restoration of Sanity

Restoration of Sanity is a two-step process.

At the first step, if the court finds that the NGI defendant no longer poses a danger to oneself or others because of a mental disorder, the defendant will be released to CONREP for a year for outpatient treatment.

At the second step, which occurs after a year in CONREP, the judge or jury determines whether the defendant has been "fully restored" to sanity. If so, the defendant is unconditionally released from CONREP (Penal Code §§ 1026.2(e), 1603, 1604)).

The community release provisions of Penal Code section 1026.2(e) do not apply if the individual has additional time to serve on a prison sentence (i.e., the crime for which the individual was found NGI was committed while they were already serving a prison sentence) or if restoration of sanity ends a stay of a previously imposed sentence (Penal Code § 1026.2(m)). Such individuals are not eligible for outpatient treatment and on a finding of restoration of sanity must be transferred to the Department of Corrections or the original sentencing court (Penal Code §1026.2(m)).

Outpatient treatment is further covered under the Conditional Release Program (CONREP) section VIII below.

Length of Commitment

A commitment is as long as the longest permitted prison sentence for the crimes the person was convicted of, including the upper term of the base offense and any additional terms for enhancements or consecutive sentences that could have been imposed. Credit for time served under Penal Code section 2900.5 (time in custody prior to imposition of sentence) may be deducted, but the term may not be reduced for good behavior or time worked while in custody (Penal Code § 1026.5(a)(1)).
The defendant is released from inpatient treatment when:

(1) sanity is "restored" and the defendant is released to CONREP as an outpatient, or

(2) the defendant has been in the hospital for as long as the maximum possible sentence for the underlying crime.

Continuing Treatment
The court may extend a defendant's commitment beyond the maximum term every two years if the underlying crime was a felony and if, by reason of a mental disorder, the defendant represents a substantial danger of physical harm to others (Penal Code §§ 1026.5(b)(l), 1026.5 (b)(8)). Under this provision, a defendant can remain hospitalized or committed indefinitely.

Involuntary Medication
The law governing persons committed as NGI's regarding their right to refuse medication is not clear.

In In re Locks (2000) 79 Cal.App.4th 890, 94 Cal.Rptr.2d 495, the California Court of Appeals concluded that individuals who are found to be not guilty by reason of insanity do not have a right to refuse medication. The court noted that under Keyhea, a judicial determination of incapacity and grave disability or that the prisoner poses a danger to self or others is required in order to involuntarily medicate; however, the Locks court reasoned that the judicial determination that the prisoner was not yet restored to sanity and not eligible for release under Penal Code Section 1026.2 creates the presumption that the patient is still a danger to self or others. Therefore, the person committed has no right to refuse medication.[5]

In In re Qawi, (see MDO section below for a discussion of this case), the California Supreme Court criticized the reasoning of the Locks court. First,

[5] In re Locks, 79 Cal.App.4th 890, 896 (2000).

the court stated that persons committed as NGIs should have their own specific criteria for suspending the right to refuse and that the application of Penal Code Section 2972(g) was not obvious.[6] Second, the court stated that "dangerousness to others" cannot be presumed because of a denial of release. Rather, "particular findings of recent acts of dangerousness pursuant to Welfare and Institutions Code Section 5300" are required.[7] Further, the Calhoun Court's application of Qawi's equal protection analysis to SVPs would seem to extend to NGIs as well. See In re Calhoun (2004) 121 Cal. App. 4th 1315, ***Cal.Rptr.2d***.

The California Supreme Court did not overrule the Locks case in deciding Qawi because the issue of whether Penal Code section 2972(g) (the code section relied on in Qawi) applies to NGI's was not explicitly before them.

MENTALLY DISORDERED OFFENDERS, MDO – Penal Code 2962 et al

[6] In Re Qawi, 32 Cal.4th 1, 27 (2004).

[7] Id.

An individual may be subject to treatment as a Mentally Disordered Offender (MDO) if they are a prisoner who, at the time of or upon termination of parole, meets the following criteria (Penal Code §§ 2960, 2962):

> (1) The prisoner has a treatable, severe mental disorder that was one of the causes of the commission of the crime, for which the defendant was incarcerated,
> (2) The disorder is not in remission or cannot be kept in remission without treatment,
> (3) The prisoner has been in treatment for the disorder for 90 days or more in the year prior to her parole or release date,
> (4) The disorder causes the prisoner to be dangerous to others, and
> (5) The crime for which the prisoner is was incarcerated involved force or violence or caused serious bodily injury as specified in Penal Code section 2962(e).

If the individual disagrees with the recommendation, they may request a Board of Parole Hearings (BPH) (Penal Code §2966(a)). If the BPH rules against the individual a petition may be filed in superior court challenging the determination (Penal Code § 2966(b)). After 60 days of inpatient treatment, the individual may request a hearing regarding outpatient treatment (Penal Code § 2964(b)).

Placement
Once certified, the inmate is committed for inpatient treatment at a state hospital, unless designated officials from DMH certify that outpatient treatment is appropriate or the inmate wins an outpatient hearing before the BPH (Penal Code § 2964). When outpatient placement is found to be appropriate, MDO parolees go into the Conditional Release Program (CONREP).

Length of Commitment
MDO commitment is technically a special condition of parole, and thus lasts the length of the parole period. The length of the parole period is determined by statute, and depends on the type of sentence imposed. Most prisoners have a maximum parole period of three years (Penal Code §§ 3060.5, 3057).
If a prisoner's severe mental disorder is not in remission or cannot be kept in remission without treatment, and if the parolee is therefore dangerous to

others, involuntary MDO commitment may be extended beyond the period of parole in one year increments, potentially indefinitely (Penal Code §§ 2970, 2972(c)).

Revocation of Outpatient Status

The community program director may revoke outpatient status when the MDO parolee cannot remain safely or receive effective treatment in the community. The MDO parolee has the right to a revocation hearing conducted by the DMH within 15 days of being placed in a secure mental health facility, or within 21 days if good cause exists. In lieu of revocation, the community program director or DMH may also hospitalize an MDO parolee pursuant to the LPS civil commitment scheme (Penal Code § 2964(a)).

Involuntary Medication

A person committed as an MDO can be compelled to take antipsychotic medication in a non-emergency situation only if a court, at the time the person is committed or recommitted, or in a separate proceeding, makes one of two findings:

> (1) The person lacks the capacity to make decisions about his medical treatment; *or*
> 2) The person is dangerous within the meaning of Welfare and Institutions Code section 5300.

The rights of persons committed as MDO's to refuse medication can be further limited by State Department of Mental Health regulations necessary to provide security for inpatient facilities[8] (In re Qawi (2004) 32 Cal.4th 1, 9-10, 7 Cal.Rptr.3d 780).

Section 5300 requires two types of findings of dangerousness. First, there must be a generalized finding of "demonstrated danger" to others. "Demonstrated danger may be based on assessment of [the person's] present mental condition, which is based upon a consideration of past behavior of the person within six years prior to the time the person attempted, inflicted, or threatened physical harm upon another, and other relevant evidence." (Welfare & Institutions Code, § 5300.5).

[8] Currently, the State Department of Mental Health has not adopted any such regulations. DMH Special Orders or Administrative Directives have not gone through the process of being adopted as regulations.

In addition to demonstrated danger, one of the following findings establishing recent[9] acts or threats of violence must be made in order to effect a section 5300 commitment;

(a) The person has attempted, inflicted, or made a serious threat of substantial physical harm upon the person of another after having been taken into custody, and while in custody, for evaluation and treatment ,
(b) The person had attempted, or inflicted physical harm upon the person of another, that act having resulted in his or her being taken into custody,
(c) The person had made a serious threat of substantial physical harm upon the person of another within seven days of being taken into custody, that threat having at least in part resulted in his or her being taken into custody.
(Welfare & Institutions Code § 5300; see also Welfare & Institutions Code § 5304, subd. (a), In re Qawi (2004) 32 Cal.4th 1, 20).

MENTALLY DISORDERED SEX OFFENDER

The MDSO statutes were repealed in 1982. However, persons committed as MDSOs before the repeal date can remain under such commitments subject to the continuing jurisdiction of the repealed statutes. A Mentally Disordered Sex Offender is any person who, by reason of a mental disorder, has a predisposition to commit sexual offenses to such a degree that the defendant is a danger to the health and safety of others. (former Welfare & Institutions Code §§ 6300-6331; Historical Note to Welfare & Institutions Code § 6300).

SEXUALLY VIOLENT PREDATORS, SVP – Welfare & Institutions Code 6600 et al

[9] In footnote 7 of the case, the Qawi court interpreted "recent" for MDO's to mean within the year prior to the commitment or recommitment.

The term "sexually violent predator" means a person who:

1) Has been convicted of a sexually violent offense against two or more victims, and
(2) Has a diagnosed mental disorder,
(3) The disorder makes him/her a danger to the health and safety of others in that it is likely that he or she will engage in sexually violent predatory criminal behavior (Welfare and Institutions Code § 6600(a)(1)).

"Sexually violent offense" means an act specified in Welfare and Institutions Code section 6600, subdivision (b) when committed by force, violence, duress, menace, or fear of immediate, and unlawful bodily injury on the victim or another person or when committed on a child under the age of fourteen years and the offending act or acts involve “substantial sexual conduct” as defined in Welfare and Institutions Code section 6600.1, and when the act results in a conviction or a finding of not guilty by reason of insanity (Welfare and Institutions Code § 6600(b)).

"Predatory" means an act is directed toward a stranger, a person of casual acquaintance with whom no substantial relationship exists, or an individual with whom a relationship has been established or promoted for the primary purpose of victimization (Welfare and Institutions Code § 6600(e)).
SVP commitments may only be sought for prisoners under sentence to the Department of Corrections or whose parole has been revoked (Welfare and Institutions Code § 6601(a)). If the screening finds that the individual is likely to be an SVP, the individual is referred for a “full evaluation” by the Department of Mental Health (Welfare and Institutions Code § 6601 (c)). If the appointed mental health professionals agree that the prisoner meets SVP criteria, information is forwarded to the county that convicted the prisoner (Welfare and Institutions Code § 6601(d-i)).
If the district attorney or county counsel decides to file a petition for commitment, a probable cause hearing and trial are held (Welfare and Institutions Code § 6602). SVP’s are committed by the court to the custody of DMH for a two-year term, with a right to annual review (Welfare and Institutions Code §§ 6604, 6605). If a court finds the person is no longer an SVP, they are unconditionally released and discharged.

Placement

Men committed under Welfare & Institutions Code section 6600 (pre-trial detainees) are held at Atascadero/Coalinga State Hospital or in county jail as they wait a probable cause hearing. Once the judge or jury has determined the person is a sexually violent predator they are committed to Atascadero/Coalinga State Hospital in the custody of the Department of Mental Health. Women committed under this section are placed at Patton State Hospital.
After confinement of at least a year, an SVP may be placed in a conditional release program if a court finds at a hearing that the person would not be a danger to the health and safety of others in that it is unlikely that he or she will engage in sexually violent criminal behavior owing to his or her diagnosed mental disorder if under supervision and treatment in the community (Welfare and Institutions Code §§ 6607, 6608).

Involuntary Medication
In a non-emergency, an SVP has the right to refuse the involuntary administration of antipsychotic medication unless found by a court to be incompetent to refuse treatment or to be a danger to others (In re Calhoun (2004) 121 Cal App. 4th 1315, 1354, 18 Cal Rptr.3d 315).

Treatment
According to the State DMH website, the treatment program for people in the SVP program, is structured into five phases.
1. Treatment Readiness
    (a) Facilitates the participants' transition from the prison culture to the treatment environment.
    (b) Prepares participants to take an active role in their therapy.
    (c) Uses didactive methods to educate participants on such topics as hospital attitudes, interpersonal skills, anger management, mental disorders, victim awareness, cognitive distortions, and relapse prevention

2. Skills Acquisition
    (a) Shifts participants' focus from education and preparation to personal therapy.
    (b) Teaches coping strategies, behavioral skills, pro-social thinking, and emotional awareness, to increase self-control.
    (c)Requires that the participants:
    Acknowledge and discuss past sexual offenses;
    Express a desire to reduce their risk of re-offending;

Agree to participate in required assessment procedures;
Be willing and able to conduct themselves appropriately in a group setting.

3. Skills Application

(a)Integrates the skills participants learned during Phase II into their daily lives.

(b)Broadens and deepens their skills in relapse prevention, coping with cognitive distortions, and developing victim awareness.

(c)Causes participants to examine their daily experience in unit life and to practice their behavioral interventions through extensive use of journals and logs.

(d)Requires that participants:

- Accept responsibility for past sexual offenses;
- Articulate a commitment to abstinence that is reflected in current behavior;
- Understand the trauma resulting from their sexual crimes;
- Are able to correct deviant thoughts;
- Demonstrate ability to manage deviant sexual urges and impulses;
- Show good ability to cope with high risk factors for re-offending;
- Cooperate with institutional supervision;
- Display skills necessary for self-regulation;
- Demonstrate ability to maintain appropriate relations with female staff;
- Display skills necessary to avoid emotional identification with children.

4. Discharge Readiness

(a)Develops a detailed Community Safety Plan developed in conjunction with the offender's assigned Conditional Release Program (CONREP).

(b)Involvement of family members and significant others in the relapse prevention plan.

(c)Focuses on how the skills in relapse prevention, managing cognitive distortions, victim empathy, and coping strategies will generalize and transfer to the community setting.

(d)Treatment teams must determine that participants:
Can fully describe the negative impact of abuse on their victims;
Acknowledge and accept past sexual offenses

Articulate commitment to abstinence;
Correct all cognitive distortions;
Able to control deviant sexual urges and interests;
Can describe a complete range of prospective high-risk factors and internal warning signs;
Cope with risky situations and thinks in ways that reduce his likelihood for re-offending in their daily lives;
Follow rule and comply with requirements of supervision;
Display no inappropriate impulsivity or inappropriate emotions;
Relate well with women and able to avoid emotional identification with children;
Conditional Release Program in the county of commitment is willing to accept participant into outpatient treatment and supervision.

5. Community Outpatient Treatment under CONREP

(a) Is administered in the offenders' county of commitment.
(b) California Superior Court approves and orders placement into this final phase of treatment.
(c) Transfers the site of ongoing treatment from ASH/CSH to the community setting.
(d) Provides intensive on-going supervision and monitoring to facilitate early detection of relapse and ensure community safety.

http://www.dmh.ca.gov/Statehospitals/Coalinga/Treatment.asp

CONDITIONAL RELEASE PROGRAM (CONREP)

CONREP is a statewide program of mental health outpatient treatment in local communities under court supervision. When an individual is committed to CONREP, the individual remains within the constructive custody of the Department of Mental Health (DMH) (Penal Code §§ 1605, 1615). Courts may order immediate outpatient commitment with CONREP instead of confinement in a state hospital if the defendant's crime was not classified as dangerous and if the community program director reports that the defendant will not be a danger to the health and safety of others and will benefit from such outpatient status (Penal Code §§ 1601,1602).
People on Incompetent to Stand Trial (IST), Not Guilty by Reason of Insanity (NGI), Mentally Disordered Offender (MDO), and Mentally Disordered Sex Offender (MDSO) commitments are all eligible for

outpatient placement in the CONREP program. Individuals on Sexually Violent Predator (SVP) commitments are also eligible for CONREP.
Note that NGI defendants must be committed to CONREP for one year before they can be fully "restored to sanity" and unconditionally released.

Placement
The director of the state hospital or treatment facility, along with the community program director, must recommend to the court that the defendant would benefit from outpatient status, and would not be a danger to the health and safety of self or others. Once completed, the court then holds a hearing to approve the outpatient plan (Penal Code §§ 1603, 1604). Persons committed under NGI may also petition the committing court themselves for release to the CONREP program (Penal Code 1026.2).

For MDO patients, however, the Board of Parole Hearing (BPH), rather than the court, makes the decision about CONREP placement (Penal Code § 2964(a) and (b)).

NGI and IST defendants charged with serious felonies as defined in must first spend six months in the state hospital or other mental health facility before they are eligible for CONREP placement (Penal Code § 1601).

Length of Commitment
CONREP outpatient status lasts for one year, and is subject to renewal. After one year, the court must hold a hearing no later than 30 days from the one-year anniversary and renew, revoke, or discharge the patient from CONREP (Penal Code § 1606). For MDSOs, NGIs, and MDOs, time spent on outpatient status, except when placed in a locked facility, is not counted as actual custody and is not credited towards the person's maximum term of commitment (although for MDOs, their maximum period of parole is not extended by placement in CONREP) (Penal Code § 1600.5).
Once per year, patients on NGI commitments may also seek release from outpatient commitment by applying for complete restoration of sanity (Penal Code § 1026.2).

Revocation
If at any time during the outpatient period, the outpatient treatment supervisor is of the opinion that the person requires extended inpatient treatment or refuses to accept further outpatient treatment and supervision;

the community program director shall request revocation of outpatient status from the superior court (Penal Code § 1608). In addition, if at any time during the outpatient period or placement with a local mental health program pursuant to subdivision (b) of Section 1026.2 the prosecutor is of the opinion that the person is a danger to the health and safety of others while on that status, the prosecutor may petition the court for a hearing to determine whether the person shall be continued on that status (Penal Code § 1609).

The CONREP director may confine the patient to a mental health facility, or even a jail, pending the revocation hearing if the defendant determines that the patient is dangerous to self or other (Penal Code § 1610). However, CONREP may house the patient in the county jail only if the jail provides treatment for the patient, as well as security for both the patient and the other inmates. The patient must be separated from the general population of the jail (Penal Code § 1610(b)).

The CONREP director must submit a written application for the court's consideration within one judicial day of the transfer stating the justification for jail confinement (Penal Code § 1610(a)). A CONREP patient confined in a facility pending revocation has the rights under Welfare and Institutions Code section 5325 and may file a writ of habeas corpus protesting the confinement (Cal. Penal Code § 1610(c)).

Inmate-Patient Advocacy in California County Jails

March 3, 2016

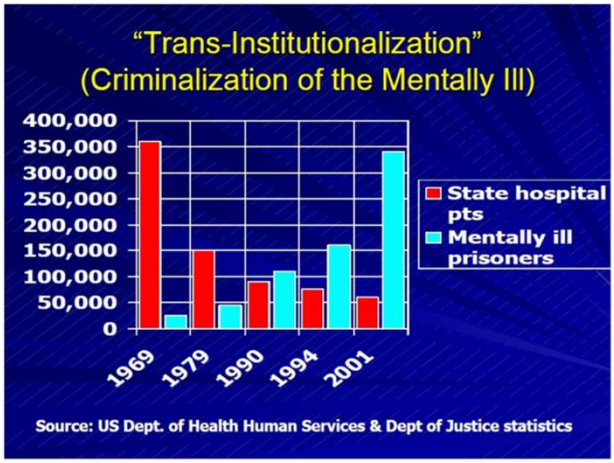
Rebecca Cervenak, Staff Attorney, Disability Rights California

Samuel Jain, Patients' Rights Attorney, Law Foundation Of Silicon Valley

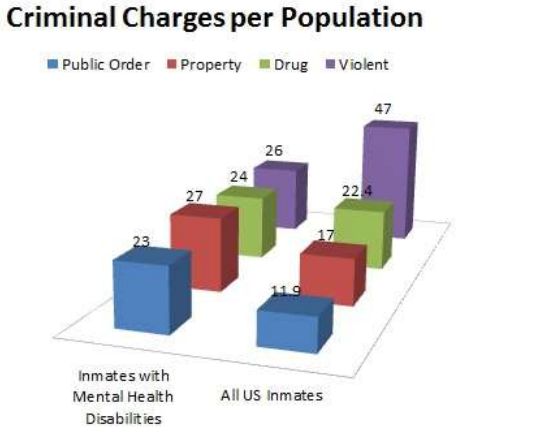
Inmates with Mental Health Disabilities

- **Sharp spike in number of inmates with mental health disabilities over the past 50 years.**
  - Around 25,000 in 1969 to nearly 350,00 in 2001.
- **Some Factors**
  - Deinstitutionalization
  - Criminalization of the Homeless
- **Led to Transinstitutionlization**

Inmates with Mental Health Disabilities



Inmates with Mental Health Disabilities



Source: US Dept of Justice 2008; NAMI 2006

PRA Authority

- Duties of patients' rights advocates apply to **every LPS correctional treatment center**.
- Authority extends to **any inmates receiving mental health treatment** in jail.
- County Patient's Rights Advocates have a right of access to county jail inmates, inmate records, jail facilities, and jail employees providing diagnostic and treatment services. Welfare & Institution Code §5500, et seq.
- Welfare and Institutions Code section 5530(a) provides that county patients' rights advocates (PRAs) shall have access to "all clients and other recipients of mental health services" in any mental health facility, program, or service at all times as are necessary to investigate or resolve specific complaints…."

LPS Designated Jail Units

- **Jails with LPS Designated Units in California:**
  - Twin Towers, Los Angeles
  - Orange County Jail
  - Sacramento County Jail
  - Santa Clara County Main Jail
  - San Diego Central Jail
  - Los Colinas Detention Facility, San Diego

LPS Designated Jail Units

- In 1996, regulations changed requiring Correctional Treatment Centers (CTCs) obtain licensure by complying with state standards.
- Many LPS designated jail units in California are designated by their respective county, but do not meet state standards.
- What does this mean?
  - Less monitoring from other authorities.
  - More likely to be out of compliance with inmate-patients' rights laws.

CTC Specific Patients' Rights

- Right to be informed of inmate-patient rights
- Right to be informed of facility services
- Right to an opportunity to discuss treatment with one's physician
- Right to informed consent
- Right to be informed of and access grievance forms
- Right to be free from mental and physical abuse
- Right to be free from unnecessary seclusion and restraint and emergency medication
- Right to confidential treatment
- Right to be treated with consideration, respect, and dignity
- Right to refuse ECT
- Right to refuse psychosurgery
- Right to review medical records, unless specific criteria is met
- Right to be free from discrimination

22 CCR § 79799

Application of LPS Patients' Rights to CTCs

- "**Inmate-patients will be afforded such rights as are commonly afforded to medical/mental patients and are consistent with jail or prison policies and procedures."**
- WIC §§ 5325 and 5325.1 LPS rights apply unless inconsistent with jail or prison policies.
- DOC "safety and security" trump card.
- Inmate-patients' rights sheets from Santa Clara County, Orange County, and Sacramento County.

Application of LPS Patients' Rights to CTCs

- **Seclusion and restraint standard**
  - Same
- **Emergency medication standard**
  - Same
- **Denial of inmate-patients' rights**
  - Denial by clinical staff
    - "Good cause" standard
    - Doctor's order
  - Denial by corrections staff
    - To maintain safety and security at the jail

Other Inmate Rights

- Visitors
- Correspondence
- Library service including access to legal reference materials
- Exercise and recreation
- Access to telephones
- Access to the courts and counsel
- Voting
- Religious observances

Title 15 §§ 1061 - 1072

Mental Health Services

Each jail must have policies and procedures to provide mental health services. These services shall include but not be limited to the following:

1. Screening for mental health problems,
2. Crisis intervention and management of acute psychiatric episodes,
3. Stabilization and treatment of mental disorders, and
4. Medication support services.

Title 15 § 1209(a)

Important Laws

- **8th Amendment to the U.S. Constitution**
- **Americans with Disabilities Act (ADA)**
- **Section 504 of the Rehabilitation Act**
- **Title 15 of California Code of Regulations**

- **Prison Litigation Reform Act**
  - Limits Attorney's Fees
  - Exhaustion Requirements
    - Exceptions
    - Even if you think there is an exception, use the jail grievance system!!

Types of Lawsuits

- Inadequate Health Care
- Excessive Force
- Failure to Protect
- Disability Discrimination

"Constitutionally Adequate" Mental Health Care

- Screening system
- Trained mental health professionals and sufficient staffing
- Accurate, complete, and confidential mh record
- Safe psychotropic medication prescriptions
- Suicide prevention program
- Treatment
- Inmate requests and Grievance procedure

Deliberate Indifference

Two elements:

(1) The seriousness of the inmate's medical need; and

(2) The nature of the defendant's response to that need. *McGuckin v. Smith,* 974 F.2d 1050, 1059 (9th Cir. 1992) (overruled on other grounds).

Restraint & Seclusion

- **Involuntary Medication**
- **Restraint**
- **Seclusion:**
  - Solitary Confinement
  - Safety Cells
  - Sobering Cells

Solitary Confinement

- Isolation and solitary confinement in correctional facilities are generally considered to be situations in which prisoners are held in their cells, alone or with a cellmate, for 22 to 24 hours per day.
- Prisoners are in solitary because they are: maximum security, administrative segregation or protective custody, or subject to short-term discipline.
- Even a short stay in conditions of extreme isolation is likely to worsen prisoners' mental health symptoms.

Out of Cell Time

For prisoners with a serious mental illness in segregation, the specialized mental health program should offer at least 10 to 15 hours per week of out-of-cell structured therapeutic activities in addition to at least another 10 hours per week of unstructured exercise or recreation.

Compare with Title 15's 3 hour requirement

Safety Cells

- Safety cells are small, windowless rooms, with rubberized walls, a pit toilet in the floor, and no furniture, bedding or source of water.
- Prisoners are not permitted normal clothing and are typically given only a blanket or "suicide smock." They are not provided with regular access to showers, telephones, outdoor recreation, visitation, or any out-of-cell time whatsoever.

Inmate Requests & Grievances

- Different types
- Administrative Remedies
- Must Exhaust *all* levels of internal grievance procedure!!

DRC Investigations

- Sacramento County Jail
- Santa Barbara County Jail
- San Francisco Juvenile Hall
- Sonoma County Jail
- San Diego County Jail
- San Diego Juvenile Hall

PRA Advocacy in Jail – What You Can Do!

- Advocate for adequate mental health services.
- Train jail staff on mental health law.
- Referring abuse complaints.

Outside Resources

- Prison Law Office – Berkeley, CA
- Root & Rebound – Oakland, CA
- Disability Rights California
- NAMI California

Contact Info

Rebecca Cervenak
Staff Attorney
Disability Rights California
(619) 239-7861
rebecca.cervenak@disabilityrightsca.org

Samuel Jain
Patients' Rights Attorney
Law Foundation of Silicon Valley
Mental Health Advocacy Project
(408) 280-2450
samuel.jain@lawfoundation.org